STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185237	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee Park Rehabilitation	2100 Cherokee Ridge Way Louisville, KY 40205

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 20402 Based on observation, interview, record review, and facility policy review, the facility failed to ensure one of 23 sampled residents (R) had a properly functioning bed, R47. R47 was observed to have a bed with a mattress that was sunken in and concaved on the right side. Observation additionally revealed the resident's electric bed was not functioning properly, as it did not raise up or down and the head of the bed also did not raise up or down. The findings include: Review of the facility's policy titled, Resident Rights, dated 03/22/2022, revealed, The resident has the right to a dignified existence . Per review of the policy, The resident has a right to be treated with respect and dignity, including: The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents .The resident has a right to a safe .comfortable and homelike environment including but not limited to receiving treatment and supports for daily living safely. Review of R47's undated Face Sheet located in the electronic medical record (EMR) under the Resident tab, revealed the facility admitted the resident on 04/14/2023 with diagnoses which included: other displaced fracture of upper end of left humerus, muscle weakness, and generalized anxiety disorder. Review of the Annual Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 03/30/2024, revealed the facility assessed R47 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact. (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: 185237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Cherokee Park Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 Cherokee Ridge Way Louisville, KY 40205	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 06/10/2024 at 1:40 PM, R47 was observed in her room sitting in a chair next to the bed. In interview during the observation, R47 stated, My bed is broken. I can't get it to go up or down and the mattress is sunken in on the right side. R47 stated, It has been like this for a while. Observation of R47's bed revealed the blue foam mattress was visibly sunken in and concaved on the right side, and the bed was plugged into the wall socket. When the up/down buttons were pushed at the foot of R47's bed, the bed did not raise or lower and the head of the bed did not raise or lower. Continued observation revealed when the up/down buttons were pushed on the right rail the bed did not raise or lower and the head of the bed did not raise or lower. During the interview, when R47 was asked if she had told anyone her bed was not working, she stated, Yes. They know about it. A guy came to look at it one time, but as you can see it's still not working. Interview with R47's family member, who was also present in the room at the time, the family member stated, When I came in to visit today, I noticed it right away and asked her why the bed was sunken in. I tried to make it go up and down and it's not working. R47 further stated, If you could get them to fix my bed that would be great. During an observation on 06/11/2024 at 9:24 AM, R47 was observed sitting in the hallway in her wheelchair. Observation of R47's room revealed the bed, present in the room the day before, was gone. Continued observation revealed the mattress from the bed, was observed in the room lying against the closet door. During interview at the time of observation, when R47 was asked where her bed was, she stated, They took it away this morning because it was broken. I slept in it last night. I woke up in it. I ate my crackers then evidently when I was in the shower they came and got it. I don't know what happened to it and now it's gone. During an interview on 06/11/2024 at 9:28 AM, Licensed Practical Nurse (LPN) 2 stated, R47 is not able to get in and out of bed on her own. She needs you to stand her up to transfer her with one person. When asked what happened to R47's bed which had been in her room, LPN 2 stated, They were going to switch the mattress out, but the head of the bed wouldn't raise up. I let the maintenance man know. When I was giving her medications this morning around 9:00 AM, the head of the bed wouldn't raise up. I sat her up in bed so she could take her medications. During observation on 06/11/2024 at 9:33 AM, the Maintenance Director was observed bringing a new bed down the hall and pushing it into R47's room. In interview at the time of observation, the Maintenance Director was asked if there had been problems with R47's previous bed in her room the day before or if there were any issues with the mattress, he stated, The motor actuator was starting to go out and the motor function wasn't functioning properly on the feet. They asked me to come about an hour ago to look at it When asked if there had been any issues brought to his attention before about R47's bed not working, he stated, No. It was a Jornes bed. Usually they work fine, but the actuator was a problem. Just today was when I was told the resident needed a new mattress. When I checked the bed this morning, I saw it was not working. The mattress also looked like over time it was caved and sunken in. I could visually see that it was sunken in. The Maintenance Director stated he had not been made aware of the bed not working until that morning and stated, No work orders have come my way. He further stated, I would have expected the staff to put in a work order. We use the TELS [electronic system for tracking repairs) system, and they all have access to it. In an additional interview on 06/11/2024 at 3:58 PM, the Maintenance Director stated that he Does quarterly audits where he goes around and checks the beds to make sure they are functioning. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During further interview on 06/11/2024 at 4:09 PM, the Maintenance Director stated he performed bed audits in April 2024, but Did not do a bed check on this side of the unit where R47's room was, and her side had not been done since October 2023. Review of the Direct Supply-Logbook Documentation, provided by the Maintenance Director, with dates from 04/22/2024 through 04/24/2024, revealed R47's bed was not one of the beds checked on the log to ensure it was functioning properly. Review of Work Orders pertaining to R47's room and provided by the Maintenance Director, revealed no work orders present for R47's bed. During an interview on 06/14/2024 at 11:33 AM, the Director of Nursing (DON) was asked if she was ever made aware of R47's bed not working properly. The DON stated, No, nothing had come to my attention. My expectation would be that the CNAs (Certified Nursing Assistants) tell the nurses then I would expect the nurse to put in a work order into the TELS system and report to maintenance. During an interview on 06/14/2024 at 11:42 AM, the Administrator stated, I would expect my staff to notify the responsible department and maintenance should be notified so he could see why it was not working. I would also expect maintenance to get a work order and look into it.

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NAME OF PROVIDER OR SUPPLIER Cherokee Park Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 Cherokee Ridge Way Louisville, KY 40205	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20402 Based on observation, interview, record review, and facility policy review, the facility failed to ensure resident choices regarding showers were honored for one resident (R) out of 23 sampled residents, R75. By not honoring resident's choices and/or preferences for bathing, the resident may not receive the care and services needed. The findings include: Review of the facility's policy titled, Resident Rights, dated 03/22/2022, noted, The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Continued review revealed The resident has a right to be treated with respect and dignity .Self-determination. The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice. Review of R75's undated Face Sheet located in the resident's electronic medical record (EMR) under the Resident tab, revealed the facility admitted on [DATE] with diagnoses to include pneumonia, major depressive disorder, muscle weakness, osteoarthritis, and malignant neoplasm of an unspecified part of right bronchus or lung. Review of R75's Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 05/29/2024 and located in the resident's EMR under the RAI tab, revealed the facility assessed R75 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. Per MDS review, the facility assessed R75 to have had no behaviors of rejection of care. Continued review of the MDS revealed R75 answered the questions herself regarding her daily and activity preferences. Further review revealed it was Very Important for R75 to choose what clothes to wear; Very Important to choose between a tub bath, shower, bed bath, or sponge bath; and Very Important to choose her own bedtime. Review of R75's Care Plan dated 05/25/2024 and located in the EMR under the RAI tab, revealed I would like to participate in independent activities of interest daily. Review of the care plan further revealed R75 had an ADL (Activity of Daily Living) self-care performance deficit r/t [related to] weakness. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/10/2024 at 11:00 AM, reveled R75 lying on her bed. In an interview, at the time of the observation, when asked by the Surveyor, Do you get showers regularly? the resident stated, Well, no. They told me I refused a shower last night. Someone just came in my room last night around 9:00 PM and said they were here to give me a shower. I told them no. I said that it was too late to be getting a shower this late. R75 stated, I told them I prefer to wash up every morning. I was already groggy and laying in my bed and someone just came in and said it was time for my shower. The resident stated, It upset me because I was already tired and sleepy. They told me I had to sign a paper. I guess saying I refused. All I remember was someone came in, saying it's your shower time. I told them, I think it's too late. Then I was told I had to sign a paper. I was too sleepy to even realize what I was signing. Review of an undated, A Wing Shower Schedule, located at the A wing nurses station, revealed various resident room numbers with certain days for showers on Mondays and Thursday, Tuesday and Friday, and Wednesday and Saturday to be given from 6:00 AM-6:00 PM. Continued review revealed other resident room numbers with certain days for showers to be given on Mondays and Thursday, Tuesday and Friday, and Wednesday and Saturday on night shift from 6:00 PM-6:00 AM. Further review of the A wing Shower Schedule revealed it listed R75's room as showers to be given on Wednesday and Saturdays on night shift from 6:00 PM -6:00 AM. Review of the CNA (Certified Nursing Assistant) Shower sheet located in the back of the A wing Shower schedule, dated 06/08/2024 and timed as 7:30 PM, noted Resident said it was too late. Further review of the CNA Shower sheet revealed a box at the bottom right-hand corner of the document that noted, If resident refuses shower/bath, please have resident sign that they refuse. As well as nurse and CNA that offered. Review of R75's Care Plan, dated 06/10/2204 and located in the EMR under the RAI tab, revealed Problem: Resident resists care (refused shower). Continued review revealed the approaches listed were: Convey an attitude of acceptance toward the resident. Maintain a calm environment and approach the resident. Reiterate the purpose and advantages of treatment for the resident. Encourage the resident to express fears and feelings. Clarify misunderstandings. Review of the Progress Notes dated 06/12/2024, located in the EMR under the Resident tab, documented Spoke with resident regarding shower preference. Moved to day shift Tuesday and Friday. Resident states understanding and in agreement with days. Review of the Progress Notes prior 06/12/2024, revealed no documented evidence to show communication took place to ask when or what days R75 would prefer to have her showers. During an interview on 06/12/2024 at 8:42 AM, Certified Nursing Assistant (CNA) 2 stated, We have a shower book at the nurse's station. It shows who is scheduled for showers on day shift and night shift for all of A wing. We have a set schedule that has been like this since I've been here for eight months now. It lists who gets showers on days and nights. When the Surveyor reviewed the A Wing Shower Schedule with CNA 2, she stated, The shower schedule shows that she (referring to R75) is a night shift shower. When the Surveyor asked CNA 2 who determined which residents got showers on days versus nights, the CNA stated, I'm not sure. If there are some people who want a shower in the morning time on days, we can always run it by the Unit Manager and usually it would be okay to change someone from a night to day shift shower. CNA 2 stated If they (resident) refuse, then I will go in with the nurse and yes, they have to sign that they refused. I have to have documentation to show they refused. CNA 2 further stated, R75 is a night shift shower. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 06/12/2024 at 8:57 AM, CNA 1 stated, We have a set schedule for 6:00 AM-6:00 PM showers and for the 6:00 PM-6:00 AM showers. Whatever residents are listed on the schedule for this day to that day and by their room numbers. That is how it's determined who is going to get a shower. CNA 1 further stated, If a resident refuses, we have them fill out a shower sheet. They have to sign their name and the nurse and CNA sign as well. During interview on 06/12/2024 at 9:07 AM, Unit Manager (UM) 1 stated, This schedule was in place before I got here. If they are a night shift shower and they refuse, then we will be asking them how come they are refusing, and if they would rather take a shower in the morning instead of at night. Then yes, we can possibly switch you. UM 1 stated, If they want a shower during the day instead of at night, we could definitely switch them to day shift. That would be no problem at all. Regarding R75, UM 1 stated, Nothing was told to me by the CNAs and the night shift nurse didn't say anything to me about this. The UM then stated, For bathing, she (referring to R75) would need minimal assistance and would need someone to be there with her just for safety concerns. During a telephone (phone) interview on 06/13/2024 at 11:39 AM, CNA 3 stated she worked night shift and Over the weekend of 06/08/2024, I walked into the resident's room and asked her if she was ready for her shower. She (referring to R75) told me 'It was too late' so I put it on the shower sheet. CNA 3 stated, I remember the resident was tired and when I gave her the shower sheet to sign that she was refusing she said, 'Just come on with it then. The CNA stated, That was the first time ever working with her. Had I known she wanted an earlier shower, I would have tried to get with one of the aides working with me to swap out to get her an earlier shower on day shift. She stated, When I come on my shift, I grab the shower book at the nurse's station and check to see which showers are on night shift and I just saw her room was located on the night showers. Even before I could gather my items as I went into her room to let her know I was going to give her a shower, she became upset and was very adamant and clearly said 'No it was too late. CNA 3 stated, R75 was already in bed when coming to offer her a shower. The CNA said, I wasn't told about the shower sheet or having someone sign they refused, I just saw it on the form where there is a section for the resident, the aide, and the nurse. I wasn't told about this. I just remember the resident was very upset and very adamant saying it was too late to be getting a shower now. She was not confused. She was very clear and that she meant no. During a phone interview on 06/13/2024 at 11:17 AM, Licensed Practical Nurse (LPN) 10 stated, From what I recall, I was getting her (referring to R75) medications ready and the CNA went in to give her a shower and the resident stated, 'No'. I remember she said that she was too tired to get up to have a shower now. LPN 10 stated, This was around 7:00 PM or 8:00 PM. She was already in bed. The LPN stated, I don't remember asking her if there was a better time she wanted a shower, and I don't recall the CNA asking her if there was another time she preferred to get her shower either. (continued on next page)

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Cherokee Park Rehabilitation	2100 Cherokee Ridge Way Louisville, KY 40205

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 06/12/2024 at 9:19 AM, the Director of Nursing (DON) stated, Those shower schedules were created prior to me coming here. It is based on the room number they are in, as to if they are a day or night shower. Certain room numbers are on nights, and some are on day shift. The DON stated, We would always accommodate a resident's preferences. If someone is on the night schedule and if the resident does not want a shower on the night shift, then that should be communicated to the nurse. It should also be documented that they refused, and another arrangement can be made if they want a shower in the mornings. Then yes of course, we can accommodate that. The DON stated, If she (referring to R75) refuses, we should be moving her to a different schedule. If it's documented anywhere they refused, then we will put a refusal in the care plan. The DON stated if R75 refused a shower, The CNA needed to document why it was not given, and why the refusal. I had not been notified of this. The DON further stated, My expectation would have been that another shower was offered the next day, or we change her to a schedule to accommodate her preferences. That wasn't done.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observation, interview, and facility documentation and policy review, the facility failed to make prompt efforts to resolve a grievance repeatedly voiced by the resident group for five out of five residents (R)38, R87, R13, R43, and R77, who attended the resident group interview, and for three additional residents, R55, R9, and R22 for a total of eight residents out of 23 sampled residents. The microwave used for reheating residents' food was removed by staff and no other mechanism was put into place to heat residents' food. This created the potential for dissatisfaction with meals and decreased quality of life. The findings include: Review of the facility's policy titled, Resident and Family Grievances, dated 05/08/2023, revealed, All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance . Prompt efforts include acknowledgment of the complaint/grievances and actively working toward a resolution of that complaint/grievance . Review of the facility's undated, Admission Packet, documentation revealed, If food needs to be prepared, reheated or stored, residents and/or the responsible party are to ask staff for assistance. Review of the facility's policy titled, Use and Storage of Food Brought in by Family or Visitors, dated 01/02/2020, revealed It is the right of the residents of this facility to have food brought in by family or other visitors . The facility staff will assist residents in accessing and consuming food that is brought in by residents and family or visitors if the resident is not able to do so on their own. 1. A resident group interview was conducted on 06/12/2024 at 10:00 AM, with five interviewable residents selected by the facility. In the interview all five residents (R38, R87, R13, R43, and R77) expressed concerns with the inability to have their food heated/reheated, stating they would like to be able to have their food heated/reheated in a microwave. R87 and R13 stated the microwave on the facility's [NAME] Unit had been removed and since that time they had not been able to have their food reheated. All the residents stated they had repeatedly raised this concern in resident council; however, had not received a satisfactory response from the facility, and were told staff were not allowed to reheat their food. R87 and R13 stated it would really be nice to have a microwave to use to heat up their food again. R87 and R13 stated they knew there was a microwave in the rehab (rehabilitation) room, but neither the residents nor staff were allowed to use it to heat up their food. 2. Three additional residents interviewed (who did not attend the resident group interview on 06/12/2024) expressed concern that they could not have food heated/reheated as follows: a. Review of the Annual Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 03/13/2024, located in the electronic medical record (EMR) under the RAI (Resident Assessment Instrument) tab, revealed the facility assessed R55 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident had intact cognition. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 06/11/202024 at 10:08 AM, R55 stated she liked to buy microwave dinners and also had leftovers she would like to reheat in a microwave. R55 stated she previously had staff heat food for her in the microwave which had been on the ([NAME]) unit. The resident stated the microwave had been removed and there was no longer a way to get food reheated. R55 further stated she no longer purchased or enjoyed microwaveable foods since there was no microwave available to heat the food up in and this had decreased her satisfaction with meals. During a follow up interview on 06/14/2024 at 11:19 AM, R55 stated she had mentioned the issue in her care plan meeting about not being able to reheat food in a microwave. She stated the staff told her it was a state regulation that prohibited them from heating residents' food in a microwave. R55 further stated the residents had complained numerous times about not having a microwave in resident council meetings. b. Review of the Quarterly MDS Assessment with an ARD of 05/29/2024, located in the EMR under the RAI tab revealed the facility assessed R9 to have a BIMS score of 15 out of 15 which indicated the resident had intact cognition. During an interview on 06/10/2024 at 12:51 PM, R9 stated the food was not served hot and there used to be a microwave so her food could be reheated. R9 stated she could no longer get her food reheated as the microwave had been removed. She stated she would like to be able to have her food reheated. c. Review of the Annual MDS with an ARD of 04/26/2024, located in the EMR under the RAI tab revealed the facility assessed R22 to have a BIMS score of 15 out of 15 which indicated the resident had intact cognition. During an interview on 06/10/2024 at 12:26 PM, R22 stated the food was not hot enough and she wanted to get the microwave back so her food could be reheated. 3. During an observation on the [NAME] unit on 06/14/2024 at 3:38 PM, revealed there was no microwave present on the ([NAME]) unit. 4. During an interview on 06/12/2024 at 8:32 AM, the Dietary Manager (DM) stated the dietary staff did not heat up residents' food in the kitchen due to it being a cross-contamination issue. The DM stated there had been a microwave for residents' use, but it had been removed about nine months ago. Per the DM's interview, there had been talk about training staff to reheat residents' food; however, this had not been implemented thus far. The DM verified there was no current system in place to heat/reheat residents' food. During an interview on 06/12/2024 at 12:02 PM, the Administrator stated there had been some complaints about the food and he had noticed an increase in food complaints after the microwave was removed (at least a few months ago). He stated the microwave used for reheating residents' food was removed from the [NAME] unit due to residents and families heating the food themselves and the associated safety issues. The Administrator stated there were other microwaves in the building in the rehab department, and in the staff breakroom for example. He further stated he thought staff were going to therapy or to the staff breakroom to heat/reheat residents' food and was not aware that residents could not get their food reheated. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/2024 at 11:26 AM, Certified Nursing Assistant (CNA) 4 stated there was no microwave on the [NAME] unit anymore; however, there were a microwaves in rehab, one on the memory care unit, and one on the A wing that could be used to heat/reheat residents' food. The CNA further stated however, there was no procedure in place for reheating food for residents. During an interview on 06/14/2024 at 9:27 AM, the Licensed Practical Nurse (LPN)/Unit Manager (UM) 2 of Unit B ([NAME] unit) stated there had been a microwave on the [NAME] unit that had been removed, and it was now located in the staff breakroom. LPN/UM 2 stated, I did not think food should be heated up by anyone other than dietary. LPN/UM 2 stated staff needed to know the temperature of the food and had to be careful that it was not too hot. LPN/UM 2 verified staff quit heating/reheating residents' food and the residents currently could not get their food reheated. During an interview on 06/14/2024 at 11:55 AM, the Activity Director (AD) stated she conducted resident council meetings and took the minutes. She stated the issue of the microwave had come up in resident council meetings at least three times with the previous Tuesday meeting being the most recent. The AD verified she had not recorded the issue in the resident council meetings however. She stated the Administrator had attended the meeting at least twice and addressed residents' questions about the food issue. The AD stated Administration was concerned about residents getting burned or hurt and that was the reason food could not be heated/reheated. She stated when concerns were raised in resident council meetings, she brought them to the daily department head meeting. The AD stated, Everybody knows (about the residents' complaint about the microwave and being able to have food heated up). She stated IT is a big, big problem. The AD further stated it had been an ongoing issue for about six months now. The AD further stated the residents offered to buy thermometers for the staff to use when heating/reheating their food.

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NAME OF PROVIDER OR SUPPLIER Cherokee Park Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 Cherokee Ridge Way Louisville, KY 40205	

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 20402 Based on observation, interview, review of the monthly resident council meeting minutes and facility policy review, the facility failed to ensure residents were aware of where to locate the state survey inspection results and ensure the results were available for review for five residents (R) out of the 23 sampled residents, R38, R13, R87, R43, and R77. The findings include: Review of the facility's policy titled, Resident Rights, dated 03/22/2022, revealed, Resident rights .The resident has a right to examine the results of the most recent survey of the facility conducted by Federal or State Surveyors and any plan of correction in effect with respect to the facility. Review of five months of the Resident Council Meeting Minutes dated, 01/02/2024, 02/06/2024, 03/05/2024, 04/02/2024 and 05/07/2024, revealed no documentation of the state survey inspection results having been discussed with residents, or where the information was posted for residents to review. During a Resident Meeting held on 06/12/2024 at 10:00 AM, R38, R13, R87, R43, and R77 were asked if they knew where the state survey inspection results were posted, and all five residents present in the meeting stated, No. R38 stated, Where is that posted? I've never heard about it. R13 stated, I haven't ever seen those. I couldn't tell you where its posted. The residents stated, It would be nice to know where it is at or at least refer to that information in our council meetings. That would be nice. R38 stated, That information has never been mentioned at our council meetings. R77 stated, No. R87 shook his head back and forth and stated, I'm not aware of where that would be posted. R43 stated, I've been here a long time, and I don't know where its posted. During interview on 06/12/2024 at 11:08 AM, the Activity Director (AD), when asked about the state survey inspection results being posted, stated, I don't know. I'm not sure. When the AD was asked if the state survey inspection results have ever been reviewed with the residents during the monthly council meetings she stated, No. Not by me. I have not done that. I didn't know I was supposed to be doing that. During interview on 06/12/2024 at 11:15 AM, when the Administrator was asked about the state survey inspection results being posted he stated, The survey results are in a binder in a cabinet. Observation on 06/12/2024 at 11:26 AM, revealed there was a large gray cabinet located at the front entrance of the facility directly in front of the reception area. Continued observation revealed the large gray cabinet was two cabinets with one cabinet on the left and one cabinet on the right with doors that were both closed. Per observation, when the door on the right side of the gray cabinet was opened, the state survey inspection binder was observed sitting on the top shelf. Further observation revealed the black binder with the survey information in it was not easily accessible to residents, families and/or visitors to review. During interview at the time of observation the AD stated she had not ever reviewed the information in the binder with the residents as she, Didn't even know where the state surveys were posted. (continued on next page)

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Cherokee Park Rehabilitation	2100 Cherokee Ridge Way Louisville, KY 40205

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/2024 at 12:09 PM, the Administrator stated, The survey binder should be up front and available for them to see. We will talk with residents, so they are aware where that information is posted.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 29015 Based on interview, facility document review, and review of the Long Term Care Resident Assessment Instrument User's Manual (LTC RAI) the facility failed to ensure one of 23 sampled residents (R) had an accurate Minimum Data Set (MDS) Assessment, R35. The facility assessed R35 to use insulin on the Minimum Data Set (MDS) Assessment; however, the MDS Coordinator confirmed the MDS information regarding insulin was erroneous. The findings include: Review of the Long Term Care Resident Assessment Instrument User's Manual (LTC RAI) version 1.18.11, dated October 2023, section N0250: revealed for insulin, it instructed to review the resident's medication administration records for the 7-day look-back period (or since admission/entry if less than 7 days). Determine if the resident received insulin injections during the look-back period. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period. Count the number of days insulin injections were received and/or insulin orders changed. Further review of the LTC RAI, section N0415: revealed High Risk Drug Classes: Use and Indication, instructed Review the resident's medical record for documentation that any of these medications were received by the resident and the indication of their use during the 7-day look-back period (or admission/entry or reentry if less than 7 days). Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room). Review of R35's Annual Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 05/02/2014, located in the electronic medical record (EMR) under the Resident Assessment Instrument (RAI) tab, revealed the facility admitted R35 on 04/27/2024, with diagnoses which included atrial fibrillation, anemia, and dementia. Further review of the MDS revealed the resident received insulin injections five out seven days during the look-back period. Review of the Physician Orders from May 2024 to June 2024, located in the EMR under the Orders tab, revealed R35 did not have insulin to be administered. During interview on 06/13/2024 at 5:55 PM, the MDS Coordinator (MDSC) confirmed that the insulin had been checked erroneously in R35's MDS.

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F 0676 Level of Harm - 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** 15406 Based on observation, interview, record review, and policy review, the facility failed to ensure, two of nine residents (R) reviewed for activities of daily living (ADLs) out of the total sample of 23 residents (R55 and R58) were provided restorative care and services to maintain their highest level of functioning resulting in a decline in function. In an interview with R55 she stated the facility cut its restorative care program in 2021. R55 and R58 declined in their ability to transfer, from being able to use a standing lift, in which they stood and participated in the transfer, to requiring the use of a Hoyer mechanical lift (lift designed to lift and transfer patients from one place to another) which was performed entirely by staff and without the residents' participation. The findings include: Review of the facility's policy titled, Restorative Nursing Programs, dated 02/01/2020, revealed It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Continued review revealed the Restorative nursing program referred to nursing interventions that promoted the resident's ability to adapt and adjust to living as independently and safely as possible. Further review revealed residents might receive restorative nursing services upon admission when not a candidate for specialized rehabilitation services, when restorative needs arise during the course of a longer-term stay, in conjunction with specialized rehabilitation therapy, or upon discharge from therapy. 1. Review of R55's undated Face Sheet located in the electronic medical record (EMR) under the Resident tab, revealed the facility admitted the resident on 07/15/2020, with diagnoses that included multiple sclerosis (MS), and contractures (a fixed tightening of muscle, tendons, ligaments, or skin) of the right and left ankles and left hand. Review of R55's Annual Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 03/14/2024 of the EMR under the RAI (Resident Assessment Instrument) tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. Per the MDS review, the facility assessed the resident to be impaired in range of motion (ROM) to both sides on the lower extremities. Continued MDS review revealed the facility assessed R55 to require substantial/maximum assistance for upper body dressing and personal hygiene. Further review revealed the facility assessed R55 as dependent for dressing her lower extremities, for toileting, for rolling left and right, and for a bed to chair transfer. In addition, the facility also assessed R55 as using a motorized wheelchair for locomotion. (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	Review of R55's Care Plan, dated 07/16/2020 and located in the EMR under the RAI tab, revealed the facility developed a problem for ADLs (Activities of Daily Living) functional status/rehabilitation potential. Continued review revealed the facility noted R55 had an ADL self-care performance deficit r/t (related to) activity intolerance, disease processes (MS), limited mobility, and musculoskeletal impairment. Per Care Plan review, the goal was, R55 will maintain some ability to assist with ADLs. Further review revealed the approaches (interventions) included: Mechanical lift (Hoyer) with two staff assistance for transfers dated 03/21/2022; bed mobility-requires extensive assist of one staff member, two to pull up dated 07/16/2020; encourage the resident to participate to the fullest extent possible with each interaction dated 07/16/2020. In addition, other approaches included: personal hygiene-requires extensive assist of one staff member dated 07/06/2020; PT (Physical Therapy/OT (Occupational Therapy) evaluation and treatment as per the medical doctor's orders dated 07/16/2020. During interview on 06/11/2024 at 10:08 AM, R55 stated she had MS and experienced a relapse with a decline in her physical abilities. She stated she received therapy and had been doing well initially, and when she came off therapy services, she received restorative nursing care which helped her to maintain her abilities. R55 stated however, the facility cut the restorative program in 2021 and although she received several rounds of therapy since then, when she discharged from therapy services she had not received restorative services to help her maintain her abilities after the restorative program was discontinued. The resident stated she previously used a standing frame as part of her restorative program and had been able to stand for up to 30 minutes. R55 stated, I have fallen well below baseline. I could transfer, with the assistance of staff, with stand and pivot then, and could sit on the side of the bed for 30 minutes independently. The resident stated now she could not participate in transfers and staff had to use a Hoyer mechanical lift to transfer her. Observation during the interview revealed R55 lying on her bed. During interview on 06/11/2024 at 4:31 PM, Registered Nurse (RN) 6 stated she had been employed at the facility prior to when R55 was admitted . RN 6 stated R55 was limited in her ADLs due to having use of her left hand only. She stated R55 had previously been able to do a transfer pivot or a transfer with the slide board; however, now staff used the Hoyer lift to transfer her because her legs were not working. RN 6 further stated the facility used to have a restorative nursing program, but did not currently have one. During an interview on 06/12/2024 at 11:47 AM, the Administrator stated he was aware of R55's desire to improve in her ADLs and stated she had received therapy. During interview on 06/12/2024 at 2:52 PM, the PT stated R55 had received therapy four times since 2022 with the most recent period being from 04/10/2024 through 05/09/2024. The PT stated initially R55 had maintained her abilities with the provision of therapy, and improved with bed exercises, positioning, and wore bilateral ankle orthotics, and maintained her ability to sit in the power wheelchair. The PT stated in R55's most recent round of therapy, the resident was transferred by therapy staff using the sit to stand transfer which required participation on her part. The PT stated however, R55 was currently not able to participate in transfers and was dependent on staff to perform transfers. The PT said during R55's most recent round of therapy her goals had been to use a standing frame and R55 made improvements and was able to stand for over 30 minutes. According to the PT interview, R55 could bear weight through her legs to increase her leg strength. The PT stated the facility provided no restorative services after therapy was discontinued. The PT further stated however, a restorative program would have been beneficial for R55, as the resident could have continued to use the standing frame. (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	During interview on 06/14/2024 at 9:17 AM, Licensed Practical Nurse (LPN)/Unit Manager (UM) 2 for B Wing stated R55 was not able to stand. LPN/UM 2 verified the facility had no restorative program; however, further stated residents could participate in the activity departments' group exercises. During an interview on 06/14/2024 at 11:36 AM, Certified Nursing Assistant (CNA) 5 stated until approximately two years ago, she had been employed at the facility as the restorative aide. She stated she had provided restorative services for R55 and the resident had been able to use the standing frame and do exercises with her compromised hand. CNA 5 stated the therapists had developed the restorative programs for residents and she had been trained in what to do for the residents. She stated R55 benefited from the restorative program, as the resident had been able to stand (for up to 15 minutes), and her hand became more functional. The CNA said R55 was less able to assist when rolling in bed now due to her left hand not working as well as it previously had. She stated R55 did not stand anymore, and staff now used the Hoyer lift to transfer her. CNA 5 further stated R55 had previously been able to push herself up using the sit to stand transfer, and the resident had been consistently transferred using the sit to stand lift prior to the discontinuance of the restorative program. During an interview on 06/11/2024 at 3:42 PM, CNA 6 stated R55 had previously used the sit to stand lift or a sliding board for transfers; however, was no longer able to do that. CNA 6 further stated staff used the Hoyer lift to transfer R55 now. During interview on 06/14/2024 at 5:42 PM, the DON stated some of R55's strength had declined and verified the Hoyer lift was now used for her transfers. 2. Review of R58's undated Continuity of Care Document in the EMR under the RAI tab, revealed the facility admitted the resident on 01/30/2023 with diagnoses including cerebral infarction (stroke) and cognitive communication deficit. Review of the Admission MDS Assessment with an ARD of 02/06/2023 in the EMR under the RAI tab, revealed the facility assessed R58 to have a BIMS score of five out of 15, which indicated the resident had severely impaired cognition. Continued MDS review revealed the facility assessed R58 to require extensive assistance with bed mobility, transfers, and locomotion on and off the unit. Further review revealed the facility additionally assessed R58 as not stable but was able to stabilize with staff's assistance for moving from seated to standing, walking, moving on and off the toilet, and surface to surface transfers. Review of the Quarterly MDS Assessment with an ARD of 04/30/2024 in the EMR under the RAI tab, revealed the facility assessed R58 to require substantial assistance for showers/bathing, upper body dressing, personal hygiene and was dependent for toileting/hygiene. Review of the MDS further revealed the facility also assessed R58 to be dependent for lower body dressing, going from sitting to lying, and from lying to sitting, ability to transfer from bed to chair and toilet transfer/ability to get on and off the toilet. (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	Review of R58's Care Plan, dated 05/11/2023, in the EMR under the RAI tab, revealed the facility had developed a problem for the resident which stated, ADLs functional status/rehabilitation potential. (R58) has impaired ability to do ADLs R/T weakness, impaired cognition. Continued review revealed the goal was for R58 to, Maintain some ability to assist with ADLs. Review further revealed the interventions included for Transfers: Hoyer lift with two staff (dated 04/15/2024). Per review of the Care Plan, the interventions also included: assist the with ADLs such as bathing, dressing, toileting, and nail care (dated 04/10/2024); for bathing the resident needed assistance of two staff for showers (dated 05/11/2023); bed mobility needs extensive assistance of one staff for turning repositioning and two for pulling up the resident in bed (dated 05/11/2023); and for toileting R58 needs checked and changed at least every two hours for incontinency (dated 05/11/2023). Observation throughout the survey revealed R58 sat in a high back wheelchair which did not have footrests and the resident's feet touched the floor. The observations are as follows: on 06/10/2024 at 12:51 PM, R58 had just finished eating lunch and staff wheeled him into the dayroom adjoining the [NAME] dining room where a large screen TV was located; on 06/10/2024 at 1:10 PM, R58 was observed to ambulate a couple of feet in the dayroom toward the TV; on 06/11/2024 at 9:47 AM, R58 was seen sitting in his wheelchair in the day room, and was not observed to ambulate in the wheelchair; and on 06/12/2024 at 8:56 AM, R58 was observed sitting in his wheelchair in his room having just finished breakfast. During interview on 06/11/2024 at 3:52 PM, CNA 6 stated R58 was dependent on staff for the provision of all ADLs except for eating. CNA 6 stated when R58 had resided on the A Wing, he had been able to use the sit to stand lift and could get into the wheelchair. The CNA stated at that time R58 could pull himself up while using the sit to stand lift. CNA 6 said after R58's fall (on 04/13/2024) he had been transferred with a Hoyer lift and now was completely dependent on staff. The CNA further stated the CNAs did not complete range of motion (ROM) or other exercise programs with residents. During interview on 06/11/2024 at 4:59 PM, LPN 1 stated R58 had previously used the sit to stand lift; however, he had gotten weaker and lost the ability to bear weight. The LPN said R58 was not currently able to stand or pivot. Per interview, LPN 1 stated R58's knees buckled when staff were transferring him with the sit to stand lift and he had fallen (on 04/13/2024). The LPN stated R58's decrease in ADLs triggered a therapy referral and he had received therapy. According to LPN 1 however, once R58's therapy was discontinued, and as the facility did not have a restorative program, the resident had not received services to maintain his abilities. During interview on 06/12/2024 at 2:42 PM, the PT stated R58 was picked up by therapy after sustaining the fall on 04/13/2024, and the PT verified R58's fall occurred when staff were using the sit to stand lift the resident's knees buckled. The PT stated R58 most recently received therapy from 04/16/2024 through 05/15/2024. According to the PT in interview, R58 was admitted to the facility with bilateral knee flexion contractures, and the resident's contractures had worsened and he was no longer able to stand up. The PT said R58 would have to stand to bear weight while using the sit to stand lift and therefore he could no longer do that. Per the PT's interview, R58 made progress while receiving therapy in his leg extension. The PT stated the facility did not provide a restorative program from which R58 could have benefited, by the provision of range of motion (ROM) exercises. The PT further stated when R58 was first admitted to the facility, he had been more capable than he was now and had been able to get to his feet without the lift with staff's assistance. The PT additionally stated R58 could no longer get to his feet. (continued on next page)

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F 0676 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/14/2024 at 5:28 PM, the DON stated the Hoyer lift was used for R58 due to the resident experiencing the fall that occurred when staff were transferring him with the sit to stand lift on 04/13/2024. The DON verified R58 had not been on a restorative program while residing in the facility. The DON stated the facility's restorative program had not been in place since she started as the facility's DON (several years ago). According to the DON in interview, residents could maintain their abilities if they participated in the activity group exercise programs. During an interview on 06/12/2024 at 11:47 AM, the Administrator stated therapy taught residents exercises they could do independently to keep their current status after they were discharged from therapy. He stated the facility did not have a restorative nursing program in place as it had been discontinued during COVID. The Administrator further stated however, residents could go to a group exercise program offered by the activity department.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, interview, record review, document review, and facility policy review, the facility failed to ensure tracheostomy (trach) care and tracheal suctioning were provided consistent with professional standards of practice, and infection control processes for two of three residents (R) observed for tracheostomy care out of the 23 sampled residents, R54 and R61. 1. Licensed Practical Nurse (LPN) 2 failed to: assess R54 after noting the oxygen saturation was 77% initially and the repeat reading was 66%; failed to suction R54 when the resident expectorated mucous after removal of the inner cannula and before the new cannula was replaced to ensure the airway was clear from mucous; and failed to have a Yankaur suction tip connected to the suction machine, an Ambu-bag present in case of emergency, and clean inner cannula supplies as required prior to performing tracheostomy care to R54. 2. LPN 1 failed to: clean R61's (trach) stoma site as ordered by the physician; failed to suction R61 to ensure her airway was cleared prior to reinserting the cannula; and failed to monitor the resident's O2 sats during the tracheostomy care. LPN 1 also failed to change gloves between performing the clean and dirty procedures of tracheostomy care and failed to have an Ambu bag present in R61's room in case of an emergency. The facility's failure to ensure tracheostomy care and tracheal suctioning were provided as necessary has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 06/11/2024, and was determined to exist on 06/11/2024, in the areas of 42 CFR 483.25. The facility was notified of the Immediate Jeopardy on 06/13/2024. An acceptable Immediate Jeopardy Removal Plan was received on 06/14/2024, which alleged removal of the Immediate Jeopardy on 06/14/2024. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 06/14/2024, prior to exit on 06/14/2024. Non-compliance remained in the areas of 42 CFR 483. 25 at a Scope and Severity (S/S) of a D while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled, Tracheostomy Care, dated 03/24/2022, revealed .Tracheostomy care will be provided according to the physician's orders, comprehensive assessment and individualized care plan such as monitoring for resident specific risks for possible complications, psychosocial needs as well as suctioning as appropriate. General considerations include: a. Provide tracheostomy care at least twice daily. b. Maintain a suction machine, a supply of suction catheters, correctly sized cannula's, and an Ambu bag easily accessible for immediate emergency care .Based upon the resident assessment, attending physician's orders, and professional standards of practice, the facility in collaboration with the resident/resident's representative will develop a care plan that includes appropriate interventions for respiratory care. The facility will ensure staff responsible for providing tracheostomy care including suctioning are trained and competent according to professional standards of practice .Clean the stoma with normal saline or sterile water moistened gauze or cotton-tipped applicator . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the reference book provided by the facility, [NAME] and [NAME], 2023, 11th Edition, pages 1019-1027, revealed .Excess secretions in the artificial airways may indicate need for suctioning before performing any other airway care .Ensure the nurse has the necessary equipment to implement all interventions that should be completed for the patient .Connect [NAME] suction catheter to suction source and have it ready for use. Ensure that suction source/machine for oral suctioning is on and functioning properly . 1. Review of R54's undated Face Sheet, provided by the facility, revealed the facility originally admitted the resident on 05/02/2024 and readmitted him on 06/03/2024, with diagnoses of acute and chronic respiratory failure, with hypoxia (low levels of oxygen in the blood) or hypercapnia (too much carbon dioxide in the blood), chronic obstructive pulmonary disease, and tracheostomy. Review of R54's Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 05/08/2024, located in his electronic medical record (EMR) under the Resident Assessment Instrument (RAI) tab, revealed the facility assessed the resident to have short term and long-term memory loss and was severely impaired in making decisions. Further review revealed there was no Brief Interview for Mental Status (BIMS) score available in the EMR. Review of R54's Physician Orders located in the EMR under the Orders tab, dated 05/01/2024, revealed orders for tracheostomy care: cleanse above and below the phalange (part of the tracheostomy tube fixed against the neck, clean inner cannula and change drain sponge, every shift. Continued review of the 05/01/2024 Orders revealed tracheostomy emergency bag to bedside: Suction catheter, spare inner cannula, and tracheostomy tube, ties, and obturator (a rigid, curved, thin tube that fits within the cannula upon insertion). Review further revealed Tracheostomy Suctioning every two hours, and as needed. Review of R54's Care Plan located in the EMR under the Care Planning tab, dated 05/03/2024, revealed the facility care planned the resident for altered respiratory status/difficulty breathing related to tracheostomy and history of respiratory failure. Continued review revealed the approaches (interventions) included assisting resident/family/caregiver in learning signs of respiratory compromise; assist with proper body alignment for optimal breathing pattern; and maintain a clear airway by encouraging to clear own secretions with effective coughing. Further review of the approaches revealed if secretions could not be cleared, suction as ordered and/or required to clear secretions; and observe/document/report abnormal breathing patterns to the physician such as increased rate, decreased rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed lip breathing, and nasal flaring. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cherokee Park Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 Cherokee Ridge Way Louisville, KY 40205	

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F 0695

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

During the trach care observation with Licensed Practical Nurse (LPN) 2 on 06/12/2024 at 9:00 AM, upon entering R54's room, the resident's oxygen tubing/mask was observed pulled down to his chest, and his left hand was on top of the tracheostomy opening. Per observation, LPN 2 replaced R54's oxygen and obtained an oxygen saturation (O2 sat), which was initially at 77%, a second reading obtained was 66%, and 97% was obtained after the oxygen mask had been replaced over the tracheostomy opening. Per observation, LPN 2 did not assess R54 after his O2 sats dropped and did not request additional assistance when the resident's O2 sats dropped to 66%. Observation of the LPN providing the tracheostomy care, revealed LPN 2 removed R54's disposable cannula, and the resident expectorated thick yellow mucus out of his tracheostomy site; however, the LPN failed to suction the resident to ensure any remaining mucus was removed and his airway was cleared of mucus prior to inserting the new cannula. Continued observation revealed although there was a suction machine located next to the resident's bed, there was no Yankaur suction tip, or Ambu-bag (a handheld device that provides respiratory support to patients having difficulty breathing), present if needed to suction the resident and/or in case of an emergency. Observation revealed LPN 2 left R54's left side of the bed to obtain a clean cannula across the room, approximately a bed length away from the resident, lying on a recliner. Further observation revealed LPN 2 failed to monitor R54's O2 sats during performance of his tracheostomy care and failed to complete the care according to the physician's orders.

During an interview on 06/12/2024 at 10:58 AM, LPN 2, when questioned on what type of training she had received related to tracheostomy care, stated she had been trained in nursing school in 1999, received skills check-offs from the facility, and were observed on demonstration in the skills lab, but never in person. LPN 2 stated, when questioned on how often the suction machine was checked, she knew it worked yesterday but there was no set schedule for checking it to ensure it was operating properly. She stated if R54's tracheostomy was dislodged she would reinsert another cannula if the hole was still open. When asked in further interview where the cannula would be located, she responded, Well they don't tape it on the wall anymore, they are supposed to be kept in the bin of supplies in their room, but his was in his chair. LPN 2 further stated, when questioned where the Ambu-bag was kept, it was in the code cart located behind the nurse's station.

2. Review of R61's undated Face Sheet, provided by the facility, revealed the facility originally admitted the resident on 02/01/2021 and was readmitted back to the facility on [DATE], with diagnoses of acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, shortness of breath, and heart failure.

Review of R61's quarterly MDS Assessment with an ARD of 05/03/2024, located in her EMR under the RAI tab, revealed the facility assessed the resident to have short term and long-term memory loss and as severely impaired in making decisions. Further review revealed no documentation of a BIMS score.

Review of R61's Physician Orders located in the EMR under the Orders tab revealed orders dated 05/21/2024, which included instructions for tracheostomy care: cleanse above and below the phalange, change disposable inner cannula, #4 Shiley (brand of trach tube), and change drain sponge. Continued review of the Orders revealed special instructions included to check around the resident's neck for breakdown related to tracheostomy collar, and to report any issues to the Medical Doctor or Nurse Practitioner. Review further revealed a tracheostomy emergency bag to the bedside to include suction catheter, spare inner cannula and tracheostomy tube, ties, and obturator size 4. In addition, review of the Orders revealed tracheostomy suction every two hours and as needed.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R61's Care Plan, dated 08/22/2022, located in the EMR under the Care Planning tab, revealed the facility care planned the resident for altered respiratory status and difficulty breathing related to chronic respiratory failure requiring tracheostomy, chronic obstructive pulmonary disease. Per review of the Care Plan, R61 pulled her tracheostomy tube out at times. Continued review of the Care Plan revealed approaches which included to continue to encourage R61 to not remove her tracheostomy; elevate her head of bed; and maintain a clear airway. Review revealed the approaches also included: if secretions could not be cleared, suction as ordered or required to clear secretions. Further review revealed the approaches additionally included to observe/document/report abnormal breathing patterns to physician such as increased rate, decreased rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed lip breathing, and nasal flaring. During an observation of tracheostomy care on 06/11/2024 at 9:30 AM, LPN 1 was observed not oxygenating the resident during tracheostomy care, not obtaining oxygen saturations during, and after tracheostomy care. LPN 1 did not clean around the stoma between the removal of the cannula, and before inserting a new one. After removing the present cannula, the resident expectorated thick yellow mucus. This mucus had not completely cleared the resident's airway, until the resident coughed a second time clearing her airway. There was no attempt to suction the resident to ensure her airway was cleared prior to reinserting the cannula. LPN 1 did not change gloves between clean and dirty during tracheostomy care. There was no adverse reaction related to the trach care that was observed. All emergency supplies were in a box in the resident's room, except for an Ambu bag. Specifically, LPN 1 did not replace the disposable cannula with a new one, did not perform tracheostomy care per physician's orders, did not monitor the oxygen saturations during tracheostomy care, and did not attempt suctioning of the resident to ensure her airway was cleared prior to inserting a new cannula. During an observation of tracheostomy care on 06/11/2024 at 9:30 AM,d LPN 1 failed to clean around R61's stoma after removal of the cannula. Per observation, after removing R61's cannula, the resident expectorated thick yellow mucus, which had not completely cleared her airway, until the resident coughed a second time clearing her airway. Continued observation revealed however, LPN 1 made no attempt to suction R61 to ensure her airway was cleared prior to reinserting the cannula, nor monitor the resident's O2 sats during the tracheostomy care. Observation revealed LPN 1 did not change gloves between performing the clean and dirty procedures of tracheostomy care, and failed to perform R61's tracheostomy care as per the physician's orders. Further observation revealed all emergency supplies were present in a box in the resident's room, except for an Ambu bag. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview conducted on 06/12/2024 at 10:18 AM, LPN 1 confirmed she had not cleaned around the resident's stoma of the tracheostomy and had placed her dirty gloves on the sterile field which should have been discarded. LPN 1 stated, when questioned about what type of training she received for tracheostomy care, she had received tracheostomy care training in nursing school in 2006. She stated the facility provided skills checkoffs every year, but no one observed the skill performance in person. LPN 1 stated she had also completed Relias training (online continuing education). She stated, when questioned what she would do if the resident's tracheostomy became dislodged, I would assess for distress, insert a new cannula if needed. LPN 1 said the Ambu-bag was kept in the code cart behind the nurse's station. According to LPN 1 in interview, she would have to call for someone to bring her the Ambu-bag in an emergency. She stated she would ensure the resident was on oxygen if the pulse oximeter (machine that measures O2 sats) was not recording accurate O2 sats, and would then get another O2 sat machine, and obtain another O2 sat on that one. LPN 1 stated the personal protective equipment (PPE) to be utilized during tracheostomy care was a gown, gloves, mask, and face shield. The LPN confirmed however, she had not been wearing a face shield during R61's tracheostomy care. During an interview on 06/12/2024 at 11:25 AM, Unit Manager (UM) 1 stated she expected tracheostomy care to be done every shift, and as needed, and for the nurses to ask for help from her if they needed anything. UM 1 stated, when questioned about her expectations of completing tracheostomy care per sterile procedure, yes I expect nurses to follow sterile procedure when performing trach care. She further stated if the oxygen oximeter was not working, nurses should check to see if the resident needed suctioning, check the resident's O2 sats again and if they were still not coming up, get another O2 sat machine to check to see if the readings were accurate. The UM stated trach care should be provided as ordered by the physician. During an interview on 06/12/2024 at 11:46 AM, UM 2 stated, when questioned about what type of tracheostomy training she had received, she received tracheostomy training through Relias, and she went to a class about three weeks to a month ago for a skills checkoff. UM 2 stated, They used a dummy to do tracheostomy care on. She stated her expectations for nursing staff concerning tracheostomy care was for the care to be done correctly. UM 2 stated the nurses should also oxygenate the resident throughout the tracheostomy care process, and keep the resident safe. She also stated, Oxygen saturations should be taken before, during, and after tracheostomy care. UM 2 stated the Ambu-bag was readily available in the crash cart behind the nursing station. She stated if a resident's oxygen saturation was low, she would ensure the tracheostomy oxygen mask was on, administer oxygen, and elevate the head of the resident's bed. In further interview UM 2 stated, when questioned if tracheostomy care was to be a sterile procedure, I think it is a sterile field. During an interview conducted on 06/12/2024 at 12:10 PM, the Director of Nursing (DON) stated she expected nursing staff to follow the facility's policy and procedure and uphold the standard of care. She stated if the nurses had any questions, they should ask for assistance. The DON stated staff received training related to tracheostomy care annually and as needed and when the nurses requested assistance. She stated if there was an educational gap identified, they would educate that nurse. The DON said last year the nurses were observed doing the tracheostomy care by the management team. She stated the Ambu-bag was located on the crash cart, and there should be one on every unit. The DON stated, when questioned what a nurse should do if a resident expectorated sputum during tracheostomy care, the resident should have been suctioned, and O2 sats should have been completed before, during, and after the procedure. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/12/2024 at 12:35 PM, the Staff Development Coordinator (SDC) was informed the Ambu-bag was kept in the crash cart and not at the bedside of the tracheostomy residents. The SDC stated however, They should have them in the residents' room. When the SDC was asked what the expectations were for nursing staff related to tracheostomy care, and resident oxygen desaturations, the SDC stated nurses should be aware of a resident's baseline, check for signs and symptoms of hypoxia and provide oxygen immediately, and obtain an oxygen saturation on the resident. The SDC stated if a resident's O2 sats were fluctuating up and down the nurse should put the call light on in case they needed assistance and assess the resident to see if the resident was hypoxic. During an interview on 06/12/2024 at 1:08 PM, the Assistant Director of Nursing (ADON) stated training on trach care and suctioning was completed for nurses for new hires and annually with all current employees. The ADON stated, the facility uses dummies for the training, we don't do any other unless we have any issues or problems such as questions about trach care, suctioning, and cleaning. The ADON stated the expectations of nurses performing trach care were, That they set up all equipment correctly prior to the procedure and there should be an Ambu-bag in the room, and one on the crash cart. During an interview on 06/12/2024 at 1:45 PM, the Administrator stated, when questioned on what his expectations were of nursing staff performing tracheostomy care and suctioning, the nurses were to follow the guidelines of the CDC (Centers for Disease Control and Prevention) and per the policies and procedures of the facility that were best practice.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 facility policy review, the facility failed to ensure one of three medication carts observed were free of expired medications which could potentially affect the efficacy of the medications. The findings include: Review of the facility's policy titled, Medication Storage, revision date of 09/2023, revealed it was the policy of the facility to ensure all medications housed on the facility's premises were to be stored in accordance with the manufacturer's recommendations and sufficient to ensure proper sanitation. In an interview with the Director of Nursing (DON) on 06/14/2024 at 5:43 PM, she stated it was her expectation that staff would dispose of medications within 28 or 30 days after the medication had been opened. During an observation conducted of the facility's Affinity Unit medication cart on 06/12/2024 at 8:30 AM, revealed a bottle of Tums (antacid medication) marked as opened on 01/30/2024, Robafen DM (cough suppressant) marked as opened 02/03/2024, Fluticasone-Salmeterol (asthma treatment) marked as opened on 04/09/2024, and Albuterol HFA (used to treat bronchospasms) marked as opened on 03/02/2024. Further observation revealed the medications were not dated with a discard date. During interview conducted on 06/12/2024 at 8:45 AM, with the Unit Manager (UM) 1, the Affinity Unit Program Director (PD), and the Licensed Practical Nurse (LPN) 13, they confirmed all the medications identified had been kept past the opened date. LPN 13, when asked how long a medication was good for after being opened, stated she believed that opened medications were good for 30 days but was not sure. In an interview on 06/14/2024 at 5:43 PM, the DON was questioned about how long medications were to be kept after being opened, and the DON stated medications should be disposed of after 28 or 30 days. The DON was questioned what her expectations of nursing staff were related to opened medications. She stated staff were expected to check the expiration and opened dates anytime they were passing medications, and get rid of the medications that were expired.

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F 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 15406

Based on observation, interview, record review, and facility policy review, the facility failed to ensure food was palatable, attractive, and at a safe and appetizing temperature for ten out of 44 (23 sampled and 21 supplemental) total residents (R), R77, R38, R43, R13, R87, R63, R75, R55, R22, R9.

Five interviewable residents (R77, R38, R43, R13, and R87), selected by the facility, in a resident group meeting all expressed concerns about the facility's food which included hot food being served cold and lacking seasoning. Five additional residents interviewed (R63, R75, R55, R22, and R9) voiced the same type of complaints. Observation of a test tray with the Dietary Manager (DM) revealed hot food temperatures were below 121 degrees Fahrenheit (F)and cold foods were above 50 degrees F. Interview with the DM revealed the hot foods on the test tray should have been served at around 121 degrees F to 125 degrees F, at a minimum; and the cold foods/beverages should have been below 50 degrees F.

The findings include:

Review of the facility's policy titled, Standardized Menu, dated 02/02/2022, revealed The facility shall provide nourishing palatable meals to meet the nutritional needs of residents . The facility will make reasonable efforts to provide food that is appetizing .

1. During the resident group meeting held on 06/12/2024 at 10:00 AM, with interviewable residents selected by the facility, all five residents (R77, R38, R43, R13, and R87) expressed concerns about the facility's food. The interviews were as follows:

-R77 stated food was the big issue at the facility, adding the hot foods were always served cold.

-R38 stated, I will try to put this in a nice way. Food has limited seasoning, this team of people who seem to have no sense of presentation of food, I call it prison mode. When you get a plate there is a slice of white sandwich bread that is thrown on top and when I get a plate that reminds me of the movie Shawshank Redemption. With seasonings they use Mrs. Dash. We would like more seasonings. R38 stated the food was, one of the weakest links here.

-R38 and R43 stated sometimes food items such as mashed potatoes might be bland and lacking seasoning and the next day the potatoes were very salty.

-All five of the residents stated the broccoli served was like tree limbs it was so hard.

-R43 stated Sometimes the meat is too tough.

-R13 stated the food was served cold, adding the night before last, it seemed as though his supper had been pulled out of the freezer and served to him.

-R87 stated the food was served cold and the staff would not reheat it. There was no microwave available to reheat their food.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Council Minutes from 01/02/2024 through 05/07/2024, provided by the facility, revealed residents expressed concerns about the food during the resident council meeting on 01/02/2024. Review of the Minutes further revealed, Residents stated they need salt and pepper so that the food would have flavor when cooked. 2. Review of the Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 05/21/2024, located in the electronic medical record (EMR) under the Resident Assessment Instrument (RAI) tab, revealed the facility assessed R63 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident had intact cognition. During interview on 06/10/2024 at 1:09 PM, R63 stated, My biggest issue is the food. Eggs are watery. The food is cold. It sucks .The coffee is lukewarm .Whatever they are feeding us should at least be hot . My biggest issue is just the food. 3. Review of the Admission MDS Assessment with an ARD of 05/29/2024, located in the EMR under the RAI tab, revealed the facility assessed R75 to have a BIMS score of 14 out of 15 which indicated the resident had intact cognition. During interview on 06/10/2024 at 11:00 AM, R75 stated the food was horrible. R75 stated the food was bland and served at room temperature. 4. Review of the Annual MDS Assessment with an ARD of 03/13/2024, located in the EMR under the RAI tab, revealed the facility assessed R55 to have a BIMS score of 15 out of 15 which indicated the resident had intact cognition. During an interview on 06/11/2024 at 10:08 AM, R55 stated she had been served an undercooked chicken leg before. The resident stated she ordered food out most of the time because she did not like the food served at the facility. R55 further stated the facility's food was not served hot and staff would not reheat the food. 5. Review of the Annual MDS Assessment with an ARD of 04/26/2024, located in the EMR under the RAI tab, revealed the facility assessed R22 to have a BIMS score of 15 out of 15 which indicated the resident had intact cognition. During interview on 06/10/2024 at 12:26 PM, R22 stated the food was bland and it was not hot enough when she received it. She stated she would like to be able to have her food reheated; however, the microwave had been removed and she could not get her food heated up. 6. Review of the Quarterly MDS Assessment with an ARD of 05/29/2024, located in the EMR under the RAI tab revealed the facility assessed R9 to have a BIMS score of 15 out of 15 which indicated the resident had intact cognition. During an interview on 06/10/2024 at 12:29 PM, R9 stated the facility's food was not hot and she did not like the broccoli. 7. During observation of the kitchen, dining room, and meal tray delivery, the drinks that were intended to be served cold such as milk, juice, and tea, revealed the facility lacked having a system in place to keep the drink temperatures cold during meal service: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. During interview on 06/12/2024 at 8:32 AM, the Dietary Manager (DM) stated beverages such as juices and water were served from carts by the staff in the dining room and to residents eating in their rooms. A cart was observed, at the time of interview, in the dining room and the cold beverages were in pitchers. Observation further revealed the beverages being served were at room temperature, with nothing such as ice, to keep the beverages cold when served. b. During lunch meal service on 06/13/2024 at 11:58 AM, two staff were observed wheeling the beverage drink cart down A hall serving drinks including lemonade, tea, water, and juice. Further observation revealed the beverages, intended to be served cold, were in pitchers at room temperature, with nothing in place to keep the beverages cold. c. During dinner meal service on 06/14/2024 at 5:15 PM, the beverage cart on the [NAME] Unit was observed with three pitchers of beverages, including juices, on it. Observation further revealed the beverages in the pitchers were at room temperature, with no mechanism in place to keep the beverages cold. 8. During observation on 06/12/2024 at 8:46 AM, a test tray was sampled alongside the DM. Per observation, the test tray was sampled after the last resident tray had been served on the [NAME] Unit. Continued observation revealed the temperature results of the test tray food were as follows: scrambled eggs were 117 degrees F and were lukewarm, verified by the DM; the fried potatoes were 95 degrees F and were cool, verified by the DM; the apple juice was 66 degrees F, verified by the DM. Further test tray observation revealed: the toast consisted of a piece of bread placed on top of the meal, which was soggy and without margarine/butter. Interview with the DM at the time of observation revealed she stated a margarine packet came with the meal and residents could add their own margarine to the bread. The DM stated the hot foods should have been at around 121 degrees F to 125 degrees F, at a minimum, when residents received their meals. The DM stated cold foods/beverages should have been below 50 degrees F when residents received their meals. During an interview on 06/12/2024 at 12:02 PM, the Administrator stated he was aware of some food complaints by residents, with an increase in complaints noted after the microwave used for heating residents' food was removed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 29015 Based on interview, record review, and facility policy review, the facility failed to ensure residents' appropriate care and services were documented for two of four sampled residents (R) reviewed for activities of daily living (ADL) care (R144 and R241) out of the 23 total sampled residents. The findings include: Review of the facility's policy titled, Incontinence, dated 05/22/2023, revealed Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. 1. Review of R144's undated Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab, revealed the facility admitted the resident on 11/22/2019 with a readmission on 01/04/2022. Further review revealed diagnoses that included intracranial injury with loss of consciousness, epileptic seizures, history of infectious and parasitic diseases, and urinary incontinence. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/20/2020, located in the EMR, under the Resident Assessment Instrument (RAI) tab revealed a staff Assessment for Cognitive Skills which indicated R144 was severely impaired-never/rarely made decisions. R144 was assessed as being total dependent of two plus persons for bed mobility, transfers, dressing, toilet use, and was total dependent with one plus person for locomotion on/off unit, eating, and personal hygiene. (Previous MDS' are unavailable due to electronic medical record program change.) Review of R144's Care Plan located in the EMR under the RAI tab, dated 11/23/2019, revealed, Resident has ADL self-care performance deficits r/t (related to) impaired mobility, multiple communication deficits, all r/t past SDH (subdural hematoma), and SAH (subarachnoid hemorrhage). Total dependence for care. Resident at times refuses staff to perform oral care, clamps mouth shut. Approaches included .total assist with bathing twice weekly and PRN (as needed) .Total dependent in care. Resident at times refuses staff to perform oral care, and clamps mouth shut, oral care am (morning), PC (after meals), and HS (evening), brush resident's teeth gently with soft toothbrush. The resident is not toileted and is total care with checking and changing. Review of the Documentation of Survey Report, provided by the facility, revealed ADL care (personal hygiene) for January 2021, was not documented as being completed for eight out of 31 days, on the 10:00 PM-6:00 AM shift; for 14 out of 31 days on the 2:00 PM-10:00 PM shift; and for 11 out of 31 days on the 6:00 AM-2:00 PM. Continued review revealed for December 2020, incontinence care was not documented as being completed for eight out of 31 days on 10:00 PM-6:00 AM; for three out of 31 days for the 2:00 PM-10:00 PM shift; and for nine out of 31 days on the 6:00 AM-2:00 PM shift. Further review revealed for November 2020, incontinence care was not documented as completed for 17 out of 30 days on 10:00 PM-6:00 AM shift; 15 out of 30 days on 2:00 PM-10:00 PM shift; and 13 out of 30 days on the 6:00 AM-2:00 PM shift. 2. Review of R241's undated Face Sheet, provided by the facility, revealed R241 was readmitted to the facility on [DATE] with diagnoses of Alzheimer's disease and weakness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee Park Rehabilitation	2100 Cherokee Ridge Way Louisville, KY 40205

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R241's admission MDS with an ARD of 02/09/2020, located in the EMR, under the RAI tab indicated a Brief Interview for Mental Status (BIMS) score of zero of 15 which revealed R241 was severely cognitively impaired. R241 was assessed as needing extensive assistance of one person assist for transfer, toilet use, and personal hygiene. Review of R241's Care Plan located in the EMR under the RAI tab, revealed R241 has bowel and bladder incontinence with potential for skin breakdown to peri area and infections. Interventions included The resident uses disposable briefs. Provide as needed and change as needed. Clean peri area with each incontinence episode. Observe the skin to peri area for signs of irritation, redness, maceration, and open areas. R241 also care planned for a deficit in self-care performance related to weakness, shortness of breath, cognitive loss, and communication deficits. Interventions included The resident requires extensive assist with showers and transfer assist into and out of the shower .The resident requires staff to assist with personal care and hygiene. Review of the Documentation of Survey Report, provided by the facility, revealed the following, ADL care (personal hygiene) for February 2020, was not documented as being complete for six out of 25 days on the 6:00 AM-2:00 PM shift; for 14 out of 25 days on 2:00 PM-10:00 PM shift; and six out of 25 days on the 10:00 PM-6:00 AM shift. Continued review revealed for March 2020, the ADL documentation was not documented as having ADL care (personal hygiene) for seven out of 31 days on the 6:00 AM-2:00 PM shift; for 16 out of 31 days on the 2:00 PM:00 PM shift; and 15 out of 31 days for the 10:00 PM-6:00 AM shift. Further review revealed for April 2020, the ADL documentation was not documented for three out of four days for the 6:00 AM-2:00 PM shift; two days out of four days for the 2:00 PM-10:00 PM shift; and two days out of four days for the 10:00 PM-6:00 AM shift. During an interview on 06/14/2024 at 4:55 PM, Unit Manager (UM) 2 stated incontinent care should have been documented. UM2 stated she thought the missing documentation was a documentation error, however, stated that if the resident's ADL care was not documented, then it was difficult to prove it was done. During interview on 06/14/2024 at 5:43 PM, the Director of Nursing (DON) verified there was a lack of documentation of personal hygiene being completed. Further, she stated she felt it was a documentation error, but was unable to confirm that. The DON added it was expected that staff provided incontinent care promptly and made sure it was documented. 28306

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NAME OF PROVIDER OR SUPPLIER Cherokee Park Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 Cherokee Ridge Way Louisville, KY 40205	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, interview, record review, and facility policy review, the facility failed to ensure its infection control guidelines were implemented for two of 23 sampled residents (R), R45 and R75. Observation of a dressing change for one of three residents R45 revealed the nurse contaminated the clean barrier that clean supplies were lying on and failed to change gloves after cleansing the resident's wound. R75's oxygen nebulizer tubing and a nebulizer mouthpiece/breathing apparatus were observed lying on the floor with no protective covering. A housekeeper was observed to sweep and mop the resident's floor with the nebulizer tubing and mouthpiece continuing to lie unprotected on the floor. The findings include: Review of the facility's policy titled, Clean Dressing Change, dated 03/24/2022, revealed Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application . 7. Wash hands and put on clean gloves. 8. Place a barrier cloth or pad next to the resident, under the wound to protect the bed linen and other body sites. 9. Loosen the tape and remove the existing dressing. If needed to minimize skin stripping or pain, moisten with prescribed cleansing solution, or use adhesive remover to remove tape. 10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. 12. Cleanse the wound as ordered, taking care not to contaminate other skin surfaces or other surfaces of the wound (i.e., clean outward from the center of the wound). Pat dry with gauze . Review of the facility's policy titled, Resident Rights, revised 03/22/2022, revealed the resident has a right to a .clean, comfortable .environment including but not limited to receiving treatment and support for daily living safely. 1. Review of R45's undated Face Sheet, provided by the facility, revealed R45 was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses of type two diabetes mellitus and pressure ulcer of sacral region, stage four. Review of R45's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/2024 located in R45's EMR under the Resident Assessment Instrument (RAI) tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. Review of R45's Physician Orders located in R45's EMR under the Orders tab, revealed an order dated 05/10/2024 which stated, Cleanse coccyx with normal saline, pat dry, apply Collagen, calcium alginate and cover with dry dressing every shift. (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 on 06/14/2024 at 2:00 PM, Licensed Practical Nurse (LPN) 3 removed the old dressing and then used the old dressing to remove the inner packing. Observation revealed as LPN 3 was removing the packing from the wound, the LPN contaminated the clean barrier that the clean dressing supplies were lying on. Per observation, LPN 3 discarded her gloves, washed her hands, and applied new gloves. LPN 3 was observed to wet the gauze and clean down the center of the wound then with the same gauze, the LPN went down the left side of the wound before discarding the gauze. Further observation revealed after cleaning the wound and with the same gloves on, LPN 3 began packing the wound with calcium alginate, covered it with a dry dressing and applied a secure dressing. LPN 3 then observed to discard her gloves and wash her hands. During interview on 06/14/2024 at 2:30 PM, LPN 3 stated she contaminated the clean barrier with the old dressing, she did not change gloves after she cleaned the wound, and before applying the new dressing to the wound. LPN 3 stated, I got nervous, and I forgot everything that I was doing. During an interview on 06/14/2024 at 3:00 PM, Unit Manager (UM) 2 stated, She should have changed her gloves after LPN 3 cleaned the wound and the supplies should had been on a clean barrier. During interview on 06/14/2024 at 4:00 PM, the Director of Nursing (DON) stated, LPN 3 should follow the infection control guidelines when performing wound care. 2. Review of the facility's policy titled, Oxygen Administration, revised 03/24/2022, revealed Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Review of R75's undated Face Sheet located in the resident's electronic medical record (EMR) under the Resident tab, revealed R75 was admitted to the facility on [DATE] with diagnoses to include pneumonia, chronic obstructive pulmonary disease (COPD), acquired absence of lung, and chronic systolic congestive heart failure. Review of R75's Admission MDS Assessment with an ARD of 05/29/2024, located in the resident's EMR under the RAI tab, revealed the facility assessed R75 to have a BIMS score of 14 out of 15 which indicated the resident was cognitively intact. The MDS review further revealed R75 was receiving oxygen therapy. Review of R75's Physician Orders, dated 05/25/2024, located in the EMR under the Resident tab, revealed an order for Albuterol Sulfate HFA aerosol inhaler-90 mcg (micrograms)/actuation; amt [amount] 2 puffs; inhalation. Every 6 hours-prn (as needed). Review of R75's Physician Orders, dated 05/28/2024, located in the EMR under the Resident tab, revealed an order to Replace and date nebulizer tubing and mouthpiece/mask. Frequency: Every shift on Mon (Monday) Day. Review of R75's Physician Orders, dated 06/03/2024, located in the EMR under the Resident tab, revealed an order for Albuterol sulfate solution for nebulization; 2.5 mg (milligrams)/0.5 ml (milliliters); amt (amount) 1 vial inhalation. Three times a day at 0800 (8:00 AM), 14:00 (2:00 PM), and 20:00 (8:00 PM). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cherokee Park Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 Cherokee Ridge Way Louisville, KY 40205	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan, dated 05/25/2024, revised 06/01/2024, located in the EMR under the RAI tab, revealed R75 had altered respiratory status/difficulty related to COPD, CHF (congestive heart failure), Hx (history) of lung CA (cancer) with pneumonectomy. During observation and interview on 06/10/2024 at 11:00 AM, R75 was observed awake, alert, and lying on her bed. During this time, R75's nebulizer tubing and nebulizer mouthpiece/breathing apparatus were observed to be lying on the floor under the bed's right side near the head of the resident's bed. Per observation, the tubing and nebulizer mouthpiece/breathing apparatus were observed to be lying on the floor and not stored in any type of container, or bag to keep it off the floor. When R75 was asked what the nebulizer was used for, the resident stated, For breathing at least three times a day. They (referring to clinical staff) come and set it up for me. When R75 was asked if the staff ever put her nebulizer mouthpiece/breathing apparatus into a bag for storage to keep it off the floor, she stated, No. During observation made on 06/10/2024 at 11:15 AM, R75's nebulizer tubing and nebulizer mouthpiece and breathing apparatus was on the floor under the bed's right side near the head of the bed. Per observation, a housekeeper was observed going into R75's room and was observed from the resident's doorway sweeping the entire room floor with a broom, including under the bed, directly where R75's nebulizer tubing, nebulizer mouthpiece, and breathing apparatus were lying on the floor. The housekeeper was observed sweeping all the dust/dirt into a folding dustpan. During this observation, R75's nebulizer tubing and nebulizer mouthpiece and breathing apparatus could still be observed from the doorway as lying on the floor in the same spot. Continued observation revealed the housekeeper did not stop what he was doing, to pick up the nebulizer contents, or proceed to get a staff member to do so. The housekeeper was then observed coming out of R75's room, putting the broom and folding dustpan onto his housekeeping cart, and then proceed to mop the entire room floor at 11:17 AM. He was observed mopping the area on the floor directly where the resident's nebulizer tubing, nebulizer mouthpiece, and breathing apparatus were. During the observation time, R75's nebulizer tubing, nebulizer mouthpiece, and breathing apparatus were observed to be lying in the same spot directly on the floor. Further observation revealed at no time did the housekeeper stop mopping, pick up the tubing or nebulizer mouthpiece contents or stop and proceed to get a staff member to pick it up. During observation made on 06/10/2024 at 11:25 AM, after the housekeeper was observed completing the sweeping and mopping of R75's room, he proceeded to walk up the hall with the housekeeping cart and went into another resident's room. Further observation revealed R75's nebulizer tubing, nebulizer mouthpiece, and breathing apparatus were still observed on the floor in the same spot under the bed's right side near the head of the bed as first identified at 11:15 AM. During interview on 06/11/2024 at 9:14 AM, regarding R75's nebulizer tubing and nebulizer mouthpiece/breathing apparatus observed on the floor, the Housekeeping/Laundry Supervisor stated, My expectation is if my staff observe oxygen tubing or something like this on the floor, I definitely would not want for my staff to sweep over it or even near it. I would expect them to get a clinical staff member. We can't pick it up with our dirty gloves. Certain things, like nebulizer tubing or nebulizer mouthpiece, they are to go get a clinical staff person. I would want them to stop what they are doing and go get a clinical staff. I would not want them to continue to sweep or mop around it. No. Absolutely not. When the Housekeeping/Laundry Supervisor was asked if her housekeeper came and told her what happened yesterday with sweeping and mopping R75's floor while the nebulizer tubing and nebulizer mouthpiece/breathing apparatus were lying on the floor, she stated, No. I would expect them to come and get me if not comfortable telling a clinical staff person. (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 interview on 06/12/2024 at 8:24 AM, Unit Manager (UM) 1 stated, If I saw something like that such as oxygen tubing or any type of nebulizer equipment or mouthpiece on the floor, then I would immediately throw it away and get a new tubing and mouthpiece. UM 1 stated, A nebulizer mouthpiece should never be observed on the floor. We should always throw it away. I think everybody has been educated to throw something like that away. If it's a housekeeper that sees something like that on the floor, they are supposed to let us know immediately so we can throw it away. UM 1 further stated, The housekeeper should have picked it up and thrown it in the trash can because this could be an infection control issue. When asked if she was made aware of the nebulizer tubing and nebulizer mouthpiece/breathing apparatus lying on the floor by the housekeeper, UM 1 stated, No. During an interview on 06/12/2024 at 8:31 AM, the Housekeeper and the Housekeeping/Laundry Supervisor, who translated the interview in Spanish for the Housekeeper stated that he [the housekeeper] recalled sweeping and mopping R75's room. He stated, I remember. When the housekeeper was asked if he recalled seeing the nebulizer tubing and nebulizer mouthpiece/ breathing apparatus lying on the floor when he was sweeping and mopping, he stated, Yes. When the housekeeper was asked if there was any reason why he swept and continued to mop the floor directly near where the nebulizer tubing and nebulizer mouthpiece/breathing apparatus were, he stated, I saw it. He stated to the Housekeeping/Laundry Supervisor in Spanish that he Knows he is not allowed to pick it up. And that it was the first time he saw it on the floor. The housekeeper further stated in Spanish to the Housekeeping/Laundry Supervisor, that he did not know he had to tell someone and was not sure if he needed to tell someone about it. The housekeeper stated in Spanish to his supervisor, Moving forward, now I was told I'm to tell a nurse or CNA if I see something like that on the floor. When he was asked if there was any reason why he did not do this when it occurred, the housekeeper stated, No. Now, I will make sure I stop my work and tell someone. During interview on 06/21/2024 at 9:19 AM, the Director of Nursing (DON) stated, regarding R75's nebulizer tubing and nebulizer mouthpiece/breathing apparatus being observed on the floor, stated, If housekeeping reported it to the nurses, then it should be replaced and ensure they have a bag for it. Even if it's a housekeeper, I would expect them to follow basic Infection Control practices and if it were one of the nursing staff, I would expect it to be replaced immediately. The DON then stated, To me an infection control has been breached and we need to come together as a team to best educate that person to make sure it doesn't happen again. The DON further stated, I would have expected the housekeeper to stop what he was doing and definitely not proceed to sweep by or even near that area, then mop too. No. 20402