STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on interviews, record review, and review of the facility's policies, it was determined the facility failed to ensure each resident or the resident's representative received adequate notice before transfer or discharge for four out of five residents (Resident (R) 3, R4, R13, and R14). The facility initiated a transfer/discharge based on the facility's inability to meet the resident's needs. However, upon complaint investigation, it was determined by interview and record review that the transfer/discharge was due to the facility needing to move the residents out of their rooms to make space for a new rehabilitation unit. Residents 3, R4, and R13 were selected based on their least likely to have a connection with the community. The residents were provided a notice of transfer/discharge on 07/26/2024. On 07/30/2024, four days after the notice was issued, the facility transferred and discharged the residents to other healthcare facilities, moving them further away from their families and friends. This was completed without providing a 30-day notification period and without obtaining the approval of the residents' State Guardian. On 07/31/2024, the residents' State Guardian was unaware the residents had already been transferred to other healthcare facilities. Review of an email the State Guardian sent to the facility revealed she requested them to hold off on transferring the residents. This resulted in psychosocial harm with R3 experiencing difficulty with adjusting to her new environment, crying, and stating, What did I do wrong? Additionally, the facility transferred R14 to the Emergency Psychiatric Services (EPS) on the evening of 08/15/2024 due to her challenging behaviors. On 08/16/2024, the facility initiated a discharge for R14 and refused to accept the resident upon return from the 08/15/2024 emergency room visit. The Emergency Psychiatric Services (EPS) explained to the facility that the resident's behaviors were related to the progression of the resident's disease process for dementia. Further, the EPS advised that the resident's medications be reviewed for the successful management of the resident's disease. The facility, however, failed to follow the recommendations of the EPS. Instead, on 08/16/2024, the facility left the resident at the hospital, refusing to accept the resident. This complicated the ability of the resident's State Guardian to place the resident within another facility. The resident remained at the hospital until, 09/12/2024, when the resident's State Guardian was finally able to place the resident in a long-term care facility. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's failure to have an effective system in place to ensure each resident's State Guardian was notified of the intent to transfer and discharge residents within the required 30 days so that approval would be granted for a safe and orderly discharge to other healthcare facilities has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/13/2024 and was determined to exist on 07/30/2024 in the area of 42 CFR 483.15, F623 Transfer and Discharge Requirements at a Scope and Severity (S/S) of a K. The facility was notified of the Immediate Jeopardy on 09/13/2024. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on 09/20/2024, alleging removal of the IJ on 09/20/2024. The State Survey Agency (SSA) determined the facility removed the IJ as alleged before exit on 09/20/2024. The facility implemented the following: 1. a. On 07/26/2024, Social Service spoke with Resident #3's appointed State Guardian and discussed the transfer of Resident #3 to a sister facility. On 07/26/2024 Social Services talked to the Ombudsman and informed them of the transfer. On 07/30/2024, four days later, the facility transferred Resident #3 to the sister facility. Resident #3 is no longer a resident of the facility. 1. b. On 07/26/2024, Social Service spoke with Resident #4's appointed State Guardian and discussed the transfer of Resident #4 to a sister facility. On 07/26/2024 Social Services talked to the Ombudsman and informed them of the transfer. On 07/30/2024, four days later, the facility transferred Resident #4 to a sister facility. Resident #4 is no longer a resident of the facility. 1. c. On 07/26/2024, Social Services spoke with R13's appointed State Guardian and discussed the transfer of R13 to a sister facility. On 07/26/2024, Social Services talked to the Ombudsman and informed them of the transfer. On 07/30/2024, four days later, the facility transferred R13 to a sister facility. R13 is no longer a resident of the facility. 2. a. All residents have the potential to be affected. 2. b. On 09/15/2024, the facility Administrator reviewed 98 residents currently in-house for facility-initiated transfer/discharge. No facility-initiated transfer/discharge notices were in effect on the 98 residents. (Facility-initiated transfer or discharge: A transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences). This does not include emergency transfers. 3.a. On 09/19/2024, the Corporate Independent Risk Manager (IRM) spoke with the State Guardian for the current residents. The Guardian educated the Corporate Independent Risk Manager on the process the State Guardian office must complete before approving a Facility-Initiated Transfer/Discharge of a resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3.b. On 09/19/2024, the Corporate Independent Risk Manager (IRM) educated in a small group setting the [NAME] President of Clinical Operations (VPCO), Signature Care Consultant (SCC), Regional Social Services, the Administrator, Interim Director of Nursing, Business Office Manager, and Social Services on the process the State Guardian office must complete for a Facility-Initiated Transfer/Discharge of a resident. The Corporate Independent Risk Manager (IRM) created two resource binders to be kept in each Social Service Office. The resource binders would include the steps needed for the state Guardian Office concerning transferring or discharging a resident with an appointed state guardian. If a new Social Service, Business Office Manager, Director of Nursing, or Administrator is hired, they will be trained in orientation by Signature Care Consultant or Corporate Independent Risk Manager on the process the State Guardian office must complete for a Facility Initiated Transfer/Discharge of a resident. 3.c. On 09/19/2024, the Senior [NAME] President of Quality requested the local Ombudsman to be a member of the newly created Facility-Initiated Transfer or Discharge Subcommittee. The local ombudsman agreed to be a team member on the Facility-Initiated Transfer or Discharge Subcommittee on 09/19/2024. This subcommittee was created on 09/15/2024. 3.d. On 09/15/2024, the facility implemented a new procedure concerning Facility initiated transfers or discharges, utilizing a subcommittee of members (Vice President of Operations (VPO), [NAME] President of Clinical Operations (VPCO), Independent Risk Manager, Signature Care Consultant, Social Services, a nurse or C.N.A. familiar with the resident, the Medical Director, and the Ombudsman. As of 09/19/2024, there has not been a meeting scheduled for the subcommittee as there has not been an identified need for a Facility-Initiated Transfer or Discharge in the facility. 4.a. An Ad Hoc Quality Assurance meeting was held on 09/15/2024 with the Medical Director, the Facility Administrator, the Interim Director of Nursing, and the Care Consultant at that time on 09/15/2024. The Facility Administrator presented the plan and information at the QAPI meeting on 09/15/2024. The Medical director attended via phone on 09/15/2024 and was notified of the implementation of the facility's improvement plan. The Medical Director reviewed the entirety of the plan and made no further suggestions. The Medical Director stated the plan was appropriate. Starting on 09/15/2024, the Facility Administrator will hold a Quality Assurance meeting daily until immediacy is removed. Then, it will decrease to monthly for recommendations and further follow-up regarding the above-stated plan. Moving forward, the Facility Administrator will continue to be the person who presents the information and audits at the QAPI Meetings, and the following members are expected to be present unless unable to attend: Facility Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Plant Ops Director, Social Services Director, Activity Director, Therapy Director, and MDS Coordinator. The QAPI Committee will determine at what frequency any ongoing audits must continue. The Administrator is responsible for implementing this plan. During a telephone interview with the District Ombudsman on 09/20/2024 at 3:05 PM, she stated the facility requested that the Ombudsman sit on the Facility-Initiated Transfer or Discharge Subcommittee. The Ombudsman joining the committee was to ensure the facility did not transfer/discharge a resident without following the appropriate guidelines and collaborating with the entire team as required. The findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's policy titled, Transfer/Discharge Notice, revised 03/25/2024, revealed the appropriate notice will be provided to the resident and/or resident representatives along with other required organizations if it is necessary to transfer or discharge a resident from a facility. Additionally, the facility will issue a notification at least 30 days before the date of transfer/discharge. 1. Review of R3's Face Sheet found in the resident's electronic medical record (EMR) revealed the facility admitted the resident on 10/06/2023 with diagnoses to include unspecified dementia, mood disturbance, and anxiety. Review of R3's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13 of 15, which indicated the resident was cognitively intact. Review of R3's Notice of Transfer or Discharge letter, dated 07/26/2024, and addressed to R3's State Guardian, revealed it was delivered in person to the resident and sent by overnight mail to the family member/legal representative with a Return Receipt Requested. According to the letter, the facility stated that the transfer was necessary for the welfare of the resident, as the facility could not meet R3's needs. The effective discharge date was 07/30/2024, four days after the notice was issued to the resident. Review of R3's EMR revealed a Resident Progress Note, dated 07/26/2024 at 4:52 PM, revealed the Social Service Director (SSD) spoke with the resident's State Guardian and informed her the resident would be transferred to a sister facility (the facilities share the same parent company). Review of R3's EMR revealed a Resident Progress Note, dated 07/26/2024 at 5:02 PM, revealed the Social Service Director (SSD) spoke with the State Long Term Care (LTC) Ombudsman and informed her the resident would be transferred to a sister facility. During an interview with Family (F) 3 on 09/11/2024 at 12:59 PM, she stated she learned the facility transferred R3 to another facility by accident from the resident's State Guardian. Family (F) 3 stated the State Guardian called her to inform her of the requested transfer and to discuss any concerns F3 would have regarding having R3 further away from the family. During the conversation on 07/30/2024 with the State Guardian, she stated the facility had requested R3 to be transferred to a sister facility. Family 3 stated she told the State Guardian that it would burden the family significantly and potentially mean they could not visit as frequently as they do. Family 3 stated the State Guardian never stated that R3 had been transferred already, only that she was scheduled to be transferred. Per the interview, F3 stated that within her discussion with the resident's State Guardian, she was informed that placement closer to the resident's family would be requested. F3 stated the facility never asked if transferring the resident would burden the family, and they never told her why the resident was transferred. Furthermore, F3 stated when she hung up the phone after speaking with the resident's State Guardian, she immediately received a call from the sister facility. According to F3, the sister facility's nurse called her to inform her the facility had admitted R3. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a continued interview with F3, on 09/11/2024 at 12:59 PM, she stated the new facility was 80 miles away from the resident's family. Further, she stated this made it difficult and even physically challenging for the family, many in their eighties, to visit R3. Previously, F3 was only 14 miles from the facility, making visiting more accessible for all the family. Additionally, due to R3's dementia, F3 stated visits can only last for 15 to 20 minutes, and sometimes R3 was not receptive to visits at all. She stated it would be an extreme burden for the family to drive 160 miles round trip to be denied a visit by R3. Additionally, F3 was upset about R3's transfer, primarily due to the facility needing approval from the State Guardian. Family 3 stated the State Guardian was still looking for a facility closer to the family. She stated she was concerned about how the facility handled the entire process and said it was all done in a [NAME] and [NAME] manner. During a telephone interview with Social Service Director (SSD), at the accepting facility, on 09/11/2024 at 3:49 PM, she stated R3 had difficulty adjusting to the transfer to her new home. Upon arrival, R3 was crying and expressed confusion as to why she was sent away from her home and would often ask, What did I do wrong? She stated R3 repeatedly requested to speak with her State Guardian about her transfer. The SSD stated R3 was slowly adjusting to her new environment over the past several weeks and was getting along well with her roommate. The State Survey Agency (SSA) surveyor requested to speak with the resident; however, the SSD stated the resident was engaged in an outside activity and was having a good day. Per the interview, the SSD stated that discussing the resident's transfer with her might upset her. 2. Review of R4's Face Sheet found in the resident's EMR revealed the facility admitted the resident on 10/29/2022 with diagnoses to include cerebral infarction, generalized anxiety disorder, and mild cognitive impairment. Review of the R4's quarterly MDS, with an ARD of 07/30/2024, revealed the facility assessed the resident to have a BIMS score of 10 of 15, which indicated the resident was moderately impaired. Review of R4's Notice of Transfer or Discharge letter, dated 07/26/2024, and addressed to R3's State Guardian, revealed it was delivered in person to the resident and the State Guardian, and sent by overnight mail to the family member/legal representative with a Return Receipt Requested. According to the letter, the facility stated the transfer was necessary for the welfare of the resident, as the facility could not meet R3's needs. The effective date of discharge was 07/30/2024, four days after the notice of transfer or discharge was issued to the resident. Review of R4's EMR revealed a Resident Progress Note, dated 07/26/2024 at 4:57 PM, revealed the Social Service Director (SSD) spoke with the resident's State Guardian and informed her the resident would be transferred to a sister facility. Per the note, the Ombudsman was also made aware of the transfer. During a telephone interview with the SSD at the accepting facility on 09/11/2024 at 3:49 PM, she stated R4 was adjusting well to his transfer and has had no complaints. The SSD stated the facility accepted the resident on 07/30/2024. According to the interview, the SSD stated R4 has not exhibited any behaviors since his arrival. Per the SSD, R4 was unavailable for an interview. During an interview with the SSD on 09/05/2024 at 4:15 PM, she stated she spoke with R3 and R4's State Guardian on 07/26/2024 regarding both of their discharges. She stated the State Guardian agreed with the transfer/discharge. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview with R3 and R4's State Guardian on 09/05/2024 at 11:15 AM, she stated the facility failed to provide a 30-day notice before the resident's discharge on 07/30/2024. The State Guardian stated she made the SSD aware through e-mails and telephone conversations discussing the possible transfer/discharge that the State Guardian's office has a process that she must follow to ensure the residents were not inappropriately discharged . The State Guardian stated she needed to obtain supervisory approval for the transfer/discharges. She also stated she informed the SSD that she would need to make a site visit to each facility before approving the transfer/discharge. She stated the facility knew the process because she had informed the administration, more than once, of the need to notify her before any transfer or discharge. 3. Review of R13's Face Sheet found in the resident's EMR revealed the facility admitted the resident on 11/29/2023 with a primary diagnosis of hemiplegia related to cerebral vascular accident (CVA), reduced mobility, psychiatric disorder, cognitive communication deficit, anxiety, unspecified psychosis, dementia, and failure to thrive. Review of R13's Notice of Transfer or Discharge letter, dated 07/26/2024, and addressed to R13's State Guardian, revealed it was delivered in person to the resident and the State Guardian. According to the letter, the facility stated the transfer was necessary for the welfare of the resident, as the facility could not meet the resident's needs. The effective date of discharge was 07/30/2024 with the resident's transfer being more than 150 miles away to the sister facility. Review of R13's EMR revealed a Resident Progress Note, dated 07/26/2024 at 4:56 PM, revealed the SSD spoke with the resident's State Guardian and informed her the resident would be transferred to a sister facility. Per the note, the Ombudsman was also made aware of the transfer. Record review of R13's MDS, dated [DATE], revealed the facility assessed the resident at discharge to have a BIMS score of 9 out of 15, which indicated the resident had moderate cognitive impairment. Review of the SSD email, dated 07/30/2024, revealed she emailed R13's State Guardian and requested a reply to her email, informing her the resident would be transferred/discharged . The resident's State Guardian replied by requesting the facility to hold off on discharging the resident. She replied, I am waiting for my supervisor's approval on this. Further review of the SSD's email, dated 07/31/2024 at 8:30 AM, revealed the resident's State Guardian emailed, Please, do not send the residents to other facilities until I get approval. This email was sent after the resident had been admitted to the sister facility. During an interview on 09/06/2024 at 10:15 AM with the Regional Nurse Consultant, she stated the residents with the least connection to the community were chosen to transfer to sister facilities. She stated the purpose of the residents' transfers was to open their rooms up for a different type of skilled services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 09/09/2024 at 10:48 AM, the SSD stated that she and the Chief Nursing Officer (CNO) called the residents' State Guardian, and she was 100% (percent) in agreement with transferring the residents to sister facilities. Per the interview, she stated she had emails to validate the State Guardian's agreement. However, a review of the emails between the SSD and the State Guardian revealed the State Guardian requested for the transfer/discharge to be held until she could obtain approval from her supervisor. 4. Review of R14's Face Sheet, found in the electronic medical record (EMR), revealed the facility admitted the resident on 02/21/2024 with diagnoses to include unspecified dementia with behavioral disturbance and major depressive disorder. Review of R14's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/21/2024 revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS), score of three out of 15, which indicated severe cognitive impairment. Review of the Psychiatry Progress Note dated 04/12/2024, at 11:46 AM, revealed the resident was referred to psych services due to her history of depression, dementia, and sleep problems. Further review of the note revealed nursing staff had reported no changes in R14's mood or cognition. Further review of the progress note revealed the resident's chart was reviewed for any medication changes, labs, behaviors, with no significant findings. Review of R14's emergency room Discharge Orders, found in the resident's EMR, dated 07/11/2024, revealed R14 was transferred from the facility to the local hospital's Emergency Psychiatric Services (EPS) for a psychiatric evaluation relating to endorsing actual harm. The resident denies this and no sign of agitation or other symptoms was noted. Continued review revealed R14 did not meet the criteria for admission. Further review revealed the resident had progressed dementia. Review of R14's Discharge MDS, dated [DATE] revealed the resident was discharged to an independent psychiatric facility. There was no BIMS score listed in this MDS. Further review of the MDS revealed the resident had a change in her baseline cognition. Further review of the MDS, under Section E, revealed the resident had no behaviors noted, at discharge. A review of a local hospital's Psychiatry Transfer Form, found in R14's EMR, revealed that R14 was admitted to the local hospital on 07/24/2024 with diagnoses to include recurrent, severe major depressive disorder with psychotic features, suicidal ideation, moderate, unspecified dementia with other behavioral disturbances. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R14's Psychiatry Notes found in the resident's EMR, dated 08/15/2024 at 6:48 PM, indicated the resident was transferred from the facility to the local hospital's Emergency Psychiatry Service (EPS) for a psychiatric evaluation due to the resident experiencing combative behavior with staff at the facility. Further review of the note revealed the resident had a diagnosis of dementia, and this was a normal progression of her disease. The note revealed the resident did not meet the criteria for admission to a psychiatric facility. Additionally, an addendum was added which listed a diagnosis of dementia with behavioral disturbances and the resident's medications should be considered and other recommendations for a more successful management of her disease. Continued review of the note revealed the facility was working on locating new placement for the resident, a locked facility. The note revealed the hospital would keep the resident overnight to allow the facility time to plan for the resident. The Director of Nursing (DON) had promised to call the physician by 9:00 AM with a plan and R14 would be discharged at that time. That call never happened and the resident was subsequently returned to the facility on the evening of 08/16/2024. The facility declined to accept this resident and she was returned to the hospital EPS and was admitted to the Behavioral Health Unit until her discharge to a Long Term Care facilty on 09/12/2024. Review of a Social Service Progress Note, found in R14's EMR, dated 08/15/2024 at 11:07 PM revealed the SSD spoke with the EPS attending physician to advise him that the facility was not the appropriate place for R14 due to her escalating behaviors, being a danger to herself and others. She documented in the progress note that R14 had recent mental decompensation, resulting in three visits to the hospital. The progress note documented that the attending physician at EPS explained that R14 was not appropriate for an acute psychiatric stay and revealed that R14 was not exhibiting the same behaviors at the hospital. Further review of the note revealed the physician explained to the SSD he assessed R14 as having a progression of dementia, which an acute psychiatric stay would not fix, nor was it appropriate at this time. According to the note, the EPS physician recommended a dementia unit due to the progression of the resident's diagnosis. During an interview on 09/09/2024 at 3:15 PM, with an Emergency Psychiatry Services (EPS), MD he stated on 08/15/2024 he spoke with the (former) Director of Nursing, and she stated if he could keep the resident overnight, she would call EPS first thing in the morning with a plan for placement. He stated the former DON never returned his call. On 08/16/2024, he stated the resident was discharged and transferred to the facility, but was turned away by staff. The EPS MD stated he could not recall the nurse's name, but when he spoke with the facility's nurse, on the night of 08/16/2024, she stated she was not going to accept the resident and would be sending her back to the hospital. With no placement, he stated the resident was subsequently admitted to the medical floor until placement could be found. During a telephone interview with Registered Nurse,(RN)2, on 09/04/2024 at 3:16 PM, she stated that when R14 returned to the facility from the hospital on 08/16/2024, she declined to accept the resident at the door. She stated the (former) DON instructed her not to accept the resident. During an interview on 09/09/2024 at 3:56 PM with the Chief Nursing Officer (CNO) for the facility, regarding R14 who was sent to EPS and not allowed to return to the facility, she stated she had been on the phone with the resident's guardian six (6) or seven (7) times about various things. She stated R14 had been in and out of the facility for behaviors. Further, she stated the facility did not have, in writing, the reason for the resident's discharge, a notice that was sent to the Ombudsman, or notification to the resident's State Guardian, that was at least 30 days before the resident was discharged from the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the Nurse Practitioner, on 09/09/2024 at 3:20 PM, she stated she was unaware of any recommendations from the EPS, which suggested the resident's medications would be reviewed with other recommendations for the management of the resident's disease. During an interview with the Medical Director, on 09/10/2024 at 4:05 PM, he stated he was not familiar with any recommendations from the Hospitalist regarding medication adjustments for the resident. Further, he stated the resident should have been referred to Psychiatric Services for any changes. During an interview on 09/09/2024 at 1:10 PM with the State Guardian, she stated that the old team seemed to understand the process but since the change in management, she has repeatedly tried to educate the facility on the process, but assistance was declined. She stated the standard process was to schedule a meeting with the resident and staff to discuss with the guardian what the need might be. Then the guardian would go to his or her next-line supervisor and provide information on the intended facility. At that time, she stated the intended or selected facility would be reviewed and approved by her team. She stated the approval would be relayed to the Interdisciplinary team (IDT) for further action. The State Guardian stated she asked the facility to look for a facility for R14 before discharging her. Per the interview, she stated she was unable to secure placement for the resident until September. During an interview on 09/10/2024 at 2:10 PM with the Medical Director, he stated he was aware of the plan to change some of the long-term beds to skilled beds and that there were residents who would be transferred to sister facilities. Further, he stated he was not responsible for the residents' transfer/discharge. During an interview on 09/09/2024 at 3:56 PM with the CNO, she stated that she was on the call with the SSD and the State Guardian during a conversation regarding the transfer of residents to sister facilities. She stated the reason she was on this call was to make sure things went smoothly. She stated there were emails to prove that the State Guardian was aware of the plan for transfer/discharge of the residents to sister facilities, to open rooms for a new type of service. The CNO revealed the facility had not provided the residents with a 30-day notice before transfer/discharge. She stated this was a learning experience for the facility. 50192

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44001 Based on observation, interview, record review, and facility policy review it was determined, the facility failed to ensure the residents' environment remained as free of accident hazards as possible and failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one for 30 sampled residents, Resident (R) 1. R1 sustained a fall between 04/16/2024 and 04/18/2024. Interviews and record review revealed staff failed to follow the resident's care plan which instructed staff to utilize the mechanical lift when transferring the resident from her bed to wheelchair. An unknown staff member transferred the resident without utilizing the resident's mechanical lift and the resident fell on her knees, resulting in a fracture of the distal right femur (broken thigh bone near the knee). The findings include: Review of the facility's policy titled Falls, with a revision date of 09/15/2023, revealed the intent of the policy was to ensure the environment was as free from accidents and hazards as possible to prevent avoidable falls. Per review, the guidelines included fall risk assessments to be performed upon admission, readmission, quarterly, annually and with a significant change of condition to identify fall risks. Continued review revealed a comprehensive care plan (CCP) was to be implemented based upon the resident's risk of falls and goals with interventions placed to reduce the risk of avoidable falls. Continued review of the facility's policy revealed the CCP should be reviewed following each fall with revisions of goals and interventions. Additional review of the facility's policy revealed the Interdisciplinary Team (IDT), and the Quality Assurance/Performance Improvement Committee (QAPI) were to perform reviews of residents' falls. Review of the facility's policy titled, Resident Rights, undated, revealed residents had the right to a safe environment. The State Survey Agency (SSA) surveyor requested a copy of a mechanical lift policy. However, the facility does not have a policy and followed the manufacturer's recommendations for mechanical lift use. Review of the facility's mechanical lift user manual titled, Maxi Move Floor Lift User Manual, undated, revealed while the lift was designed for safe usage with one caregiver, there are circumstances, such as contractures, of the individual that may dictate the need for two-person transfers. Further, it stated it is the responsibility of each facility to determine if one or two person transfers is more appropriate based on the task, the resident load, the environment, and capability and skill level of the staff member. Review of R1's Face Sheet found in the resident's electronic medical record (EMR) revealed the facility admitted the resident on 04/29/2016 with diagnoses to include quadriplegia following a motor vehicle accident in 2015, contracture of both knees, and Alzheimer's disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/02/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact. Continued review of the MDS Section GG - Functional Abilities and Goals revealed R1 did not attempt a sit to stand due to her medical conditions. Additionally, R1 was totally dependent (resident does none of the effort to complete the activity or the assistance of two or more helpers was required for the resident to complete the activity) on staff to transfer her from the bed to her wheelchair. Review of the R1's quarterly MDS, with an ARD of 07/31/2024, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Continued review of the MDS Section GG - Functional Abilities and Goals revealed R1 did not attempt a sit to stand due to her medical conditions. Additionally, R1 was totally dependent (resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) on staff to transfer her from the bed to her wheelchair. Review of R1's Comprehensive Care Plan (CCP), dated 03/22/2023, revealed R1 was identified as a fall risk on 03/19/2020 related to impaired balance, use of psychotropic medications, dependent (with transfers, pain, muscle weakness, and contractures). Interventions placed on 08/11/2021 were to use a mechanical lift with transfers. It did not specify how many staff were to assist with the mechanical lift for transfers. There were no revisions noted. Continued review of the CCP revealed the resident was identified as having a self-care deficit due to a decline in activities of daily living (ADL) with interventions to include, two staff assist required for bed mobility, initiated on 07/24/2024. Review of R1's PT Evaluation & Plan of Treatment, dated 04/11/2024, revealed that PT assessed R1 as being dependent at baseline on safely transferring from lying to sitting on the side of the bed with no back support. Further review revealed the resident had non-weight bearing status in bilateral lower extremities (BLE). Further review revealed the resident was dependent on staff for chair/bed-to-chair transfers, and due to R1's diagnosis of quadriplegia, sit-to-stand was non-applicable. Review of R1's Physical Therapy Treatment Encounter Note, dated 04/18/2024, revealed the physical therapist (PT) noticed increased swelling in R1's right lower extremity and informed the nurse on duty. According to the note, R1 had tenderness in the area but no severe pain with movement. Review of R1's, Change In Condition (CIC), dated 04/18/2024 at 2:47 PM, revealed the former Director of Nursing (DON) assessed R1 for a CIC related to her right knee. According to the CIC report, the former DON found non-pitting edema with redness and warmth in R1's right knee. The former DON did not conduct any additional review of systems. The nurse practitioner (NP) and R1's responsible party were notified. Review of R1's Nurse Progress Notes, dated 04/18/2024 at 3:58 PM, revealed R1 presented with swelling, redness, and warmth in the right knee. Resident 1 denied any pain. According to the progress note, R1 stated that she did not fall or hit her leg on anything. The nurse notified the NP, who ordered a stat (immediate) radiograph (x-ray) of the right knee. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility Reported Incident (FRI), undated, revealed on 04/18/2024 at approximately 2:30 PM, R1 was assessed by PT as having edema to her right knee. According to the FRI, R1 stated she did not have any pain, nor did she know why her knee was swollen. R1 denied having fallen or injuring her knee. The resident was again questioned on 04/19/2024 and stated during an incorrect transfer, she hurt her knee. Further review revealed no staff had any knowledge of a fall or incorrect transfer. Review of R1's, Fall Event Report, dated 04/19/2024 at 10:55 AM, revealed the resident had a witnessed fall with injury out of her bed. According to the report, R1 denied any complaint of pain and reported that she fell a few nights ago, but was unable to recall the date/time of the fall. Review of R1's Fall Risk Score Total, dated 04/19/2024 at 10:55 AM, revealed a fall score of 14, indicating a high risk for falls. The evaluation revealed R1 required staff assistance for mobility and transfer. Review of R1's, Nursing Progress Note, dated 04/19/2024 at 10:58 AM, revealed the resident stated that a few days ago the aide was helping transfer her from bed to her wheelchair. During the transfer, the resident fell . The resident states that she currently has no pain. Review of R1's, Nursing Progress Note, dated 04/19/2024 at 11:00 AM, revealed the radiology report was faxed to the triage nurse for the nurse practitioner to review. Review of R1's, Nursing Progress Note, dated 04/19/2024 at 11:04 AM, revealed R1 was transferred to a local hospital related to a right knee fracture. The State Survey Agency (SSA) surveyor requested a copy of R1's x-ray report from the Care Consultant on 09/09/2024 at 5:00 PM, however, the facility did not provide the document. Review of R1's Emergency Department (ED) Note, dated 04/19/2024 at 5:54 PM, revealed R1 presented to the ED following a fall and was assessed with symptoms of pain, swelling, and loss of mobility in the right lower extremity. According to the ED notes, R1 stated during a transfer from the bed to her wheelchair, one aide tried to do the transfer alone but was unable to and dropped R1 on the floor. Per the note, an x-ray was performed at 2:49 PM on 04/19/2024, and the findings showed an acute, comminuted (broken into multiple fragments) and impacted (high-impact forces or sudden, severe compression) fracture of the distal right femur. Further review of the ED notes revealed R1 rated her pain as four (meaning moderate pain) on a universal pain scale of one to 10, with 10 indicating worst pain possible. At 1:32 PM, R1 received morphine (an opiate pain reliever) 4 milligrams intravenously (IV) for pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During observation and interview with R1 on 09/04/2024 at 12:30 PM, she stated she had fallen and broken her femur in April 2024 while being transferred from her bed to the wheelchair. The resident stated she required a mechanical lift for all transfers because she was quadriplegic. She stated she explained this to the Certified Nursing Assistant (CNA) who came to assist her with transferring her from her bed to the wheelchair. R1 stated the aide insisted she could transfer the resident without the mechanical lift and asked the resident to stand up, despite informing the aide she could not use her legs. The resident stated that while sitting in her bed the CNA assisted her to the side of the bed and tried to lift her. The resident stated she then fell . R1 stated that after the fall, EMS transferred her to the hospital where she underwent surgery. The resident stated she was unable to identify the CNA and never saw the CNA again. Further interview with R1, on 09/04/2024 at 12:30 PM, she stated that after the fall, other staff members helped her back into bed. She stated the nurses did not assess her after the fall, despite the obvious deformity of her leg, which she believed indicated a fracture. R1 stated that she had informed the staff about her pain for several days, but no action was taken until she arrived at the Emergency Department (ED). She stated she did not receive pain medication after her injury. The State Survey Agency (SSA) Surveyor asked the resident to rate her pain utilizing the Pain Scale of 1 to 10, with 10 being the most severe pain. R1 stated her pain was about a 7 out of 10, which indicated severe pain. The resident stated her pain was finally relieved by intravenous (IV) pain medication upon arrival at the hospital. During an interview with Family (F) 6, on 09/12/2024 at 11:20 AM he stated that the facility notified him in April 2024 that R1 had fallen. He stated the facility did not provide details on how the fall occurred. However, when he spoke to R1, she explained that a CNA had come in to her room to transfer her into a wheelchair, but did not have a mechanical lift in the room. He stated R1 told the CNA three times that she could not stand and needed the mechanical lift, but the CNA insisted on transferring her without it. As a result, F6 stated R1 fell on to her knee during the transfer. Family 6 stated R1 told him that several staff members entered the room and placed her back into bed after the fall, but he is unsure if a nurse assessed R1 for injuries at that time. He stated R1 informed him that she had expressed concerns related to pain and something in her leg not feeling right to the staff for several days after the fall, but her concerns were ignored. Family 6 stated during a conversation with R1's orthopedic surgeon, the physician noted that R1's injury would have caused excruciating pain for someone without a spinal cord injury. However, due to R1's injury, her pain was dulled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Paramedic on 09/12/2024 at 2:13 PM, he stated on 04/19/2024 around 12:00 PM, when he arrived at the facility to transfer R1 to the local hospital, he was informed by LPN5 that R1 had a fractured femur. He stated he reviewed paperwork which included x-rays dated 04/19/2024 at 5:18 PM. He stated he was concerned the facility was negligent in responding to the resident's needs after her fall and their failure to transport the resident to the hospital earlier. Per the interview, he stated LPN5 mentioned that they were unsure when R1 fell , but an x-ray was taken on 04/18/2024. LPN5 described the incident as an unwitnessed fall and stated that staff found R1 on the floor, but no one took responsibility for the fall, and the exact cause remained unknown. He stated he assessed R1 and noted that she was alert and oriented to person, place, time, and situation. The Paramedic stated that R1 informed him that during a transfer to her wheelchair, They dropped me and expressed frustration, stating, I told them for two days something wasn't right, but they ignored me and did nothing. The paramedic observed tenderness and R1 complained of pain in her right knee and leg. Upon assessment, he stated R1 had swelling of her knee and distal aspect of the right thigh, as well as external rotation of the right foot. During an interview with CNA4 on 09/06/2024 at 10:35 AM, she stated residents transferred by a mechanical lift usually require the assistance of two persons. She stated she has received training on how to use the mechanical lift and the proper reporting protocol for falls. CNA4 stated she was not aware of the specific mechanical lift policy. Additionally, she stated that although a care plan may require a mechanical lift, if she is able to do it alone, she would transfer the resident without the aid of the lift and stated further, I just go and do it. During an interview with CNA2 on 09/06/2024 at 1:15 PM, she stated that it always takes two people to use a mechanical lift. She stated that a resident deemed to require a mechanical lift cannot be lifted by just one person. During an interview with Licensed Practical Nurse (LPN) 6 on 09/09/2024 at 4:42 PM, she stated that R1 was not bedbound and does get out of bed once or twice a week. LPN6 stated R1 was dependent upon staff due to her diagnosis of quadriplegia and was care planned to use a mechanical lift for chair/bed-to-chair transfers. LPN6 stated further that on 04/18/2024, the PT informed her that R1 had redness and swelling in her knee. She stated she assessed R1 who complained of a sore knee. LPN6 noted that the PT was with her during the assessment. LPN6 stated R1's right leg was red and swollen but with no bruising. In a continued interview, on 09/09/2024 at 4:42 PM, LPN6 stated she assessed R1 and called the on-call Advance Practice Nurse Practitioner (APRN), who ordered a stat x-ray. She stated she believed the x-ray provider performed the procedure that same afternoon, but she did not recall the time. She stated the results were not back when her shift ended; however, LPN6 stated she reported to RN2 to look for R1's x-ray results. She stated that when she returned to work, she could not believe that R1 had a fractured leg because she did not believe the resident fell on her shift and the resident did not complain of pain. During an interview with Registered Nurse (RN) 2 on 09/10/2024 at 2:05 PM, she stated she cared for R1 during night shift on 04/18/2024. She stated she remembered knowing about the resident's fall but did not recall receiving R1's x-ray results report while on duty. She stated that the contracted x-ray service company would usually call the nurse on duty when an abnormal result, such as a fracture, occurred. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with RN4 on 09/20/2024 at 2:38 PM, she stated she was unaware of a mechanical lift policy; however, staff were to follow the manufacturer's guidelines for mechanical lift use. Further, she stated she had not read the guidelines nor knew where to find the manufacturer's guidelines for the lift. RN4 stated that current nursing standards were to use two persons during a mechanical lift unless told otherwise. She stated she was unaware of any incident when staff transferred R1 without using a mechanical lift. During an interview with RN5 on 09/20/2024 at 2:38 PM, she stated staff should document the use of a mechanical lift as an intervention in the resident's care plan. RN5 stated that staff can provide one-person assistance during a mechanical lift transfer based on the resident's needs, but she stated current nursing standards require the use of a two-person assist during a mechanical lift transfer for the safety of the resident. RN5 stated she was unsure of where to find the manufacturer ' s guidelines and had not read them. During a telephone interview with Unit Manager (UM) 1 on 09/11/2024 at 3:58 PM, she stated she was unfamiliar with R1, although she resides on UM1's unit. She stated it was her expectation for staff to follow the care plan for mechanical lifts. She stated if a resident was care planned for a mechanical lift, she expected the staff to use a mechanical lift for transfers. Additionally, UM1 stated it was important to follow the care plan so that staff would not compromise residents' safety by attempting to move them without a mechanical lift. During an interview with the PT on 09/10/2024 at 10:27 AM, she stated the therapy department had been regularly attending to R1, since admission. According to the PT, R1 has incomplete quadriplegia and experiences occasional pain and limited mobility. The therapist had been working with R1 on bed mobility and observed no swelling or pain in R1's knee the day before. However, on 04/18/2024, the PT noticed swelling, redness, and warmth in R1's lower femur and knee. The therapist informed LPN6 about the issue, and LPN6 said she would address it. During the assessment, R1 appeared alert and oriented and did not complain of pain. The PT also noted that R1 did not know what caused her knee to swell. During an interview with the APRN on 09/10/2024 at 10:12 AM and 3:20 PM, the APRN stated that she was not on duty at the time of the incident and could not recall specific concerns regarding R1's fall and femur fracture. She noted that the nurse calls the on-call APRN when a resident falls and she expected staff to inform her of any falls and report any delays in care, such as a delayed x-ray. She stated if a bone was deformed or the resident needed emergent care, she would send the resident to the ED. She stated it was important that all care plans were followed. Further, the APRN stated the facility's policies and procedures should be followed to ensure the safety and well-being of the residents. She further stated that resident-centered care was important to maintain the resident's quality of life. During a telephone interview with the former DON on 09/12/2024 at 11:15 AM, she stated she was the DON from April 2024 to July 2024. She stated that R1 fell , but the cause could not be identified. She indicated that she conducted most of the investigation with the Care Consultant. Further, she stated she did not have additional information to add related to the resident's fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Care Consultant on 09/10/2024 at 12:24 PM, she stated she and the former Director of Nursing (DON) investigated R1's injury. She said the investigation involved reviewing R1's medical record and conducting staff interviews. Per the interview, the Care Consultant stated the resident's recollection of the event changed and she could not identify the staff member involved. She stated staff interviews did not reveal any specific event or incident that led to the resident's injury. Further interview on 09/10/2024 at 12:24 PM, the Care Consultant stated a one- or two-person assist may be required to use the mechanical lift depending on the situation. She stated that there was no specific mechanical lift policy; however, it was her expectation staff adhered to the mechanical lift manufacturer's instructions. In addition, the Care Consultant stated it was her expectation that staff would follow the resident's care plans and provide timely updates for any change in condition. During an interview with the Interim Director of Nursing (IDON) on 09/20/2024 at 11:48 AM, she stated she has been at the facility since 09/03/2024 to train the ADON and has since taken on the role of IDON. The IDON revealed that staff members were trained in using the mechanical lift, and she stressed the importance of training to prevent any potential safety risks for the residents. The IDON stated CNAs could access resident care plans in the EMR, and they carried paper care plans for quick reference. She stated that following the care plan was crucial for providing resident-centered care. During an interview with the Administrator on 09/17/2024 at 2:32 PM, he stated it was his expectation staff followed all the facility's policies to keep residents safe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44001 Based on observation, interview, review of the Centers for Disease Control and Prevention's (CDC) document, review of medication package inserts, and review of the facility's policy, the facility failed to ensure appropriate environmental controls were used to preserve their integrity in one of two medication refrigerators. Additionally, the facility failed to ensure drugs and biologicals were stored per currently accepted professional principles for six of 96 residents (Residents (R) 7, R8, R9, R10, R27, and R28). Observation on 09/04/2024, revealed one opened and undated vial of purified protein derivative (PPD), (used in a tuberculin skin test for tuberculosis) was found in the [NAME] Unit medication refrigerator. On 09/04/2024, during an observation of the medication cart on the 700 Hall, it was noted that multiple eye drops and insulin vials were not dated when opened. All the insulin pens were found to be opened and undated. Additionally, four insulin pens were not stored in separate plastic bags. One insulin pen lacked the original pharmacy label and had the resident's name written on it with a dark marker. The writing was barely legible due to the pen being dark blue. An antibiotic ointment was stored in the same drawer as insulin and eye drops. The findings include: Review of the facility's policy titled, Medication Storage, dated 01/2023, revealed the purpose of the policy was to ensure medications and biologicals were stored properly following manufacturer's recommendations to maintain their integrity. Per the policy, the pharmacy dispensed medication and containers that met state and federal labelling requirements. The medications were to remain in these containers. Internally administered medications were to be stored separately from ointments. Further review of the policy revealed medication storage conditions were monitored on a regular basis as a random quality assurance (QA) check. Review of the facility's policy titled, Medication Administration, revised 06/24/2024, revealed the purpose of the policy was to ensure medications and biologicals were administered in accordance with the manufacturer's recommendations to maintain their integrity. Per the policy, licensed staff should check the expiration date on the package/container. Review of the package insert/product label revealed PPD was used as an aid in the detection of infection with mycobacterium. Further review revealed a multi-dose vial of PPD, which had been opened and used, should be discarded after 30 days. 1. Observation of the [NAME] Unit's medication room refrigerator on 09/04/2024 at 10:10 AM, revealed one opened vial of PPD, not stored in its original packaging, with no opened date listed on the vial. The original packaging was on the shelf next to the vial, but it did not have an open date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed Practical Nurse (LPN) 1 on 09/04/2024 at 10:13 AM, she stated the nursing staff monitored refrigerators routinely to check for outdated or expired medications and vaccines. She stated when a medication was expired it should be sent back to pharmacy or discarded. LPN1 stated she did not know why the PPD vial was not dated. However, she stated it was important to date and store medication according to the manufacturer's instruction and the facility's policy to ensure the safety of the residents. 2. Observation of the 700 Hall medication cart on 09/04/2024 at 11:18 AM, revealed R7's insulin lispro was opened and not dated; R8's insulin lispro, insulin glargine, Lantus, latanoprost 0.005%, Betimol 0.5% eye drops, and Novolog pen were opened and not dated. R8's Novolog pen had no original pharmacy label, but the resident's name was written on the dark blue pen in barely visible black ink; R9's insulin lispro, insulin glargine, and Ketorolac 0.5% eye drops were open and not dated; R10's insulin lispro was opened and not dated; R27's Betimol 0.5% eye drops and Dorzolamide HCL 2% eye drops were opened and not dated; and R28's Bacitracin ointment was open, not dated, and stored with insulin pens and vials, and with eye drops. The tube was not in its original package and had no identifying resident label. During an interview with LPN1 on 09/04/2024 at 11:18 AM, she stated she was the nurse in charge of the 700 Hall medication cart. LPN1 stated that according to the facility's policy, nursing staff should date all vials, pens, and ointments when opened. She stated she was unsure if anyone in the facility conducted routine medication audits on any of the medication carts. The LPN stated nursing staff should discard all expired medicines. LPN1 further stated all opened eye drops, and insulin should be discarded 30 days after opening. During an interview with LPN7/Unit Manager (UM) on 09/10/2024 at 9:57 AM, she stated the nurse taking the cart was responsible to check for undated or expired medications. LPN7/UM stated as the Unit Manager she did not do formal audits of the medication carts and was unaware the 700 Hall medication cart had multiple opened and undated medications. She stated it was her expectation that nurses and Kentucky Medication Aides (KMA) label the medication vial, bottle, or insulin pen with the date it was opened. She stated further it was her expectation nurses and KMAs ensure medications were not expired prior to administering any medication. During an interview with the Infection Preventionist/Staff Development Coordinator (IP/SDC) on 09/06/2024 at 1:35 PM, she stated nurses working the medication carts were responsible for checking the medication carts and refrigerators for expired medications. She stated nursing leadership did not conduct formal audits of the medication carts and refrigerators. She stated that nurses were educated on policies and procedures related to medication administration and as nurses should follow nursing standards to label and date medication when opened. She stated it was her expectation that nurses and KMAs monitor the medication carts and the medication refrigerator to ensure the integrity of medications administered to residents. She stated it was important for the safety of the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Assistant Director of Nursing (ADON) on 09/20/2024 at 11:27 AM, she stated it was her expectation staff followed all the facility's medication administration policies and procedures. The ADON stated nurses and KMAs must date all multiuse medications when opened. The ADON stated it was important that nurses date all medications upon opening them to maintain the efficacy of the medication and for the safety of the residents. The ADON stated further that the nurse or KMA assigned to the cart was responsible to ensure that all medications were dated and labeled. She stated she did not require nurses to check every medication on the medication cart for expiration dates. The ADON stated nurses should ensure medications were not expired prior to administering any medication. During an interview with the Interim Director of Nursing (IDON) on 09/20/2024 at 11:48 AM, she stated it was her expectation that medications in the medication cart and refrigerator were stored according to the facility's policy and manufacturer's guidelines. She stated multi-dose vials should be dated when opened and discarded according to labeling instructions, and medication should not be stored in the refrigerator door. She further stated it was important to discard all expired medications to ensure their efficacy. The IDON stated she did not know why the bottle of PPD was not dated when opened. She stated it was important to date medication when opened and store all refrigerated medication properly to ensure the safety of the residents and safeguard the efficacy of the medication. During an interview with the Care Consultant (CC) on 09/20/2024 at 10:15 AM, she stated there was no scheduled medication cart audits by nurse leadership. The CC stated it was her expectation nurses and KMAs date medications when opened according to facility's policy. She stated if a nurse observed that a medication was opened and not dated, she should check the delivery date of the medication and if it was greater than the recommended shelf-life or was expired, it should be disposed of appropriately. She stated it was important to monitor the medication carts and the medication refrigerator to ensure the integrity of medications administered to residents. She stated it was important for the safety of the residents. During an interview with the Administrator on 09/17/2024 at 2:32 PM, he stated it was his expectation staff followed all of the facility's policies to keep residents safe. During a telephone interview with the Medical Director on 09/10/2024 at 4:05 PM, he stated it was his expectation staff followed all of the facility's policies and procedures related to all resident care. He stated it was important for the safety and well-being of the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, record review, and review of the facility's policies and review of the contracted company's policies and documents it was determined the facility failed to store food in the residents' refrigerator in a safe and sanitary manner. This affected 25 of 96 current residents. Observation of [NAME] Unit's resident food freezer on [DATE] revealed there was no thermometer in the freezer. An unfrozen ice gel pack was observed in the freezer. Additionally, multiple frozen food boxes were stored inside grocery bags, and were unlabeled and undated. The boxes of food were not frozen solid. The freezer compartment floor was dirty with melted liquid, packaging debris, dirt, food particles, and hair. The findings include: Review of the Federal Food and Drug Administration's (FDA) document titled, Safe Food Handling, current as of [DATE], revealed the freezer operating temperature should be zero degrees Fahrenheit (F). Frozen food should be frozen solid. Staff should reject if fluids or water stains appeared in the bottom of the freezer or on packaging; or if there was ice crystals or frozen liquids on the food or the packaging. Review of the Dietary Service Agreement, between the facility and the contracted service provider (CSP), dated [DATE], revealed the Registered Dietitian (RD) shall inspect all areas of the dietary department. Additionally, the RD was responsible to provide guidance and training to the Dietary Manager and dietary staff as required. Review of the CSP's Job Description titled, Dining Services Director/Account Manager, not dated, revealed the Dining Services Director was responsible for food safety and would ensure that established sanitation and safety standards were maintained. Review of the [NAME] Unit's nourishment refrigerator and freezer temperature logs on [DATE] at 11:37 AM, revealed the freezer temperature was recorded as four degrees Fahrenheit (F) on [DATE]. Staff previously logged temperatures of two degrees F on [DATE], six degrees F on [DATE], and three degrees F on [DATE]. On [DATE] at 11:45 AM, [DATE] at 9:57 AM, [DATE] at 1:56 PM, and [DATE] at 10:15 AM, State Survey Agency (SSA) surveyor requested documentation for ,d+[DATE], ,d+[DATE], and ,d+[DATE] of the nourishment refrigerator/freezer temperature logs. The facility did not provide the requested documentation. On [DATE] at 9:57 AM, [DATE] at 1:56 PM, and [DATE] at 10:15 AM, the SSA surveyor requested a Resident Food/Nourishment Storage policy. The facility did not provide the requested documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the [NAME] Unit's resident nourishment freezer on [DATE] at 11:37 AM, revealed the freezer unit felt warm and it was noted that there was no thermometer in the freezer. The recorded temperature on the facility's Temperature Log, dated [DATE] was four degrees F. Staff previously logged temperatures of two degrees F on [DATE], six degrees F on [DATE], and three degrees F on [DATE]. An unfrozen ice gel pack was observed in the freezer. Additionally, multiple frozen food boxes stored inside grocery bags were unlabeled and undated. The freezer compartment floor was noted to have melted liquid, packaging debris, dirt, food particles, and hair. During an interview with the Interim Director of Nursing (IDON) on [DATE] at 12:01 PM, she stated the night shift nurses monitored the nourishment refrigerator/freezer and documented the temperature on the posted Temperature Log. She stated everyone was responsible to ensure that the refrigerator and freezer were kept clean and sanitary and ensured food was stored according to policy. She stated the nourishment refrigerator/freezer was used for residents only and no staff food should be stored with resident food. Additionally, the IDON stated that all residents' food should be labeled and dated. During an interview with LPN7/Unit Manager (UM) on [DATE] at 9:57 AM, she stated that the refrigerator and freezer temperatures were taken daily on the night shift. She stated the freezer should be at zero degrees F or below. During an interview with Licensed Practical Nurse (LPN) 11 on [DATE] at 3:12 PM, she stated it was everyone's responsibility to check expiration dates, log refrigerator and freezer temperatures, and keep the nourishment refrigerator clean. LPN11 stated there was no set cleaning schedule, but the night shift clinical staff, the UM, and the dietary staff cleaned it weekly. The LPN stated the freezer should be at 32 degrees F. During an interview with Registered Nurse (RN) 3 on [DATE] at 3:12 PM, she stated it was everyone's responsibility to check expiration dates, log refrigerator and freezer temperatures, and keep the nourishment refrigerator clean. RN3 stated there was no set cleaning schedule, but the night shift clinical staff, the UM, and the dietary staff cleaned it weekly. RN3 stated the freezer should be at 32 degrees F. During an interview with the Dining Services Director (DSD) on [DATE] at 2:20 PM, he stated dietary staff stocked the nourishment refrigerator daily with snacks and ordered supplements. He stated stock was rotated. He stated that if staff saw that the nourishment refrigerator was not working properly, it would be his expectation that they notified the UM or himself. During a continued interview with the DSD on [DATE] at 3:55 PM, he stated that it was everyone's responsibility to ensure the cleanliness of the nourishment refrigerator, check the temperature of both the refrigerator and freezer, and monitor food expiration dates. He stated that the nursing staff was in charge of recording temperatures on the daily temperature log and that he followed the CDC's food storage guidelines. The DSD also stated the residents' nourishment freezer should be maintained below 32 degrees F. The DSD stated storing residents' food according to food safety guidelines was important for the safety of the residents and to prevent food-borne illness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview with the RD on [DATE] at 11:52 AM, she stated she was currently covering for someone on leave. The RD stated the CSP provided dietary services, including RD clinical services. She stated the CSP followed a policy and procedure manual, but there were occasions when there were policies not included in their manual. In such cases, the RD stated she referred to the facility's specific policy. She stated the dietary staff was responsible for stocking the refrigerators to ensure there were nutritional supplements for the residents. She stated the dietary staff was also responsible for disposing of anything not related to residents, such as staff items. During continued interview the RD on [DATE] at 11:52 AM, she stated, I believe it's the nursing staff that is responsible for keeping the refrigerators cold. The RD stated it was a team effort. She stated that whoever was going in to stock the refrigerator and clean it should be responsible for checking to ensure the temperature was within acceptable parameters. The RD stated it was her expectation that everything in the residents' nourishment refrigerator and freezer should be labeled. She stated for proper storage the freezer temperature should remain at zero degrees F or colder for the safety of the residents and to prevent any food-borne illness. During an interview with the Interim Director of Nursing on [DATE] at 11:48 AM, she stated it was everyone's responsibility to check the refrigerator freezer. She stated the ambassadors continually check their areas in the facility, including the residents' nourishment refrigerator freezer. She stated that everyone was responsible for ensuring the residents' food was dated and not expired. Additionally, she stated that it was everyone's responsibility to ensure that it was clean and that the daily temperatures were logged. The DON state the freezer should be 32 degrees F or below. During a telephone interview with the Chief Executive Officer (CEO) on [DATE] at 2:32 PM, he stated it was his expectation that all staff follow the facility's policy and procedures to ensure the safety of both residents and staff. During a telephone interview with the Medical Director on [DATE] at 4:05 PM, he stated it was his expectation staff followed all the facility's policies and procedures related to all resident care. He stated it was important for the safety and well-being of the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, record review, and review of the facility's policies, the Centers for Medicare and Medicaid Services (CMS), and the Centers for Disease Control and Prevention (CDC) guidelines, it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent and control the development and transmission of communicable diseases affecting five of 96 Residents (Resident 5 (R5), R17, R18, R21, R23). Observation on 09/04/2024 revealed the doors to two droplet precaution isolation rooms, rooms [ROOM NUMBERS], remained open. The trash can inside R17 and R18's room, was overflowing with contaminated personal protective equipment (PPE). An opened bag of hand sanitizer gel was found on top of two boxes of opened gloves on the PPE cart located outside of R23's room, Observation on 09/06/2024 revealed Licensed Practical Nurse (LPN) 2 failed to clean shared vital sign equipment after use on R19's and failed to don (put on) appropriate PPE when entering R30's room, an enhanced-barrier precaution (EBP) room. Observation on 09/06/2024 revealed CNA5 and Unit Manager (UM) 1 failed to don (put on) appropriate PPE when entering R21's room, an EBP room, and failed to properly handle contaminated linen. Observation on 09/09/2024 revealed Registered Nurse (RN) 1 failed to perform hand hygiene after removing contaminated gloves, and before donning a clean pair of gloves. The findings include: Review of the CDC's Guidelines Clinical Safety: Hand Hygiene for Healthcare Workers, dated 02/27/2024, revealed hand hygiene should be used immediately before touching a patient, after touching a patient or patient's surroundings, and immediately after glove removal. Review of the CDC's signage titled, Special Droplet/Contact Precautions, revised 03/09/2020, revealed the door to the isolation room must remain closed. Review of the facility's policy, Infection Control, dated 01/23/2024, revealed the policy's purpose was to maintain a safe, sanitary, and comfortable environment and help prevent and manage transmission of diseases and infections. According to the policy, staff would prevent infections and implement isolation precautions, including standard and transmission-based precautions and provide for the safe cleaning and reprocessing of resident care equipment. Review of the facility's policy, Transmission-Based Precautions (TBP), dated 09/15/2023, revealed TBPs were initiated when a resident developed signs and symptoms of a transmissible infection. Transmission-based precautions may include contact precautions, droplet precautions, or airborne precautions. According to the policy, TBPs signage informs the staff of the CDC precautions and the instructions for use of PPE. PPE (i.e., gloves, gowns, and masks) were maintained outside the resident's room so that anyone entering the room could apply the appropriate equipment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Enhanced-Barrier Precautions, dated 09/15/2023, revealed the policy's purpose was to maintain a safe, sanitary, and comfortable environment and help prevent and manage transmission of diseases and infections. Signage was placed at the room entrance to inform staff of the need for and the type of precaution(s) Additionally, the signage informed the staff of instructions for use of PPE. Review of the facility's policy, Infection Control Disinfection of Non-Critical Patient Care Equipment, dated 01/23/2024, revealed the purpose of the policy was to maintain a safe sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. According to the policy noninvasive, non-critical portable clinical items shared among residents were part of the patient's immediate surroundings and may pose a threat of pathogen transmission. Routine cleaning disinfection should occur for non-critical patient care devices at a minimum when visibly soiled and on a regular basis between patients with an Environmental Protection Agency (EPA) registered hospital disinfectant. The facility did not provide a Hand Hygiene Policy. 1) Observation of the Blue Unit on 09/04/2024 at 8:55 AM, revealed an empty PPE cart outside R17's and R18's room. There were two boxes of opened gloves on top of the cart, with a computer and its cord also placed on top of the gloves. Additionally, the door to the room, which was a droplet isolation room, was open. The trash can inside the room was overflowing with contaminated PPE. Further observation revealed two opened boxes of gloves on top of the PPE cart outside of R23's room. Additional observation of R23's room revealed an open hand sanitizer bag on top of the gloves. Continued observation revealed that the door to R5's room, a droplet isolation room, was open. During an interview with CNA4 on 09/06/2024 at 10:35 AM, she stated she received training upon hire and throughout the year on infection control. CNA4 stated signs on the door indicated the type of PPE required to enter the room. She stated the doors to droplet/contact precaution rooms must remain closed. She could not say why the doors were left open. In addition, CNA4 stated staff were responsible for emptying the trash when it was full and taking it to the soiled utility room. Continued interview revealed staff should store PPE inside individual PPE carts located outside of each TBP room. She stated following infection control policies and keeping trash emptied and doors closed were important to prevent the spread of disease between residents and staff. During an interview with CNA3 on 09/06/2024 at 11:22 AM, she stated she received infection control training, including types of TBPs and using PPE. She stated that signs on the door indicated the type of isolation and the PPE required to enter the room. She stated the doors to droplet/contact precaution rooms should be kept closed if the resident was in the room. Continued interview revealed staff were responsible for emptying trash and bagging contaminated linen before leaving the room. She stated staff take linen and trash to the soil utility room. In addition, CNA3 stated PPE should be stored inside the PPE carts located outside rooms under TBP. She stated following facility policy, and ensuring doors to TBP rooms were closed was important to prevent cross-contamination and the spread of infection to residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA2 on 09/06/2024 at 1:15 AM, she stated doors to droplet isolation rooms must remain closed and that staff must put on PPE according to the signage before entering a TBP room. CNA2 stated before exiting the room staff should remove and dispose of the PPE in the trash. CNA2 stated PPE should be stored inside the PPE carts located outside of each TBP room. She stated following facility policy was important to prevent infections. 2) Observation of the Blue Unit on the 400 Hall on 09/06/2024 at 8:55 AM, revealed CNA6 exited R17's and R18's room, a droplet precaution isolation room, and did not doff her N95 respirator mask. During an interview with CNA6 on 09/06/2024 at 8:55 AM, she stated another staff member, whose name she could not recall, informed her that she was required to wear a N-95 respirator while in a droplet precaution room. However, she stated she was unaware she needed to remove the respirator after leaving the room. CNA6 stated she received infection control training, including information on types of TBPs and proper use of PPE when she was hired. CNA6 emphasized the importance of disposing contaminated PPE before leaving a room to prevent the spread of infection. 3) On 09/06/2024 at 9:05 AM, during an observation of the Blue Unit on the 200 Hall, LPN2 was observed performing a vital sign assessment and administering medications to R19. LPN2 brought the portable vital sign machine from room [ROOM NUMBER] across the hall to plug it into an electrical outlet. After using the machine LPN2 did not clean and disinfect it. Continued observation revealed LPN2 then entered R30's room, an EBP room, without donning PPE and used a portable wrist blood pressure (BP) cuff to take a blood pressure on R30. LPN2 placed the cuff on the medication cart without cleaning and disinfecting it. During an interview with LPN2 on 09/06/2024 at 9:17 AM, he stated he should have worn PPE in the EBP room. He did not provide an explanation for not following the facility's policy. LPN2 stated he received infection control training, including information on types of TBPs and proper use of PPE, when he was hired. Additionally, LPN2 stated signs were posted on the doors to EBP and TBP rooms to guide the staff and indicate the type of isolation and the PPE required to enter the room. LPN2 stated it was important to follow the signs posted on the door and follow the facility's policy to clean and disinfect shared equipment before and after use to prevent cross contamination and this spread of disease. 4) On 09/06/2024 at 9:20 AM, during an observation of the Blue Unit on the 200 Hall, CNA5 and Unit Manager (UM) 1 were observed providing direct care to R21, who was under EBPs. Both UM1 and CNA5 were wearing gloves, but they did not wear all of the appropriate PPE when repositioning R21 and changing his bed linens. Continued observation revealed R21's television remote fell on the floor. CNA5 picked up the remote but did not clean and disinfect it before putting it back on the bed. Additionally, CNA5 threw soiled linen on the floor. Neither the UM nor CNA bagged the contaminated linen before leaving the room. During an interview with CNA5 on 09/06/2024 at 9:28 AM, she stated this was her first day on the floor, and she was still getting used to the workflow. CNA5 stated she received infection control training, including information on types of TBPs and proper use of PPE when she was hired. She also noted that signs on the door indicated the type of isolation and the PPE required to enter the room. CNA5 stated she forgot to take the linen out of the room. She stated it was important to follow infection control policy, so residents 'do not catch diseases. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with UM1 on 09/06/2024 at 9:28 AM, she stated she only needed a gown in an EBP room if she provided direct care to the resident. She stated full PPE was only required when staff provided direct care to a resident. UM1 stated that staff must wear a gown and gloves during high-contact resident care, such as bathing, device care, and wound care. Additionally, UM1 stated she did not stop to educate CNA5 about throwing contaminated linen on the floor because she did not want to do it in front of the SSA surveyor. She stated it was important to place contaminated linen in a plastic bag and not throw it on the floor to prevent the spread of infection. 5) During an observation of the Blue Unit on the 400 Hall on 09/09/2024 at 11:15 AM, Registered Nurse (RN) 1 was observed in the hallway removing her gloves. RN1 did not perform hand hygiene after doffing the gloves. The RN then took a new pair of gloves from the medication cart located in the hallway and did not perform hand hygiene before donning the new gloves. During an interview with RN1 on 09/09/2024 at 11:15 AM, she stated she should not have worn gloves in the hall. Furthermore, she stated she should have performed hand hygiene after removing her gloves and before donning a new pair. Per the interview, RN1 stated hand hygiene should be immediately before touching a patient, after touching a patient or patient's surroundings, and immediately after glove removal. She stated she received infection control training, including information on hand hygiene, types of TBPs, and the proper use of PPE when she was hired. She stated further it was important to follow infection control guidelines to prevent the spread of infection and keep residents safe. During an interview with the Infection Prevention/Staff Development Coordinator (IP/SDC) on 09/06/2024 at 1:35 PM, she emphasized the importance of following infection prevention and control procedures (IPCP). The IP/SDC stated it was important to keep room doors closed if the resident was on droplet precautions to prevent the spread of infectious droplets outside the room. She stated it was the responsibility of staff to empty trash when full. She stated staff know to doff PPE inside the resident's room. The IP/SDC stated it was never appropriate to doff PPE in the hallway. Per the interview, staff were to bag contaminated PPE and linen and place it in hampers in the dirty utility room. She stated that in an EBP room, staff do not need PPE if they do not anticipate contact with the resident or their belongings; however, staff must don PPE for direct care or if they touch the resident's belongings. Furthermore, the IP/SDC stated she expected staff to perform hand hygiene with alcohol-based hand rub (ABHR), or soap and water, before and after each resident's care. She stated that all staff were to use gel when going in and out of rooms. According to the IP/SDC, staff must hand sanitize before and after donning and doffing of all PPE. In addition, all shared medical equipment, such as the rolling vital sign machine and BP cuffs, should be sanitized between each resident use with Clorox Bleach Wipes. She stated it was important to prevent contamination of clean supplies and stop the spread of infection. During continued interview, the IP/SDC stated the facility followed its policies and CDC guidelines and that it was essential to adhere to policies and procedures to prevent the spread of infection, especially to residents at risk of infection or rehospitalization . The IP/SDC stated nurse leadership, including the DON, ADON, and the Unit Managers (UM), were well-trained in infection prevention and control practices. She stated they usually do monthly in-service with ongoing education related to hand hygiene, CDC guidelines, and personal protective equipment. She stated they do not formally audit staff, but if she saw a breach in infection control, she stopped and educated staff on the spot. The IP/SDC stated it was her expectation that staff knew what type of isolation precaution the resident was in and keep up with daily changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185300	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summerfield Rehab & Wellne	1877 Farnsley Road Louisville, KY 40216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with the Interim Director of Nursing (IDON) on 09/20/2024 at 9:15 AM, she stated staff received training on infection control upon hire. She stated the IP/SDC and nursing leadership monitored staff for infection control compliance. Further interview revealed the purpose of cleaning and sanitizing shared equipment, proper hand hygiene, and correct use of PPE was to decrease the risk of transmission of infection. The IDON stated it was her expectation all staff followed the facility's policy and procedures related to ICP. During an interview with the Administrator on 09/17/2024 at 2:32 PM, he stated it was his expectation staff followed all the facility's policies to keep residents safe. During a telephone interview with the Medical Director on 09/10/2024 at 4:05 PM, he stated it was his expectation staff followed all the facility's policies and procedures related to all resident care. He stated it was important for the safety and well-being of the residents.