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	01/28/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to treat each resident with dignity, and care in a manner and environment that promotes maintenance or enhancement of his or her quality of life for three (3) of seventy-one (71) sampled residents (Residents #1, #11, and # 324). Resident #324 stated he/she was not incontinent, but staff told the resident to use a brief, causing Resident #324 to sit in his/her own feces and urine until assisted. Resident #1 had a severe hearing impairment. He/she had a caption phone in his/her room that had not been functional for an unknown amount of time. The facility was made aware by the resident, but failed to ensure the resident had an effective means of communication. Certified Nursing Assistant (CNA) #11 left Resident #11 lying naked in bed while obtaining supplies during a bed bath. The findings include: Review of the facility's policy titled Resident Rights, revised 09/13/2023, revealed the facility would protect each resident's right to be treated with dignity. 1) Review of Resident #324's Face Sheet revealed the facility admitted the resident on 01/03/2024 with diagnoses that included pneumonia, gastroesophageal reflux disease, muscle weakness, difficulty walking, type 2 diabetes mellitus, Guillain-Barre syndrome, chronic inflammatory demyelinating polyneuritis, hypertension, atrial fibrillation, and congestive heart failure. Resident #324 currently had a stage III pressure ulcer. Review of Resident #324's Admission Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) which indicated the resident was cognitively intact. Further review revealed the facility assessed the resident as dependent on staff for toileting, bathing, and lower body dressing. Continued review revealed the facility assessed the resident as frequently incontinent of bowel and bladder. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident's #324's Baseline Care Plan, dated 01/04/2024, revealed the resident's bowel and bladder elimination was within normal limits. The Care Plan goal was to maintain present patterns without adverse side effects. Review of the Care Plan, revised on 01/23/2024, revealed the resident was not care planned for incontinence of bowel and bladder. The resident was care planned for activities of daily living (ADL) with a long term goal to maintain functional ability with no significant decline through the next review. An intervention stated staff would provide incontinence care needs and toileting needs every shift. Review of a Progress Note, dated 01/04/2024 at 2:25 PM, revealed when Resident #324 arrived at the facility, he/she was alert and oriented to person, place, and time. It was noted that the resident was continent of bowel and bladder. Observation and interview with Resident #324, on 01/22/2024 at 4:10 PM, revealed he/she was very upset over the treatment he/she had received at the facility. He/she stated on the first night at the facility he/she was told by a CNA that he/she would have to wear briefs. Resident #324 stated, The aide said that if I soiled the bed, I could just lie in it till they got around to cleaning me up. Resident #324 could not remember the CNA's name. The resident stated, I felt coerced to wear diapers although I am fully continent. It's undignified and I am embarrassed. During the observation and interview, on 01/22/2024 at 4:10 PM it was noted that there was a bedside commode in the room and a bedpan in the bathroom. The resident stated that he/she had never used the bedside commode while in the facility because it required staff assistance to place him/her on it. Resident #234 stated that there was never enough staff available to help him/her when needed. Additionally, Resident #324 stated that he/she suffers from constipation, and when laxatives were given, it became very difficult to control his/her bowel movements. The resident stated those were the only times when he/she has had incontinent episodes. The resident stated that he/she was forced to wet and soil his/her brief because staff would take so long to provide assistance. Resident #324 further stated that if staff came when he/she rang the bell, he/she was fully capable of using the bedpan. In an interview with Licensed Practical Nurse (LPN) #4, on 01/23/2024 at 4:15 PM, she stated Resident #324 was alert and oriented and capable of expressing his/her preferences. The LPN stated the resident was continent of bowel and bladder and would call for assistance with the bedpan. LPN #4 stated the resident did have some incontinent diarrhea stools while on antibiotic therapy. In an interview with the Administrator, on 01/28/2024 at 5:05 PM, she stated it was her expectation that each resident be treated with dignity. She stated that it was one hundred percent the resident's right to make choices. She stated it was important because the facility was the resident's home and they had the right to make their own decisions. She further stated it was her expectation that all staff were to assist residents and answer lights. 49267 2) Review of Resident #1's Face Sheet revealed the facility admitted the resident on 06/24/2021 with diagnoses of bilateral sensorineural hearing loss, chronic obstructive pulmonary disease (COPD), and Type II diabetes. Review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS' score of fourteen (14) out of fifteen (15), indicating the resident was cognitively intact. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Care Plan, dated 12/10/2023, revealed an intervention to provide adaptations as needed for hearing loss. Observation on 01/22/2024 at 3:21 PM revealed Resident #1 was able to effectively read lips when his/her roommate was directly in his/her view. Additional observations revealed the caption phone on the resident's bedside table was on and connected to power. In an interview on 01/24/2024 at 8:53 AM, Resident #1 stated his/her phone had not worked in a long time. The resident stated it worked when he/she first came to the facility in 2021. He/She further stated he/she notified staff multiple times, but it was never repaired. Resident #1 stated he/she thought it just needed to be connected to the Internet. In an interview on 01/24/2024 at 9:02 AM with Resident #79 (Resident #1's roommate), he/she stated he/she helped Resident #1 communicate with staff. A phone interview was attempted with Resident #1's daughter on 01/24/2024 at 2:57 PM. A message was received that calls were not accepted and there was no capability of leaving a voicemail message. There were no alternate numbers listed for the resident's daughter, and Resident #1 was unable to provide an alternate telephone number. A phone interview was attempted with Resident #1's son on 01/24/2024 at 3:01 PM. A voicemail message was left and Resident #1's son replied via text message and stated he would call later in the evening after work. The State Survey Agency (SSA) Surveyor never received a phone call. A phone interview was attempted twice more with Resident #1's son on 01/23/2024 at 11:01 AM and 12:52 PM, and a return call was never received. In an interview CNA #5, on 01/25/2024 at 10:22 AM, she stated Resident #1 read lips well. She further stated she knew Resident #1 had a phone that did not work. CNA #5 stated at some point the facility had some type of trouble with phones and a phone company, so maybe that had something to do with the problem, but she did not really know. In an interview with the Plant Director, on 01/26/2024 at 12:14 PM, he stated he did not know much about Resident #1's phone other than he heard at some point it needed Internet. He further stated the phone was an issue he was responsible for and it would be addressed. In an interview with the DON, on 01/26/2024 at 4:20 PM, she stated she was not aware of an issue with Resident #1's phone. She was then notified by the SSA Surveyor that Resident #1 had a caption phone that allowed him/her to talk to people outside of the facility, and the phone was not functional. In an interview with the Medical Records Registered Nurse (RN) on 01/27/2024 at 2:39 PM, he stated he looked at the phone a short time ago and it was connected to Wi-Fi. He further stated he used his phone to call Resident #1's phone and captions appeared. He stated the problem was with the number she had called, he explained the issue to the resident, and she verbalized understanding. He stated he obtained alternate contact numbers of family members for Resident #1. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In further interview with the DON, on 01/28/2024 at 2:02 PM, she stated the facility used white boards or other written means to communicate with hearing impaired residents. The DON was not able to address outside communication for hearing impaired residents. The DON stated she was not aware of Resident #1's caption phone and did not know the care plan was not followed. She further stated a hearing impairment with interventions for communication should be addressed on a care plan. In an interview with the Administrator, on 01/28/2024 at 6:19 PM, she stated she made sure care plans were followed through clinical meeting reviews, policy and procedures, and communication with the DON and MDS coordinator. The Administrator stated it was her expectation that all channels of communication, both inside and outside the facility, were available for hearing impaired residents. 46710 3) Review of Resident #11's Face Sheet revealed the facility admitted the resident on 06/26/2018 with diagnoses including congestive heart failure, acute respiratory failure, and chronic obstructive pulmonary disease (COPD). Review of Resident #11's Quarterly MDS, dated [DATE], revealed the facility assessed the resident with a BIMS' score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility assessed the resident as dependent on staff for upper and lower body dressing, bathing, and personal hygiene. Observation on 01/25/2024 at 11:06 AM revealed CNA #11 providing Resident #11 with a partial bed bath and incontinence care. Resident #11 was completely naked, and the curtain was open when the SSA Surveyor entered the room. Resident #11's roommate (Resident #59) was also present in the room, within view of Resident #11's naked body. Further observation revealed CNA #11 closed the curtain, but the resident remained naked with no sheet or towel covering him/her from 11:08 AM to 11:12 AM while CNA #11 left the room to obtain additional linens. In an interview on 01/25/2024 at 4:22 PM, CNA #11 stated her process to provide a resident with privacy while changing his/her briefs or clothes was to close the door and the curtain. Per interview, CNA #11 would cover the resident with a towel or a sheet if she had to leave the room to get supplies. CNA #11 further stated keeping the resident covered was important for resident dignity and privacy. In continued interview, CNA #11 stated she forgot to cover Resident #11 when she left the resident's room to obtain additional linens. In an interview on 01/28/2024 at 2:03 PM, the DON stated it was her expectation that staff cover a resident if they had to leave to obtain additional supplies during a bed bath. In an interview on 01/28/2024 at 5:05 PM, the Administrator stated it was her expectation that each resident be treated with dignity because the facility was the resident's home. She further stated it was important in promoting resident dignity for staff to cover a resident if they needed to leave the room during a bed bath.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46710 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to honor the resident's right to self-determination as related to choosing his/her daily schedule for one (1) of seventy-one (71) sampled residents (Resident #4). The facility failed to get Resident #4 out of bed timely in the morning according to his/her preferences. The findings include: Review of the facility's policy titled, Resident Rights, revised 09/13/2023, revealed the facility was to respect the resident's individuality and value their input by providing them a dignified existence through self-determination related to provision of care and services. Review of Resident #4's Face Sheet revealed the facility admitted the resident on 12/20/2014, with diagnoses that included polyneuropathy, generalized muscle weakness, and anxiety disorder. Review of Resident #4's Annual Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status Score (BIMS) score of fifteen (15) out of fifteen (15), which indicated the resident was cognitively intact. Continued review revealed the facility assessed Resident #4's preferences for his/her daily schedule which included choosing his/her bedtime, choosing what to wear, and doing his/her favorite activities, which were all very important to him/her. Review of Resident #4's Quarterly MDS, dated [DATE], revealed the facility assessed the resident with a BIMS' score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Continued review revealed the facility assessed Resident #4 to need moderate assistance with lower body dressing. Further review revealed the facility additionally assessed the resident as dependent for sit-to-stand and bed-to-chair transfers. Review of Resident #4's care plan revealed the facility identified Resident #4 required extensive assist from one (1) staff member for dressing and was dependent on two (2) staff members and a mechanical lift for transfers. Further review revealed the facility had not specified on the care plan when Resident #4 preferred to get up in the morning or go to bed at night. Review of the Certified Nursing Assistant (CNA) Care Guide, undated, revealed no documented evidence of Resident #4's preference for a time to be dressed for the day. In an interview on 01/22/2024 at 3:24 PM, Resident #4 stated staff did not get him/her out of bed until between 10:00 AM and 11:00 AM, or sometimes later. Resident #4 stated he/she preferred to get up before 10:00 AM; however, there was usually only one (1) aide assigned to the hall, so it took them a long time to get to his/her room. In further interview, Resident #4 stated he/she had told multiple staff members he/she wanted to get up by 9:30 AM, but staff did not honor his/her request. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/23/2024 at 11:08 AM revealed Resident #4 was lying on his/her bed, with unbrushed hair, wearing a hospital gown, scowling, and speaking with a raised voice about wanting to get up for the day. In an interview on 01/23/2024 at 11:08 AM, Resident #4 stated he/she was sick of this place never getting him/her ready for the day before lunch time. In additional interview on 01/23/2024 at 2:40 PM, Resident #4 stated staff assisted him/her in getting dressed and up into his/her wheelchair after lunch. The resident stated CNA #1 was slow and lectured residents about not being able to assist them according to their preferred schedule because there were so many residents needing assistance. Additional observations on 01/24/2024 at 10:16 AM, on 01/25/2024 at 10:22 AM, and on 01/27/2024 at 10:02 AM revealed Resident #4 still lying on his/her bed, wearing a hospital gown, and with unbrushed hair. In an interview on 01/23/2024 at 3:40 PM, CNA #1 stated she knew Resident #4 preferred to get dressed and out of bed by 10:00 AM. However, she was not able to honor that request because she had twenty-two (22) residents in her assignment that morning and several of them were totally dependent on staff for care and unable to voice their needs. The CNA stated she felt bad about not being able to get Resident #4 up earlier in the day, but she felt the residents who were unable to speak up for themselves needed attention first. In further interview, CNA #1 stated she tried to explain why she got other residents up before Resident #4, but the resident did not accept her explanation. In an interview on 01/28/2024 at 2:03 PM, the Director of Nursing (DON) stated she knew Resident #4 but she believed the resident had not made his/her preferences known regarding getting up in the morning. She stated when a resident expressed a preference regarding their care, it was her expectation for staff to update the CNA care guide, and the nurse should update the care plan, and honor the resident's preference. In further interview, the DON stated residents were to express their preferences, and the process was if the resident expressed a preference, it should be put in the care plan and the CNA care guide. In an interview on 01/28/2024 at 5:05 PM, the Administrator stated she expected all residents to be treated with dignity and respect. She further stated her expectations included honoring the resident's preferences for when to get up for the day, because residents deserved to make decisions in their home. In further interview, the Administrator indicated it was up to residents to make their preferences known.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on interview and record review, it was determined the facility failed to notify the Power of Attorney (POA) of a fall and transfer to the hospital for one (1) of seventy-one (71) sampled residents (Resident #326). The findings include: Review of Resident #326's Face Sheet revealed the facility admitted the resident on 09/29/2023 with diagnoses to include metabolic encephalopathy, urine retention, cognitive communication deficit, generalized muscle weakness, history of falling, type 2 diabetes mellitus, and generalized anxiety disorder. Resident #326 was admitted to the facility with an indwelling catheter. Review of Resident #326's Admission Minimum Data Set (MDS) for resident assessment and care screening, dated 10/06/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15), indicating moderate cognitive impairment. Review of Resident #326's Discharge Summary, dated 09/29/2023, revealed the resident was admitted to the hospital with urinary retention, and was then discharged on [DATE] from the hospital with an indwelling Foley (brand name) catheter. Review of Resident #326's Change in Condition (CIC) Note, dated 10/06/2023 at 9:30 PM and recorded on 10/07/2023 at 2:07 AM, revealed the event note did not provide details of when and how Resident #326's son was notified regarding the CIC. Review of the Nurse's Progress Note, dated 10/06/2023 at 9:30 PM (recorded as a late entry on 10/07/2023 at 2:17 AM), documented Resident #326's fall and transfer to the hospital. Per the Progress Note, the RN #10 stated Nurse observed resident in the floor laying on his/her left side. Resident observed to have increased confusion and was unable to give details of what exactly (he/she) was trying to do. Resident c/o [complaints of] left hip pain and a small laceration bleeding from the back of the resident[s] head. Full head to toe assessment was completed. On call notified with orders to send to ED [emergency department] for eval [evaluation] and treat. Family and DON [Director of Nursing] notified. EMS [emergency medical services] transported to hospital. LPN #10 did not provided identifying information in the progress not about the family member with whom they spoke. In an interview with Resident #326's son and POA, on 01/27/2024 at 12:11 PM, he stated the facility failed to contact him about Resident #326's fall with injury and subsequent transfer to the hospital. The son stated the resident was admitted to the facility on [DATE]. He further stated his parent showed signs and symptoms of a urinary tract infection (UTI) on the day of admission from the hospital, and he had requested for the nurse (who he did not remember the name of) to ask the provider to obtain a urinalysis (UA). However, the son stated the urinalysis was never obtained. On 10/01/2023, when the son visited his parent, he was told that Resident #326 had a rough weekend and had pulled out his catheter. The son requested a UA again, but it was not done. On 10/02/2023, the son asked once again if the UA was done, but it was not. Per the son, he was familiar with the signs and symptoms his parent exhibited when they had a UTI. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview, the son mentioned that he went out of town for two (2) days and visited his parent when he returned on 10/04/2023. He asked the nurse (whose name he did not remember) for an update, but she told him there were no updates. The son stated he did not find out about Resident #326's transfer to the hospital until later in the day on 10/07/2023. He stated his stepsister called him after she had gone to the facility to visit Resident #326 and was told the resident was not there. The son stated, My stepsister asked if I knew that [parent] had been taken to the hospital. The son stated he was not notified about this incident. The son further stated he answers his phone twenty-four (24) hours a day, seven (7) days a week and when he looked back through his call log and messages, there were no calls or voicemail messages from the facility on 10/06/2023 or 10/07/2023. He further stated, I understand that the facility has a lot to do, and they are under a tremendous burden, but I need to be notified if [my parent] deteriorates, falls, or gets transferred to a hospital. The State Survey Agency (SSA) Surveyor attempted to contact LPN #10 on 01/27/2024 at 9:29 AM. The phone was disconnected. During an interview with the DON, on 01/27/2024 at 2:34 PM, she stated the nurses were educated to chart a CIC and notifications to family in a progress note and under an event note. If not able to reach the family, they try to recontact family. Nurses were also expected to notify family and the DON if there was a fall with injury. She stated she was notified regarding Resident #326's fall and transfer and stated staff called the resident's son with the CIC. During an interview with the Administrator, on 01/28/2023 at 5:05 PM, she stated it was her expectation for the staff to follow the facility's policy related to notifying family regarding fall with injury and transfer to another facility. It was important that the resident representative was informed to make any required decisions.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635 Based on observation, interview and review of facility policy it was determined the facility failed to provide a safe, clean, comfortable and homelike environment for five (5) of seventy-one (71) sampled residents, (Residents #44, #55, #60, #65, and #88). Observations during the survey revealed a continuous odor of urine on the 100 Unit. During interview with Resident #44, he/she stated that he/she kept the door closed to cut down on the odor; however, he/she could smell the odor when the door opened. During interview with Resident #55, he/she stated he/she moved quickly down the hallway to avoid the odor. Observation revealed Resident #60 had excessive accumulation of dead skin under the books and puzzles pieces on the bedside table and excessive dead skin under the foot of the bed. Observation revealed soiled/stained linens on Residents #65's and #88's beds. Neither resident was able to recall the last time their bed linens had been changed. The findings include: Review of the facility's policy, Resident Rights, dated 09/2023, revealed all residents had the right to be treated with respect and dignity. Further review revealed all residents were to be treated in a manner and in an environment that promoted maintenance or enhancement of quality of life. 1a. Observation on 01/23/2024 and 01/24/2024 revealed a strong odor of urine occurring on the 100 Unit in the hallway 8:30 AM and 1:30 PM daily. Continued observation revealed urine odors on the 100 Unit on 01/25/2024 at 2:05 PM and on 01/26/2024 at 8:15 AM. On 01/26/2024 at 4:40 PM there was a light odor of urine on the 100 unit. Review of the Face Sheet revealed the facility admitted Resident #44 on 09/18/2023 with diagnoses including Allergic Rhinitis, Asthma, and Anxiety. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 12/13/2023 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), which indicated the resident was cognitively intact. During interview with Resident #44 on 01/27/2024 at 4:43 PM he/she stated that he/she kept the door closed due to sensitivity to light and sound. The resident stated he/she could smell the odor entering the room after the door was opened. Resident #44 stated the strong odor of urine from the hallway was offensive. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. Review of the Face Sheet revealed the facility admitted Resident #55 on 07/27/2023 with diagnoses including major depression, and obesity. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/19/2023 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) which indicated the resident was cognitive intact. During interview with Resident #55 on 01/27/2024 at 4:45 PM he/she stated there was always a strong odor in the hall and he/she moved quickly through the hall because of the bad odor. Resident #55 stated the odor was stronger in other different places in the halls. Resident #55 stated he/she thought the odor was coming from other residents that were not clean. During interview with Housekeeper #1 on 01/23/2024 at 2:56 PM she stated she was assigned to clean the 100 Unit and half of the 200 Unit. She stated in residents' rooms she mopped the floors daily, cleaned the bathroom sink, toilet and replaced toilet paper. She further stated she thought the regular housekeeper assigned to the 100 Unit did not clean very well. During interview with the District Manager for Housekeeping, on 01/25/2024 at 11:36 AM, he stated his expectation was for staff to empty all trash, spot clean daily, stock supplies, clean bathroom, clean vertical surfaces and all high touch areas in residents' rooms. He stated he expected his staff to sweep, mop, and clean the bathroom in each resident's room daily including spraying the trash can and/or sink to keep odor under control daily. 2. Review of Resident #60 Quarterly MDS, dated [DATE] revealed the facility admitted Resident #60 on 06/09/2018 with diagnoses that included anemia, hypertension and dementia. Review of the MDS, dated [DATE] revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (13) out of fifteen (15) which indicated the resident was cognitively intact. Observation in Resident #60's room on 01/22/2024 at 6:42 PM revealed an excessive amount of dead skin present on Resident #60's bedside tray table. There were two (2) black books sitting on top of puzzle pieces with dead skin around and under the puzzle pieces. The floor under the foot of Resident #60's bed was covered with dead skin. The pillowcase at the head of the bed was stained with dried blood. Resident #60's polo style shirt, he/she was wearing in bed contained dried blood stains on it. The resident's Khaki pants lying over the foot of the bed had dried blood and other stains on them. Continued observation revealed Resident #60 used white tissue to blot the blood oozing from the left side of the resident's neck. The resident then discarding the tissue to the right side of the bed hitting a full trash receptacle and falling onto the floor. Observation in Resident #60 room on 01/23/2024 at 11:03 AM revealed it still contained dead skin at the foot of the bed and on the bedside table. Observation of Resident #60's physical appearance revealed Resident #60 had excessive dermatitis on both arms, head, and neck. Resident #60 also had opened wounds on his/her neck and hands that he/she refused to let staff treat or cover the bleeding wounds. The pillowcase was stained with dried blood. Continued observation revealed the trash receptacle was full and overflowed. The sheets on the bed were disheveled and stained. The bedside table was covered with two (2) black books, puzzle pieces, and dead skin under the puzzle pieces. (continued on next page)

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	185300	A. Building B. Wing	01/28/2024

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with Resident #60 on 01/23/2024 at 11:03 AM, he/she stated, You just do not get it. They never come in here to clean. I must go and get my own sheets and towels. Many times, I grab extra off the cart and put them in my dresser. Resident #60 stated I have to take out my own garbage. They do not do anything around here. This place is a 'shit hole'. During interview with Housekeeper #3, who was assigned to the 300 Hall, on 01/23/2024 at 10:31 AM, she stated that was her first day to work on that hall. She stated she noted Resident #60's room needed to be cleaned badly. During interview with Registered Nurse (RN) #2 on 01/24/2024 at 10:15 AM she stated Resident #60 could be very difficult to deal with at times. He/she could be verbally abusive, and she had heard him/her become aggressive. RN #2 stated, I bring (him/her) (his/her) pills and check on (him/her). She stated she knew Resident #60's room was filthy, but it was not easy dealing with his/her outbursts. Observation of Resident #60's room on 01/24/2024 at 2:19 PM revealed the bedside table had remnants of dead skin next to the drink cup. During interview with the District Manager of Housekeeping, on 01/25/2024 at 11:35 AM he stated he expected staff to complete the assignments. He stated there was a process to follow when a resident refused to have their room cleaned. He stated his staff should inform him and he would contact the Social Services Director. The District Manager of Housekeeping stated he was familiar with Resident #60, who could sometimes be difficult to deal with and some staff refused to go into Resident #60's room until he/she asked them to come in. He stated he was aware Resident #60's floor and bedside table were dirty and had not been cleaned, but he was not aware of the build-up of dirt under the resident's bed on 01/22/2024 and 01/23/2024. Observation of Resident #60's room on 01/26/2024 at 1:59 PM revealed there continued to be dead skin on the bedside table and floor. 3. Review of Resident #65's face sheet revealed the facility admitted the resident on 10/29/2022 with diagnoses of osteomyelitis and reduced mobility. Review of Resident #65's Quarterly MDS, dated [DATE], revealed a BIMS' score of fourteen (14) out of fifteen (15) which indicated intact cognition. Observation on 01/23/2024 at 1:23 PM revealed visible dried stains to Resident #65's bed linens. Observation revealed multiple small oval and round stains to the pillowcases that were light brown and light red in color. Continued observation revealed specks of scattered light brown stains and overall dingy gray color to the white sheets. During interview with Resident #65, on 01/23/2024 at 4:21 PM, he/she stated he/she was not sure the last time the linens had been changed. He/she further stated, he/she thought they were last changed three (3) or four (4) days ago but he/she could not say for sure. 4. Review of Resident #88's face sheet revealed the facility admitted the resident on 05/28/2022 with diagnoses of chronic obstructive pulmonary disorder (COPD), chronic nausea, and dysphagia oropharyngeal phase. Review of Resident #88's Quarterly MDS, dated [DATE], revealed a BIMS' score of twelve (12) out of fifteen (15) which indicated moderate impaired cognition. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/23/2024 at 9:13 AM revealed visible stains to Resident #88's bed linens. Observation revealed three (3) round dried stains that were approximately twelve inches in diameter and light brown in color in the middle of the bed. During interview with Resident #88, on 01/23/2024 at 9:13 AM, he/she stated he/she could not remember the last time the sheets on his/her bed had been changed. During interview with CNA #19, on 01/28/2024 at 10:01 AM, he stated he did not usually work at this facility, but he changed bed linens routinely and as needed wherever he worked. During interview with the Director of Nursing (DON), on 01/27/2024 at 2:22 PM, and on 01/28/2024 at 2:02 PM and 01/28/2024 at 4:40 PM, she stated she expected dirty briefs to be disposed of and taken outside as soon as possible. The DON stated she expected each resident's room to be cleaned daily. In continued interview with the DON, she stated Resident #60 could be quite difficult, but that was no excuse for him/her to have a dirty room. In further interview with the DON, she stated she expected all staff responsible for changing bed linen to observe daily to see if the linen was visibly soiled and needed changing. During an interview with the Administrator, on 01/28/2024 at 11:25 AM, on 01/28/2024 at 6:17 PM, and on 01/28/2024 at 6:19 PM, she stated her expectations were for the facility to be free from any odors. The Administrator stated housekeeping staff were expected to perform their assigned duties for all residents' rooms and other areas of the facility. She stated they will usually have one side of a hall and the hall adjacent to that. She stated he expectation was for all rooms to be cleaned (moped, trash removed, and bathrooms cleaned daily). The Administrator stated they have residents who refuse the services. She explained that the process was to get the Social Services Director, along with the Housekeeping Director together to work with residents to clean dirty areas. She stated Resident #60 went to visit another resident daily, so they would try to clean when he/she was out of the room. She stated it was her expectation that resident rooms, including bed linens were always clean. She further stated the facility did not have a policy for changing linens and that it was based on need. 49050 49267

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46710 Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs for nine (9) of seventy-one (71) sampled residents (Residents #1, #4, #11, #39, #41, #48, #59, #325, and #381). Resident #59's care plan had interventions to provide incontinence care, which staff failed to implement causing emotional distress. Resident #41's care plan had interventions for falls. However, observations revealed these interventions were not implemented. Resident #381 was identified as a fall risk with an intervention placed in the care plan but not implemented. Resident #39's and #48's care plans were not developed to address the resident's hydration needs to decrease the likelihood of dehydration through adequate fluid intake. Resident #325's care plan was developed for pain management; however, the facility failed to implement these interventions. Resident #1's care plan stated the facility would provide a communication device; however, the facility failed to implement this intervention. Resident #11's care plan was not developed for management of supplemental oxygen therapy. Resident #4's care plan did not specify the resident's preferences for getting out of bed in the morning, though the resident had expressed his/her wishes repeatedly. The findings include: Review of the facility's Comprehensive Care Plan policy, last revised 09/15/2023, revealed the facility would develop and implement a comprehensive person-centered care plan for each resident. A licensed nurse and/or the Interdisciplinary Team (IDT) was to develop and maintain a comprehensive care plan that identified the highest level of functioning the resident might be expected to maintain. Per the policy, care plan interventions were implemented after consideration of the resident's problem areas and their causes. Interventions were to address the underlying source(s) of the problem area(s) rather than addressing only symptoms and triggers. The facility's policy noted the comprehensive care plan was to be developed within seven (7) days of the completion of the resident's comprehensive assessment. The policy stated the care plan should reflect the current status of the resident. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy, Resident Rights, dated 09/15/2023, revealed all residents were to be treated in a manner and in an environment that promoted maintenance or enhancement of quality of life. 1. Review of Resident #59's Face Sheet revealed the facility admitted the resident on 01/25/2023 with diagnoses including unspecified dementia, need for assistance with personal care, and overactive bladder. Review of Resident #59's Annual Minimum Data Set (MDS) Assessment, dated 12/06/2023, revealed the facility assessed the resident using a Brief Interview for Mental Status (BIMS) with a score of fifteen (15) of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility assessed the resident as dependent on staff for toileting hygiene. Review of Resident #59's Care Plan, dated 12/21/2023, revealed the facility assessed the resident as incontinent of urine and needing staff assistance for incontinence care. Further review revealed the interventions for incontinence care included providing incontinence care after each incontinence episode. Continued review revealed the facility assessed the resident as at risk for skin breakdown related to incontinence and impaired mobility and included the intervention, Keep clean and dry as possible. Minimize skin exposure to moisture. Observation on 01/23/2024 at 9:51 AM revealed Resident #59's call light was on, and the resident was lying in bed, fidgeting with his/her blanket, and looking toward the hallway with an anxious look on his/her face. Further observation revealed Resident #59 reported to Registered Nurse (RN) #1 that he/she had soiled his/her briefs and needed incontinence care. Resident #59 further stated he/she had last been changed around 5:00 AM. Further observation revealed RN #1 failed to provide the resident with incontinence care and informed the resident that Certified Nursing Assistant (CNA) #1 was busy but would come change the resident's brief soon. In continued observation, Resident #59 became increasingly agitated and stated, I can't be going through this every day. It didn't used to be like this, but now it takes them so long to come change me! Further observation at 10:32 AM revealed CNA #4 provided incontinence care to Resident #59. Observation revealed Resident #59's brief was saturated with urine, as well as the absorbent pad, draw sheet, and fitted sheet over the resident's mattress. While CNA #4 changed Resident #59's brief, the resident began crying and stated, I can't be going through this every day! and What did I ever do to them? I try to be nice, and it never pays off! It never used to be like this, but I need to be cleaned up! In an interview on 01/22/2024 at 4:42 PM, Resident #59 stated aides changed his/her brief once in the morning and once in the afternoon, and the sheets were often soaked before the aides provided incontinence care. Resident #59 further stated there were not enough aides to assist all the residents, and he/she felt frustrated when waiting for incontinence care. In an interview on 01/23/2024 at 3:40 PM, Certified Nursing Assistant (CNA) #1 stated she could not provide care to all the residents as needed when she was the only aide assigned to the hall. Per interview, CNA #1 did not know how to access the care plan in the computerized charting system. 2. Review of Resident #41's Face Sheet revealed the facility admitted the resident on 07/20/2018 with diagnoses including hemiplegia affecting left non-dominant side, epilepsy, and unspecified dementia. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #41's Annual Minimum Data Set (MDS) Assessment, dated 10/29/2023, revealed the facility assessed the resident using a Brief Interview for Mental Status (BIMS) with a score of two (2) of fifteen (15), indicating the resident was severely cognitively impaired. Further review revealed the facility failed to fill out the assessment for the resident's functional status (Section GG). Review of Resident #41's Care Plan, dated 01/23/2024, revealed the facility identified Resident #41 as at risk for falls and included interventions such as keeping the bed in low position, fall mats to the left side of bed, and keeping the resident's wheelchair within reach. Observation on 01/23/2024 at 8:58 AM revealed Resident #41's bed was elevated high off the floor while the resident was in bed asleep. Further observation on 01/28/2024 at 9:52 AM revealed Resident #41's bed was elevated high off the floor while the resident was asleep. In an interview on 01/23/2024 at 2:47 PM, Certified Nursing Assistant (CNA) #7 stated she did not know how to find out what care the residents needed as this was her first day working on the floor, though she received three (3) days of orientation the week before. CNA #7 stated she did not know if Resident #41 was at risk for falls, nor did she know if Resident #41's bed should have been lowered from its current elevated level. In an interview on 01/23/2024 at 2:55 PM, CNA #21 explained she worked on the odd number rooms on the 300 Hall, and she was not familiar with the residents in the even number rooms. While standing at Resident #41's room, CNA #21 observed Resident #41's bed up in a higher than normal bed position. In continued interview, CNA #21 was unable to say if the resident's bed was supposed to be in a low position. Per interview, CNA #21 stated she did not know how to find out what care the residents required other than what she was told during report from the previous shift. In an interview on 01/28/2024 at 11:55 AM, Registered Nurse (RN) #2 stated that Resident #41 was at risk for falls, and his/her bed should be kept in the lowest position. Per interview, RN #2 stated Resident #41 would sometimes raise his/her own bed but that staff members should lower it when they saw it elevated. In an interview on 01/28/2024 at 2:03 PM, the Director of Nursing (DON) stated Resident #41 liked to use his/her bed controls to raise the bed sometimes, but she expected staff to lower it back down when they noticed it was elevated. In an interview on 01/28/2024 at 5:05 PM, the Administrator stated she expected each care planned fall prevention measure to be followed by staff. Per interview, the Administrator stated Resident #41 might raise his/her bed but that staff should lower it during routine safety rounds. 3. Review of Resident #381's Face Sheet revealed the facility admitted the resident on 12/14/2023 with diagnoses to include displaced fracture of cervical vertebra with routine healing, difficulty in walking, lack of coordination, and long term use of anticoagulants (blood thinners). Review of the Brief Interview for Mental Status (BIMS), dated 01/09/2024, revealed the facility assessed Resident #381 as being cognitively intact, scoring thirteen (13) of fifteen (15). (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #381's Comprehensive Care Plan, dated 01/27/2024, revealed the facility assessed the resident as a fall risk with a goal to minimize potential for fall related to injury with a target date of 04/02/2024. Interventions included Dycem (a material applied to prevent slippage or provide a better grip) to the wheelchair was placed on the care plan with an approach date of 01/19/2024. Observation on 01/27/2024 at 8:00 AM revealed Resident #381 in bed, and the wheelchair in his/her room without Dycem to the cushion of the wheelchair. During an interview with Certified Nursing Assistant (CNA) # 9 on 01/25/2024 at 11:30 AM, she stated she was caring for Resident #381 and knew the resident was a fall risk, so she kept his/her bed in low position. She stated she did not look at the Care Plan, and the facility had not offered training on that task. CNA #9 stated, when asked if Dycem was in Resident #381's wheelchair, that she did not know what that was. During an interview on 01/26/2024 at 10:30 AM with Licensed Practical Nurse (LPN) #3, she stated she was caring for Resident #381 and knew he/she was a fall risk. She stated the resident fell last night, and no additional supervision was being provided to Resident #381. During an interview on 01/27/2024 at 1:50 PM with LPN #9, she stated she was agency and had been working at the facility off and on for about six (6) months; and the last time was about three (3) weeks ago. She stated she was taking care of Resident #381, but had not viewed Resident #381's care plan and was just going by what night shift had reported to her. She stated she had taken care of Resident #381 in the past, at least three (3) weeks ago. LPN #9 stated she was unsure if Resident #381 had been a fall risk but was now since his/her fall last night. She stated if Resident #381 had Dycem ordered to his/her wheelchair, it should be placed so the resident could sit on it and not slip off. She stated the only fall intervention, she thought, was a bedside commode in the room. During an interview on 01/28/2024 at 4:00 PM with the Director of Nursing (DON), she stated the nurse should place an intervention on the care plan immediately after a fall, and the care plan should be followed. 43694 4. Review of Resident #48's Face Sheet revealed the facility initially admitted the resident on 10/26/2020 with diagnoses of kidney disease, respiratory failure, epilepsy, and type 2 diabetes. Review of Resident #48's Quarterly Minimum Data Set (MDS) dated [DATE], revealed the facility assessed the resident with a Brief Interview of Mental Status (BIMS) score of ten (10) of fifteen (15) signifying the resident was moderately cognitively impaired. The MDS revealed the resident was set-up only for eating. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #48's person-centered Comprehensive Care Plan (CCP) established on 09/19/2023, revealed the resident used an indwelling catheter and staff were to encourage adequate fluid intake as recommended by dietary (09/19/2023). Continued review revealed the facility care planned the resident for dehydration and fluid maintenance on 03/31/2023 with the intervention to assess the resident for signs and symptoms of dehydration as needed. Staff were to assist the resident with fluid intake as needed (03/21/2023). Staff were also to encourage fluids to help prevent constipation (03/21/2023), monitor risk of dehydration and nutritional needs, monitor intake of food and liquids (03/12/2021) and observe for signs and symptoms of dehydration (03/21/2021). The CCP revealed the resident required set up assistance with his/her meals (11/06/2020). Review of Resident #48's Nutrition Evaluation completed by Registered Dietitian #2 on 08/16/2023, revealed she assessed the resident required 1950 milliliters of fluid intake per day. Review of Resident #48's Nutrition Evaluation dated 10/03/2023, revealed RD #2 evaluated the resident and assessed him/her to require 2030 ml of fluids per day. Review of Resident #48's daily fluid intake log, revealed in October, November, December 2023 and January 2024, the facility failed to provide documented evidence the resident took in and or was monitored for his/her daily fluid intake as outlined in the CCP. 5. Review of Resident #39's Face Sheet revealed the facility admitted the resident on 11/29/2023 with diagnoses of cerebral infraction, malnutrition, and psychosis. Review of Resident #39's Nutrition Evaluation Therapy form dated 12/07/2023 revealed the Registered Dietitian (RD) assessed the resident with a daily fluid intake need of 1420 to 1660 milliliters (ml). Review of Resident #39's Admission Minimum Data Set (MDS) Assessment, dated 12/05/2023, revealed the facility assessed the resident with a Brief Interview of Mental Status (BIMS) score of two (2) of fifteen (15) signifying a severe cognitive impairment. The facility assessed the resident as needing supervision, cueing, touching, and steadying while eating. The resident had a contracture to the right hand and wrist. Review of Resident #39's Comprehensive Care Plan (CCP), initiated 12/04/2023, revealed staff was to encourage the resident's oral food and fluid intake, monitor the resident for swallowing concerns (12/07/2023), encourage the resident to eat in the common area to increase intake (12/19/2023), refer to Restorative Dining (12/19/2023), and observe for side effects of antipsychotic medication such as dry mouth and urinary retention (12/20/2023). Resident #39's hydration needs were not added to the care plan until 01/23/2024, noting staff was to offer the resident fluids within limits, and limits were not noted on the care plan. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Continued review of Resident #39's CCP, revealed a problem area for dehydration/fluid maintenance was created on 01/23/2024; the facility listed that date as the date the problem started but also as the edited date. Interventions were created on 01/23/2024 for dehydration/fluid maintenance as being at risk for fluid volume deficit related to impaired cognition and risk of malnutrition, both diagnoses present upon admission. Staff was to offer the resident fluids of his/her choice within limits (01/23/2024). The care plan revealed ADL problem was developed on 01/23/2024 related to functional ability deficits secondary to impaired mobility, impaired cognition, seizures and stroke, all diagnoses which were also present upon admission. Interventions were to set the resident up with meals and provide support as needed for consumption and help with incontinent care every shift (01/23/2024). 44001 6. Review of Resident #325's Facesheet revealed he/she was admitted on [DATE] with diagnoses to include pain in left ankle and joints of the left foot, type 2 diabetes, and chronic obstructive pulmonary disease (COPD). Review of Resident #325's Provider Progress Note, dated 01/10/2024, revealed the resident was admitted with left ankle pain due to tenosynovitis. Further review revealed the resident complained of ongoing right ankle pain, which increased with movement and improved with pain medication. Review of Resident #325's Discharge Summary from an acute care hospital, dated 01/08/2024, revealed the resident had a discharge diagnosis of left ankle pain due to tenosynovitis. Further review revealed the resident's pain had not resolved, and he/she remained in quite a bit of pain with tenderness in the left foot. Review of Resident #325's Admission Minimum Data Set (MDS) Assessment, dated 01/14/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15), indicating the resident was cognitively intact. Review of Resident #325's person-centered Comprehensive Care Plan (CCP), revised 01/23/2024, revealed the facility care planned the resident at risk for pain related to left ankle tenosynovitis (inflammation of the tendon sheath where muscle connects to bone) and diabetic neuropathy. Nursing staff was to administer pain medications as ordered and to monitor and record the effectiveness of the medications. Nursing staff was to assess the effects of pain on the resident and to notify the physician if the resident did not demonstrate relief or reduction of pain with current treatment regimen. Further intervention included that nursing staff was to observe and record any complaints of pain, to include the location, duration, quantity, quality, and alleviating factors or aggravating factors. Nursing staff was also to observe and record any nonverbal signs of pain including guarding, moaning, restlessness, grimacing, and diaphoresis. Review of Resident #325's Physician's Orders, dated 01/09/2024, revealed a medication order for acetaminophen (analgesic to treat minor aches and pain) 325 mg (milligrams), two (2) tablets by mouth every four (4) hours and oxycodone-acetaminophen (opioid pain reliever to treat moderate to severe pain) 7. 5-325 mg one (1) tablet by mouth every six (6) hours as needed for pain. Review of Resident #325's Medication Administration Record (MAR), dated 01/2024, revealed the resident received two (2) acetaminophen 325 mg tablets on 01/21/2024 at 6:40 AM. It was charted as being effective with no time given for follow up assessment of pain. (continued on next page)

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview with Resident #325 on 01/22/2024 at 5:30 PM, the resident stated that in the early morning, on 01/21/2024, he/she woke up with severe pain radiating down his/her left ankle and foot. The resident stated that he/she first rang the call light at 3:33 AM to request pain medication. The resident stated at 6:38 AM the nurse gave the resident two (2) acetaminophen tablets, after he/she requested oxycodone-acetaminophen. Review of Nurse Progress Notes revealed there was no nursing note recorded on 01/21/2024 which documented nursing observations to include the location, duration, quantity, quality, and alleviating factors or aggravating factors related to Resident #325's complaint of pain. 49267 7. Review of Resident #1's Face Sheet revealed the facility admitted the resident on 06/24/2021 with diagnoses of bilateral sensorineural hearing loss, chronic obstructive pulmonary disease (COPD), and type 2 diabetes. Review of Resident #1's care plan, dated 12/10/2023, revealed an identified problem of hearing loss and an intervention in place that provided adaptations as needed for hearing loss. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 12/02/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) of fifteen (15), which indicated no impaired cognition. Observation on 01/22/2024 at 3:21 PM revealed a caption phone on Resident #1's bedside table. The phone was on and connected to power. Additional observation revealed no visible captions on the telephone when the resident attempted an outside call. During an interview with Resident #1 on 01/24/2024 at 8:53 AM, the resident stated his/her phone had not worked in a long time. The resident stated it worked when he/she first came to the facility in 2021. The resident further stated he/she notified staff multiple times, but it was never fixed. Resident #1 stated he/she thought it just needed an internet connection. In an interview on 01/28/2024 at 2:02 PM with the Director of Nursing (DON), she stated she was not aware of Resident #1's caption phone and did not know the care plan was not followed. She further stated a hearing impairment with interventions for communication should be addressed on a care plan and staff should follow it. 8. Review of Resident #11's Face Sheet revealed the facility admitted the resident on 06/26/2018 with diagnoses including congestive heart failure, acute respiratory failure, and chronic obstructive pulmonary disease (COPD). Review of Resident #11's Quarterly Minimum Data Set (MDS) Assessment, dated 11/08/2023, revealed the facility assessed the resident using a Brief Interview for Mental Status (BIMS) with a score of fifteen (15) of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility did not indicate on the MDS assessment that Resident #11 received supplemental oxygen therapy during the look-back period. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Observation on 01/23/2024 at 9:51 AM, on 01/24/2024 at 3:25 PM, on 01/25/2024 at 11:06 AM, and on 01/26/2024 at 6:22 PM revealed Resident #11 was wearing a nasal cannula, attached to an oxygen concentrator, set to deliver two (2) liters of oxygen per minute. Review of Resident #11's care plan, dated 12/22/2023, revealed the facility failed to include supplemental oxygen therapy management in Resident #11's care plan. In an interview on 01/27/2024 at 4:21 PM, Registered Nurse (RN) #5 stated parameters for oxygen therapy management should have been located on Resident #11's care plan, but she had not looked to see if interventions were included on Resident #11's care plan. In an interview on 01/28/2024 at 2:03 PM, the Director of Nursing (DON) stated her expectations were for oxygen therapy to be included in the resident's care plan. She further stated she was unable to pinpoint how the process failed with Resident #11's orders and care plan not being developed. In an interview on 01/28/2024 at 5:05 PM, the Administrator stated the process for care plan development was for the Interdisciplinary Team (IDT), which included the DON and MDS Coordinator, to review the discharge information from the acute care facility and talk with the resident to ensure relevant care areas were included in the resident's care plan. She further stated the facility was in the process of conducting a root cause analysis as to why the oxygen therapy was not added to Resident #11's care plan. 9. Review of Resident #4's Face Sheet revealed the facility admitted the resident on 12/20/2024 with diagnoses including polyneuropathy, generalized muscle weakness, and anxiety disorder. Review of Resident #4's Annual Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident's preferences for his/her daily schedule. Further review revealed the resident indicated choosing his/her bedtime, choosing what to wear, and doing his/her favorite activities were all very important to him/her. Review of Resident #4's Quarterly Minimum Data Set (MDS) Assessment, dated 11/30/2023, revealed the facility assessed the resident using a Brief Interview for Mental Status (BIMS) with a score of fifteen (15) of fifteen (15), indicating the resident was cognitively intact. Continued review revealed the facility assessed the resident as dependent for sit-to-stand and bed-to-chair transfers. Review of Resident #4's care plan revealed the facility identified Resident #4 required extensive assist from one (1) staff member for dressing and was dependent on two (2) staff members and a Hoyer lift for transfers. Further review revealed the facility did not specify when Resident #4 preferred to get up in the morning or go to bed at night. Review of the CNA Care Guide, not dated, revealed no documentation of Resident #4's preference for a time to be dressed for the day. In an interview on 01/22/2024 at 3:24 PM, Resident #4 stated staff did not get him/her out of bed until between 10:00 AM and 11:00 AM, or sometimes later. Resident #4 stated he/she had told multiple staff members he/she wanted to get up by 9:30 AM, but staff did not honor his/her request. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Observation on 01/23/2024 at 11:08 AM revealed Resident #4 was in bed, wearing a hospital gown, wanting to get up for the day. Additional observation on 01/24/2024 at 10:16 AM, on 01/25/2024 at 10:22 AM, and on 01/27/2024 at 10:02 AM revealed Resident #4 in bed, wearing a hospital gown, with unbrushed hair. In an interview on 01/23/2024 at 11:08 AM, Resident #4 stated he/she was sick of this place never getting him/her ready for the day before lunch time. In additional interview on 01/23/2024 at 2:40 PM, Resident #4 stated staff assisted him/her in getting dressed and up into the wheelchair after lunch. In an interview on 01/23/2024 at 3:40 PM, CNA #1 stated she knew Resident #4 preferred to get dressed and out of bed by 10:00 AM, but she was not able to honor that request because there were too many dependent residents in her assignment that she needed to take care of first. In an interview on 01/28/2024 at 2:03 PM, the Director of Nursing (DON) stated she was not aware of Resident #4's preference to get out of bed earlier in the morning. She further stated when a resident expressed a preference regarding their care, it was her expectation for staff to update the CNA care guide, and the nurse should update the care plan. In an interview with Registered Nurse (RN) #2 on 01/28/2024 at 4:32 PM, she explained it was important for staff to follow the resident's care plan to ensure the resident received the correct care and treatment and prevent him/her from getting hurt. She explained care plans should be current and up-to-date with new interventions as needed. She stated floor nurses could update the care plan in urgent situations, but they were usually updated in the morning meeting by the clinical team. During an interview with Minimum Data Set (MDS) Nurse #1 on 01/28/2024 at 10:38 AM, she stated she completed assessments, reviewed hospital records, interviewed residents and family, and looked at any special treatment the resident received to help with development of the comprehensive care plan upon admission. She stated the clinical team met every morning Monday through Friday to review care plans. MDS Nurse #1 said it was up to the floor nurse to determine if something was missing from a resident's care plan and follow up with the physician. She stated there was a form the admitting nurse completed and provided to the MDS nurse. She stated the department heads were responsible for ensuring the accuracy of the care plan as it related to new orders. MDS Nurse #1 stated nurses updated care plans when there was a resident change and informed aides of the change. She further stated any changes and new intervention(s) were reviewed the next day in the clinical meeting. She stated if new interventions were added on a weekend, those interventions were reviewed the following Monday. MDS Nurse #1 stated all floor staff, nurses, aides, and agency staff were responsible for reviewing care plans prior to providing resident care. MDS Nurse #1 stated new orders should be added to the care plan immediately with a new intervention and that could be done by the floor nurse. She stated nurses should update the care plan when an event happened. She stated after the care plan was updated the nurse should inform the aides of the changes. MDS #1 explained all floor staff, nurses, aides, and agency staff should review the care plan before they provided care for a resident. She stated aides had a care guide which was on each unit in a binder. She also called it the ADL (Activities of Daily Living) Book. The MDS Nurse stated it was up to the clinical team to keep those books up-to-date, between the Director of Nursing (DON) and the Unit Managers. MDS Nurse #1 stated she could not identify where a breakdown occurred in not developing or implementing interventions in care plans. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Minimum Data Set (MDS) Coordinator on 01/28/2024 at 10:45 AM, she said her expectation for all staff was to view residents' care plans, adding the CNAs had an ADL binder they referred to as well for care to be provided to residents. She stated a resident's care plan should be revised quarterly, change of condition, and with any orders. She stated the process for developing a comprehensive care plan was to review discharge information from the acute care facility and speak with the resident and his/her family to determine what care the resident required. She further stated care plans were updated in the clinical meeting on each weekday, based on new orders or incidents noted for each resident. In further interview, the MDS Coordinator stated, I'm not going to tell you we are caught up with the care planning process and ensuring that each resident's care plan was up-to-date with his/her current treatments. During an interview with the Director of Nursing (DON) on 01/28/2024 at 4:00 PM, she stated it was her expectation for staff to view and follow care plans, adding the care should be reflected in the care plan. In an interview on 01/28/2024 at 5:05 PM, the Administrator stated she expected all residents to be treated with dignity and respect. She further stated that included honoring the resident's preferences for when to get up because residents deserved to make decisions in their home. In further interview, the Administrator stated resident care needs and preferences should be recorded in the CNA Care Guide. The Administrator stated her expectations were for the care plan to be resident-specific and for staff to implement care planned interventions. During additional interview with the Administrator on 1/28/2024 at 6:10 PM, she stated the facility ensured that daily reviews of resident assessments were performed by the DON, Unit Managers, and clinical leaders, with care plans created to ensure assessments were current. She stated she made sure care plans were followed through clinical meeting reviews, policy and procedures, and communication with the DON and MDS Coordinator.

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46710 Based on observation, interview, record review, review of the facility's job descriptions, and review of the facility's policy, it was determined the facility failed to provide necessary services to a resident who was incapable of carrying out activities of daily living to maintain personal hygiene for one (1) of seventy-one (71) sampled residents (Resident #59). Resident #59 was dependent on staff to perform toileting hygiene; staff failed to change Resident #59's briefs timely resulting in the resident experiencing emotional distress, crying because he/she was left laying in a bed soaked with urine. The findings include: Review of the facility's policy, Activities of Daily Living, dated 09/15/2023, revealed the facility was to provide needed assistance for residents who were unable to perform activities of daily living, including toileting. Review of the facility's Certified Nursing Assistant (CNA) job description, dated 03/2021, revealed CNAs were responsible for promptly answering residents' call lights and assisting with residents' needs. Review of the facility's Charge Nurse job description, dated 03/2021, revealed the nurse was responsible for promptly answering residents' call lights and assisting with residents' needs. Further review revealed the Charge Nurse was responsible for confirming that CNAs were aware of residents' care plans and confirming that appropriate care was rendered. Review of Resident #59's face sheet revealed the facility admitted the resident on 01/25/2023 with diagnoses that included unspecified dementia, need for assistance with personal care, and overactive bladder. Review of Resident #59's Annual Minimum Data Set (MDS) Assessment, dated 12/06/2023, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15), which indicated the resident was cognitively intact. Further review revealed the facility assessed the resident as dependent on staff for toileting hygiene. Review of Resident #59's care plan, dated 12/21/2023, revealed the facility assessed the resident as incontinent of urine and needing staff assistance for incontinence care. Further review revealed the interventions for incontinence care included providing incontinence care after each incontinence episode. Continued review revealed the facility assessed the resident as at risk for skin breakdown related to incontinence and impaired mobility and included the intervention, Keep clean and dry as possible. Minimize skin exposure to moisture. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Observation on 01/23/2024 at 9:51 AM revealed Resident #59's call light was on, the resident was lying in bed, fidgeting with his/her blanket, and looking toward the hallway with an anxious look on his/her face. Further observation revealed Resident #59 reported to Registered Nurse (RN) #1 that he/she had soiled his/her brief and needed incontinence care. Resident #59 further stated he/she had last been changed around 5:00 AM. Further observation revealed RN #1 failed to provide the resident with incontinence care and informed the resident that Certified Nursing Assistant (CNA) #1 was busy, but would come change the resident's brief soon. In continued observation, Resident #59 became increasingly agitated and stated, I can't be going through this every day. It didn't used to be like this, but now it takes them so long to come change me! Continued observation at 10:32 AM, revealed CNA #4 provided incontinence care for the resident, and Resident #59's brief was saturated with urine, as well as the absorbent pad, draw sheet, and fitted sheet over the resident's mattress. While CNA #4 changed Resident #59's brief, the resident began crying and stated, I can't be going through this every day! and What did I ever do to them? I try to be nice, and it never pays off! It never used to be like this, but I need to be cleaned up! In an interview on 01/22/2024 at 4:42 PM, Resident #59 stated aides changed his/her brief once in the morning and once in the afternoon, and the sheets were often soaked before the aides provided incontinence care. Resident #59 further stated there were not enough aides to assist all the residents, and he/she believed they were doing their best but he/she felt frustrated when waiting for incontinence care. In additional interview with Resident #59 on 01/23/2024 at 10:17 AM, he/she stated aides had last provided incontinence care at 5:00 AM. Per interview, Resident #59 told several staff members that he/she needed to be changed before breakfast, but he/she did not recall their names. Resident #59 stated staff members told him/her to wait until after breakfast. Resident #59 stated he/she called the service desk if staff did not answer the call light timely. In an interview on 01/23/2024 at 3:40 PM, Certified Nursing Assistant (CNA) #1 stated she was assigned to twenty-two (22) residents that morning and helped each resident as quickly as she could. The CNA stated it was too hard to provide care to that many residents for just one (1) person. She stated when she had that many residents, which happened frequently, she knew residents had to lay wet for longer than they should. Per interview, CNA #1 felt sad for residents who had to wait for incontinence care, but she was doing the best she could with a heavy assignment. In an interview on 01/23/2024 at 5:48 PM, Registered Nurse (RN) #1 stated she did not address Resident #59's incontinence needs because she had a lot of medicine to administer, dressings to change, and other nursing responsibilities. She stated she did not have time to help the aide too. In an interview on 01/28/2024 at 2:03 PM with the Director of Nursing (DON), she stated it was her expectation for any nurse or aide to provide incontinence care to a dependent resident every two (2) hours and upon the resident's report of an incontinence episode. The DON stated it was inappropriate for a nurse to tell a resident to wait for the aide to provide incontinence care. In an interview on 01/28/2024 at 5:05 PM, the Administrator stated it was her expectation for all licensed staff to provide incontinence care immediately when a resident reported he/she had soiled briefs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45990 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 assistance devices to prevent accidents for two (2) of seventy-one (71) sampled residents (Residents #41 and #381). 1. Resident #381 sustained a fall on 01/18/2024; however, the facility failed to develop and implement new interventions to address the resident's safety and prevention of further falls. Resident #381's Comprehensive Care Plan was revised after the fall on 01/18/2024 to place Dycem (a nonslip material used to help stabilize/hold objects firmly in place in a resident's wheelchair); however, this intervention was not implemented by facility staff. 2. Resident #41 fell out off his/her bed on 01/14/2024, and observation during the State Agency Survey revealed the resident's bed was in an elevated position. The findings include: Review of the facility policy titled, Falls dated 06/01/2015 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) was to perform reviews of residents' falls. 1. Review of Resident #381's face sheet revealed the facility admitted the resident on 12/14/2023, with diagnoses to include displaced fracture of the cervical vertebra with routine healing, difficulty in walking, long term use of anticoagulants (blood thinners), and lack of coordination. Review of the Entry Tracking Minimum Data Set (MDS) assessment dated [DATE], revealed no documented entries for Section GG regarding mobility and assistive devices. Review of the MDS assessment dated [DATE], revealed the facility assessed Resident #381 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating he/she was cognitively intact. Review of the facility's event report dated 01/18/2024 at 12:38 PM, revealed Resident #381 had fallen out of his/her wheelchair while attempting to pick up a straw. Per review, Resident #381 did not sustain any injuries. Review of the facility's Interdisciplinary Team (IDT) meeting notes dated 01/19/2024 at 8:56 AM, revealed the root cause analysis (RCA) concluded Resident #381 had slid out of the wheelchair. Further review revealed an intervention was placed for Dycem to Resident #381's wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Fall Risk Assessment tool revealed the facility assessed Resident #381 to have a risk score of sixteen (16), which determined the resident was at high risk for falls. Review of the event report dated 01/27/2024, revealed a nurse found Resident #381 lying on his/her back on the floor between the air conditioning unit and bed. Continued review revealed when Resident #381 was asked what had happened, the resident stated, I was trying to get up to bathroom. Review of the IDT meeting notes dated 01/27/2024 at 8:47 AM, revealed the RCA concluded Resident #381 had been attempting to self- ambulate to the bathroom. An intervention was placed for a low air loss (LAL) bolstered mattress which was ordered. Review of the Fall Risk Assessment tool dated 01/27/2024 revealed the facility assessed Resident #381 to be a high risk for falls with a score of twenty-seven (27). Review of Resident #381's CCP with a creation date of 01/22/2024, revealed the facility care planned the resident for falls as a Problem category. Continued review revealed an intervention for Dycem to the resident's wheelchair. During observation on 01/26/2024 at 8:58 AM, Dycem was observed underneath a padded cushion on Resident #381's wheelchair. Observation on 01/27/2024 at 8:00 AM, revealed Resident #381 lying on his/her bed, with his/her wheelchair in his/her room and no Dycem observed on the wheelchair. Review of the Physician's Orders dated 12/14/2023 through 01/28/2024, revealed an order dated 12/15/2023, for a pressure relieving redistributing mattress. Review of the Activities of Daily Living (ADL) binder for the 700 Hall revealed a document titled, Assignment 700, last updated 11/29/2023, revealed columns which included: the room number; resident's name; incontinent supply; shower schedule; thickened fluid/fluid restriction; oxygen; fluid restriction; lift sling size; transfer assist; mobility bar; toileting; additional skin interventions; and safety interventions. Further review revealed additional columns listing toileting/urine and transfer/assist. Review further revealed however, Resident #381's name was not listed on the Hall 700 documentation. During an interview with Certified Nursing Assistant (CNA) #9 on 01/25/2024 at 11:30 AM, she stated she was caring for Resident #381 that day and knew the resident was a fall risk and kept his/her bed in low position. In continued interview CNA #9 stated she did not look at the residents' Care Plan and also stated the facility had not offered training on that task. CNA #9 stated she had not worked any of the times Resident #381 sustained falls; however, she tried to offer increased supervision by constantly walking the hall. She further stated when asked if Dycem was to be in Resident #381's wheelchair, she stated she did not know what that was. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA #10 on 01/27/2024 at 10:20, she stated she was taking care of Resident #381 that day. CNA #10 stated she had not gotten report on Resident #381 that day. When the State Survey Agency (SSA) Surveyor asked CNA #10 about the fall Resident #381 sustained last night, the CNA said she had not been told anything about that. When the SSA Surveyor asked the CNA how she knew what care to provide Resident #381 if she had not received report, she stated she looked in the ADL book. She further stated the ADL book was located in the nurses' station and it had schedules in it and told the CNA's what they needed to know about how the resident got up and down and what their needs were. During an interview with the Physical Therapy Rehabilitation Director (PTRD) on 01/25/2024 at 12:05 PM, she stated Resident #381 had started therapy after he/she sustained a cervical fracture following a fall. She stated Resident #381 was a fall risk and should have Dycem to his/her wheelchair. The PTRD stated Resident #381 was getting stronger and felt like moving about more and do things on his/her own. In an additional interview with the PTRD on 01/26/2024 at 9:00 AM, she stated Dycem was to be in contact with the person sitting in chair/wheelchair. During an interview on 01/26/2024 at 10:30 AM, Licensed Practical Nurse (LPN) #3 she stated she was caring for Resident #381 that day and knew the resident was a fall risk. The LPN further stated the resident had sustained a fall last night, and said no additional supervision was being provided to Resident #381. During an interview on 01/27/2024 at 1:50 PM, with LPN #9 she stated she was an agency nurse and had been staffing at the facility off and on for about six (6) months, with the last time being about three (3) weeks ago. She stated she was taking care of Resident #381 that day. However, she had not viewed the resident's CCP and was providing care just going by what night shift had reported to her. The LPN stated she had taken care of Resident #381 in the past. When the SSA Surveyor asked if Resident #381 was a fall risk, during the time she had worked for the facility, she said she was unsure, but knew the resident was one now since his/her fall. In continued interview she said if Resident #381 had Dycem ordered to his/her wheelchair it should have been placed there so the resident could sit on it and not slide out of the chair. LPN #9 further stated she was unsure if any other interventions had been placed, other than she thought a bedside commode was in the resident's room. 2. Review of Resident #41's face sheet revealed the facility admitted the resident on 07/20/2018, with diagnoses including hemiplegia (paralysis of one side of the body) affecting his/her left non-dominant side, epilepsy, and unspecified dementia. Review of Resident #41's Annual MDS assessment dated [DATE], revealed the facility assessed the resident with a BIMS' score of two (2) out of fifteen (15), indicating the resident was severely cognitively impaired. Further review revealed the facility had not completed the assessment for the resident's functional status (Section GG). Review of Resident #41's care plan, dated 01/23/2024, revealed the facility identified Resident #41 as at risk for falls and developed interventions such as keeping the bed in low position (added 07/30/2021), fall mats to the left side of his/her bed, and keeping the resident's wheelchair within reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's document titled, Event Report, dated 01/14/2024, revealed staff found Resident #41 lying on the floor after he/she attempted to self-transfer from the wheelchair to the bed. Further review revealed the facility assessed the resident as at high risk for falls due to cognitive limitations and unsteady gait. Observation on 01/23/2024 at 8:58 AM, revealed Resident #41's bed was elevated high off the floor while the resident was lying on the bed with his/her eyes closed. Further observation on 01/23/2024 at 8:58 AM and on 01/28/2024 at 9:52 AM, revealed Resident #41's bed remained elevated high off the floor while the resident was lying on the bed with his/her eyes closed. In an interview on 01/23/2024 at 4:53 PM, Resident #41 stated he/she fell out of bed last month. In an interview on 01/23/2024 at 2:47 PM, Certified Nursing Assistant (CNA) #7 stated she did not know how to find out what care residents needed, as this was her first day working on the floor. In further interview, CNA #7 stated she did not know if Resident #41 was at risk for falls, nor did she know if the resident's bed should have been lowered from its current elevated level. CNA #7 did not lower Resident #41's bed at that time. In an interview on 01/23/2024 at 2:55 PM, CNA #21 explained she worked on the odd number rooms on the 300 Hall, and she was not familiar with the residents in the even numbered rooms, where Resident #41 resided. While standing at Resident #41's room, CNA #21 observed Resident #41's bed up in a higher than normal bed position; however, she did not go and lower the resident's bed. CNA #21 stated she was unable to say if the resident's bed was supposed to be in a low position or not. Per interview, CNA #21 further stated she did not know how to find out what care the residents required, other than what she was told during report from the previous shift. In an interview on 01/28/2024 at 11:55 AM, Registered Nurse (RN) #2 stated Resident #41 was at risk for falls and his/her bed should have been kept in the lowest position. Per interview, RN #2 stated Resident #41 would sometimes raise his/her own bed, but staff should lower the bed when they saw it elevated. In an interview on 01/28/2024 at 2:03 PM, the Director of Nursing (DON) stated Resident #41 liked to use his/her bed controls to raise the bed sometimes; however, she expected staff to lower it back down when they noticed it was elevated. Per interview, the DON further stated she expected resident-centered care plan interventions to be followed by all staff. In an interview on 01/28/2024 at 5:05 PM, the Administrator stated she expected each care planned fall prevention measure to be followed by staff. Per interview, the Administrator stated Resident #41 might raise his/her bed, but staff should lower it during their routine safety rounds. In an interview with the Minimum Data Set (MDS) Coordinator on 01/28/2024 at 10:45 AM, she stated it was her expectation for all staff to review all resident CCPs, adding the CNAs had an ADL binder they referred to as well for care to be provided to residents. She stated the ADL binder was to be updated, she thought by the Director of Nursing (DON), Assistant Director of Nursing (ADON) or Unit Managers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 01/28/2024 at 4:00 PM, she stated she had held the title for about six (6) months and her job duties included oversight of the clinical component of the facility, which included nurses and nurse aides. She stated her oversight included providing education; assuring tasks were being performed; and directing staff tasks. The DON stated her expectation of staff was for them to follow residents' CCP and the facility's CCP process. When the SSA Surveyor asked her about falls, she stated the process was when a fall occurred an event was to be opened, and the nurse should place intervention(s) immediately, and notify her (DON) by phone when it occurred. The DON further stated the Interdisciplinary Team (IDT) then reviewed the event and the interventions put in place. In an interview with the Administrator on 01/28/2024 at 6:10 PM, she stated she had held her title for about five (5) months at the facility. The Administrator stated it was her expectation of staff to follow the Care Plan for each resident. When the SSA Surveyor asked her about falls at facility, she stated a pattern had not been identified and there were no concerns related to falls, adding a fall risk assessment was to be performed to assure the safety of the resident. 46710

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43694 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide the necessary hydration needs for two (2) of seventy-one (71) sampled residents, (Resident #48 and Resident #39). Review of Resident #48's Nutrition Therapy Evaluation completed by the Registered Dietitian (RD) on [DATE] revealed the facility assessed the resident to require 1950 milliliters (ml) daily for his/her fluid intake. The Nutrition Evaluation completed by the RD on [DATE] revealed the facility assessed Resident #48 to require 2030 ml/daily for fluid intake. However, review of Resident #48's fluid intake log for October, November, and [DATE] and [DATE], revealed those daily needs were not met. The facility failed to document any refusals by Resident #48 to account for a reason the need was not met. Review of Resident #39's Nutrition Therapy Evaluation completed on [DATE], revealed Resident #39 required the daily intake of 1420 to 1660 ml of fluid. However, review of the resident's daily fluid intake log revealed those needs were not met for fifteen (15) days out of twenty-four (24) in [DATE] and twenty-eight (28) days out of thirty-one (31) days in [DATE]. The findings include: Review of the facility's Hydration Policy, dated [DATE], revealed residents would be provided sufficient amounts of fluid to maintain proper hydration to the extent possible. Per the policy, facility staff would offer fluids to residents throughout all shifts. The policy stated fluids were to be available to the residents at mealtimes, between meals, and at the bedside, as needed and as requested. Per the policy, the dietitian would assess each resident for the daily hydration needs quarterly and as needed, and any changes in the resident's hydration status would be reported to a licensed nurse and an assessment would be completed. 1. Observation on [DATE] at 3:25 PM, revealed Resident #48 was sleeping, almost flat on his/her back, had oxygen on, was in a hospital gown, and had a low air flow mattress. There was no water at the bedside. Observation on [DATE] at 8:45 AM, revealed Resident #48's breakfast tray was sitting on the tray table over the bed, the resident was sleeping, and had not touched any of his/her food. Observation on [DATE] at 1:30 PM, revealed Resident #48 was sleeping, and no water was in the room for the resident to drink. Observation on [DATE] at 10:00 AM, revealed Resident #48 was sleeping, and no water was in the room for the resident to drink. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on [DATE] at 8:37 AM, revealed Resident #48 was leaned all the way over to the left in the bed, and the resident did not have the ability to lift himself/herself back up. The resident was awake and tried to feed himself/herself; however, the resident could not reach the food. Per the observation, the resident reached the milk and attempted to drink it but began to choke. The State Survey Agency (SSA) Surveyor got staff to assist. The SSA Surveyor talked to the resident while waiting for staff to come. The resident had the look of panic on his/her face. Registered Nurse (RN) #2 arrived and attended to the resident. Review of Resident #48's Face Sheet revealed the facility initially admitted the resident on [DATE] with diagnoses of kidney disease, respiratory failure, epilepsy, and type 2 diabetes. Review of Resident #48's Hospital Discharge Summary, dated [DATE], revealed on [DATE], the resident was found hard to arouse, was very pale in color, and had a weak hand grip. The summary stated the resident had a blood pressure of ,d+[DATE], pulse of 54, and oxygen saturation of 92 percent with two (2) liters of oxygen. The resident was sent to the Emergency Department (ED) and was admitted for treatment for acute hypoxic respiratory failure, urinary tract infection (UTI), and toxic metabolic encephalopathy. Review of Resident #48's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed the resident with a Brief Interview of Mental Status (BIMS) score of ten (10) of fifteen (15), which indicated the resident was moderately cognitively impaired. The MDS assessment revealed the resident was dependent on staff for bed mobility and transfers; set-up only for eating; and, the resident had a catheter in place. Review of Resident #48's Comprehensive Care Plan revealed staff was to encourage adequate fluid intake as determined by dietary as of [DATE]. Per the care plan, staff was to assist the resident with fluids as needed to prevent dehydration as of [DATE]. Review of Resident #48's Nutrition Therapy Evaluation completed by Registered Dietitian (RD) #2 on [DATE], revealed she assessed the resident for 1950 milliliters of fluid intake per day. The facility documented the following fluid intake for Resident #48 for [DATE] after the assessment: on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] the facility did not document any fluid intake for the resident. Further review for the resident's fluid intake revealed the following: on [DATE], 760 ml; [DATE], 720 ml; [DATE], 660 ml; [DATE], 600 ml; and [DATE], 480 ml. Review of Resident #48's census revealed he/she was present in the facility [DATE] through [DATE]. Review of Resident #48's Nutrition Therapy Evaluation, dated [DATE], revealed RD #2 evaluated the resident and assessed him/her for 2030 ml of fluids per day. The facility documented Resident #48's fluid intake for [DATE] as [DATE], 660 ml; [DATE], 240 ml; [DATE], 480 ml; [DATE], 780 ml; [DATE], 240 ml; [DATE], 920 ml; [DATE], 720 ml; [DATE], 720 ml; and [DATE], 340 ml. On [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] through [DATE] there was no documented evidence of fluid intake for Resident #48. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #48's daily fluid intake log for [DATE], revealed the facility documented the following intake: on [DATE], 780 ml; [DATE], 480 ml; [DATE], 650 ml; [DATE], 120 ml; [DATE], 600 ml; [DATE], 620 ml; [DATE], 480 ml; and [DATE], 480 ml. There was no documented evidence of fluid intake monitoring for Resident #48 on [DATE], [DATE] through [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] through [DATE]. Review of Resident #48's census, revealed the resident was present in the facility for the entire month of [DATE]. Review of Resident #48's census, revealed the resident was in the hospital [DATE] through [DATE]. Review of Resident #48's daily fluid intake log for [DATE], revealed [DATE], 660 ml; [DATE], 240 ml; [DATE], 620 ml; [DATE], 240 ml; [DATE], 480 ml; [DATE], 480 ml; [DATE], 480 ml; [DATE], 480 ml; [DATE], 240 ml; [DATE], 225 ml; and [DATE], 240 ml. The log also revealed the facility failed to provide documented evidence of any fluid intake for [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] through [DATE], [DATE] and [DATE]. 2. Observation on [DATE] at 9:00 AM of Resident #39, revealed the resident was sleeping, with the television tray next to the bed. However, the resident did not have any drinking water present at his/her bedside. Observation on [DATE] at 1:40 PM of Resident #39, revealed the resident was in his/her bed watching television, and the resident did not have drinking water available. Observation on [DATE] at 8:40 AM of Resident #39, revealed breakfast trays had not yet been served, and the resident did not have drinking water available at his/her bedside. Observation on [DATE] at 10:00 AM, revealed Resident #39's bed was in a low position, the resident had placed his/her cup on the fall mat next to the bed on the floor. The resident was able to reach down, pick up his/her cup, and lift it to his/her mouth. The cup had a straw in it, and the resident attempted to take a drink, but the cup had very little fluid in it, and a slurp could be heard. The resident laughed and shrugged his/her shoulders. Per the observation, Resident #39 was able to communicate well, when asked yes and no questions. Also, the resident was able to say he/she was in the Navy but could not remember what he/she did in the Navy. The observation revealed the resident had the ability to make some needs known. Review of Resident #39's Face Sheet revealed the facility admitted the resident on [DATE] with diagnoses of cerebral infraction, malnutrition, and psychosis. Review of Resident #39's Nutrition Evaluation Therapy form, dated [DATE], revealed the Registered Dietitian (RD) assessed the resident with a daily fluid intake need of 1420 to 1660 milliliters (ml). Review of Resident #39's census revealed he/she was present in the facility for the entire month of [DATE]. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #39's daily fluid intake log for [DATE], revealed the facility did not provide documented evidence the resident received 1420 ml of fluid per day starting [DATE]. The resident's medical record revealed also on [DATE] the resident took in 480 ml of fluid; [DATE], 960 ml; [DATE], 720 ml; [DATE], 0 ml; [DATE], 480 ml; [DATE], 1090 ml; [DATE], 240 ml; [DATE], 480 ml; [DATE], 480 ml; [DATE], 850 ml; [DATE], 480 ml; [DATE], 240 ml; [DATE], 720 ml; [DATE], 600 ml; and [DATE], 480 ml. Review of Resident #39's daily fluid intake log for [DATE], revealed the facility failed to provide documented evidence of daily fluid intake for [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Additionally, the intake log revealed the resident's daily fluid intake was [DATE], 960 ml; [DATE], 1080 ml; [DATE], 480 ml; [DATE], 1200 ml; [DATE], 480 ml; [DATE], 480 ml; [DATE], 480 ml; [DATE], 240 ml; [DATE], 480 ml; [DATE], 640 ml; [DATE], 1120 ml; [DATE], 1280 ml; [DATE], 1120 ml; [DATE], 960 ml; [DATE], 760 ml; [DATE], 1320 ml; [DATE], 600 ml; [DATE], 1280 ml; [DATE], 720 ml; [DATE], 1120 ml; [DATE], 480 ml; and [DATE], 640 ml. Review of Resident #39's Admission Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of two (2) of fifteen (15), signifying a severe cognitive impairment. The facility assessed the resident as needing supervision, cueing, touching, and steadying while eating. The resident had a contracture to the right hand and wrist. Review of Resident #39's Comprehensive Care Plan (CCP) initiated [DATE] revealed staff was to encourage the resident's oral food and fluid intake, monitor the resident for swallowing concerns ([DATE]), encourage the resident to eat in the common area to increase intake ([DATE]), refer to Restorative Dining ([DATE]), and observe for side effects of antipsychotic medication such as dry mouth and urinary retention ([DATE]). Resident #39's hydration needs were not added to the care plan until [DATE], noting staff was to offer the resident fluids within limits, and limits were not noted on the care plan. In an interview with the Activities Director on [DATE] at 11:21 AM, she stated she helped serve drinking water and ice to the residents. She explained it was important for the residents who were able to drink fluids to have the needed fluid intake daily. The Activities Director stated a resident could become sick if he/she did not take in fluids daily. She stated she talked with the residents and encouraged them to drink throughout the day. In an interview with Certified Nursing Assistant (CNA) #19 on [DATE] at 10:05 AM, he stated he counted residents' fluid intake when he picked up trays and throughout the day when he checked on the residents. He stated there was staff who brought around water and ice. CNA #19 stated he charted fluid intake right after he saw the resident with a drink. He stated it was important to keep track of a resident's fluid intake, and if there was a change, he informed the nurse so the nurse could assess the resident. CNA #19 explained for the residents who were unable to drink on their own, he offered them sips throughout the day. He stated, for residents' health and safety, it was important to monitor the residents' intake and output. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Certified Nursing Assistant (CNA) #23 on [DATE] at 4:10 PM, she explained she wrote down each resident's fluid intake after meals. She stated she tried to encourage residents to drink the necessary fluids throughout the day. The CNA also stated there were some residents that needed physical assistance to be able to drink, and in that case those residents were offered a few sips at a time. CNA #23 stated if she noticed a resident did not take in enough fluids for the day, she would notify the nurse. She explained if the resident did not get enough fluids, it could have a negative impact on how much the resident used the bathroom and that could be a concern. CNA #23 said Resident #39 had the ability to drink water on his/her own and did better with the use of a straw. In an interview with Registered Nurse (RN) #2 on [DATE] at 4:32 PM, she stated she encouraged residents to take fluids when she administered medication. She stated if an aide reported to her a resident had not taken in the daily needed fluid, she would go and assess the resident. She explained the meal tickets had the required daily fluid intake for each resident, and aides were expected to document the intake for each meal and throughout the day. RN #2 stated if a resident was not able bodied , she would help and encourage the resident to drink the water. She stated she would try to find out if there was a reason the resident did not want to drink the water. RN #2 stated concerns for residents who did not take in the necessary fluids could be dehydration which could lead to a urinary tract infection (UTI) and weight loss. She stated she would contact the Medical Director to determine what course of action was needed. RN #2 stated Resident #48 was able to eat and drink on his/her own until recently with a decline in health. RN #2 stated Resident #39 had the ability to drink on his/her own but required constant reminders to do so. In an interview with the Director of Nursing (DON) on [DATE] at 2:17 PM, she was unable to determine why Resident #48's and Resident #39's missing documentation of daily fluid intake was not caught and addressed in the clinical whiteboard meeting which was held Monday through Friday in the morning. She stated a report of fluid intake was printed each day and reviewed for concerns. The DON stated items of concern were addressed in real time in those daily meetings. She stated she was unable to explain why Resident #48 and Resident #39 had so many undocumented days of fluid intake and why a plan was not established to ensure their daily needs were met. The DON stated in nursing if something was not documented, it meant it did not happen. She explained there would be many concerns for a resident who did not get his/her daily needed fluid intake,such as dehydration and/or a urinary tract infection (UTI). The DON stated the facility had a Hydration program two (2) times a week throughout the facility in which additional fluids were provided. In an interview with the Administrator on [DATE] at 6:10 PM, she stated she expected all residents to be provided the necessary daily fluids to meet their intake needs. She explained if a resident was not taking in the necessary fluids daily it would need to be addressed as it could cause serious health concerns for the resident. She also could not explain why concerns for these two (2) residents were not identified and addressed in the morning meeting. The Administrator stated she expected all staff members to follow the policies of the facility, and any concerns were to be reported to the nurse and followed up by the DON.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46710 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice for five (5) of seventy-one (71) sampled residents (Residents #1, #8, #11, #324, and #381). Resident #11 received oxygen (O2) without a Physician's Order. Additionally, Residents #1, #8, #11, and #381 had O2 tubing that was not labeled nor dated. Furthermore, Resident #324's nebulizer machine was not stored in a plastic bag when not in use. The findings include: Review of the facility's policy titled, Oxygen Administration, revised 07/25/2022, revealed oxygen therapy was supposed to be administered as ordered by a physician. Further review revealed staff were to check the resident's medical record to confirm the presence of a complete and appropriate physician's order. Continued review revealed staff were to change the oxygen tubing weekly. 1a) Review of Resident #11's Face Sheet revealed the facility admitted the resident on 06/26/2018 with diagnoses including congestive heart failure, acute respiratory failure, and chronic obstructive pulmonary disease (COPD). Review of Resident #11's Care Plan, dated 12/22/2023, revealed the facility failed to include supplemental oxygen therapy management in Resident #11's care plan. Review of Resident #11's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) with a score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility did not indicate on the MDS that Resident #11 received supplemental oxygen therapy during the look-back period. Review of Resident #11's Physician Orders, updated on 01/13/2024, revealed the facility failed to have an order for the oxygen. There was no order to describe the parameters for supplemental O2 therapy, including flow rate, associated monitoring, and frequency of tubing change. Observations on 01/23/2024 at 9:51 AM, on 01/24/2024 at 3:25 PM, on 01/25/2024 at 11:06 AM, and on 01/26/2024 at 6:22 PM, revealed Resident #11 was wearing a nasal cannula, attached to an O2 concentrator, set to deliver two (2) liters of O2 per minute. In an interview with Registered Nurse (RN) #5, on 01/27/2024 at 4:21 PM, she stated supplemental O2 should not be administered without a Physician's Order. She further stated she was aware Resident #11 was wearing a nasal cannula, but could not find the order for O2 therapy in the electronic medical record (EMR). Per interview, RN #5 stated she would call the physician to find out what O2 flow rate Resident #11 required. (continued on next page)

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	185300	A. Building B. Wing	01/28/2024

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Nursing (DON), on 01/27/2024 at 4:32 PM, she stated her expectations for supplemental O2 therapy were for nurses to follow Physician's Orders to initiate or adjust a resident's O2 therapy. She further stated she could not find Physician's Orders for Resident #11's O2 therapy, but needed to investigate further to determine the cause of this system failure. In an interview with the Medical Director, on 01/28/2024 at 2:43 PM, he stated when a resident was admitted or returned from the hospital, the facility's process was for the nurse to take verbal orders over the telephone for O2 as needed. He further stated the process was subject to human error if a nurse failed to enter an order. In an interview with the Administrator, on 01/28/2024 at 5:05 PM, she stated her expectations were for orders to be in place for a resident's supplemental O2 therapy. 1b) Observations on 01/23/2024 at 9:51 AM, and on 01/24/2024 at 3:25 PM, revealed that Resident #11's O2 tubing was not dated. In an interview with Registered Nurse (RN) #5, on 01/27/2024 at 4:21 PM, she stated O2 tubing should be labeled with the date it was changed. She further stated the facility's process was to follow physician's orders to change O2 tubing, which was usually ordered for once per week on night shift. In further interview, RN #5 could not locate orders for tubing changes for Resident #11. In an interview with the DON, on 01/27/2024 at 4:32 PM, she stated O2 tubing should be changed once per week. In an interview with the Administrator, on 01/28/2024 at 5:05 PM, she stated her expectations were for clinical staff to follow physician's orders and the facility's policies and procedures in regards to O2 tubing changes. 49267 2) Review of Resident #1's Face Sheet revealed the facility admitted the resident on 06/24/2021 with diagnoses of bilateral sensorineural hearing loss, chronic obstructive pulmonary disease (COPD), and Type 2 diabetes. Review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of fourteen (14) out of (15), indicating cognition intact. Review of Resident #1's Care Plan, dated 06/28/2021, revealed the resident was assessed for impaired O2 exchange with supplemental O2 as ordered. Review of Resident #1's Physician Orders, dated 07/05/2021, revealed an open-ended order for O2 therapy. Further review revealed an updated open-ended order for O2 therapy was entered on 01/26/2024. Further review of Resident #1's Physician Orders, dated 06/28/2023, revealed an open-ended order to change O2 tubing weekly. Further review revealed an updated open-ended order for O2 tubing was entered on 01/27/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 01/26/2024 at 4:12 PM, and on 01/27/2024 at 3:21 PM, revealed O2 tubing for Resident #1 was not labeled and dated. In an interview with the DON, on 01/27/2024 at 4:32 PM, she stated O2 tubing should be changed once per week. In additional interview with the DON, on 01/28/2024 at 2:02 PM, she stated nurse leaders were responsible for changing O2 tubing and it was changed weekly. She further stated if unlabeled tubing was identified or tubing was observed to be on the floor, it should be replaced immediately and labeled and dated correctly. In an interview with the Administrator, on 01/28/2024 at 5:05 PM, she stated her expectations were for clinical staff to follow physician's orders and the facility's policies and procedures regarding changing O2 tubing. 3) Review of Resident #381's Face Sheet revealed the facility admitted the resident on 12/14/2023 with diagnoses to include emphysema, supraventricular tachycardia, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). Review of Resident #381's BIMS, dated 12/14/2023, revealed the facility assessed the resident with a score of thirteen (13) out of fifteen (15), indicating cognition intact. Review of Resident #381's Care Plan, dated 12/20/2023, revealed health related complications and impaired O2 gas exchange due to COPD and pulmonary nodule. The goal stated staff would minimize potential for complications through the next review. Continued review revealed no interventions for O2 therapy. Review of Resident #381's Physician Orders, dated 12/14/2023 through 01/28/2024, revealed orders dated 12/21/2023 for continuous O2 at two (2) liters. Review of Resident #381's Medication Administration Record (MAR), dated 01/01/2024 through 01/28/2024, revealed entries for continuous O2 at two (2) liters with entries as being performed, but no columns for O2 tubing changes. Observations on 01/22/2024 at 5:45 PM, and on 01/26/2024 at 8:58 AM, revealed Resident #381's O2 tubing on the concentrator was not dated. An attempt was made by the State Survey Agency (SSA) Surveyor to call the facility's Director of Respiratory by telephone, on 01/26/2024 at 3:07 PM, however, there was no answer and a call was never returned after leaving a message. In and interview with LPN#3, on 01/26/2024 at 10:30 AM, when asked about Resident #381's O2 tubing not being dated, she stated she thought there was an order to change the tubing. In an interview with the DON, on 01/27/2024 at 3:00 PM, she stated the reason the O2 tubing should be changed was to decrease the growth of bacteria in the tubing, and the tubing should be changed every seven (7) days. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In continued interview with the DON, on 01/28/2024 at 4:00 PM, she stated new staff were trained on how often to change O2 tubing, adding she had not seen any O2 tubing not dated. She further stated there was not a document to keep track of the O2 tubing changes. 44000 4) Review of Resident #8's Face Sheet, revealed the facility admitted the resident on 08/24/2018 with the diagnoses of chronic obstructive pulmonary disease (COPD), personal history of pulmonary embolism, and shortness of breath. Review of Resident #8's Care Plan, initiated 03/26/2020, revealed the resident had the potential for altered respiratory status and exacerbation of respiratory symptoms, related to diagnoses of COPD. The goal stated the resident would not exhibit signs of respiratory distress, and the interventions directed staff to administer O2 as ordered and observe O2 precautions. Review of Resident #8's Physician Orders, dated 04/14/2023, revealed an order for nursing to change O2 tubing every week, on Sunday. Observations on 01/22/2024 at 4:16 PM and on 01/24/2024 at 1:15 PM, revealed Resident #8's O2 tubing on the concentrator was dated 12/01/2023. Further observation revealed the resident was sitting in a wheelchair, and the O2 tubing he/she was wearing was not dated. In an interview with LPN #6, on 01/27/2024 at 3:22 PM, she stated residents who had an order for O2 also had an order to change the O2 tubing every week. She stated she was notified by an alert on the computer when the O2 tubing needed to be changed. In an interview with LPN #4, on 01/27/2024 at 4:04 PM, he stated he knew when to change the O2 tube by looking at the date on the tube and changing it every week. In an interview with the DON, on 01/27/2024 at 2:59 PM, she stated she was not aware of who supplied the O2 to the facility. She stated the nurses date the O2 tubing once a week, and the nurse must look at the date on the tube and change it prior to the expiration date. She further stated that she, the medical records person, unit managers, and regional nurses check to assure the tubing was changed prior to the expiration date. She was not aware of who was accountable to make sure the tubing was changed prior to the expiration date, and there was a schedule on the white board in the conference room. She further stated she expected staff to change the tubing as ordered and if soiled, and bacteria could grow in the tube if it was not changed when needed. In an interview with the Administrator, on 01/26/2024 at 10:25 AM, she stated the facility did not utilize in house respiratory therapists and therefore did not have a respiratory services agreement. She further stated staff should follow the facility's policy and change the O2 tubing as ordered. 44001 5) Review of the facility's policy titled, Oxygen Administration, revised 07/25/2022, revealed staff were to change the oxygen tubing weekly. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #324's Face Sheet revealed the facility admitted the resident on 01/03/2024 with diagnoses to include pneumonia, acute pulmonary edema, acute respiratory failure with hypoxia, personal history of congenital malformations of the heart and circulatory system, atrial fibrillation, and congestive heart failure. Review of Resident #324's Admission MDS, dated [DATE], revealed the facility assessed the resident with a BIMS' score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility's assessment indicated that Resident #324 received supplemental O2 therapy. Review of Resident #324's Physician's Orders, with a start date of care on 01/04/2024, revealed the physician ordered O2 therapy via nasal cannula at two (2) liters per minute continuous. Review of Resident #324's MAR, dated 01/01/2024 to 01/24/2024, revealed entries for O2 at two (2) liters per minute continuous, with entries as being performed, but no columns for O2 tubing changes. Review of Resident #324's Care Plan, revised 01/23/2024, revealed the facility care planned the resident to include supplemental O2 therapy management. Observation of room [ROOM NUMBER] on 01/22/2024 at 4:30 PM, revealed the nebulizer machine tubing was not dated. The nebulizer machine and tubing were sitting on top of the resident's bedside commode, and it was not inside a protective plastic bag. In an interview with Resident #324, on 01/25/2024 at 10:40 AM, the resident stated the last date the O2 had been changed was 01/17/2024, adding that was the first time the O2 tubing had been changed since his/her admission on 01/03/2024. Resident #324 stated the tubing often hit the floor during transfers and the staff did not clean or replace the dirty tubing. In an interview with the DON, on 01/27/2024 at 3:00 PM, she stated the reason O2 tubing should be changed was to decrease the growth of bacteria in the tubing, and the tubing should be changed every seven (7) days. In continued interview with the DON, on 01/28/2024 at 2:02 PM, she stated nurse leaders were responsible for changing O2 tubing weekly and as needed (PRN). She further stated if unlabeled tubing was identified or tubing was observed to be on the floor, it should be replaced immediately and labeled and dated correctly. She stated new staff were trained on how often to change O2 tubing, adding she had not seen any O2 tubing not dated. Furthermore, she stated O2 supplies, including nebulizer machines, should be placed inside a protective plastic bag when not in use. When asked if there was a document to keep track of the oxygen tubing changes, she stated there was not. In an interview with the Administrator, on 01/28/2024 at 5:05 PM, she stated her expectations were for clinical staff to follow physician's orders and facility's policies and procedures regarding changing O2 tubing.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 44001 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure pain management was provided to residents who required such services. The facility failed to ensure pain medication was administered as needed and as ordered to the resident per the Physician's Orders, the Comprehensive Care Plan, and the goals and preferences for one (1) of seventy-one (71) sampled residents (Resident #325). The findings include: Review of the facility's policy titled, Pain Management, revised 09/01/2023, revealed the facility would ensure that pain management was provided, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Review of the facility's policy titled, Medication Administration General Guidelines, dated 09/2018, revealed when necessary medications were administered the complaints or symptoms for which the medication was given should be documented. Review of Resident #325's Face Sheet revealed the facility admitted the resident on 01/08/2024 with diagnoses to include pain in the left ankle and joints of the left foot, type 2 diabetes, and chronic obstructive pulmonary disease (COPD). Review of Resident #325's Discharge Summary from the hospital, dated 01/08/2024, revealed the resident had a discharge diagnosis of left ankle pain due to tenosynovitis (inflammation of the protective sheath that surrounds tendons). Further review revealed the resident's pain had not been resolved and he/she remained in quite a bit of pain with tenderness in the left foot. Review of Resident #325's Admission Minimum Data Set (MDS) Assessment, dated 01/14/2024, revealed in the Pain Assessment Interview, the resident self-reported not having constant pain within the last five (5) days, and no further assessment was completed. Further review revealed the resident had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15)which indicated the resident was cognitively intact. Review of Resident #325's Baseline Care Plan (BCP), dated 01/09/2024, revealed the resident was assessed as verbalizing or exhibiting signs of pain or at risk for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #325's Person-Centered Comprehensive Care Plan (CCP), revised 01/23/2024, revealed the resident was care planned for being at risk for pain related to left ankle tenosynovitis and diabetic neuropathy, updated 01/21/2024. Nursing staff were to administer pain medications as ordered and to monitor and record the effectiveness of the medications, updated 01/21/2024. Nursing staff were to assess the effects of pain on the resident, and notify the physician if the resident did not demonstrate relief or reduction of pain with the current treatment regimen, updated 01/21/2024. Further review revealed interventions that included: nursing staff were to observe and record any complaints of pain, to include the location, duration, quantity, quality, and alleviating factors or aggravating factors, updated 01/21/2024. Nursing staff were also to observe and record any nonverbal signs of pain including guarding, moaning, restlessness, grimacing, and diaphoresis, updated 01/21/2024. Review of Resident #325's Physician Orders, dated 01/09/2024, revealed a medication order for acetaminophen (analgesic to treat minor aches and pain) 325 mg (milligrams), two (2) tablets by mouth every four (4) hours and oxycodone-acetaminophen (opioid pain reliever to treat moderate to severe pain) 7. 5-325 mg one (1) tablet by mouth every six (6) hours as needed (PRN) for pain. Review of Resident #325's Medication Administration Record (MAR), dated 01/2024, revealed the resident was receiving acetaminophen tablet 325 mg (milligrams), two (2) tablets by mouth every four (4) hours PRN for pain. Additionally, the resident was receiving oxycodone-acetaminophen; 7.5-325 mg one (1) tablet by mouth every six (6) hours PRN for pain. The resident received two (2) acetaminophen 325 mg tablets at on 01/21/2024 at 6:40 AM. It was charted as being effective with no time given for follow up assessment of pain. Review of Resident #325's Provider Progress Note, dated 01/10/2024, revealed the resident was admitted with left ankle pain due to tenosynovitis. Further review revealed the resident complained of ongoing right ankle pain, which increased with movement and improved with pain medication. Review of Resident #325's Progress Notes, dated 01/10/2024, revealed no nursing progress notes were entered on 01/21/2024 related to observation of any complaints of pain, to include the location, duration, quantity, quality for Resident #325's complaint of pain, and request for medications. During an interview with Resident #325, on 01/22/2024 at 5:30 PM, the resident stated that in the early morning, on 01/21/2024, he/she woke up in severe pain radiating down his/her left ankle and foot. The resident stated his/her ankle and foot were swollen and felt warm to the touch. He/she stated that he/she rang the call light at 3:33 AM to request pain medication. At 3:43 AM, a Certified Nursing Assistant (CNA) answered the call light. The CNA came into the resident's room, turned off the call light, and stated she would tell Registered Nurse (RN) #9 about the resident's pain. The resident stated that RN #9 did not come to the room. The resident waited and rang the call light again at 5:00 AM. At 6:00 AM, the call light had not been answered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During continued interview Resident #325 stated, The staff was ignoring the call light for 2 hours and 54 minutes. He/she stated they were sure of the timing because he/she had set the timer on his/her phone to time the staff's response. The resident stated RN #9 peeked his head in the room at 6:15 AM and asked what he could do for the resident. Resident #325 stated he/she told the RN that he/she was experiencing pain and requested Oxycodone-acetaminophen pain medication. The resident stated RN #9 did not assess the pain or check the left ankle and foot. At 6:38 AM, RN #9 returned with two (2) acetaminophen tablets. The resident stated, I was not given the Oxycodone-acetaminophen I asked for. After waiting so long for the nurse, I needed the stronger pill to get relief. The Tylenol didn't touch the pain. The resident stated at 6:47 AM he/she placed a call to 911 to get help. Review of the Police Incident Report, dated 01/21/2024, revealed police were dispatched to the facility at 6:50 AM after the resident called 911 and stated the reason for the request was, Staff withholding pt [patient] meds [medications]. Review of the Police Run Report, dated 01/21/2024, revealed a Police Department Officer (Badge ID #7134) arrived at the facility at 6:50 AM and reported, Victim stated on 01/21/24 in the early morning hours that [he/she] was in very uncomfortable pain. Victim pressed the call button for the nurse and no one ever came into the room. Victim then again pressed the call button and began a timer. [He/she] stated it took 2 hours and 54 minutes before anyone came in and checked on [him/her]. No further interviews were taken by the Officer. In an interview, on 01/28/2024 at 2:03 PM, the Director of Nursing (DON) stated she expected that medications were administered timely and as per the Physician's Orders. She stated if the resident had pain medication ordered as needed the medication should be administered when the resident had pain She further stated it was her expectation that nursing staff follow physician orders and follow the care plan. In an interview, on 01/28/2024 at 5:05 PM, the Administrator stated her expectations were for the care plan to be resident-specific and for staff to implement care planned interventions. She stated she expected staff to provide timely assistance to residents, emphasizing that staff were expected to administer pain medicatons for residents in pain, as ordered.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46710 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for two (2) out of seventy-one (71) sampled residents (Residents #11 and #17). During medication pass observations, the facility failed to have magnesium 400 milligrams (mg) available for Resident #11. Furthermore, the facility failed to have polyethylene glycol 17 grams (Miralax) and a lidocaine 5% patch available for Resident #17. The findings include: Review of facility's policy titled, Medication Administration, dated 09/2018, revealed medications were to be administered as prescribed and in accordance with good nursing practices. 1) Review of Resident #11's Face Sheet revealed the facility admitted the resident on 06/26/2018 with diagnoses including congestive heart failure, acute respiratory failure, and chronic obstructive pulmonary disease (COPD). Review of Resident #11's Electronic Medication Administration Record (eMAR), dated 01/2024, revealed the physician ordered magnesium oxide four hundred (400) milligrams (mg) by mouth once per day. Further review revealed Registered Nurse (RN) #1 charted the medication as unavailable on 01/23/2024. Observation on 01/23/2024 at 9:51 AM revealed RN #1 prepared medications for Resident #11, but could not locate the magnesium oxide pills in the medication cart. Further observation revealed RN #1 marked the medication as not available and proceeded with medication administration. In an interview on 01/23/2024 at 9:51 AM, RN #1 stated her process for an unavailable medication was to notify pharmacy after she finished medication pass to get the medication delivered for the next day. 2) Review of Resident #17's Face Sheet revealed the facility admitted the resident on 10/06/2016 with diagnoses including diverticulitis (inflammation of the intestines), muscle weakness, and type 2 diabetes. Review of Resident #17's eMAR, dated 01/2024, revealed the physician ordered two (2) patches of lidocaine five percent (5%) to be applied to the resident's back every day for twelve (12) hours. Further review revealed staff marked the medication as unavailable on 01/15/2024, 01/19/2024, 01/22/2024, 01/24/2024, and 01/27/2024. Continued review revealed the physician ordered polyethylene glycol 17 grams (Miralax) to be administered once per day. Per record review, LPN #9 marked polyethylene glycol 17 grams (Miralax) as unavailable on 01/26/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/26/2024 at 8:33 AM revealed Licensed Practical Nurse (LPN) #9 found Resident #17's lidocaine 5% patch was not available. Further observation revealed LPN #9 reordered the medication from the eMAR system, and a message displayed that LPN #9 had previously reordered the medication on 01/24/2024. In an interview on 01/26/2024 at 8:33 AM, LPN #9 stated she ordered Resident #17's lidocaine patch on 01/24/2024 and showed that date in the electronic Medication Administration Record system. In further interview, she stated she had not worked since 01/24/2024 and did not realize the medication had not been delivered. Per interview, LPN #9 stated pharmacy made multiple deliveries to the facility each day and the lidocaine patch should have been on one of the deliveries. A phone interview was attempted with the pharmacy representative, on 01/28/2024 at 4:17 PM, however, the State Survey Agency (SSA) Surveyor was left on hold and never received an answer. In an interview on 01/28/2024 at 2:03 PM, the Director of Nursing (DON) stated the process for ensuring medications were available to be administered timely was for staff to reorder any medication that was low, whether that was on the reminder sticker on the card or when they noticed a multi-dose bottle, such as polyethylene glycol (Miralax), was low. She further stated she had not been notified of an issue with medication delivery, but she would investigate if she became aware of medications being missed or administered late. In an interview on 01/28/2024 at 5:05 PM, the Administrator stated the facility's process for ensuring medications were available to be administered timely was for the nurse to reorder any medication that was running low. She further stated the pharmacy typically sent a thirty (30) day supply of medications, but she did not know if a resident's maintenance medications were refilled automatically.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44000 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure that medications were stored in proper temperatures and other appropriate environmental controls to preserve their integrity for two (2) of two (2) refrigerators. Additionally, it was determined the facility failed to ensure opened and in-use vials of tuberculin skin test (TST) solution, eye drops, and inhalers were not expired, on three (3) of five (5) medication carts. The findings include: 1. Review of the facility policy titled, Medication Storage, revised [DATE], revealed medications requiring refrigeration or temperatures between thirty-six (36) degrees Fahrenheit (F) and forty-six (46) degrees F, were to be kept in a refrigerator with a thermometer to allow for temperature monitoring. A temperature log or tracking mechanism would be maintained to verify that the temperature was within accepted limits. Observation of the medication refrigerator on the Blue Unit, on [DATE] at 4:07 PM, revealed the temperature was thirty-two (32) degrees F. The thermometer was located on the middle shelf, in the middle of the shelf, approximately six (6) inches from the front of the shelf, and there were vials of insulin and insulin pens in the refrigerator. Review of the temperature log, located on the left side of the medication refrigerator on the Blue Unit, revealed Temperature of refrigerator must be between 36 - 41 degrees F. Freezer must be at or below freezing. If not contact maintenance immediately! Further review of the temperature log revealed the following documentation: a. Documentation on [DATE] revealed the temperature was thirty-four (34) degrees F; however, it was not documented that maintenance was notified. b. Documentation on [DATE] revealed the temperature was thirty-two (32) degrees F; however, it was not documented that maintenance was notified. c. Documentation on [DATE] revealed the temperature was thirty-four (34) degrees F; however, it was not documented that maintenance was notified. d. Documentation on [DATE] revealed the temperature was thirty-five (35) degrees F; however, it was not documented that maintenance was notified. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the medication refrigerator on the Green Unit, on [DATE] at 4:37 PM, revealed the temperature was thirty-three (33) degrees F. The thermometer was located on the middle shelf, in the middle of the shelf, approximately six (6) inches from the front of the shelf. Continued observation revealed there were five (5) bottles of insulin, eleven (11) insulin pens, an emergency kit, a pneumonia vaccine, and a hepatitis B vaccine in the refrigerator. During an interview with Licensed Practical Nurse (LPN) #8, at the time of the observation, she stated, I need to turn it up. When asked why she needed to turn it up, she stated if the temperature was too low the medication may not be effective and could possibly cause an adverse reaction, and medical complications. Further observation of the medication refrigerator on the Green Unit, on [DATE] at 10:16 AM, revealed the temperature was fifty-two (52) degrees F. The thermometer was located on the middle shelf, in the middle of the shelf, approximately six (6) inches from the front of the shelf. During an interview with the Director of Nursing (DON) at the time of the observation, she stated she expected staff to keep the temperature between thirty-six (36) degrees F to forty-one (41) degrees F. She stated the medications may not be effective if not at the correct temperature, and this could cause an adverse effect on a resident. She further stated all refrigerated medications would be wasted. Further observation of the medication refrigerator on the Blue Unit, on [DATE] at 10:40 AM, revealed the temperature was twenty-eight (28) degrees F. The thermometer was located on the middle shelf, in the middle of the shelf, approximately six (6) inches from the front of the shelf. Continued observation revealed the original temperature flow sheet had been replaced with a new one, beginning on [DATE]. During further interview with the DON at the time of the observation, she stated an adverse reaction could be possible if medications were not stored at the correct temperature. During an interview with the Pharmacist, on [DATE] at 3:08 PM, he stated there could potentially be harm to a resident if a medication was not stored at the correct temperature. During an interview with the Administrator, on [DATE] at 10:25 AM, she stated she expected staff to follow the policy on storage of medications. She stated she was not aware of any issues with medications not stored at the correct temperature, and she would expect staff to let her know if there were any issues with medication storage. Three (3) requests were made for a copy of the temperature logs for the last three (3) months, however, they were not provided. 2. Review of the facility's policy titles, Medication Administration - General Guidelines, revised [DATE], revealed the nurse shall place a 'date opened' sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened. Further review revealed multi-use eye drops and ointments should be disposed of twenty-eight (28) days after initial use and multidose vials shall be labeled to assure product integrity, considering the manufacturers' specifications. Continued review revealed nursing staff should document the date opened on multi-dose vials on the attached auxiliary label. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the Blue Unit 100 Hall medication cart, on [DATE] at 6:25 PM, revealed three (3) bottles of eye drops that were opened and not dated. During an interview with the Certified Nursing Assistant/Kentucky Medical Assistant (CNA/KMA) #3 at the time of the observation, she stated she was not aware the medications were not dated. She stated she knew the facility's policy required medications to be dated after opening and to remove the medications after twenty-eight (28) days. Observation of the 400 Hall medication cart, on [DATE] at 4:25 PM, revealed there was an opened albuterol inhaler not dated. During an interview with Registered Nurse (RN) #1, at the time of the observation, she stated medications should be dated when opened. She further stated medications may not be effective if out of date and could also potentially harm a resident. Observation of the 100 Hall medication cart, on [DATE] at 10:01 AM, revealed there was an opened, undated, bottle of TST solution. During an interview with LPN #4 at the time of the observation, she stated she could not verify when the bottle was opened, and the solution may not be effective if out of date. She stated this could lead to an inaccurate test result and potentially harm the resident and other residents. Observation of the Blue Unit 200 Hall medication cart, on [DATE] at 4:35 PM, revealed an opened, undated, bottle of eye drops. During an interview with LPN #3, at the time of the observation, she stated she did not know why the eye drops were undated. She stated there could be harm to a resident if the eye drops were outdated. Observation of the medication refrigerator on the Green Unit, on [DATE] at 4:37 PM, revealed there was an opened, undated, bottle of TST solution. During an interview with the DON, on [DATE] at 2:59 PM, she stated that she and the unit managers monitored the medication carts to assure the medications were dated when opened, and not expired. She stated she did not know why there were medications on the cart that were opened and undated. The DON stated she expected staff to follow the policy. During an interview with the Administrator, on [DATE] at 10:25 AM, she stated she expected staff to follow the policy on the storage of medications. She was not aware of any issues with medications being undated after opening, and she would expect staff to let her know if there were any issues with medication storage. 50192

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44001 Based on interview, record review, and review of the facility's policies, it was determined the facility failed to obtain the resident's needs, preferences, and religious, cultural, and ethnic needs for one (1) of seventy-one (71) sampled residents, (Residents #325). The findings include: Review of the facility's policy, Resident Rights, revised 09/13/2023, revealed the facility would protect each resident's right to promote enhancement of quality of life. It further stated that when providing care, the facility would respect the resident's individuality. Review of the facility's policy, Dining and Food Preferences, revised 10/2022, revealed the facility would identify individual food preferences for all residents. The policy stated that the Dining Services Director, or designee, would interview the resident to complete a food preference interview within seventy-two (72) hours of admission. Per the policy, the purpose of the interview was to determine the resident's food and beverage preferences. Review of Resident #325's Face Sheet revealed the facility admitted the resident on 01/08/2024 with diagnoses to include type 2 diabetes, morbid obesity, and gastroesophageal reflux disease. Review of Resident #325's Admission Minimum Data Set (MDS) Assessment, dated 01/14/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15), indicating the resident was cognitively intact. Review of Resident #325's Physician Orders under the Dietary Flow Sheet, initiated 01/25/2024, revealed Resident #325 was ordered a controlled carbohydrate diet (CCD). Special instruction included no pork. Review of Resident #325's Baseline Care Plan, dated 01/09/2024, revealed there were no specific instructions regarding religious preferences to avoid pork products. Review of Resident's #325's Care Plan, revised 01/23/2024, revealed the resident was care planned for Nutritional Status, with goals to include the resident would not have significant weight changes. An intervention was care planned on 01/21/2024, to maintain the goal with a diet as ordered, with no pork. Review of Resident #325's Progress Notes, dated 01/04/2024 through 01/25/2024, revealed no notes relating to religious dietary restrictions. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #325 and his/her daughter on 01/22/2024 at 5:30 PM, the resident stated he/she had been served pork products since admission, even though he/she had repeatedly told staff that he/she did not eat pork due to religious reasons. The resident stated, on 01/18/2024, he/she had requested to speak with the Registered Dietician but had not been contacted by anyone in the dietary department. Further interview revealed the resident spoke to the Director of Nursing (DON), on 01/18/2024, regarding his/her meals and other concerns. Resident #325 stated he/she spoke with the DON about his/her grievances, but stated, Nothing has changed. The State Survey Agency (SSA) Surveyor requested copies of Resident #325's grievance reports since his/her admission from the Director of Social Services (SSD), on 01/26/2024 at 2:07 PM. However, during an interview with the SSD, she stated there was no documentation of any grievance filed by or on behalf of Resident #325. In an interview on 01/28/2024 at 5:03 PM, the DON stated it was her expectation that a resident's dietary restrictions were honored. The DON stated she spoke to the resident recently, but it was not related to meal preferences. In an interview on 01/28/2024 at 5:05 PM, the Administrator stated it was her expectation that each resident be treated with dignity. She stated that it was one hundred percent (100%) the resident's right to make choices. She stated it was important because the facility was the resident's home, and the resident had the right to make his/her own decisions.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 32635 Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to provide palatable hot and cold food for four (4) of one of seventy-one (71) sampled, (Residents #8, #12, #38, and #88). In addition, observation of the test tray on 01/27/2024 revealed the hot food tested colder and cold beverages tested warmer than the required temperatures. The cooked oatmeal cereal had a watery consistency. The findings include: Review of the facility policy's titled, Food: Quality and Palatability, dated 02/2023, revealed the term food palatability referred to the taste and/or flavor of the food. Per the policy, food should be safe and appetizing, and food should be at the appropriate temperature as determined by the type of food to ensure the resident's satisfaction and to minimize the risk for scalding and burns. Review of the facility's policy titled, Food: Preparation, dated 02/2023, revealed the Dining Services Director/Cook(s) would be responsible for food preparation techniques which minimized the amount of time that food items were exposed to temperatures greater than 41 degrees Fahrenheit (F) and/or less than 135 degrees (F). 1. Review of the facility's form Service Line Checklist, dated 01/27/2024, revealed milk or juice temperatures were not recorded, and the eggs tested 164 degrees F, and the oatmeal tested 170 degrees F. Observation on 01/27/2024 at 8:01 AM revealed the meal cart was sent from the kitchen to the 400 Hall at 8:02 AM. Observation at 8:03 AM revealed staff started serving residents breakfast trays on the 400 Hall, and the last resident tray was served at 8:13 AM. Further observation with the Dietary Manager revealed a test tray on the 400 Hall contained a plate that did not feel hot to the touch. The observation of the test tray also revealed scrambled eggs at 105 degrees F; orange juice at 58 degrees F; and milk at degrees 50 F. The food tasted warm or room temperature and not hot. The oatmeal was watery and appeared more like cream of wheat consistency. In an interview with the Dietary Manager (DM) on 01/27/2024 at 8:20 AM and 01/27/2024 at 10:21 AM, he stated he tested trays weekly and had tested that the hot food was warm. He stated the hot plates were so hot to touch because a few plates were laid out near the steam table. The DM stated the plates could cool down. He stated all the plates were being used, so the time between meal service breakfast and lunch and lunch and supper service was about thirty-five (35) minutes to heat up all the plates. The DM stated when the dishes came back, they were washed, and put back into the plate warmer and were not hot. He stated cold beverages were brought from the refrigerator, one (1) tray at a time. The DM stated he had conducted test trays once weekly and found the food temperatures in the same range. 46710 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #12's Annual Minimum Data Set (MDS) Assessment, dated 09/13/2023, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of eleven (11) of fifteen (15), indicating the resident had moderate cognitive impairment. Review of Resident #12's care plan, dated 01/18/2024, revealed the facility identified the resident as at risk for weight loss and included interventions such as reviewing the resident's food preferences and offering substitutes if the resident consumed less than fifty percent (50%) of a meal. Observation on 01/22/2024 at 6:08 PM revealed Resident #12 eating dinner, starting with the vanilla ice cream. Further observation revealed Resident #12 lifted the cover off his/her plate, made a disgusted face, shook his/her head, and ate only the French fries. Further observation of Resident #12's meal tray revealed the fried fish filet appeared soggy, with discolored, hard-appearing spots inside. In an interview on 01/22/2024 at 6:12 PM, Resident #12 shook his/her head when asked if the food was good. Resident #12 shook his/her head again, pointed to the discolored part of the fish filet, and frowned. 49267 3. Review of Resident #88's Quarterly MDS Assessment, dated 12/19/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of twelve (12) of fifteen (15), which indicated moderate impaired cognition. Observation on 01/22/2024 at 2:20 PM revealed Resident #88's lunch tray still on his/her bedside table. Observation of the lunch meal revealed it was not appealing in appearance. Per the observation, the lunch meal consisted of a small piece of turkey breast that was approximately three (3) inches by two (2) inches in size and placed on top of one (1) slice of dry white bread. Also observed for the lunch meal were diced cucumbers with onions and plain potato chips. During an interview on 01/22/2024 at 3:33 PM with Resident #88, he/she stated the food did not taste good and that it needed work. During an additional interview on 01/27/2024 at 2:22 PM with Resident #88, he/she stated the food was terrible. Resident #88 raised the lid on his/her plate and said, Look at that. Would you eat it?

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635 Based on observation, interview, and review of the facility's policies, it was determined the facility failed to store and prepare food under sanitary conditions. Observation on [DATE] on the initial kitchen tour revealed ingredient containers not dated; and scoops, a set of solid stainless steel bowls, and a strainer stored sitting up. Continued observation during the supper meal service revealed no hand washing between glove changes, and a staff member patted the surface of the plate into the plate holder using a bare hand. The findings include: Review of the facility's policy titled, Receiving, dated ,d+[DATE], revealed all food items would be appropriately labeled, dated, and stored properly to ensure appropriate and timely utilization based on the principle of first in-first out (FIFO). Review of the facility's policy titled, Staff Attire, dated ,d+[DATE], revealed fingernails would be kept clean, trimmed, filed, and maintained. Use of nail polish, acrylic and gel nails was not permitted unless wearing intact gloves, in good repair, when handling food. Observation on [DATE] at 3:43 PM, during the initial kitchen tour, revealed three (3) large round clear containers of one (1) labeled thickener, one (1) labeled breadcrumbs and one (1) labeled salt that did not have a use by date. Continued observation revealed scoops turned up in the dish tray, a nested set of solid stainless steel bowls, and a colander turned up and not turned over on the shelf. Observation on [DATE] at 5:31 PM during supper service tray line, revealed a Dietary Aide touching the middle of the plate, put the plate into the base, and patted the plate into the base with bare hands that had long painted nails. Further observation revealed the cook and an aide did not wash their hands between glove changes. In an interview with Cook #1 on [DATE] at 9:45 AM, she stated food should be labeled with the use by date and then thrown out when it had expired. She stated, if not dated, food could spoil and old food could be used. She stated staff must wash their hands when changing gloves, touching their face, leaving the kitchen and re-entering, and when changing stations to prevent cross contamination. She stated to move plates, suction cups should be used to prevent touching them on the surface to prevent cross contamination. In an interview with Cook/Diet Aide #2 on [DATE] at 10:10 AM, Cook/Aide #2 stated food should be dated with an opened date and last date to be used. She stated food products should be labeled for identification so the wrong food ingredient would not be used because some food ingredients looked the same. Cook/Diet Aide #2 stated hands should be washed upon entering the kitchen, changing gloves, and changing tasks. She stated staff should handle the plate with four (4) fingers underneath the plate and the thumb on the rim not to touch the middle of the plate. Cook/Diet Aide #2 stated touching the plate surface could cause cross contamination. She stated dishware should be turned over to remain clean. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with Dietary Aide #3 on [DATE] at 10:13 AM, he stated staff labeled food with the date opened and the use by date. He stated staff should wash their hands after every event between glove changing. He stated dishware should be stored so water could drain and nothing could fall into the dishware. He stated plates should be touched from the bottom to avoid getting germs from the hands on the surface of the plate. In an interview with the Dietary Manager (DM) on [DATE] at 3:33 PM and on [DATE] at 10:22 AM, he stated food should be labeled and dated to identify the food item and to see that it was not expired. He stated staff should wash their hands between change of gloves and on return to the kitchen to prevent cross contamination. He stated dishware should be turned upside down to dry and to prevent them from being contaminated by other food or debris falling into the dishware. The DM stated plates should be handled by the bottoms of the plates because physical cross contamination from touching the surface with bare or gloved hands would be a concern. He stated fingernails should be short, and staff should wear gloves if nails were long with polish. In an interview with the Director of Nursing on [DATE] at 2:26 PM, she stated her expectations were for food to be labeled and dated, staff to use appropriate hand hygiene with glove changing, and safe dishware storage to prevent cross contamination. In an interview with the Administrator on [DATE] at 11:25 AM, she stated her expectation was for staff to follow safe food handling protocols.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49050 Based on observation, interview, record review and review of the facility's assessment, it was determined the facility failed to ensure the Facility Assessment was clear on evaluating its resident population; identifying the resources needed; and the level of staffing for each unit, to provide the necessary care and services to match the acuity level of the community. The findings include: Review of the document titled, Facility Assessment, [NAME] 2023 Facility Assessment, Resident Population Profile 08/05/2022-08/04/2023, revealed three (3) columns were assigned for: Admissions/Stays, % of Admissions/Stays, and Frequency Relative to Benchmark. The first two (2) columns had quantitative data where the last column was assigned (High-Low), with no quantitative data. The assessment utilized the Barthel Index which measured the degree of assistance required by an individual on ten (10) mobility and self-care Activities of Daily Living (ADL) items. Low ADL function score < 30 indicated total dependence, moderate ADL function score 31-59 indicated severe dependency, and high ADL function score >60 indicated slight dependency. The Facility Assessment failed to determine the amount of staff to match the level of care involved for each resident. Further review revealed no evidence the Facility Assessment determined the amount of staff needed to provide quality of care to the residents based on resident acuity. In the section titled, Staffing, Training, Services and Personnel, all ADLs for overall staffing, staff training/Competencies, and Services were scored as sufficient, instead of quantitative data. Another section titled, Acuity-Diseases, Conditions, and Treatments indicated either sufficient or not applicable for staffing requirements. During an interview with Social Services Director (SSD), on 01/24/2024 at 10:34 AM, she stated she was familiar with the facility's assessment. However, she was not involved in the process of determining its composition. During an interview with the Director of Nursing (DON), on 01/28/2024 at 2:05 PM, she stated, she did not have anything to do with the Facility Assessment as that was handled by the Administrator. During an interview with Administrator, on 01/28/2024 at 6:17 PM and 01/28/2024 at 7:14 PM, she stated she was the person responsible for completing the Facility Assessment. She stated she could explain the facility's assessment by admissions, percent of admissions, and frequency rates related to benchmarks. She stated, for example, Activities of Daily Living (ADLs) had three hundred and ninety-five (395) residents which equated to 66.3 percent of the residents. The frequency relative to benchmark indicated low. She further stated she could not give a value for what low indicated, or any of the other values. She stated the Facility Assessment document was used across the company, but it was hard to understand. She stated the Facility Assessment did not clearly indicate the discipline and amount of staff needed to provide quality of care to the residents based on the residents' acuity.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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, review of the facility's fact sheet Preventing the Spread of Bloodborne Pathogens, review of the facility's online education course outline, Bloodborne Pathogens and the Use of Standard Precautions, review of Assure Platinum Blood Glucose Monitoring System Cleaning and Disinfecting QA/QC Reference Manual, Microdot (brand) bleach wipes manufacturer's instructions, Cleaning and Disinfecting Recommendations,'; review of the facility's internal resource Common Infections, PPE & Isolation Guidelines,; review of the CDC's Enhanced Barrier Precaution (EBP) door signage, and review of the facility's policies, it was determined the facility failed to implement recommended interventions for the cleaning and disinfecting of a shared glucometer (glucose monitoring device), according to manufacturer's instructions. This affected two (2) of seventy-one (71) sampled residents (Residents #325 and #327). The facility had twenty-six (26) residents that required glucose monitoring. Observation on 01/22/2024 of Licensed Practical Nurse (LPN) #1, performing a blood glucose fingerstick using a shared glucometer between Residents #325 and #327 revealed the LPN failed to clean and disinfect the glucometer per the manufacturers' instructions between resident use. In addition, LPN #1 failed to perform hand hygiene between the residents. Further observation on 01/25/2024 of LPN #4 cleaning and disinfecting the glucometer after use on Resident #332 revealed LPN #4 did not use barriers for the machine, failed to disinfect it correctly, and failed to place it in its disinfection case for storage. The facility's failure to have an effective system in place to ensure residents had blood glucose fingersticks performed using a clean and disinfected glucometer has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 01/24/2024 and was determined to exist on 01/22/2024 in the area of 42 CFR 483.80 Infection Control at a Scope and Severity (S/S) of a J. The facility was notified of the Immediate Jeopardy (IJ) on 01/24/2024. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on 01/26/2024 alleging removal of the IJ on 01/27/2024. The State Survey Agency (SSA) determined the removal of the IJ as alleged before exit on 01/28/2024, which lowered the S/S to an E while the facility develops and implements a Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. Furthermore, the facility failed to follow its infection prevention and control policies and procedures regarding the handling of linens to prevent the spread of infection, and failed to disinfect a shared lift. The findings include: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Infection Control, revised 10/2018, revealed the facility established guidelines for implementing isolation precautions, including standard and transmission-based precautions, and to provide guidelines for the safe cleaning and reprocessing of reusable resident care equipment. Continued review of the policy revealed that all personnel would be trained on infection control policies and practices upon hire and periodically thereafter. Per the policy, the quality assurance and performance improvement (QAPI) committee and the infection control committee were responsible to review and revise the facility's Infection Prevention and Control Program (IPCP) and to assist department heads and managers to ensure that infection control policies and practices were implemented and followed. Review of the facility's policy titled, Glucometer Cleaning and Disinfecting, revised 01/24/2024, revealed the purpose of cleaning glucometers was to minimize the risk of transmitting bloodborne pathogens. The review revealed cleaning and disinfection procedures should be performed to clean dirt, blood, and other bodily fluids off the exterior of the glucometer before performing the disinfectant procedure. Furthermore, the policy stated all licensed staff would follow the manufacturer's guidelines and recommendations for cleaning and disinfecting of the glucometer. Review of the Assure Platinum Blood Glucose Monitoring System Cleaning and Disinfecting QA/QC Reference Manual, revised 12/2014, revealed the blood glucose meters needed to be cleaned and disinfected after each use. The manual stated cleaning and disinfecting was accomplished according to the manufacturer's guidelines with an Environmental Protection Agency (EPA) registered disinfectant or germicide that was approved for a health care setting. Per the manual, Microdot (brand) bleach wipes were approved for use with the Assure Platinum (brand) glucometer. Review of the Microdot bleach wipes instructions, Cleaning and Disinfecting Recommendations, no date, revealed to thoroughly clean the glucometer surface; wrap the glucometer with a bleach wipe, covering all surfaces of the glucometer; and place the wrapped glucometer face down inside the disinfection case. The instructions continued, with the lid closed, activate a timer for three (3) minutes to allow the glucometer to remain in contact with the bleach wipes. Review of the facility's policy titled, Transmission Based Precautions, dated 09/15/2023, revealed transmission-based precautions (TBP) included contact precautions, droplet precautions, and airborne precautions. The policy stated TBP were initiated when a resident developed signs and symptoms of a transmissible infection or had a laboratory confirmed infection and was at risk for transmitting the infection to other residents. 1. Review of the facility's Glucose Monitoring list, dated 01/23/2024, revealed the list contained twenty-four (24) residents, including Residents #325 and #327. Review of the facility's Glucose Monitoring list, dated 01/24/2024, revealed the list contained twenty-six (26) residents, including Resident #325 and #327. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Continuous observation, on 01/22/2024 at 6:22 PM, of Licensed Practical Nurse (LPN) #1, while performing a pre-meal blood glucose test revealed LPN #1 entered Resident #325's room holding a blue plastic basket with Resident #325's insulin pen, a bottle of glucose testing strips, unwrapped gauze, unused lancets, alcohol wipes, and band aids. The LPN performed a blood sugar finger stick on Resident #325. LPN #1 exited the room without performing hand hygiene (HH). She was carrying the shared glucometer inside the basket on top of the other supplies. LPN #1 failed to clean the glucometer used on Resident #325. LPN #1 then walked into Resident #327's room with the basket of supplies and the contaminated glucometer and performed a blood sugar finger stick on the resident. She did not perform HH prior to entering the room. LPN #1 then exited the room with the glucometer inside the basket. She did not clean the glucometer prior to exiting Resident #327's room nor did she perform HH upon exit. In an interview with LPN #1 on 01/22/2024 at 6:30 PM, she stated she cleaned the glucometer after each use. She stated she had just used a bleach wipe which was located on her medication cart. The State Survey Agency (SSA) Surveyor asked LPN #1 to demonstrate how she cleaned the glucometer. LPN #1 placed the contaminated glucometer in the top drawer of the medication cart without a barrier. LPN #1 stated, I used these. She then opened the bottom drawer of the medication cart and took out a container of Microdot bleach wipes. LPN #1 stated she tried to pull a wipe out of the container but realized the container had never been opened and was still factory sealed. The LPN then stated, I didn't clean it [the glucometer] between sticks. I'm not going to lie to you. When asked about the cleaning process of the glucometer, LPN #1 stated it should be cleaned after every use and left wet for five (5) minutes. In continued interview with LPN #1 on 01/22/2024 at 6:30 PM, she stated the shared glucometer should be stored in a plastic container after cleaning. Although she pointed to a blue plastic lid, she was unable to find the bottom part of the container. Observation, at the time of the interview, revealed there was a blue lid on the medication cart, but no disinfection container was available. Furthermore, when interviewed about placing the contaminated glucometer and Resident #325's insulin pen on top of unused clean lancets and the blood glucose monitoring strips, she stated that was how she carried her supplies from room to room. LPN #1 stated she did not consider placing contaminated equipment on clean supplies was an infection control breach. The LPN stated, Nothing touched a resident. She stated she received IPCP training upon hire and annually. When interviewed related to the significance of cleaning and disinfecting multi-use equipment and performing HH before and after direct resident care, LPN #1 explained that those actions helped to prevent the spread of infection. In an interview with Registered Nurse (RN) #1 on 01/23/2024 at 10:02 AM, she stated her practice for cleaning shared glucometers was to wipe them down with an alcohol wipe after each use. She further stated she cleaned the glucometer at the beginning of her shift with a bleach wipe. Per the interview, the facility trained her to clean the glucometers but did not specify which wipe to use. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the Director of Nursing/Infection Preventionist (DON/IP) and the Minimum Data Set/Infection Preventionist (MDS/IP) Nurse on 01/23/2024 at 1:27 PM, they stated all staff members were trained on IPCP. The DON/IP stated the facility followed state and federal guidelines to prevent the spread of infection. The DON/IP stated the facility did not have a specific policy addressing shared equipment, and clinical staff members were trained to clean multiuse or shared equipment, including vital sign equipment, glucometers, and Hoyer lifts (brand of mechanical lift) after each use. The DON/IP stated, Everyone who is clinical receives this on hire. She stated it was her expectation for staff using shared and multi-use equipment to clean and disinfect the equipment after each use with a bleach wipe and to wait for the appropriate time. The DON/IP further stated clinical staff members were aware of kill times, and they were posted on the bleach wipe container. During the interview the DON/IP stated, We use an alcohol swab to clean bleach residue off the glucometer and use a bleach wipe first for proper kill time. I'd have to refer to the container for kill time, but I believe it's two (2) or three (3) minutes. The DON/IP stated that she and the unit managers continually perform visual audits and on the spot education. However, she stated, We don't keep paper records of those audits. Both the DON/IP and the MDS/IP Nurse stated following IPCP guidelines were important to prevent the spread of infectious material. Observation with the DON, on 01/24/2024 at 8:55 AM, revealed there were currently twelve (12) shared glucometers being used throughout the facility, and all should be kept on the medication carts. Further observation revealed seven (7) of the eight (8) medication carts had glucometers, with two (2) on the 100 Hall; one (1) on the 200 Hall; one (1) on the 400 Hall; one (1) on the 500 Hall; two (2) on the 600 Hall; two (2) on the 700 Hall; and one (2) on the 800 Hall. One (1) glucometer was found on the 300 Hall treatment cart. The 300 Hall glucometer was stored in a blue plastic tray with unwrapped gauze, band aids, lancets, alcohol wipes, and packaged needles. In additional interview with the DON/IP on 01/24/2024 at 9:15 AM, she stated to prevent cross contamination, shared glucometers should not be stored inside the plastic basket along with other supplies on the medication cart. She stated they should be placed in a container with a lid after cleaning and disinfecting per manufacturer's instructions. When asked who was responsible for ensuring IPCP compliance and addressing breakdowns related to infection control, the DON stated that unit managers and nurse leadership perform weekly audits of the medication carts and daily visual rounds of clinical staff performing direct care to ensure compliance with IPCP. The DON/IP stated of the residents who received glucose monitoring, one (1) resident had a bloodborne pathogen. She stated Resident #329 had a diagnosis of HIV. Additionally, she stated Resident #329 had a diagnosis of diabetes and received insulin and blood glucose monitoring before meals. Review of Resident #329's Face Sheet revealed the facility admitted the resident on 01/17/2024 with diagnoses to include human immunodeficiency virus (HIV) disease, type 2 diabetes mellitus, and history of urinary tract infections. Resident #329 was on the Glucose Monitoring list. Review of Resident #331's Face Sheet revealed the facility admitted the resident on 01/12/2024 with diagnoses to include type 2 diabetes mellitus and acute and chronic hepatitis B (HBV). Resident #331 was on the Glucose Monitoring list. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 01/25/2024 at 3:45 PM during quality monitoring, by a Regional Care Consultant Nurse, of Licensed Practical Nurse (LPN) #4 performing a blood glucose fingerstick on Resident #332, revealed LPN #4 retrieved the glucometer from the top drawer of the medication cart. The glucometer was resting on top of an open roll of bandage tape along with a pair of bandage scissors. It was in close contact with various items in the drawer. LPN #4 placed the glucometer on the medication cart without using a barrier sheet, and then collected the necessary supplies in a plastic cup. LPN #4 proceeded to the resident's bedside and put the supplies on the bedside table. The blood glucose fingerstick was performed, and immediately after the procedure, the LPN placed the contaminated glucometer, with the test strip still engaged on top of the resident's bedside table without using a barrier. LPN #4 then moved to the resident's sink and placed the glucometer on a barrier. The LPN removed the Microdot bleach wipe container from the cart and placed it on the resident's sink without using a barrier. The LPN gloved and cleaned the glucometer. The glucometer was then wrapped with bleach wipes; however, LPN #4 did not cover all four (4) sides, and it was placed on top of the medication cart using a barrier instead of being put in the disinfectant case as per manufacturer's instructions. In an interview with LPN #4 on 01/25/2024 at 3:45 PM, he stated that all clinical staff had received training to include written instruction and a test regarding how to clean and disinfect glucometers. However, he stated he did not receive a live demonstration and was not asked to demonstrate proper technique back. 2. Observation on 01/23/2024 at 3:10 PM, revealed a dirty towel on the floor in the 400 Hall outside of room [ROOM NUMBER]. The towel remained on the floor for five (5) minutes while multiple staff members walked past it. When the DON noticed the towel, she picked up the towel and placed it in a plastic bag, which she then put in the soiled utility room. Observation, on 01/23/2024 at 5:30 PM, revealed a dirty sheet lying in the entrance of room [ROOM NUMBER], which extended to the hallway of the 700 Hall. In an interview with the Director of Housekeeping on 01/24/2024 at 5:00 PM, the Director stated linen should never be thrown on the floor or other surfaces in the room or in the hallway. The Director stated linen should be bagged and taken to the dirty utility promptly. Observation on 01/25/2024 at 8:30 AM, revealed Certified Nursing Assistant (CNA) #14 walking down the 800 Hall holding clean linens against her uniform. In an interview with CNA #14 she stated she had been trained on IPCP policies. She stated linen should be held away from the body to prevent the spread of germs. In an interview with the MDS/IP Nurse on 01/24/2024 at 8:35 AM, she stated staff should not hold linen up against their clothing. She stated linen should be held away from the body to prevent cross contamination. She stated when she saw staff members failing to follow IPCP policies she would stop and educate them on the spot. 3. Observations on 01/22/2024 at 3:38 PM and on 01/23/2024 at 3:27 PM revealed the sit-to-stand lift in the 400 Hall was visibly soiled with a brown substance streaked on the foot pad and bottom bar of the lift. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 01/23/2024 at 3:27 PM, the Director of Nursing (DON) stated the lifts should be cleaned after every use and when visibly soiled. She further stated she would clean the lift and re-educate staff. In an interview with the Regional Care Consultant (RCC) Nurse on 01/28/2024 at 5:32 PM, she stated that all staff should follow IPCP to prevent the spread of infection in the facility. In an interview with the Director of Regulatory on 01/28/2024 at 2:45 PM, she stated the role of the Director of Regulatory was to assist the facility and train the nursing leadership and staff. Additionally, she stated regional nurses were assigned to help the DON by providing resources. The Director of Regulatory emphasized that all staff members should follow the facility's IPCP. She also mentioned that the facility followed state and federal guidelines, and if CMS required something to be followed, the facility should comply with the requirements. She stated it was important to prevent the spread of infection. During an interview with the Administrator on 01/28/2024 at 5:05 PM, the Administrator stated it was her expectation for the staff to follow the facility's IPCP, which included current standards, policies, and procedures based on state and federal regulations. She stated the QAPI committee reviewed policies annually. When asked if following current guidelines was important to provide a safe environment and to help prevent the spread of infections, she stated, Yes. She reported nurse leadership ensured quality assurance and compliance with IPCP through a triple check system that included daily visual rounds at the bedside and of clinical staff performing direct care. She added that although daily rounding by nurse leadership was not documented, issues were resolved through a root cause analysis of the failure. According to the Administrator, the root cause of the staff's failure to clean the glucometers was that staff did not understand the education. She further emphasized that the facility followed state and federal regulations, including the state health department recommendation. She stated all staff should follow IPCP to prevent the spread of infection in the facility. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on 01/26/2024, alleging removal of the IJ on 01/27/2024. Review of the IJ Removal Plan revealed the facility implemented the following: 1. Residents #325 and #327 were assessed by a licensed nurse on 01/24/2024 using a Risk for Infection Assessment, in which each resident was assessed for any signs and symptoms of infections. A full set of vital signs was included in the assessment. Residents #325 and #327's physician and responsible parties were notified of the potential for bloodborne pathogen exposure on 01/24/2024 by a licensed nurse. Glucometer Cleaning and Disinfecting Policy was revised on 01/24/2024 by the Governing Body, which included the [NAME] President (VP) of Regulatory, VP of Clinical Operations, VP of Operations, and the VP of Clinical Reimbursement. LPN #1 was educated by the Chief Nursing Officer (CNO) on 01/24/2024 on Preventing the Spread of Bloodborne Pathogens. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 01/24/2024 all twenty-six (26) residents receiving accu-checks (blood glucose monitoring) were assessed by a licensed nurse to ensure there were no signs and symptoms related to bloodborne pathogen exposure. In addition, on 01/24/2024, all residents receiving accu-checks and/or the residents' representatives and physicians were notified of the potential bloodborne pathogen exposure. Each was offered lab testing related to the potential bloodborne pathogen exposure. This was completed by licensed nurses. On 01/24/2024, physician's orders were obtained for twenty-five (25) of the twenty-six (26) residents and/or resident representatives who requested lab testing completed. A hepatitis (HEP) and human immunodeficiency virus (HIV) exposure panel was obtained on 01/26/2024 for twenty-three (23) of the twenty-six (26) residents. One (1) resident refused labs, one (1) resident was transferred to the hospital on 01/25/2024, and one (1) resident was discharged home on 01/25/2024 prior to the lab being drawn. An at Risk for Infection care plan was implemented and completed on 01/24/2024 for each of the twenty-six (26) residents. Testing was offered and he/she is expected to return to the facility. Resident #325 refused and then was admitted to the hospital. Resident #325 was offered and refused, wishing to have it done at his/her PCP. 3. Education by the Regional Care Consultant (RCC) Nurse, Director of Regulatory, and the Vice-President (VP) of Clinical Operations on the Glucometer Cleaning and Disinfecting process per the manufacturers' guidelines and on bloodborne pathogens was provided to the Director of Nursing (DON), Minimum Data Set (MDS) Nurses, and licensed nurses on 01/24/2024. A posttest was given requiring a minimum score of one hundred percent (100%). Those who did not receive a score of one hundred percent (100%) were reeducated and tested again, until a score of one hundred percent (100%) was achieved. Any nurse not receiving education by 01/24/2024 would be provided with the education prior to working their next shift. Due to a breach in infection control practices observed on 01/24/2024 during observation of an accu-check being performed, all licensed nursing staff were immediately reeducated. The RCC Nurse, Director of Regulatory, and the VP of Clinical Operations revised the education to include the required steps of completing an accu-check per the manufacturers' guidelines and on the cleaning and disinfection process of the glucometer per manufacturers' guidelines. The revised reeducation was done on 01/25/2024 and required a competency review with a return demonstration. This was repeated until each licensed nurse on the day and evening shifts passed the competency return demonstration with one hundred percent (100%) accuracy. The RCC Nurse arrived at the facility prior to the day shift on 01/26/2024 so that any licensed nurses that had not been educated and were scheduled to work were reeducated prior to working their shift. Any licensed nurse not receiving reeducation by 01/26/2024 would not work until they had completed reeducation and passed the competency return demonstration. All new licensed nurses or agency nurses would be educated by a member of nursing management during orientation prior to providing resident care. Starting 01/25/2024, the DON, Assistant DON, Unit Managers, MDS Nurse, or Regional Nurses would observe ten (10) accu-checks weekly for four (4) weeks, being performed with the cleaning and disinfecting process after the accu-check had been performed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. An ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held on 01/24/2024 with the Medical Director and the QAPI Team Members, which included the DON, Administrator, and the Administrator in Training. The QAPI Committee would meet daily for seven (7) consecutive days, starting on 01/25/2024, then weekly for four (4) weeks, then monthly thereafter for recommendations and further follow up regarding the plan of correction. Audit documentation would be submitted to the QAPI Committee for review and to ensure compliance. The Administrator was responsible for the oversight of the removal plan to ensure ongoing compliance. The State Survey Agency validated implementation of the facility's IJ Removal Plan as follows: 1. Review of the Risk for Infection Assessments dated 01/24/2024 confirmed Residents #325 and #327 were assessed by the DON and each resident was assessed for any signs and symptoms of infections. A full set of vital signs was included in the assessment. Review of the Risk for Infection Assessments dated 01/24/2024 confirmed Residents #325 and #327's physician and responsible parties were notified by the Director of Nursing (DON) of the potential for bloodborne pathogen exposure on 01/24/2024. Review of the revised Glucometer Cleaning and Disinfecting Policy, dated 01/24/2024, revealed it included the addition of 1) licensed staff would follow the manufacturer's guidelines and recommendations for the cleaning and disinfecting of the glucose monitors; and 2) the staff would receive education on cleaning and disinfecting the glucose monitors per the manufacturer's guidelines upon hire and as needed. Review of signed documentation related to LPN #1's reeducation by the Chief Nursing Officer (CNO), dated 01/24/2024, indicated LPN #1 was educated on the Glucometer Cleaning and Disinfecting Policy, the Infection Control Policy, and Preventing the Spread of Bloodborne Pathogens education module by the American Red Cross. 2. Review of the Risk for Infection Assessment sheets, dated 01/24/2024, revealed the DON, the RCC Nurse, and the Director of Regulatory (also a nurse) performed a risk assessment on all twenty-six (26) residents receiving accu-checks (glucose monitoring). Review of the Risk for Infection Assessment sheets, dated 01/24/2024, revealed the DON, the RCC Nurse, and the Director of Regulatory notified all residents and/or the residents' representatives and physician of the potential bloodborne pathogen exposure. Review of lab orders dated 01/24/2024 for twenty-five (25) of the twenty-six (26) residents receiving accu-checks, revealed a HEP and HIV Exposure Panel was ordered by the physician for residents and/or resident representatives who requested lab testing. One (1) resident was discharged on [DATE]. Review of the completed lab orders revealed a HEP and HIV Exposure Panel lab draw was completed on 01/26/2024 for twenty-three (23) of the twenty-six (26) residents. One (1) resident refused labs, one (1) resident was transferred to the hospital on 01/25/2024, and one (1) resident was discharged home on 01/25/2024 prior to the lab being drawn. (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	01/28/2024

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Care Plans revealed a Risk for Infection care plan was implemented on 01/24/2024 for each of the twenty-six (26) residents to include the resident was at risk for potential adverse effects related to potential bloodborne pathogen exposure. Interventions included to notify the provider of the potential exposure, perform a nurse assessment for signs and symptoms of adverse effects, obtain labs as ordered by the provider, and notify the resident and/or responsible party of the potential exposure. 3. Review of education, posttests with a score of one hundred percent (100%) achieved, and sign-in sheets, dated 01/24/2024, revealed thirty-one (31) nursing staff members were educated on the Glucometer Cleaning and Disinfecting process per the manufacturers' guidelines and on bloodborne pathogens, and it was provided by Nursing Leadership. Review of the revised reeducation, completed on 01/25/2024 to 01/26/2024, revealed training and education to include Glucometer Cleaning and Disinfecting and Blood Glucose Testing, with return demonstration competency tests, signed by the staff and educator, showing one hundred percent (100%) accuracy achieved for thirty (30) nursing staff. Review of the quality assurance (QA) audits revealed the Regional Nurses observed three (3) accu-checks being performed with the cleaning and disinfecting process after the accu-check had been performed on 01/26/2024 and 01/27/2024. Observation on 01/28/2024 at 11:30 AM of Licensed Practical Nurse (LPN) #4 performing a blood glucose fingerstick on Resident #330, revealed LPN #4 performed the procedure and cleaned and disinfected the glucometer correctly, per manufacturers' instructions. Observation on 01/28/2024 at 11:45 AM of RN #7 (Agency) performing a blood glucose fingerstick on Resident #90, revealed RN #7 performed the procedure and cleaned and disinfected the glucometer correctly, per manufacturers' instructions. Observation on 01/28/2024 at 12:01 PM of LPN #10 performing a blood glucose fingerstick on Resident #97, revealed LPN #10 performed the procedure and cleaned and disinfected the glucometer correctly, per manufacturers' instructions. Observation on 01/28/2024 at 12:15 PM of RN #2 performing a blood glucose fingerstick on Resident #20, revealed RN #2 performed the procedure and cleaned and disinfected the glucometer correctly, per manufacturers' instructions. In interviews with Licensed Practical Nurse (LPN) #4 on 01/28/2024 at 11:30 AM; RN #7 on 01/28/2024 at 11:45 AM; LPN #10 on 01/28/2024 at 12:01 PM; and RN #2 on 01/28/2024 at 12:15 PM, all stated the RCC Nurse conducted one-on-one (1:1) training for all nurses on how to properly clean and disinfect glucometers. All stated the nurse trainer provided live demonstrations and had the nurses perform a return demonstration to ensure proper understanding. All stated infection control training was important in preventing the spread of disease. All stated they had received a live demonstration and education to include written instruction and a test regarding how to perform blood glucose monitoring and how to clean and disinfect glucometers per the manufacturer's instructions. They further stated they had to pass the written test with one hundred (100%) accuracy, and they were required to perform a return demonstration. (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	01/28/2024

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the RCC Nurse on 01/28/2024 at 5:32 PM, she stated she was responsible for providing education to all nurses working in the facility on how to clean and disinfect glucometers. She stated that she had provided training to all nurses before the start of their shift, which involved both instruction and live demonstration. After that, she stated each nurse was required to provide a return demonstration to ensure compliance. She stated the education was based on the manufacturer's instructions for the glucometer and Microdot bleach wipes. In an interview with the Director of Regulatory on 01/28/2024 at 2:45 PM, she stated nursing staff received education on cleaning and disinfecting glucometers from the RCC Nurse. She stated the training was followed by a return demonstration to ensure the staff understood it. The Director of Regulatory reported the education was based on manufacturers' instructions for the glucometer and Microdot bleach wipes. 4. Review of the QAPI sign-in sheet dated 01/24/2024 revealed the QAPI Committee, which included the Medical Director, Administrator, DON, Risk Manager, VP of Clinical Operations, VP Regulatory, VP Operations, and Administrator in Training, had a meeting. Review of the QAPI sign-in sheet dated 01/25/2024 revealed the QAPI Committee, which included the Medical Director, Administrator, DON, MDS Nurse, and the Social Services Director, had a meeting. Review of the QAPI sign-in sheet dated 01/26/2024 revealed that the QAPI Committee, consisting of the Medical Director, Administrator, DON, MDS Nurse, and Social Services Director, had a meeting. During an interview with the VP of Clinical Operations on 01/26/2024 at 3:43 PM, he stated the QAPI Committee had convened to address the IJ findings. He stated the committee discussed the education and re-education of staff, as well as the progress of staff education and competency training. He stated the Medical Director, Administrator, DON, and other nursing leadership members met daily on 01/24/2024, 01/25/2024, and 01/26/2024 as part of the IJ removal plan. 46710