STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185333	A. Building B. Wing	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Klondike Nursing and Rehabilitation Center	3802 Klondike Lane Louisville, KY 40218

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44486 Based on interview, record review, review of the facility's investigation, and the facility's policies, it was determined the facility failed to protect residents from sexual abuse, for two (2) of twenty-two (22) sampled residents (Resident 3 (R3) and Resident 5 (R5)). On 08/07/2023 Resident 4 (R4) told R3 (his/her) stuff does not work, and R4 touched R3's knee. On 09/12/2023 R4 was observed with his/her hand on R5's buttock. On 11/15/2023 Resident 6 (R6) was observed with his/her hand on R5's breast. The findings include: Review of the facility's policy titled, Abuse Prohibition, dated 10/24/2022, revealed the facility prohibited abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter patient) property, and exploitation for all patients. Per policy review, abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Continued review revealed abuse also included the deprivation by an individual, including a caretaker, of goods or services that were necessary to attain or maintain physical, mental, and psychosocial well-being. Review revealed instances of abuse of all residents, irrespective of any mental or physical condition, caused physical harm, pain, or mental anguish. Further review revealed it included verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. In addition, further review revealed willful, as used in the definition of abuse, meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Review of the policy further revealed sexual abuse was defined as non-consensual sexual contact of any type with a resident. Review of the facility's policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, revealed residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Continued review revealed that included but was not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revealed the resident abuse, neglect and exploitation prevention program consisted of a facility-wide commitment and resource allocation. Per policy review, the program was to support the following objectives: protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including other residents; establish and maintain a culture of compassion and caring for all residents, particularly those with behavioral, cognitive or emotional problems. Additional review revealed the program was also to implement measures to address factors that might lead to abusive situations, for example, help staff understand how cultural, religious and ethnic differences could lead to misunderstanding and conflicts. 1. (a). Review of the Admission Record revealed the facility admitted Resident 3 (R3) on 04/21/2021, with diagnoses which included: unspecified dementia; general anxiety disorder; cerebral infarction due to unspecified occlusion or stenosis of the right middle cerebral artery; and abnormal posture. Review of R3's Quarterly Minimum Data Set (MDS) Assessment, dated 06/16/2023, revealed the facility assessed him/her to have a Brief Interview for Mental Status (BIMS) score of eleven (11) out of fifteen (15), which indicated he/she had moderate cognitive impairment. (b). Review of Resident #4's (R4) Admission Record revealed the facility admitted the resident on 06/21/2023, with the following diagnoses: unspecified dementia; cognitive communication deficit; major depressive disorder, recurrent, mild. Review of R4's Re-admission MDS Assessment, dated 06/27/2023, revealed the facility assessed the resident to have a BIMS' score of nine (9) of fifteen (15), indicative of moderate cognitive impairment. Review of R4's Comprehensive Care Plan (CCP) revealed the facility care planned the resident for impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium: dementia, which was initiated 06/23/2023. However, further review revealed no documented evidence the facility care planned R4 for sexually inappropriate behaviors, even though R4's psychiatry services provider (PA) stated during interview the resident had a history of those behaviors. Review of the facility's Long Term Care Facility - Self-Reported Incident Form Initial Report, dated 08/07/2023, revealed R3 reported when he/she was visiting with other residents in the courtyard, R4 told him/her that his/her stuff does not work, and then touched R3's knee. Continued review revealed R3 indicated he/she thought when R4 said his/her stuff it meant his/her private parts. Per review, the residents were separated and had no injury/harm. Further review revealed R4 indicated he/she was swatting away a fly from his/her knee, and the resident was educated on not touching others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's Progress Notes *NEW*, effective date 08/07/2023, read as follows: Both the Social Service Director (SSD) and Director of Nursing (DON) spoke to R4 due to (d/t) him/her making sexually inappropriate comments to another resident of the opposite sex. Continued review revealed they explained to the resident that his/her behavior was inappropriate. Per the Note, R4 stated he/she wanted to share with his/her friend how he/she felt. Further review revealed the SSD and DON explained to R4 that he/she needed to defer from making sexually inappropriate comments. In addition, R4 shared that he/she wanted to be referred elsewhere; however, then said he/she liked living at the facility. Review further revealed both psychiatric (psych) and the counselor were to see R4 regarding his/her behavior. Review of R3's Progress Notes *NEW*, effective date 08/07/2023, revealed the SSD met with R3 regarding the inappropriate statement that was directed to him/her from another resident (R4). Further review revealed R3 stated he/she was upset in the moment; however, now was okay. Review additionally revealed the SSD was to have psych supportive counseling see resident. During an interview, on 01/17/2024 at 2:35 PM, R3 stated he/she recalled the time last summer when another facility resident touched him/her. R3 stated R4 took his/her hand and was patting his/her leg while they were talking. R3 stated that made him/her feel a little upset that R4 was touching him/her. R3 stated it was a bad thing having R4 touching my leg and R3 stated he/she told R4 not to do it. 2. (a). Review of the Admission Record revealed the facility admitted Resident 5 (R5) on 05/18/2023, with diagnoses that included Alzheimer's Disease, Dementia, and Type 2 Diabetes Mellitus without complications. Review of R5's Quarterly MDS Assessment, dated 09/22/2023, revealed the facility assessed the resident to have a BIMS' score of zero (0) out of fifteen (15), which indicated the resident had severe cognitive impairment. Review of R5's Comprehensive Care Plan (CCP), initiated on 09/27/2023, revealed the facility care planned the resident for a focus of R5 has a tendency to hug and rub and shows non-sexual affection to others. This is a way that (he/she) communicates with others. Further review revealed R5's goal was he/she would not rub, touch, or hug any staff or resident inappropriately by next review. The one (1) intervention was staff will encourage R5 to keep his/her hands to himself/herself and not touch staff or other residents. However, record review revealed Resident #5 was a severely cognitively impaired resident. (b). Review of Resident 4 (R4)'s, Admission Record revealed the facility admitted the resident on 06/21/2023, with the following diagnoses: unspecified dementia; cognitive communication deficit; and major depressive disorder, recurrent, mild. Review of R4's Re-admission MDS Assessment, dated 06/27/2023, revealed the facility assessed the resident to have a BIMS' score of nine (9) of fifteen (15), which indicated he/she had moderate cognitive impairment. Review of the facility's Long Term Care Facility - Self-Reported Incident Form Initial Report, dated 09/12/2023, revealed during breakfast R4 was seen rubbing on R5's left buttock at which time R4 was redirected. Staff remained with R5. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's Progress Notes *NEW*, effective date 09/13/2023, read as follows: (R4) was seen by psych as an acute visit on 09/12/2023 due [to] inappropriate sexual behavior (see psych note for details). Per review, R4 was started on Climara (Estradiol) Patch, (a medication used in the treatment of aggressive behavior in patients with advanced dementia). Continued review revealed currently R4 was on one on one (1:1) supervision, meaning one (1) staff member was assigned to supervise only R4, until he/she was seen by psych the next week. Further review revealed the SSD spoke to R4, and the resident stated that he/she was doing fine and slept well last night. In addition, Resident had been encouraged [sic] to sit with male peers in the dining room, with no behaviors noted. Review of the Psychiatry Progress Note, dated 09/12/2023, revealed the chief complaint/reason for the visit was Acute PsychMed visit for inappropriate sexual behavior. Continued review revealed when the provider asked R4 about touching another female resident, the resident reported he/she was touching me on my hand and my shoulders. I thought that meant for me to touch him/her. Further review revealed the resident was referring to had advanced dementia and was unable to communicate with staff or others. Additional review of the Psychiatry Progress Note revealed it was reported that (R4) touched (R5's) left buttock. Review of the Psychiatry Progress Note, dated 09/12/2023, revealed Orders for this Visit were to start the resident on a Climara patch 0.05 mg weekly due to diagnosis of Vascular dementia with other behavioral disturbances. Review of R4's Order Listing, revealed an order for Climara Transdermal Patch Weekly 0.05 MG/24 HR (Estradiol). Continued review revealed apply one (1) patch transdermally every Wednesday for vascular dementia with behavioral disturbances and remove per schedule. Observation on 01/12/2024 at 12:10 PM revealed R4 sat in his/her wheelchair at a table in the facility's dining room, with no other facility residents seated near R4. During an interview, on 01/22/2023 at 1:20 PM, the Physician's Assistant (PA) stated she was the facility's psychiatry services provider and had been since July 2022. The PA stated lots of the facility's residents did not have the capacity to make decisions about sexual relations based on their BIMS' scores, past medical histories, and conversations with the residents. Per interview, the PA stated R5 had advanced stage dementia and his/her daughter did not understand what R5 said, and that R5 was not able to verbally communicate. The PA stated R5's advanced state of dementia did not give R5 the capacity to make decisions about sexual relations. She stated R4 had vascular dementia and a history of sexually inappropriate behavior. The PA stated that due to R4's vascular dementia diagnosis, his/her cognition could change day by day. She stated R4's mental status waxed and waned, and R4 was confused at baseline. The PA stated she had talked with R4 multiple times about how sometimes, when R4 said things people took it the wrong way and that could make staff and other residents feel uncomfortable. Further interview revealed the PA stated R4 had been started on a Climara patch, which had been effective for R4. The PA additionally stated the Climara patch was a pretty low dose, however, could be increased if needed. 3. (a). Review of Resident 6 (R6)'s Admission Record, revealed the facility admitted R6 on 11/29/2021, with diagnoses that included unspecified dementia, altered mental status and anxiety disorder. Review of R6's Quarterly MDS Assessment, dated 09/07/2023, revealed the facility assessed the resident to have a BIMS' score of ninety-nine (99), which indicated the resident was unable to complete the interview. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R6's Comprehensive Care Plan (CCP), initiated on 12/03/2021, revealed the facility care planned a focus for R6 who had a history of exhibiting physical behaviors related to history of touching all the tables and other residents. The CCP goal was R6 would demonstrate less [sic] episodes of physical behaviors touching tables and other residents. Staff would intervene to divert R6 by giving alternative objects or activities. (b). Review of R5's Comprehensive Care Plan (CCP), initiated on 09/27/2023, revealed the facility care planned the resident for a focus of having a tendency to show non-sexual affection towards others, such as hugging and rubbing, which was the way he/she communicated with others. Continued review revealed R5's goal was for him/her to not rub, touch, or hug any staff or resident inappropriately by next review. Further review revealed there was only one (1) intervention noted that staff were to encourage R5 to keep his/her hands to himself/herself and not touch staff or other residents. (This was an intervention to be implemented for a severely cognitively impaired resident.) Review of the facility's Long Term Care Facility - Self-Reported Incident Form Initial Report, dated 11/15/2023, revealed R6 was observed having his/her left hand under R5's shirt on his/her left breast, they were both in the common area on couch. Continued review revealed an LPN statement which noted CNA 1 came to me and told me we need to keep them separated and I did not know why until she told me what had happened. Review of R6's Progress Notes *NEW*, effective date 11/15/2023, read as follows: Social Services Director (SSD) visited R6 and used a translator app to speak to resident. SSD explained to resident that (he/she) needs to keep (his/her) hands to (himself/herself) and not touch others inappropriately (especially females). R6 shook (his/her) head indicating (he/she) understood. Review of R6's Psychiatry Progress Note, date of service 11/21/2023, revealed R6 was seen by the facility's psychiatric care provider for a chronic psych medication follow up visit in the long-term care setting for medication management. Interval events: noted were since last visit, staff report that R6 was seen with his/her hand under the shirt of a female resident holding her breast. Further review of Psychiatry Progress Note read as follows: When R6 is asked how he/she is doing he/she reports I'm fine. R6 unable to recall recent event of inappropriate sexual behavior. During an interview, on 01/22/2023 at 1:20 PM, the Physician's Assistant (PA), who was the facility's psychiatric care provider, stated when the facility admitted R6 he/she came from the hospital and was very confused. The PA stated R6 had a history of bipolar & dementia and had no capacity to make decisions about sexual relations. During an interview, on 01/17/2024 at 4:08 PM, R5's family member (F1) stated in the country her relative was from people touched each other to show they were friendly. F1 stated if R5 saw a person he/she would touch that person and thought that made the person happy, and R5 was that way even before he/she had dementia. F1 stated the facility notified her about R6 touching R5 on the breast, and after that the residents no longer sat together. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 01/17/2024 at 10:20 AM, RN1 stated she was aware that R5 touched people. RN1 stated R5's dementia was very bad, and she was not sure if R5 understood what people said to him/her. The RN stated most of the time R5 expressed himself/herself by touching others. RN1 stated R5 would pat RN1's arm and smile at staff when they were trying to do anything for him/her, like check his/her blood glucose level. RN1 stated staff noticed R5's way of communicating was by touching other people, and staff always tried to keep an eye on him/her. RN1 further stated it was not okay for R6 to put his/her hands on R5's breast. During an interview, on 01/11/2024 at 1:30 PM, CNA 1 stated after lunch R5 and R6 sat in the television area and watched television. She stated on 11/15/2023 she came into the television area and saw R5's shirt was pulled up, and saw R6 rubbing R5's breast. CNA1 stated when she saw R6 touching R5, she told him/her to stop; however, R6 did not stop. She stated she separated the two (2) residents, and notified the nurse. During an interview, on 01/23/2024 at 8:50 AM, the Director of Nursing (DON) stated R6 just touched R5 one (1) time and she had not seen that type of behavior from R6 before the 11/15/2023 incident or afterwards. The DON stated she knew R5 and R6 were friends and did not want to limit their friendship; however, the facility staff tried to keep R5 and R6 separated. During an interview, on 01/23/2024 at 9:55 AM, the facility's Administrator stated she expected staff to do frequent rounding to ensure inappropriate touching was not going on. She stated if a resident was touchy-feely, staff needed to make sure the resident was involved in activities and stayed busy. The Administrator stated she always liked to involve family who could give her some history on a resident, and that staff kept an eye on R5 and R6, due to the 11/15/2023 incident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44486 Based on interview, record review, review of the facility's investigations and policies, it was determined the facility failed to implement the comprehensive person-centered care plan for one (1) of twenty-two (22) sampled residents (Resident #10 (R10). The facility care planned R10 with an intervention for using a mechanical stand-alone lift when being transferred from the bed to the wheelchair. However, on 06/20/2023, facility staff transferred R10 from the bed to the wheelchair without using a mechanical stand-alone transfer lift. As a result R10 sustained a laceration to his/her lower right leg which required transfer to a higher level of care for emergent treatment. The findings include: Review of the facility's policy titled, Care Plans - Baseline, revised March 2022, read as follows: A baseline plan of care to meet the resident's immediate health and safety needs was to be developed for each resident within forty-eight (48) hours of admission. Continued review revealed the baseline care plan was to include instructions needed to provide effective, person-centered care of the resident which met professional standards of quality care. Further review revealed the baseline care plan must include minimum healthcare information necessary to properly care for the resident including, but not limited to the following: initial goals based on admission orders and discussion with the resident/representative; Physician's orders; dietary orders; therapy services; social services; and Preadmission Screening and Resident Review (PASARR). Review of the facility's policy titled, Safety and Supervision of Residents, revised July 2017, revealed the facility strived to make the environment as free from accident hazards as possible. Continued review revealed employees should be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. Further review revealed resident safety and supervision and assistance to prevent accidents were facility-wide priorities. Review of the Admission Record for R10 revealed the facility admitted the resident on 03/07/2023, with diagnoses which included difficulty in walking, weakness, and orthostatic hypotension. Review of the Quarterly Minimum Data Set (MDS) Assessment for R10 dated 06/01/2023, revealed the facility assessed him/her to have a Brief Interview for Mental Status (BIMS) score of seven (7) of fifteen (15), indicating the resident had severe cognitive impairment. Further review of R10's MDS Assessment revealed the facility assessed R10 as requiring extensive physical assistance of two (2) plus persons to transfer between surfaces including to or from the bed, chair, wheelchair, or standing position. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R10's Comprehensive Care Plan (CCP) revealed the facility care planned the resident with a focus of requiring assistance or was dependent (on staff) for his/her Activities of Daily Living (ADL) care: in bathing, grooming, personal hygiene, dressing, bed mobility, transfer, locomotion, and toileting related to a nondisplaced pubic ramus fracture (a type of crack or break in a person's pelvis), initiated on 03/07/2023. Further review of R10's CCP revealed interventions for staff to provide R10 with extensive to total assist of one (1) to two (2) for bed mobility, and assist R10 into his/her wheelchair using a mechanical stand-alone transfer lift. Review of the Progress Notes *NEW*, effective date 06/20/2023 at 9:35 AM, read as follows: Aide was transferring R10 from the bed to the wheelchair. Continued review revealed R10 stated his/her leg was hurt, and once he/she was transferred to the wheelchair, the resident was assessed as to the location of his/her stated pain. Further review revealed a bleeding laceration to R10's lower right leg was observed. In interview on 01/22/2024 at 3:33 PM, Licensed Practical Nurse (LPN) 17 stated she remembered last June when Certified Nursing Assistant (CNA) 4 transferred R10 from his/her bed to the wheelchair (without using a mechanical lift as care planned). The LPN stated she had been waiting for CNA 4 to finish transferring R10 and heard the resident say ouch. She stated CNA 4 told her R10 was bleeding and showed her where. LPN 17 stated she assessed R10's injury and called Emergency Medical Services (EMS). She stated she had not been helping CNA 4 transfer R10, because R10 was a stand-pivot-sit (SPS) transfer, and did not require use of a mechanical lift for transfer. LPN 17 further stated she had never known staff to use a mechanical lift when transferring R10. Review of the Progress Notes *NEW*, effective date 06/20/2023 at 6:00 PM, revealed R10 was transferred back to the facility with the laceration to his/her right lower leg having wound closure strips, and a non-adhesive dressing in place. Further review revealed no new orders had been received. During an interview on 01/17/2024 at 10:05 AM, the Director of Rehab (DOR) stated R10 had some reflexive tone, which meant the resident extended his/her legs out when being moved. The DOR stated last June when CNA 4 was getting R10 up from the bed, the resident kicked out his/her legs. According to the DOR, R10 had been sitting on his/her bed with his/her wheelchair to the right. In continued interview the DOR stated when CNA 4 picked up R10 from off the bed the resident's right leg hit the wheelchair. The DOR stated CNA 4 had been doing a SPS transfer of R10, and at the time of the incident the SPS transfer was what therapy was working on, for the resident's transfers. The DOR further stated after R10's incident, staff was educated to keep their own legs in between R10's, so he/she could not flail, or two (2) aides could transfer the resident from the bed to the wheelchair. During an additional interview on 01/18/2024 at 3:05 PM, the DOR stated she was part of the facility's interdisciplinary team (IDT) and helped set the therapy goals for residents. The DOR stated the facility's interventions to meet residents' goals were discussed in the facility's morning meeting where we run through the gamut of things. She stated she expected the therapy recommendations which the IDT had agreed upon in the morning meetings to be communicated and implemented by staff. Additionally, when the State Survey Agency (SSA) Surveyor showed the DOR a copy of a resident's care plan, she stated she had never seen the document. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 01/22/2024 at 4:30 PM, the MDS Coordinator stated residents' care plans were communication tools used by all members of the team who provided care for the residents. The MDS Coordinator further stated care plans were important in order for the team to know what was going on with the residents. During an interview on 01/23/2024 at 8:50 AM the DON stated residents' care plans were important because the care plan was what we go by (when providing resident care) and every licensed nurse in the facility could revise residents' care plans. She stated Social Services and Activities could revise their portions of care plans, and that care plan revisions should be made immediately after a resident had a change of status. The DON stated the nurses became aware of care plan revisions because the revisions showed up on the resident's care profile and nurses got it in report. She also stated the Utilization Data System (UDA) alerted people. Additionally, the DON stated if the way a resident transferred from the bed to the wheelchair changed, Certified Nursing Assistants (CNAs) knew of the change from the electronic health record (EHR) and in report. During further interview the DON stated if the facility did not follow residents' care plans, people could be misinformed and that could lead to potential incidents. In interview on 01/23/2024 at 9:55 AM, the Administrator stated she expected staff to ensure resident's care plans were followed. The Administrator stated if staff did not follow residents' plan of care, their needs would not be met.

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44486 Based on interview, record review, review of the facility's investigation, and the facility's policies, it was determined the facility's interdisciplinary team (IDT) failed to review and revise the comprehensive care plan with each assessment, including both the comprehensive and quarterly review assessments, to prevent falls for one (1) of twenty-two (22) sampled residents (Resident 9 (R9). R9 sustained twenty-two (22) falls in 2023, one (1) of which resulted in the resident experiencing a subdural hematoma, and a rib fracture during another one (1) of the falls. Review of Resident 9's Comprehensive Care Plan (CCP) revealed the facility care planned R9 for his/her risk for falls related to a history of falls prior to admission. The current interventions included staff to encourage R9 to keep his/her walker at a safe distance when ambulating throughout facility; anti-tippers to his/her wheelchair; and an intervention to encourage him/her to use a reacher to grab items out of reach. However, in interview the Director of Rehabilitation (DOR) stated R9 did not have the ability to lock the brakes on his/her wheelchair therefore, those were no longer on the resident's wheelchair. The DOR also stated R9 did not have the cognitive ability to use a reacher. The findings include: Review of the facility's policy titled, Care Plans - Baseline, revised March 2022, revealed A baseline plan of care to meet the resident's immediate health and safety needs was developed for each resident within forty-eight (48) hours of his/her admission. Per review, the baseline care plan included instructions needed to provide effective, person-centered care of the resident that met professional standards of quality care. Review revealed the baseline must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: initial goals based on admission orders and discussion with the resident/representative; Physician orders; dietary orders; therapy services; social services; and Preadmission Screening and Resident Review (PASRR). Further review revealed the baseline care plan was used until the staff could conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan, no later than twenty-one (21) days after admission. Additional review revealed the baseline care plan was to be updated as needed to meet the resident's needs until the comprehensive care plan was developed. (continued on next page)

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	185333	A. Building B. Wing	01/23/2024

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy, Falls and Fall Risk, Managing, revised March 2018, revealed resident conditions that might contribute to the risk of falls included delirium and other cognitive impairment, lower extremity weakness, and incontinence. Per review, staff, with the input of the attending Physician, were to implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk of or with a history of falls. Continued review revealed if falls recurred despite initial interventions, staff were to implement additional or different interventions, or indicate why the current approach remained relevant. Record review revealed if the underlying causes could not be readily identified or corrected, staff were to try various interventions, based on assessment of the nature or category of the falls, until falling was reduced or stopped, or until the reason for the continued falling was identified as unavoidable. Further review revealed staff were to monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. In addition, if the resident continued to fall, staff were to re-evaluate the situation and determine whether it was appropriate to continue or change current interventions. Review further revealed as needed, the attending Physician would help staff reconsider possible causes that might not previously have been identified. Review of R9's Admission Record revealed the facility admitted him/her on 12/05/2018, with diagnoses which included: agitation, paranoid schizophrenia, dementia, difficulty in walking, weakness, and restlessness. Review of R9's Quarterly Minimum Data Set (MDS) Assessment, dated 05/12/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15), which indicated he/she was severely cognitively impaired. Further review of R9's MDS Assessment revealed the facility assessed R9 to require supervision or touching assistance to walk ten (10) feet, and to be frequently incontinent of bladder and occasionally incontinent of bowel. Review of R9's Comprehensive Care Plan (CCP), initiated on 11/10/2021, revealed the facility care planned the resident for a focus related to at risk for falls due to his/her history of falls prior to admission, medications, prolonged hospitalization and changes in his/her environment and routine. Continued review revealed the care plan goal was for R9 to have no falls with injury through the target review date. Per review, interventions included staff to encourage R9 to keep his/her walker at safe distance when ambulating throughout the facility; encourage the resident to ask for assistance with the use of the walker and for transfers. Continued review revealed the interventions also included staff were to encourage R9 to toilet when awake during the night. Further review of R9's CCP initiated on 11/10/2021, revealed additional interventions initiated on 09/20/2023, for R9's fall risk: to keep his/her walker within arm's reach while lying on his/her bed; anti-tippers to the resident's wheelchair. In addition, a basket attached to R9's wheelchair was to assist with carrying his/her purse and items purchased which was initiated on 05/01/2023; and an intervention to encourage R9 to use a reacher to grab items out of reach instead of reaching and grabbing with his/her arms. Observation on 01/18/2024 at 2:25 PM, revealed R9 seated in his/her wheelchair in the hallway across from the dining room, with his/her brief pulled down around his/her ankles. Continued observation revealed Registered Nurse (RN) 8 saw R9 with his/her brief off and assisted the resident to the restroom. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Fall reports for R9 revealed he/she sustained twenty-two (22) documented falls in 2023, seventeen (17) which were either unwitnessed or the witness was not identified. Continued review revealed three (3) of the falls occurred between the hours of 12:00 AM and 4:00 AM and were documented as related to R9's toileting needs. Review of the Progress Notes *NEW*, effective date 06/05/2023 at 12:41 PM, revealed it was reported to the Director of Nursing (DON) that R9 had been lowered to the floor by staff secondary to his/her losing his/her footing. Per review, it was also reported to the DON that R9 never hit the floor with his/her head, never lost consciousness, and denied pain. Continued review revealed the resident's walker had been in use, and he/she had non-skid footwear in use. Further review revealed R9 had been walking in the hallway when change of plain occurred. Additionally, review revealed the nurse reported R9's appearance was different, his/her demeanor was off, his/her vital signs were normal; however, the nurse was sending R9 to the hospital for evaluation. Review further revealed the DON notified the Advanced Practice Registered Nurse (APRN) who was in house at the time. Review of the facility's Long Term Care Facility - Self-Reported Incident Form Initial Report, dated 06/07/2023, read as follows: R9 was lowered to the floor by staff due to lost footing. Per review, R9 had experienced a change in color and demeanor, and was sent to hospital emergency room (ER) for evaluation. Further review revealed on 06/07/2023, the hospital diagnosis was subdural hematoma (SDH), meaning a bruise inside R9's skull, of unknown origin. Review of the facility's Long Term Care Facility - Self-Reported Incident Form Final Report, dated 06/13/2023, revealed (the facility) was unable to determine cause/origin of (R9's) subdural hematoma (SDH). Per review, the hospital had not determined the cause of the resident's SDH. Continued review revealed (R9) was still in the hospital but his/her return to (the facility) was anticipated. The Report stated the facility had developed and followed the resident's care plan and interventions for (R9) on an ongoing basis. Further review revealed Psych Services followed (R9) for multiple psychiatric co-morbidities. In addition, review further revealed (R9's) care plan was to be updated as necessary, and staff would continue to monitor. In interview on 01/18/2024 at 8:05 AM, the Assistant Director of Nursing (ADON) stated when R9 sustained the fall on 06/05/2023, the resident did not lose consciousness. According to the ADON, when R9 fell , the nurse said R9 appeared off, so he/she was sent to the ER where scans were completed for R9, and revealed the resident had a SDH. The ADON stated the facility was not aware R9 had a SDH until the report came back from the ER, and she could not say R9's SDH was definitely from the 06/05/2023 fall. Review of the hospital document titled, Discharge Summary, dated 06/16/2023, revealed R9 had been admitted to acute care after sustaining the fall on 06/05/2023. Continued review revealed R9 was discharged from acute care on 06/16/2023, with a discharge diagnosis of Subdural hematoma (on 06/05/2023). Per review, the Active Problems was noted as Dementia (05/05/2023), and it was recommended R9's blood pressure (BP) systolic be below 140; holding oral anti-coagulants; Urinary retention: urology consulted, a Foley was placed, follow up to be arranged in one (1) week for a voiding trial. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Notes *NEW*, with an effective date 06/22/2023 at 2:08 PM, revealed the Interdisciplinary Team (IDT) met and reviewed R9's fall from 06/22/2023, and determined the root cause was slipped, shoe untied. Continued review revealed the intervention to implement was to encourage R9 to allow staff to double tie his/her shoes until Social Services (SS) could obtain some Velcro shoes for him/her. Review of the Progress Notes *NEW*, effective date 06/22/2023 at 3:35 PM, revealed R9 returned from the hospital via ambulance, and was alert and oriented to self, and able to make some needs known. Continued review revealed R9 had been diagnosed with fractured ribs. Review further revealed a Foley catheter had been placed at the hospital related to urinary retention. Additionally, the recommendation from the hospital was to have R9 follow up with urology. Review of the Progress Notes *NEW*, with an effective date of 06/22/2023 at 3:41 AM, revealed R9 had been found lying on the floor in the bathroom on his/her back, with his/her walker in the bathroom, and the contents of a basket on the floor. Continued review revealed R9's tennis shoes were on; however, his/her left shoe observed as untied. Per review, the nurse assessed R9 and his/her vital signs (vs) were stable. Further review revealed R9 reported he/she slipped and hit his/her head going to the restroom and had complaints of (c/o) pain, but was unable to state where the pain was located. In addition, review revealed the Primary Care Provider (PCP) made recommendations to send R9 to the emergency room (ER) for evaluation related to an unwitnessed fall and c/o of hitting his/her head. In interview on 01/18/2024 at 2:30 PM, Registered Nurse (RN) 8 stated he liked to ensure R9 was as busy as possible because if the resident got distracted he/she got into trouble. The RN stated R9's behaviors often came from when the resident needed to go to the bathroom. RN 8 stated if staff were not present with R9, when he/she needed to go to the bathroom, the resident would take himself/herself to the bathroom; however, we preferred he/she not do that. RN 8 stated he could not think of any (care plan) interventions to keep R9 from falling. He stated he would take R8 to the bathroom and listen to his/her needs. In interview on 01/18/2024 at 3:05 PM, the Director of Rehab (DOR) stated the therapy department set goals for residents and gave input to nursing staff, and reviewed care plan interventions together with nursing. The DOR stated once the IDT agreed on an intervention for a resident, the DOR expected nursing leadership to take the DOR's advice or recommendations for residents and communicate those interventions to the nursing department. In continued review, the DOR stated R9 did not have the ability to lock the brakes on his/her wheelchair, so there were no longer anti-tippers on his/her wheelchair. However, the State Survey Agency (SSA) Surveyor shared with the DOR there was still a care plan intervention, initiated on 09/20/2023, for R9 to have anti-tippers to resident's wheelchair. During continued interview on 01/18/2024 at 3:05 PM, the SSA Surveyor shared with the DOR there was a care plan intervention, initiated on 05/01/2023, for R9 to have a basket attached to his/her wheelchair to assist with carrying items. The DOR stated R9 had a basket on his/her rollator (type of walker with a seat) before; however, the resident no longer had it due to not going to the facility's vending machine anymore to buy snacks. During the interview the SSA Surveyor shared with the DOR, R9's care plan intervention initiated on 05/31/2023, for staff to encourage him/her to use a reacher to grab items out of his/her reach instead of trying to reach and grab the items with his/her arms. The DOR stated however, R9 did not have the cognitive ability to use a reacher. In addition, when the SSA Surveyor showed the DOR a copy of R9's care plan, she stated she had never seen the document before. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	In further interview 01/18/2024 at 3:05 PM, the DOR stated Physical Therapy (PT) had just discharged R9. The DOR stated R9 was not safe to ambulate with a walker anymore. The DOR stated when R9 got fidgety, staff were able to get the resident up to walk; however, R9 got up on his/her own at times, which he/she was never safe doing that. Observation, on 01/18/2024 at 2:55 PM, revealed there was not a basket attached to R9's wheelchair. In an interview on 01/18/2024 at 2:55 PM, the Activities Director stated she just looked at a resident's care plan when it comes up, usually quarterly, and did not know if R9 should have a basket attached to his/her wheelchair. During an interview, on 01/22/2024 at 4:30 PM, the MDS Coordinator stated residents' care plans were communication tools used by all members of the team who were providing care to residents. The MDS Coordinator stated care plans were important, so the team knew what was going on with the residents. She stated any licensed nurse could revise residents' care plans, and Social Services and Activities could revise their sections of the care plan. The MDS Coordinator stated residents' care plans should be updated every ninety-two (92) days, and whenever there was a change in the resident's condition. She stated if care plans were not revised, potentially a resident fall could happen. During an interview, on 01/23/2024 at 8:50 AM, the Director of Nursing (DON) stated the facility had tried everything to try to prevent R9 from falling, and acknowledged the resident's care plan needed to be revised. The DON stated residents' care plans were important because the care plan was what we go by (when providing resident care) and every licensed nurse in the facility was able to revise residents' care plans. According to the DON, Activities and Social Services were able to revise their part of residents' care plans, and stated care plan revisions should be made immediately after a resident had a change of status. The DON stated the nurses became aware of care plan revisions because the revisions showed up on the resident's care profile and nurses got it in report. Additionally, the DON stated if a resident's care plan changed, Certified Nursing Assistants (CNAs) knew of the change from the electronic health record (EHR) and in report. Further interview revealed the DON stated if the facility did not follow or revise residents' care plans people could be misinformed and that could lead to potential incidents. During an interview, on 01/23/2024 at 9:55 AM, the Administrator stated she expected staff to ensure resident's care plans were followed and updated. In the event of someone who was known to fall, the Administrator stated she expected nursing to make sure falls interventions were in place and ensure the interventions were working. Additionally, if an intervention was not working, the Administrator stated it should be switched. She stated some effective falls intervention were to bring residents to the common area, keep residents up and about so staff could keep eyes on the residents, and get family involved. She stated staff could make more frequent rounds. The Administrator stated the facility's rounding standard was every two (2) hours, but for a frequent faller staff should check on the resident more than every two (2) hours. She stated when staff passed by the room of the resident who was a frequent faller, they should make a habit of checking on the resident. The Administrator stated if staff did not update residents' plan of care, residents' needs would not be met.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 31274 Based on interview, record review, and review of the facility's policy and nursing standards of practice, it was determined the facility failed to ensure care and services were provided in accordance with accepted standards of clinical practice for one (1) of twenty-six (26) sampled residents, Resident #6. On the morning of 10/04/2023, Certified Nursing Assistant/Certified Medication Technician (CNA/CMT) #1 and Registered Nurse (RN) #2 were administering residents' medications at the same time and might have administered Resident #19's medication to Resident #6. Resident #6 was transferred to the hospital Emergency Department (ED) for evaluation and observation of possible adverse effects. The findings include: Review of the facility's policy, Administering Medications, revised 04/2019, revealed medications were administered in a safe and timely manner, and as prescribed. Further review revealed the individual administering medications verified the resident's identity before giving the resident's medications. Review of the article, Understanding the Basics of Medication Administration, dated 12/16/2015, revealed in the principles of medication administration nurses must personally prepare the properly ordered medications and personally administer those medications. Additional review revealed it was not an accepted practice to prepare any type of medication for another person to administer, nor was it acceptable practice to administer a medication that another staff member had prepared. Further review revealed the reasons included that medication preparation and administration were fraught with potential for error. Review of the article, Medication Safety: Go Beyond the Basics, dated 05/10/2016, from Lippincott Nursing Center revealed that safely administering medications required that the nurse must prepare medications for one (1) patient at a time. (a). Review of Resident #6's Electronic Medical Record (EMR) revealed the facility admitted Resident #6 on 11/29/2021, from a psychiatric facility where he/she had been admitted after altered mental status. Resident #6's diagnoses upon admission to the facility included unspecified Dementia, Altered Mental Status, and unspecified Psychosis not due to a substance or known physiological condition. Review of Resident #6's Progress Note dated 10/04/2023 at 9:59 AM, revealed a Change in Condition was noted after the nurse notified the Assistant Director of Nursing (ADON) that the resident was administered the wrong medications. Further review revealed the on call provider was notified with a new order received from the Physician to send Resident #6 to the ED for closer monitoring. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(b). Review of Resident #19's EMR revealed the facility admitted the resident on 12/06/2022, with diagnoses including Cerebral infarction due to unspecified occlusion, Type 2 Diabetes Mellitus and Unspecified Convulsions. Review of Resident #19's Physician's Orders and Medication Administration Record (MAR) revealed the resident's scheduled medications for the morning of 10/04/2023, included Vitamin B12 1000 micrograms (mcg), Folic Acid 1 mg, Metformin 1000 mg, Pepcid 20 mg, Pioglitazone (a diabetic medication) 30 mg, Vitamin D tablet, 125 mcg, Zoloft (an antidepressant) 50 mg, Keppra (a medication used to control epilepsy) 500 mg, Metoprolol (high blood pressure medication) 25 mg, Baclofen (a muscle relaxant) 20 mg, Buspirone HCL (medication used to treat anxiety) 10 mg and Oxycodone (narcotic pain medication) 5 mg. Review of the hospital ED Summary Notes, dated 10/04/2023, revealed Resident #6's vital signs upon arrival to the ED were: blood pressure (B/P) 125/71 millimeters mercury (mm); respiration rate of 16 breaths per minute; heart rate 48 beats per minute; and oxygenation saturation of 95% on room air. Continued review revealed Resident #6's blood glucose level was 102 mg/deciliter (dL) and a repeat glucose level at 11:53 AM was 107 mg/dL. Review of the Summary further revealed a 12 lead electrocardiogram (EKG) identified Resident #6 to have bradycardia (slower than expected heart rate). Per review of the Summary Notes revealed the evaluation concern was due to Resident #6 having received a betablocker medication as well as Oxycodone and Metformin medications. Further review revealed Resident #6's B/P was benign and he/she appeared non-drowsy and was in no distress. Additional review revealed Resident #6 was considered safe to return to the nursing home after exhibiting no symptoms from receiving the wrong medications. Observation of medication administration by Licensed Practical Nurse (LPN) #7, LPN #17 and CNA/CMT #1 across all three (3) medication carts on 01/11/2024, beginning at 8:02 AM, revealed no observation of the LPN's or CNA/CMT preparing more than one (1) resident's medications at a time. Observation of all the drawers in the carts during medication pass revealed no advance prepared medications. During interview with Resident #6 on 01/11/2024 at 11:51 AM, he/she stated I don't know in response to question of whether any of the nurses had ever made a mistake with his/her medications. During interview with Resident #19 on 01/22/2024 at 11:33 AM, he/she stated on the day Resident #6 went to the hospital, Registered Nurse (RN) #2 brought both Resident #6 and himself/herself medicine in the cups as usual. Resident #19 stated RN #2 gave one (1) cup to Resident #6 then the other to him/her. The resident stated after receiving the cup of medicine, he/she did not recognize the pills in the cup, and handed the cup back to RN #2, who took the cup and discarded the pills. In further interview, Resident #19 stated another nurse brought the right medicine back to him/her. The resident stated since then, the nurses brought only one (1) resident's medicines at a time and he/she had no further incidents with his/her medicines. During interview with CNA/CMT #1 on 01/10/2024 at 3:48 PM, she stated she knew the residents fairly well because since she could not give all medications, such as insulin injections or gastrostomy tube (g-tube) medications. She stated when she was done with her medication pass, she made residents' appointments and performed other supportive tasks, such as putting away supplies, and worked the dining room during meals. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an additional interview with CNA/CMT #1 on 01/11/2024 at 1:25 PM, she stated on 10/04/2023, she did not recall the reason she pulled the residents' medications, it might have been that the day shift nurse was running late, and the night shift nurse stayed over to help. In continued interview, CNA/CMT #1 stated she pulled Residents #6's and #19's medications, as they were roommates when the nurse went to give the medications. She stated she was not sure there had really been a mistake because Resident #6 suffered no ill effects from receiving the wrong medications, as the resident was sent out to the hospital for monitoring and had no bad outcome. CNA/CMT #1 stated she was not sure why the nurse thought she might have given the wrong medications in error. She stated she should not have prepared two (2) residents' medications at the same. The CNA stated she knew the reason was that it was not an accepted standard of practice to prepare more than one (1) person's medications at a time due to the potential for error. She further stated she did receive re-education afterwards as did the nurse. During interview with RN #1 on 01/16/2024 at 3:59 PM, she stated she thought the night nurse was going to stay a couple of hours after shift to help pass medications because we were short staffed. She stated the CMT pulled the medications and gave them to the nurse or it might have been the other way around, she was not sure. During interview, she stated the medication pass was on the split cart and she was working on the South Unit. RN #1 stated she might have taken over the cart while the other nurse and CMT sorted the situation out with the Director of Nursing (DON) and ADON. She further stated her understanding was that the only person who got wrong medications was Resident #6, and she thought Resident #19 got the right medications. During telephone interview with RN #2 on 01/16/2024 at 4:08 PM, she stated she had stayed over from night shift on 10/04/2023, because they were short staffed. In interview, she stated the CMT had set up medicines for Resident #6 and Resident #19 with their room numbers noted on the cups. She stated she gave Resident #6 the medications that were marked for him/her. RN #2 stated she typically would never, ever pre-pull medications or give medications she had not prepared herself; however, she had done so that day. She stated the CMT put the wrong medications in Resident #6's cup, and the medications in that cup were meant for Resident #19. RN #2 stated the CMT had placed Resident #6's medications in the cup marked for Resident #19. In continued interview, she stated Resident #19 recognized a pain pill and told her the rest of the medication were not his/hers. RN #2 stated Resident #6 had already taken the medications in the cup she had given him/her, so she had no way to make sure if there had been a mistake or not. In continued telephone interview with RN #2 on 01/16/2024 at 4:08 PM, she stated she was shook up because Resident #19 took Metformin and some other medications that could have been detrimental to Resident #6's health. She stated she immediately reported the possible medication error to the ADON immediately. RN #2 stated they notified the attending medical provider, got paperwork together and sent Resident #6 out immediately to the ED. The RN stated Resident #6 seemed fine; however, they were being cautious and sent him/her out to the ED. RN #2 stated she recalled thinking it was odd that the pain pill was in the cup, and was not with the other medications. In additional interview, RN #2 stated pre-pulling meds was not in the facility's policy, nor was giving medications to more than one (1) resident at a time. She stated she always prepared one (1) medication cup for one (1) resident at a time, and passed them as she went, taking her cart from patient to patient. In final interview, RN #2 stated she admitted that protocol was not followed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the DON on 01/23/2024 at 8:46 AM, she stated on 10/04/2023 the day nurse was running late, so the night nurse agreed to stay over for a couple of hours and was helping the CMT pass medications. She stated it was not an accepted practice to pre-pull multiple medications for residents. In continued interview, she stated the CMT had told her she was trying to help the RN since she knew the residents, but the CMT was aware that we do not do that here. The DON stated they sent Resident #6 out to the hospital for evaluation and he/she returned that same afternoon. In additional interview, the DON stated RN #2 and CNA/CMT #1 were re-educated on medication administration, particularly on not pre pulling and preparing more than one (1) resident's medication at a time, and received disciplinary actions. During interview with the Administrator on 01/23/2024 at 9:55 AM, she stated she expected nurses and CMT's to follow the facility's policy, which was important because failing to follow the policy could precipitate a major error with adverse outcomes for the residents. The Administrator stated pre-pulling medications, pulling medications for multiple residents, or one (1) staff pulling medications and another staff member administering it were examples of what could cause a major error with adverse resident outcomes.

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	185333	A. Building B. Wing	01/23/2024

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Klondike Nursing and Rehabilitation Center	3802 Klondike Lane Louisville, KY 40218

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44486 Based on interview, record review, review of the facility's investigation and policies, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for two (2) of twenty-two (22) sampled residents (Residents 9 (R9) and Resident 10 (R10)). 1. R9 sustained twenty-two (22) falls in 2023, seventeen (17) of which were either unwitnessed, or the witness was not identified. The facility had incomplete information/documentation to help determine the root cause of R9's numerous falls. Three (3) of R9's falls in 2023 occurred between the hours of 12:00 AM and 4:00 AM, and were documented as related to R9's toileting needs. However, the facility initiated only one Comprehensive Care Plan (CCP) intervention related to his/her falls and toileting issues, on 09/26/2023, nearly nine (9) months after the resident had sustained seventeen (17) falls prior to the intervention. Additionally, R9 sustained a subdural hematoma during one (1) of the falls and a rib fracture during another fall. 2. The facility care planned R10 to require a mechanical stand-alone transfer lift when transferred from the bed to the wheelchair. However, on 06/20/2023, staff failed to transfer R10 with the lift as care planned; the resident sustained a laceration to his/her lower right leg which required transfer to the hospital Emergency Department (ED) for emergent treatment of the wound. The findings include: Review of the facility's policy, Safety and Supervision of Residents, revised July 2017, read as follows: The facility strives to make the environment as free from accident hazards as possible. Continued review revealed employees were to be trained on potential accident hazards and demonstrate competency regarding how to identify and report accident hazards and try to prevent avoidable accidents. Further policy review revealed resident safety and supervision and assistance to prevent accidents were facility-wide priorities. Review of the facility's policy, Falls and Fall Risk, Managing, revised March 2018, read as follows: A fall is defined as unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). Continued review revealed an episode where a resident lost his/her balance and would have fallen, if another person or the resident had not caught himself/herself, was considered a fall. Per policy review, a fall without injury is still a fall. Further review revealed unless there was evidence suggesting otherwise, if a resident was found on the floor, a fall was considered to have occurred. Additional policy review revealed residents' conditions that might contribute to the risk of falls included delirium and other cognitive impairment, lower extremity weakness, and incontinence. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Further review of the facility's Falls and Fall Risk, Managing policy read as follows: The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 1(a). Review of Resident 9 (R9)'s Admission Record revealed the facility admitted the resident on 12/05/2018. Continued review revealed R9 had the following diagnoses: dementia, paranoid schizophrenia, difficulty in walking, weakness, restlessness, and agitation. Review of R9's Quarterly Minimum Data Set (MDS) Assessment, dated 05/12/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of seven (7) of fifteen (15), which indicated the resident had severe cognitive impairment. Further review of R9's MDS Assessment revealed R9 required supervision or touching assistance to walk ten (10) feet. Review of R9's Comprehensive Care Plan (CCP), initiated on 11/10/2021, revealed the facility care planned a focus for the resident as at risk for falls related to: his/her history of falls prior to admission; prolonged hospitalization ; medications; and change in environment and routine. Continued review of the CCP revealed the goal was that R9 would have no falls with injury through the target date review. Per review, interventions included staff to intervene and encourage R9 to keep his/her walker at a safe distance in relation to when he/she was ambulating throughout the facility; staff to encourage the resident to ask for assistance when using the walker and transfers; and staff to encourage R9 to toilet when awake during the night. However, the facility initiated only one Comprehensive Care Plan (CCP) intervention related to R9's falls and toileting issues, on 09/26/2023, nearly nine (9) months after the resident had sustained seventeen (17) falls prior to the intervention. The facility's 09/26/2023 intervention for R9 was a large sign placed on restroom door to assist (R9) to identify restroom. Review of the facility's Fall reports for R9 revealed the resident had twenty-two (22) documented falls in 2023. Per review, seventeen (17) of the twenty-two (22) falls that occurred in 2023 were noted as unwitnessed or to have an unidentified witness. Additional review revealed three (3) of R9's falls occurred between the hours of 12:00 AM and 4:00 AM, and were documented as related to R9's toileting needs. (continued on next page)

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	185333	A. Building B. Wing	01/23/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Notes *NEW*, effective date 06/05/2023 at 12:41 PM, read as follows: reported to the Director of Nursing (DON) R9 had been lowered to the floor by staff secondary to the resident losing his/her footing. Continued review revealed it had been reported R9 never hit his/her head on the floor, never lost consciousness, and denied pain. Per review, R9's walker had been in use, and he/she had non-skid footwear on. Continued review revealed R9 had been walking in the hallway when a change occurred. Further review revealed the nurse reported R9's appearance was different, his/her vital signs were normal; however, the resident's demeanor was off and the nurse was sending him/her to the hospital for evaluation. In addition, the DON notified the Advanced Practice Registered Nurse (APRN) who had been in house at the time. Review of the facility's Long Term Care Facility - Self-Reported Incident Form Initial Report, dated 06/07/2023, read as follows: (R9) was lowered to the floor by staff due to losing his/her footing. Per review, R9 had experienced a change in color and demeanor. Continued review revealed R9 was sent to the hospital emergency room (ER) for evaluation. In addition, on 06/07/2023 a hospital diagnosis indicated a subdural hematoma (a pool of blood between the brain and its outermost covering) of unknown origin. Review of the facility's Fall report titled, #377 Injury of, dated 06/07/2023 at 11:07 AM, revealed Nursing Description: R9 had an incident on 06/05/2023, and was sent to acute care. Continued review revealed per acute care on 06/06/2023, the facility was notified R9 had a subdural hematoma (SDH) and contusions to his/her head. During an interview on 01/18/2024 at 8:05 AM, the Assistant Director of Nursing (ADON) stated when R9 fell on [DATE], he/she did not lose consciousness. The ADON reviewed the report titled #375 Fall, dated 06/05/2023, and stated there was no loss of consciousness (LOC) of R9 documented. The ADON further stated when R9 fell , the nurse said R9 appeared off. so he/she was sent to the ER where scans were done on the resident, and revealed he/she had a SDH. Review of the document titled, Discharge Summary, dated 06/16/2023, revealed R9 was admitted to acute care after sustaining his/her 06/05/2023 fall, and was discharged from acute care on 06/16/2023. Per review, R9's Discharge Diagnoses: Principal Problem was noted as Subdural hematoma (06/05/2023), and Active Problems: Dementia (05/05/2023). Further review revealed the recommendations were: blood pressure (BP) systolic below 140; holding the resident's oral anti-coagulants (OAC); urinary retention: urology consulted, placed foley (brand of indwelling catheter); and arrange for follow up in one (1) week for a voiding trial. (b). Review of the Progress Notes *NEW*, effective date 06/22/2023 at 3:41 AM, read as follows: R9 was found in his/her bathroom lying on his/her back. Per review, R9's walker was in the bathroom with the contents of a basket lying on the floor; his/her tennis shoes were on; however, the left shoe was observed as untied. Continued review revealed R9 was assessed by the nurse with (w) stable vital signs (vs) a respiratory rate (rr) of sixteen (16), and oxygen saturation (O2 sats) at 100% on room air (RA). Further review revealed R9's blood pressure (BP) was 170/84; his/her pulse regular (reg) at seventy (70), and the resident had complaints of (c/o) pain but was unable to state where the pain was located. Additional review revealed R9 stated he/she slipped and hit his/her head going to the restroom. Review further revealed the Primary Care Provider (PCP) responded with recommendations to send R9 to the ER for evaluation (eval) related to (r/t) an unwitnessed fall and c/o of hitting head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Notes *NEW*, effective date 06/22/2023 at 2:08 PM, read as follows: the Interdisciplinary Team (IDT) met and reviewed R9's fall from 06/22/2023, with the root cause noted as slipped, shoe untied. Further review revealed the intervention was noted as encourage R9 to allow staff to double tie his/her shoes until Social Services (SS) could obtain some Velcro shoes for him/her. Review of the Progress Notes *NEW*, effective date 06/22/2023 at 3:35 PM, read as follows: R9 returned from the hospital via ambulance, alert and oriented to self, and was able to make some needs known. Continued review revealed R9 had been diagnosed with fractured ribs. Further review revealed a Foley catheter had been placed at the hospital related to urinary retention. Review additionally revealed a recommendation from the hospital to have R9 follow up with urology, and no new orders were sent from the hospital. In interview on 01/18/2024 at 2:30 PM, Registered Nurse (RN) 8 stated he liked to ensure R9 was as busy as possible because if the resident got distracted he/she got into trouble. The RN stated R9's behaviors often came when the resident needed to go to the bathroom. RN 8 stated if staff were not present with R9, when he/she needed to go to the bathroom, the resident would take himself/herself to the bathroom; however, we preferred he/she not do that. Additionally, RN8 stated off the top of his head he could not think of (care plan) interventions to keep R9 from falling. He stated he would take R8 to the bathroom and listen to his/her needs. RN8 stated if patient, you can figure it out. The RN stated R9 wanted attention occasionally and every time he went by the resident he would speak to the resident. Regarding R9's falls, RN8 stated they were because he/she was trying to get somewhere, either into bed, out of bed, into the bathroom or out the door. RN8 stated one time R9 had told him he/she was going home and was easily redirected. During an interview, on 01/18/2024 at 3:05 PM, the Director of Rehab (DOR) stated the therapy department set goals for residents and gave input related to therapy to nursing staff. The DOR stated R9 had just been discharged from physical therapy (PT) and was not safe to ambulate with a walker anymore. Per the DOR, when R9 got fidgety, staff could get him/her up and walk; however, the resident was able to get up on his/her own, but was never safe doing that. 2. Review of R10's Admission Record revealed the facility admitted the resident on 03/07/2023, with the following diagnoses: difficulty in walking, weakness, and orthostatic hypotension. Review of R10's Quarterly MDS assessment dated [DATE], revealed the facility assessed the resident to have a BIMS' score of seven (07) out of fifteen (15), which indicated he/she had severe cognitive impairment. Further review of R10's MDS Assessment revealed the facility also assessed the resident to require extensive two (2) plus (+) persons physical assist to transfer between surfaces, including to or from the bed, chair, wheelchair, and a standing position. Review of R9's Comprehensive Care Plan (CCP), revealed the facility care planned a focus, initiated on 03/07/2023, for the resident to require assistance or was dependent on staff for his/her Activities of Daily Living (ADL) care with bathing, grooming, personal hygiene, dressing, bed mobility, transfer, locomotion, and toileting related to a nondisplaced pubic ramus fracture. Further review revealed the interventions included staff to assist R10 to sit in his/her wheelchair using a mechanical stand-alone transfer lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Notes *NEW*, effective date 06/20/2023 at 9:35 AM, revealed the Aide was transferring R10 from the bed to the wheelchair. Further review revealed R10 stated his/her leg was hurt. Continued review revealed once R10 was transferred to the wheelchair, he/she was assessed regarding the location of stated pain, and bleeding was observed on the laceration to his/her lower right leg. Observation, on 01/11/2024 at 9:55 AM revealed the DOR and the Physical Therapy Assistant (PTA) transferred R10 from his/her bed to his/her wheelchair using a sling under the resident and a mechanical lift. During an interview, on 01/22/2024 at 3:33 PM, Licensed Practical Nurse (LPN) 17 stated she recalled last June when Certified Nursing Assistant (CNA) 4 transferred R10 from his/her bed to the wheelchair. LPN 17 stated she was waiting for CNA 4 to finish the transfer when R10 said ouch and the CNA showed her where the resident was bleeding. LPN 17 stated she assessed R10's injury and called Emergency Medical Services (EMS). LPN 17 stated she had not helped CNA 4 transfer R10, as the resident was a stand-pivot-sit (SPS) transfer. Further interview revealed the LPN stated R10 had not required use of a mechanical lift for transfer and she (LPN 17) had never known staff to use a mechanical lift to transfer R10. Review of the Progress Notes *NEW*, effective date 06/20/2023 at 6:00 PM, read as follows: R10 transferred back to facility; laceration to right lower leg with wound closure strips in place; woven gauze and a non-adhesive dressing. Further review revealed no new orders (NNO) received. During an interview, on 01/17/2024 at 10:05 AM, the DOR stated R10 had some reflexive tone, which meant the resident extended his/her legs when he/she was moved. The DOR recalled last June when CNA 4 was getting R10 out of bed and the resident kicked out his/her legs. Per the DOR's recollection, R10 had been sitting on his/her bed with his/her wheelchair to the right. The DOR further stated when CNA 4 picked up R10, the resident's right leg hit the wheelchair. During further interview, the DOR stated CNA 4 was doing a SPS transfer. The DOR stated after R10's incident, staff were educated to keep their own legs in between R10's legs, so the resident could not flail, or two (2) aides could transfer R10 from the bed to the wheelchair. In an additional interview on 01/18/2024 at 3:05 PM, the Director of Rehab (DOR) stated the therapy department set goals for residents and gave input to nursing staff, and care plan interventions were reviewed together with nursing. Once the IDT agreed on an intervention for a resident, the DOR expected nursing leadership to take the DOR's advice or recommendations for residents and communicate those interventions to the nursing department. Additionally, when the State Survey Agency Surveyor showed the DOR a copy of R9's care plan, she stated she had never seen the document. During an interview, on 01/22/2024 at 4:30 PM, the MDS Coordinator stated residents' care plans were communication tools used by all members of the team providing care to residents. The MDS Coordinator stated care plans were important, so the team knew what was going on with the residents and knew how to meet their care needs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 01/23/2024 at 8:50 AM, the Director of Nursing (DON) stated the facility had tried everything to try to prevent R9 from falling, and R9's care plan needed to be revised. The DON stated residents' care plans were important because the care plan was what we go by (when providing resident care) and every licensed nurse in the facility could revise residents' care plans. She stated Social Services and Activities could revise their portions of care plans, and that care plan revisions should be made immediately after a resident had a change of status. During an interview, on 01/23/2024 at 9:55 AM, the Administrator stated she expected staff to ensure resident's care plans were followed and updated. In the event of someone who was known to fall, the Administrator stated she expected nursing to make sure falls interventions were in place and ensure the interventions were working. Additionally, if an intervention was not working, the Administrator stated it should be switched. The Administrator stated for a frequent faller staff should check on the resident more than every two (2) hours. When staff passed by the room of the resident who was a frequent faller, they should make a habit of checking on the resident.