STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sycamore Heights Health and Rehabilitation	2141 Sycamore Avenue Louisville, KY 40206

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 0656 Level of Harm - Immediate jeopardy to resident health or safety 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** 49350 Based on observation, interview, record review, and facility document and policy review, the facility failed to have an effective system to develop and implement the comprehensive care plan with effective interventions to protect residents from accidents and hazards for one (1) of fifteen (15) sampled residents (Resident #7). The facility admitted Resident #7 (R7) with diagnoses of paranoid schizophrenia and impulse disorder. The facility care planned the resident on 11/01/2023, for attempting to manipulate objects such as forks and coat hangers into protective objects, as he was seeing hallucinations in his room. However, the facility failed to develop interventions for staff to continuously monitor and document the findings to ensure objects he could manipulate into weapons were removed from his room. On 03/11/2024 at approximately 3:40 AM, a Certified Nurse Aide (CNA) entered Residents #7 and #6's shared room and observed Resident #6 lying on his bed with blood on his face and a laceration to the left eye. The CNA observed R7 sitting in a chair next to R6's bed, with a bloody, plastic fork in one (1) hand, and both hands covered with blood. R7 told staff he thought R6 was trying to hurt him. The facility's failure to have an effective system in place to ensure each resident's care plan was developed and implemented to protect residents has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 04/01/2024 and was determined to exist on 03/11/2024 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; and 42 CFR 483.25 Quality of Care, F689 at a Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was also identified at 42 CFR 483.25 Quality of Care, F689. The facility was notified of the Immediate Jeopardy on 04/01/2024. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on 04/05/2024, alleging removal of the IJ on 03/15/2024. An Extended Survey was initiated on 04/08/2024. The State Survey Agency (SSA) validated the facility's IJ Removal Plan on 04/12/2024. The SSA determined the IJ had been removed 03/15/2024, as alleged and was Past IJ. Refer to F689. The findings include: (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy entitled, Comprehensive Care Plans, implemented on 08/30/2022, and revised 02/2024, revealed the facility was to develop and implement a comprehensive person-centered care plan for each resident, which met their medical, physical, mental, and psychosocial needs. Continued review of the policy revealed the facility's care plan process was to include an assessment of each resident's strengths and needs and incorporate the resident's personal and cultural preferences in developing goals for their care. Review of the facility's policy titled, Accidents and Supervision, dated 01/02/2020, and revised 02/21/2024, revealed the facility was to provide a resident environment as free of accident hazards as possible, and provide each resident adequate supervision and assistive devices to prevent accidents. Continued review revealed the facility would implement interventions to reduce hazards and risks, and monitor for effectiveness, and modify those interventions when necessary. 1. Review of Resident #6's (R6) medical record revealed the facility admitted him on 08/18/2022, with diagnoses including unspecified dementia and major depressive disorder. Review of R6's Quarterly Minimum Data Set Assessment (MDS) dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 01 which indicated he was severely cognitively impaired. An interview was not conducted. Review of R6's comprehensive person-centered care plan revealed the facility care planned the resident on 08/18/2022, for cognitive loss and dementia with a goal for the resident to have positive experiences in his daily routine without overly demanding tasks and without becoming overly stressed. Continued review revealed the interventions included encouraging small group programs, verbalization of his feelings, supervision with Activities of Daily Living (ADLs) respecting his right to make decisions and supporting and reassuring the resident in new situations. Review of the nurse's progress note, documented by Registered Nurse #3 (RN3) on 03/11/2024 at 5:02 AM, revealed a Certified Nurse Aide (CNA) entered R6's and R7's shared room, and saw R6 injured with blood all over his face and bed. Continued review revealed the CNA called for RN3 to come to the room. Per review of the Note, when the RN entered the room, she observed R6 seriously injured, and not responding to verbal commands. The review revealed the resident's roommate (R7) was observed sitting next to R6's bed holding a fork and toothpaste in his hands which were all bloody. The facility transferred R6 was to the hospital related to his injuries. Observation of R6 on 03/27/2024 at 11:05 AM, revealed the resident had one to one (1:1) supervision due to the recent event of being injured by R7. Continued observation revealed R6's left eye had a covering taped over it. 2. Review of Resident #7's (R7) medical record revealed the facility admitted him on 05/22/2023, with diagnoses including unspecified dementia, impulse disorder, and paranoid schizophrenia. Review of R7's Quarterly MDS assessment dated [DATE], revealed the facility assessed the resident to have a BIMS score of 00, indicating he was severely cognitively impaired. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R7's care plan revealed the facility care planned him on 11/01/2023, for attempting to manipulate objects such as coat hangers and forks into protective objects related to his hallucinations. Per review Social Services Director #18 (SSD18) developed the care as she had discussions with the resident and had seen him holding objects. Continued review revealed staff were to be aware and lessen the resident's efforts to make protective objects which had the potential to be unsafe. The interventions included: serving only plastic ware to the resident on his meal trays; and having staff monitor the resident's room to prevent him from having materials which could be manipulated into protective objects. Review of the nurse's progress note, documented by RN3 on 03/11/2024 at 6:05 AM, revealed on 03/11/2024 at 6:05 AM, when she entered R7's room, she observed him sitting next to R6's bed holding a bloody fork in one (1) hand and both hands were all bloody. Continued review revealed the resident's roommate, R6 was seriously injured on his face and his left eye. Further review revealed RN3 called the police and they came to the facility, and emergency medical services (EMS) transported the victim (R6) to the hospital. In addition, the RN noted R7 needed to be sent out for evaluation as well, as he was in his room pacing quietly at the time. Record review revealed the facility transferred Resident #7 to the hospital on 03/11/2024, under a mental inquest warrant (involuntary admission of a mentally handicapped person). In interview on 03/29/2024 at 1:40 PM, the Administrator stated R7 would not be returning to the facility after his hospitalization . In interview on 03/27/2024 at 3:07 PM, RN3 stated on the night of the incident she was assigned to care for both Residents #6 and #7. RN3 stated she thought the incident had taken place around 4:00 AM or 5:00 AM. She stated her shift had started around 6:00 PM or 7 :00 PM, the previous night (03/10/2024). RN3 stated on the morning of the incident, a CNA went into the residents' room to check on them during her rounds and discovered R7 sitting next to R6's bed holding a bloody fork. She stated the CNA came to get her, and she went to the residents' room. The RN stated she saw R7 sitting beside R6's bed with blood on him and R6 was injured and not responding well. RN3 stated 911 and emergency medical services (EMS) were called and responded to the facility. In an interview with RN4 on 03/27/2024 at 4:10 PM, he stated he was the nurse who took over for RN3 on 03/11/2024. He stated he had provided care for R7 several time in the past and was familiar with him and his safety concerns and how he was always talking about self-protection. In an interview on 03/29/2024 at 1:00 PM, RN4 stated people had brought R7 things like combs from time to time, and once the resident had a sharp point comb that staff took away to be on the safe side. He stated that prior to the incident, R7 had been having visual and auditory hallucinations. RN4 stated facility staff had not had a day to day working fear of R7; however, they knew the resident had hallucinations. The RN stated when he had concerns about a resident he shared those concerns with the DON in order to have the resident's care plan updated. He stated nursing staff were not required to review residents' care plans daily; however, he did look at them for sure when the resident was new. In continued interview RN4 stated he had continually worked with R7 to help him focus on things that were real like television (TV) in order to keep him oriented. He stated in the auditory side of R7's hallucinations, he would have conversations with people that were not there. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interview on 04/01/2024 at 1:39 PM, the former SSD/Memory Care Director #18 (SSD/MCD18) stated she recalled working with R6 and R7, but did not recall any specific incident regarding R7 harming anyone. She stated she recalled that R7 had severe hallucinations and used items as weapons to defend against the hallucinations. The SSD/MCD18 stated she saw R7 with items like a coat hanger and a fork in his hand and saw him explaining to others that he wanted to use those items to defend himself. She stated she had never seen R7 use those items as a weapon against another person though. The SSD/MCD18 stated she recalled on at least three (3) separate instances R7 holding objects he perceived as items of defense against his hallucinations. She stated she initiated R7's care plan because she was the person with the firsthand knowledge that he was perceiving items as weapons. However, she did not know how the facility ensured the intervention for monitoring R7 took place. In interview on 04/01/2024 at 12:00 PM, Dietary Manager #21 (DM21) stated the plastic ware intervention for R7 began around 11/07/2023. She stated the head nurse instructed her to put the plastic utensils in place with instruction to take them out after each meal. The DM stated a meal tray card was created that noted plastic utensils were to be used for R7, and the utensils needed to be removed after each meal. She stated R7 was served with a plastic spoon and fork with each meal; he was not given a knife. DM21 stated she and other staff collected the utensils after each meal and made rounds to ensure all the utensils were taken out of R7's room. The DM stated staff were not required to sign anything like a log sheet or document electronically to verify that the utensils had been removed. She further stated they also confirmed in the kitchen that R7's tray returned with the utensils on them. In addition, she stated the plan was to communicate and talk to the nurses about the removal of R7's plastic utensils. DM21 stated R7 was permitted to eat alone in his room and did not require observation by staff. During an interview with Certified Nurse Aid #8 (CNA8) she stated on 04/01/2024 at 12:43 PM. on the evening of the incident she was caring for Resident #7. She stated she did not recall where resident had dinner on the night of the incident. She stated Resident #7 was always had plastic utensils with meals, and staff ahd to pick them up after the meal. However, she stated she was not told why. CNA8 stated that she had not been required to tell anyone when she checked R7's tray for the plastic utensils. She stated there had been no formal documentation process required for documenting the removal of the plastic ware. In an interview on 03/28/2024 at 9:30 AM, the DON stated she had been involved in conducting the facility's internal investigation after the incident took place. She stated she was not aware of R7 having any significant symptoms prior to the incident that occurred on 03/11/2024. The DON stated she did not recall if any specific changes were made to R7's care plan once his schizophrenia diagnosis was recognized. The DON stated she felt the supervision on the night of the incident by staff had been adequate. She stated after the incident took place, staff education was provided regarding dementia residents and behaviors that were not normal. In an interview on 03/29/2024 at 2:00 PM, the DON stated she did not feel R7 had been a danger to anyone prior to the incident. The DON stated R7 had not shown any aggression towards staff, so We were not doing more monitoring. She stated she did not know how or why the monitoring intervention ended up on the care plan other than being made aware of an incident where a hanger was broken but said she also did not know specifics of that incident. The DON stated she believed it would be easier for a resident to harm someone if he/she were allowed to have objects in his/her room. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator provided a copy of the meal ticket record from 11/08/2023 (when the DM said the intervention for plastic ware began) for R7. Review of the meal ticket document revealed it noted staff were to remove all plastic ware at the end of the resident's meal. The Administrator provided an undated document entitled, profile care plan approaches. Per review of this document, staff were to monitor what was in R7's room to prevent him from having materials that could be manipulated into protective items. However, there was no documentation noting how often staff were to monitor the resident's room/environment for those items or that staff consistently monitored the resident's room. In interview on 03/29/2024 at 1:40 PM, the Administrator stated she had not thought R7 was a danger to anyone in the facility prior to the incident and had not felt the resident required increase monitoring. The Administrator stated staff became concerned when R7 broke a clothes hanger in a room, and they felt he could have used it as a weapon. She stated staff had been required to remove the utensils from the resident's room. However, they did not document this. intervention. She stated R7 was ambulatory and had no restrictions and could ambulate freely throughout the unit. During the interview, she stated it was the facility's duty to maximize safety for all residents, and staff needed to be observant and aware of what was taking place around them.

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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 - Immediate jeopardy to resident health or safety 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** 49350 Based on observation, interview, record review, facility document and policy review, the facility failed to provide an effective system to monitor and supervise residents to prevent accidents hazards for one (1) of fifteen (15) sampled residents (Resident #6). On 03/11/2024 at approximately 3:40 AM, Resident #6 (R6) and Resident #7 (R7), who were roommates, were in their room alone with the door opened. Staff entered the residents' room and observed R7 sitting in a chair next to R6's bed, with a plastic fork in one hand and both hands covered with blood. R6 was lying on his bed with blood on his face and a laceration to his left eye. When staff asked R7 about the incident the resident stated he did it because he believed R6 was trying to harm him. The facility's failure to have an effective system to ensure each resident received adequate supervision and monitoring to prevent accident hazards has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 04/01/2024 and was determined to exist on 03/11/2024, in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; and 42 CFR 483.25 Quality of Care, F689 at a Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was also identified at 42 CFR 483.25 Quality of Care, F689. The facility was notified of the Immediate Jeopardy on 04/01/2024. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on 04/05/2024, alleging removal of the IJ on 03/15/2024. A Partial Extended Survey was initiated on 04/08/2024. The State Survey Agency (SSA) validated the facility's IJ Removal Plan on 04/12/2024. The SSA validated the immediacy of the IJ had been removed on 03/15/2024, as alleged, prior to the start of the survey. The IJ was determined to be Past Immediate Jeopardy. The findings include: Review of the facility's policy entitled, Abuse, Neglect, and Exploitation, dated 01/02/2020 with a revision date of 08/30/2022, revealed the facility was to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibited and prevented abuse, as well as neglect and exploitation of residents. Review of the facility's policy entitled, Accidents and Supervision, revised 02/21/2024, revealed the residents' environment was to remain as free of accident hazards as possible. Continued review revealed each resident was to receive adequate supervision and assistive devices to prevent accidents which included: identifying, evaluating and analyzing hazards and risks, and implementing interventions to reduce those hazards and risks. Per policy review, the facility was to monitor for effectiveness, and modify interventions when necessary. Further review of the policy revealed supervision was an intervention which meant mitigating accident risk, and the facility was to provide adequate supervision to prevent accidents for its residents. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of R6's medical record revealed the facility admitted him on 08/18/2022, with diagnoses that included unspecified dementia, major depressive disorder, and insomnia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed R6 to have a Brief Interview for Mental Status (BIMS) score of 01,. This score indicated severe cognitive impairment; an interview was not completed. Review of R6's Nursing Progress Note dated 03/11/2024 at 5:02 AM, documented by Registered Nurse (RN) #3 revealed upon entering R6's and R7's shared room, a Certified Nurse Aide (CNA) found R6 injured with blood all over his face and bed. Per review of the Note, the CNA called RN3 to come to the room. The RN found R6 seriously injured, and breathing but not responding to verbal commands. Continued review of the Note revealed R7 was sitting next to R6's bed with a fork in one (1) of his hands, with both hands all bloody. Further review revealed RN3 asked the roommate (R7) what had happened, and the roommate said, I cannot take it anymore. In addition, RN3 and the CNA quickly went out of the room when they found out the roommate (R7) had caused the injury to R6 and called the police. Review of the Note also revealed R6 was taken to the hospital right away. 2. Review of R7's medical record revealed the facility admitted the resident on 05/22/2023, with diagnoses which included unspecified dementia, paranoid schizophrenia, and impulse disorder. Review of the Quarterly MDS assessment dated [DATE], revealed the facility assessed R7 to have a BIMS' score of 00, which indicated severe cognitive impairment. Continued record review revealed Resident #7 had a state appointed guardian. Review of R7's comprehensive care plan revealed on 11/01/2023, the facility developed a care plan problem noting the resident attempted to manipulate objects, such as forks or coat hangers into protective objects to use, due to him seeing hallucinations in his room which bothered him. Continued review revealed Social Services Director (SSD) #18 had initiated the care plan dated 11/01/2023. Additional review revealed the goal which noted staff were to be aware and mitigate the resident's efforts to make protective objects which had the potential to be unsafe. Further review revealed the interventions included: psychiatry support with medication and talk therapy; serving him only plastic ware with meal trays; and monitoring what was in his room to prevent him from having materials that could be manipulated. The facility provided an undated document entitled, profile care plan approaches for R7. The document stated that staff would monitor what was in the resident's room to prevent him from having materials that could be easily manipulated into protective materials (weapons). However, Review of R7's Nursing Progress Note dated 03/11/2024 at 6:05 AM, written by Registered Nurse (RN) #3, revealed upon entering R6's and R7's shared room, R7 was observed sitting next to his roommate's bed (R6) with a fork in one (1) had and both hands all bloody. Continued review of the Note revealed R6 was seriously injured on his face and left eye. RN3 noted this nurse asked R7 what had happened, and the resident stated, I cannot take it anymore. Per review of the Note, RN3 called the police, and they came to the facility and emergency medical services (EMS) took the victim, (R6) to the hospital. The Director of Nursing (DON) and Nurse Practitioner (NP) were notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a progress note dated 03/20/2024 and transcribed by Nurse Practitioner #3 (NP3) revealed R6 had sustained, left orbital floor and medial wall fracture, a para-falcine subarachnoid hemorrhage, left eye subconjunctival hemorrhage, a full-thickness canaliculus laceration in the left eye, and a vitreous hemorrhage in the left eye with traumatic mydriasis. Patient had undergone repair of his lacrimal structure. Observation of R6 on 03/27/2024 at 11:05 AM, revealed the resident had staff present performing one on one (1:1) supervision and care of him. Per observation, R6's left eye had a covering taped over it. During an interview with RN3 on 03/27/2024 at 3:07 PM, she stated she had been the nurse assigned to both R6 and R7 on the night of the incident. RN3 stated she thought the incident took place around 4:00 AM or 5:00 AM in the morning on 03/11/2024. She stated her shift had started around 6:00 PM or 7:00 PM the previous night (03/10/2024), and R7 had been acting normally. However, RN3 stated when a nurse aide went into the residents' (shared) room to check on them during her rounding she discovered Resident #7 holding a bloody fork. She stated the aide left the room to get her (RN3). She stated she immediately went to the room and saw blood on R7 and R6 was seriously injured and not responding well. A call was placed to 911 due to Resident #6's condition and to the police related to the incident. She stated when she first entered the room, R7 was sitting in a chair near R6's bed and told her he cannot take it anymore. In interview on 03/29/2024 at 1:00 PM, RN4 stated he had not ever seen the resident perceive plastic utensils as weapons, nor had he heard him discussing such prior to the 03/11/2024 incident. RN4 stated people had given R7 things like combs from time to time. He stated he recalled a time R7 had a comb with a sharp point that staff took away from the resident to be on the safe side. He stated staff would engage in interventions like reorientation and reality checks to help R7 when he had hallucinations or impulse issues. RN4 stated prior to the 03/11/2024 incident, R7, had experienced visual and auditory hallucinations. Per the RN, staff had not had a day to day working fear of R7, and knew the resident had hallucinations. He stated nursing staff looked at residents' care plans when the resident was new; however, they were not required to review the care plans daily. He stated R7 had auditory hallucinations (as well as visual hallucinations) where he conversed with people who were not there. In continued interview on 03/27/2024 at 3:07 PM, RN3 stated EMS and law enforcement responded. The RN stated a police officer took the bloody fork that R7 was still holding and moved him over to his bed. RN3 stated she asked R7 why he was saying, I cannot take it anymore and why the incident took place, and the resident provided a disorganized and non-sensical response. She stated she stood at the residents' room door, but did not enter the residents' room. The RN stated other staff also did not enter the room, as they were afraid if they started trying to move him (R6), R7 would begin acting out again, and exacerbate his condition. RN3 stated when EMS personnel arrived, they quickly moved R6 to the stretcher and transported him out to the emergency room (ER). The RN further stated R7 remained in the room and was placed on 1:1 monitoring for the remainder of the shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interview on 03/27/2024 at 6:00 PM, Psych Nurse Practitioner (PNP4) #4 stated initially the facility had not been told R7 had a psych history. He stated he saw the resident for the first time around August of 2023. The Psych NP stated over time R7 became more delusional and he saw in an old medical record from a previous hospitalization that R7 that he had a history of paranoid schizophrenia. PNP4 stated R7's behaviors continued to be monitored and assessed and treated. However, by November 2023 the resident was becoming more aggressive and started to need some Geodon (an antipsychotic medication). During an interview with city Metro Police Officer #22 on 03/28/2024 at 6:12 PM, he stated he was dispatched to the facility on [DATE], because of the assault of R6 by R7. He stated staff told him they refused to intervene physically because they were afraid of R7. The Police Officer stated R6 had blood on his face and had blood splattered on the wall behind him. He stated the staff members were all standing outside of the residents' room door, and nobody had done anything to separate the two (2) residents. He stated it was clear no one had done anything to render aid to R6. Metro Police Officer #22 stated he asked R7 why he did it (assaulted R6) and the resident stated R6 was trying to do something to harm his (R7's) family. The Police Officer stated it was clear R7 was talking out of his mind. He stated he was taken aback by the fact that nursing staff had done nothing to render aid or evaluate the residents. Per the Police Officer, staff stated they wanted to wait until EMS arrived before they did anything further. In continued interview on 03/28/2024 at 6:12 PM, Metro Police Officer #22 stated when he arrived on the scene, R7 had a potato chip bag clip in his hand, and the fork that he used in the assault was sitting on his nightstand covered in blood. He stated R7's hands were covered with blood, and the victim (R6) did not speak to the officer much, just indicated he was okay. The Police Officer stated the suspect, R7 was compliant, and his focus stayed on R7 as he was not thinking clearly. He stated the group working was an all-female staff, and they stated they were afraid of R7 and did not want to approach him. The Police Officer stated nobody really assessed the victim (R6) until EMS arrived and assessed the resident. During an interview with CNA3 on 03/28/2024 at 10:30 AM, she stated she had been assigned to the care of both R6 and R7 on the night of the incident. She stated R7 could become anxious at times and had episodes where he paced in the hallway. However, on that night he had been very calm. The CNA stated both residents were typically quiet, but when she performed her rounds around 4:00 AM, and entered the residents' room, what she saw didn't seem real. CNA3 stated R7 was sitting right beside R6, and there was blood everywhere. She stated R7 had blood on his arms and had not been moving. The CNA stated, the team decided to standby and be at the room as an intervention. CNA #3 stated staff feared for their own safety, and law enforcement was called. She stated staff had not attempted to move R7 until law enforcement arrived. The CNA stated she had been afraid of R7 prior to the incident as he was a large, tall guy who was intimidating. She stated she had conversations in the past with R7 where he made her afraid but could not think of a time where she formally discussed or reported her fear or to the facility's leadership or reported the resident to leadership. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sycamore Heights Health and Rehabilitation	2141 Sycamore Avenue Louisville, KY 40206

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with CNA8 on 04/01/2024 at 12:43 PM, she stated she had worked at the facility since November 2022. She stated on the evening of the incident, she was caring for R7; however, she did not recall where R7 ate his meal, whether it was in his room or in the dining hall that night. She stated R7 was always served plastic utensils with meals, and they (the utensils) had to be picked up after every meal. CNA8 said she did not recall how she was first informed R7 had to use plastic utensils or why. The CNA stated the intervention had been in place for a few months before the incident took place. She stated she was simply told that whatever was taken into R7's room, she needed to bring back out of the room. The CNA stated when she removed R7's dietary trays and utensils, her process had been to just check the utensils, then remove the tray from the room, and place it on a dietary cart. CNA4 stated she had not been required to tell anyone when she checked R7's tray for the plastic utensils, and there had been no formal documentation process required for documenting the removal of the plastic ware. In interview on 04/01/2024 at 1:39 PM, the former SSD/Memory Care Director #18 stated she recalled R6 and R7 and remembered working with both. She stated a collection of occurrences had taken place with R7's behaviors, but she did not recall a specific incident regarding Resident #7 harming anyone. SSD/Memory Care Director #18 stated R7 had experienced severe hallucinations and had made items such as forks or coat hangers into what he thought were weapons he could use to defend against the hallucinations. She stated she had never seen R7 use an item as a weapon against another person. Per the SSD/Memory Care Director #18, she had seen R7 explaining to others he wanted to use those type items to defend himself. She stated R7 told staff he would keep the items in his hand to protect himself against the people he perceived to be in his room. She further stated she personally had seen at least three (3) separate instances where Resident #7 was holding objects he perceived as items of defense against his hallucinations. The SSD/Memory Care Director #18 stated she initiated R7's care plan (on 11/01/2023) because she was the person who had the firsthand knowledge that the resident was perceiving items as weapons. In addition, she stated she did not know how the facility ensured the intervention for monitoring R7 took place. Review of a copy of the facility's meal ticket record for R7, provided by the Administrator, dated 11/08/2023, revealed facility staff were to remove all plastic ware after the resident's meal. During an interview with Dietary Manager #21 (DM21) on 04/01/2024 at 12:00 PM, she stated she started working at the facility on 07/03/2023. DM21 stated she was aware of the incident in which R7 injured R6. She stated the use of plastic ware for R7 had been put into place for the resident's safety around 11/07/2023. However, she was not told specifically why the resident needed plastic ware. DM21 stated the head nurse instructed her to put the plastic utensils in place with instructions to take the utensils out of R7's room after each meal. The DM stated a meal tray card was created that stated plastic ware utensils were to be used for R7 and were to be removed with the completion of each meal. She stated she and other staff collected R7's utensils after each meal and also made rounds to make sure all utensils were taken out of the resident's room. DM21 stated they also confirmed the utensils used by R7 were on the resident's tray upon return to the kitchen. In continued interview on 04/01/2024 at 12:00 PM, the DM stated R7 was permitted to eat alone in his room and did not require observation. She stated sometimes the CNAs collected meal trays and sometimes dietary staff did it, but they all always communicated with each other when the tray had been picked up and that it had the utensils on it. The Dietary Manager stated staff had never been required to sign a log sheet or were required to electronically document the verification that R7's utensils had been removed as required. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 03/28/2024 at 9:30 AM, the Director of Nursing (DON) stated she had been involved in the facility's internal investigation. She stated she was unaware of Resident #7 ever having displayed any significant symptoms prior to the event on 03/11/2024. The DON stated she did not recall if any specific changes were made to R7's care plan once his schizophrenia diagnosis was recognized. She stated in the weeks leading up to the incident on 03/11/2024, expectations or procedures for supervision had not changed because R7 had not displayed any type of assaultive behaviors. The DON stated she felt the supervision of R7 on the night of the incident by the staff had been adequate. She stated after the incident education for staff had been provided regarding dementia residents and behaviors that were not normal. Per the DON, it was her expectation if a staff member witnessed abuse of resident, they were to intervene to separate the residents, and place both residents on 1:1 supervision. She also stated her expectations included for a nurse to assess each of the residents involved and report the event to the DON and/or Administrator. In an additional interview in 03/29/2024 at 2:00 PM, the DON stated she had not felt R7 was a danger to anyone, and he had not shown aggression towards staff or other residents before the incident, so we were not doing more monitoring of him. The DON stated no one had ever seen R7 make a weapon. The DON stated she did not know why or how the problem noting the resident attempted to manipulate objects, such as forks or coat hangers into protective objects due to him seeing hallucinations in his room had ended up on his care plan, other than an incident with him breaking a coat hanger. She stated she did not believe the incident could have been prevented if monitoring for items such as forks or coat hangers had been happening more frequently. The DON stated the resident could have made a weapon out of a chair if he wanted to, and he would have needed more supervision if that occurred. In interview on 03/29/2024 at 1:40 PM, the Administrator stated she had not felt R7 was a danger to others in the facility before the incident occurred (on 03/11/2024) and had not thought he required increased monitoring. She stated when R7 broke a clothes hanger in a room, staff became concerned, as they thought the resident could have used it as a weapon. The Administrator stated the facility had not documented removing R7's plastic ware at meal's end on a log sheet or in his medical record, but staff had been required to remove the plastic ware from the resident's room. She stated R7 was ambulatory, and had freely ambulated about his unit with no restrictions to prevent him from possessing small objects. The Administrator stated she felt staff had done a good job keeping harmful objects out of the resident's room prior to the incident. She stated staff needed to be aware and observant of what was taking place around them.