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	09/20/2024

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 50442 Based on interview, record review, and review of the facility's policy, the facility failed to ensure the resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility. This affected all residents in the facility. During a Group Interview conducted on 09/18/2024 by the State Survey Agency (SSA), Resident (R) 25 and R70 both complained they did not receive mail on Saturdays. In an interview with the Activitie's Director on 09/20/2024, it was confirmed, mail delivered on Saturday was locked in her office until Monday morning. The findings include: Review of the facility's policy titled, Resident Rights, dated 01/02/2022, revealed the resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Further review revealed residents had the right to send and receive mail, and to receive letters, packages, and other material delivered to the facility for the resident through a means other than the postal service. During a Group Interview, conducted on 09/18/2024 at 3:00 PM, by the SSA, R25 and R70 both stated they did not receive mail on Saturdays. Review of R25's Quarterly Minimum Data Set (MDS) Assessment, dated 08/21/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a 15 out of 15 indicating intact cognition. Review of R70's Quarterly MDS Assessment, dated 07/23/2024, revealed the facility assessed the resident as having a BIMS of a 15 out of 15 indicating intact cognition. In an interview with the Director of Nursing (DON), on 09/19/2024 at 3:24 PM, she stated she thought the residents received mail on Saturdays, but she was unsure. In an interview with Unit Manager (UM)2, on 09/20/2024 at 8:56 AM, he stated he thought activitie's personnel passed out resident mail on Saturdays, the same as they did the rest of the week. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Activitie's Director, on 09/20/2024 at 9:18 AM, she stated mail delivered on Saturday was locked in her office until the Business Office Manager could go through it and remove the facility's mail on Monday morning. The Activitie's Director further stated, after the facility's mail was removed from Saturday's mail, the residents' mail would then be delivered. In an interview with the Assistant Director of Nursing (ADON), on 09/20/2024 at 9:24 AM, he stated he did not know if mail was delivered to residents on Saturday. In an interview, on 09/20/2024 at 11:18 AM, the Administrator stated it was his expectation the Manager on Duty (MOD) passed out the residents' mail on Saturdays.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30898 Based on interview, record review, and review of the facility's policy, the facility failed to ensure Advanced Directives were completed by the Legal Guardian for one (1) of 25 sampled residents, Resident (R)43. Although a Judge signed a court order to appoint the Cabinet for Health and Family Services (CHFS) Guardianship for R43, effective [DATE]; the facility did not verify the resident's code status, and accepted a Kentucky Emergency Medical Services (EMS) Do Not Resuscitate (DNR) Order form, dated [DATE], signed by R43's family member. The findings include: Review of the facility's policy titled, Residents' Rights Regarding Treatment and Advance Directives reviewed/revised [DATE], revealed the facility supported and facilitated a resident's right to request, refuse, and/or discontinue treatment and formulate an advance directive. Per policy, an advance directive was a written instruction recognized under State law related to the provision of health care when an individual was incapacitated. Further review of the policy, revealed during the care planning process the facility would review with the legal representative whether they desired to make any changes related to any advance directives. Review of R43's Face Sheet located in the Electronic Medical Record (EMR) revealed the facility admitted the resident on [DATE]. Further review of R43's Face Sheet revealed diagnoses including vascular dementia, cognitive communication deficit, and cerebral infarction. Review of R43's Kentucky Emergency Medical Services (EMS) Do Not Resuscitate (DNR) Order form revealed the R43's family member signed the form on [DATE]. Review of R43's Physician's order, dated [DATE], revealed orders for DNR code status. Review of R43's Comprehensive Care Plan, dated [DATE] revealed the resident's code status was DNR, as of [DATE], with an intervention to withhold Cardiopulmonary Resuscitation (CPR) in the event the resident was found without pulse or respirations. Review of the Order of Appointment of Conservator from the Commonwealth of Kentucky, dated [DATE], revealed a Judge signed R43's court order to appoint the Cabinet for Health and Family Services (CHFS) Guardianship, as the resident's Conservator. Review of the Order of Appointment of Guardian from the Commonwealth of Kentucky, dated [DATE], revealed a Judge signed CHFS Guardianship as R43's appointed Guardian. Review of the Kentucky Emergency Medical Services (EMS) Do Not Resuscitate (DNR) Order form, dated [DATE], revealed R43's family member signed the DNR form. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R43's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of zero (0) out of 15, indicating severe cognitive impairment. During an interview, on [DATE] at 11:16 AM, the State Guardian (SG) stated R43 was a full code status (meaning if the resident's heart or lungs stopped working the medical staff is permitted to perform necessary procedures to save their lift including CPR). The SG stated the state was appointed the resident's guardian on [DATE] and no one else had the authority to make a change to R43's code status after the state was appointed her guardian. The SG further stated even if a resident had an advance directive of DNR prior to state guardianship, once the state became the resident's guardian the resident's code status became full code. The SG also stated for a resident under state guardianship to change to a DNR code status, the decision did not come from her, but a state nurse would need to complete a review of the resident's medical condition to determine if a DNR status was appropriate. The SG stated she informed the facility's Social Services Director and the Director of Nursing the resident was a full code once the SG was appointed. During an interview, on [DATE] at 3:28 PM, Registered Nurse (RN) 5 stated when a resident returned from the hospital the facility checked the resident's code status from the hospital. She stated R43 transferred to the hospital in [DATE]. She further stated R43 was on another hall at that time and she did not work with her when she returned from the hospital. In an interview on [DATE] at 3:41 PM, RN4 stated she could not recall if she worked with R43 when she returned from the hospital in [DATE]. She stated a resident's code status did not change upon return from the hospital unless there was a drastic change in care. She further stated if a resident had a State Guardian (SG), the SG was responsible for a resident's advanced directive and the facility's management handled it. RN4 stated an advance directive let the facility know what the resident's end of life choices were. She stated if a resident's code status was DNR, she would not provide the resident CPR if the resident's heart stopped and the resident could possibly die. In an interview on [DATE] at 4:01 PM, Unit Manager (UM)1 stated when a resident returned from the hospital, the resident's advance directive was handled by the social services department. He stated the resident's code status should be updated when the resident returned from the hospital. The UM further stated the purpose of the DNR was to prevent CPR. He stated if a resident did not receive needed CPR the resident could expire. He further stated when a resident returned from the hospital, social services was responsible to review resident's code status during the Interdisciplinary Team (IDT) meetings. Further, he could not recall if R43's code status was reviewed in the IDT. During an interview on [DATE] at 4:30 PM, the Director of Nursing (DON) stated social services reviewed the advance directives and reviewed re-admissions in the IDT meeting. The DON stated if a resident in the facility was later provided a State Guardian (SG), the social services department was responsible to follow up with the SG for the resident's code status. The DON stated she could not recall discussing R43 with the SG. She further stated only the SG could sign advance directives for a resident after the resident obtained a SG. The DON also stated she could not remember if R43's advance directives were discussed when she returned from the hospital in [DATE]. She stated the DNR form reflected the wishes of the resident or their Power of Attorney (POA). She further stated if a resident had a SG and was to be full code status, but the DNR form was signed by someone other than the SG for DNR code status, the resident would not receive CPR and a potential outcome could be death. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on [DATE] at 2:10 PM, the Administrator stated R43 went to the hospital after the State became her guardian and the hospital obtained the DNR form from the resident's family member. She stated upon the resident's return, the facility took the information from the hospital.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47349 Based on observation, interview, record review, and review of facility policies, the facility failed to implement the comprehensive person-centered care plan in order to meet the resident's medical, and nursing needs for three (3) of 25 sampled residents, Resident (R)45, R52, and R83. Observation on 09/17/2024 and 09/18/2024, revealed R45's Comprehensive Care Plan (CCP) was not implemented related to oxygen settings. Furthermore, observation on 09/17/2024, revealed R83's CCP was not implemented related to wearing a smoking apron while smoking. Moreover, continuous observation on 09/19/2024 from 8:15 AM to 10:15 AM, revealed staff had not checked R52's brief or taken him to the bathroom, as per the CCP. The findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 08/30/2022, revealed it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, to meet a resident's medical, physical, mental, and psychosocial needs. 1. Review of the facility's Resident Smoking policy, last reviewed/revised 04/24/2024, revealed . all safe smoking measures will be documented on each resident's care plan and communicated to all staff . who will be responsible for supervising resident's while smoking. Review of R83's History and Physical note, dated 08/04/2024, located in the Electronic Medical Record (EMR), revealed the facility admitted the resident on 08/01/2024 with diagnoses including peripheral vascular disease, degenerative joint disease, and tobacco abuse. Review of R83's Admission Minimum Data Set (MDS) Assessment, dated 08/05/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating intact cognition. The MDS Assessment further revealed the resident smoked cigarettes. Review of R83's Comprehensive Care Plan (CCP), revised 09/17/2024, revealed a focus of Respiratory, specifically nicotine dependence, related to smoking cigarettes. The goal stated the resident would be injury free from unsafe smoking practices. An intervention dated 08/02/2024, revealed the resident required a smoking apron while smoking. A continuous observation of R83, was conducted on 09/17/2024 from 9:00 AM until 9:25 AM, and during this time the resident smoked two (2)cigarettes without wearing a smoking apron. A continuous observation of R83 was conducted on 09/17/2024 from 11:00 AM until 11:23 AM, and during this time the resident smoked one (1)cigarette without wearing a smoking apron. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with R83, on 09/16/2024 at 2:48 PM, he stated he had five (5) opportunities per day for smoking. He further stated the facility did not provide a smoking apron for him when he smoked. During further interview with R83, on 09/20/2024 at 4:45 PM, he stated he was never offered a smoking apron, but if he were offered one, he would have worn it when he smoked. In an interview with the Activity Director (AD), on 09/20/2024 at 11:58 AM, she stated she checked the care plans for residents who smoked in order to be aware of any interventions related to smoking. Afterwards, she notified her staff of the interventions. She further stated if a resident was care planned to wear a smoking apron while smoking, but did not, ashes could drop on his clothes, or he could drop a cigarette onto himself which could lead to a burn. During an interview with the Social Services Director (SSD), on 09/20/2024 at 12:13 PM, she stated if R83 was care planned to wear a smoking apron and did not wear the apron when smoking, he could possibly burn himself. During an interview with the Minimum Data Set (MDS) Coordinator, on 09/20/2024 at 2:13 PM, she stated she had entered the care plan intervention for R83 to wear a smoking apron while smoking. She further stated if a resident had a care plan intervention to wear a smoking apron and did not wear the apron, this could lead to a burn or severe injury. In an interview with the Registered Nurse (RN)1, on 09/20/2024 at 2:30 PM, she stated she would review the resident's care plan to identify what interventions were to be implemented for a resident who smoked. In an interview with the Administrator, on 09/20/2024 at 3:28 PM, she stated she did not think R83 was assessed for smoking independently. She further stated if R83 should wear a smoking apron and did not wear the apron, the cigarette could cause burns, ruin his clothing, or start a fire. 2. Review of the facility's policy titled, Oxygen Administration, revised 03/24/2022, revealed oxygen is administered under orders of a physician. Further review revealed the resident's care plan would identify the interventions, based on the resident's orders, specifically, equipment setting for prescribed oxygen flow rates. Review of R45's Face sheet dated 09/18/2024, located in the Electronic Medical Record (EMR), revealed the facility admitted R45 on 06/18/2021 with diagnoses including unspecified dementia and acute pulmonary edema (congestion). Review of the Admission Minimum Data Set (MDS) Assessment, dated 08/21/2024, revealed the facility assessed R45 as having a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. Additional review of the MDS revealed R45 received oxygen therapy. Review of R45's Comprehensive Care Plan (CCP), revised 09/18/2024, revealed she required oxygen therapy for acute pulmonary edema (congestion). The goal stated she would not have signs of hypoxia (low oxygen levels in body tissues). An intervention to administer oxygen at two (2) liters per minute was initiated on 04/04/2023. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R45's Active September 2024 Physician's Orders revealed orders to administer oxygen at two (2) liters per minute with a start date of 06/07/2023. An observation on 09/17/2024 at 10:25 AM, revealed the oxygen setting on R45's oxygen concentrator (medical device that provides extra oxygen) was set at three (3) liters per minute. An observation on 09/18/2024 at 2:24 PM, revealed R45's oxygen setting on her oxygen concentrator was set at three (3) liters per minute. During an interview, with the Director of Nursing (DON), on 09/19/2024 at 4:29 PM, she stated it was the nurse's responsibility to ensure the correct oxygen setting on the concentrator to ensure the resident was receiving oxygen as per the physician's orders and the care plan. In further interview, she stated if the resident received too much oxygen it could cause an increased heart rate, and restlessness, along with other adverse effects. In an interview with the Administrator, on 09/20/2024 at 3:42 PM, she stated if staff did not not follow R45's care plan related to oxygen therapy, this could cause changes in the resident's condition such as respiratory changes, and a change in her mental status. 50442 3. Review of the facility's policy titled, Activities of Daily Living, dated 08/15/2020, revealed a resident that was unable to carry out activities of daily living (ADLs) would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Further review revealed the facility would maintain individual objectives of the care plan with periodic review and evaluation. Review of R52's Face Sheet located in the Electronic Medical Record (EMR), revealed the facility admitted the resident on 10/01/2021 with diagnoses including dementia, type II diabetes, major depressive disorder, attention and concentration deficit, and hyperlipidemia. Review of R52's Quarterly Minimum Data Set (MDS) Assessment, dated 07/15/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderate cognitive impairment. Per the MDS, R52 required partial to moderate assistance with toileting and personal hygiene; could walk independently, and was incontinent of bowel and bladder. Continued review of R52's MDS revealed he was not assessed as rejecting care. Review of R52's Comprehensive Care Plan, dated 07/22/2024, revealed a focus of urinary incontinence with a goal stating the resident would not experience skin breakdown because of incontinence. The interventions included: check for incontinence episodes every two (2) hours, initiated on 07/22/2024. Further review of R52's CCP, dated 07/22/2024, revealed a focus of resistant to care with a goal stating the resident would not exhibit resistance to care. The interventions included actively involving the resident in his care, establishing clear boundaries, contact family if resident resisted care, and reiterate the purpose and advantage of treatment to the resident. All interventions were initiated on 07/22/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional review of R52's CCP, dated 07/22/2024, revealed a focus of impaired decision making related to dementia with a goal that he would have positive experiences in daily routine without overly demanding tasks and without being overly stressed. The interventions included provide cues and supervision for activities of daily living (ADLs), initiated on 07/22/2024. In an interview with Family Member (F)5, on 09/17/2024 at 6:00 PM, she stated it was an ongoing issue for R52 to be left in a soiled bed and in dirty clothing. F5 stated she just wanted the facility to take care of R52 by following what was written in R52's care plan which was to change or toilet the resident every two (2) hours. F5 further stated the nurses and floor managers did not help or supervise the aides to ensure R52's care plan was followed. In an interview with F6, on 09/17/2024 at 6:26 PM, she stated staff should be following the care plan related to toileting R52 every two to three (2 to 3) hours, but was not following through with this. Recently, when she came to visit R52, he was found in a wet bed. She stated she was now R52's guardian and was tired of the excuses for why R52 was not getting the care he needed. F6 stated there was not enough staff to take care of the residents appropriately. F6 further stated each time she talked with the Director of Nursing (DON) or the Administrator about why R52 was left wet, they would tell her that they were short staffed. Observation of R52, on 09/19/2024 at 08:15 AM, revealed the resident was sitting in his recliner eating breakfast. Observation of R52, 09/19/2024 at 8:20 AM, revealed a State Registered Nurse Aide (SRNA) entered R52's room. She checked on him, asking him if he needed anything, but did not take the resident to the bathroom or provide incontinence care. Observation on 09/19/2024 at 9:28 AM, revealed RN2 entered R52's room to take his vital signs and administer his medications. RN2 did not take R52 to the bathroom or check to see if he needed incontinence care. Observation on 09/19/2024 at 9:50 AM, revealed SRNA9 entered R52's room, found him asleep, and left the room without toileting him or providing incontinence care. Continuous observation on 09/19/2024 from 8:15 AM to 10:15 AM, revealed staff did not provide incontinence care for R52 or assist him to the bathroom. In an interview, on 09/19/2024 at 10:22 AM, with RN2, he stated he was assigned to R52 today, and the SRNAs rounded on residents at different times depending on the the residents' needs. He stated some residents needed more frequent monitoring. RN2 stated he expected his SRNAs to round on all residents at least hourly, and to follow the residents' care plans. In an interview with SRNA9, on 09/19/2024 at 10:25 AM, she stated she was assigned to R52 today, and the resident was incontinent of bowel and bladder. She further stated she had to remind him to go to the bathroom, as he would not go to the bathroom on his own. SRNA9 stated the resident needed to be taken to the toilet every one (1) to two (2) hours. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 09/20/2024 at 8:56 AM, Unit Manager (UM)2 stated SRNAS should check on R52 and provide incontinence care or toilet the resident every two (2) hours as per the CCP. UM2 stated R52 did refuse to be toileted or changed at times, and if he refused, they should try again later. In an interview with the Assistant Director of Nursing (ADON), on 09/20/2024 at 9:24 AM, he stated staff should be rounding on R52 every two (2) hours. When staff rounded on R52, he should be taken to the bathroom and provided incontinence care if he was soiled as per the care plan. Further, if he refused incontinence care or toileting, staff should try again later. The ADON stated R52 was known to refuse care, such as toileting and getting his brief changed. In an interview, with the Director of Nursing (DON), on 09/19/2024 at 3:24 PM, she stated staff should check on R52 every two (2) hours to see if he was soiled and provide incontinence care or to take him to the bathroom for toileting as per the care plan. The DON stated R52 was care planned for refusal of care and often did refuse to allow staff to change his brief or take him to the toilet. If he refused incontinence care, staff should try again later or have another staff member try to provide care. In an interview with the Administrator, on 09/20/2024 at 11:18 AM, she stated she expected staff to toilet or check R52 to see if he was wet/soiled every two (2) hours as per the care plan. She further stated, sometimes R52 did refuse incontinence care and would deny that he was wet. He would sometimes not allow staff to provide other care and would refuse to get out of bed. The Administrator stated when R52 refused care, staff should get someone else to try to approach him in an attempt to provide the care that was needed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 50442 Based on observation, interview, record review, and review of the facility's policies, the facility failed to ensure residents who were unable to carry out Activities of Daily Living (ADLs) received the necessary services related to toileting and incontinence care for one (1) of 25 sampled residents, Resident (R)52. The findings include: Review of the facility's policy titled, Activities of Daily Living, dated 08/15/2020, revealed a resident that was unable to carry out activities of daily living (ADLs) would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Further review revealed the facility would maintain individual objectives of the care plan and periodic review and evaluation. Review of facility's policy titled, Perineal Care, dated 01/02/2020, revealed it was the practice of the facility to provide perineal care for all incontinent residents during routine baths and as needed in order to promote cleanliness and comfort, prevent infections to the extent possible, and prevent and assess for skin breakdown. Review of the facility's policy titled, Dementia Care, dated 01/02/2020, revealed that it was the policy of the facility to provide the appropriate treatment and services to every resident who displayed signs of, or was diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. Review of R52's Face Sheet' located in the Electronic Medical Record (EMR) revealed the facility admitted the resident on 10/01/2021 with diagnoses which included dementia, type II diabetes, major depressive disorder, attention and concentration deficit, and hyperlipidemia. Review of R52's Quarterly Minimum Data Set (MDS) Assessment, dated 07/15/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 10 out of 15, revealing moderate cognitive impairment. Further review of the MDS, revealed R52 required partial to moderate assistance with toileting, and personal hygiene, and walked independently. R52 was further assessed as incontinent of bowel and bladder. Additional review of R52's MDS revealed he was not assessed as rejecting care. Review of R52's Comprehensive Care Plan, dated 07/22/2024, revealed a focus of urinary incontinence with a goal stating the resident would not experience skin breakdown because related to incontinence. The interventions initiated 07/22/2024 included: check for incontinence episodes every two (2) hours, and use a brief at night when resident was in bed, but use underwear when resident was out of bed. Further review of R52's CCP, dated 07/22/2024, revealed a focus of resistant to care with a goal stating the resident would not exhibit resistance to care. The interventions initiated 07/22/2024 included: actively involve the resident in his care, establish clear boundaries, contact family if resident resists care, and reiterate the purpose and advantage of treatment to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER: Sycamore Heights Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 2141 Sycamore Avenue Louisville, KY 40206	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional review of R52's CCP, dated 07/22/2024, revealed a focus of impaired mobility to perform or complete toileting activities as evidenced by resisting care. The goal stated resident would maintain adequate nutrition, hydration, and elimination. The interventions initiated 07/22/2024 included: allow resident to choose options, encourage resident to take gradually increasing responsibility for hydration, nutrition, elimination, sleep, activity, and other self-care needs, and maintain a calm environment and approach to resident. Continued review of R52's CCP, dated 07/22/2024, revealed a focus of impaired decision making related to dementia with a goal that he would have positive experiences in daily routine without overly demanding tasks and without being overly stressed. The interventions initiated 07/22/2024 included: provide cues and supervision for activities of daily living (ADLs), and respect resident's right to make decisions. Review of R52's Event Report, dated 04/03/2024, revealed resident refused his brief to be changed. The Interdisciplinary Team (IDT) team met to discuss the event; and it was noted the family wanted to be notified when he refused care. Review of R52's Event Report dated 06/11/2024, revealed the resident was exhibiting the behavior of removing his unsoiled brief frequently. Staff spoke with his guardian and evaluations were received from psychiatry and the Advanced Practice Registered Nurse (APRN). The IDT met to discuss ways to prevent this behavior. The evaluation portion of the Event Report, revealed the resident's care plan was updated with new interventions from the IDT team meeting. The report stated the interventions were in place and effective; however, the report did not specify which interventions had been put in place. During an interview, with Family Member (F)5, on 09/17/2024 at 6:00 PM, she stated R52 was often left in a soiled bed and in dirty clothing and this was an ongoing issue. F5 stated R52 did not get the help he required with his activities of daily living (ADLs). F5 further stated the Administrator wanted to meet monthly to discuss this issue and how to alleviate it, but she did not want to meet monthly. F5 stated she just wanted the facility to take care of R52 by following what was written in his care plan which was to change or toilet the resident every two (2) hours. F5 stated there was no chain of command at the facility, and no one was held accountable when R52 did not receive the required care. Per interview, the nurses and floor managers did not help or supervise the aides. F5 further stated, once she found R52 without a brief because the brief was laying on his bedside commode. Additional interview with F5, on 09/17/2024 at 6:00 PM, revealed on another occasion she found R52 sitting in wet clothing. She then rang the call bell and called out to get him cleaned up. She further stated the aide did not come for 20 minutes and by that time F5 had R52 cleaned up and his clothes changed. F5 stated R52 had dementia and would tell staff that he did not need to be changed or was not wet even though he required incontinence care. F5 stated there was frequent staff turn over at the facility and staff was often unaware of R52's medical diagnosis of dementia. In continued interview, she stated she spoke with a nurse last week after finding R52 wet again, but she could not remember which nurse. The nurse thought R52 should turn on the call light and ask to go to the bathroom or to be changed. F5 stated R52 had dementia, and he could not remember to turn on his call light. She stated that was the first and only time she saw this nurse working at the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with F6, on 09/17/2024 at 6:26 PM, she stated she was R52's guardian and was tired of the excuses for why R52 was not getting the care he required as per his care plan. She stated staff should be following the care plan related to toileting him every two to three (2 to 3) hours, but were not following through with this. Per interview, on a recent visit, R52 was found in a wet bed. F6 further stated each time she talked with the Director of Nursing (DON) or the Administrator about why R52 was left wet, they would tell her that they were short staffed. F6 stated there was not enough staff to take proper care of the residents. Observation of R52 on 09/18/2023 at 1:30 PM revealed he was sitting in his recliner watching television and eating his lunch in his room. R52's room smelled of urine. R52 stated he was able to clean himself up, and he could get himself up unassisted and take himself to the bathroom. When asked if he was wearing a brief, R52 stated he wore regular underwear and not a brief. During an interview, on 09/18/2024 at 1:41 PM, with State Registered Nurse Aide (SRNA)4, she stated she was assigned to R52 today and when assigned to the resident she would check on him at 7:00 AM after breakfast, after lunch, and right before going home in the evening. Further, she checked on him every two to three (2-3) hours to see if he was soiled, and if he was not soiled, she would take him to the bathroom. SRNA4 further stated R52 did refuse care at times, and when he refused to get changed or to be toileted, she would redirect him and he would usually allow her to provide incontinence care or take him to the bathroom. During an interview, with Registered Nurse (RN)1, on 09/18/2024 at 1:58 PM, she stated she was assigned to R52 today, and the aides rounded on the resident every two (2) hours. RN1 stated R52 was incontinent, and would refuse care or refuse to be changed or toileted at times. Observation of R52, on 09/19/24 at 8:15 AM, revealed R52 was sitting in his recliner eating breakfast. Observation of R52, on 09/19/2024 at 8:20 AM, revealed an SRNA entered R52's room. She asked him if he needed anything, but did not take the resident to the bathroom or check his brief. Observation on 09/19/2024 at 9:28 AM, revealed RN2 entered R52's room to obtain his vital signs and administer his medications. RN2 did not provide incontinence care, nor did the nurse take the resident to the bathroom. Observation on 09/19/2024 at 9:50 AM, revealed SRNA9 entered R52's room, found him asleep, and then left the room without toileting or checking to see if the resident required incontinence care. Continuous observation of R52 on 09/19/2024 from 8:15 AM to 10:15 AM, revealed staff did not check R52's brief to assess if he required incontinence care or assist him to the bathroom. During an interview on 09/19/24 at 10:22 AM, with RN2, he stated some residents needed more frequent monitoring, but he expected his SRNAs to round on residents at least hourly. He stated he was assigned to R52 today and the resident should be checked hourly as he was dependent on staff for ADLs. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with SRNA9, on 09/19/2024 at 10:25 AM, she stated she was assigned to R52 today, and the resident was incontinent of bowel and bladder. She further stated she had to check him for incontinence and remind him to go to the bathroom, as he would not go to the bathroom on his own. SRNA9 further stated the resident needed to be taken to the toilet every one (1) to two (2) hours. During an interview on 09/20/2024 at 8:56 AM, Unit Manager (UM)2 stated the SRNAS should check on R52 and provide incontinence care or toilet the resident every two (2) hours. UM2 stated R52 did refuse to be toileted or changed at times, and if he refused, they should approach the resident later. During an interview with the Assistant Director of Nursing (ADON), on 09/20/2024 at 9:24 AM, he stated staff should be rounding on R52 every two (2) hours, and during rounds the resident should be taken to the bathroom and provided incontinence care if he was soiled. He stated if R52 refused incontinence care or toileting, staff should try again later. Further, if the resident continued to refuse care, this should be reported to the nurse and the nurse should document the refusals in R52's medical record. He stated at that point the nurse assigned to the resident, should try to perform incontinence care as the resident would allow. The ADON further stated R52 was known to refuse care, such as toileting and getting his brief changed. During an interview with the Director of Nursing (DON), on 09/19/2024 at 3:24 PM, she stated it was her expectation staff follow facility policies and state regulations while providing care for R52. She further stated staff should check on R52 every two (2) hours to see if he was soiled and provide incontinence care or to take him to the bathroom for toileting as per the care plan. The DON stated R52 was care planned for refusal of care and often refused to allow staff to change his brief or take him to the toilet. During those times when he refused incontinence care, staff should try again later or have another staff member try to provide care. During an interview with the Administrator, on 09/20/2024 at 11:18 AM, she stated she expected staff to toilet or check R52 to see if he was wet/soiled at least every two (2) hours. She further stated, sometimes R52 refused incontinence care and denied that he was wet. He would sometimes not allow staff to provide other care or would refuse to get out of bed. The Administrator further stated when R52 refused care, staff should have someone else to try to approach him in an attempt to provide the care that was needed. Staff should then report any refusals of care to their managers. The Administrator stated, because of R52's dementia, he was not aware he could no longer care for himself as he once did. Further, it was difficult at times to provide R52 care when he refused, as staff could not force a resident to do something. She stated the key to providing care for R52 after he refused care, was to allow him time to think about it, and then reapproach him.

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	185348	A. Building B. Wing	09/20/2024

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47349 Based on observation, interview, record review and review of facility policy, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for one (1) of nine (9) residents who smoked out of a total sample of 25 residents, Resident (R)83. The facility was a smoke free facility and only those residents who were grandfathered in could smoke on facility grounds. However, R83 was admitted after the facility went smoke free and was observed on 09/17/2024 smoking on facility grounds, without wearing a smoke apron. Furthermore, there was no documented evidence a smoking evaluation was completed for this resident to ensure the resident could safely smoke. The findings include: Review of the facility's Smoking Policy, undated, located within the Admission Agreement packet, revealed the facility was a non-smoking facility. Further review revealed residents who smoked were supervised. Additional review revealed a Safe Smoking Evaluation was to be performed and include accommodations the resident would need, example: smoking apron. Review of the facility's Resident Smoking policy, last reviewed/revised 04/24/2024, revealed residents who smoke will be further assessed, using the Resident Safe Smoking Assessment. The policy further revealed, all safe smoking measures will be documented on each resident's care plan and communicated to all staff . who will be responsible for supervising resident's while smoking. Review of R83's History and Physical note, dated 08/04/2024, located in the resident's Electronic Medical Record (EMR), revealed the facility admitted R83 on 08/01/2024 with diagnoses which included peripheral vascular disease, degenerative joint disease, and tobacco abuse. Review of R83's Admission Minimum Data Set (MDS) Assessment, dated 08/05/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Further review of the MDS, revealed the resident smoked cigarettes. Review of R83's Comprehensive Care Plan (CCP), revised 09/17/2024, revealed an intervention stating the resident required a smoking apron while smoking, dated 08/02/2024. Review of the facility's list of residents who smoked, provided by the Administrator, on 09/16/2024, revealed R83 was not listed. Continuous observation of R83, was conducted on 09/17/2024 from 9:00 AM until 9:25 AM, while the resident was smoking in the courtyard, in the designated smoking area. R83 was observed to smoke two (2) cigarettes. R83 handled both cigarettes without difficulty; however the resident was not wearing a smoking apron as per the care plan. R83 was observed to be supervised by an activity staff member while smoking. Ashtrays were observed in the courtyard. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further continuous observation of R83 was conducted on 09/17/2024 from 11:00 AM until 11:23 AM, while the resident was in the courtyard, in the designated smoking area. R83 was observed to smoke one (1) cigarette without wearing a smoking apron. He was being supervised by an activity staff member. Ashtrays were observed in the courtyard. R83 was observed to handle the cigarette without difficulty. During an interview with R83, on 09/16/2024 at 2:48 PM, he stated the facility had a designated smoking area, outside in the courtyard. He further stated he had five (5) opportunities per day for smoking, but the facility did not provide a smoking apron for him when he smoked. He stated the facility staff was always present when he smoked. In a follow up interview with R83, on 09/20/2024 at 4:45 PM, he stated he was never offered a smoking apron, but if he were offered one, he would have worn it when he smoked. An interview was conducted with Hospitality Aide (HA)1, on 09/20/2024 at 11:39 AM, with translation assistance from Unit Manager2. HA1 stated the Activitie's Director (AD) or the resident's nurse would notify her of interventions or assistance needed for the residents when they smoked. She stated a resident who would need to wear a smoking apron, but did not, could have an accident and burn his skin. In an interview with the Activitie's Assistant (AA), on 09/20/2024 at 11:46 AM, she stated she was given a list of residents who smoked along with their safety requirements from her supervisor, the Activitie's Director (AD). She stated her list was updated every six (6) months and with every new resident admission. She further stated R83 did not go to the courtyard to smoke because the facility admitted him after the facility went smoke free. She stated a resident who would need to wear a smoking apron, but did not, could burn himself or burn holes in his clothes. In an interview with the AD, on 09/20/2024 at 11:58 AM, she stated she would review the care plan or speak with the Director of Nursing (DON) or the Nursing Administrator for required safety interventions for a resident who smoked. Afterwards, she notified her staff of the interventions. She stated if a resident refused to wear a smoking apron, she documented the refusal in the progress notes of the EMR and the nurse was notified. She stated if a resident had an intervention in his care plan to wear a smoking apron, but did not, ashes could drop on his clothes, or he could drop a cigarette onto himself which would lead to a burn. She stated residents admitted after the facility became smoke-free were not allowed to smoke. No documentation of R83's refusal to wear a smoking apron was found in the EMR. In an interview with the Social Services Director (SSD), on 09/20/2024 at 12:13 PM, she stated the residents received the facility's smoking policy on admission to the facility. She further stated the only residents who smoked were the ones who were grandfathered in. She could not recall when the facility became smoke-free. The SSD stated she thought R83 had to check himself out to smoke, meaning he would have to leave the facility to smoke. She stated she did not know R83 was smoking in the courtyard. She further stated if R83 had an intervention on his care plan to wear a smoking apron and did not, he could possibly burn himself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Minimum Data Set (MDS) Coordinator, on 09/20/2024 at 2:13 PM, she stated she entered the intervention to wear a smoking apron while smoking on R83's care plan. The MDS coordinator stated she did not know when the facility became smoke- free. She stated the primary nurse would perform the Safe Smoking Evaluation, which determined if interventions were needed for a resident who smoked. The MDS coordinator could not locate the Safe Smoking Evaluation in R83's EMR. She further stated if a resident had a care plan intervention to wear a smoking apron and did not, this could lead to a burn or severe injury. In an interview with the Registered Nurse (RN) 1, on 09/20/2024 at 2:30 PM, she stated she did not observe the residents while they smoked. However, she stated if a resident had a care plan intervention to wear a smoking apron and did not, this could lead to an injury or burn. In an interview with the Admissions Director, on 09/20/2024 at 2:55 PM, she stated the facility became a smoke-free facility last year, but she could not recall the date. She stated a resident admitted after the facility became smoke-free, would need to sign themselves out of the facility and smoke off the facility's property. In an interview with the Administrator, on 09/20/2024 at 3:28 PM, she stated the facility was a smoke-free facility when R83 was admitted . She stated R83 should not have been on the grandfathered list. She further stated she did not think R83 was assessed to evaluate if he could smoke independently; however, the resident did not exhibit any unsafe smoking tendencies. In further interview, she stated if R83 should wear a smoking apron and did not, the cigarette could cause burns, ruin his clothing, or a fire could be started.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47349 Based on observation, interview, record review, and review of facility policy, the facility failed to provide oxygen as ordered for one (1) of 25 sampled residents, Resident (R)45. Although R45's Active Physician's orders revealed orders to administer oxygen at two (2) liters per minute via nasal cannula, observation on 09/17/2024 and 09/18/2024, revealed the resident was receiving oxygen at three (3) liters per minute. The findings include: Review of the facility's Oxygen Administration policy, revised 03/24/2022, revealed oxygen was administered under orders of a physician. Further review revealed the resident's care plan would identify the interventions, based on the resident's orders. Review of R45's Face Sheet, located in the resident's Electronic Medical Record (EMR), revealed the facility admitted R45 on 06/18/2021 with diagnoses including unspecified dementia and acute pulmonary edema (congestion). Review of R45's Quarterly Minimum Data Set (MDS) Assessment, dated 08/21/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. The MDS further revealed the resident received oxygen therapy. Review of R45's Active Orders, dated 09/2024, revealed a physician's order, with a start date 06/07/2023, to administer oxygen at two (2) liters per minute via nasal cannula. Review of R45's Comprehensive Care Plan (CCP), revised 09/18/2024, revealed a focus of oxygen therapy for acute pulmonary edema (congestion). The goal stated the resident would not have signs of hypoxia (low oxygen levels in body tissues). An intervention to administer oxygen at two (2) liters per minute was initiated on 04/04/2023. Observation on 09/17/2024 at 10:25 AM, revealed the oxygen setting on R45's oxygen concentrator (medical device that provides oxygen) was set at three (3) liters per minute, while the resident was receiving oxygen via nasal cannula. Observation on 09/18/2024 at 2:24 PM, revealed R45's oxygen setting on her oxygen concentrator was set at three (3) liters per minute, while the resident was receiving oxygen via nasal cannula. During an interview with Registered Nurse (RN)4, on 09/19/2024 at 3:41 PM, she stated it was the nurse's responsibility to check physician's orders and check the oxygen concentrators to ensure residents were receiving oxygen as ordered. Furthermore, she stated too much oxygen could cause the resident harm. During an interview with Unit Manager (UM)1, on 09/19/2024 at 4:01 PM, he stated the oxygen concentrator setting was to be checked by the nurse constantly, but at a minimum once every shift. He further stated, too much oxygen could cause the resident's breathing to slow down with the potential of death. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, with the Director of Nursing (DON), on 09/19/2024 at 4:29 PM, she stated it was the nurse's responsibility to ensure the correct oxygen setting on the concentrator. She further stated the oxygen setting was to be checked according to the physician's orders. In continued interview, she stated if the resident received too much oxygen it could cause an increased heart rate, and restlessness, along with other adverse effects. During an interview with the Administrator, on 09/20/2024 at 3:32 PM, she stated the nurse should compare the physician's orders for oxygen administration with the settings of the oxygen concentrator to ensure a correct setting. She stated an incorrect oxygen setting could cause the resident to have respiratory issues.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50442 Based on observation, interview, and review of facility policy, the facility failed to ensure drugs were stored under proper temperature controls; and were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions. Observation on 09/18/2024, revealed the top drawer of the medication cart for Hallway A, had a cup of pills with a resident's first name handwritten on the cup. Additionally, observation revealed eye drops and suppositories were stored in the door of the refrigerator in the hallway B medication room. The findings include: Review of the facility's policy titled, Medication Storage, dated 05/20/2020, revealed it is the policy of the facility to ensure all medications housed on our premises be stored in accordance with the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Further review revealed during medication pass, medications must be under the direct observation of the person administering the medications or locked in the medication storage area. Refrigerated products were to be stored in refrigerators located in the pharmacy and at each medication room. Temperatures were to be maintained within 36-46 degrees Fahrenheit. Review of the facility's policy titled, Medication Administration, dated 01/21/2022, revealed medications are administered by licensed nurses, or other staff who were legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 1. During observation of medication pass on 09/18/2024 at 9:20 AM, with Registered Nurse (RN)3, it was noted there was a cup of pills with a resident's first name handwritten on the cup in the top drawer of Medication Cart A. During an interview with RN3, on 09/18/2024 at 9:20 AM, she stated she had pulled the medications and put them in a cup and then realized the resident had gone to therapy. She further stated she placed the cup of medications in the medication cart drawer and elected to wait until the resident returned from therapy to administer the medication. In further interview, RN3 stated she was unsure of what issues could occur with leaving the cup of pills in the medication drawer because she knew who they belonged to and the resident's name was written on the cup. In an interview with Unit Manager (UM)2, on 09/20/2024 at 8:56 AM, she stated if a resident was not available to take their medications, he expected staff to dispose of the medications and pull new medications when the resident was available. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Assistant Director of Nursing (ADON), on 09/20/2024 at 9:24 AM, he stated it was his expectation for staff to dispose of medications if the resident was not available to take them once they had been prepared. He stated a cup of pills should never be put back in the medicine cart for later because staff might forget to give them, or the pills might get lost. Further, depending on the type of medication, this could cause a bad outcome. In an interview with the Director of Nursing (DON), on 09/19/2024 at 3:24 PM, she stated if the medications had been pulled for administration and placed in a cup, and the resident was not available in order for medications to be administered, the medications should not be saved. Instead, they should be disposed of appropriately and this should be noted in the resident's. Further, the family and the physician should be notified. In continued interview, she stated when the resident returned to the facility, she expected staff to find out if the physician wanted the medications administered or held. In an interview with the Administrator, on 09/20/2024 at 11:18 AM, she stated it was her expectation staff made sure the resident was available before they pulled the resident's medications for administration. She stated if staff did inadvertently pull the medications for a resident that was out of the facility or busy at an activity, the medications should be thrown away. Further, she stated a cup of pills should not be placed back into the medication cart because the medications could get lost, forgotten, or given to another resident. 2. Observation on 09/18/2024 at 9:55 AM, of the medication refrigerator in the medication room on Hallway B, revealed there were eye drops and suppositories stored in the door of the refrigerator. There was a thermometer in the door with the medications and it read 43 degrees Fahrenheit. During an interview, on 09/18/2024 at 9:55 AM, RN4 stated medications should not be stored in the door of the refrigerator because there could be fluctuations in temperature causing them to loose their potency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32635 Based on observation, and interview, the facility failed to store food in accordance with professional standards for food service safety for three (3) of four (4) unit refrigerators used to store food for residents. Observation on 09/18/2024 of the resident nourishment refrigerators for the A-D, E, and F units, revealed ice packs stored in the freezer compartments. The findings include: Observation on 09/18/2024 at 9:18 AM, of the E unit resident nourishment refrigerator, revealed five (5) ice packs in the freezer stored along with one (1) mesh bag of popsicles, one (1) box of popsicles, and one (1) frozen sweet and sour chicken dinner. Observation on 09/18/2024 at 9:22 AM, of the F unit resident nourishment refrigerator, revealed eight (8) ice packs stored in the freezer. Observation on 09/18/2024 at 9:42 AM, of the A-D unit resident nourishment refrigerator, revealed three (3) ice packs stored along with one (1) popsicle. During an interview, on 09/20/2024 at 10:33 AM, with Unit Manager1 for the A-D unit, he stated ice packs were to be stored in the medication refrigerators and not in the resident nourishment refrigerators. He stated storing the ice packs in the resident nourishment refrigerators could lead to cross-contamination with food. In an interview with Unit Manager2 for B, E, and F units, on 09/20/2024 at 12:00 PM, he stated the ice packs should not be stored in the resident nourishment refrigerators as this was an infection control issue. He further stated the ice packs should be stored in the medication refrigerators. During an interview with the Administrator, on 09/20/2024 at 2:09 PM, she stated the ice packs were used to keep applesauce, supplements, and pudding cold on the medication cart. She further stated the ice packs should be stored in the medication room refrigerators.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50442 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and helped prevent the development and transmission of communicable diseases and infections for five (5) of seven (7) sampled residents reviewed for infection control out of a total sample of 25 residents, Resident (R)2, R51, R78, R83, R340. Observation on 09/19/2024 at 8:45 AM, revealed Registered Nurse (RN)2 entered R2's room without donning proper Personal Protective Equipment (PPE) while the resident was in enhanced barrier precautions (EBP). RN2 provided direct contact resident care by obtaining R2's vital signs. RN2 then exited R2's room with the blood pressure machine, and failed to sanitize the machine. Additionally, observation on 09/19/2024 at 8:51 AM, revealed the Minimum Data Set (MDS)/Infection Prevention (IP) Nurse, and the Admission Coordinator (AC) entered R2's EBP room without donning proper PPE and shut the door. In an interview, the nurses stated they had provided direct contact resident care without the proper PPE. Observation of medication pass, on 09/18/2024, revealed Certified Medication Technician (CMT)3 dropped R78's pill onto the top of the medication cart, picked up the pill with her ungloved hand, placed the pill in the cup with the other medications, and administered the cup of pills to the resident. Observation on 09/18/2024, revealed RN2 failed to sanitize the blood pressure machine after using it on R83, and before using it on R51. Observation on 09/18/2024, revealed RN3 failed to sanitize the blood pressure machine after using it on R340. The findings include: 1. Review of R2's Face Sheet located in the Electronic Medical Record (EMR) revealed the facility admitted the resident on 03/28/2013 with diagnoses including dementia, cerebral infarction, and major depressive disorder. Review of R2's Physician's Orders, dated 07/23/2024, revealed orders for Enhanced Barrier Precautions related to Suprapubic catheter use. Observation on 09/19/2024 at 8:45 AM, revealed Enhanced Barrier Protection (EBP) signage posted on R2's door (Room E9). There was Personal Protective Equipment (PPE) outside the door to include gloves and gowns. RN2 entered the room without donning gloves or gown. RN2 was then observed to bring a blood pressure machine out of R2's room. RN2 failed to sanitize the machine before taking it down the hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview, on 09/19/2024 at 9:21 AM, with RN2, he stated the EBP signage meant that he should wear gloves when providing direct resident care for R2. He stated he had obtained R2's vital signs with the blood pressure machine which was considered direct resident care. In further interview, he stated the blood pressure machine he used for obtaining R2's vital signs should have been disinfected with bleach wipes after use. 2. Observation on 09/19/2024 at 8:51 AM, revealed Enhanced Barrier Protection (EBP) signage posted on R2's door (Room E9). The Minimum Data Set (MDS)/Infection Prevention (IP) Nurse, and the Admission Coordinator (AC) entered R2's room without donning PPE and closed the door. Upon exiting the room, the MDS/IP Nurse and the AC were interviewed and questioned about the care they were providing in Room E9. The MDS/IP Nurse stated they were pulling R2 up in the bed and emptying his catheter. When asked what the signage on the door meant, the MDS/IP nurse and the AC both stated they should have donned a gown and gloves prior to entering the room and providing resident care. 3. Observation of medication pass, on 09/18/2024 at 9:07 AM, revealed Certified Medication Technician (CMT)3 dropped a pill for R78 onto the top of the medication cart. CMT3 picked up the pill with her ungloved hand, placed the pill in the cup with the other medications, and administered the cup of pills to the resident. In an interview, on 09/18/2024 at 9:07 AM, with CMT3, she stated R78's pill fell on to the medication cart and should not have been picked up and placed with the rest of R78's medications for administration due to infection control reasons. During an interview, on 09/20/2024 at 8:56 AM, Unit Manager (UM)2 stated any pill dropped on the medication cart should be discarded. Additionally, UM2 stated if a resident was in EBP, staff should don a gown and gloves prior to entering the resident's room to provide direct resident care. UM2 defined direct resident care as care that involved touching the resident and stated delivering a meal tray or water was not considered direct resident care. In an interview, with the Assistant Director of Nursing (ADON), on 09/20/2024 at 9:24 AM, he stated he expected anyone administering a medication to dispose of any pills that had been dropped. He further stated he expected PPE (gown and gloves) to be donned when staff was performing direct resident care for a resident with EBP orders. He clarified that pulling a resident up in bed or emptying a catheter was considered direct resident care, but delivering water, a meal tray, or answering a resident's question was not be considered direct resident contact. In an interview, on 09/19/2024 at 3:24 PM, with the Director of Nursing (DON), she stated staff should dispose of any pills that were dropped on the medication cart. Additionally, she stated when staff saw an EBP sign on a resident's door, they should view it as a stop sign. It should alert staff the resident had a wound or a portal for infection such as a catheter, feeding tube, or intravenous (IV) catheter. Per interview, staff was expected to perform hand hygiene and put on a gown and gloves prior to entering the resident's room with EBP signage to provide care. She stated staff had received multiple training sessions related to EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Administrator, on 09/20/2024 at 11:18 AM, she stated if staff dropped a pill on the medication cart, she would expect the staff member to discard the pill. In further interview, the Administrator stated she expected staff to read and adhere to the signage for EBP. This meant that if staff was providing hands on care, they should don PPE. The PPE needed was a gown and gloves for EBP. 4. Observation on 09/18/2024 at 8:13 AM, revealed RN2 obtained vital signs on R83 using the blood pressure (B/P) machine, and then administered R83's medications. RN2 failed to sanitize the B/P machine before taking it into R51's room and using it to obtain vital signs on R51. Afterwards, RN2 again failed to sanitize the B/P machine, and left it in the hallway. In an interview on 09/19/2024 at 9:21 AM, with RN2, he stated the blood pressure machine should be sanitized after use and between residents. 5. Observation on 09/18/2024 at 9:19 AM, revealed RN3 took the blood pressure machine into R340's room to obtain her vital signs. RN3 failed to sanitize the blood pressure machine afterward. In an interview with RN3, on 09/18/2024 at 9:19 AM, she stated the blood pressure machine should be sanitized after use, and before using it on another resident.