STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185456	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Place	3526 Dutchmans Lane Louisville, KY 40205

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44974 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for one (1) of twenty-three (23) sampled residents (Resident #79). Resident #79 had outpatient surgery on 01/22/2024, to change his/her gastrostomy tube (g-tube) to a jejunostomy tube. However, upon return to the facility after the outpatient surgery, the facility failed to revise Resident #79's care plan to reflect the changes in his/her feeding tube. The findings include: Review of the facility policy titled, Care Plan Revisions Upon Status Change undated, revealed the purpose of the policy was to provide a consistent process for reviewing and revising the care plan for residents experiencing a status change. Further review revealed the Minimum Data Set (MDS) Coordinator and the Interdisciplinary Team (IDT) were to discuss the resident's condition and collaborate on intervention options. In addition, the care plan was to be updated with new or modified interventions. Review of the Admission record for Resident #79 revealed the facility admitted the resident on 05/24/2023, with diagnoses that included Dysphagia (inability to swallow) following a Cerebrovascular Accident, Gastrostomy tube placement, Acute Respiratory Failure with Hypoxia, and aspiration. Review of Resident #79's Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of (00) which indicated severe cognitive impairment. Review of Resident #79's medical record revealed since his/her original admission on 03/22/2023, the resident experienced three (3) hospitalization s. Per review, those hospitalization s were: on 06/23/2023 for aspiration pneumonia; on 08/24/2023 after sustaining a fall; and on 11/30/2023 for aspiration Pneumonia. Continued record review revealed on 01/22/2024, Resident #79 had an outpatient procedure performed to replace his/her g-tube (a feeding tube in the stomach) for a jejunostomy tube (a feeding tube inserted into the small intestine). (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #79's Care Plan revealed no documented evidence the facility revised the care plan regarding the resident's g-tube being changed to a jejunostomy tube on 01/22/2024. Review of Resident #79's Care Plan revealed a focus initiated on 03/22/2023, for the resident as at risk for complications due to his/her Dysphagia diagnosis and being on tube feeding, and being NPO (nothing by mouth). Per review of the focus related to the resident's risk for complications, revealed the goal was for the resident to remain free of complications related to tube feeding. Continued review revealed the focus was revised on 07/05/2023, to include Resident #79's being on bolus g-tube feedings which had been started on 06/27/2023. Further review revealed the care plan interventions included: checking for tube placement and gastric contents/residual volume per the facility's protocol; recording and documenting abnormal findings and notifying the physician; elevating the head of his/her bed during and for thirty (30) minutes after administering his/her tube feeding; providing local care to the g-tube site as ordered; and observing for signs or symptoms of infection. Review of Resident #79's Physician Orders dated 01/22/2024, revealed the current orders for the resident's Jejunostomy tube (enteral) feeding order. Continued review revealed Resident #79 was to receive Two Cal 2. 0 (a nutritionally complete, high-calorie formula) at thirty (30) milliliters (mls) per hour continuously tor a total volume of 720 mls over twenty-four (24) hours. During an interview on 02/09/2024 at 7:30 PM, the Resident Assessment Instrument (RAI) Coordinator stated the facility had recently hired two (2) new MDS who were in training at that time. She stated the purpose of residents' Care Plans was to guide staff in caring for the resident and his/her needs. The RAI Coordinator stated the admitting nurse was responsible for initiating a new resident's baseline care plan. She stated the baseline care plan was to be generated within the first forty-eight (48) hours of the new resident's admission. The RAI Coordinator stated if revisions were required with order changes, functional changes, or any other change the Unit Managers (UM), Floor Nurses, Executive Director (ED) and/or Director of Nursing (DON) could update the resident's Care Plan. She stated although it was usually the Unit Manager or the Assistant Director of Nursing (ADON) who revised residents' Care Plans. The RAI Coordinator stated the expectations were for residents' Care Plans to be revised as quickly as possible; however, she stated a resident's care plan did not direct his/her care it was only a guide. She further stated staff should always look at the resident's Kardex and orders, and any communicate any changes during the shift change report. In addition, the RAI Coordinator stated if a resident's Care Plan was not revised with necessary interventions incidents could occur. She further stated that the care plan should have been revised and updated with the changes for Resident #79 in order to provide appropriate treatment. During an interview with the Executive Director (ED) on 02/09/2024 at 7:50 PM, she stated her expectation was for care plans to be revised as soon as possible when necessary, to ensure appropriate care was provided to meet the residents' needs. The ED further stated that Resident #79's care plan should have been updated as soon as possible with the changes in the resident's status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 02/09/2024 at 9:15 PM, she stated her expectation was care plans to be updated/revised as soon as possible when necessary to direct the care being provided to meet the residents' needs. She stated revisions to care plans were completed during the facility's morning meetings after reviewing residents' order changes. The DON stated oversight was provided by checking charts for necessary revisions/updates to residents' care plans by the Interdisciplinary Team (IDT) members during their meetings. She further stated the IDT members included herself, the ED, ADON, the Registered Dietician (RD), Unit Managers (UM), MDS staff, and therapy department staff. The DON further stated Resident #79's care plan should have been updated with changes immediately following the resident's change in status.