

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/04/2025
NAME OF PROVIDER OR SUPPLIER Seneca Place		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 Dutchman's 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview, record review, and review of facility documents and policy, the facility failed to resolve a grievance related to a missing item in a timely manner for 1 of 3 residents (Resident (R) 83) reviewed for personal property. The findings included: Review of facility policy, Grievances, effective 10/01/2024, revealed 3. Definitions 'Prompt efforts to resolve include facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance. The policy specified, G. In accordance with the resident's/patient's right to obtain a written decision regarding the grievance, the Grievance Official will issue a written decision on the grievance to the resident/patient or representative at the conclusion of the investigation. The written decision will include at a minimum the date received, steps taken to investigate, summary of findings, statement of confirmation or non-confirmation, corrective actions, and the date of decision. Review of facility admission Record revealed the facility admitted Resident #83 on 09/23/2024. According to the admission Record, the resident had a medical history that included a diagnosis of moderate, recurrent, major depressive disorder. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/10/2025, revealed Resident #83 had adequate hearing, clear speech, was able to express their ideas and wants, and had clear comprehension. The MDS revealed the facility assessed Resident #83 with a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Review of Resident #83's Care Plan Report included a focus area, initiated on 12/20/2024, that indicated the resident exhibited signs of cognitive impairment related to their BIMS score. Interventions directed staff to encourage and support the resident's family to bring in familiar items that the resident recognized to promote security in the environment (initiated 12/20/2024). Review of facility form, Inventory of Resident's Belongings, dated 09/24/2024, revealed Resident #83's list of personal belongings included a cell phone. Review of facility document, Report of Concern, dated 10/18/2024, revealed Family Member (FM) #6 filed a grievance regarding Resident #83's missing cell phone. A Report of Concern section titled, Follow Up/Resolution, indicated, Corrective Action Taken: Conduct facility search. Family refused to have phone replaced. The report indicated the grievance was confirmed and status of Resolved/Satisfied. The Report of Concern revealed the complainant was notified on 10/18/2024, but there was no signature for the complainant or the resident to validate notification. The report was signed off on 10/19/2024 by responsible staff, namely the Social Services Director (SSD). During a telephone interview on 07/02/2025 at 1:59 PM, FM #6 stated Resident #83 had a cell phone on admission to the facility, but it disappeared. FM #6 stated they purchased another cell phone for Resident #83, which cost \$800.00, and that one also went missing. FM #6 stated \$345.00 was still owed on the resident's first phone, so the family provided Resident #83 with another family member's old phone. FM #6 confirmed they spoke with the SSD regarding the missing cell phone but stated the SSD did nothing and acted like she did not care. During an interview on 07/03/2025 at 11:07 AM, the SSD stated she recalled Resident #83 reported a missing cell phone charger the prior year, and it was immediately replaced. The SSD stated she was not aware of a missing cell phone. During a follow up telephone interview on 07/03/2025 at 11:36 AM, the facility's documentation of satisfactory grievance resolution was discussed with FM #6. FM #6 repeated that they told the facility about the missing phone and nothing was done about it. FM #6 denied they had any conversations with the facility regarding a resolution of the grievance and stated they would never have refused an offer to replace the cell phone. During a follow up interview on 07/04/2025 at 10:43 AM, the SSD recalled she spoke with Resident #83's family member regarding the missing cell phone, but the family member refused the facility's offer to replace the cell phone. During an interview on 07/04/2025 at 10:45 AM, the Director of Nursing (DON) stated she was aware Resident #83's phone was missing, noting it was discussed by the team. The DON stated her expectation was that the facility's policy would be followed, and there should be documentation such as a signature from the resident's family member to acknowledge or approve the facility's grievance resolution. During an interview on 07/04/2025 at 11:10 AM, the Executive Director (ED) stated that all grievances should be filed, reviewed, and followed up with a resolution. The ED confirmed the person who filed a grievance should sign off as acknowledgement or agreement regarding the resolution.</p>		