STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185462	A. Building B. Wing	07/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Terrace Health Campus	9700 Stonestreet Road Louisville, KY 40272

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 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. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide showers to residents who required assistance with their activities of daily living (ADLs), for 2 of 13 residents sampled for ADL care (Resident (R)96 and R100).The findings include:1. Review of the Resident Face Sheet for R96 revealed the facility admitted the resident on 08/09/2024, with a diagnosis of end stage renal disease. Further review revealed the facility discharged R96 on 09/15/2024. Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 08/15/2024, revealed the facility assessed R96 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. Further review revealed the facility assessed R96 to require substantial/maximal assistance with showering/bathing.Review of R96's Care Plan initiated 08/12/2024, the facility developed a Profile Care Guide for R96, to communicate the resident's care needs. Continued review revealed the interventions included staff to provide R96 a shower on Tuesdays and Fridays during the second shift.Review of the facility's shower/bath history report for R96, for the timeframe of 08/09/2024 through 08/31/2024, revealed no documented evidence the resident received a shower, bath, or bed bath from 08/15/2024 through 08/22/2024, a total of eight days. Continued review of the facility's shower/bath history report for R96, for the timeframe from 09/01/2024 through 09/13/2024, revealed staff documented the resident did not receive a shower, bath, or bed bath from 09/07/2024 through 09/12/2024, a total of six days.During interview on 07/18/2025 at 10:43 AM, Certified Resident Care Associate (CRCA) 5 stated she did not recall R96. She reported residents had scheduled showers based on their room numbers, and showers were provided twice a week.2. Review of the Resident Face Sheet for R100 revealed the facility admitted the resident on 04/22/2025, with a diagnosis of displaced intertrochanteric left femur fracture. Further review revealed the facility discharged R100 on 05/14/2025. Review of the admission MDS Assessment, with an ARD of 04/28/2025, revealed the facility assessed R100 to have a BIMS score of 12, which indicated moderate cognitive impairment. Further review revealed the facility assessed R100 to require substantial/maximal assistance with showering/bathing.Review of R100's Care Plan revealed a problem statement initiated 04/23/2025, which indicated the resident required staff assistance to complete safe-care and mobility functional tasks completely and safety. Further review revealed no documented evidence of how often R100 was to be provided showers/baths or when the showers/baths were to be performed.Review of R100's Resident Progress Notes dated 05/04/2025 at 10:34 PM, revealed a family member of the resident inquired about when the last time the resident was given a shower.Review of the facility's shower/bath history report for R100, for the timeframe of 04/22/2025 through 05/14/2025 , revealed no documented evidence the resident was provided a shower, bath, or bed bath from 04/23/2025 through 04/27/2025, a total of five days; or from 05/06/2025 through 05/12/2025, a total of seven days.During interview on 07/19/2025 at 10:05 AM, the Director of Health Services (DHS) Float, the facility's former DHS, stated resident showers were scheduled to be given twice a week unless the resident wanted to have a shower more frequently. The DHS Float said a bed bath was offered as an alternative to a shower. The DHS Float stated bathing documentation was documented in the resident's electronic health record. The DHS Float further stated if a resident went six or eight days with no bathing activity, she expected a refusal to be documented. The DHS Float additionally said going six to eight days without a shower did not meet the facility's expectations.During interview on 07/19/2025 at 11:19 AM, the Executive Director (ED) stated a resident going six to eight days without bathing would not meet the facility's expectations. The ED further stated however, there could be extenuating circumstances, like being sent out to a hospital or refusals as to why there would be no documentation of bathing.Based on interview and record review, the facility failed to provide showers to residents who required assistance with their activities of daily living (ADLs), which affected 2 (Resident #96 and Resident #100) of 13 residents reviewed for ADL care. Findings included: (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A “Resident Face Sheet” revealed the facility admitted Resident #96 on 08/09/2024. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of end stage renal disease. The Resident Face Sheet indicated the facility discharged the resident on 09/15/2024. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/15/2024, revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident required substantial/maximal assistance with showering/bathing. Resident #96's “Care Plan” initiated 08/12/2024, indicated the resident had a “Profile Care Guide” to communicate resident care needs. Interventions directed staff to provide the resident a shower on Tuesdays and Fridays during the second shift (initiated 08/12/2024). Resident #96’s shower/bath history report, for the timeframe from 08/09/2024 through 08/31/2024, revealed no documented evidence the resident received a shower, bath, or bed bath from 08/15/2024 through 08/22/2024, a total of eight days. Resident #96’s shower/bath history report, for the timeframe from 09/01/2024 through 09/13/2024, revealed staff documented the resident did not receive a shower, bath, or bed bath from 09/07/2024 through 09/12/2024, a total of six days. During an interview on 07/18/2025 at 10:43 AM, Certified Resident Care Associate #5 stated she did not recall Resident #96, residents had scheduled showers based on their room numbers, and showers were provided twice a week. 2. A “Resident Face Sheet” indicated the facility admitted Resident #100 on 04/22/2025. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of displaced intertrochanteric left femur fracture. The Resident Face Sheet indicated the facility discharged the resident on 05/14/2025. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/28/2025, revealed Resident #100 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial/maximal assistance with showering/bathing. Resident #100’s “Care Plan” included a problem statement initiated 04/23/2025, that indicated the resident required staff assistance to complete safe-care and mobility functional tasks completely and safety. The Care Plan revealed it did not include how often or when the resident was to be provided with showers/baths. Resident #100’s “Resident Progress Notes” dated 05/04/2025 at 10:34 PM, that indicated a family member of the resident inquired about when the last time the resident was given a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #100’s shower/bath history report, for the timeframe from 04/22/2025 through 05/14/2025 , revealed no documented evidence the resident was provided a shower, bath, or bed bath from 04/23/2025 through 04/27/2025, a total of five days; or from 05/06/2025 through 05/12/2025, a total of seven days. During an interview on 07/19/2025 at 10:05 AM, the Director of Health Services (DHS) Float, the facility’s former DHS, stated resident showers were scheduled to be given twice a week unless the resident wanted to have a shower more frequently. The DHS Float stated a bed bath was offered as an alternative to a shower. The DHS Float stated that bathing documentation was documented in the resident’s electronic health record. According to the DHS Float, if a resident went six or eight days with no bathing activity, she expected a refusal to be documented. The DHS Float stated that generally going six to eight days without a shower did not meet expectations. During an interview on 07/19/2025 at 11:19 AM, the Executive Director stated that a resident going six to eight days without bathing would not meet expectations, but there could be extenuating circumstances, like being sent out to a hospital or refusals.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility policy review, and review of the insulin pen instruction manual, the facility failed to ensure a medication error rate was not 5 percent (%) or greater for 1 of 4 residents observed during the medication administration task, (Resident (R)89).The findings include:Review of the facility policy titled, Medication Administration- General Guidelines, revised 11/2018, revealed medication were to be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Further review of the policy revealed under the Procedures was included the FIVE RIGHTS- Right resident, right drug, right dose, right route and right time were applied for each medication being administered.Review of the Instructions for Use Lantus Solostar instruction manual, revised 12/01/2021, revealed under, Step 3: Perform a safety test, which noted to always perform the safety test before each injection. Per review, doing that ensured you get an accurate dose by, including ensuring the pen and needle work properly, and removing air bubbles. Per review of the manual revealed to select a dose of 2 units by turning the dosage selector clockwise, and take off the outer needle cap and keep it to remove the used needle after injection. Continued review revealed to take off the inner cap and discard it, hold the pen with the needle pointing upwards, tap the insulin reservoir so that any air bubbles rise up towards the needle, and press the injection button all the way in. Check if insulin comes out of the needle tip. The instructions indicated, You must perform safety tests before you use the pen until you see insulin coming out of the needle tip. If you see insulin coming out of the needle tip, the pen was ready to use. Further review revealed if insulin was not seen coming out before taking a dose, you could get an underdose or no insulin at all. This could cause high blood sugar.Review of the Instructions for Use Humalog [NAME] KwikPen insulin lispro (100 units/mL [milliliter], 3mL pen) instruction manual, revised 03/31/2020, revealed, priming the pen was to be done before each injection. Per review, priming the pen meant removing air from the needle and cartridge that might collect during normal use. Per review, it was important to prime the pen so that it would work correctly, and if you do not prime the pen before each injection, you may get too much or too little insulin. Continued review of the manual revealed, Step 5: To prime your Pen, turn the Dose Knob to select 2 units. Step 6: Hold your Pen with the Needle pointing up. Tap the Cartridge holder gently to collect air bubbles at the top. Step 7: Continue holding your Pen with the Needle pointing up. Further review revealed to push the Dose Knob in until it stopped, and '0' was seen in the Dose Window, the hold the Dose Knob in and count to 5 slowly. Additionally review revealed You should see insulin at the tip of the needle.Review of the Resident Face Sheet for F89 revealed the facility admitted the resident on 06/26/2024, with a diagnosis of type 2 diabetes mellitus with hyperglycemia (high blood sugar).Review of the Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 04/21/2025, revealed the facility assessed R89 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. Further review of the MDS Assessment revealed the facility assessed R89 to receive insulin injections each day during the seven-day assessment period.Review of R89's Care Plan revealed the facility developed a problem statement initiated 06/27/2024, that indicated the resident was at risk for hypoglycemia (low blood sugar)/hyperglycemia related to diabetes mellitus. Further review revealed the interventions included staff to administer the resident's medications as ordered (initiated 06/27/2024). Review of R89's Physician Order Report, for the timeframe of 06/19/2025 through 07/19/2025, revealed an active order dated 01/242025, for Humalog [NAME] KwikPen U-100 insulin pen, with instructions to inject 3 units subcutaneously before meals,. Further review of the Physician Order Report revealed an order dated 01/24/2025, for Lantus Solostar U-100 insulin pen, with instructions to inject 25 units subcutaneously once a day.Observation, during medication administration, on 07/17/2025 at 5:51 AM, Registered Nurse (RN) 1 prepared R89's medications, to include Humalog [NAME] KwikPen insulin pen and a Lantus Solostar insulin pen. Per observation, RN 1 selected a dose of 3 units on the Humalog [NAME] KwikPen insulin pen and administered the medication to the resident. Continued observation revealed RN 1 selected a dose of 25 units on the Lantus Solostar insulin pen and administered the medication to the resident. Further observation revealed RN 1 did not complete the safety test for the Lantus Solostar insulin pen as specified by the manufacturer and also did not prime the needle for the Humalog [NAME] KwikPen as specified by the manufacturer prior to administering the medications. (The two medication errors out of the 26 opportunities, resulted in a 7.69% medication error for R89) During interview on 07/17/2025 at 7:01 AM, RN 1 stated she