STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185333	A. Building B. Wing	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Klondike Nursing and Rehabilitation Center	3802 Klondike Lane Louisville, KY 40218

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 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** 34116 Based on interview, record review, and facility policy review it was determined the facility failed to ensure advance directives were in the clinical record for two (2) of thirty-seven (37) sampled residents, Resident #10 and #45. The findings include: 1. Review of facility policy, Health Care Decision Making, revised [DATE], revealed it was the right of all patients to participate in their own health care decision-making, which included the right to decide whether they wish to request, accept, refuse, or discontinue treatment, and to formulate or not formulate an advance directive. The purpose of the policy was to assure the patients' wishes concerning health care decisions were communicated to all staff so patients' rights were honored and their wishes executed at the appropriate time. The policy revealed a copy of the advance directive and/or portable medical orders were placed in the medical record upon admission and the inter-professional team would be notified of the directive. If the patient/resident representative had not brought the document(s) to the Center, the Center Admissions Designee would advise the patient/resident representative that wishes would not be honored without a copy in the medical record and would request the patient/resident representative bring the document(s) to the Center as soon as possible. Review of the clinical record revealed the facility admitted Resident #45 on [DATE] with diagnoses including Atherosclerotic Heart Disease of Native Coronary Artery, Hypertension, Spinal Stenosis, Type 2 Diabetes Mellitus, and Dysphagia. Review of the Physician Orders revealed a Do Not Resuscitate (DNR) order, dated [DATE]. Further review of the clinical record revealed no advance directive. The facility did not provide a copy of Resident #45's advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Unit Manager (UM) for South Hall, on [DATE] at 3:00 PM, revealed the admission nurse and UM were responsible for ensuring a copy of the advance directive was in the clinical record and an order entered in the electronic record. The UM revealed she did not audit Resident #45's admission records to verify the clinical record was complete. According to the UM, the Director of Nursing (DON) and Minimum Data Set (MDS) Coordinator audited charts during the morning meeting and notified UM's if records were missing, including the advance directive. She stated the clinical record should include a copy of Resident #45's advance directive to ensure the resident's wishes were respected; however, he/she would be considered a Full Code until there was a directive on the chart. Interview with the Social Services Director (SSD), on [DATE] at 3:40 PM, revealed the Admissions Director was responsible for ensuring a copy of Resident #45's advance directive was in the clinical record. She stated the interdisciplinary team (IDT) also reviewed advance directives during care plan meetings with the resident/responsible party. According to the SSD, the advance directive was a legal document that communicated the resident's wishes for code status. Interview with the Admissions Director (AD), on [DATE] at 9:29 AM, revealed she obtained the consent for code status/advance directive upon admission. She stated after the resident signed a DNR consent, she scanned the document to the electronic record and gave the consent to the DON for the physician's signature. The AD further revealed Medical Records was responsible for ensuring the signed consent was placed in the clinical record. The AD revealed she did not obtain an advance directive for Resident #45. Interview with the Assistant Director of Nursing (ADON), on [DATE] at 4:08 PM, revealed the Admissions Director was responsible for obtaining advance directive/consent during the admission process and ensuring the directive was filed in the chart. She further revealed UM's were responsible for audits of the clinical record to ensure accuracy of the physician orders and admission assessment. Interview with the DON, on [DATE] at 6:35 PM, revealed the Admissions Director was responsible for initiating the advance directive and the SSD was supposed to follow-up on it. The DON further revealed she audited admission orders during the daily clinical meeting and stated the IDT reviewed advance directives during care plan meetings to verify accuracy. The DON revealed Resident #45's DNR order was from a previous admission in 2017. Interview with the Administrator, on [DATE] at 7:41 PM, revealed he had not identified any issues related to advance directives. 15879 2. Review of the clinical record for Resident #10 revealed the facility admitted the resident on [DATE] with diagnoses including Quadriplegia, Diabetes Mellitus, Contractures, Pressure Ulcers, and Hypertension. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed the facility assessed Resident #10 with a Brief Interview for Mental Status (BIMS) exam score of fifteen (15) and determined the resident was interviewable. Interview with Resident #10, on [DATE] at 2:44 PM, revealed the resident completed an advance directive and supplied the facility with a copy. (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 the advance directive section of the clinical record revealed no advance directive in the chart. Review of the physician orders revealed Resident #10 was a full code. Review of the Nurse Practitioner progress notes dated [DATE] revealed facility staff were to attempt resuscitation or cardiopulmonary resuscitation (CPR) on Resident #10. Interview with the Assistant Director of Nursing (ADON), on [DATE] at 8:50 AM, revealed Resident #10 did not have an advance directive on file.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34116 Based on observation, interview, and facility policy review it was determined the facility failed to ensure a homelike environment for one (1) of thirty-seven (37) sampled residents, Resident #25. The plastic covering on Resident #25's over bed table was partially peeled off and exposed bare particle board surface underneath. In addition, observations of the Resident's smoking area revealed an unkept area containing cigarette butts and trash. The findings include: 1. Review of the facility's Resident Rights revealed the resident had the right to receive treatment, care, and services in an environment that promoted maintenance or enhancement of each resident's quality of life. Observation of Resident #25's room, on 09/03/19 at 2:50 PM, revealed the brown plastic covering of the over bed table was torn and peeled away exposing a bare particle board surface. Interview with Resident #25, on 09/05/19 at 1:25 PM, revealed the over bed table needed to be replaced because he/she liked the house to look cute. Interview with Certified Nursing Assistant (CNA) #2, on 09/05/19 at 1:58 PM, revealed she had not noticed the torn up over bed table and stated the torn lamination was kind of sharp and could cut a residents skin. CNA #2 further revealed she liked everything in order at her house and did not consider the table homelike. Interview with the South Hall Unit Manager (UM), on 09/05/19 at 3:00 PM, revealed she performed walking rounds of the unit and had not noticed any issues with peeling plastic on the over bed tables. She stated it was important to ensure the tables were in good repair because it did not look nice and a resident could get skin tears. Interview with the Assistant Director of Nursing (ADON), on 09/06/19 at 4:08 PM, revealed she performed daily rounds of resident rooms to ensure they were clean. She stated she was not aware of any issues with peeling plastic on over bed tables and stated the missing plastic was an infection control issue. Interview with the Director of Nursing (DON), on 09/06/19 at 6:35 PM, revealed she attempted daily rounds of resident rooms but stated she was not aware of any issues with over bed tables. 38739 2. Review of Resident Rights revealed a resident had the right to receive treatment, care, and services that were in an environment that promoted, maintained or enhanced each resident's quality of life. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, on 09/03/19 at 1:30 PM, revealed a red metal container by the back gate at the back of the courtyard with flying insects that appeared to be wasps, entering and exiting the container. Observation, on 09/03/19 at 1:56 PM, revealed multiple residents attempted to enter/exit the smoking area/courtyard. Observations revealed residents unable to open the door or they became impinged with the door as they attempted to go through the door with a wheelchair. Further observation revealed a manually operated door. Observation, on 09/05/19 at 1:44 PM, revealed Resident #11 in the courtyard with a smoking bib present to his/her front chest and lap area. The apron contained multiple, large cracks to the front of the bib. Observation, on 09/03/19 at 2:09 PM, revealed Resident #16 attempted to open the door to the courtyard and failed. Continued observation revealed Resident #16 made multiple attempts while in a wheelchair to open the door and staff eventually assisted the resident through the door. Continued observations, on 09/05/19 at 1:45 PM, revealed the courtyard contained leaves and dry brush-like matter encircling the sides of the courtyard edge up to two (2) feet in width. The leaves and matter held old discarded cigarette butts, which contained too many to count throughout the three (3) sides of the courtyard. A red metal container was noted present and appeared approximately one-quarter (1/4) full. The courtyard contained six (6) large plastic rings, white paper, both thin and thick to all three (3) sides of the courtyard. Further observations revealed a green heavy plastic cover/awning, identified by residents who were in the courtyard as the cover they used when it rained. The cover/awning contained large tears and open areas on the top through which the sky was observed. In addition, a ceiling fan, under the cover, contained blades all broken in various degrees. Interview with Resident #25, on 09/03/19 at 1:56, revealed he/she sat out in the smoking area as much as possible. Resident #25 stated when it rained the cover did not protect him/her or other residents from the rain. Interview with the Maintenance Director, on 09/05/19 at 1:48 PM, revealed the Activity Director notified him when the facility required new smoking aprons and stated he was not required to inspect the aprons. He stated the facility last used a landscape company to clean the courtyard about three (3) months ago. He stated he observed the cigarette butts in the courtyard, mixed in among the dry leaves and debris, which could cause a fire. He further stated the area was not clean nor pleasant to look at. Interview with the Activity Director, on 09/05/19 at 2:23 PM, revealed staff changed the smoking aprons every so often. She stated the residents had complained about the condition of the cover/awning and they were not able to keep from being wet. She stated the cover/awning condition was discussed in resident council last month and a grievance form was completed. She stated the previous administrator stated he would have the cover/awning repaired but it never occurred. She stated she supervised residents in the courtyard when smoking and provided education to residents when she observed residents throwing cigarette butts to the ground. She further stated the courtyard contained a large amount of dry leaves and brush. Interview with the Assistant Director of Nursing (ADON), on 09/06/19 at 4:08 PM, revealed the courtyard was unattractive and a fire hazard with the cigarette butts in the leaves. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON), on 09/06/19 at 6:35 PM, revealed she was unaware of the holes with the cover/awning in the smoking area and stated her attention was not focused on the cover. She stated the facility cleaned the cigarette butts and stated she thought the cigarette butts blew out of the ash tray. The DON stated the courtyard currently looked better than before and she was unaware the fan blades were broken off under the cover in the courtyard. She stated maintenance staff were responsible to monitor the courtyard, and the equipment in the courtyard. She stated she knew Residents #6 and #25 regularly utilized the courtyard and sought protection under the cover/awning during rain. She stated it was important for residents to be outside. She further stated the facility previously discussed the condition in the courtyard and it was horrible to look at. Interview with the Center Executive Director, on 09/06/19 at 7:41 PM, revealed residents had approached him previously with complaints about the cover/awning. He stated the facility utilized a landscaping company for the courtyard which lacked obvious preventive maintenance.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 34116 Based on interview, record review, and review of the Centers for Medicare and Medicaid REsident Assiessment Instrument 3.0 Manual, it was determined the facility failed to ensure the discharge Minimum Data Set (MDS) was transmitted within fourteen (14) days of completion for one (1) of thirty-seven (37) sampled residents, Resident #1. The findings include: Review of the Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) 3.0 Manual, Chapter 5.2, dated October 2018, revealed the long-term care facility must transmit the MDS Discharge Assessment within fourtenn (14) days of the completion date. Review of the clinical record revealed the facility discharged Resident #1 on 03/28/19. Interview with the MDS Coordinator, on 09/06/19 at 3:47 PM, revealed Resident #1's discharge MDS assessment was not transmitted timely. According to the Coordinator, the discharge assessment did not appear on the transmit list because of an error. She revealed she audited MDS assessments of current residents to ensure they were transmitted; however, she did not audit the assessments of discharged residents. Interview with the Administrator, on 09/06/19 at 7:41 PM, revealed he was not aware of any issues related to timely submission of MDS assessments.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 42322 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to develop and implement a baseline care plan for one (1) of thirty-seven (37) sampled residents, Resident #3. Record review discovered no baseline care plan for Resident #3 initiated within forty-eight (48) hours of admission. The findings include: Review of facility policy, Person-Centered Care Plan, revised 07/01/19, revealed the center developed and implemented baseline, person-centered care plans within forty-eight (48) hours for each resident that included the instructions needed to provide effective and person-centered care that met professional standards of quality care. Review of the clinical record revealed the facility admitted Resident #3 on 03/30/19 with diagnoses to include Unspecified Dementia with Behavior Disturbances, Chronic Atrial Fibrillation, Cognitive Communication Deficit, Generalized Muscle Weakness, and Difficulty Walking. Review of the Minimum Data Set (MDS) Admission Assessment, dated 04/06/19, revealed Resident #3 needed extensive assistance with mobility, toileting, personal hygiene, and dressing. Resident received antipsychotic, antidepressant, and anticoagulant medications on seven (7) of the last seven (7) days, and Activities of Daily Living, Falls, Pressure Ulcers, Psychotropic Drug Use, and Urinary Incontinence were triggered care areas on the assessment. Review of care plans revealed the facility initiated a baseline care plan on 04/04/19, five (5) days after admission. Interview with the MDS Coordinator, on 09/06/19 at 4:11 PM, revealed the facility did not initiate the baseline care plan within forty-eight (48) hours. She referenced the care plan and was unable to explain why it was not completed timely nor did she know who was responsible for her duties in her absence. She stated she checked for admission orders daily to follow up with care plans and made any needed corrections. Interview with the Director of Nursing (DON), on 09/06/19 at 7:11 PM, revealed the admitting nurse initiated the baseline care plan upon the resident's admission, and the MDS Coordinator reviewed the care plan for needed corrections. She stated nursing staff audited charts nightly but did not document these audits.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observation, record review, and interview it was determined the facility failed to ensure a comprehensive care plan was implemented for three (3) of the thirty-seven (37) sampled residents, Residents #10, #37, and #45. Resident #45 did not have a nutrition care plan related to a therapeutic diet. In addition the facility failed to initiate a comprehensive care plan for an identified area to the right heel and the left foot under the little toe for Resident #10 and the call light for Resident #37 was not working. The findings include: 1. Record review of the facility policy titled, Skin Integrity Management revised 07/01/19, revealed staff should continually observe and monitor patients for changes and implement revisions to the plan of care as needed. The policy revealed the purpose of the policy was to provide safe and effective care to prevent the occurrence of pressure ulcers, manage the treatment, and promote healing of the wounds. The policy revealed a care plan should be developed and included prevention and treatment. Record review revealed the facility admitted Resident #10 on 06/07/17 with diagnoses of Quadriplegia, Contracture, Pressure Ulcer, Reflux, Hypertension, Obesity, Diabetes, Neuromuscular Dysfunction of the Bladder, and Colostomy. Record review of the annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/24/19, revealed Resident #10 had a Basic Interview for Mental Status (BIMS) of fifteen (15), which indicated the resident was interviewable. The MDS further revealed Resident #10 was totally dependent and needed the assist of one person for bed mobility, transfer, dressing, eating, toilet use, and bathing. The MDS further revealed Resident #10 had a limited range of motion (ROM) on both upper and lower extremities and had one (1) stage four (4) pressure ulcer to the coccyx. Record review of the comprehensive care plan revealed a problem was listed for actual skin breakdown related to a Stage IV pressure ulcer to the coccyx and left heel, not right heel. Interventions included evaluating the wound daily, including surrounding tissue and any presence of drainage. It further revealed if a new wound was discovered it was to be reported to the physician. Review of the care plan revealed the resident was to be monitored for signs and symptoms of skin breakdown, blistering, redness, and drainage. Weekly skin assessments were to be done and should have included measurements and descriptions of the wound. Positioning devices were to be utilized to prevent pressure. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Observation on 09/06/19 at 10:30 AM, during the wound assessment with Registered Nurse (RN) #1 and License Practical Nurse (LPN) #2 revealed Resident #10 was lying on a Dermaflow mattress and had black booties on both feet. LPN #1 moved the black boot from the left foot and the wound on the bottom of the left foot under the little toe stuck to the black boot and the boot had to be peeled away from Resident #10's foot. Observation revealed no bleeding was noted. Observation revealed the left black boot had dried white substance in it that had touched the area on the foot. Observation of the left foot on the bottom under the little toe revealed a nickel size red area with pink tissue surrounding. RN #1 wrapped the left foot with kerlix and put the dirty black boot back on the foot. Interview with RN #1 revealed the area under the toe was noted yesterday but they did not have an order for a treatment. RN #1 revealed she would call the physician to get an order. Interview further revealed since the skin was stuck to the boot it could cause a skin tear or infection to the wound. Observation, on 09/06/19 at 10:30 AM, of the right foot, revealed the black boot was removed and there was no bandage on the right heel. The black boot on the right foot had white dried material in it that was directly on the heel wound. The area to the right heel was approximately silver dollar size. Interview with RN #1 revealed the dark area to the right heel was unstageable and looked like a deep tissue wound to her. Observation with the Wound Nurse, on 09/06/19 at 4:30 PM, revealed Resident #10's feet had black booties on them and they were wrapped in kerlix. Observation further revealed she removed the kerlix from the left foot and removed the kerlix and dressing from the right heel and the dressing to the heel stuck to the wound. Interview during the observation with the Wound Nurse, on 09/06/19 at 4:30 PM, revealed the pressure area on the left foot under the little toe should have been reported to the physician and treatment should have been obtained when it was first noted. She revealed Resident #10 was diabetic and at risk for pressure sore formation and infection. She further revealed the area under to left foot looked like something had pressed against it causing pressure. She stated the area was blanchable and probably a Stage one (1) or Stage two (2) pressure area. She revealed it was not a blister area and it looked like it may open. Interview with the Wound Nurse, on 09/06/19 at 4:45 PM, revealed a care plan should have been initiated for the right heel and the left foot. Interview with the Minimum Data Set (MDS) Coordinator LPN on 09/06/19 at 5:00 PM revealed she was not aware of any wound areas to the right heel or to the left foot under the little toe. She revealed if Resident #10 had a new area it would have been discussed at the morning meetings and she was not aware of any discussion about the new wound areas. She stated if they had discussed the heel and new area to Resident #10's feet she would have double checked the comprehensive care plan and if it had not been updated she would have updated it. The MDS Coordinator further revealed a care plan should have been initiated for the right heel and the left foot under the toe because the care plan directs the care for the resident. The MDS Coordinator reviewed the current comprehensive care plan and revealed a problem for the new skin issues had not been addressed. She further stated that any of the nursing staff could update or intiate a care plan. Interview with the Director of Nursing (DON), on 09/06/19 at 7:31 PM, revealed the area on Resident #10's right heel had been brought up at the clinical meeting on Tuesday morning and her and the MDS coordinator updated the care plan at that time to reflect the area. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview on 09/06/19 at 2:36 PM, with the Administrator, revealed he expected the staff to follow the policy and he monitored the staff by following policy. He revealed his main tool was quality assessment and observations. 34116 2. Review of the policy Person-Centered Care Plan, revised 07/01/19, revealed a comprehensive person-centered care plan must be developed for each patient and must describe services that were to be furnished; any services that would otherwise be required but were not provided due to the patient's exercise of rights, including the right to refuse treatment; any specialized services or specialized rehabilitative services the Center would provide as a result of PASRR recommendations; and in consultation with the patient and the resident representative(s), goals for admission and desired outcomes, preference and potential for future discharge, and discharge plan, as appropriate. Observation, on 09/04/19 at 11:41 AM, revealed a water pitcher and straw on Resident #45's over bed table. Observation, on 09/05/19 at 8:49 AM, revealed Resident #45 seated in bed eating breakfast served with regular, thin consistency orange juice and coffee. Review of the clinical record revealed the facility admitted Resident #45 on 07/17/19 with diagnoses to include Type 2 Diabetes Mellitus, Dysphagia, and Cognitive Communication Deficit. Review of the Care Plan for nutritional risk revealed goals of the plan included adequate swallowing as evidenced by no choking. Interventions included providing a regular liberalized diet with ground meat and nectar thick liquids as ordered; and no water pitcher at bedside. Interview with Certified Nursing Assistant (CNA) #2, on 09/05/19 at 8:58 AM, revealed she served Resident #45 thin liquids for breakfast. Interview, on 09/05/19 at 3:00 PM, with the Unit Manager (UM) for South Hall revealed Resident #45 was prescribed a therapeutic diet with nectar thick liquids and should not have a water pitcher in the room. Interview with the Assistant Director of Nursing (ADON), on 09/06/19 at 4:08 PM, revealed the purpose of the care plan was to ensure proper care to meet resident needs. The ADON revealed Resident #45's care plan for nutritional risk was not implemented related to the therapeutic diet and fluid consistency. Interview with the Director of Nursing (DON), on 09/06/19 at 6:35 PM, revealed CNA's and nurses were responsible for ensuring residents were served the correct therapeutic diet and liquids. She further revealed nurses were responsible for ensuring CNA's provided water pitchers to the appropriate residents according to the therapeutic diet. Interview with the Administrator, on 09/06/19 at 7:41 PM, revealed the facility had not identified any issues related to implementation of care plans. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	3. Observation, on 09/03/19 at 2:55 PM, revealed Resident #37 lying on his/her right side at the edge of the bed and the call light attached to the left 1/4 rail located behind the resident. Interview during observation revealed the resident had a bowel movement in his/her brief and could not reach the call light. Further observation of Resident #37, on 09/03/19 at 3:41 PM, revealed the resident's call light was missing the red push button and not functional. Interview with the resident during observation revealed the call light had been broken for a long time. Interview with CNA #1, on 09/03/19 at 3:42 PM, during observation of Resident #37 revealed she gave the resident the call light after incontinent care but had not noticed it was broken. Review of the clinical record revealed the facility admitted Resident #37 on 10/15/18 with diagnoses to include Mild Intellectual Disabilities, Alzheimer's Disease, and Hypertension. Review of the Brief Interview for Mental Status (BIMS) exam, dated 08/05/19, revealed the facility assessed the resident with a total score of 10 out of 15 and determined he/she was interviewable. Review of the annual Minimum Data Set (MDS), dated [DATE], revealed Resident #37 was totally dependent upon staff for bed mobility and toileting. Review of the Resident #37's Care Plan for Fall Risk, revised 05/01/19, revealed the resident had a history of falls prior to admission. Interventions included placing the call light within reach while in bed or close proximity to the bed. Interview with the South Hall Unit Manager (UM), on 09/05/19 at 3:00 PM, The UM further revealed Resident #37's fall risk care plan was not implemented related to the call light access. Interview with the ADON, on 09/06/19 at 4:08 PM, revealed the purpose of the care plan was to ensure proper care to meet resident needs and stated Resident #37's care plan was not implemented because the call light was broken. Interview with the Maintenance Director, on 09/03/19 at 3:50 PM, revealed he was not aware of the broken call light. He stated he rounded routinely in resident rooms for maintenance items but could not verbalize how this call light was missed, or how long the call light was broken. Interview with the DON, on 09/06/19 at 6:35 PM, revealed she tried to round and scan resident rooms daily but she was not always successful. She stated the South Hall UM mainly did rounds of the rooms, which included observing call lights to ensure they were within reach; however, the lights were not checked for function. The DON revealed she was not aware of any issues related to broken call lights and stated it was the responsibility of the Maintenance Director to monitor call lights. Interview with the Administrator, on 09/06/19 at 7:41 PM, revealed he was not aware of any concerns related to implementation of care plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185333	A. Building B. Wing	09/06/2019

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 34116 Based on interview, record review, and facility policy review it was determined the facility failed to ensure the activity department provided community outings to meet the interests of residents. The findings include: Review of Resident Rights revealed residents had the right to participate in social, religious, and community activities if the activities did not interfere with the rights of other residents in the nursing facility. Review of the policy Program Components, revised 04/01/18, revealed the Recreation Department would create a program environment that supported an individual's well being and wellness. The purpose of the policy was to provide an ongoing person-centered recreation program that incorporated the individual's interests, hobbies, and cultural preferences which were integral to maintaining and improving a resident's/patient's physical, mental, and psychosocial well being and independence. Review of the Job Description for Center Executive Director (CED), effective 01/01/16, revealed an essential function of the CED role was to create a culture of Service Excellence which focused on the patient experience, and was responsive to patients/families concerns and grievances. Interview with Resident #10, on 09/04/19 at 2:05 PM, revealed residents were not able to go on community outings because the facility's two (2) buses had been broken down for over a year. Review of Resident Council Meeting Minutes, dated 04/09/19, revealed residents would like more movie outings and picnics. Review of Resident Council Meeting Minutes, dated 05/14/19, revealed residents would like more picnics and movie outings. Review of Resident Council Meeting Minutes, dated 08/13/19, revealed residents would enjoy a movie outing when the facility bus was fixed. Interview with the Activities Director, on 09/04/19 at 3:41 PM, revealed residents often talked about community outings, especially during resident council meetings, but there was always something wrong with the bus. She revealed it would be important for residents to go on outings to get a change of scenery; however, it had probably been about a year since there was a leisure outing because of maintenance issues with the bus. According to the Activities Director, the Center Executive Director (CED) was aware of the issue and was in the process of having the bus repaired. Interview with the Administrator, on 09/06/19 at 7:41 PM, revealed he was aware of maintenance issues with the facility bus. He stated one bus caught fire and was not usable; and the lift and air conditioner was not working on the other bus. The CED revealed the facility obtained quotes and approval for the repair of the bus. According to the CED, the bus needed to be taken to the mechanic for repair.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 15879 Based on observation, record review, and interview it was determined the facility failed to ensure that a resident who acquired a pressure sore on the foot received proper treatment to facilitate wound healing and not worsening of the wound for one (1) resident out of the thirty-seven (37) sampled residents. Resident #10 had a blistered on the right heel that had worsened and an unidentified pressure area on the bottom of the left foot under the little toe. The findings include: Record review of the facility policy titled, Skin Integrity Management revised 07/01/19, revealed staff should continually observe and monitor patients for changes and implement revisions to the plan of care as needed. The policy revealed the purpose of the policy was to provide safe and effective care to prevent the occurrence of pressure ulcers, manage the treatment, and promote healing of the wounds. Review further revealed one practice standard was to include all patients who had a newly identified skin impairment on the centers twenty-four (24) hour summary report. Wound observations and measurements should be completed an documented on the skin integrity report upon initial identification of an altered skin integrity. The wounds should be monitored daily for the presence of any decline and it should be documented. The policy revealed a care plan should be developed and included prevention and treatment. The physician or nurse practitioner and the family should be notified. Daily monitoring of the ulcer should be documented with what the site looked like, the status of the dressing and the status of the surrounding tissue. It should also be documented of any decline in the area and the physician should be notified of the decline. Record review revealed the facility admitted Resident #10 on 06/07/17 with diagnoses of Quadriplegia, Contracture, Pressure Ulcer, Reflux, Hypertension, Obesity, Diabetes, Neuromuscular Dysfunction of the Bladder, and Colostomy. Record review of the annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/24/19, revealed Resident #10 had a Basic Interview for Mental Status (BIMS) of fifteen (15), which indicated the resident was interviewable. The MDS further revealed Resident #10 was totally dependent and needed the assist of one person for bed mobility, transfer, dressing, eating, toilet use, and bathing. The MDS further revealed Resident #10 had a limited range of motion (ROM) on both upper and lower extremities and had one (1) stage four (4) pressure ulcer to the coccyx. Record review of the comprehensive care plan revealed a problem was listed for actual skin breakdown related to a Stage IV pressure ulcer to the coccyx and left heel, not right heel. Interventions included evaluating the wound daily, including surrounding tissue and any presence of drainage. It further revealed if a new wound was discovered it was to be reported to the physician. Review of the care plan revealed the resident was to be monitored for signs and symptoms of skin breakdown, blistering, redness, and drainage. Weekly skin assessments were to be done and should have included measurements and descriptions of the wound. Positioning devices were to be utilized to prevent pressure. Observation on 09/03/19 at 3:29 PM, revealed Resident #10 was sitting up in his/her motorized scooter. Observation further revealed blue booties were lying on the floor. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident #10, on 09/03/19 at 3:29 PM, revealed he/she wore the blue booties at night when in bed. Resident #10 stated he/she was a quadriplegic and was unable to move his/her arms . Resident #10 stated the black button on the wheelchair, that he/she can touch with the his/her head was broken. Resident #10 stated he/she could not move the wheelchair up and back which helped to relieve pressure on the coccyx where there was a pressure sore. Resident #10 stated it would be okay for this surveyor to observe the wound and the treatment. Observation of Resident #10, on 09/06/19 09:12 AM, revealed the resident was lying in bed and watching TV. Observation on 09/06/19 at 10:30 AM, during the wound assessment with Registered Nurse (RN) #1 and License Practical Nurse (LPN) #2, revealed Resident #10 was lying on a Dermaflow mattress and had black booties on both feet. The over-bed table had resident items on it and the wound supplies, which included packages of gauze, kerlix, Integrity Wound Cleaner, and skin prep, were placed onto the over-bed table without it being cleaned off and a barrier was not applied. Observation revealed the resident had black booties on both feet. Observation further revealed RN #1 removed the old dressing with serosanguious drainage on it, from the left gluteal fold (coccyx) and placed it directly on Resident #10's bed with the soiled side up. RN #1 continued the assessment and placed an optifoam dressing back on the wound. RN #1 removed her gloves and washed her hands. LPN #2 removed the black boot from the left foot and the wound on the bottom of the left foot under the little toe stuck to the black boot and the boot had to be peeled away from Resident #10's foot. Observation revealed no bleeding was noted. Observation revealed the left black boot had dried white substance in it that had touched the area on the foot. Observation of the left foot on the bottom under the little toe revealed a nickel size red area with pink tissue surrounding . RN #1 wrapped the left foot with kerlix and put the dirty black boot back on the foot. Interview with RN #1 revealed the area under the toe was noted yesterday but they did not have an order for a treatment. RN #1 revealed she would call the physician to get an order. Interview further revealed since the skin was stuck to the boot it could cause a skin tear or infection to the wound. Observation, on 09/06/19 at 10:30 AM, of Resident #10's right foot, revealed the black boot was removed by RN #1 and there was no bandage on the right heel. The black boot on the right foot had white dried material in it that was directly on the heel wound. The area to the right heel was approximately silver dollar size . Interview with RN #1, during the observation of the right foot, revealed the dark area to the right heel was unstageable and looked like a deep tissue wound to her. She further revealed it had skin prep on it and the boot was dirty and filthy as well. RN#1 revealed the black boots needed to be taken to the laundry. Interview revealed Resident #10 had some new boot that therapy had ordered but they were not in yet. Observation with the Wound Nurse, on 09/06/19 at 4:30 PM, revealed Resident #10's feet had black booties on them and they were wrapped in kerlix. Observation further revealed she removed the kerlix from the left foot and the right heel and the dressing to the heel stuck to the wound. (continued on next page)

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	185333	A. Building B. Wing	09/06/2019

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview during the observation with the Wound Nurse, on 09/06/19 at 4:30 PM, revealed the pressure area on the left foot under the little toe should have been reported to the physician and treatment should have been obtained when it was first noted. She revealed Resident #10 was diabetic and at risk for pressure sore formation and infection. She further revealed the area under the left foot looked like something had pressed against it causing pressure. She stated the area was blanchable and probably a Stage one (1) or Stage two (2) pressure area. She revealed it was not a blister area and it looked like it may open. Interview with the Wound Nurse, on 09/06/19 at 4:45 PM, revealed the right heel was necrotic and unstageable. She further revealed the boots were dirty and needed to be changed. The wound nurse revealed a skin assessment monitoring sheet should have been started for the right heel and the left foot in order to monitor if the areas were worsening and the healing process. She revealed after reviewing the clinical record for Resident #10 that no skin assessment monitoring sheet had been started, the physician had not been notified, and there was no treatment obtained for the areas. She further revealed she did not see any documentation that the family had been notified of the areas and they should have been. The wound nurse further revealed the documentation should include what the pressure area looked like, the size and a skin monitoring sheet should have been started with that information documented on it. She revealed Resident #10 was at risk for infection and could loose his foot. She revealed a care plan should have been initiated for the right heel and the left foot and he/she should have clean boots. Interview, on 09/06/19 at 4:45 PM, with Resident #10 revealed he had not gotten any clean boots put on since this surveyor had been in the room earlier with RN #1. Record review of the physician orders revealed a treatment to the coccyx directed staff to cleanse the wound with Microcyn, pack with maxorb rope, apply calazime to the wound edges and cover with a dry dressing and it was to be done daily. The orders further revealed skin prep was to be applied to the left and right heels. Record review revealed there was no documentation that the physician had been notified of the new blister to the right heel and to the pressure area to the left foot under the little toe. Record review revealed there was no new treatments obtained for the right heel and no treatment obtained for the new pressure area on the left foot. Record review of the progress notes for 09/03/19 at 1:39 AM, revealed treatment was completed as ordered. A dressing was noted on Resident #10's right heel. The dressing was removed and an opened blister was noted and had bled. It further revealed skin prep and lotion was applied. Review revealed there was no documentation the physician had been notified of the ruptured blister. Record review of the progress notes for 09/04/19 and 09/05/19 revealed there was no documentation that the physician had been notified of the blister area to the right heel. Record review of the progress notes for 09/06/19 revealed there was no documentation that the physician had been notified of the darkened area to the right heel or the newly identified area to the left foot under the little toe. Record review of the skin checks done from 5/30/19 to 8/30/19 revealed pressure areas were noted for the right buttock, the coccyx, and left buttock. Review further revealed there was no documentation of any skin issues to the right or left heels. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with the Minimum Data Set (MDS) Coordinator LPN, on 09/06/19 at 5:00 PM, revealed she was not aware of any wound areas to the right heel or to the left foot under the little toe. She revealed if Resident #10 had a new area it would have been discussed at the morning meetings and she was not aware of any discussion about the new wound areas. Interview with the Nurse Practitioner (NP), on 09/06/19 at 6:27 PM, by telephone, revealed Resident #10 had recurring problems with blister areas but she was not aware they were recurring again. The NP revealed she thought someone might have called her today about the skin prep order but she was not aware of any wound to the bottom of the left foot under the little toe and no one had described the area to the right heel to her. She revealed she would expect staff to inform her of the new wound. The NP revealed typically blisters do not turn black. Interview with RN #3, on 09/06/19 at 7:50 PM, revealed she noticed the area to the right heel Monday because there was a dressing on the right foot so she removed it and there was a small blister to the heel, which was about the size of the end of your thumb. RN #3 reveal the blister was partially ruptured and the skin look wrinkly and had a bloody look to it. She stated the boots were dirty from the drainage of the blister. RN #3 stated she cleaned the area, dried it, and left it open to air. She stated she obtained clean boots and put them on Resident #10. She further revealed she did not call the physician or start a skin assessment because she thought someone else had done it since there was a dressing on the right heel when she noticed it. The dressing was undated and did not have a signature on it of who had done the treatment. RN #3 stated it was a standard of care that if you find a new wound you should start the skin assessment monitoring, call the physician, obtain a physicians order, start the treatment, start the skin assessments with measurements and description of the wound. RN #3 stated she did not do a skin assessment that night and was not aware of any skin issues on the left foot under the little toe. Interview with the Director of Nursing (DON), on 09/06/19 at 7:31 PM, revealed Resident #10 had recurring blisters and sitting rubbed the blister. She revealed new boots had been ordered for the resident but they had not come in yet. She stated if the boots were dirty they should have been removed and clean boots applied. She stated the area to the right heel was very small, dimelike in area, a couple of days ago when RN #1 had informed them of the area to the heel. She stated they use skin prep to toughen the heel and it would help absorb the blister. She further stated the reason the boot stuck to the wound under the left foot little toe was because staff did not let the skin prep dry and it became like a liquid bandage. She stated skin assessments should be done weekly to monitor the areas and they should be looked at every day. The DON did not want to review the chart as requested in order to verify if the skin assessments, progress notes, and care plan had been done or not on the right heel and left foot. The DON revealed since the areas were not significant changes then the physician did not have to be called. The DON revealed the area to the right heel had been brought up at the clinical meeting on Tuesday morning and her and the MDS coordinator updated the care plan at that time to reflect the area. Interview with the Administrator, on 09/06/19 at 2:36 PM, revealed he expected the staff to follow the facility policies and he monitored the staff by following policy. He revealed his main tool was quality assessment and conducting observations.

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	185333	A. Building B. Wing	09/06/2019

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 34116 Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure one (1) of six (6) sampled residents was served thickened liquids according to the physician's order, Resident #45. The findings include: Review of the policy Therapeutic Diets, revised 09/2017, revealed a therapeutic diet was defined as a diet ordered by a physician, or delegated registered or licensed dietitian, as part of the treatment for a disease or clinical condition. The purpose of a therapeutic diet was to eliminate or decrease specific nutrients in the diet (e.g. sodium), or to increase specific nutrients in the diet (e.g. potassium), or to provide food that a resident was able to eat (e.g. mechanically altered diet). The policy revealed diets were prepared in accordance with the guidelines in the approved Diet Manual and the individualized plan of care. Review of the policy Dining and Food Preferences, revised 09/2017, revealed the individual tray assembly ticket would identify all food items appropriate for the resident/patient based on diet order, allergies & intolerances, and preferences. Observation, on 09/04/19 at 11:41 AM, revealed a water pitcher and straw on Resident #45's over bed table. Observation, on 09/05/19 at 8:49 AM, revealed Resident #45 seated in bed eating breakfast served with regular, thin consistency orange juice and coffee. Observation of Resident #45, on 09/06/19 at 8:56 AM, revealed the resident was eating breakfast in his/her room and there was a water pitcher on the over bed table. Review of the clinical record revealed the facility admitted Resident #45 on 07/17/19 with diagnoses to include Type 2 Diabetes Mellitus, Dysphagia, and Cognitive Communication Deficit. Review of Resident #45's Modified Barium Swallow Study, dated 8/30/19, revealed recommendations for mechanical soft diet and nectar thick liquids; no straws; small bites and sips; and strict upright positioning with all intake related to moderate oropharyngeal dysphagia. Further review of the clinical record revealed a physician's order, dated 08/30/19, for a regular/liberalized diet with ground meat texture and nectar like thickened liquids to prevent aspiration. Interview with CNA #2, on 09/05/19 at 8:58 AM, revealed she referred to the nameplate at the entrance to the room to determine if a resident was prescribed thickened liquids. She stated an n indicated the resident received nectar thick liquids and an h honey thick liquids. Observation of Resident #45 nameplate during interview revealed there was no label indicating the resident was prescribed thickened liquids. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA #3, on 09/05/19 at 9:03 AM, revealed the nameplate at the entrance to the resident room was labeled with the consistency of thickened liquids and stated the tray ticket also listed the type of diet and consistency. She stated a resident could potentially choke, aspirate, or get pneumonia if the wrong consistency was served. According to the CNA, the nurse or CNA was responsible for verifying the tray to ensure the prescribed diet was served. Interview, on 09/05/19 at 3:00 PM, with the Unit Manager (UM) for South Hall revealed Resident #45 was prescribed a therapeutic diet with nectar thick liquids and should not have a water pitcher in the room. She further revealed UM's were responsible for ensuring the name plate was labeled correctly when the diet was changed; however, she forgot to label Resident #45's. Further interview with the UM revealed nurses placed a copy of new diet orders in the Dietary Manager's mailbox located in the business office and after hours gave the copy to the night cook. The UM stated the dietary department was responsible for ensuring the correct therapeutic diet and liquid consistency was listed on the tray ticket. Observation of Resident #45, on 09/06/19 at 8:56 AM revealed the resident seated in bed eating breakfast and a water pitcher with a straw on the over bed table. Further observation revealed the order for nectar thick liquids was not listed on the tray ticket or on nameplate at the door. Interview with the Dietary Aide, on 09/06/19 at 9:36 AM, revealed she was responsible for verifying tray tickets in the kitchen to ensure residents were served the correct diet and liquids; however, she did not really have to look at the tickets because she knew who was on thickened liquids. She stated it was important to serve the prescribed consistency because a resident could choke on thin liquids and aspirate. Further interview with the Dietary Aide revealed nurses brought diet change orders to the kitchen and the Dietary Manager was responsible for entering the change in the computer. She stated diet orders received after hours was placed on the Dietary Manager's desk to enter the next morning. Interview with the Dietary Manager (DM), on 09/06/19 at 9:44 AM, revealed she was responsible for revising the tray tickets with new diet orders. The Manager revealed Resident #45 was prescribed thickened liquids; however, the order was not listed on the tray ticket. Interview with the Speech Therapist (ST), on 09/06/19 at 2:00 PM, revealed he assessed Resident #45, noticed the resident had trouble swallowing, and recommended a swallow study. The ST further revealed he was not aware of any concerns related to the resident's prescribed therapeutic diet or liquids. Interview with the Assistant Director of Nursing (ADON), on 09/06/19 at 4:08 PM, revealed staff were responsible for verifying the tray ticket when passing out meal trays to ensure the prescribed diet was served. She stated the labels on the name plates were inconsistent and should not be used as a reference for fluid consistency. According to the ADON, there was no audit process in place to ensure the label on the name plates were accurate and stated there was a risk a resident could choke or aspirate if the label was incorrect. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview with the ADON revealed nurses were responsible for ensuring CNA's were aware of those residents prescribed thickened liquids, fluid restrictions, or were nothing by mouth (NPO) when they passed water pitchers. According to the ADON, she monitored CNA's and resident care daily during walking rounds. Interview with the DON, on 09/06/19 at 6:35 PM, revealed she was not aware of any issues related to communication of new diet orders. The DON stated nurses and CNA's were responsible for verifying tray tickets to ensure the correct therapeutic diet and liquids were served. She revealed nurses kept up with the water pitchers and stated a list of residents who received a pitcher was posted in the kitchen and on the resident's name plate. The DON further revealed name plates were labeled for those residents on thickened liquids; however, she did not have a hand in the process and thought speech therapy labeled them. The DON revealed water pitchers were changed every night and nurses were responsible for checking behind CNA's to verify the appropriate residents received a pitcher. The DON stated she assumed the system worked because the facility did not have any residents with aspiration pneumonia. Interview with the Administrator, on 09/06/19 at 7:41 PM, revealed he was not aware of any concerns related to therapeutic diets.

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F 0710 Level of Harm - Actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 15879 Based on observation, record review, and interview it was determined the facility failed to notify the physician of a worsening blister and the development of a new pressure area for one (1) out of the thirty-seven (37) sampled residents. Resident #10 had a blister on the right heel that had worsened and an unidentified pressure area on the bottom of the left foot under the little toe. The findings include: Record review of the facility policy titled, Skin Integrity Management revised 07/01/19, revealed staff should continually observe and monitor patients for changes and implement revisions to the plan of care as needed. The policy further revealed there should be documentation of any decline and the physician should be notified of the decline. Record review of the facility policy titled, Change In Condition: Notification dated 11/28/16, revealed the facility must immediately consult with the patients physician when there was a need to alter treatment significantly and, that would be when, there was a need to discontinue, or change an existing form of treatment, or to commence a new form of treatment. Record review revealed the facility admitted Resident #10 on 06/07/17 with diagnoses of Quadriplegia, Contracture, Pressure Ulcer, Hypertension, Obesity, Diabetes, Neuromuscular Dysfunction of the Bladder, and Colostomy. Record review of the annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/24/19, revealed Resident #10 had a Basic Interview for Mental Status (BIMS) of fifteen (15), which indicated the resident was interviewable. The MDS further revealed Resident #10 was totally dependent and needed the assist of one person for bed mobility, transfer, dressing, eating, toilet use, and bathing. The MDS further revealed Resident #10 had a limited range of motion (ROM) on both upper and lower extremities and had one (1) stage four (4) pressure ulcer to the coccyx. Record review of the comprehensive care plan, revealed a problem was listed for actual skin breakdown, related to a Stage IV pressure ulcer to the coccyx and left heel, not right heel. Interventions included evaluating the wound daily, including surrounding tissue and any presence of drainage. It further revealed if a new wound was discovered it was to be reported to the physician. Review of the care plan revealed the resident was to be monitored for signs and symptoms of skin breakdown, blistering, redness, and drainage. Weekly skin assessments were to be done and should have included measurements and descriptions of the wound. Positioning devices were to be utilized to prevent pressure. Interview with Resident #10, on 09/03/19 at 3:29 PM, revealed he/she was a quadriplegic and was unable to move his/her arms or legs. (continued on next page)

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	185333	A. Building B. Wing	09/06/2019

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F 0710 Level of Harm - Actual harm Residents Affected - Few	Observation, on 09/06/19 at 10:30 AM, during the wound assessment with Registered Nurse (RN) #1 and License Practical Nurse (LPN) #2 revealed Resident #10 was lying on a Dermaflow mattress and had black booties on both feet. LPN #1 removed the black boot from the left foot and the wound on the bottom of the left foot under the little toe stuck to the black boot and the boot had to be peeled away from Resident #10's foot. Observation of the left foot on the bottom under the little toe revealed a nickel size red area with pink tissue surrounding. RN #1 wrapped the left foot with kerlix and put the dirty black boot back on the foot. Interview with RN #1 revealed the area under the toe was noted yesterday but they did not have an order for a treatment. RN #1 revealed she would call the physician to get an order. Observation, on 09/06/19 at 10:30 AM, of the right foot revealed the black boot was removed and there was no bandage on the right heel. Observation of the right heel revealed a dark area that was approximately silver dollar size . Interview with RN #1 revealed the dark area to the right heel was unstageable and looked like a deep tissue wound to her. She further revealed it had skin prep on it. Interview during the observation with the Wound Nurse, on 09/06/19 at 4:30 PM, revealed the pressure area on the left foot under the little toe should have been reported to the physician and treatment should have been obtained when it was first noted. She revealed Resident #10 was diabetic and at risk for pressure sore formation and infection. She further revealed the area under to left foot looked like something had pressed against it causing pressure. She stated the area was blanchable and probably a Stage one (1) or Stage two (2) pressure area. She revealed it was not a blister area and it looked like it may open. Interview with the Wound Nurse, on 09/06/19 at 4:45 PM, revealed the right heel was necrotic and unstageable. The wound nurse revealed a skin assessment monitoring sheet should have been started for the right heel and the left foot in order to monitor if the areas were worsening and the healing process. She revealed after reviewing the clinical record for Resident #10 that no skin assessment monitoring sheet had been started, the physician had not been notified, and there was no treatment obtained for the areas. She further revealed she did not see any documentation that the family had been notified of the areas and they should have been. The wound nurse further revealed the documentation should include what the pressure area looked like, the size and a skin monitoring sheet should have been started with that information documented on it. She revealed Resident #10 was at risk for infection and could loose his foot. Record review of the physician orders revealed prep was to be applied to the left and right heels. Record review revealed there was no documentation the physician had been notified of the new blister to the right heel, nor the pressure area to the left foot under the little toe. Record review revealed there was no new treatments obtained for the right heel and no treatment obtained for the new pressure area on the left foot. Record review of the progress notes for 09/03/19 through 09/05/19 revealed there was no documentation that the physician had been notified of the blister area to the right heel. Record review of the progress notes for 09/06/19 revealed there was no documentation that the physician had been notified of the darkened area to the right heel or the newly identified area to the left foot under the little toe as observed earlier that morning. (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Few	Record review of the skin checks done from 5/30/19 to 8/30/19 revealed pressure areas were noted for the right buttock, the coccyx, and left buttock. Review further revealed there was no documentation of any skin issues to the right or left heels. Interview with the Nurse Practitioner (NP), on 09/06/19 at 6:27 PM by telephone, revealed Resident #10 had recurring problems with blister areas but she was not aware they were recurring again. The NP revealed she thought someone might have called her today about the skin prep order; however, she was not aware of any wound to the bottom of the left foot under the little toe and no one had described the area to the right heel to her. She revealed she would expect staff to inform her of the new wound. The NP revealed typically blisters do not turn black. Interview with RN #3, on 09/06/19 at 7:50 PM, revealed she noticed the area to the right heel Monday. She revealed she did not call the physician or start a skin assessment because she thought someone else had done it since there was a dressing on the right heel when she noticed it. The dressing was undated and did not have a signature on it of who had done the treatment. RN #3 revealed it was a standard of care that if you find a new wound you should start the skin assessment monitoring, call the physician, get an order, start the treatment, start the skin assessments with measurements and description of the wound. RN #3 revealed she did not do a skin assessment that night and was not aware of any skin issues on the left foot under the little toe. Interview with the Director of Nursing (DON), on 09/06/19 at 7:31 PM revealed Resident #10 had recurring blisters and sitting rubbed the blister. The DON revealed since the areas were not significant changes then the physician did not have to be called. Interview with Administrator, on 09/06/19 at 2:36 PM, revealed he expected staff to follow facility policy and he monitored the staff by following policy. He revealed his main tool was quality assurance process improvement and observations.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 38739 Based on record review and interview it was determined the facility failed to provide two (2) of three (3) Certified Nursing Aides (CNA) with a performance evaluations annually for Employee #2 and #3. The findings include: The facility failed to provide a policy for employee performance evaluations. Review of the file for Employee #2, on 09/06/19 at 2:00 PM, revealed the employee's file did not contain a performance evaluation. Continued review revealed the facility listed a hire date of 12/01/12. Review of the file for Employee #3, on 09/06/19 at 2:05 PM, revealed the employee's file did not contain a performance evaluation. Continued review revealed the facility listed a hire date of 08/10/17. Interview with the Director of Nursing (DON), on 09/06/19 at 5:39 PM, revealed she was not provided an annual performance evaluation. She stated staff were not given staff evaluations in the year she has been the DON and added performance evaluations review the strengths and weakness of staff. She stated the tool allowed staff and the facility to set goals for performance and to work toward the goals. She stated the performance evaluations also identified poor work habits and performance which may affect the care provided to residents. The DON stated staff were evaluated annually and she was aware regulations included performance evaluations yearly with which the facility was to comply. Interview with Genesis Nurse, on 09/06/19 at 5:45 PM, revealed the corporation was without a policy for staff performance review. Interview with the Center Executive Director, on 09/06/19 at 7:04 PM, revealed he was surprised to learn evaluations were not required and there was no facility policy.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 38739 Based on observation and interview it was determined the facility failed to ensure the daily staffing information was posted for public view. Observations revealed the facility failed to post the staffing post on 09/06/19. Interviews with the Unit Manager and the Director of Nursing (DON) revealed the posted staff information was not completed for the week on 09/02/19 through 09/06/19. The findings include: The facility was unable to provide a policy regarding posting of staffing information. The facility was unable to provide documentation of posted staffing information for 09/02/19 through 09/06/19. Observation, on 09/06/19 at 2:50 PM, revealed the no posted staffing information at the main entrance or at the entrance of the two (2) units, north and south, in the facility. Interview with the Unit Manager, on 09/06/19 at 2:50 PM, revealed she was responsible to post the nursing information daily. However, the Unit Manager stated she was not here at the facility for the week until 09/06/19. She stated the posted staffing information included the number of staff for each licensure level for each shift, the hours for each shift with the total hours for the day in addition to the resident census. She stated she placed the posted information to each unit but not at the entrance of the facility. She stated the DON assigned her to post the information each day of the week except weekends. Interview with the DON, on 09/06/19 at 2:52 PM, revealed staffing information was posted daily. She stated she assigned the Unit Manager to complete the documentation and post it daily. However, she stated the unit manager was out of the building all week, nor did she (the DON) post the information in the Unit Manager's absence. Additionally, the DON stated it was her responsibility to ensure the information was posted. She stated the posted staffing information was to be visible to all which informed all about the staffing level in the facility. Interview with the Executive Center Director, on 09/06/19 at 7:41 PM, revealed he was unaware posted staff information was not visible or posted in the facility. However, he stated it was supposed to be posted daily.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 15879 Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure infection control policies were followed during a dressing change for one (1) of thirty-seven (37) sampled residents, Resident #10. Observations revealed staff failed to sanitize or provide a barrier to a table surface prior to placing dressing change supplies on the surface. Additionally, staff's hair fell into a soiled dressing just removed from Resident #10's buttock area. The findings include: Review of the facility policy, Wound Dressing Policy, revised 01/02/14, revealed staff performed wound dressings using aseptic technique, which decreased the risk of wound contamination and cross contamination during dressing changes. Review of the facility policy, Wound Dressing Aseptic, revised 11/28/17, revealed staff gather supplies and a clean barrier. Staff were to clean the over-bed table and a barrier applied before supplies were placed on the table. The policy further revealed a plastic bag should be in reach for the soiled dressing and the dressing and gloves were discarded according to policy. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 06/07/17 with diagnoses to include Quadriplegia, Diabetes Mellitus, Contractures, and Pressure Ulcers. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/24/19 revealed the facility assessed Resident #10 with a Brief Interview for Mental Status (BIMS) exam score of fifteen (15) and determined the resident was interviewable. The MDS further revealed Resident #10 was totally dependent on staff with one (1) person assist for bed mobility, transfers, dressing, eating, toilet use, and bathing. The MDS further revealed Resident #10 had limited range of motion (ROM) on both the upper and lower extremities and had one (1) stage four (4) pressure ulcer to the coccyx. Observation, on 09/06/19 at 10:30 AM, during the wound assessment with Registered Nurse (RN) #1, revealed Resident #10 lying on a Dermaflow mattress. Continued observations revealed RN #1 placed wound care items, including packages of gauze, kerlix, Integrity Wound Cleaner, and skin prep onto the over-bed table, which also contained some personal items. RN #1 failed to sanitize the table and nor was a barrier applied. Observation further revealed RN #1 removed the old dressing from the left gluteal fold and placed it directly onto Resident #10's bed with the soiled side up. The soiled dressing contained serosanguious drainage as stated by RN #1. RN #1 held her head down by the soiled dressing and some of her hair fell on to the dressing with the serosanguious drainage on it. RN #1 moved her head and stated she did not want her face to get into the dressing. RN #1 removed her gloves and washed her hands when finished. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, on 09/06/19 at 11:00 AM, with RN #1 revealed she did not clean the over-bed table off when she laid the supplies on it because it was not a sterile procedure and all she had to do was to open packages. RN #1 revealed she usually put the old dressing in her glove as she removed the glove however she stated she only had two (2) gloves on and not three (3) like normal so she just laid the dirty dressing on the bed until she pulled the gloves off and then wrapped them. RN #1 revealed normally she pulled her hair up out of the way and she did not realize her hair had fallen into the old dressing that was lying on the bed. RN #1 revealed it was a risk for everyone because germs could transfer from one (1) person to another. RN #1 revealed she was going to wash her hair immediately. Interview with the Director of Nursing (DON), on 09/06/19 at 2:36 PM, revealed staff can move items around on the over-bed table and they did not have to clean the table if they were just putting supplies on it. The DON further revealed it was not appropriate to put the old dressing on the residents' bed because it could pose a risk of the dressing having something on it that would be transferred to the bed. The DON further revealed the nurse's hair falling into the old dressing was an infection control issue. She revealed if the old dressing had germs on it then that could be passed from room to another room. Interview, on 09/06/19 at 2:36 PM, with the Administrator, revealed staff should follow the Infection Control Policy.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure the call light was accessible and functional for one (1) of thirty-seven (37) sampled residents, Resident #37. The findings include: Review of the policy Call Lights, revised 10/01/12, revealed the purpose of the policy was to ensure safety and communication between staff and patients. The policy further revealed all patients would have a call light or alternative communication device within their reach at all times when unattended. Review of Resident Rights and Services revealed a resident had the right to reside and receive services in a nursing facility with reasonable accommodations of individual needs and preferences, except when accommodations would endanger the health or safety of the resident or other residents. Review of the policy Routine Maintenance, revised 06/01/17, revealed requests for routine maintenance on the physical plant, fixtures, and equipment would require a work order. Each service location would establish designated areas where work order requests were to be picked up. The Maintenance Supervisor or designee would pick up the work order on a predetermined schedule, and prioritize work orders. Once the work order was completed, the maintenance supervisor or designee would write the action taken on a work order. Completed work orders would be filed and maintained for one year. Observation, on 09/03/19 at 2:55 PM, revealed Resident #37 lying on his/her right side at the edge of the bed and the call light attached to the left 1/4 rail located behind the resident. Interview during observation revealed the resident had a bowel movement in his/her brief and could not reach the call light. Further observation of Resident #37, on 09/03/19 at 3:41 PM, revealed there was no push button on the call light and it was not functioning. Interview with the resident during observation revealed the call light had been broken for a long time. Interview with CNA #1 during observation revealed she provided incontinent care for Resident #37 and gave him/her the call light; however, she had not noticed the light was broken. Review of the clinical record revealed the facility admitted Resident #37 on 10/15/18 with diagnoses to include Mild Intellectual Disabilities, Alzheimer's Disease, and Hypertension. Review of the Brief Interview for Mental Status (BIMS), dated 08/05/19, revealed the facility assessed the resident with a total score of 10 out of 15 and determined he/she was interviewable. Review of the annual Minimum Data Set (MDS), dated [DATE], revealed Resident #37 was totally dependent upon staff for bed mobility and toileting. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the South Hall Maintenance Log, dated August 2019, revealed no work order requests for repair of Resident #37's call light. Review of the facility's TELS system Work Orders, dated July 1 through [DATE], revealed no work orders requests for Resident #37 call light. Interview with the Maintenance Director, on 09/03/19 at 3:50 PM, revealed he performed maintenance rounds on twelve (12) rooms weekly to inspect for maintenance issues; however, he could not recall the last time he inspected Resident #37's room because he did not document the date, room, or findings of the inspections. He revealed it was important to ensure call lights were functional so residents could alert staff if they needed something. Further interview with the Maintenance Director, on 09/05/19 at 11:19 AM, revealed he performed monthly call light audits of twelve to fifteen (12 -15) random rooms to ensure lights were functional, lighting when pressed in the resident's room and at the nurses' station; however, he did not record the room numbers that were audited. He stated he was confident all the facility's call lights were functional because staff would report any issues. The Maintenance Director was not sure when he last inspected Resident #37's call light. Interview with the South Hall Unit Manager (UM), on 09/05/19 at 3:00 PM, revealed each department head was assigned to audit specific rooms for cleanliness and fall hazards, and she assumed call lights; however, she was new to the UM role and was not assigned to audit rooms. According to the UM, she performed walking rounds of the unit to monitor care and observe for fall risk issues. Interview with the Assistant Director of Nursing (ADON), on 09/06/19 at 4:08 PM, revealed all department heads audited assigned rooms to observe for cleanliness, clutter, and ensure call lights were within reach; however, call lights were not checked to ensure proper functioning. She revealed staff were responsible for entering work orders in the TELS system, notifying maintenance, and replacing the broken call light with a working light from another room. According to the ADON, a resident would not have a way to ask for help or get the attention of staff if the call light were not accessible or broken. Interview with the Director of Nursing (DON), on 09/06/19 at 6:35 PM, revealed she tried to scan resident rooms every day but sometimes it was way too busy and stated the South Hall UM mainly did the rounds. She stated call lights were checked during rounds to ensure they were within reach, but were not checked for function. According to the DON, the Maintenance Director was responsible for monitoring call lights. Interview with the Administrator, on 09/06/19 at 7:41 PM, revealed he was not aware of any issues related to broken call lights or call light audits.