STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. Building B. Wing	04/05/2019

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 35750 Based on observation, interview, and facility policy review, it was determined the facility failed to ensure residents received their personal clothing items back from laundry in a timely manner for eight (8) of eight (8) sampled residents, Resident #5, #22, #26, #29, #32, #47, #50, and #71. The findings include: Review of the facility's policy, Quality of Life - Accommodation of Needs, revised August 2009, revealed the facility's environment and staff behaviors were directed toward assisting residents in maintaining and/or achieving independent functioning, dignity, and well-being. The resident's individual needs and preferences would be accommodated to the extent possible. Interview during the Resident Group Meeting, on 04/02/19 at 2:20 PM, revealed Resident #5, #22, #26, #29, #32, #47, #50, and #71 stated they did not get their personal clothing back from laundry in a timely manner, and sometimes not at all. Observation of the Laundry Room, on 04/05/19 at 10:29 AM, revealed five (5) large containers of soiled resident clothing. Interview with Laundry Staff, on 04/05/19 at 10:29 AM, during the observation, revealed the facility only had one (1) working dryer, as the other one was broken, and she had five (5) large containers of personal clothing items to process. She stated the Certified Nursing Assistants (CNA) would call and tell her a resident was looking for their clothes. She stated she felt bad because the residents did not have their clothes. Interview with CNA #1, on 04/04/19 at 9:41 AM, revealed the facility had a big problem with the laundry and residents reported missing clothing items such as trousers, shirts, underwear, and dresses. CNA #1 stated some residents understood they had to wait a long time to get their clothes laundered; however, they should not have to wait for a week or more and the situation was not acceptable for the residents. Interview with CNA #2, on 04/04/19 at 9:51 AM, revealed some residents were missing their personal clothing items and she went to the laundry to see if she could locate the items; however, sometimes the clothes were not found. CNA #2 further stated clothes were expensive and if residents' personal clothes were lost, they might not be able to buy any. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CNA #3, on 04/04/19 at 10:17 AM, revealed residents had informed her about missing clothes and she was unsure if the items had been located. She stated residents should get their clothes back in a timely manner, in about two (2) days, after sending the items to the laundry. Interview with CNA #4, on 04/04/19 at 11:25 AM, revealed she was aware several residents were missing clothes, such as shirts and pants, and she was unsure if the facility had resolved the issue. The CNA stated residents had a right to get their laundered clothes back within two (2) days of sending their clothes to the laundry. Interview with the Housekeeping Supervisor, on 04/05/19 at 10:40 AM, revealed he was concerned about not having adequate equipment, as the facility had only one (1) working dryer at the time. He stated residents stopped him frequently and asked about their clothes and the residents were frustrated about not getting them back. Interview with the Director of Nursing (DON), on 04/05/19 at 2:22 PM, revealed she knew residents had missing clothing items and she spoke to housekeeping about the missing items; however, a lot of time the clothes were not lost but had not come back from laundry. She stated residents should receive their clothing items back in a timely manner and should have clean clothes available in their closet. She was aware one of the dryers in the laundry was not working.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 35750 Based on interview, facility policy review, and review of Resident Council Concern Forms, it was determined the facility failed to act upon and effectively resolve grievances from Resident Council related to missing clothing. The findings include: Review of the facility's policy, Grievance/Complaints Filing, revised April 2017, revealed any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, and behavior of other residents, staff members, theft of property, or any concern regarding his or her stay at the facility. The facility reviewed all grievances, complaints, or recommendations, which stemmed from resident or family groups concerning resident care in the facility, and responded on such issues in writing. The Administrator delegated the responsibility of grievance and/or complaint investigations to the Grievance Officer who was the Licensed Social Worker of the facility. During a grievance investigation, the Grievance Officer took immediate action to prevent further potential violations of resident rights. The Administrator reviewed the findings with the Grievance Officer and determined what the corrective action, if any, needed to be undertaken. The resident, or person filing the grievance and/or complaint on behalf of the resident, was informed (verbally and in writing) of the findings of the investigation and the actions taken to correct an identified problem. Interview during the Resident Group Meeting, on 04/02/19 at 2:20 PM, revealed eight (8) of eight (8) residents reported their clothes did not come back from the laundry timely, sometimes not at all, which had been reported to the facility and nothing had been done. In addition, the residents stated they did not know how to file grievances and receive an acceptable response to their grievances. Review of the facility's Interdisciplinary Team Resident Council Concerns Form, dated March 2019, revealed the Resident Council agreed the turnaround time for laundry took a long time, sometimes residents ran out of personal clothes to wear, and sometimes residents did not get their clothes back at all. The Follow-up/Action Taken, dated 03/27/19, revealed there was going to be a new laundry method so personal items were delivered on first and second shift, and clothes must be labeled to get back in a timely manner. Interview with Certified Nursing Assistant (CNA) #1, on 04/04/19 at 9:41 AM, revealed if a resident voiced a grievance she reported it to the supervisor to see if it could be resolved. She further stated the facility had a problem with the laundry and residents were not happy about it and reported missing clothing items such as trousers, shirts, underwear, and dresses. CNA #1 stated some residents understood they had to wait a long time to get their clothes laundered; however, they should not have to wait for a week or more. She stated residents had the right to get their clothes back. Interview with CNA #2, on 04/04/19 at 9:51 AM, revealed she relayed resident grievances to the nurse on duty, and the nurse reported the concerns to the Social Services Director (SSD) or the Administrator. She knew some residents were missing their personal clothing items and she would go to the laundry to see if she could locate the items; however, sometimes she was not successful. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CNA #3, on 04/04/19 at 10:17 AM, revealed if a resident had a grievance, a form was completed. She recalled some residents spoke to her about missing clothes and she was unsure if the items were located. The CNA stated residents should get their clothes back in a timely manner, which was about two (2) days after sent to the laundry. CNA #3 stated if the clothing items were lost, the facility should replace them, and if not then the grievance was not resolved. Interview with CNA #4, on 04/04/19 at 11:25 AM, revealed the SSD addressed grievances. She stated the facility had not educated her on the grievance process. She further stated she was aware several residents were missing clothes and was unsure if the facility had resolved the issue. The CNA stated residents had a right to get their clothes back from laundry within two (2) days. Interview with Licensed Practical Nurse (LPN) #3, on 04/04/19 at 11:38 AM, revealed if a resident had a concern about personal clothing items she went to the SSD and let her know the clothes were missing and the SSD would look into the issue. However, she stated she had never completed a grievance form on behalf of a resident. Interview with the Assistant Director of Nursing (ADON), on 04/05/19 at 12:02 PM, revealed Social Services handled the grievances and anyone could fill out a grievance form. She further stated the Administrator followed-up and signed off on all grievances, and when grievances occurred, there was a seventy-two (72) hour period to resolve the grievance. The ADON stated if residents were missing clothes it was the facility's responsibility to replace them, and stated the facility was behind on that effort. She further stated if residents did not get their clothing items back, then it was an unresolved grievance. Interview with the Director of Nursing (DON), on 04/05/19 at 2:22 PM, revealed grievances went to SSD and the SSD would forward it to the correct department. She knew residents had missing clothing items and stated residents should receive their clothing items back from laundry in a timely manner. Interview with the SSD, on 04/04/19 at 10:39 AM, revealed she received grievances from residents and from staff on behalf of the residents. The facility had a grievance form and at times, she completed the forms and filled out grievances regarding missing clothes. The SSD stated the various department heads addressed the grievances and she usually did a follow-up; however, she had not followed-up on the missing clothing items and expected nursing staff to follow-up to resolve the grievance. She put grievances on the log, which was a summary of the resident's concern and reviewed them with the Administrator who signed off on them; however, after she gave them to the Administrator she did not know how the Administrator resolved the grievances. Continued interview with the SSD, on 04/05/19 at 3:05 PM, revealed she did not regularly attend the resident council meetings, and was not involved in educating residents on the grievance process. She further stated when she spoke to residents about their rights, she told them to speak to the DON and the Administrator or the nurse. The SSD further stated she thought follow-up on resident's rights such as grievances should probably occur every six (6) months. She stated she had not followed-up on the laundry issue because it was an ongoing issue since the facility had recently changed housekeeping services. The SSD stated the facility, including her, had not followed-up on the residents' grievances regarding their missing clothes. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator, on 04/05/19 at 3:29 PM, revealed the SSD passed grievances to the various department heads but he should have followed-up to see if the grievances had been resolved and then signed off on the form. He stated he was responsible to ensure resident grievances were resolved properly per facility policy. The Administrator stated the missing clothing items were a concern and he would ensure the facility followed the grievance process in the future.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 35750 Based on observation and interview, it was determined the facility failed to provide a clean and sanitary environment in one (1) of two (2) shower rooms, which effected residents on three (3) of six (6) hallways, Halls A, B, and C. Observations of the C Hall Shower Room revealed black matter on the bottom of the walls, cracked tiles, a soiled brief, and other soiled items. The findings include: The facility did not provide a policy regarding maintenance/housekeeping. Observation of the C Hall Shower Room, on 04/02/19 at 3:38 PM, revealed a black matter on the lower wall border, an area about a foot high that appeared wet with water damage to the surface, a soiled brief on the floor, and a soiled cloth atop the hamper. Observation of the C Hall Shower, on 04/05/19 at 9:11 AM, revealed dark black matter on the lower wall border, the tile floor was cracked and appeared black in the corners. The smaller shower stall had a cracked wall, the curtain and shower rug appeared soiled, and there was a soiled towel on the chair. Interview with Certified Nursing Assistant (CNA) #4, on 04/04/19 at 11:33 AM, revealed housekeeping cleaned the shower room but some residents would not shower in there because they suspected mold. She stated previously there were smells and staff left soiled linens on the floor and generally, the shower room was a mess. The CNA stated CNAs were to clean up the shower room after each resident, dispose of linens, dispose of used briefs, and then housekeeping followed with general cleaning. According the CNA #4, the mold had been an ongoing issue since she started working at the facility about seven (7) months ago, and she noticed a smell in the shower room several times. Interview with Licensed Practical Nurse (LPN) #3, on 04/04/19 at 11:44 AM, revealed she was not often in the shower; however, when she went in there it smelled of feces. She was concerned about the shower not being cleaned/sanitized after staff gave residents their showers. The LPN stated she saw a soiled brief on the floor that should have been in the trash, and she was concerned about dark spots on the shower walls. However, she had not reported this to the Director of Nursing (DON), Administrator, or Maintenance. LPN #3 stated although she was not an expert about mold she was concerned about it because residents could have respiratory issues. Interview with the Maintenance Director, on 04/05/19 at 9:11 AM, revealed he inspected the C Hall Shower Room about two (2) months ago and noticed the shower leaked; however, no staff had submitted a request for repairs of the leak. He stated the smaller shower stall was cracked and water got in there. He further stated the floor of the larger shower stall was cracked and he saw black in the corners. He stated he saw a dirty shower rug and a used towel on a shower chair and the curtain was dirty and there was water damage on the paint because the shower walls sweated. The Maintenance Director stated this was unsanitary for residents and the facility needed to provide a clean shower room. Additionally, he stated the water damage could attract rodents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Housekeeper, on 04/05/19 at 9:38 AM, revealed when she found dirty linens in the shower room, she put them in a bag and placed the bag in the soiled utility room. If she found black residue in a shower, she sprayed a chemical on it, let it sit, and then wiped or scraped it off. She further stated black spots or residue could be build up, could be mold, or it could be marks from the shower chair. The Housekeeper stated mold could be a health risk for the residents. Interview with the Housekeeping Supervisor, on 04/05/19 at 10:11 AM, revealed the C Hall Shower Room was disorganized, had uneven floors, and what appeared to be a lot mold on the floor. The Housekeeping Supervisor stated the nursing staff should straighten the area after use and housekeeping should then clean after. He added the condition of the shower room was below standard and could affect the health of residents. Interview with the Assistant Director of Nursing (ADON), on 04/05/19 at 11:50 AM, revealed nursing staff was to clean up any mess they made in the shower room and the nurses should monitor the condition of the shower room and notify housekeeping when appropriate. The ADON stated the facility provided verbal instruction to nursing staff on facility expectations of a clean shower room. Interview with the DON, on 04/05/19 at 2:06 PM, revealed nursing staff should retrieve any items they use in the shower room, disinfect the shower and equipment, and notify housekeeping if necessary for follow-up. The DON stated she had not identified any concerns regarding shower room cleanliness, and added a clean shower room prevented the spread of infection. In addition, the DON stated a dirty shower room might cause a resident to refuse showers. Interview with the Administrator, on 04/05/19 at 3:17 PM, revealed he recently became aware of cleanliness issues in the shower room on the C Hall. He stated mildew would be concerning for residents as it was an air quality issue and an unclean shower room was an infection control issue. The Administrator stated the facility conducted rounds to ensure shower rooms were presentable and clean.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **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 obtain wound care orders upon readmission to the facility for one (1) of twenty-one (21) sampled residents, Resident #36. The findings include: The facility did not provide a policy for Admission Assessments and Physician Orders. Review of the clinical record revealed the facility admitted Resident #36 on 12/12/18, with diagnoses to include Parkinson's Disease, Repeated Falls, Type 2 Diabetes, Polyosteoarthritis, and Atrial fibrillation, and readmitted the resident on 03/13/19, after hospitalization for a fractured hip. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15) and determined he/she was interviewable. Observation, on 04/01/19 at 7:19 PM, revealed Resident #36 lying in bed with an abductor cushion positioned between his/her legs. Interview during observation revealed the resident had fallen and sustained a fractured a hip. The resident further stated he/she had a surgical wound and treatment; however, the dressing had only been changed twice since he/she was readmitted . Review of the Hospital Discharge Summary, dated 03/13/19, revealed the resident was admitted for management of a traumatic left femoral neck fracture, which required left hip hemiarthroplasty (operation to treat a broken hip). Further review revealed there were no physician orders for treatment of the surgical site. Review of the Nursing Admission Assessment, dated 03/13/19, revealed the resident had stitches to the left hip. Review of Admission Orders, dated 03/13/19, revealed no order to address the residents left hip surgical site. Further review revealed an order to cover the left hip with a dry dressing and change every other day or as needed; however, the order was not obtained until 03/28/19. Review of the Treatment Administration Record (TAR), dated March 2019, revealed the left hip dressing was changed on 03/29/19 and 03/31/19. Interview with Licensed Practical Nurse (LPN) #6, on 04/04/19 at 2:29 PM, revealed the Unit Manager was responsible for verifying physician orders for Resident #36's admission. She stated it would be important to notify the physician for a treatment order to prevent potential infection and ensure the wound healed. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing (ADON), on 04/05/19 at 9:32 AM, revealed the assigned nurse was responsible for verifying readmission orders with the physician and it was not the sole responsibility of the Unit Manager. She stated she entered Resident #36's orders according to the discharge summary; however, she should have notified the physician for clarification related to the surgical site. She stated there was a risk for infection if the dressing was not changed according to physician orders. Further interview revealed all orders were reviewed during the daily clinical meeting to ensure orders were entered correctly and care planned; however, no issues were identified related to Resident #36's physician orders. Interview with the Director of Nursing (DON), on 04/05/19 at 2:31 PM, revealed the assigned nurse was responsible for obtaining and verifying physician orders for residents readmitted to the facility. She stated the nurse should have notified the physician to ensure there was an appropriate treatment order for the wound. Interview with the Administrator, on 04/05/19 at 3:42 PM, revealed the Unit Manager, ADON, and DON were responsible for oversight of the clinical process to ensure systems were in place and effective. He further revealed he was not aware of any issues related to physician orders for Resident #36.

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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** 34116 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to implement or develop the care plan for two (2) of twenty-one (21) sampled residents, Resident #8 and #36. The facility care planned for Resident #36 to have on non-skid footwear for ambulating/transfers; however, staff failed to implement Resident #36's care plan to prevent a fall and the resident fell and sustained a fractured hip. In addition, the facility failed to develop a care plan related to Resident #8's dental problems. The findings include: Review of the facility's Care Plan Policy, revised December 2016, revealed the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy further revealed the comprehensive care plan would describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of the facility's policy, Falls Management Program Guidelines, effective 12/01/18, revealed the purpose of the policy was to maintain a hazard free environment, mitigate fall risk factors, and implement preventative measures. Identified risk factors should be evaluated for the contribution they might have to the resident's likelihood of falling and care plan interventions should be implemented that address the resident's risk factors. 1. Review of the clinical record revealed the facility admitted Resident #36 on 12/12/18, with diagnoses to include Parkinson's Disease, Repeated Falls, Type 2 Diabetes, Polyosteoarthritis, and Atrial Fibrillation. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15) and determined he/she was interviewable. Further review of the MDS revealed the resident required the assistance of two (2) persons for transfers and one (1) person for toileting. Review of the Care Plan, initiated 12/13/18, revealed the resident was at high risk for falls. Interventions included non-skid footwear for ambulating/transfers, anticipating the resident's needs, and ensuring prompt response to all requests for assistance. Observation of Resident #36, on 04/01/19 at 7:19 PM, revealed the resident in bed with an abductor cushion positioned between his/her legs. Interview during observation revealed he/she went to the bathroom unassisted when staff did not answer the call light, because he/she did not want to pee on himself/herself, and fell and sustained a hip fracture a few weeks ago. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Notes, dated 03/07/19 at 9:15 PM, revealed Resident #36 was transferred to the emergency room (ER) for evaluation of the left hip related to an unwitnessed fall and complaints of excruciating pain. Further review of the Physician Orders, dated 03/07/19, revealed an order to transfer the resident to the ER for evaluation of the left hip pain. Review of the ER Note, dated 03/07/19, revealed Resident #36 arrived at the ER at 8:27 PM and the x-ray of the left femur revealed an acute fracture of the left femoral neck. Review of the Interdisciplinary Team (IDT) Post Fall Review, signed 03/08/19, revealed the resident was wearing open heel slippers at the time of the fall; however, review of the care plan revealed the resident was to have non-skid footwear for ambulating and transfers. Interview with Certified Nursing Assistant (CNA) #5, on 04/05/19 at 8:38 AM, revealed Resident #36 required assistance with transfers and toileting; however, the resident was good by himself/herself prior to the fall. Interview with CNA #3, on 04/05/19 at 1:37 PM, revealed she checked on residents every one (1) to two (2) hours and stated the CNAs were responsible for ensuring fall interventions were in place. According to CNA #3, some residents required supervision in the bathroom to ensure their safety. Interview with Licensed Practical Nurse (LPN) #5, on 04/04/19 at 2:29 PM, revealed Resident #36 needed the assistance of one (1) person for transfers and toileting. The nurse stated she tried to monitor throughout the shift to ensure CNAs assisted residents with Activities of Daily Living (ADL). The nurse stated the purpose of the care plan was to communicate resident needs and prevent future falls. Interview with the Assistant Director of Nursing (ADON), on 04/05/19 at 9:32 AM, revealed Resident #36 should be an assist of one (1), but he/she had the capability to transfer independently. She further revealed improper footwear was the root cause of the fall. She asked the resident what happened and the resident said he/she had on open heeled shoes and his/her foot came out the shoe and he/she lost his/her balance and fell . The ADON stated she monitored staff throughout the day; however, she did not use an audit tool to document her findings. Interview with the Director of Nursing (DON), on 04/05/19 at 2:31 PM, revealed staff was responsible for implementing the care plan based on the assessed needs of the resident. Interview with the Administrator, on 04/05/19 at 3:42 PM, revealed he was not aware of any concerns related to implementation of care plans. 2. Review of the clinical record revealed the facility admitted Resident #8 on 03/18/13, with diagnoses to include Guillain-Barre Syndrome, Hemiplegia and Hemiparesis affecting the left non-dominant side, Chronic Pain, and Chronic Obstructive Pulmonary Disease (COPD). Review of the Quarterly MDS, dated [DATE], revealed the facility assessed Resident #8 with a BIMS score of fifteen (15) of fifteen (15) and determined he/she was interviewable. (continued on next page)

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident #8, on 04/02/19 at 9:00 AM, revealed the resident had a toothache for about a week. According to the resident, he/she took medication for pain and the facility scheduled a dental appointment. Further review of the clinical record revealed a care plan was not developed to reflect Resident #8's dental problems. Interview with LPN #5, on 04/03/19 at 1:48 PM, revealed the nurse was responsible for initiating new problems on the care plan. She stated she was not aware of Resident #8's toothache and stated she learned recently through hearsay. Interview with the MDS Coordinator, on 04/05/19 at 3:31 PM, revealed she revised care plans quarterly and the nurses or Unit Managers were responsible for developing care plans with episodic issues. Interview with the ADON, on 04/05/19 at 9:32 AM, revealed she first became aware of Resident #8's dental issues within the last 24 hours. She revealed there were some communication issues and staff sometimes did not give full details or the extent of a resident's problem. Interview with the DON, on 04/05/19 at 2:31 PM, revealed care plans were developed and revised to ensure resident needs were met. Interview with the Administrator, on 04/05/19 at 3:42 PM, revealed he was not aware of any concerns related to care plans.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 provide effective supervision to prevent accidents for one (1) of two (2) sampled residents, Resident #36. Per interview, on 03/07/19, Resident #36 resident fell and sustained a hip fracture when he/she transferred without assistance in the bathroom. Per interview and record review, the resident was not wearing non-skid footwear, which was an intervention the facility had put in place for the resident to prevent falls. The findings include: Review of the facility's policy, Falls Management Program Guidelines, effective 12/01/18, revealed the purpose of the policy was to maintain a hazard free environment, mitigate fall risk factors, and implement preventative measures. The policy revealed a fall risk assessment should be included as part of the admission, quarterly, and when a fall occurred. Identified risk factors should be evaluated for the contribution they might have to the resident's likelihood of falling and care plan interventions should be implemented that address the resident's risk factors. Review of the facility's policy, Quality of Life - Accommodation of Needs, revised August 2009, revealed in order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed towards assisting the residents in maintaining independence, dignity, and well-being to the extent possible and in accordance with the residents' wishes. Review of the clinical record revealed the facility admitted Resident #36 on 12/12/18, with diagnoses to include Parkinson's disease, Repeated Falls, Type 2 Diabetes, Polyosteoarthritis, and Atrial Fibrillation. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15) and determined he/she was interviewable. Further review of the MDS revealed the resident required the assistance of two (2) persons for transfers and one (1) person for toileting. Review of the Care Plan, initiated 12/13/18, revealed the resident was at high risk for falls. Interventions included non-skid footwear for ambulating/transfers, anticipating resident's needs, and ensuring prompt response to all requests for assistance. Observation, on 04/01/19 at 7:19 PM, revealed Resident #36 lying in bed with an abductor cushion positioned between his/her legs. Interview during observation revealed the resident had fallen in the bathroom and fractured a hip. The resident stated he/she activated the call light but staff did not respond and he/she went to the bathroom unassisted because he/she did not want to pee on himself/herself. Review of the Fall Risk Assessment, dated 03/07/19, revealed the facility assessed the resident with a score of 25 indicating he/she was at moderate risk for a fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Situation, Background, Assessment, Recommendation (SBAR) Note, dated 03/07/19, revealed Resident #36 sustained an unwitnessed fall at around 1:00 PM. According to the note, there were no changes in the resident's condition following the fall, including functional status. Further review revealed the resident complained of hip pain and a physician's order was obtained for an x-ray of the left hip. Review of the Progress Notes, dated 03/07/19 at 9:15 PM, revealed Resident #36 was transferred to the emergency room (ER) for evaluation of the left hip related to an unwitnessed fall. Review of the ER Note, dated 03/07/19, revealed Resident #36 arrived at the ER at 8:27 PM and x-ray of the left femur revealed an acute fracture of the left femoral neck. Review of the Interdisciplinary Team (IDT) Post Fall Review, signed 03/08/19, revealed there were no predisposing diseases or conditions that might have contributed to the fall. The review revealed the resident was wearing open heel slippers at the time of the fall; however, review of the care plan revealed the resident was to have non-skid footwear when ambulating/transfer. Further review revealed an intervention to ensure the slippers were put up. Interview with Certified Nursing Assistant (CNA) #5, on 04/05/19 at 8:38 PM, revealed she went to Resident #36's room to pick up a lunch tray when she heard someone say help me. The CNA stated she looked in the bathroom, discovered the resident lying on the floor, and notified the nurse. Further interview with CNA #5 revealed she provided incontinent care later in the afternoon and stated the resident was still hurting. According to the CNA, the resident needed one (1) person to assist with transfers and toileting; however, the resident was good by himself/herself prior to the fall. The CNA did not recall if the resident's call light was activated. Interview with CNA #3, on 04/05/19 at 1:37 PM, revealed she checked on residents every hour or two (2) and when she answered call lights. She revealed staff should be aware of resident needs to ensure their safety and stated CNAs were responsible for ensuring interventions were in place to prevent potential falls, including appropriate footwear. Interview with Licensed Practical Nurse (LPN) #5, on 04/04/19 at 2:29 PM, revealed the root cause of the fall was the resident got up unassisted to the bathroom; however, she could not recall if the call light was activated because she was charting at the nurses' station at the time of the fall. Interview with the Assistant Director of Nursing (ADON), on 04/05/19 at 9:32 AM, revealed Resident #36 was able to transfer and toilet independently prior to the fall, depending on how the resident felt, and improper footwear was the root cause of the fall. She stated she asked the resident what happened and the resident said he/she had on open heeled shoes and his/her foot came out the shoe and he/she lost his/her balance and fell . The ADON revealed she did not know if the resident's call light was activated or not and she did not think there was a call light report. Interview with the Director of Nursing (DON), on 04/05/19 at 2:31 PM, revealed the Unit Managers were responsible for monitoring CNAs and nurses to ensure compliance and resident safety. Interview with the Administrator, on 04/05/19 at 3:42 PM, revealed the Unit Manager, ADON, and DON were responsible for oversight of the clinical process to ensure systems were in place and working.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure one (1) of one (1) residents received oxygen therapy in accordance with professional standards of practice and physician's order, Resident #16. Resident #16 had a physician order to administer oxygen at two (2) liters per minute (LPM) to maintain oxygen saturation levels greater than 90%, and check every shift. However, observation revealed the resident's oxygen was set at three (3) LPM, and record review revealed the saturation levels were not checked every shift as ordered. The findings include: Review of the facility's Oxygen Administration Policy, dated October 2010, revealed the procedure included to review the physician's orders for oxygen administration, review the resident's care plan to assess for any special needs of the resident, and place the resident on the prescribed oxygen. Review of the facility's Medication and Treatment Orders Policy, dated July 2016, revealed medications would be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Review of Resident #16's clinical record revealed the facility admitted the resident on 01/05/19, with diagnoses of Atrial Fibrillation, Malignant Neoplasm of Unspecified Site of Unspecified Breast, Malignant Neoplasm of Uterus, and Chronic Kidney Disease. Review of Resident #16's Admission Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of thirteen (13) of fifteen (15) and determined the resident was interviewable. Further review of the MDS revealed Resident #16 received oxygen therapy. Review of Resident #16's Physician Orders, dated 01/18/19, revealed staff was to administer the resident oxygen at two (2) LPM per nasal cannula continuous to maintain oxygen saturation greater than 90% and check every shift. However, review of Resident 16's Weights and Vitals Summary data, dated 01/18/19 through 04/04/19, revealed oxygen saturation levels were not recorded on 03/11/19, 03/13/19, and 03/24/19. Further review revealed oxygen saturation levels were not recorded every shift on 01/18/19, 02/07/19, 02/10/19, 02/11/19, 02/13/19, 02/14/19, 02/17/19, 02/21/19, 02/23/19, 02/25/19, 02/27/19, 03/01/19, 03/02/19, 03/05/19, 03/07/19, 03/10/19, 03/12/19, 03/14/19, 03/15/19, 03/18/19, 03/19/19, 03/28/19, 03/31/19, 04/01/19, and 04/04/19. In addition, observation of Resident #16, on 04/02/19 at 11:10 AM and 04/05/19 at 9:41 AM, revealed the resident was receiving oxygen at three (3) LPM per nasal cannula instead of the ordered two (2) LPM. Interview with Resident #16, on 04/05/19 at 9:43 AM, revealed he/she was not aware of anyone changing the flow rate on the oxygen or checking his/her oxygen levels using a pulse oximeter. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #16's caregiver, on 04/05/19 at 9:47 AM, revealed she worked from 9:00 AM until 1:00 PM three days a week to provide activities of daily living (ADLs) care and cleaned the resident's room; however, she did not provide oxygen services for the resident. Further interview revealed she had seen nursing staff check the resident's oxygen saturation levels using a pulse oximeter and had not seen nursing staff change the flow rate of the oxygen. Interview, on 04/05/19 at 10:13 AM, with Licensed Practical Nurse (LPN) #7 revealed she was required to provide oxygen care to residents which included checking the oxygen flow rate and oxygen saturation levels, then recording the information on the Treatment Administration Record (TAR) every shift in the facility's electronic data system. Further interview revealed if the oxygen flow rate and saturation level was not recorded in the electronic system, then it was considered not done. Resident #16's oxygen flow rate should be set at two (2) LPM per physician order. The LPN then checked Resident #16's oxygen setting and confirmed the resident was not receiving oxygen at the physician ordered rate. Interview with the Assistant Director of Nursing (ADON), on 04/05/19 at 11:15 AM, revealed nurses were required to assess each resident's oxygen flow rate every shift to ensure the resident was receiving the physician ordered amount of oxygen and per policy. Further interview revealed she was not aware the oxygen saturation levels were not checked every shift for Resident #16. Interview with the Director of Nursing (DON), on 04/05/19 at 2:20 PM, revealed nursing staff was to take the oxygen saturation levels, ensure the oxygen flow rate was correct, obtain orders to get oxygen saturation levels, record oxygen rate and saturation levels in electronic system, and change the oxygen tubing weekly on Sundays during the 11:00 PM - 7:00 AM shift. The Unit Managers were to ensure orders were correct and nursing staff were completing job tasks. Further interview revealed the numerous missing entries of the oxygen saturation levels on Resident #16's TAR could be a result of not understanding how to document in the electronic system; however, the facility switched to the electronic system in May 2018.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents received timely treatment and care to manage pain for one (1) of twenty-one (21) sampled residents, Resident #36. Resident #36 fell on [DATE] at approximately 1:00 PM. The resident complained of hip pain at approximately 3:30 PM; however, was not sent out to the hospital for evaluation and treatment until approximately 8:00 PM, four (4) and a half hours later. The findings include: Review of the facility's policy, Acute Condition Changes - Clinical Protocol, revised December 2015, revealed direct care staff, including Nursing Assistants would be trained in recognizing subtle but significant changes in the resident and how to communicate these changes to the nurse. Before contacting a physician about someone with an acute change of condition, the nursing staff should make detailed observations and collect pertinent information to report to the physician, and nursing staff should contact the physician based on the urgency of the situation. According to the policy, staff would monitor and document the resident's progress and responses to treatment, and the physician would adjust treatment accordingly. If it was decided, after sufficient review, that care or observation could not reasonably be provided in the facility, the attending physician would authorize transfer to an acute hospital, emergency room , or another appropriate setting. Review of the clinical record revealed the facility admitted Resident #36 on 12/12/18, with diagnoses to include Parkinson's disease, Repeated Falls, Type 2 Diabetes, Polyosteoarthritis, and Atrial Fibrillation. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15) and determined he/she was interviewable. Observation of and interview with Resident #36, on 04/01/19 at 7:19 PM and 04/04/19 at 9:02 AM, revealed the resident in bed with an abductor cushion positioned between his/her legs. The resident stated he/she had fallen in the bathroom and fractured a hip. The resident stated when he/she fell ; he/she heard a crack and stated it hurt very badly. The resident revealed he/she could not recall if the nurse administered pain medication because, when you hurt like that, it is like you go out of it. The resident further stated after the fall, the facility did not send him/her to the emergency room (ER) until four (4) or five (5) hours later. Review of Resident #36's neurological assessments, dated 03/07/19, revealed the resident complained of pain beginning at 3:30 PM and continued throughout the day until he/she was transferred to the ER at approximately 8:00 PM; however, the severity of the pain was not assessed. Further review revealed there was no assessment for motor function of the left lower extremity from 12:30 PM to 3:30 PM. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #36's Medication Administration Record (MAR), dated March 2019, revealed a physician order, with a start date of 12/13/18, for Norco 5-325 milligram (mg) every six (6) hours as needed for pain. Further review revealed there was no documentation for administration of pain medication on the day of the fall, 03/07/19; however, review of the Controlled Drug Record for Norco 5-325 milligram (mg) revealed staff removed pain medication from the package at 2:00 PM and 8:00 PM. Review of the Situation, Background, Assessment, Recommendation (SBAR) Note, dated 03/07/19, revealed Resident #36 sustained an unwitnessed fall at around 1:00 PM. There were no changes in the resident's condition following the fall, including functional status; however, the neurological assessment revealed there was no assessment for motor function of the left lower extremity from 12:30 PM to 3:30 PM. Further review of the SBAR revealed the resident complained of hip pain and a physician's order was obtained for an x-ray of the left hip. Review of the Progress Notes, dated 03/07/19 at 9:15 PM, revealed Resident #36 was transferred to the ER for evaluation of the left hip related to an unwitnessed fall and complaints of excruciating pain with severity rated as ten (10) out of ten (10) (pain scale from one (1) to ten (10). Further review revealed there was no documentation regarding pain assessment or management prior to 9:15 PM. Review of the ER Note, dated 03/07/19, revealed Resident #36 arrived at the ER at 8:27 PM with a pain score of ten (10) out of ten (10). Further review revealed x-ray of the left femur revealed an acute fracture of the left femoral neck. Interview with Licensed Practical Nurse (LPN) #5, on 04/04/19 at 2:29 PM, revealed she assessed Resident #36 post fall and discovered the resident had difficulty with movement of the left leg because it hurt. She stated she notified the physician and received an order for an x-ray, but did not request it STAT (immediate) because the resident was not complaining of severe pain. LPN #5 revealed the resident complained of increased pain severity (eight (8) out of ten (10)) about an hour after the fall and she administered pain medication; however, she did not document the pain assessment or administration of the medication, and she did not document if the pain medication was effective. Further interview with LPN #5 revealed x-ray results were faxed to the main nurses' station (A, B, and C Halls) and nurses used their own judgement to check for results. According to LPN #5, she gave report at the end of the shift for LPN #6 to follow-up with the resident. Interview with LPN #6, on 04/04/19 at 4:11 PM, revealed Resident #36 was grimacing and appeared to be in distress when he performed initial rounds at around 3:00 PM. He revealed LPN #5 reported the resident had fallen around 12:00 PM or 1:00 PM; however, x-ray staff had not arrived yet. He stated at around 5:00 PM, he called to find out the status of the x-ray and discovered it was not ordered STAT. The LPN stated because the resident was in severe pain, he requested the order be changed to STAT. The nurse further revealed when he assisted with the x-ray the resident was in excruciating pain. According to LPN #6, the x-ray should have been performed within an hour or so of the fall. He stated he waited a while to notify the physician of the resident's pain because he was waiting for the x-ray results to come back, but the resident's pain was so bad he went ahead and called the physician. According to LPN #6, the x-ray report/results had not arrived prior to the resident's transfer to the ER. The facility did not provide a copy of the resident's x-ray results. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview, on 04/04/19 at 2:34 PM, with the [NAME] President of Operations for the radiology company revealed LPN #5 called in a routine x-ray order at 12:52 PM. He further revealed LPN #6 changed the order to STAT at 4:14 PM, the x-ray was completed at 5:38 PM, and the report was faxed to the facility at 5:58 PM with findings of a femoral neck fracture; however, interview with LPN #6 revealed the results were not received prior to the resident's transfer to the ER (approximately 8:00 PM). Interview with the Unit Manager, on 04/05/19 at 1:37 PM, revealed nurses were responsible for monitoring the fax machine for x-ray results. The UM further revealed there was only one (1) fax machine for the facility and reports could potentially get mixed in with other paperwork. She stated the facility did not have a tracking system for x-ray reports and the current process for receipt of reports was not effective. Interview with the Assistant Director of Nursing (ADON), on 04/05/19 at 9:32 AM, revealed LPN #5 assessed Resident #36 post-fall and the resident did not have classic signs and symptoms of a fractured hip. She revealed the resident was able to bear weight and stand when staff assisted him/her back to the wheelchair following the fall. The ADON stated she did not have the nurse order the x-ray STAT because the resident was not screaming out in pain. According to the ADON, the nurse should have sent the resident to the ER if the pain medication was not effective. The ADON revealed she was not aware of any issues related to pain management or delay of the x-ray results. Interview with the Administrator, on 04/05/19 at 3:42 PM, revealed he was not aware of any issues related to timeliness of x-ray reports/results. He further revealed there was potential for both psychosocial and physical harm related to pain management; however, he was not aware of an issues related to Resident #36's pain management post fall.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34116 Based on observation, interview, and facility policy review, it was determined the facility failed to ensure medications were stored securely in two (2) of five (5) medication carts, carts A and B. The findings include: Review of the facility's policy, Storage of Medications, revised April 2007, revealed compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals should be locked when not in use, and trays or carts used to transport such items should not be left unattended if open or otherwise potentially available to others. Observation, on 04/01/19 at 6:20 PM, revealed medication cart A, located in front of the A, B, and C Halls' nurses' station, was unlocked and unattended. Observation of medication pass, on 04/01/19 at 8:35 AM, revealed Licensed Practical Nurse (LPN) #3 left medication cart B unlocked while she administered medication to Resident #13. Interview with LPN #3, on 04/03/19 at 8:59 AM, revealed the medication cart should remain locked to prevent a resident, visitor, or staff from accessing the medication; however she forgot to lock the cart because she was distracted talking to the resident. Observation, on 04/03/19 at 2:50 PM, revealed medication cart A was unlocked in front of the A, B, and C Halls' nurses' station and a resident was seated in a wheelchair across from the cart. Interview with LPN #4, on 04/01/19 at 6:39 PM, revealed the medication cart should be locked at all times to prevent resident access; however he forgot to lock the cart when he went to the supply room. He revealed a resident could get sick if he/she took a medication not prescribed for them. Interview, on 04/05/19 at 1:58 PM, with the Unit Manager (UM) for A, B, and C Halls revealed she monitored medication carts daily and had not noticed any unlocked carts. Interview with the Assistant Director of Nursing (ADON), on 04/05/19 at 9:32 AM, revealed she monitored medication carts throughout the day and had not identified any concerns related to unlocked carts. Interview with the Director of Nursing (DON), on 04/05/19 at 2:31 PM, revealed she randomly checked medication carts during the day to ensure they were secured. The DON stated she was not aware of any issues related to unsecured carts. Interview with the Administrator, on 04/05/19 at 3:42 PM, revealed he monitored the facility randomly during the evening/night shift and had not identified any concerns with unlocked medication carts.

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	185348	A. Building B. Wing	04/05/2019

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **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 obtain emergency dental services for one (1) of two (2) sampled residents, Resident #8. The findings include: Review of the facility's policy, Dental Services, revised December 2016, revealed routine and 24-hour emergency dental services were provided to residents through a contract agreement with a licensed dentist that came to the facility monthly, or through referral to the resident's personal dentist, community dentist, or other health care organization(s) that provided dental services. The policy revealed social services representatives would assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible. Review of the clinical record revealed the facility admitted Resident #8 on 03/18/13, with diagnoses to include Guillain-Barre Syndrome, Hemiplegia and Hemiparesis affecting the left non-dominant side, Chronic Pain, and Chronic Obstructive Pulmonary Disease (COPD). Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #8 with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15) and determined he/she was interviewable. Interview with Resident #8, on 04/02/19 at 9:00 AM, revealed the resident had a toothache that started about a week ago. According to the resident, a dental appointment was scheduled; however, the dentist could not evaluate him/her until 05/08/19. The resident further revealed he/she took pain medication and used an oral anesthetic, which helped with the pain but did totally relieve the pain. Review of the Medication Administration Record (MAR) Notes, dated 03/11/19, revealed the resident requested pain medication for complaints of a toothache. Interview with Licensed Practical Nurse (LPN) #5, on 04/03/19 at 1:48 PM, revealed Resident #8 had complained of a toothache for a couple of weeks and she assumed the Unit Manager scheduled a dental appointment. LPN #5 stated it was important to ensure the resident was seen by the dentist to prevent a potential abscess of the tooth. Interview with Unit Manager (UM), on 04/05/19 at 1:58 PM, revealed Resident #8 had complained of a toothache off and on for a couple of weeks and stated the Social Services Director (SSD) scheduled an appointment for May. The UM stated a toothache could potentially effect a resident's ability to eat, nutrition, or activities of daily living. According to the UM, the facility did not have a provider for 24-hour emergency dental care. Interview with the SSD, on 04/03/19 at 2:33 PM, revealed Resident #8 made her aware of dental concerns at the beginning of March and she attempted to schedule an appointment but hit major hurdles. According to the SSD, the facility's current dental provider was hard to work with; however, she did not report the issue to the Director of Nursing (DON) or Administrator. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing (ADON), on 04/05/19 at 9:32 AM, revealed the facility was responsible for ensuring residents received 24-hour emergency dental care and it would not be appropriate for Resident #8 to wait until May for an appointment. She revealed the facility was having problems scheduling dental appointments due to issues with the payor source. Interview with the Administrator, on 04/05/19 at 3:42 PM, revealed residents should have access to emergency dental care when needed and he stated he was not aware of any issues with dental providers and scheduling of appointments.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34116 Based on interview, record review, and facility policy review, it was determined the facility failed to ensure controlled medications were accurately documented for one (1) of twenty-one (21) sampled residents, Resident #36. Record review revealed nurses signed out controlled medication on the Controlled Drug Record; however, the medication was not documented on the Medication Administration Record (MAR) as administered. The findings include: Review of the facility's policy, Administering Medications, revised December 2012, revealed the individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. If a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication should initial and circle the MAR space provided for that drug and dose. The facility did not provide a policy for Accountability of Controlled Medications. Record review revealed Resident #36 had a physician order, dated 12/13/18, for Hydrocodone-Acetaminophen (Norco) 5-325 milligram (mg), one (1) tablet by mouth every six (6) hours as needed (PRN) for pain. Review of Resident #36's Controlled Drug Record, for February 2019, revealed staff signed out sixty-three (63) doses of Norco 5-325 mg. However, review of the MAR, for February 2019, revealed forty-eight (48) of the doses were not documented as administered to the resident. Further review of the Controlled Drug Records, for March 2019, revealed staff signed out twenty (20) doses of the Norco; however, review of the MAR, for March 2019, revealed fifteen (15) of the doses were not documented as administered to the resident. Interview with Licensed Practical Nurse (LPN) #5, on 04/04/19 at 2:29 PM, revealed she was responsible for signing out controlled medication on the Controlled Drug Record and documenting the administration on the MAR. She stated all PRN medications administered should be documented on the MAR to ensure pain management and to prevent a potential medication error. The LPN stated not all of the doses of Norco were accounted for because the MAR was not accurate. The nurse stated she was bad at documenting and needed to work on it. Interview with LPN #6, on 04/04/19 at 4:11 PM, revealed controlled medication should be signed out on the drug record when removed and on the MAR when administered. He further revealed the nurse should also follow up after the medication was administered and document the effectiveness on the MAR. He stated there were times when he might not have documented on the MAR because he was busy. According to the LPN, there was a potential for misappropriation of narcotics related to the missing entries on the MAR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing (ADON), on 04/05/19 at 9:32 AM, revealed Resident #36's MAR was not accurate and stated she could not determine if the Norco was effective because the nurse did not document the administration or follow-up on the MAR. She further revealed the lack of documentation posed a risk for potential diversion of the controlled medication. The ADON revealed she did not audit MARs or drug records to ensure accuracy and stated she was not aware of any concerns prior to the survey. Interview with the Director of Nursing (DON), on 04/05/19 at 2:31 PM, revealed staff was to sign out controlled medication on the drug record and documents administration on the MAR to ensure accountability, as well as, effectiveness of the medication. She stated there was a potential for ineffective pain management and/or potential for diversion related to the lack of documentation. The DON revealed the pharmacy reviewed the MARs and drug records monthly and she was not aware of any concerns. Interview with the Administrator, on 04/05/19 at 3:42 PM, revealed he was not aware of any concerns related to controlled drug records and MAR documentation. He revealed it was concerning there was no administration record of the controlled medication, which resulted in inadequate accountability.

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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. 34116 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to maintain infection control during wound care for one (1) of three (3) sampled residents, Resident #37. The findings include: Review of the facility's policy, Infection Control Guidelines for All Nursing Procedures, revised August 2012, revealed Standard Precautions would be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard Precautions applied to blood, body fluids, secretions, and excretions regardless of whether or not they contained visible blood, non-intact skin, and/or mucous membranes. Review of the facility's policy, Handwashing/Hand Hygiene, revised August 2015, revealed the facility considered hand hygiene the primary means to prevent the spread of infections. Use of an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water, were used before handling clean or soiled dressings, gauze pads, etc; before moving from a contaminated body site to a clean body site during resident care; and after removing gloves. The use of gloves did not replace hand washing/hand hygiene. The policy revealed integration of glove use along with routine hand hygiene was recognized as the best practice for preventing healthcare-associated infections. Record review revealed Resident #37 had a wound to the abdomen with orders for wound care and dressing change. Observation, on 04/01/19 at 7:01 PM, revealed Resident #37 in bed watching television. Interview during observation revealed the resident had a daily treatment for an abdominal wound. Observation of wound care for Resident #37, on 04/03/19 at 1:41 PM, revealed Licensed Practical Nurse (LPN) #5 performed hand hygiene and donned gloves prior to the treatment. LPN #5 removed the soiled dressing from the wound, removed her gloves, and discarded them in the trash. The nurse did not perform hand hygiene and donned new gloves, opened a bottle of normal saline, and cleansed the wound. With the same gloves, she scooped up Medi-honey gel with her finger and applied it to the wound. She removed the gloves, did not perform hand hygiene, donned new gloves, applied a silver alginate dressing to the wound, and covered it with a 4 x 4 border gauze. Interview with LPN #5, on 04/03/19 at 1:48 PM, revealed she should have changed gloves after cleaning the wound and before applying the new dressing to prevent transfer of dirty material to the wound. LPN #5 further revealed she probably should have used a Q-tip or tongue blade to apply the Medi-honey; however, she thought it was okay to use a gloved finger. According to LPN #5, a wound could potentially get infected or worsen as a result of improper technique. Interview with the Assistant Director of Nursing (ADON), on 04/05/19 at 9:32 AM, revealed nurses were responsible for ensuring proper hand hygiene and infection control technique during wound care.