STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185237	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee Park Rehabilitation	2100 Cherokee Ridge Way Louisville, KY 40205

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings included:Review of facility policy, Indwelling Catheter Use and Removal, dated 06/13/2025, indicated, d. Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodgement of the catheter; and e. securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the bladder.Review of facility document, Resident Face Sheet indicated the facility admitted Resident #13 on 02/23/2023. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of obstructive and reflux uropathy and chronic stage 3 kidney disease.Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2025, revealed the facility assessed Resident #13 with a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had an indwelling catheter.Review of Resident #13's Care Plan revealed a problem statement initiated 02/23/2023 that indicated the resident required an indwelling urinary catheter related to obstructive uropathy. Interventions directed staff to secure the catheter to prevent pulling or dislodgement (initiated 09/01/2023).Review of Resident #13's Physician Order Report for the timeframe 06/09/2025-07/09/2025, revealed an order dated 02/27/2023 that directed staff to secure the catheter to prevent pulling or dislodgement every shift.During an observation on 07/06/2025 at 2:10 PM, Resident #13 wore shorts and the resident's urinary catheter tubing was not secured and hung between the resident's legs.During a concurrent observation and interview on 07/07/2025 at 11:19 AM, Resident #13 was in a wheelchair in their room with shorts on. The resident's urinary catheter tubing hung freely and was not secured. Resident #13 stated staff secured the tubing sometimes when they went out of the facility, but staff removed it when they returned. During an interview on 07/07/2025 at 2:48 PM, Certified Nurse Aide (CNA) #12 stated the nurses applied the securement device for a resident's urinary catheter, and the CNAs made sure the urinary catheter tubing was in the securement device. CNA #12 stated the urinary catheter tubing should be secured so it did not pull, tug, or hurt. CNA #12 stated Resident #13 usually had a securement device on but was not sure why it was not on 07/07/2025.During a concurrent interview and observation on 07/07/2025 at 3:04 PM, CNA #13 stated the nurses made sure a resident's catheter tubing was secured. CNA #13 observed Resident #13 and stated the resident's urinary tubing was not secured and would let the nurse know.During a concurrent observation and interview on 07/07/2025 at 3:28 PM, Registered Nurse (RN) #14 stated the nurse was responsible to make sure a resident's catheter tubing was secured. RN #14 observed Resident #13 and stated the resident's urinary catheter tubing was not secured, and it should have been secured to prevent pulling, leaking, and infection. RN #14 placed a leg strap and secured the indwelling catheter tubing.During an interview on 07/07/2025 at 3:44 PM, Licensed Practical Nurse Unit Manager (LPN UM) #15 stated the urinary catheter tubing should be secured so it did not pull/or and cause damage. LPN UM #15 stated Resident #13's ability to remove the securement was care planned as of 07/07/2025.During an interview on 07/08/2025 at 2:28 PM, the Director of Nursing (DON) stated she expected a resident's urinary catheter tubing to be secured. The DON stated the facility sometimes had a resident who did not like the securement device or could not tolerate the adhesive but did find the securement devices useful. The DON stated the urinary catheter tubing needed to be secured to prevent the catheter tubing from being pulled and displaced. During an interview on 07/09/2025 at 1:55 PM, the Administrator stated he would defer to nursing about a resident's urinary catheter tubing being secured.

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, document review, and facility policy review, it was determined the facility failed to ensure their medication error rate was 5 percent (%) or less. There were 3 errors out of 27 opportunities, which resulted in a 11.11% medication error rate for 1 of 7 residents (Resident #13) observed for medication administration. The findings included:Review of facility policy, Medication Administration, revised 02/01/2025, indicated, 14. Administer medication as ordered in accordance with manufacturer specifications.Review of manufacturer information, Lantus insulin glargine injection 100 units/mL [milliliter] manufacturer specification with a copyright date of 2022, indicated Step 3. Perform a Safety Test Dial a test dose of 2 units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. Step 4. Select the Dose Make sure the window shows 0 and then select the dose. Otherwise you will inject more insulin than you need and that can affect your blood sugar level.Review of the undated FlexTouch 2U [units] increment pens manufacturer specification indicated, Priming your Demonstration Pen: Step 7: Turn the dose selector to select 2 units Step 8: Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top. Step 9: Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0'. The 0 must line up with the dose pointer. A drop of Test Medium should be seen at the needle tip. If you do not see a drop of Test Medium, repeat steps 7 to 9, no more than 6 times. If you still do not see a drop of Test Medium, change the needle and repeat steps 7 to 9. Selecting your dose: Step 10: This 2-unit increment Pen is designed to deliver the number of unit dialed. Do not perform any dose conversions. Turn the dose selector to select the number of units you need to inject. Review of the Resident Face Sheet indicated the facility admitted Resident #13 on 02/23/2023. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus with hyperglycemia.Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2025, revealed the facility assessed Resident #13 with a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident received insulin injections daily during seven-day assessment period.Resident #13's Care Plan included a problem statement initiated 02/23/2023, that indicated the resident had a potential for hypo/hyperglycemia related to diabetes mellitus. Interventions directed staff to administer medications as ordered (initiated 02/23/2023).Resident #13's Physician Order Report, for the timeframe 06/09/2025 - 07/09/2025, revealed an order dated 04/04/2025 for Novolog FlexPen U-100 insulin, inject 6 units subcutaneously before meals at 7:30 AM, 11:30 AM, and 4:00 PM and an order dated 04/07/2025, for Novolog FlexPen U-100 insulin, inject 2 unit per sliding scale if the resident's blood sugar was 150 milligrams per deciliter (mg/dL) to 200 mg/dL. An additional order dated 04/15/2025, for Lantus Solostar U-100 insulin, inject 40 unit subcutaneously twice a day.During a concurrent medication administration observation and interview on 07/08/2025 at 7:40 AM, Registered Nurse (RN) #10 performed a fingerstick blood glucose on Resident #13 and the resident's blood sugar was noted to be 172 mg/dL. RN #10 prepared Resident #13's medications, to include Novolog FlexPen and Lantus Solostar insulin pens. RN #10 did not perform a safety check of the Lantus Solostar insulin pen and failed to prime the needle as specified by the manufacturer for the Lantus Solostar insulin and the Novolog FlexPen. RN #10 stated she did not know how to prime the injection pens. RN #10 also failed to administer 6 units of Novolog FlexPen to the resident.During an interview on 07/09/2025 at 6:54 AM, RN #10 stated she should have primed the insulins with 2 units then turned to the dose that was ordered. RN #10 stated the insulin needle needed to be primed to make sure there was no air and to make sure the resident got the right dose.During a follow-up interview on 07/09/2025 at 10:31 AM, RN #10 stated she did not administer the 6 unit of Novolog on 07/08/2025 to Resident #13. During a telephone interview on 07/09/2025 at 12:52 PM, the Pharmacy Consultant stated the process for insulin pen administration would be to identity the resident, confirm the dose, staff should wash their hands, clean the pen with alcohol before attaching the needle, normally perform an air shot or what was called priming, then dial up the dose, clean the site, then administer the insulin. The Pharmacy Consultant stated it was important to prime the needle to make sure the correct dose of insulin was being administered and to

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, it was determined the facility failed to label and discard expired food items in 1 of 3 resident nourishment refrigerators (A-Wing nourishment refrigerator).The findings included:Review of facility policy, Use and Storage of Food Brought in by Family or Visitors, reviewed 06/17/2025, revealed, 2. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated a. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. b. The prepared food must be consumed by the resident within 3 days. c. If not consumed within 3 days, food will be thrown away by facility staff. D. The facility will not be responsible for maintaining any reusable items. During an observation of the A-Wing resident nourishment refrigerator on 07/07/2025 at 10:40 AM, the surveyor noted two, undated and unlabeled clear plastic bowls of salad; two packs of unlabeled and undated cookies; one brown unlabeled and undated plastic bag that contained a molded slice of ice cream pie; four unlabeled and undated ice cream cupcakes; and one unlabeled and undated leftover fast-food meal. During an interview on 07/07/2025 at 10:47 AM, the Culinary Manager stated the food should have been labeled with a date and resident name. Per the Culinary Manager, the nursing staff was responsible for ensuring all food items were labeled and dated.During an interview on 07/07/2025 at 3:39 PM, the Administrator confirmed the food items were inappropriately stored in the A-Wing nourishment refrigerator.During an interview on 07/09/2025 at 10:44 AM, Licensed Practical Nurse (LPM) Unit Manager (UM) #17 stated all foods were to be labeled, dated, and removed after a week if opened. LPN UM #17 stated it was the responsibility of nursing staff to check the contents of the nourishment refrigerator daily. During an interview on 07/09/2025 at 11:00 AM, the Assistant Director of Nursing (ADON) stated all food should be labeled with a date and name and discarded after three days. The ADON stated the nursing staff were responsible for the contents of the resident nourishment refrigerators.During an interview on 07/09/2025 at 11:14 AM. the Director of Nursing (DON) stated all food items brought in by family should be labeled and dated. According to the DON, the nursing and dietary staff should remove food items after three days. During a follow-up interview on 07/09/2025 at 11:31 AM, the Administrator stated all resident refrigerators should be checked by staff daily for non-labeled and dated foods items.