STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185335	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of South Louisville	1120 Cristland Road Louisville, KY 40214

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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. Based on observation, interview, record review, and facility policy review, the facility failed to ensure physician orders were followed related to the administration of supplemental oxygen for 1 of 5 residents residents sampled for respiratory care (Resident (R)18) of a total resident sample of 24 residents. The findings include: Review of the facility policy titled, Oxygen Administration Policy, revised 05/30/2024, revealed, Purpose: Oxygen therapy is administered as ordered by a physician. Per policy review, Check the resident's medical record to confirm the presence of a complete and appropriate physician's order. Review of the Face Sheet for R18 revealed the facility admitted the resident on 04/10/2024, with diagnoses that included: acute on chronic diastolic (congestive) heart failure (CHF), acute and chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease (COPD). Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 10/17/2024, revealed the facility assessed R18 as having a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. Continued review of the MDS revealed the facility assessed R18 to have shortness of breath with exertion when sitting, and when lying flat and to require oxygen therapy. Review of R18's Comprehensive Care Plan revealed the facility identified a problem dated 04/12/2024, that indicated the resident had impaired oxygen gas exchange related to COPD/respiratory failure/CHF and required oxygen therapy. Continued review of the care plan revealed interventions which included staff to administer R18's supplemental oxygen as ordered (initiated 04/12/2024). Review of R18's physician's Orders revealed an active order for supplemental oxygen to be administered via nasal cannula at 3 liters per minute (L/min) continuously every shift, with a start date of 08/13/2024. Observation on 01/19/2025 at 1:16 PM, revealed R18 in his/her room, seated in a wheelchair, receiving supplemental oxygen via a nasal cannula. Further observation revealed the oxygen concentrator was set at 4 L/min and not the ordered 3 L/min. Review of R18's Medication Administration History, for the timeframe of 01/01/2025 through 01/20/2025, revealed on 01/19/2025, Registered Nurse (RN) 3 (dayshift nurse) and RN 4 (nightshift nurse) both documented administering supplemental oxygen to R18. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 01/20/2025 at 9:19 AM, RN 2 stated R18's supplemental oxygen should have been flowing at 3 L/min. RN 2 stated the nurses needed to check R18's oxygen every morning to see if it flowing at the correct rate. She said she had not checked the resident's oxygen yet that morning. RN 2 reported the nursing staff had orders in the facility's electronic health record (EHR) and the nurses needed to check the orders every morning. She stated the nurses were to sign that they checked the supplemental oxygen rate. Observation at 9:21 AM, revealed RN 2 entered R18's room and confirmed the resident's oxygen concentrator was set at 4 L/min rate and not the ordered 3 L/min rate. In interview, at the time of observation, R18 stated staff turned it up the oxygen when he/she was out of breath. In additional interview, at the time of observation, RN 2 stated the night nurse must have increased R18's supplemental oxygen. Review of R18's Progress Notes, for the timeframe from 01/18/2025 through 01/21/2025, revealed no documented evidence of notification to the physician or Nurse Practitioner (NP), by facility nurses, for the increase in the resident's supplemental oxygen. During telephone interview on 01/21/2025 at 5:01 PM, RN 4 stated R18 should have been on 3 L/min of supplemental oxygen as ordered. RN 4 stated typically, during medication administration, she checked the resident's supplemental oxygen amount to ensure it was flowing correctly. She reported she worked the night shift (6:00 PM to 6:00 AM) on 01/18/2025 and said at the end of her shift, R18 had been in bed and the supplemental oxygen was set at 3 L/min. RN 4 further stated RN 3 had been the RN who worked on 01/19/2025, during the day shift (6:00 AM to 6:30 PM). During telephone interview on 01/21/2025 at 6:00 PM, RN 3 stated she thought R18's supplemental oxygen was to be on 3 L/min. RN 3 said every morning, during medication administration, she checked R18's supplemental oxygen rate and oxygen saturation (O2) rate because the resident had pneumonia. She stated she worked the day shift on 01/19/2025 (when R18's oxygen was at 4 L/min). RN 3 stated R18 asked her about the supplemental oxygen that morning, and RN 3 said she checked the oxygen concentrator, and it was at the prescribed rate of 3 L/min in the morning time. She reported she was not aware of how or why the amount of R18's supplemental oxygen was adjusted differently and stated no other nurse changed the amount. RN 3 further stated she had not contacted the physician to increase the amount of supplemental oxygen. During interview on 01/22/2025 at 10:06 AM, R18 stated he/she did not change the settings on the oxygen concentrator. R18 further stated, I don't mess with the medical stuff. During telephone interview on 01/23/2025 at 3:23 PM, the NP stated the expectation was if resident's supplemental oxygen needed to be increased, the provider or herself needed to be notified. The NP further stated the medical staff did not want a resident to have more supplemental oxygen than needed, to avoid them becoming dependent on the supplemental oxygen. During interview on 01/23/2025 at 2:55 PM, the Director of Nursing (DON) stated nurses were to be checking residents' supplemental oxygen rates when administering medication and when checking on the residents. The DON further stated the nurses should be following the physician's orders. During interview on 01/23/2025 at 4:28 PM, the Chief Executive Officer (CEO)/Administrator stated the nurses should follow the physician's orders to the best of their ability.

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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. Based on observation, interview, record review, the insulin manufacturers' instructions for use, and facility policy review, the facility failed to ensure the medication error rate was less than 5%. This was evidenced by 2 medication errors out of 34 opportunities, resulting in a medication error rate of 5.88%, which affected 1 of 5 residents observed during medication pass (Resident (R) 63) out of a total resident sample of 24. The findings include: Review of the facility policy titled, Medication Administration, revised 06/24/2024, revealed, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Further review revealed, Guideline: 1. Medication are administered in accordance with written orders of the prescriber. Review of the facility policy titled, Physicians Orders, revised, 11/16/2023, revealed, the Policy Statement noted, It is the standard of this facility that physician orders are followed, and reviewed to ensure delivery of applicable care. Per review, the facility's standard also included staff being alert for changes in (a resident's) condition related to new orders, and need to notify the physician for adverse effects from new orders or potential order changes as needed. Continued review revealed, Guideline: 1. Each resident will have physician's orders to guide the facility in caring for and treating each resident. 2. Licensed Nurses and Medication Aides are expected to follow physician's orders. Review of the Lantus SoloStar (insulin glargine injection) Instruction Leaflet, revised 11/2018, revealed to follow the instructions completely each time the SoloStar insulin was used to ensure an accurate dose. Per review, if the instructions were not followed a person might get too much or too little insulin, which might affect their blood glucose. Continued review revealed, Important information for use of SoloStar: included, Always perform the safety test before each injection. Review of the Instruction Leaflet revealed, Step 3. Perform a Safety test included Performing the safety test ensures that you get an accurate dose by: - ensuring that pen and needle work properly and remove air bubbles. Further review revealed to select a dose of 2 units by turning the dosage selector; take off the outer needle cap and keep it to remove the used needle after injection; and take off the inner needle cap and discard it. In addition, review revealed to hold the pen with the needle pointing upwards; tap the insulin reservoir so that any air bubbles rise up towards the needle; press the injection button all the way in, and check if insulin comes out of the needle tip; and You might have to perform the safety test several times before insulin is seen. Review of the Eli Lilly and Company's website, reference for the Instructions For Use for the Humalog KwikPen, revised 07/2023, revealed, Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you no not prime before each injection, you may get too much or too little insulin. Continued review revealed, Step 6: To prime your Pen, turn the Done Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the tip. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until is stops, and '0' is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the pen. Review of the Resident Face Sheet for R63 revealed the facility admitted the resident on (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/21/2022, with a medical history that included diagnoses of type 2 diabetes mellitus with unspecified complications. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 11/12/2024, revealed the facility assessed R63 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. Further MDS review revealed the facility assessed R63 to receive hypoglycemic medication during the assessment timeframe. Review of R63's physician's Orders revealed an active order dated 12/16/2024, for Lantus Solostar U-100 insulin pen, 16 units to be injected under the skin for diabetes mellitus twice a day. Continued review of the Orders also revealed an active order dated 01/22/2025, for Humalog KwikPen Insulin, with instructions to administer per the following sliding scale: - If blood sugar is less than 70, call the physician. - If blood sugar is 200 to 249, give one unit. - If blood sugar is 250 to 299, give two units. - If blood sugar is 300 to 349, give three units. - If blood sugar is 350 to 399, give four units. - If blood sugar is 400 to 450, give five units. - If blood sugar is greater than 450, give five units. - If blood sugar is greater than 450, call the physician. Further review revealed the order included special instructions to give the insulin before meals, at 7:00 AM, 11:15 AM, and 5:00 PM. During observation of medication administration on 01/22/2025 at 7:32 AM, Registered Nurse (RN) 7 checked R63's blood glucose level at 333. Observation at 7:53 AM, revealed RN 7 obtained a Lantus insulin pen that was dated 01/19/2025 and then stated, I immediately turned the dial to 16 units (without performing the safety test as per the manufacturer's instructions). Observation at 8:10 AM, revealed RN 7 administered 16 units of insulin from the Lantus pen to R63 right lower abdomen. During observation of medication administration on 01/22/2025 at 8:26 AM, RN 7 removed the cover from a new Humalog pen and attached a needle. Per observation, RN 7 entered R63's room, dialed the Humalog pen to 3 units and administered the insulin to the resident's left lower abdomen. During interview, at the time of observation, RN 7 confirmed the Humalog pen was new and stated, I shot out six units prior to administering the units. However, observation revealed RN 7 had not primed the insulin pen (as per the manufacturer's instruction) after the needle was attached. During interview on 01/22/2025 at 4:15 PM, RN 7 stated when a new insulin pen was received, that was the only time it was primed with six units. RN 7 stated when a new insulin pen was delivered, there was no specific instructions included, just the pen in a plastic bag, with a label with instructions on dosing. RN 7 reported the insulin pen did not need to be primed any more than what the pharmacy staff stated. The RN further stated if the insulin pen was primed before each use, then you are wasting it. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During phone interview on 01/23/2025 at 11:25 AM, the Facility Pharmacist (FP) stated there were specific instructions for each insulin pen and said staff should refer to the manufacturer's instructions. The FP said the insulin pen's contained extra insulin in each vial in order to verify/test it was working properly. Per the FP in interview, the Lantus pen makers always indicated to perform a safety dose check before administering the insulin, by turning the dose selector to two units and holding the pen end up, so any air bubbles would rise up each time. The FP further stated the customary practice for the Humalog insulin was to make sure the needle was on correctly and primed. During phone interview on 01/23/2025 at 3:23 PM, the Nurse Practitioner (NP) stated manufacturers' instructions should be followed regarding preparing insulin pens for resident use. The NP further stated it was expected medications were given as prescribed. During interview on 01/23/2025 at 1:28 PM, the Director of Nursing (DON) stated the expectation was for nurses to follow the physician's orders and guidelines. In interview on 01/23/2025 at 2:46 PM, the Chief Executive Officer (CEO)/Administrator stated it was the expectation that nursing staff followed physician's orders and the manufacturers' guidelines.

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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. Based on interview, record review, facility document and policy review, the facility failed to maintain a complete and accurate medical record for 1 of 5 residents sampled for unnecessary medications (Resident (R) 18) out of a total resident sample of 24. Observation revealed staff did not accurately document the correct dosage of insulin administered to R18. The findings include: Review of the facility policy titled, Physicians Orders, revised 11/16/2023, revealed it was the facility's standard for physician orders to be followed and reviewed to ensure delivery of applicable care. Continued review revealed staff were to be alert for changes in (a resident's) condition related to new orders, and the need to notify the physician for adverse effects from new orders or potential order changes as needed. Review of the facility document titled, Job Description for Charge Nurse a licensed practical nurse (LPN) or registered nurse (RN), updated December 2011, revealed the Essential Duties & Responsibilities included to Report all discrepancies noted concerning physician's orders, diet change, charting error, etc. [et cetera], to the Nurse Supervisor, Unit Manager or ADON [Assistant Director of Nursing]/DON [Director of Nursing]. Continued review of the Job Description revealed, Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures. Further review revealed, Prepare and administer medication as ordered by the physician. In addition, review revealed the document had been electronically signed by LPN 5 on 10/25/2018. Review of the Face Sheet for F18 revealed the facility admitted the resident on 04/10/2024, with diagnoses that included type 2 diabetes mellitus without complications. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 10/17/2024, revealed the facility assessed R18 as having intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Further review revealed the facility additionally assessed R18 as receiving insulin injections each day during the seven-day look back period of the Assessment. Review of R18's Care Plan revealed the facility identified a problem, initiated 04/12/2024, for the resident's diagnosis of diabetes and risk for an adverse event. Continued review revealed the interventions (initiated 04/12/2024) which included: staff being alert for signs and symptoms of hypoglycemia/hyperglycemia; completing blood glucose monitoring as ordered; and obtaining laboratory tests as ordered. Review of R18's physician's Orders revealed an active order with a start date of 11/15/2024, for insulin glargine insulin pen, 100 unit/milliliters (u/mL), 3 mL. Further review revealed the instructions noted to administer 35 units under R18's skin at bedtime related to diabetes. Review of R18's Medications Administration History, for the timeframe from 11/01/2024 through 11/30/2024, revealed LPN 5 documented the following glargine insulin pen dosages as administered to the resident: 11/16/2024 - 13 units. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/17/2024 - 33 units. 11/19/2024 - 33 units. 11/20/2024 - 33 units. 11/22/2024 - 33 units. 11/27/2024 - 33 units. 11/30/2024 - 33 units (not the 35 units as ordered). Review of R18's Medications Administration History, for the timeframe from 12/01/2024 through 12/31/2024, revealed LPN 5 documented the following glargine insulin pen dosages as administered to the resident: 12/01/2024 - 33 units. 12/03/2024 - 33 units. 12/04/2024 - 33 units. 12/10/2024 - 33 units. 12/11/2024 - 33 units. 12/14/2024 - 33 units. 12/15/2024 - 33 units. 12/25/2024 - 36 units (not the 35 units as ordered). During telephone interview on 01/23/2025 at 9:15 AM, LPN 5 stated she had given R18 the correct dosage; however, had entered the wrong dosage amount in the electronic health record. She stated a lot of times she got interrupted, and might have documented an incorrect amount as a result of that. LPN 5 reported R18 did have an order for 33 units at one time; however, knew the correct dose currently was 35 units. During interview on 01/23/2025 at 2:59 PM, the DON stated she expected the documentation in residents' medical records to be accurate.

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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. Based on observation, interview, facility document and policy review, the facility failed to ensure it established and maintained an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents sampled for enhanced barrier precautions (Resident (R)298) out of a total resident sample of 24. Observation revealed staff failed to wear the proper personal protective equipment (PPE) when providing care to R298, who was on enhanced barrier precautions (EBP). The findings include: Review of the facility policy titled, Enhanced Barrier Precautions Policy, revised 03/25/2024, revealed the facility's infection control policies and practices was intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infections. Further review of the policy revealed, 5. EBP are indicated for residents who have chronic wounds and/or indwelling medical devices regardless of MDRO [multi-drug resistant organism] status. Review of an undated facility document titled, Enhanced Barrier Precautions, revealed R298 was on EBP. Review of the Resident Face Sheet for R298 revealed the facility admitted the resident on 01/10/2025, with diagnoses that included fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with healing. Review of R298's Care Plan revealed the facility identified a problem, initiated on 01/13/2025, that noted the resident required EBP related to a surgical incision and an indwelling catheter. Continued review revealed an intervention for staff to wear PPE as indicated (initiated 01/13/2025). Per review additional review of R298's Care Plan, the facility identified a problem for R298 for potential for complications related to an indwelling catheter, initiated 01/20/2025, with interventions that included staff to provide catheter care as needed. Review of R298's Physician Order Report, dated 01/23/2025, revealed an active order, with a start date of 01/13/2025, for the resident to be on EBP due to a surgical incision. Continued review of the Physician Order Report revealed an active order with a start date of 01/20/2025, to change R298's catheter bag as needed and to contact the physician if the indwelling catheter or balloon size needed to be changed. Observation on 01/19/2025 at 1:36 PM, revealed R298's room door had a sign indicating the resident was on EBP and staff were to wear a gown and gloves when completing high-contact resident care activities, that included device care such as urinary catheters. Continued observation revealed however, Certified Nursing Assistant (CNA) 12 emptied R298's urinary catheter bag wearing only gloves. During interview on 01/19/2025 at 1:38 PM, CNA 12 stated she only wore gloves; however, should have worn a gown and gloves as per the resident's EBP. During interview on 01/23/2025 at 3:06 PM, the Director of Nursing (DON) stated she expected staff (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to wear a gown and gloves when coming in contact with residents on EBP. During interview on 01/23/2025 at 1:46 PM, the Chief Executive Director (CEO)/Administrator stated he expected staff to follow the facility's guidance regarding residents on EBP.