STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185029	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Post Acute and Rehabilitation Center	920 South Fourth Street Louisville, KY 40203

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 50000 Based on observation, interview, record review and review of the facility policy, the facility failed to ensure all drugs used in the facility were labeled in accordance with professional standards, including expiration dates, and with appropriate accessory and cautionary instructions for two of five medication carts. Observation revealed medications for Resident (R) 66 and R42 were not labeled with an opened date, and medications labeled for R12, R26, and R77 contained different medications than what the medications were labeled for. The findings include: Review of the facility policy titled, Labeling & Storage, undated, revealed all medications and biologicals were to be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices. Further review of the policy revealed labels for individual drug containers must include the resident's name, prescribing Physician, name of the medication, prescribed dose, strength and quantity, date drug was dispensed, appropriate instructions and precautions, route of administration and when applicable the expiration date. 1. Review of the face sheet for R12 revealed the facility admitted the resident on 08/10/2015, with diagnoses of dementia, heart disease with a pacemaker and peripheral vascular disease. Review of the medication orders for R12 revealed the resident was prescribed Potassium chloride (medicine used to treat low potassium) extended release (ER) 20 milliequivalent (mEq) two tablets oral, once a day; and Furosemide (medicine used to treat extra fluid in the body) 10 milligram (mg) 1 tablet oral, once a day. Observation on 06/07/2024 at 12:59 PM of R12's medication box labeled potassium chloride 20 mEq (mEq) revealed it contained two individual packaged pills identified on the packaging as Furosemide 20 milligrams (mg), with no resident label. 2. Review of the face sheet for R26 revealed the facility admitted the resident on 10/13/2014, with diagnoses of chronic respiratory failure, cerebral infarction, and heart failure. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medication orders for R26 revealed the resident was prescribed Benzonatate (a medicine used for cough) 100 mg capsule as needed, three times a day; and Carvedilol (a medicine used to treat high blood pressure and heart failure) 12.5 mg tablet, two times a day. Observation on 06/07/2024 at 12:59 PM, of R26's medication box labeled for Benzonatate 100 mg revealed it contained two individual packaged pills identified on the packaging as Carvedilol 25 mg, with no resident label. 3. Review of the face sheet for R42 revealed the facility admitted the resident on 01/18/2022, with diagnoses of dementia, type 2 diabetes, and high blood pressure. Review of the medication orders for R42 revealed the resident was prescribed Admelog SoloStar insulin pen, four times a day via subcutaneous injection based on a sliding scale for blood sugar results. Observation on 06/07/2024 at 12:59 PM, of R42 Admelog SoloStar insulin pen revealed no opened date documented on the pen or its packaging. 4. Review of the face sheet for R66 revealed the facility admitted the resident on 08/27/2021, with diagnoses of type 2 diabetes, and dementia. Review of R66's medication profile revealed the resident was prescribed Flonase nasal spray, one spray, one time a day. Observation on 06/07/2024 at 4:25 PM, of R66's medications revealed the resident had a Fluticasone nasal spray dated as opened on 01/24/2024. 5. Review of the face sheet for R77 revealed the facility admitted the resident on 12/28/2023, with diagnoses of cerebral infarction, high blood pressure, and atrial fibrillation. Review of R77's medication orders revealed the resident was prescribed acetaminophen 325 mg, two tablets every four hours as needed; and folic acid one mg tablet every morning. Observation on 06/07/2024 at 12:59 PM, of R77's medication box labeled acetaminophen 325 mg revealed it contained two individual packaged pills identified on the packaging as folic acid 1 mg, with no resident label. In an interview with Certified Medication Technician (CMT) 1 on 06/07/2024 at 3:00 PM, she stated the facility switched pharmacy providers in the past couple of weeks, and the medication from the previous pharmacy was still being used due to the abundance of supply. She stated it was important to label medications when opened so residents did not receive expired medications that could cause them adverse problems. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Licensed Practical Nurse (LPN) 5 on 06/07/2024 at 1: 24 PM, she stated two weeks ago the facility switched pharmacies and went to a new method of medication administration by using timed dose packs with all the medications contained in them. LPN 5 stated it had been confusing during medication administration because the facility still had an abundance of medication from the previous pharmacy that was in boxes and packaged individually and the new rolls all together. She stated it was important to check each individual packaged resident medication to ensure the resident was receiving the right medication. LPN 5 further stated she attended training on the new medication system, but it was still confusing at times because the facility still had the old system too. In an interview with Registered Nurse (RN) 1 on 06/07/2024 at 3:20 PM, she stated she was an agency nurse and had not worked at the facility for a while but had worked there previously. RN 1 stated she received training on the facility's new medication administration process from the floor manager, and if she had any questions, she could ask a fell ow staff nurse or go to the floor manager. She stated it was important for all medications to be labeled when opened so the nurse could determine the expiration date, which was important for resident safety. In an interview with the Unit 2 Manager on 06/06/2024 at 10:52 AM, she stated the facility had changed pharmacies and the previous supplier had sent a 90-day supply of medications leaving an abundance of medications that were currently being stored in the medication storage room in sealed bags. The Unit 2 Manager stated the facility had contacted the previous pharmacy twice to come pick up the medications; however, they had not done so yet. She stated staff received extensive training from the new pharmacy, and there was a resource book on the unit for reference. The Unit 2 Manager stated staff also had access to a 24-hour help desk if questions or problems with medications arose. She further stated to date she had only heard positive comments from staff using the new pharmacy system and was unaware of any concerns with the new medication administration process. In an interview with the Director of Nursing (DON) on 06/07/2024 at 4:20 PM, she stated the facility was working with a new pharmacy and there had been an adjustment period due to the previous supplier having done a 30-day supply of residents' medications, and now the new supplier did a seven day supply. She stated prior to the end of the previous supplier's contract, they had completed a 90-day refill for residents' medications, meaning the new supplier could not refill the medications until the 90 days was complete. The DON stated the new medication administration went into effect on 06/01/2024, and all staff received extensive training the two weeks leading up to the launch of it. In an interview with the facility's Administrator on 06/07/2024 at 2:40 PM, he stated the previous pharmacy was expected to send a courier to pick up the remaining medications on 05/27/2024, and they had not arrived to do so yet. He stated the facility had contacted the pharmacy regarding the medications and still had not been given a date for reconciliation. The Administrator stated currently the medications were being contained in a locked medication storage room in sealed bags until the previous supplier collected them. He stated the new pharmacy sent a trainer to the facility, and they had completed staff training on an individual basis that was very extensive. In addition, the Administrator stated there was a 24-hour help line and the nighttime nurse supervisors and the unit managers received additional training and were a resource if medication issues arose.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50192 Based on observation, interview, and review of the facility policy, it was determined the facility failed to ensure food was stored in accordance with professional standards for food service safety related to ensuring all food and drinks were checked for timely use and expiration dates. Observation on [DATE] revealed approximately 45 milk cartons in two milk crates dated [DATE]. The findings include: Review of the facility's Dietetic Solutions Operations Policy dated [DATE], under the Cold Storage Areas, revealed staff were to store cold foods until their used by date or expiration date. Observation during the kitchen tour on [DATE] at 11:55 AM, revealed two milk crates with approximately 45 milk cartons dated [DATE] stored in it. In interview with the Dietary Manager (DM), at the time of observation, she stated she had no concerns regarding the milk stored in the walk-in cooler. The State Survey Agency (SSA) Surveyor showed the approximately 45 cartons of out-of-date milk to the DM. She stated milk was delivered to the facility on a weekly basis, sometimes more often if needed. The DM stated she expected staff to rotate the milk on a First In - First Out method to ensure freshness. She said she had several new employees and felt that might have been part of the problem. The SSA Surveyor witnessed the DM create a laminated sign to hang on future crates of returnable products in order for the mistake not to happen again. During interview on [DATE] at 12:04 PM, the [NAME] stated any out of date products were to be removed immediately and the DM notified for direction related to gaining the credit for damaged goods. During an interview with the Administrator on [DATE] at 2:45 PM, he stated the process to ensure fresh food was to rotate the product using the First In - First Out method. He stated a potential for adverse reaction to an expired food or drink could exist. The Administrator stated his expectation of lower level staff was for them to report any concerns to their Dietary Manager.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45990 Based on observation, interview, record review, review of facility policy, and the Center for Disease Control and Prevention (CDC) guidance, it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent and control the development and transmission of communicable diseases and to implement interventions for protection for three of twelve (12) sampled residents (R), R71, R234, and R238. R71 had an indwelling medical device, a gastrostomy tube (G-tube). Observation revealed however, no Enhanced Barrier Precautions (EBP) signage posted on R71's room door and no Personal Protective Equipment (PPE) supplies available outside the resident's room. R234 had an indwelling medical device, a PEG tube. Observation revealed Licensed Practical Nurse (LPN) 6 turned R234 to his/her side without donning the appropriate PPE. Additionally, observation revealed no EBP signage posted on the resident's door and no PPE supplies located outside the door. R238 had an indwelling medical device, a percutaneous endoscopic gastrostomy (PEG) tube. Observation revealed however, no EBP signage posted on R238's room door and no PPE supplies available at the entrance of the resident's door. The findings include: Review of the facility policy titled, Isolation Precautions Guidelines undated, revealed the facility would take appropriate precautions to prevent transmission of pathogens. Further review revealed upon initiation of isolation precaution, signage for the use of specific PPE was to be placed in a conspicuous location outside the resident's room. Review of the facility policy titled, Enhanced Barrier Precautions, (EBP) undated, revealed precautions were to be taken to reduce transmissions of Multidrug-resistant organisms (MDROs) to staff hands and clothing during high contact care activities. Continued review revealed EBP were indicated for residents with open wounds that required a dressing and for indwelling medical devices regardless of colonization. Per review, the guidelines included an order was to be obtained for EBP precautions for residents with wounds, and/or indwelling medical devices such as feeding tubes, urinary catheters, and tracheostomies even if the resident was not known to be infected or colonized with a MDRO. Further review revealed PPE was necessary when performing high contact care activities such as: dressing; bathing; transferring; providing hygiene; changing linens and briefs; and wound and device care. In addition, review further revealed PPE was to be available immediately near or outside a resident's room. Review of the facility's signage for Enhanced Barrier Precautions revealed providers and staff must wear gloves and a gown for high contact resident care activities. 1. Review of R71's face sheet revealed the facility admitted the resident on 07/22/2022, with diagnoses to include cerebral infarction (stroke), dysphagia (difficulty swallowing), and high blood pressure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R71's order set revealed EBP isolation precautions started on 04/04/2024. Review of R71's Comprehensive Care Plan (CCP) dated 04/04/2024, revealed the facility identified a problem for the resident for risk of infection related to having a G-tube. Continued review revealed the interventions included staff were to utilize appropriate PPE when providing personal and G-tube care for the resident. Observation on 06/07/2024 at approximately 1:35 PM, revealed however, revealed no signage posted on the resident's door, nor of PPE supplies stored outside the room. 2. Review of R234's face sheet revealed the facility admitted the resident on 12/22/2023, with diagnoses to include cerebral infarction (stroke), and dysphagia (difficulty swallowing). Review of R234's order set revealed no documented evidence of an order for EBP. Review of R234's CCP undated, revealed the facility had identified a problem for the resident as risk of infection due to having a PEG tube with a goal date of 09/07/2024. Further review revealed the interventions included staff were to utilize PPE when providing care for the resident, with status listed as current. Observation on 06/05/2024 at 2:15 PM, revealed LPN 6 turning R71 to his/her right side with no gown donned, and only wearing gloves. Additional observation revealed R71's G-tube site to the upper abdominal area had feeding solution and water infusing through the tube per pump. Further observation revealed no signage posted to the resident's room door, not of PPE supplies stored at the door. 3. Review of R238's face sheet revealed the facility admitted the resident on 05/28/2024, with diagnoses to include chronic obstructive pulmonary disease (COPD), and dysphagia (difficulty swallowing). Review of R238's order set dated 05/28/2024, revealed no documented evidence of an order for EBP. Review of R238's CCP undated, revealed the facility had identified a problem for the resident for EBP due to having a peg tube. Continued review revealed the interventions included staff were to utilize appropriate PPE when providing the resident's care. Observation on 06/07/2024 at approximately 1:35 PM, revealed however, no EBP signage posted on R238's room door, nor of PPE stored next to the resident's room door. Further observation revealed PPE stored in proximity at the resident room next door. During interview with Certified Nursing Assistant (CNA) 8 on 06/06/2024 at 1:55 PM, he stated he could not recall receiving any training on EBP from the facility. Further interview revealed CNA 8 was unable to state/identify conditions when EBP precautions were to be taken. During interview with CNA 5 on 06/07/2024 at 1:55 PM, she stated the facility had not provided any training on EBP; however, she had received that training through the agency she worked for. CNA 5 further stated if a resident had a feeding tube there was no need to put on PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA 6 on 06/07/2024 at 2:30 PM, she stated she had received infection control training through the agency she worked for. She further stated it was important to follow signage for isolation, including EBP to prevent transmission of germs to other residents and to protect oneself. During an interview with LPN 4 on 06/07/2024 at 1:50 PM, he stated the facility gave on the spot trainings for new admissions or if a resident's status changed. LPN 4 stated however, he could not really recall receiving EBP training at the facility. Continued interview revealed LPN 4 was unable to identify instances for when a resident was to be on EBPs. He stated, when asked why it was important to follow isolation protocol, that it was important to prevent contamination. Interview with the 200 Hall Unit Manager (UM) on 06/06/2024 at 2:05 PM, she stated it was important to follow EBP isolation for prevention of spreading infection. She stated staff were to follow the in-house training given by the facility. In an addition interview on 06/07/2024 at 2:20 PM, the 200 Hall UM stated signage on residents' room doors let staff know what type of PPE to wear, which not only protected staff but residents as well. During an interview with the Infection Preventionist (IP) on 06/06/2024 at 10:40 AM, she stated it was important to have signage on isolation residents' room doors so staff knew what PPE to wear for resident care, and they received trainings on isolation from her or the Staff Development Coordinator. During an interview with the Director of Nursing (DON) on 06/06/2024 at 10:40 AM, she stated residents were to be placed on EBP if they had any type of medical line or device and R71, R234, and R238 should have been on EBP. In additional interview on 06/07/2024 at 3:20 PM, she stated infection control trainings were performed as needed if any concern was identified. She stated there were scheduled trainings on the facility's computer-based training program. The DON stated all agency staff were given educational packets to review prior to working at the facility. She stated her concern if staff were not following signage for isolation, there would be a risk for spreading infection. The DON further stated her expectation was that staff should know what PPE to use for a resident's care. In an interview with the facility's Administrator on 06/07/2024 at 2:55 PM, he stated his expectations were for staff to stay up to date on all trainings and to follow the trainings and procedures for all isolation precautions, including the use of signage on the residents' door. He stated his concern if staff were not following precaution signage and training, was that they were placing themselves and residents at risk for harm from possible infection.