Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	R-C 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{P 000}	Initial Comments Based on the acceptable Plan of Correction and the on-site revisit survey 03/21/2024, it was determined the facility had achieved compliance on 03/13/2024, as alleged.	{P 000}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Initial Comments A Relicensure and Complaint Survey, investigating complaints KY00035749 and KY00040382, was initiated on 02/21/2024 and concluded on 02/23/2024. KY00040382 was unsubstantiated. KY00035749 was substantiated with deficient practice identified. A "Type A" Citation was issued to the facility on 02/27/2024 related to KY00035749. Based on the finding of the Relicensure and Complaint Survey concluded on 02/23/2024, it was determined the facility failed to ensure Resident #1 was free from abuse by Care Manager (CM) #1. Review of the facility's policy on Abuse, Neglect, & Exploitation-Preventing, Reporting and Investigation, revealed team members must not engage in, nor permit anyone else to engage in abuse, neglect, or exploitation of any resident. Review of Resident #1's medical record revealed a note from the Primary Care Physician (PCP), dated 01/18/2021, indicating Resident #1 had dementia. On 02/19/2022, at approximately 8:30 PM, Registered Nurse (RN) #1 knocked and entered Resident #1's room and observed Resident #1 naked in bed with CM #1, who was also naked and on top of Resident #1. The incident was reported to the facility's previous Executive Director and Resident Care Coordinator. However, they determined the resident had a consensual sexual relationship with CM #1. Therefore, the facility had no documentation of a thorough investigation related to the incident. After the incident, the resident's family informed the Executive Director, Resident #1 had stated he/she was in a relationship for about one (1)	P 000		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Continued From page 1 month with CM #1, and they had kissed several times. Upon the resident's return to the facility, the Executive Director and Resident Coordinator met with him/her, and the resident cried and explained how embarrassed he/she was about the entire situation. Based on the findings of the investigation, it was determined that the facility's failure to protect the resident from abuse by a caregiver and failure to thoroughly investigate the incident placed the resident in imminent danger and created substantial risk that death or serious mental or physical harm to residents could occur. The facility was notified of the imminent danger on 02/23/2024.	P 000		
P 050	902 KAR 20:036 3(4) Section 3. Administration and Operation (4) Patient rights. Patient rights shall be provided for pursuant to KRS 216.510 to 216.525. This requirement is not met as evidenced by: Based on interview, record review, review of the facility's documents, and review of the facility's policy, it was determined the facility failed to promote resident's rights by ensuring all residents were free from mental and physical abuse for one (1) of five (5) sampled residents, Resident #1. Review of the Previous Executive Director's (PED) written statement completed on 02/20/2022, revealed she identified Resident #1 and Care Manager (CM) #1, an agent (staff) of	P 050	A .With respect to the specific resident/ situation cited: Agency team member involved in incident was immediately removed from community and incident reported to state, authorities, and employer. Resident (who no longer resides at community) was sent to hospital for examination. B.With respect to how the facility will identify residents/situations for the identified concerns: Senior Executive Director and/or designee(s) will interview sample of TMs to assess for comprehension of mandated reporting policy and address any concerns with retraining.	2/19/24 3/7/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 050	Continued From page 2 the facility, were in a consensual relationship. Therefore, the PED concluded Resident #1 had not been abused. The findings include: Review of the facility's Abuse, Neglect, & Exploitation-Prevention, Reporting and Investigation policy, last revised on 02/14/2022 (changed policy number only), revealed team members must not engage in, nor permit anyone else to engage in, abuse, neglect, or exploitation of any resident. Additionally, the policy revealed the Executive Director managed and directed the abuse investigation and implemented corrective action as indicated by the results of the investigation. Review of the Abuse: Child, Elder, Intimate Partner document provided by the facility, undated, revealed sexual abuse was defined as any type of nonconsensual sexual contact or a sexual act with any person incapable of giving consent. Review of the Professional Staffing Agreement between the facility and the staffing agency, dated 03/30/2020, revealed the agency would comply with all applicable, local, state, and federal laws, regulations, statues, and rules. The agreement also revealed, notwithstanding any other provision in the agreement, that the facility remained responsible for ensuring that any service provided pursuant to this agreement complied with applicable laws. Review of Resident #1's Face Sheet revealed the facility admitted the resident on 02/08/2021 with diagnoses of major depressive disorder, anxiety, and insomnia. It also revealed the resident's	P 050	Facility Response: Completed interview of 6 team members from 2/29/24 to 3/5/24 C. With respect to what systemic measures have been put into place to address the stated concern: Senior Executive Director and/or designee will retrain department heads on the process for conducting internal investigations. D. With respect to how the plan of correction will be monitored: The Senior Executive Director or designee will report findings of the audits (described in section C) to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after the 3 months, the Quality Assurance Performance Improvement Committee will re-evaluate and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. Facility Response: Completed retraining on 3/5/24 The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur. of the plan of correction and addressing and resolving variances that may occur.	3/7/2024 3/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 050	Continued From page 3 daughter was his/her durable Power of Attorney (POA). Review of Resident #1's Primary Care Physician (PCP) Progress Note, dated 01/18/2021, revealed Resident #1 had worsening dementia prior to moving to the facility. However, a dementia diagnosis was not added to Resident #1's Electronic Medical Record (EMR). In an interview with the Senior Resident Care Director (SRCD), a Registered Nurse (RN), on 02/21/2024 at 12:20 PM, she stated Resident #1 was on Donepezil (used to treat Alzheimer's type dementia) ten (10) milligrams (mg) which indicated the resident had a memory impairment. She stated the previous facility staff should have ensured the resident had a dementia diagnosis in his/her file upon admission. Review of Resident #1's Progress Note, completed on 02/20/2022 at 1:06 AM by RN #1, revealed during medication administration at 8:44 PM on 02/19/2022, he entered Resident #1's room and saw CM #1 in bed with Resident #1, and they were both naked. Further, the note stated CM #1 was lying on top of Resident #1. Per the note, RN #1 told CM #1 to get up and get dressed. The note stated CM #1 said, "They told me to make the resident happy, so I was just making him/her happy." Per the note, RN #1 escorted CM #1 out of the facility. In an interview with RN #1 on 02/22/2024 at 2:00 PM, he stated on 2/19/2022, he worked 2:00 PM to 10:00 PM. He stated he went to give Resident #1 his/her nighttime medication and found the resident naked in bed with CM #1. He stated CM #1 was also naked and lying on top of Resident #1. He stated he had both of them immediately	P 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 050	Continued From page 4	P 050		

get out of bed and get dressed. RN #1 stated he made sure Resident #1 was safe in his/her room, as he followed CM #1 out of the facility and watched as he left the property. RN #1 stated he immediately called his supervisor, the Resident Care Coordinator (RCC), and explained the incident. He stated the resident informed the RCC the relationship was consensual with the staff member, and it had been going on for about a month. RN #1 stated that Resident #1 stated that he/she had kissed CM #1 a few times. RN #1 stated it was never appropriate, ethical, or morally correct for a resident and a staff member to have any kind of sexual or intimate relationship.

In continued interview with RN #1 on 02/22/2024 at 2:00 PM, he stated the Previous Executive Director (PED) arrived on-site, and she called the police, who responded. He stated no police report or report number was provided to the facility because the police were informed the relationship was consensual. He stated the police found no wrongdoing, after they interviewed Resident #1.

The State Survey Agency (SSA) Surveyor attempted to reach the previous Resident Care Coordinator (RCC), on 02/22/2024 at 2:45 PM, using the phone number on file at the facility. However, she had resigned her position, and the phone had been disconnected.

The SSA Surveyor attempted to reach Resident #1's daughter, the Power-of-Attorney (POA), on 02/22/2024 at 3:00 PM. However, the phone had been disconnected.

Review of Resident #1's Progress Note completed on 02/20/2022 at 12:19 AM by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 050	Continued From page 5 PED, revealed she called and talked to an Emergency Department (ED) nurse and informed the nurse that the relationship between the resident and the staff member was consensual, and therefore no abuse occurred. The note stated the ED nurse told the PED that she would not report the incident as elder abuse. Review of Resident #1's Progress Note completed on 02/20/2022 at 1:51 AM by the Resident Care Coordinator (RCC), revealed at 9:34 PM (02/19/2022), while on the phone with the resident, Resident #1 stated he/she was in a consensual relationship with the staff member. The note revealed the RCC arrived at the facility at 10:00 PM, and the PED and RN #1 talked to Resident #1's Power-of-Attorney (POA). Per the note, the POA stated the resident had talked about being in a relationship with CM #1 for a while. The note stated the POA told them that the resident spoke of him often and informed the POA they had kissed several times. The note revealed the POA did not report the information to the facility because she thought it was nothing more than a crush. Review of Resident #1's Progress Note completed on 02/20/2022 at 1:09 PM by the PED, revealed she noted she contacted the hospital and was informed by the nurse that Resident #1 refused to be examined because he/she said the "sexual relationship with Care Manager #1 was consensual." Review of the Emergency Department (ED) Provider Note, dated 02/20/2022, revealed Resident #1 was seen for a "witnessed sexual assault today at nursing home." Review of the ED microbiology report, dated 02/20/2022 at 3:21 PM, revealed the resident was tested for	P 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 050	Continued From page 6 chlamydia and gonorrhea (bacteria that were sexually transmitted) and was negative for both. Review of Resident #1's Progress Note completed on 02/20/2022 at 8:32 PM by the PED, revealed the family was present at the facility, and the POA said, "We have a lawyer involved and he will take care of this. Care Manager #1 has to be stopped; my family member is a victim." Review of Resident #1's Progress Note completed on 02/20/2022 at 8:50 PM by the RCC, revealed the police were on site and interviewed Resident #1. Per the note, Resident #1 reported to the police the relationship with CM #1 was consensual, and he/she did not want to press any charges against him. It was noted Resident #1 stated that he/she "did not know (he/she) was not allowed to have a relationship with a worker." Per the note, the POA asked the police officer for a police report number and was informed there would not be a police report. Review of Resident #1's Progress Note completed on 02/20/2022 at 9:31 PM by the RCC, revealed the resident told them that he/she was told by the doctors at the Emergency Department that he/she had testing done to ensure he/she did not contract a Sexually Transmitted Infection (STI). In an interview with the Senior Resident Care Coordinator on 02/22/2024 at 4:10 PM, she stated it was never appropriate for an agent of the facility to have a sexual or girlfriend/boyfriend relationship with a resident. In an interview with the Interim Executive Director on 02/22/2024 at 4:39 PM, she stated it was never okay or acceptable for a staff member,	P 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 050	Continued From page 7 volunteer, or anyone who worked with residents to have a sexual relationship with a resident. She stated anything other than a "normal family relationship" between staff and a resident was unacceptable. She stated this was true, even if the resident was of sound mind.	P 050		
P 055	902 KAR 20:036 3(5) Section 3. Administration and Operation (5) Adult protection. PCHs and SPCHs shall have written policies that assure the reporting of allegations of abuse, neglect, or exploitation of adults pursuant to KRS 209.030, including evidence that all allegations of abuse, neglect, or exploitation shall be thoroughly investigated internally to prevent further potential abuse while the investigation is in progress. This requirement is not met as evidenced by: Based on interview, record review, document review, and review of the facility's policy, it was determined the facility failed to identify abuse occurred and therefore failed to complete a thorough investigation followed by corrective action, for one (1) of five (5) sampled residents, Resident #1. In an interview with Registered Nurse (RN) #1 on 02/22/2024 at 2:00 PM, he stated on 02/19/2022 at approximately 8:30 PM, he went to Resident #1's room to give nighttime medication. He stated when he entered Resident #1's room he saw Resident #1 lying on his/her back, naked, and Care Manager (CM) #1 in bed, also naked,	P 055	A. With respect to the specific resident/ situation cited: Agency team member involved in incident was immediately removed from community and incident reported to state, authorities, and employer. Resident (who no longer resides at community) was sent to hospital for examination. In-service on Intimacy and Resident Rights completed by Senior Executive Director/ Senior Resident Care Director In-service on Resident Right conducted by our Ombudsman B. With respect to how the facility will identify residents/situations for the identified concerns: Senior Executive Director and/or designee(s) will interview sample of residents to assess for any concerns with abuse, neglect, or exploitation. C. With respect to what systemic measures have been put into place to address the stated concern: Team members will complete retraining on Fraternization, Mandated Reporting, and Resident Rights. Ongoing training will be completed upon hire for all Team Members, annually and PRN throughout the year.	2/19/24 3/7/24 3/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 055	Continued From page 8 and on top of Resident #1. He stated he witnessed both the staff member and the resident get up and get dressed. He stated he had the resident sit in the room while he escorted CM #1 off the property. RN #1 stated he immediately contacted his supervisor, the Resident Care Coordinator (RCC). The findings include: Review of the facility's document Abuse: Child, Elder, Intimate Partner, undated, revealed sexual abuse was defined as any type of nonconsensual sexual contact or a sexual act with any person incapable of giving consent. Review of the facility's Abuse, Neglect, & Exploitation-Prevention, Reporting and Investigation policy, last revised on 02/14/2022 (changed policy number only), revealed sexual abuse was defined as any form of nonconsensual sexual contact, including but not limited to inappropriate touching, sexual harassment, sexual coercion, sexually explicit photographing, or sexual assault. Additionally, per the policy, team members must not engage in, or permit anyone else to engage in, abuse, neglect, or exploitation of any resident. Further review revealed the Executive Director would implement corrective actions as indicated by the results of the investigation. Review of Resident #1's Face Sheet revealed the facility admitted the resident on 02/08/2021, with diagnoses of major depressive disorder, anxiety, and insomnia. Also, it revealed the resident's durable Power of Attorney (POA) was his/her daughter. Review of Resident #1's Primary Care Physician	P 055	D. With respect to how the plan of correction will be monitored: The Senior Executive Director or designee will report training compliance to the Quality Assurance Performance Improvement Committee monthly for 3 months. During and after the 3 months, the Quality Assurance Performance Improvement Committee will re-evaluate and initiate necessary action or extend the review period, as needed based on issues identified or trends observed. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur. of the plan of correction and addressing and resolving variances that may occur. Meeting 3/13/24	3/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 055	Continued From page 9 (PCP) Progress Note, dated 01/18/2021, revealed Resident #1 had worsening dementia prior to moving to the facility. However, a dementia diagnosis was not added to Resident #1's Electronic Medical Record (EMR). In an interview with the Senior Resident Care Director (SRCD), a Registered Nurse (RN), on 02/21/2024 at 12:20 PM, she stated Resident #1 was on Donepezil (used to treat Alzheimer-type dementia) ten (10) milligrams (mg) which indicated the resident had a memory impairment. She stated the previous facility staff should have ensured the resident had a dementia diagnosis in his/her file upon admission. Review of the facility's investigation into the incident with Resident #1 and Care Manager (CM) #1, on 02/19/2022, revealed the Previous Executive Director determined Resident #1 and CM #1 were in a consensual sexual relationship. However, the facility failed to provide a detailed and thorough investigation. The investigation included a statement from Registered Nurse (RN) #1 who found the two (2) in bed together on 02/19/2022 and a statement written by the Previous Executive Director (PED) to account for her findings when she talked to the resident and the agency staff involved. Additional statements were not provided from any other staff members who cared for Resident #1 or from other residents. The facility failed to provide any documented evidence all residents in the facility were assessed to determine if they too had been abused. Further, the facility's policy required corrective action after an investigation, and the facility failed to provide any evidence corrective action was taken. The State Survey Agency (SSA) Surveyor	P 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101074	A. BUILDING: _____ B. WING _____	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF LOUISVILLE	6700 OVERLOOK DRIVE LOUISVILLE, KY 40241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 055	Continued From page 10 attempted to reach the previous Resident Care Coordinator (RCC), on 02/22/2024 at 2:45 PM, using the phone number on file at the facility. However, she had resigned her position, and the phone had been disconnected. The SSA Surveyor attempted to reach Resident #1's daughter, the Power-of-Attorney (POA), on 02/22/2024 at 3:00 PM. However, the phone had been disconnected. In an interview with the Senior Resident Care Coordinator on 02/22/2024 at 4:10 PM, she stated she was a Registered Nurse (RN), and she filled in on-site when the position of Resident Care Coordinator was vacant. She stated she would not make any statement concerning whether a complete and thorough investigation was done. She stated since she was not present at the time, she would not comment. She stated staff should never have a relationship with a resident. She stated staff members were never allowed to have a sexual or intimate partner relationship with a resident. In an interview with the Interim Executive Director on 02/22/2024 at 4:39 PM, she stated it was never appropriate for an agent of the facility to have a sexual/partner relationship with any resident, regardless of the cognitive ability of the resident. She stated even if a staff member heard two (2) staff talking about abuse of a resident, that staff member would still be expected to report the incident so it could be fully investigated. She stated only a "normal family relationship" which was not intimate between staff and a resident was acceptable. The Interim Executive Director stated a full and complete investigation should have been completed.	P 055		