STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185015	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madisonville Health and Rehabilitation, LLC	419 North Seminary Street Madisonville, KY 42431

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 review of facility policy, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. This failure had the potential to affect all residents who consumed meals from the kitchen.Observation of the kitchen, on 05/20/2026, revealed multiple food items uncovered in the freezer and dry storage pantry; and a box of uncovered oatmeal cookie dough in the freezer stored underneath an ice-covered condenser. Additionally, there were several large bins which contained salt, sugar, and breadcrumbs, which were soiled on the outside.Further, observation on 05/21/2026, revealed the [NAME] was not wearing a beard net properly, in order to cover all facial hair. Additionally, observation revealed the box of uncovered oatmeal cookie dough was again in the freezer stored underneath the ice-covered condenser, and had not been discarded.The findings include:Review of the facility policy titled, Food Storage-Dry Goods, dated 10/2019, revealed the facility's policy would ensure all dry goods were appropriately stored in accordance with guidelines of the Food & Drug Administration (FDA) Food Code. Further, the Dietary Manager would ensure that all packaged and canned food items should be kept clean, dry, and properly sealed.Review of the facility policy titled, Food Storage-Cold, dated 10/2019, revealed the facility's policy would ensure all frozen and refrigerated food items were appropriately stored in accordance with guidelines of the Food & Drug Administration (FDA) Food Code. Further, the Dietary Manager would ensure all food items were stored properly in covered containers and arranged in a manner to prevent cross contamination.Review of the facility policy titled, Staff Attire, dated 10/2019, revealed the Dietary Manager would ensure all staff members had facial hair properly restrained. Review of the facility policy titled, Job Description; Dietary Manager, dated 10/2019, revealed the Dietary Manager's duties and responsibilities would manage the operation of the dietary department including meeting company policies, and state and federal regulations regarding safe food handling techniques. Additionally, food storage areas would be monitored to ensure health and sanitation regulations were being met. 1. Observation of the kitchen's dry storage pantry, on 05/20/2026 at 10:00 AM, revealed one large bag of bow-tie pasta, two bags of spaghetti noodles, one bag of linguine noodles, and one large bag of rigatoni noodles which were opened and unsealed. 2. Observation of the walk-in freezer, on 05/20/2026 at 10:15 AM, revealed a large box of personal-sized pizza packages with one package opened and uncovered. Further observation revealed a box of sausage patties, a box of Salisbury steak patties, a box of pork patties, and a box of beef steak fritters, all in their original containers; however, all boxes were uncovered and the contents inside the boxes were exposed to air contaminants. Additionally, observation of the freezer on 05/20/2026 at 10:15 AM, revealed a box of uncovered oatmeal cookie dough stored underneath an ice-covered condenser which had an excessive amount of ice build-up. During this observation, the Dietary Manager moved the box of uncovered oatmeal cookie dough box to another shelf.During an interview with the Dietary Manager, on 05/20/2026 at 10:25 AM, she stated all dietary staff had been trained and educated on food storage and safety. She further stated staff should ensure food was covered securely to prevent cross-contamination when stored. 3. Continued observation of the kitchen, on 05/20/2026 at 10:35 AM, revealed several large bins which contained (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	salt, sugar, and breadcrumbs. The bin covers and front of the bins were soiled with grime and what appeared to be dried drops of liquids. During the observation, the Dietary Manager stated she had just overlooked cleaning the outside of the bins.4. During a second observation of the kitchen, on 05/21/2026 at 11:30 AM, Cook1's beard net was positioned between his mouth and chin and did not fully cover his moustache and beard hair.During an interview with Cook1, on 05/21/2026 at 11:35 AM, and on 05/22/2026 at 11:10 AM, he stated he was aware the beard net should be covering all of his facial hair, but he did not realize it had slipped down. He further stated there was the potential for hair to fall into a resident's food causing contaminated food which may cause illness, if he wore his beard net improperly. 5. A second observation of the walk-in freezer, on 05/21/2026 at 11:45 AM, revealed the same box of oatmeal cookie dough was again stored underneath the freezer condenser and had not been discarded once discovered on 05/20/2026.During a follow up interview with the Dietary Manager, on 05/22/2026 at 11:20 AM, she stated it was her expectation for all dietary staff to ensure all food items were sealed or covered properly and dated before being stored in the dry pantry and/or the freezer. She further stated the box of oatmeal cookie dough that had been opened, uncovered and left underneath the condenser in the freezer should have been discarded when discovered. Additionally, the Dietary Manager stated hairnets and beard nets were to be worn properly covering all exposed hair, including facial hair, to prevent cross-contamination She further stated she would never want to serve residents unsafe food. During an interview with the Administrator, on 05/22/2026 at 2:00 PM, she stated it was her expectation for dietary staff to follow facility policy and procedures to ensure proper food storage. Further, she stated all food items were to be sealed properly to prevent concerns with contamination. Additionally, she stated all staff should wear hair and beard nets in a proper manner to ensure all hair was contained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and review of facility policy, the facility failed to establish and maintain 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.During observation of the laundry room on 05/22/2026, the two staff members present were asked to verbalize the process on handling soiled linen. They both stated they only wore gloves when handling soiled linen instead of the standard precaution of donning gloves and a gown. This failure had the potential to affect all residents in the facility.Additionally, the facility failed to ensure proper infection control procedures during wound care treatment for one of three sampled residents reviewed for wound care, Resident (R)67. During observation of wound care on 05/20/2026, Licensed Practical Nurse (LPN)2 set up a sterile field while wearing clean gloves and placed a plastic bag in the floor for soiled wound care materials. She then failed to perform hand hygiene and don new gloves before attempting to clean the resident's wound.The findings include:Review of the facility policy, titled Infection Prevention and Control Program, reviewed/revised 04/2026, revealed laundry and direct care staff would handle, store, process, and transport linens to prevent spread of infection.Review of the facility policy, titled Laundry, reviewed 04/2026, revealed that laundry staff would be in-serviced on handling linens and laundry on a regular basis.An interview was conducted on 05/22/2026 at 11:18 AM, with the Housekeeping Floor Technician who was working in the laundry room on that date. She stated laundry staff wore gloves when handling soiled laundry. She further stated she thought they were supposed to wear long gloves, but regular gloves were all they had available for use. In further interview, the Housekeeping Floor Technician stated she knew she was supposed to wear an apron when handling the dirty laundry but didn't know where they were kept as she did not normally work in the laundry. She stated she just helped out in the laundry when there was no one else.During an interview, on 05/22/2026 at 11:20 AM, with the Laundry Technician, she stated it was her second day in that position. She stated she was told the previous day to wear gloves when handling the dirty laundry but had not been told to wear an apron or gown, and did not know where the aprons were kept. When questioned if she had someone precepting her, she said someone from housekeeping worked with her yesterday.Observation of the laundry room on 05/22/2026 at 11:25 AM, with the Housekeeping Floor Technician and the Laundry Technician, revealed no aprons or gowns were located.During an interview, on 05/22/2026 at 12:15 PM, with the Infection Control Nurse, she stated the facility had already started working on things in the laundry room. When questioned what she meant by that, she stated an employee from laundry came to her and asked her about the concern of not wearing a gown or apron while handling laundry. She stated the laundry was handled by an outside company and not by the facility. The Infection Control Nurse further stated standard precautions should be followed and monitored by herself, including the laundry process. She acknowledged, even though staff handling the laundry were not facility employees, improper handling of the laundry could affect the facility residents and staff.During an interview, on 05/22/2026 at 1:35 PM, with the Administrator, she stated the laundry staff were actually employees of an outside company and not the facility. In further interview, the Administrator agreed laundry staff should be monitored for infection control even though they were contracted out by an outside company.2. Additional review of the facility policy, titled Infection Prevention and Control Program, reviewed/revised 04/2026, revealed all staff will perform proper hand hygiene to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene shall be performed in accordance with the facility established hand hygiene procedures.Review of the facility policy, titled Wound Treatment Management, reviewed/revised 04/2026, revealed to promote wound healing of various types of wounds, it is the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.Review of R67's Face Sheet located in the Electronic Medical Record (EMR), revealed the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility admitted the resident on 04/16/2026, with diagnosis including history of atherosclerotic heart disease, hypertension, and non-Alzheimer's dementia.Review of R67's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/04/2026, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated severe cognitive impairment.Observation of R67's wound care treatment on 05/20/2026 at 11:25 AM, performed by LPN2, revealed the nurse donned clean gloves, set up a sterile field on the side table and placed a plastic bag on the floor for soiled materials. LPN2 then failed to remove her gloves, perform hand hygiene and don new gloves before picking up the normal saline/wound cleanser to begin wound treatment to the resident's left buttocks wound. LPN2 was then stopped by the State Survey Agency (SSA) Surveyor. During interview with LPN2 during this process, she stated, I should have changed my gloves and washed my hands after setting up the clean field and prior to attempting to clean the wound and put the soiled gloves in a proper container instead of throwing them in a bag on the floor.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, record review, and review of facility policy, the facility failed to provide food that accommodated resident preferences for 1 of 26 residents in the dining room during meal service on 05/20/2026, Resident (R) 69. Observation of lunch meal service on 05/20/2026, revealed R69 was given ice cream as a substitute item for dessert, without asking if he wanted the scheduled strawberry shortcake dessert.The findings include: Review of the facility policy, titled Resident Rights, reviewed 04/2026, revealed the resident has the right to and the facility must have promoted and facilitated resident self-determination through the support of resident choice. The resident has the right to make choices about aspects of his life in the facility. Review of R69's Face Sheet located in the Electronic Medical Record (EMR), revealed the facility admitted the resident on 01/25/2024 with diagnoses including history of a stroke, hypertension, and non-Alzheimer's dementia. Review of R69's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/04/2026, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated moderate cognitive impairment. During observation of lunch meal service in the dining room on 05/20/2026 at 12:25 PM, R69 received a cup of chocolate ice cream for dessert instead of pureed strawberry shortcake as was indicated on his meal card. During an interview, on 05/20/2026 at 12:30 PM, R69 stated he wanted the strawberry shortcake, not the ice cream but he was not asked which dessert he wanted. The resident never received the serving of strawberry shortcake. During an interview, on 05/21/2026 at 12:10 PM, with the Dietary Manager, she stated the staff should have pureed the strawberry shortcake for the resident if that was the dessert listed on his meal card. She further stated staff should not have selected an alternative dessert for R69 without asking him what dessert he wanted. During an interview, on 05/22/2026 at 1:24 PM, with the Administrator, she stated ice cream was an acceptable substitution for cake, but residents should be asked what substitute desserts they would prefer.