STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185038	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Kenton	401 East 20th Street Covington, KY 41014

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, it was determined the facility failed to provide a safe, clean, comfortable and homelike environment.The findings include: Review of the facility's policy titled, Homelike Environment, last revised February 2021, revealed residents would be provided with a safe, clean, comfortable, and homelike environment, emphasizing independence and personal needs and preferences. Review of the facility's grievance logs for the previous six months revealed grievances from 12/17/2025 and 12/29/2025, expressing concerns about residents not having needed supplies, and about the small dining room remaining inaccessible. Although no resolution was documented regarding a supply issue, it was noted the facility was getting quotes for the small dining room repair. Additionally, a grievance dated 02/18/2026 noted a ceiling tile in the Honor dining room needed to be replaced and had a resolution of the tile being replaced. Review of the Resident Council minutes for the previous six months revealed a 10/24/2025 Resident Council meeting with residents expressing they would like the small dining room to be usable by Thanksgiving. Review of minutes from the 12/17/2025 Resident Council meeting revealed residents were concerned about not getting needed supplies and aides putting the wrong size briefs on residents. Also, residents continued expressing concerns regarding the need for the small dining room to be repaired. In an interview on 03/22/2026 at 5:08 PM with State Tested Nursing Assistant (STNA) 1, she stated the facility frequently did not have enough supplies to care for residents. She stated a lot of staff buy things for themselves, such as hand sanitizers and soaps, as facility runs out of them. She further stated the facility did not always have clean linens or supplies, which has been an issue for a few months. STNA1 stated the facility ran out of briefs at times, which is reported to nursing, who calls central supply to see if they are available downstairs. When not available, the Administrator is called, and supplies are purchased locally. In an interview with STNA7 on 03/23/2026 at 3:35 PM, she stated there had been housekeeping budget cuts, causing the facility to run low on supplies. STNA7 stated the facility has ran out of washcloths and disposable bed pads at times and staff has had to cut up towels to use as washcloths for peri-care. STNA stated the previous central supply staff told the STNAs the facility budgeting for briefs to be changed once every six hours. She stated, especially with residents on diuretics, every six hours was not sufficient, and it was not uncommon for residents to require being changed six or seven times during a 12-hour shift. She further stated when the facility ran out of briefs, residents have had to use a larger or smaller size and have complained. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with STNA8 on 03/24/2026 at 9:00 AM, she stated the facility did run out of supplies on the unit and had to look in central supply downstairs when they do not have supplies. She stated sometimes the facility was low on linens; staff plan on two rounds of linens a day, but sometimes they need more, which could mean there are no linens available for night shift if they need them. STNA8 stated the facility sometimes ran low on peri-care supplies, like soaps or washcloths, and may run out of specific sizes of briefs and have had to use a different size. STNA8 further stated, depending on the medication residents are on, staff may need to clean some residents up more often than others. In an interview with the Activities Director on 03/24/2026 at 9:06 AM, she stated some residents had complained to her about not getting briefs. She stated the new central supply person drops briefs off on Tuesdays and Fridays, and has extra supplies if residents run out. In interview with Central Supply on 03/25/2026 at 8:27 AM, she stated she had just been in that role since the beginning of March 2026. She stated housekeeping handled washcloths, and she was unaware of any shortage. She further stated she was responsible for resident briefs and makes an inventory list of everything she has in central supply that she goes by. She stated since she has been in her current role, she has not had any issues. Central Supply stated she implemented stocking resident rooms on Tuesdays and Fridays to make sure everyone had enough briefs, and to also keep track of resident use and needs, as she noticed briefs were disappearing too quickly from central supply. She stated she was not aware of any residents complaining of not having enough briefs or not having the right size of briefs. She stated staff should not be getting briefs from other resident rooms, as briefs are resident-specific, and there were always staff present that could get briefs from central supply. 1. Observation on entry to the facility on [DATE] at 1:30 PM revealed a small dining room/activity room in the main hall, off the elevator, with tables and chairs blocking the entryways. Continued observation revealed the floor was wavy with buckled wood grain tiles throughout. Continued observation on 03/22/2026 at 3:40 PM revealed the bathroom in room [ROOM NUMBER] had an uneven floor on entry. [NAME] staining was observed on the back of the seat of a raised toilet. A line of rust-colored stains stretched from a soap dispenser down past a (non-functional) wall outlet with staining on the baseboard beneath. A light over the shower was observed with a cracked plastic cover with a dead moth inside. In an interview with the Maintenance Assistant (MA) on 03/25/2026 at 10:08, he stated he did room rounds once a month, looking at lights, extension cords, plugs, and handrails. He stated he was not aware of any issues in the bathroom of room [ROOM NUMBER] but thought it would be a be a housekeeping issue to keep the walls clean. He stated he was not sure who would have installed a soap dispenser over an outlet, but it should be moved. He stated he had not noticed the tiles in the Honor dining room and wasn't sure how long the small dining room had been closed off. The MA stated staff can request work orders, which are in a box at the nurses' station, and by the receptionist window downstairs, which would then go to the director and to him. In an interview with the Maintenance Director on 03/24/2026 at 3:28 PM, he stated the small dining room was damaged due to a water leak from the ice machine, which someone had moved, causing the drain to shift. He stated this was not caught right away, which caused it to damage the floor. He stated he believed it happened in late October 2025 or early November 2025. He stated the facility has been getting quotes to get the floor redone, but due to the age of the building, contractors do not want (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to work without having extensive testing done to ensure the flooring does not have asbestos. He stated it would cost $4,500 just to have the floor tested and would result in 4 holes in four different areas of the floor. The Maintenance Director stated he was not aware of any issues in the Honor dining room, or in the bathroom of room [ROOM NUMBER]. He stated his assistant does rounds in resident rooms, while he deals with the entirety of the building. In further interview with the Maintenance Director after a brief tour on 03/24/2026 at 3:38 PM, he acknowledged the bathroom outlet in room [ROOM NUMBER], although not live, would need to be removed and covered. He further stated he would expect housekeeping to make maintenance aware of issues, such as a broken light cover in the shower in room [ROOM NUMBER]. The Maintenance Director stated there were usually tables in the Honor dining room where the tile damage was and believed the rubber tiles had shrunk. 2. Observation on 03/24/2026 at 11:06 AM revealed approximately a 10' x 10' section of flooring in the Honor dining room of broken and mismatched wood grain tiles, some with gaps or 1 or more between them, stretching from the exterior wall and window. A ceiling tile was missing near the wall/window. In an interview with the Housekeeping Manager (HM) on 03/25/2026 at 10:21 AM, she stated she was aware of staining in the room [ROOM NUMBER] bathroom which had been there at least two or three months, and she and housekeeping staff had tried unsuccessfully to get that stain out. She stated since the State Survey Agency (SSA) first reported the issue, a new soap dispenser had been put into place, with plans to remove the old one. She stated she would not consider that bathroom to be a homelike environment, and also acknowledged the floor needed to be replaced in there as well. The HM stated the floors in the facility needed to be replaced in several areas, including the small dining room due to water damage. She stated she was aware of the damaged and ill-fitting tiles in the Honor dining room, as her staff cannot run an auto scrubber in there due to concern of further damaging the floor. She stated management was aware of the floor. She stated there had been a leak in the Honor dining room as well, which had caused the floor to get worse in the last month or so. The HM stated if staff see issues, it is her expectation for staff to let her know so the issue can be addressed. 3. Observation on 03/22/2026 at 2:30 PM in room [ROOM NUMBER] revealed the wall with the window had an exposed crack with the underlying sheetrock visible. Further observation revealed that the ceiling tiles above the door entrance had one tile missing and six tiles stained and sagging. No moisture was observed on the floor beneath the affected area during the observation. In an interview with Licensed Practical Nurse (LPN) 1 on 03/22/2026 at 2:30 PM, she stated there had been a leak in the room and reported that maintenance was aware of it; however, no repairs had been made. In an interview with the Maintenance Director on 03/23/2026 at 9:20 AM, he stated the leak was caused by the heating, ventilation, and air conditioning (HVAC) system and that repairs had not yet been completed, as he was waiting for warmer weather to address the issue. 4. Observation on 03/23/2026 at 9:20 AM in the Providence hallway revealed blue border floor tiles lifting and separating from the floor surface along the length of the hallway. The hallway floor also had large scuff marks, and the tile in the center of the hallway appeared dull and soiled. In an interview with the Housekeeping Manager on 03/25/2026 at 8:30 AM, she stated staff were unable to strip and wax the floor due to the condition of the tile. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Regional Maintenance Director on 03/23/2026 at 9:21 AM, he stated the facility was in the process of obtaining quotes to replace the floor tile at a future date. He further stated the building was older and required multiple repairs. 5. Observation on 03/22/2026 at 5:44 PM of the floor in room [ROOM NUMBER] appeared to be buckled and wavy. In an interview with the Maintenance Director on 03/24/2026 3:30 PM, he stated a water leak in the wall coil assist located in the ceiling caused the floor to buckle. The facility had plans to repair the flooring in rooms [ROOM NUMBERS]. In an Interview with the Director of Nursing (DON) on 03/26/2026 at 9:58 AM, she stated her expectation was the facility, as it was the resident's home, should be kept clean, and should be made as nice as possible for residents. She stated she was unaware of the current status of the small dining room but acknowledged it needed to be repaired. She stated she wanted all spaces utilized for the benefit of residents. She stated her expectation was for all facility floors to be even, clean, dry, and free from clutter for resident safety and use In an interview with the Administrator on 03/26/2026 at 1:42 PM, she stated the facility was in the final process of getting a quote approved for repairing the floor in the small dining room. She stated the floor in the Honor shower room needed to be redone, and the facility had already started replacing holes in the floor. She stated it was her expectation that it was the resident's home, and it should be a homelike environment, with simple concerns addressed in the moment, and major repairs addressed as the facility was able to find appropriate contractors.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the facility's job description, and review of the facility's policy, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 6 of 25 sampled residents, Resident (R) 10, R11, R23, R32, R47, and R67. The care plans for R10, R11, R47, and R67 were not fully developed at admission to reflect their diagnoses. For R23 and R32, their care plans were fully developed, but staff did not implement the interventions in their care plans. The findings include: Review of the facility's policy titled, Care Plan, Comprehensive Person-Center, revised date 03/2022, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy also stated services would be provided or arranged by the facility and outlined in the Comprehensive Care Plan [CCP] that were trauma informed. Review of the facility's MDS Coordinator Job Description, dated with a 2024 Copyright, stated the MDS Nurse was responsible for the implementation and ongoing evaluation of each resident's comprehensive plan of care. 1. Observation on 03/22/2026 at 1:30 PM revealed no signage on the door indicating Resident (R) 11 required Enhanced Barrier Precautions (EBP). Review of R11's admission Record revealed the facility admitted the resident on 08/18/2025 with diagnoses of behavioral and emotional disorders, anoxic brain injury, and PEG tube status. Review of R11's Care Plan revealed R11 was care planned on 03/10/2026 for requiring tube feedings and also at risk of infections, requiring EBP, dated 03/10/2026. During an interview on 03/25/2026 at 9:35 AM with the Physician Assistant (PA), she stated R11 was admitted with a percutaneous endoscopic gastrostomy (PEG) tube in place on 08/18/2025. During an interview on 03/25/2026 at 9:35 AM with the Minimum Data Set (MDS) Nurse, she stated R11 was under EBP related to the PEG tube, and this should have been added to his care plan, upon admission, prior to 03/10/2026. 2. Observation on 03/22/2026 at 1:30 PM revealed no signage on R47's door indicating the resident required EBP. Review of R47's admission Record revealed the facility admitted the resident on 07/25/2025 with diagnoses of end stage renal disease with dependence on renal dialysis and congestive heart failure. Review of R47's Care Plan, undated revealed there was no focus for the dialysis catheter or for the resident being under EBP. Review of R47's Orders revealed R47 had an order for EBP, dated 03/23/2026. During an interview on 03/25/2026 at 9:35 AM with PA, she stated R47 currently had a dialysis catheter and a fistula. She stated the resident was admitted with the catheter while she was waiting to get the fistula and for it to mature. During an interview on 03/25/2026 at 9:35 AM with the MDS Nurse, she stated R47 should have been care planned for the dialysis catheter and EBP upon her admission on [DATE]. 3. Observation on 03/22/2026 at 1:30 PM revealed R23's room had no signage on the door indicating she required EBP. Review of R23's admission Record revealed the facility admitted the resident on 01/21/2022 with diagnoses of diverticulitis of intestine with perforation and colostomy status. Review of R23's Orders revealed an order for EBP, dated 03/23/2026, and an order for colostomy care every shift, dated 07/04/2024 (original order for colostomy care dated 01/21/2022). Review of R23's Care Plan revealed R23 was care planned for EBP on 06/12/2023. During an interview on 03/25/2026 at 9:35 AM with the MDS Nurse, she stated she was told that residents with colostomies did not require EBP. She stated she did not remember who told her this, but she left EBP on the care plan and was going to question if the resident still required EBP. She stated staff should be following the care plan interventions. 4. Observation on 03/22/2026 at 5:41 PM revealed License Practical Nurse (LPN) 1 administered medications to R32 via a PEG tube without checking for placement prior to pushing the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication. Review of R32's admission Record revealed the facility admitted the resident on 01/01/1973 with diagnoses of cerebral palsy, epilepsy, and gastrostomy status. Review of R32's Care Plan revealed R32 was care planned for staff to check placement and gastric contents/residual volume prior to medication administration and per facility protocol, dated 04/21/2023. 5. Review of the admission Record for R67 revealed the facility admitted the resident with an initial admission date of 01/30/2023 and most recently on 12/30/2024, both with a diagnosis of Post Traumatic Stress Disorder (PTSD).Review of the Care Plan Report for R67, most recently updated 02/23/2025 revealed no focus for the PTSD diagnosis. Review of R67's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/06/2026, revealed a mood severity score of 18, indicating the resident was affected by difficulty sleeping, little interest in participating in activities, and feeling depressed or hopeless nearly every day. It also included the diagnosis of PTSD.Review of R67's Psychiatry Progress Note, dated 03/03/2023, revealed R67 was seen for a consult/medication management for a history of multiple mental health diagnoses, including PTSD and Schizoaffective Disorder, both due to the onset of trauma in her teen years. Additionally, R67 continued to have nightmares related to abuse.6. Review of R10's admission Record revealed the facility admitted the resident on 03/16/2016 with diagnoses including post-traumatic stress disorder (PTSD) and borderline personality disorder.Review of R10's quarterly MDS, with an ARD of 01/01/2026 revealed an active diagnosis of PTSD.Review of R10's Comprehensive Care Plan, undated, revealed no evidence that the facility had addressed the resident's PTSD diagnosis, including identification of triggers, symptoms, or interventions to support trauma-informed care and prevent re-traumatization.In an interview on 03/26/2026 at 10:22 AM, the Social Services Director (SSD) stated a care plan addressing R10's PTSD, including triggers, symptoms, and interventions, had not been completed. The SSD further stated it was important that staff was aware of a resident's PTSD diagnosis and triggers to provide resident-centered care and avoid re-traumatization.During an interview on 03/25/2026 at 11:17 AM with the MDS Nurse, who was also Licensed Practical Nurse (LPN) 7, she stated she was unaware the PTSD focus had been missed. She stated the plan of care did include some behavioral concerns, just not specific to the PTSD diagnosis. She stated it was important to include this because the resident could be retraumatized if it was not identified, with or without potential triggers.During an interview on 03/25/2026 at 2:15 PM with the Director of Nursing (DON), she stated since the MDS Nurse was an LPN, it was her job as the RN/DON to sign off on her work. She stated the diagnosis for PTSD had been overlooked on the care plan and not having it there could cause the residents unnecessary harm by unknowingly re-traumatizing them. During additional interview on 03/25/2026 at 3:31 PM with the DON, she stated it was her expectation that care plans were fully developed and communicated so staff knew how to properly take care of residents.During an interview on 03/26/2026 at 1:33 PM with the Administrator, she stated she expected an accurate assessment and plan of care for the residents. She stated failure to do this could result in a resident not receiving the appropriate care and could result in unnecessary adverse outcomes. She stated the MDS Nurse was responsible for fully developing care plans, and it was important for them to be accurate and followed to meet the needs of the residents.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the manufacturer's guidance, and review of the facility's policies, the facility failed to ensure that a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 6 of 6 residents sampled for enteral feeding, Resident (R) 32, R36, R38, R46, R50, and R78. Observations on 03/22/2026 and 03/23/2026 included tube feedings hanging that were not timed or dated with the connector tips without end caps; medications administered via the feeding tube without checking for placement prior to administration; and a tube feeding that was started two hours late and continued past the ordered stop time. In addition, R36 was sent to the Emergency Department on 07/02/2025 and 03/05/2026, after the adult day care center became concerned with the resident's gastrostomy tube status, and R36 was diagnosed with abdominal wall cellulitis without the facility's staff documenting the abnormal findings or contacting the provider. The findings include:Review of the facility's policy titled, Enteral Nutrition, revised November 2018, revealed nursing staff and the provider were responsible for monitoring residents for signs and symptoms of inadequate nutrition, altered hydration, and complications related to enteral nutrition. The policy indicated staff was trained to recognize and report complications associated with feeding tubes, including aspiration, tube misplacement or migration, skin breakdown at the insertion site, and gastrointestinal symptoms such as nausea, vomiting, diarrhea, and abdominal cramping. The policy further indicated that failure to confirm feeding tube placement prior to initiating feedings might increase the risk of aspiration.Review of the facility's policy titled, Gastrostomy/Jejunostomy Site Care, revised October 2011, revealed staff was to maintain the cleanliness of the gastrostomy or jejunostomy site to prevent irritation, breakdown, and infection. The policy indicated staff was to assess the site for redness, pain, swelling, or drainage and report signs of infection to the supervisor and physician. The policy further indicated that ongoing signs of irritation or infection were to be addressed and reported in accordance with facility policy and standards of practice.Review of the manufacturer's guidance from [NAME]'s Guide to Adult Tube Feeding, dated 09/2022, revealed ready-to-use enteral formula in a closed system (ready-to-hang) could remain hanging for up to 48 hours when the system remained closed and intact. The guidance further revealed that ready-to-use formula decanted into a bag (open system) could hang up to eight hours. Additionally, the manufacturer's guidance instructed that once the formula was opened, the container should be labeled with the date and time, and any unused formula should be covered and stored in a refrigerator. The guidance further indicated that handling of the feeding system should be performed in a manner to prevent contamination, including avoiding contact with components that would come into contact with the formula. Further review of the manufacturer's guidance revealed that leakage around the gastrostomy tube site was not expected and was considered a sign of an underlying problem that might increase the risk of skin breakdown and infection. The guidance also indicated that signs of infection at the stoma site might include redness, drainage, and irritation and could require evaluation and intervention. 1. Review of R36's admission Record revealed the facility admitted the resident on 12/16/2019 with diagnoses to include gastrostomy status, dysphagia, and gastro-esophageal reflux disease without esophagitis.Review of R36's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 02/16/2026, revealed the Brief Interview for Mental Status (BIMS) was not conducted because the resident was unable to complete it. The Staff Assessment for Mental Status was completed and indicated the resident was severely impaired for daily decision making and never/rarely made decisions. Further review revealed the resident was coded as receiving 51 percent or more of total calories and fluid intake via parenteral or tube feeding.Review of R36's Comprehensive Care Plan [CCP], undated, indicated the resident was care-planned for tube feeding related to dysphagia, chewing problems, and (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	swallowing problems. An intervention initiated on 02/28/2023 was to monitor signs and symptoms of infection and to check tube placement and gastric contents/residual volume. The goals included R36 would remain free of complications related to tube feeding.Review of the Order Summary Report, dated 06/07/2025, revealed staff should monitor the gastrostomy tube site for signs or symptoms of infection every shift to support infection prevention. Additionally, on 01/26/2026, the physician ordered enteral feeding to start at 4:00 PM and stop at 5:00 AM: Glucerna 1.5, 60 milliliters (ml) for 13 hours a day.Review of the Incident Report, dated 07/02/2025 from the adult day care center, revealed R36 presented with complications related to the gastrostomy (G-tube), including abnormal findings requiring transfer to the Emergency Department (ED) for further evaluation. Documentation indicated concerns with the G-tube site, prompting emergency medical services transport.Review of R36's Emergency Department Record, dated 07/02/2025, revealed R36 was diagnosed with abdominal wall cellulitis. However, the facility's clinical record contained no evidence that staff had identified or documented signs or symptoms of infection prior to the resident leaving the facility to attend the adult day care center.Review of the Incident Report, dated 03/05/2026 from the adult day care center, revealed R36 presented with complications related to the gastrostomy (G-tube), including leakage and inability to flush the tube. Documentation indicated the resident exhibited signs of distress, and assessment of the tube site revealed abnormal findings requiring intervention. The report further indicated the resident required transfer to the ED via emergency medical services for evaluation.Review of R36's Emergency Department Record, dated 03/05/2026, revealed the resident was diagnosed with abdominal wall cellulitis. However, the facility's clinical record contained no evidence that staff identified or documented signs or symptoms of infection prior to the resident leaving the facility to attend the adult day care center.Observation on 03/22/2026 at 2:40 PM revealed R36 lying in bed with the head of the bed elevated. The resident was not receiving enteral feeding at that time. However, a feeding container was observed hanging from an IV pole, spiked, and primed with formula, without a protective cap covering the connector. The feeding pump and IV pole were observed with dried formula residue. Further observation of Licensed Practical Nurse (LPN) 1 performing G-tube care at that time revealed the site was reddened with approximately a quarter-sized amount of yellowish-green drainage present around the stoma.During an interview with LPN1 on 03/22/2026 at the time of observation, she stated the feeding container had been spiked the previous day, used from 4:00 PM to 5:00 AM, and would be reused for the next feeding. LPN1 stated the connector should be covered. However, the facility did not provide caps, so it remained uncovered between feedings. LPN1 further stated the resident's G-tube site frequently leaked.Observation on 03/22/2026 at 6:30 PM revealed R36 remained in bed with no enteral feeding in progress. An interview with LPN1 at that time revealed she had fallen behind and planned to start the enteral feeding shortly.Observation on 03/22/2026 through 03/26/2026 revealed R36's intravenous (IV) pole and enteral feeding pump had a large amount of dried feeding residue present on the exterior surfaces of the pump, along the IV pole, and at the base of the pole.During an interview with the Physician Assistant (PA) on 03/25/2026 at 2:50 PM, she stated she had not been notified by staff of excessive leakage at R36's G-tube site and indicated that such leakage could contribute to recurrent cellulitis at the site. She further stated, if notified of excessive drainage, she would have changed the g-tube size or ordered a gastrointestinal (GI) consultation.2. Observation on 03/22/2026 at 1:21 PM revealed R46 had a tube feeding hanging and infusing which was not dated or timed.Review of R46's admission Record revealed the facility initially admitted R48 on 01/21/2016 with diagnoses of cerebral palsy, malnutrition, and epilepsy.Review of R46's quarterly MDS, with an ARD of 01/18/2026, revealed the BIMS score was undetermined due to the resident being rarely/never understood.Review of R46 Orders revealed an order for enteral feeding, Nutren 2.0 continuous at 25 ml/hour, dated 01/26/2026.3. Observation on 03/22/2026 at 1:34 PM revealed R32 had a tube feeding hanging, which was not dated or timed, not infusing, and the administration set was hung on the IV pole with no end caps.Additional observation on 03/22/2026 at 5:41 PM revealed Licensed Practical Nurse (LPN) 1 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered medications to R32 via the percutaneous endoscopic gastrostomy (PEG) tube without checking for placement prior to pushing the medication.Review of R32's admission Record revealed the facility admitted the resident on 01/01/1973 with diagnoses of cerebral palsy, epilepsy, and gastrostomy status.Review of R32's quarterly MDS, with an ARD of 01/18/2026, revealed a BIMS score was undetermined due to the resident being rarely/never understood.Review of R32's Care Plan, revealed R32 was care planned for staff to check placement and gastric contents/residual volume per facility protocol, dated 04/21/2023.Review of R32's Orders revealed an order for tube feeding, Fibersource HN at 60 ml/hour for 14 hours, turn on at 4:00 PM and turn off at 6:00 AM, dated 08/10/2024.4. Observation on 03/22/2026 at 1:35 PM revealed enteral nutrition, without the opening time and date identified for both R38 and R50, hanging from a pole with the tubing primed, and without a protective covering on the end of the opened tubes.During an interview on 03/22/2026 at 1:48 PM with Licensed Practical Nurse (LPN) 1, she stated that these were her residents, but she was not the nurse responsible for hanging the tube feeding. She stated the night shift hung them and was responsible for dating the bags, and she would put the date and time on the bag if she had hung it. She stated the tube feeding itself was good for 48 hours after it was hung but could not identify with certainty when these bags were hung. She stated, if it was hung for too long, it could spoil, and the resident could get sick. The nurse also stated ends of the tubing were not covered because no caps were available. Not having caps, she stated, could allow germs to be administered to the resident when the tubing was connected and could also make the resident sick. She stated she checked for PEG tube placements prior to administering medications (however, this was not observed).During an interview on 03/23/2026 at 4:00 PM with the Physician Assistant (PA), she stated there was a possibility for introducing bacteria to feeding tube sites if the feeding tube system was not capped when not in use.5. Review of R78's admission Record revealed the facility admitted the resident on 11/12/2021 with diagnoses to include gastrostomy status, dysphagia, and gastro-esophageal reflux disease without esophagitis.Review of R78's quarterly MDS, with an ARD of 01/18/2026, revealed BIMS was not conducted because the resident was unable to complete it. The Staff Assessment for Mental Status was completed and indicated the resident was severely impaired for daily decision making, and never/rarely made decisions. Further review revealed the resident received 51 percent or more of total calories and fluid intake via parenteral or tube feeding.Review of the Comprehensive Care Plan [CCP], undated, indicated the resident was care-planned for tube feeding related to dysphagia, chewing problems, and swallowing problems. An intervention was to monitor signs and symptoms of infection and to check for tube placement and gastric contents/residual volume. The goals included that R78 would remain free of complications related to tube feeding. Further review revealed R78 had a focus on alteration in nutrition due to dehydration, tube feeding, swallowing problems, and being overweight. An intervention was to provide feeding and water flushes per order and monitor for signs and symptoms of residuals. The goal was to tolerate tube feeding and water flushes per order with no signs or symptoms of residuals.Review of the Order Summary Report, dated 11/12/2021, revealed staff should monitor the G-tube site for signs or symptoms of infection every shift for infection prevention and enteral feed to start at 4:00 PM and stop at 5:00 AM, Fiber source 1.5 at 50 ml for 13 hours a day.Observation on 03/22/2026 at 2:00 PM revealed a G-tube feeding setup present in the resident's room. The enteral feeding container was observed hanging on an IV pole with tubing already spiked and primed. The feeding bag was labeled with the date 03/22/2026 and the time at 6:00 PM. At the time of observation, the feeding was not infusing, and the labeled time indicated the feeding had not yet been initiated for that scheduled administration (approximately 3.5 hours prior to the labeled time). The end of the feeding tube connector was observed uncovered, with no protective cap in place. The Kangaroo feeding pump and IV pole were observed to have dried tan feeding residue present on the exterior surfaces.Observation on 03/22/2026 at 6:01 PM revealed LPN1 administered medication via R78's G-tube without verifying tube placement or checking for gastric residual prior to administration. Following medication administration, LPN1 proceeded to (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	connect the enteral feeding. The review of the physician's order indicated the feeding was to begin at 4:00 PM. At the time of observation, the feeding was initiated approximately two (2) hours later than ordered. The feeding tube connector remained uncovered and was not cleansed prior to connection to the resident's G-tube.During an interview with LPN1 on 03/22/2026 at 6:01 PM, conducted at the time of the observation, she stated she typically initiated tube feedings during medication administration. LPN1 further stated the facility did not provide protective caps for feeding tube connectors and acknowledged that leaving the connector uncovered placed the resident at risk for infection. She stated she had previously notified the facility of the lack of protective caps; however, no action had been taken.Observation on 03/23/2026 at 9:00 AM, 11:11 AM, 2:12 PM, and 3:15 PM revealed R78's enteral feeding was infusing at 50 ml per hour. The review of the physician's order indicated that the feeding was to be discontinued at 5:00 AM.Observation on 03/23/2026 at 3:30 PM revealed R78 lying in bed with a large amount of emesis present on the chest of her gown and on the bed linens. In an interview at that time, Licensed Practical Nurse (LPN) 7 stated she had been running behind and had not turned off the feeding.Observation on 03/22/2026 through 03/26/2026 revealed R78's IV pole and enteral feeding pump had a large amount of dried feeding residue present on the exterior surfaces of the pump, along the IV pole, and on the base of the pole.During an interview with the [NAME] Product Line representative on 03/24/2026 at 4:46 PM, he stated he had referenced the Guide to Adult Tube Feeding and confirmed that the guidance applied to both home and facility settings. He stated a closed feeding system must remain closed and protected to maintain its integrity, and once the system was disconnected and the tubing tip was left exposed without a protective cap, it was no longer considered closed and was at risk of contamination.During an interview with the Registered Dietitian (RD) on 03/24/2026 at 9:48 AM, she stated enteral feedings should be administered according to the prescribed schedule to ensure the resident received the ordered nutritional intake. She stated there could be minor variations in timing to accommodate care needs; however, feedings should remain consistent with the prescribed regimen. The RD further stated feeding tube connectors should be covered to prevent contamination and reduce the risk of infection, and enteral feedings should not be left hanging longer than recommended timeframes. She stated concerns of excessive leakage at the G-tube site should be reported for further evaluation.During an interview with the Physician Assistant (PA) on 03/25/2026 at 2:50 PM, she stated enteral feedings should be administered in accordance with the physician's order to ensure the resident received the prescribed caloric intake and to reduce the risk of adverse effects from overfeeding. She further stated leaving the feeding tube port uncovered increased the resident's risk for infection. During an interview with the Director of Nursing (DON) on 03/26/2026 at 2:00 PM, she stated feeding tube connectors should be covered to prevent contamination and reduce the risk of infection. She further stated enteral feeding was to be administered according to physician orders and should not be hung longer than the recommended timeframes. The DON stated that if a resident has more than minimal leakage at the G-tube site, nursing staff are expected to notify the physician for further evaluation and management.During additional interview on 03/25/2026 at 3:31 PM with the Director of Nursing (DON), she stated it was her expectation that tube feedings should never be uncapped when not in use, and a new system should be set up if it is found undated, untimed, or uncapped. She stated they should always be dated and timed, and they were normally good for 24 hours, depending on the tube feeding and manufacturer. She stated it was important to make sure the residents were getting fresh tube feedings to help prevent infection.During an interview with the Administrator on 03/26/2026 at 11:00 AM, she stated she had not been made aware of concerns related to uncovered feeding tube connectors, prolonged hanging of enteral feeding, or excessive leakage at a resident's G-tube site. She stated staff was expected to report care concerns so they could be addressed. The Administrator further stated that enteral feedings should be administered according to physician orders, and equipment should be maintained in a clean and sanitary manner.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and review of the facility's documents and policy, the facility failed to provide food and drink served at a safe and appetizing temperature to residents. The lunch test tray on 03/24/2026 revealed food items that were in the temperature danger zone range for both hot and cold foods. Resident attendees in the Resident Council meeting on 03/23/2026 stated they received cold food at mealtimes. Also, on 03/23/2026, Resident (R) 45 stated she received cold food all the time. This deficient practice had the potential to affect all 78 current residents that received food prepared in the kitchen. The findings include: Review of the facility's policy titled, Food Preparation and Service, dated 2001, revealed the temperature danger zone for food temperatures was above 41 degrees Fahrenheit (F) and below 135 degrees Fahrenheit (F). Per the policy, that temperature range promoted the rapid growth of pathogenic microorganisms that caused foodborne illness. The policy stated potentially hazardous foods must be maintained at or below 41 degrees F or at or above 135 degrees F. Observation of R45 in her room on 03/22/2026 at 5:44 PM revealed there were several snacks at the bedside.Review of R45's admission Record revealed the facility admitted the resident on 11/25/2025 with diagnoses of diabetes mellitus type 2, major depressive disorder, and anxiety. Review of R45's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/22/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, which indicated the resident was cognitively intact. In an interview with R45 on 03/22/2026 at 5:44 PM, she stated she received cold food all the time. In an interview with the Resident Council meeting attendees on 03/23/2026 at 2:00 PM, the residents stated they received cold food at mealtimes. Review of the facility's document Providence Pavilion Test Tray Assessment, for the lunch dated 01/05/2026 with no time given, in the main (Honor) dining room's mechanical soft diet revealed the temperatures for baked ravioli at125 degrees F; cauliflower at 120 degrees F; apple bar at 55 degrees F; and milk at 42 degrees F. Review of the facility's document Providence Pavilion Test Tray Assessment, for the lunch dated 01/22/2026 with no time given, in the Rehabilitation Unit's regular diet revealed the temperature for baked chicken at 130 degrees F; rice pilaf at 127 degrees F; and carrots at 121 degrees F. Review of the facility's document Providence Pavilion Test Tray Assessment, for the dinner dated 02/02/2026 with no time given, in the main (Honor) dining room with the diet not stated revealed the temperatures for cold ham and cheese sandwich at 47 degrees F; carrots at 118 degrees F; pudding at 48 degrees F; and juice at 52 degrees F. Review of the facility's document Providence Pavilion Test Tray Assessment, for the lunch dated 02/25/2026 with a start time of 12:36 PM and an end time of 12:40 PM, in the Providence Unit's regular diet revealed the temperatures for rosemary chicken at 131 degrees F; mushroom rice at 122 degrees F; and au gratin cauliflower at 118 degrees F.Review of the facility's document Providence Pavilion Test Tray Assessment, for the lunch dated 03/12/2026 with no time given, in the main (Honor) dining room's diet puree revealed the temperatures for broccoli at 124 degrees F; mashed potatoes at 132 degrees F; and milk at 43 degrees F. Observation on 03/24/2026 at 12:55 of the last tray cart delivered to the Honor Unit revealed it contained the test tray. Observation of the test tray on 03/24/2026 at 1:04 PM, tested by the Dietary Manager, revealed the temperatures for the beef stroganoff at 121 degrees F; lemonade at 61 degrees F; and broccoli at 117 degrees F. All of these foods were in the temperature danger zone of 41 degrees F to 140 degrees F for hot foods and over 41 degrees F for cold foods. Taste tests by two State Survey Agency (SSA) Surveyors revealed they described the temperatures of the beef stroganoff as room temperature, the broccoli as cold, and the lemonade as warm to the taste. In an interview with the Dietary Manager on 03/24/2026 at 1:10 PM, she stated she liked the temperature of hot food served to residents at 130 degrees F. She stated the steam tables for the dining rooms were turned on one-half hour prior to meal service. In an interview with the Registered Dietitian (RD) on 03/24/2026 at 9:55 AM, she stated she completed sanitation walk throughs and test trays. She stated the hot food was always hot, and the (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperatures recorded were showed the hot food was hot.In a continued interview with the RD on 03/24/2026 at 1:04 PM, she stated department heads always passed out trays. She stated more people passed trays because staff was taking temperatures to ensure the temperatures were good for the test tray audit. She stated the temperatures were accurate with regular everyday meal pass because administration wanted department heads to pass trays. In an interview with the Director of Nursing on 03/25/2026 at 12:39 PM, she stated her expectation was for residents to receive food at the proper temperature. In an interview with the Administrator on 03/26/2026 at 1:40 PM, she stated her expectation was for food temperatures to be adequate when served to residents. She stated the hot food should be hot, and the cold food should be cold.

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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 the facility's policies, the facility failed to store, prepare, and serve food in accordance with professional standards for food safety. Observations revealed the nourishment refrigerators on the Purpose, Providence, and Honor Unit were not clean. In addition, opened but not dated food containers were observed on the Honor Unit and the kitchen, and the kitchen contained an item that was unrefrigerated which should have been refrigerated. The deficient practice had the potential to affect all 80 current residents. The findings include: Review of the facility's policy titled, Refrigerators and Freezers, dated 2001, revealed refrigerators and freezers were kept clean, free of debris, and disinfected with sanitizing solution on a scheduled basis and more often as necessary. Review of the facility's policy titled, Food Receiving and Storage, dated 2001, revealed all foods stored in the refrigerator or freezer were covered, labeled, and dated with use by date. Observation of the main dining room Honor Unit refrigerator on 03/22/2026 at 1:18 PM revealed the refrigerator and freezer were soiled with dry food products throughout each side and on the shelves. Further observation revealed an opened grape jelly container sitting on top of the refrigerator, not dated and not stored in the refrigerator. The label stated to store in the refrigerator after opening. Observation of the Pavilion Unit refrigerator and freezer on 03/22/2026 at 1:20 PM revealed soiled shelves with dried food in both sides of the shelves. Observation of the Purpose Unit dining room refrigerator and freezer on 03/22/2026 at 5:28 PM revealed the refrigerator was soiled with dried food. In an interview with State Trained Nurse Aide (STNA) 7 on 03/22/2026 at 4:54 PM, she stated Dietary was responsible to clean the unit nourishment refrigerators. Observation of the kitchen on 03/24/2026 at 11:58 AM revealed two opened and undated grape jelly containers found out of the refrigerator. In an interview with the Dietary Manager on 03/25/2026 at 10:05 AM, she stated the nourishment refrigerators were cleaned twice weekly and any spills should be cleaned up by staff. She stated they kept the jelly out to make peanut and butter jelly sandwiches. She stated the grape jelly should be dated when opened and kept in the refrigerator. In an interview with the Director of Nursing on 03/25/2026 at 12:39 PM, she stated her expectation for the nourishment refrigerators was for them to be clean. In an interview with the Administrator on 03/26/2026 at 1:40 PM, she stated her expectation was for staff to wipe up any spills in the nourishment refrigerators and maintain the cleanliness of the nourishment and resident refrigerators.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) signage, and review of the facility's policies, 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 for 12 of 25 sampled residents, Resident (R) 1, R3, R11, R18, R23, R32, R38, R47, R50, R66, R68, and R78. Observations on 03/22/2026, 03/23/2026, and 03/24/2026 revealed tube feedings hanging on poles but not timed or dated and without end caps, shared equipment not disinfected between resident use, residents on Enhanced Barrier Precautions (EBP) that had no signage for that on their room doors, and contaminated supplies placed on a surface without that surface being disinfected prior to placing uncontaminated items on it. The findings include: Review of the facility's policy titled, Infection Prevention and Control Program [IPCP], dated 12/2023, revealed members of the IPCP committee performed surveillance of staff adherence to IPCP practices. The policy stated the IPCP provided a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases, with the responsibility of coordination and oversight by the Infection Preventionist (IP). Further review revealed infection prevention included educating staff members and ensuring they adhered to proper techniques and procedures for Enhanced Barrier Precautions (EBP) and Transmission-Based Precautions (TBP). Review of facility's policy titled, Standard Precautions, revised date 09/2022, revealed, Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed. Review of the facility's policy titled, Administering Medications, version 2.1, revised April 2019, revealed medications were to be administered in a safe manner. The policy further stated staff was to follow established infection control procedures (e.g., hand hygiene, antiseptic technique, and appropriate infection control measures) during medication administration. Review of the facility's policy titled, Administering Medications, revised April 2019, revealed staff was to follow infection control practices, including proper cleaning and disinfection of equipment and surfaces between resident use. Review of the CDC signage for Enhanced Barrier Precautions, undated, revealed a gown and gloves were required for high-contact resident care activities for residents with a central line, a urinary catheter, a feeding tube, or wound care for any skin care requiring a dressing. 1. Observation on 03/22/2026 upon entry at 1:30 PM revealed Enhanced Barrier Precaution (EBP) signage was not posted on the doors of the rooms for Resident (R) 11, R47, or R23, who were all under EBP. In addition, observation on 03/22/2026 at 2:54 PM revealed R18's room had no EBP signage even though the resident was under EBP. a. Review of R11 admission Record revealed the facility admitted the resident on 08/18/2025 with diagnoses of behavioral and emotional disorders, anoxic brain injury, and major depressive disorder.Review of R11's Care Plan revealed R11was care planned on 03/10/2026 for requiring tube feedings and also having risk of infections, requiring EBP, dated 03/10/2026.During an interview on 03/25/2026 at 9:35 AM with the Physician Assistant (PA), she stated R11 was admitted with a percutaneous endoscopic gastrostomy (PEG) tube in place on 08/18/2025.During an interview on 03/25/2026 at 9:35 AM with the Minimum Data Set (MDS) Nurse, she stated R11's Enhanced Barrier Precautions (EBP) related to his percutaneous endoscopic gastrostomy (PEG) tube should have been added to his care plan, upon admission, prior to 03/10/2026, and signage posted on his room door.b. Review of R23's admission Record revealed the facility admitted the resident on 01/21/2022 with a diagnoses of congestive heart failure, diverticulitis of intestine with perforation, and colostomy.Review of R23's Orders revealed an order for EBP dated 03/23/2026 and colostomy care every shift dated 07/04/2024 (original order for colostomy care dated 01/21/2022).Review of R23's Care Plan revealed R23 was care planned for EBP on 06/12/2023.During an interview on 03/25/2026 at 9:35 AM with the MDS Nurse, she stated she was told that residents with colostomies did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	require EBP. She stated she did not remember who told her this but that she left it on the care plan and was going to question if the resident still required EBP. She stated staff should be following the care plan interventions.c. Review of R47's admission Record revealed the facility admitted the resident on 07/25/2025 with diagnoses of chronic obstructive pulmonary disease (COPD), end stage renal disease with dependence on renal dialysis, and congestive heart failure.Review of R47 Orders revealed R47 had an order for EBP, dated 03/23/2026.During an interview on 03/25/2026 at 9:35 AM with the PA, she stated R47 currently had a dialysis catheter and a fistula. She stated the resident was admitted with the catheter while she was waiting to get the fistula and for it to mature.During an interview on 03/25/2026 at 9:35 AM with the MDS Nurse, she stated R47 should have been care planned for the dialysis catheter and EBP upon her admission on [DATE].d. Observation on 03/22/2026 at 2:54 PM revealed R18 had an indwelling urinary catheter.During an interview on 03/22/2026 at 3:46 PM with State Trained Nurse Aide (STNA) 1, she stated R18 had an indwelling urinary catheter and was on EBP. She stated an EBP sign should have been posted on the resident's door, but it was never posted when she changed from her rehab room over a month ago. During an interview on 03/25/2026 at 3:31 PM with the Director of Nursing (DON), she stated, The person that was doing IP [Infection Prevention] before me said it was done [referring to the signage being hung], and it wasn't. She stated it was important to have the correct signage up and visible to help keep the resident from contacting infections that could be avoidable.2. Observation on 03/22/2026 at 1:34 PM revealed Resident (R) 32 had a tube feeding (TF) hanging, which was not dated or timed. The TF was not infusing, and the administration set was hung on the pole with no end caps. Additional observation on 03/22/2026 at 1:35 PM revealed enteral nutrition without the opening time and date identified for both R38 and R50, hanging from a pole with the tubing primed, and without a protective covering on the end of the open tubes. Further observation on 03/22/2026 at 1:37 PM revealed enteral nutrition without the opening time and date identified for R78, hanging from a pole with the tubing primed, and without a protective covering on the end of the open tube. Review of R32's Orders revealed an order for tube feeding, Fibersource HN at 60 milliliters (ml)/hour for 14 hours, turn on at 4:00 PM and turn off at 6:00 AM, dated 08/10/2024. During an interview on 03/22/2026 at 1:58 PM with License Practical Nurse (LPN) 1, she stated she was not the nurse who hung the tube feedings for R32, and she thought it was done by the previous night shift nurse. She stated tube feedings were good for 48 hours once hung per the facility's policy. She stated if it was hung for too long, it could spoil, and the resident could get sick. She stated the facility did not have end caps to place onto the tube feeding systems when they were disconnected from the residents and not in use. She stated not having end caps could allow germs to be administered to the resident when the tubing was connected and could also make the resident sick. During an interview on 03/23/2026 at 2:20 PM, LPN4 stated the unit with the residents with tube feedings was not her usual unit. She stated she did not understand why there were never any names or dates on the tube feeding bottles. She stated when she hung tube feedings, she knew to put that information on the bottles/bags, and she changed the tubing at the same time. She stated not doing so could cause the resident to get sick from old tube-feeding. She also stated she was unaware of any type of cap for the end of the tube feed tubing. During an interview on 03/23/2026 at 4:00 PM with the Physician Assistant (PA), she stated there was a possibility of introducing bacteria to feeding tube sites if the feeding tube system was not capped when not in use. During an interview on 03/25/2026 at 3:31 PM with the Director of Nursing (DON), she stated it was her expectation that tube feedings should never be uncapped when not in use, and a new system should be set up if it was found undated, untimed, or uncapped. She stated they should always be dated and timed, and they were normally good for 24 hours, depending on the tube feeding and the manufacturer. She stated it was important to make sure the residents were getting fresh tube feedings to help prevent infection. During an interview on 03/26/2026 at 1:19 PM with the Administrator, she stated it was her expectation that staff followed orders and dated and timed tube feedings when they were initiated. She stated this was important to prevent medication errors and for (continued on next page)

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	185038	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Kenton	401 East 20th Street Covington, KY 41014

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection control. 3. Observation on 03/22/2026 at 4:37 PM revealed Registered Nurse (RN) 1 performed a blood glucose check for R68 using the medication cart surface to prepare supplies. After completion, RN1 placed the used glucometer and supplies on the medication cart surface, cleaned the glucometer, and disposed of the used lancet and test strip. However, the surface was not cleaned or disinfected after contamination. RN1 then placed supplies for another resident on the same surface without disinfecting the area and was preparing to perform the next blood glucose check when the State Survey Agency (SSA) Surveyor intervened and instructed RN1 to stop. During an interview with Registered Nurse (RN) 1 on 03/22/2026 at the time of the observation, she stated she forgot to disinfect the medication cart surface before placing supplies for another resident. RN1 further acknowledged she should have cleaned the cart surface between residents to prevent cross-contamination. 4. Observation on 03/23/2026 at 8:42 AM, revealed RN5 failed to clean the blood pressure (BP) cuff between its use on R3 and R66.During an immediate interview, RN5 stated she normally would clean the cuff with Sani-wipes but forgot. She stated she did not have any wipes in her cart, but they were usually in the cart. She stated not cleaning the equipment between residents could expose residents to germs and increase the risk of making them sick. 5. Observation on 03/24/2026 at 3:14 PM revealed STNA4 and LPN3 used the mechanical lift to place R1 back to bed. They then placed the mechanical lift in the hall after it was used but did not clean it after use. During an interview on 03/24/2026 at 3:35 PM with STNA4, she stated the mechanical lift should be cleaned after it was used to prevent the spread of germs. During an interview with the Director of Nursing (DON) on 03/23/2026 at 2:30 PM, she stated staff should follow infection control practices, including disinfecting shared surfaces and equipment between resident use to prevent cross-contamination.During an interview on 03/26/2026 at 1:19 PM with the Administrator, she stated it was her expectation that staff would follow policies, CDC guidance, and clean shared equipment between each use. She stated it was her expectation that the appropriate signage and precautions be in place to keep the residents and the staff safe from developing any new issues.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's documents and policy, the facility failed to maintain an effective pest control program to ensure the facility was free of pests and rodents. Observations on 03/22/2026 and 03/23/2026 revealed gnats in multiple areas of the facility. In addition, in interviews with residents and staff on 03/22/2026, 03/23/2026, and 03/24/2026, they reported seeing pests in the facility, including gnats, roaches, and mice. The deficient practice had the potential to affect all 80 current residents in the facility.The findings include: Review of the facility's policy titled, Homelike Environment, dated 2001, revealed residents were provided with a safe, clean, comfortable, and homelike environment. Review of the facility's contract with the pest control company, dated 10/16/2017, revealed pest coverage for mice, rats, spiders, centipedes, water bugs, silverfish, and roaches. Review of the pest invoices, dated 01/14/2026 to 03/02/2026, revealed the facility had a pest control program; however, the facility continued to keep outside doors opened which allowed the mice, cockroaches, and gnats to enter the building. 1. Observation of room [ROOM NUMBER] on 03/22/2026 at 1:45 PM revealed two urinals sitting on a bedside table, one empty and one one-third full of urine, with gnats flying around them. In an interview on 03/26/2026 at 9:58 AM with the Director of Nursing (DON), she stated regarding room [ROOM NUMBER], the resident in question did not like anyone touching his things, and there was not much staff could do. 2. Observation of the kitchen on 03/22/2026 at 2:27 PM revealed the delivery and emergency door held open with a milk crate creating a gap between the two doors. Continued observation on 03/22/2026 at 2:30 PM revealed the double reach in freezer had gnats flying around the opened freezer doors. 3. Observation of the bathroom in room [ROOM NUMBER] on 03/22/2026 at 3:40 PM revealed a cracked plastic overhead light with a large dead moth inside. 4. Observation of room [ROOM NUMBER] on 03/23/2026 at 9:08 AM revealed an enclosed mouse glue trap behind a chair near the entryway to the resident's room. In an interview with the resident in room [ROOM NUMBER] on 03/23/2026 at 9:03 AM, he stated he had seen a mouse, and it came from under the chair in the room. He stated he had also seen some cockroaches on the walls, which disappeared into the ceiling tiles, and some gnats. The resident stated he reported it to staff, and pest control came and sprayed. He stated he had not seen any bugs since. 5. Observation of the Providence Unit dining room on 03/23/2026 at 10:25 AM revealed two coffee cups, one plate, and one fork in the sink and one tray over the sink with gnats on the dishware. 6. Observation of the main hallway leading to the kitchen on 03/23/2026 at 11:45 AM revealed two side doors to the courtyard opened and with the wind blowing into the building. The hallway led to the kitchen area and into the first floor of the building. 7. Observation of the kitchen on 03/24/2026 at 11:58 AM revealed the kitchen back door held open with a milk crate which formed a gap between the two doors. 8. Observation of the outside of the building on 03/25/2026 at 8:02 AM revealed the side door facing the parking lot held open with two chairs. The sign posted on the front and inside of the door stated, Stop do not use door. The door led straight ahead to the cement stairs to an area downstairs. The right archway led to the courtyard and the side door which opened into the building and led to the hall door near the kitchen. In an interview with Resident 45 on 03/22/2026 at 5:44 PM, she stated she found in her room, a mouse between the screen and window. She stated she could touch its tail. She stated the next morning the mouse was gone, and mouse droppings were in the window. She stated she had received a meal tray with mouse droppings. In an interview on 03/23/2026 at 3:35 PM with State Trained Nurse Aide (STNA) 7, she stated the facility had big roaches, and she had just killed one that day. She stated she had only seen roaches in the hallways and not in the residents' rooms. She stated the facility had a problem with flies and gnats, especially in dining rooms. She stated pest control had been through spraying the facility, but she did not think it was effective. She stated she had heard residents and family members in the dining room complain about the gnats. In an interview on 03/22/2026 at 5:08 PM with STNA1, she stated she saw a roach (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that morning. She stated although she had not seen any mice, she knew some night shift staff, as well as some residents, had complained of seeing mice. She stated pest control came to the facility and sprayed routinely and also left glue traps for mice. In an interview with STNA8 on 03/24/2026 at 9:00 AM, she stated she had not seen any mice, although she had heard others had complained about mice. She stated she had seen gnats flying around, and they had been a problem since late last year, with a decline during the winter months. She stated she wiped things down, which helped out a little, and the exterminator came to the facility and sprayed, which helped for a little while. In an interview with the Director of Maintenance on 03/24/2026 at 3:30 PM, he stated residents had too much opened food in their rooms. He stated one resident collected cups from trays daily and kept them in her room. He stated he expected the kitchen door to be kept closed. He stated he expected the side door to be kept closed except when in use for deliveries, for an emergency exit, and when taking trash out of the building. He stated the doors should not be left opened, which allowed pests to enter. In an interview with the Dietary Manager on 03/25/2026 at 10:05 AM, she stated the doors should be shut unless staff was taking trash out. She stated keeping the door opened would allow pests to enter and possibly cross-contaminate the food.In additional interview with the DON on 03/25/2026 at 12:39 PM, she stated the door to the kitchen should remain closed for safety and to prevent pests from entering.In continued interview with the DON on 03/26/2026 at 9:58 AM, she stated the facility should be kept clean and as nice as possible for residents. In an interview with the Administrator on 03/26/2026 at 1:40 PM, she stated she expected staff to provide residents with a homelike environment.