STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185069	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Manor	3300 Tates Creek Road Lexington, KY 40502

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, record review, and review of the facility's document and policies, the facility failed to provide resolutions and/or provide precise documentation on resolutions related to reported missing items for 3 out of 13 sampled residents, Resident (R) 30, R95, and R119.R30 and R95 reported in the Resident Council meeting, on 02/10/2026, they had made grievances to staff related to missing items of clothing without ever having their grievances resolved. Review of the facility's document Grievance Logs, dated 09/17/2025, also revealed R119 reported missing items of clothing, and the resident was discharged on 09/26/2025 without having the resident's grievance resolved. The findings include:Review of the facility's policy titled, Grievances/Complaints, revised 01/20/2026, revealed the resident had the right to voice grievances to the facility or other agency or entity that heard grievances without discrimination or reprisal and without fear of discrimination or reprisal. This policy was to ensure the prompt resolution of resident grievances. Per the policy, it was best customer service practice to resolve a grievance within three business days if applicable. The policy further stated the resolution should include the date the grievance was received; a summary statement of the resident's grievance; the steps taken to investigate the grievance; and a summary of the pertinent findings or conclusions regarding the residents concern(s). The summary of the pertinent findings or conclusions should include a statement as to whether the grievance was confirmed or not confirmed; any corrective action taken or to be taken by the facility as a result of the grievance; and the date the written decision was issued.Review of the facility's policy titled, Resident Damaged or Missing Property, revised 01/31/2025, revealed the facility would provide a process in the event of loss or damage to a resident's property. Per the policy, it was the organization's policy that our facilities would take reasonable steps to protect all personal items brought in by residents or their families and to search to the best of our ability for any lost items. Review of the facility's policy titled, Resident Rights, revised 01/31/2025, revealed all residents had the right to be treated with respect and dignity. These rights would be promoted and protected by the facility. Review of the facility's Job Description, Social Services Director [SSD], dated May 2022, revealed the SSD would identify and participate in process improvement initiatives that improved customer experience, enhanced workflow, and/improved the work environment. During a Resident Council meeting on 02/10/2026 at 11:00 AM, R30 stated she had been missing a green North Face shirt since 09/11/2025. She stated the facility was aware of the missing shirt since that time, and as of 2/10/2026, she had not received a response or reimbursement.During a Resident Council meeting on 02/10/2026 at 11:00 AM, R95 stated he had been missing several pairs of pants and several shirts. He stated he had reported it to multiple staff members around the first part of February 2026. However, he stated he had not received a response/reimbursement or had the items returned to his possession. Review of the facility provided Grievance Logs, dated 09/17/2025, revealed R119 reported missing one pair of gray/black/white/pink flannel, size small, pants and one pair of navy/green/white flannel, size small, pants. Further review revealed the Laundry Account Manager documented those items were not found in the laundry, and the resident needed reimbursement. Review of the Facility's Matrix System, on 2/11/2026, revealed R119 was discharged from the facility on 09/26/2025, without the (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grievance being resolved. Additional review, for the last six months, revealed R95's grievance was not listed on the log. During an interview with the Laundry Account Manager on 02/11/2026 at 12:35 PM, he stated he was aware of R95's missing items and an investigation had begun, but it was not resolved yet. He stated he was informed of the grievances for his department from the Administrator, Social Services Director, and at stand-up meeting in the mornings. He stated he determined what was missing, got a brief description, and started an investigation to locate the items. He stated if the item(s) were not found, he would inform the Administrator or Social Services Director. He stated, after he reported the item(s) were not found, his department was no longer responsible for the missing item(s). During an interview with the Social Services Director (SSD) on 02/11/2026 at 12:46 PM, she stated when a resident filed a grievance for a missing item, she called the facility or resident representative, if one was available for the resident. She stated the resolution depended on what the family representative requested. She stated, if a reimbursement was needed, she had the family present the receipt, and the corporate office would disburse the funds. She stated if the resident or family representative did not have a receipt for the missing item, no reimbursement could be given.During an interview with the Social Services Assistant on 02/11/2026 at 12:55 PM, she stated residents needed a receipt to be reimbursed for items missing, lost, or stolen at the facility. She stated if there was no receipt provided; they would not be reimbursed. She stated when grievances were filed, the Social Services department gave the grievance to the appropriate department to prompt an investigation. She stated she and the SSD were responsible for keeping track of the logs for proper documentation and giving agreeable resolutions to the residents and/or family representatives. During an interview with the Administrator on 02/12/2026 at 3:30 PM, she stated the Social Services department was responsible for the documentation and resolutions for grievances filed by residents, family representatives, and visitors. She stated her expectation was for grievances to be resolved within five business days. She stated she expected staff to document the filed grievances on the log and document when and how the grievance was resolved.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, and review of the facility's policy, the facility failed to implement the comprehensive person-centered care plan for 1 of 18 sampled residents, Resident (R) 7. The findings include:Review of the facility's policy titled, Comprehensive Care Plans, revised [DATE], revealed each resident's comprehensive person-centered care plan would be developed and implemented and would include measurable objectives and time frames to meet the resident's medical, nursing, mental, and psychosocial needs as identified in their comprehensive assessment. Further review revealed each resident's care plan was designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, and should be revised as necessary with changes. Review of R7's Face Sheet revealed the facility admitted the resident on [DATE] with diagnoses including type 2 diabetes with neuropathy and stroke. Review of R7's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of [DATE], 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. Further review revealed the resident was assessed to require substantial to maximum assistance with mobility tasks. Review of R7's, Comprehensive Care Plan, dated [DATE], revealed the resident's functional mobility status required two staff members when the resident transferred. Further review revealed R7 was listed as a two-person assist at all times because of previous false allegations the resident made against staff. In an interview with State Registered Nurse Aide (SRNA) 5 on [DATE] at 10:10 AM, he stated he provided care for R7. He stated the resident had experienced a stroke, her left side was weak, and she required two people for assistance with mobility. However, observation on [DATE] at 9:31 AM revealed when the State Survey Agency (SSA) Surveyor entered R7's room, she stated she just called for staff assistance because her brief needed to be changed. SRNA5 entered the resident's room and cleaned her without assistance from another staff member. The resident indicated she was not finished and asked SRNA5 for assistance to the bathroom. Further observation revealed SRNA5 assisted R7 to a sitting position on the bedside while he retrieved her wheelchair located on the other side of the bed. The SSA Surveyor observed R7 at the bedside with her feet on the floor. Further observation revealed the resident became weak, started to sway, and called out to SRNA5 for help. Once the resident steadied herself on the bed, SRNA5 transferred the resident from her wheelchair to the toilet in the bathroom. No other staff members were present. When asked what was on the resident's plan of care related to mobility assistance, SRNA5 stated he did not know off the top of his head. In an interview with SRNA4 on [DATE] at 10:06 AM, she stated R7 was not typically assigned to her, but she was today. SRNA4 stated the resident had left-sided weakness and required two people for assistance. In an additional interview with SRNA5 on [DATE] at 2:03 PM, when asked why extra assistance was not requested when he transferred R7 earlier in the day, he stated he thought he was just nervous because the SSA Surveyor was in the room. SRNA5 stated he normally changed R7's brief and pulled her up in bed by himself, but the resident needed two when she transferred. He further stated it was important that proper assistance was used when a resident transferred to prevent accidents or injury. In an interview with the MDS Coordinator on [DATE] at 2:26 PM, she stated not only MDS updated care plans, but also Nursing, Dietary, and Social Services. She stated the care plan guided staff, so they knew a resident's care needs. She further stated it was important care plans were correct, updated, and followed so residents were kept safe, and their needs were met. In an interview with the Director of Nursing (DON) on [DATE] at 2:53 PM, she stated R7 was at risk for falls, unable to get up without assistance, and had safety interventions listed on her care plan. The DON stated how a resident transferred was listed on the SRNA Kardex (plan of care). She stated because R7 was a potential fall risk, she required two staff members for transfers. She further (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the resident was also care planned for false accusations and therefore required two people for assistance with personal care at all times. The DON stated it was her expectation that staff followed care plans, so residents were kept safe. In an interview with the Administrator on [DATE] at 3:17 PM, she stated she attended care plan conferences and clinic meetings because it helped her know what was going on in the facility and with residents. She stated the purpose of a care plan was to help staff know where residents were in their care, what their preferences were, and any changes that occurred. The Administrator stated it was her expectation that staff followed interventions listed on the care plan, so residents were properly cared for and protected.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure residents were adequately assisted to prevent accidents from occurring for 1 of 7 sampled residents, Resident (R) 7. The findings include: Review of the facility's policy titled, Resident Rights, revised [DATE], revealed all residents would be treated in a manner and in an environment that promoted maintenance or enhancement of quality of life. Review of the facility's policy titled, Accidents and Incidents, revised [DATE], revealed the facility intended to provide an environment free from accidents and incidents that were avoidable. Review of R7's, Face Sheet revealed the facility admitted the resident on [DATE] with diagnoses including type 2 diabetes with neuropathy and stroke. Review of R7's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of [DATE], 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. Further review revealed the resident was assessed to require substantial to maximum assistance with mobility tasks. Review of R7's, Comprehensive Care Plan, dated [DATE], revealed the resident's functional mobility status required two staff members when the resident transferred. Further review revealed R7 was listed as a two-person assist at all times because of previous false allegations the resident made against staff and her need for substantial to maximum assistance with mobility tasks. Review of a daily Skilled Nursing Note, dated [DATE], revealed R7 was a fall risk and was provided education by nursing staff related to fall prevention and safety management. Review of point of care (POC, the facility's software) documentation, dated [DATE] to [DATE], revealed R7 required two people for transfer assistance. In an interview with State Registered Nurse Aide (SRNA) 5 on [DATE] at 10:10 AM, he stated he provided care for R7. He stated the resident had experienced a stroke, her left side was weak, and she required two people for assistance with mobility. However, observation on [DATE] at 9:31 AM revealed when the State Survey Agency (SSA) Surveyor entered R7's room, she stated she just called for staff assistance because her brief needed to be changed. SRNA5 entered the resident's room and cleaned her without assistance from another staff member. The resident indicated she was not finished and asked SRNA5 for assistance to the bathroom. Further observation revealed SRNA5 assisted R7 to a sitting position on the bedside while he retrieved her wheelchair located on the other side of the bed. The SSA Surveyor observed R7 at the bedside with her feet on the floor. Further observation revealed the resident became weak, started to sway, and called out to SRNA5 for help. Once the resident steadied herself on the bed, SRNA5 transferred the resident from her wheelchair to the toilet in the bathroom. No other staff members were present. When asked what was on the resident's plan of care related to mobility assistance, SRNA5 stated he did not know off the top of his head. During an interview with SRNA4 on [DATE] at 10:06 AM, she stated R7 was not typically assigned to her, but she was today. SRNA4 stated the resident had left-sided weakness and required two people for assistance. In an additional interview with SRNA5 on [DATE] at 2:03 PM, when asked why extra assistance was not requested when he transferred R7 earlier in the day, he stated he thought he was just nervous because the SSA Surveyor was in the room. SRNA5 stated he normally changed R7's brief and pulled her up in bed by himself, but the resident needed two staff when she transferred. He further stated it was important that proper assistance was used when a resident transferred to prevent accidents or injury. In an interview with the Director of Nursing (DON) on [DATE] at 2:53 PM, she stated from what she recalled, R7 was care planned for false accusations and therefore always required two staff members for personal care. The DON stated R7 was at risk for falls and depended on staff for assistance with mobility. She further stated the resident's mobility limitations were listed on the plan of care with appropriate interventions for resident safety. In an interview with the Administrator on [DATE] at 3:17 PM, she stated it was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her expectation that staff followed each resident's functional mobility plan of care, so all residents were protected and kept safe.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of the facility's policy, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys for 1 of 6 medication/treatment carts, a North Hall medication cart. The findings include: Review of the facility's policy titled, Medication Storage, dated 01/2025, revealed, In order to limit access to prescription medications, only licensed nurses, pharmacy staff, or those lawfully authorized to administer medications (such as medication aides) were allowed access to medication carts. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended to by persons with authorized access. Observation on 02/10/2026 at 3:11 PM revealed the medication cart on the North Hall for Rooms 101-105 was unlocked and unattended. During an interview on 02/10/2026 at 3:12 PM with Licensed Practical Nurse (LPN) 2, she stated she just walked away from the cart for a minute and did not usually leave her cart unlocked. She stated this instance was a one off. She stated the medication cart should always be kept locked when not attended to prevent other people from getting into it. During an interview on 02/10/2026 at 2:21 PM with the North Hall Unit Manager, she stated the medication carts were, for the residents' safety, supposed to be locked anytime staff stepped away from the cart. During an interview on 02/12/2026 at 2:50 PM with the Director of Nursing (DON), she stated she was made aware of the cart being left unlocked. She stated it was her expectation that the medication carts would always be locked if unattended. She stated that it was important for resident safety and to prevent anyone from getting into it. During an interview on 02/12/2026 at 2:56 PM with the Administrator, she stated it was her expectation that the medication carts were locked so no one could get into the cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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) guidelines, review of the facility's documents, 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 1 of 18 residents sampled for infection control, Resident (R) 66.Observation on [DATE] revealed Resident (R) 66, who was not on contact isolation for Clostridium Difficile (C-diff), was residing in a room with R62, who was on contact isolation for C-diff. According to CDC guidelines, residents who were positive for C-diff should be roomed with other C-diff positive residents when single patient rooms were not available. The findings include:Review of the facility's policy titled, Infection Control, revised date [DATE], revealed, Facility infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.Review of the facility's policy titled, Transmission Based Precautions, revised [DATE], revealed, Transmission Based Precautions [TBP] are initiated when a resident develops signs and symptoms of a transmissible infection or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. The policy also revealed, The facility makes every effort to use the least restrictive approach to managing individuals with potentially communicable infections. Transmission Based Precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures.Review of the CDC's guidelines, Summary of Recommendations, not dated, revealed, Determine patient placement based on the following principles: Route(s) of transmission of the known or suspected infectious agent; Risk factors for transmission in the infected patient; Risk factors for adverse outcomes resulting from a Hospital Acquired Infection (HAI) in other patients in the area or room being considered for patient placement; Availability of single patient rooms; Patient options for room sharing (e.g., cohorting patients with the same infection).Observation on [DATE] at 1:01 PM revealed R66, who was not on contact isolation for C-diff, was residing in a room with R62, who was on contact isolation for C-diff. No enhanced barrier precaution signage was noted to be visible to indicate that R66 was on Enhanced Barrier Precautions (EBP). Contact Precaution signage was hanging outside of the room with no indication of which resident it applied. The curtain between the two residents was not pulled closed to keep them separated, and both residents could be viewed from the doorway.1. Review of R66's Face Sheet revealed the facility admitted the resident on [DATE] with diagnoses of seizures, aphasia, dysphagia, stroke, and gastrostomy tube (a tube inserted into the stomach to deliver nutritional products for individuals with swallowing disorders (dysphagia).Review of R66's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview for Mental Status [BIMS] was not conducted due to the resident being rarely/never understood.Review of R66's Care Plan revealed the resident was care planned for requiring Enhanced Barrier Precautions (EBP) related to enteral feedings, initiated on [DATE] and edited on [DATE].Review of R66's Orders revealed R66 had an order for EBP due to enteral feeding, dated [DATE].2. Review of R62's Face Sheet revealed the facility admitted the resident on [DATE] with diagnoses of dementia, dysphagia, stroke, and gastrostomy tube.Review of R62 quarterly MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of three out of 15, indicating R62 was severely cognitively impaired.Review of R62's Care Plan revealed the resident was care planned for requiring Contact Precautions related to C-Diff, initiated on [DATE].Review of R62's Orders revealed R62 had an order for Contact Precautions, dated [DATE].Review of R62's Diagnostic Order Review revealed C-Diff was detected on [DATE].Review of the Daily Census Report for [DATE] to [DATE] revealed there were several rooms that had openings in which to move R66 with the correct precautions in place. On [DATE], one resident was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharged , one resident was on hospital leave, and one resident expired, leaving an in-house census documented at 88. On [DATE], two residents were discharged , one resident was on hospital leave, and there were three admissions, leaving an in-house census documented at 89. On [DATE], one resident was discharged , and one resident was on hospital leave, leaving an in-house census documented at 88. On [DATE], two residents were discharged , and one resident was on hospital leave, leaving an in-house census documented at 85. On [DATE], two residents were discharged , two residents were on hospital leave, and there were three admissions, leaving an in-house census documented at 85. On [DATE], two residents were on hospital leave, and there was one admission, leaving an in-house census documented at 86. On [DATE], there was one discharge, and two residents were on hospital leave, leaving an in-house census documented at 85.Review of the facility's document Residents in Isolation for the North Hall, dated February 2026, revealed for the residents' room, R66 was on EBP with isolation stocked and correct signage, and R62 was on Contact Isolation with isolation stocked and correct signage.The State Survey Agency (SSA) Surveyor unsuccessfully attempted to interview R66 and R62 on [DATE] at 1:01 PM due to their low BIMS score and R66 being aphasic.The SSA Surveyor unsuccessfully attempted to interview R66's representative on [DATE] at 9:09 AM.The SSA Surveyor unsuccessfully attempted to interview R62's representative on [DATE] at 9:14 AM.During an interview on [DATE] at 1:01 PM with Licensed Practical Nurse (LPN) 2 and the Infection Prevention Nurse (IP), they stated neither resident in their room used the restroom, and gown and gloves were required for all staff who cared for R62. They stated EBP was used for R66. They stated all staff had to use soap and water after caring for either resident and must don (put on) Personal Protective Equipment (PPE) if they went past the curtain.During an interview on [DATE] at 2:21 PM with the North Unit Manager (UM), she stated staff was treating both residents in their room (R62 and R66) as contact since they were sharing a room. She stated, When our beds are locked, they have to cohort if they are not using the same bathroom. When asked if the facility was in a bed lock when R62 was diagnosed with C-diff, she stated she was not sure.During an interview on [DATE] at 3:35 PM with the Nurse Practitioner (NP), he stated, I am not sure about the regulations. To my knowledge they're supposed to be in a private room when they have C-diff.During an interview on [DATE] at 10:32 AM with the IP, she stated the facility followed CDC guidelines for infection control. She stated she was not comfortable answering hypothetical questions when asked if R66 was at an increased risk of contracting C-diff while being roomed with R62 for seven days prior to being moved into a different room. She stated, Our signage says what we need to use the PPE for, and they were treating both residents in their room as on contact precautions. She stated it was her expectation for staff to follow infection control practices. She stated she rooms residents per CDC guidelines. She stated, ultimately you would place a resident with C-diff in a private room, but they might have to be in residence with another until a private room was available. She stated she believed R66 was not moved to another room because the facility was in a bed lock until [DATE]. She stated she did not have a room in which to move one of them. She stated the facility had a bed open up on Tuesday, [DATE], to her understanding, in which to move R66. She stated it was important to room residents appropriately to prevent the spread of infection.During an interview on [DATE] at 9:32 AM with the Director of Nursing (DON), she stated residents should only be roomed together if they had the same infection for infection control. In an additional interview on [DATE] at 2:50 PM with the DON, she stated the facility should be following the CDC guidelines for patient safety.During an interview on [DATE] at 2:56 PM with the Administrator, she stated she was not aware if the facility was in a bed lock that prevented R66 from being moved to a more appropriate room. She stated it was her expectation that staff would follow the CDC guidelines, and that it was important in preventing the spread of infections.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidance, and review of the facility's document and policies, the facility failed to ensure each resident was offered and provided the COVID-19 vaccine for 1 of 18 sampled residents, Resident (R) 79. R79 requested COVID-19 vaccination; however, this was not ordered or provided. The findings include: Review of the facility's policy titled, Resident Rights, revised 01/31/2025, revealed all residents would be treated in a manner and in an environment that promoted maintenance or enhancement of quality of life, and all residents had the right to participate in decisions and care planning. Review of the facility's policy titled, Vaccines and Immunizations, revised 1/30/2026, revealed the facility followed CDC guidance for immunizations to minimize the risk of residents acquiring, transmitting, or experiencing complications from communicable diseases. Review of the facility's policy titled, COVID-19, dated 01/31/2025, revealed guidelines for COVID-19 would be conducted following accepted national standards through the CDC, Centers for Medicare and Medicaid Services (CMS), and local state agencies. Review of CDC guidance found at www.cdc.gov/vaccines/hcp/vis/current-vis.html revealed the COVID-19 vaccine was recommended for everyone six months of age and older. It also revealed older adults and people of any age with certain underlying medical conditions (like heart, lung disease, or diabetes) were more likely to get very sick with COVID-19. Further review revealed people who were up to date with COVID-19 vaccination had a lower risk of severe illness, hospitalization, and death from COVID-19 than people who were not up to date. Review of R79's Face Sheet revealed the facility admitted the resident on 12/17/2024 with diagnoses including Huntington's disease, cerebrovascular disease, and personal history of COVID-19. Review of R79's annual Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 10/01/2019, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, which indicated the resident was cognitively intact. Further review revealed R79's COVID-19 vaccination status was marked as not up-to-date. Review of the facility's document Flu, Pneumococcal and COVID Consent, dated 10/31/2025, revealed R79 signed, dated, and consented Yes to the COVID vaccine. The State Survey Agency (SSA) Surveyor requested a list of residents that requested but were not given a COVID-19 vaccine. Review of the documentation provided revealed one current resident (R79) and one discharged resident that requested vaccination but were not given a COVID-19 vaccine. During an interview with R79 on 02/10/2026 at 11:27AM, she stated she asked the Infection Preventionist (IP) multiple times for administration of the COVID-19 vaccine. R79 stated she did not remember when she first asked for the vaccine but was promised multiple times by the IP that it would be ordered and given. Additionally, R79 stated she had not currently received the COVID-19 vaccine. During an interview with the IP on 02/12/2026 at 10:32 AM, she stated COVID-19 vaccines were not scheduled but rather offered/administered at admission and any other time a resident requested a vaccine. She stated a single vaccine could be ordered anytime and typically arrived within a few days. When asked about R79, the IP stated the resident requested a COVID-19 vaccine on more than one occasion, but she failed to ensure it was ordered. The IP was unable to state when R79 first requested the vaccine. She further stated she should have ordered the vaccine immediately. The IP stated it was important vaccines were administered timely, so the spread of infection was prevented and residents were protected. During an interview with the Activities Director (AD) on 02/12/2026 at 2:47 PM, she stated R79 initially requested a COVID-19 vaccine in October 2025. She further stated, to her knowledge, R79 had not yet received the vaccine. During an interview with the Director of Nursing (DON) on 02/12/2026 at 2:53 PM, she stated residents were initially asked about all vaccines including COVID-19 and consented at admission. She further stated if a resident declined vaccines at admission (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185069	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Manor	3300 Tates Creek Road Lexington, KY 40502

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and later decided they wanted one, the vaccine was ordered and administered as soon as possible. The DON stated it was her expectation that staff obtained consent and administered vaccines in a timely manner to any resident that wanted one. She further stated residents had the right to receive vaccines at any time, and it was important they were administered so residents were protected and kept safe. During an interview with the Administrator on 02/12/2026 at 3:17 PM, she stated it was important residents were protected, and she was not sure why R79's COVID-19 vaccine was not received. The Administrator stated it was her expectation that residents were offered and received vaccines if they wanted them. She further stated it was important vaccines were administered timely to help prevent the spread of communicable diseases.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on interview and review of the facility's binder, the facility failed to ensure survey results, certification results, and results of complaints made during the three preceding years, and any related plan of correction was made available for any individual to view upon request. The findings include:Review, on 02/11/2026 at 3:13 PM, of the facility's provided binder that should have contained results of surveys, certifications, and complaints made during the preceding three years revealed it did not have the Recertification Survey results, conducted on 11/26/2024, or the Plan of Correction documents for that survey included in the binder for public viewing.During an interview with the Administrator on 02/12/2025 at 3:30 PM, she stated she was unaware of the binder missing any survey, certification, or complaints made during the three past years or any missing related Plan of Correction. She stated it was a requirement by the state to have the binder current and up to date, so it was available to anyone who would like to view the binder.