STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185076	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradford Heights Nursing & Rehabilitation	950 Highpoint Drive Hopkinsville, KY 42240

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Observation, interview, and facility policy review revealed the facility failed to maintain a homelike environment for residents related to peeling paint on the walls in room [ROOM NUMBER], holes in the wall in rooms [ROOM NUMBER], and stained ceiling tiles in rooms 100, 107, 109, and 119. This affected four (4) out of 20 sampled residents, R11, R12, R19, and R20.The findings include: Review of the facility's policy, titled, Resident Rights Policy, reviewed 04/2026, revealed residents had a right to a safe, clean, comfortable, and homelike environment.Request for the facility's maintenance policy revealed that they didn't have any policies pertaining to maintenance of their building.Observation of room [ROOM NUMBER] on 05/26/2026 at 4:00 PM revealed three (3) stained ceiling tiles in the left corner of the room and above the window. The fabric window covering was also stained. The tiles were yellowish-brown from apparent moisture.Observation of room [ROOM NUMBER] on 05/26/2026 at 4:03 PM revealed staining on two (2) ceiling tiles in the far-right corner of the room adjacent to the stain on the other side of the wall in room [ROOM NUMBER]. The tiles were stained yellowish-brown from apparent moisture.Observation of room [ROOM NUMBER] on 05/26/2026 at 4:15 PM revealed 10 stained ceiling tiles down the middle of the room for the entirety of the room's length. The tiles were stained yellowish-brown from apparent moisture.Observation of a small supply closet on 05/26/2026 at 4:20 PM near the nurse's station in 100 hall revealed three (3) stained ceiling tiles, one of which was bowed significantly. The closet door was open and inside were open plastic cupboards containing disposable cups, spoons, isolation gowns, a box of N95 disposable respirator masks, aerosol masks with tubing, oxygen tubing, nasal cannulas, and various other oxygen tubing and supplies. The tiles were stained yellowish-brown from apparent moisture.Observation of room [ROOM NUMBER] on 05/26/2026 at 4:30 PM revealed three (3) stained ceiling tiles, one of which was bowed significantly, in the far-right corner of the room. The tiles were stained yellowish-brown from apparent moisture.Observation of room [ROOM NUMBER] on 05/29/2026 at 9:35 AM revealed a 20-inch x 12-inch hole in drywall with paint missing above R11's bed.Further observation of room [ROOM NUMBER] on 05/29/2026 at 9:45 AM revealed an 8-inch x 1-inch line of peeling paint to the left of the window. There was a 3-inch x 2-inch hole in the ceiling tile above Bed B's TV. There was a 30-inch x 18-inch section of peeling paint below the window on the left side. There was also a 40-inch x 3-inch line of peeling paint along the right side of the window frame. There was a 13-inch x 3-inch hole in the wall at the head of bed B near the floor. There was a 5-inch x 1 inch scrape in the paint behind bed A and a 14-inch x 2-inch scrape in paint along the wall where the mattress of bed A met the wall. Additionally, there was a 2-inch x 2.5-inch round spot of missing paint below the clock above dresser B. There was a pile of R12's clothes and shoes in the corner of the room covered in white dust and particles from the crumbling paint.Observation of room [ROOM NUMBER] on 05/29/2026 revealed a 21-inch x 4-inch hole in the wall to the left of the air conditioner along the floor.During an interview with the Maintenance Director on 05/26/2026 at 12:09 PM, he stated that about 6-8 weeks ago there was heavy rain and the building's gutters were clogged, resulting in a roof leak. He further stated the gutters had since been cleaned and there were no leaks since. He stated water was (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coming in through the ceiling and stained the ceiling tiles in rooms [ROOM NUMBERS]. He further stated that the stained ceiling tiles were replaced. He reported that maintenance issues were always fixed promptly and that there were no other major repairs needed to the building at that time.During an interview with R20 on 05/28/2026 at 4:55 PM, she stated that the peeling paint and holes in the walls of her room did not make her feel like she was at home. She further stated that she didn't like the condition of the room.During an interview with R12 on 05/29/2026 at 9:45 AM, she stated that the crumbling paint in her room bothered her because paint dust was getting onto her belongings.During an interview with R11 on 05/29/2026 at 9:35 AM, she stated that the hole in her wall had been there since she had lived in room [ROOM NUMBER]. She further stated that it made her feel very unsafe and that she didn't like to look at it.During an interview with R19 on 05/29/2026 at 10:30 AM, she stated she wished the hole in her wall wasn't there and further stated that she tried not to look at them.During an interview with the Administrator on 05/29/2026 at 4:15 PM, she stated the residents were very comfortable with the Maintenance Director and would usually let him know if they wanted something repaired. She further stated that if the Maintenance Director knew about an issue, he would take care of it promptly.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Observation, interview, and review of facility policies revealed the facility failed to provide assistance with incontinence care in a timely manner for four (4) of 10 sampled residents (R1, R6, R7, and R14).The findings include: Review of the facility's policy titled, Resident Rights Policy, reviewed 04/2026, revealed residents had the right to receive services in the facility with reasonable accommodation of the resident's needs and preferences.Review of the facility's policy titled, Activities of Daily Living Policy, revised 04/2026, revealed residents who were unable to carry out activities of daily living would receive the necessary services to maintain good personal hygiene.Review of the facility's policy titled, Perineal Care Policy, reviewed 04/2026, revealed it was the practice of the facility to provide perineal care to all incontinent residents as needed in order to promote cleanliness and comfort, as well as to prevent infection and skin breakdown.Observation of the 300 hall on 05/27/2026 at 9:38 AM revealed Resident (R)6's call light engaged. His room smelled of feces upon entry. There were two (2) staff members observed sitting at the 300 hall's nurses station.During an interview with R6 on 05/27/2026 at 9:38 AM, he reported that he signaled with his call light approximately 15 minutes before (9:23 AM) to request to be cleaned due to an episode of bowel incontinence. He stated that someone (he was unsure of whom) had responded and said they would be right back to get him cleaned up. He stated that it bothered him when he had to wait forever and with further questioning, he stated that 20 minutes was too long for him to sit in a soiled brief waiting to be cleaned. Continued observation revealed a CNA entered his room to change his brief at 9:49 AM, approximately 26 minutes after he initially made the request.During an additional interview with R6 on 05/27/2026 at 1:25 PM, he stated it bothered him to have to wait over 20 minutes to be cleaned but that the staff member did the best she could.During an interview with R1 on 05/26/2026 at 10:05 AM, she stated she only got changed one time per shift at night. She further stated that when she pressed her call light to request to be changed, the Certified Nursing Assistant (CNA) told her she (the CNA) would be back in a minute, which turned into hours. She reported that she had to sit in a wet brief for over three (3) hours a few nights prior to this interview. She also stated she was always incontinent, and it made her miserable to have to sit in a wet brief for so long.During an interview with R7 on 05/26/2026 at 2:25 PM, she stated she had to sit in feces for two (2) hours a couple weeks ago. She stated that it took two (2) people to provide incontinence care for her due to her size. She further stated there were only two CNAs on the floor working at the time, which forced her to wait until they were both available to get her cleaned up. She reported that having to sit in her feces for two (2) hours made her feel dirty and disgusting.During an interview with R14 on 05/28/2026 at 2:15 PM, she reported that she had to wait about 40 minutes in a wet brief the night prior to this interview before being changed. She stated she signaled on her call light twice while staff were having a little party at the nurse's station outside her room. Additionally, she stated the CNAs were rude to her and closed her door so she couldn't see them after the second time she called requesting to be changed. She became tearful and stated that it made her feel terrible to have to wait for 40 minutes because she got raw in her perineal area if she had to sit in a soiled brief for too long.During an interview with CNA1 on 05/26/2026 at 9:52 AM, she described her normal workload as taking care of 12 to 14 residents in the 200 hall. Additionally, she stated, if someone called out sick the resident load would increase to 18 to 20 residents per CNA, depending on the census. She further stated the increased workload made it difficult to give good care to everyone but that she did the best she could.During an interview with CNA3 on 05/26/2026 at 10:44 AM, she stated that on days when another CNA had called out sick, her assignment became unmanageable and she was not able to give adequate care to some of the residents. She further stated that people frequently called out of work.During an interview with CNA4 on 05/26/2026 at 11:05 AM, she stated it is not uncommon for a CNA to be assigned to 20 residents on a shift, which, she stated, made it extremely hard to take care of residents to an adequate standard. She further stated a normal assignment is to care for 12 to 15 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents in the 300 hall. She reported that people called out of work almost every day and that the facility attempted to find coverage, but they were not always able to do so.During an interview with CNA6 on 05/29/2026 at 11:00 AM, she stated, CNAs rounded every two hours and in between as needed.During an interview with LPN3 on 05/29/2026 at 11:20 AM, she stated, CNAs rounded every hour on residents who were care planned for that, otherwise every two hours.During an interview with the Director of Nursing (DON) on 05/29/2026 at 3:40 PM, she stated, CNAs round every two hours on residents to check for soiled briefs, and as needed. Additionally, she stated that the charge nurse monitored to make sure that rounding is done. She reported her expectation was for a resident's soiled brief to be changed within 10 minutes, and no longer than 15 minutes after an episode of incontinence.During an interview with the Administrator on 05/29/2026 at 4:15 PM, she stated, CNAs rounded every two hours on residents, which was an expectation, but that rounding was not necessarily monitored. Additionally, she stated, her expectation was for call lights to be answered within 15 minutes. She further stated that residents wouldn't want to have to sit in a soiled brief for a long time because it would make them feel yucky and gross.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview, record review, and review of the facility policies, the facility failed to ensure pain assessments were completed prior to and after the administration of as needed (PRN) narcotic pain medications for four (4) out of four (4) sampled residents, Resident (R)4, R8, R16, and R18.The findings include: Review of the facility's policy, titled, Pain Management Policy, revised 04/2026, revealed the facility would utilize a systematic approach for recognition, assessment, treatment, and monitoring of pain. It further revealed, the facility would use a pain assessment tool, appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. The policy stated, Facility staff will reassess resident's pain management at established intervals for effectiveness and / or adverse consequences.Review of the facility's policy, titled, PRN Medication Policy, reviewed 04/2026, revealed documentation would be provided in the resident's medical record to show adequate indications for a medication's use. Further, the policy advised that, when administering a PRN medication, staff must document the reason why the resident needed the medication, the time of administration, and an evaluation of the effectiveness of the medication.Review of R18's undated Resident Face Sheet revealed the facility admitted her on 06/02/2022 with diagnoses including but not limited to cerebral infarction, neuralgia, and unspecified pain.Review of the comprehensive care plan for R18 revealed she was initially care-planned for pain on 09/19/2022 as being at risk for pain related to impaired mobility, gastroesophageal reflux disease, and osteoporosis. This problem also noted that R18 had neck pain. Interventions for the problem included, administer medications as ordered, and, [R18] prefers to have pain controlled by oral medication as prescribed per physician. Further review of R18's care plan revealed an additional problem for pain added on 04/27/2025 related to her cerebrovascular accident (CVA) and osteoporosis. The long-term goal, with target date of 06/05/2026, stated, will not have complication related to opioid use and listed interventions included medications / treatments as ordered, as well as reviewing pain as needed.Review of R18's Medication Administration Record (MAR), dated, 03/01/2026 - 03/31/2026, revealed four (4) documented administrations of Hydrocodone-Acetaminophen 5-325 milligram tablets, complete with pain assessments before and after administration. Per the MAR, R18 could receive the medication every 8 hours as needed for pain. Review of the Medication Monitoring / Control Record for this medication revealed 17 tablets were removed for R18 from 03/01/2026 - 03/31/2026. Documentation of 13 PRN doses were missing from the MAR, including a pain assessment and reevaluation of R18's pain before and after administering the medication.Review of R18's MAR, dated, 04/01/2026 - 04/30/2026, revealed two (2) documented administrations of Hydrocodone-Acetaminophen 5-325 milligram tablets, complete with pain assessments before and after administration. Review of the Medication Monitoring / Control Record for this medication revealed 10 tablets were removed for R18 from 04/01/2026 - 04/30/2026. Documentation of eight (8) PRN doses were missing from the MAR, including a pain assessment and reevaluation of R18's pain before and after administering the medication.Review of R4's undated Resident Face Sheet revealed the facility admitted her on 08/17/2019 with diagnoses including but not limited to diastolic heart failure, wedge compression fracture of T11-T12 vertebra, and unspecified pain.Review of the comprehensive care plan for R4 revealed she was initially care-planned for potential pain on 11/02/2022 related to age, decreased mobility, restless leg syndrome (RLS), and muscle spasms. Interventions included administering medications as ordered. Further review of the care plan revealed an additional pain problem added on 04/27/2025, stating, [R4] is receiving opioid related to decreased mobility, RLS, and muscle spasms. The long-term goal, with target date of 06/16/2026, stated, [R4] will not have complication related to opioid use and interventions included medications / treatments as ordered, as well as reviewing pain as needed.Review of R4's MAR, dated, 03/01/2026 - 03/31/2026, revealed one (1) documented administration of Tramadol 50 mg. Per the MAR, this medication could be administered every six (6) (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours as needed for pain. Review of the Medication Monitoring / Control Record for this medication revealed 9 tablets were removed for R4 from 03/01/2026 - 03/31/2026. Documentation of 8 PRN doses were missing from the MAR, including a pain assessment and reevaluation of R4's pain before and after administering the medication.Review of R4's MAR, dated, 04/01/2026 - 04/30/2026, revealed one (1) documented administration of Tramadol 50 mg. Review of the Medication Monitoring / Control Record for this medication revealed six (6) tablets were removed for R4 from 04/01/2026 - 04/30/2026. Documentation of five (5) PRN doses were missing from the MAR, including a pain assessment and reevaluation of R4's pain before and after administering the medication.Review of R4's MAR, dated, 05/01/2026 - 05/31/2026, revealed no documented administrations of Tramadol 50 mg. Review of the Medication Monitoring / Control Record for this medication revealed seven (7) tablets were removed for R4 from 05/01/2026 - 05/31/2026. Documentation of seven (7) PRN doses were missing from the MAR, including a pain assessment and reevaluation of R4's pain before and after administering the medication.Review of R16's undated Resident Face Sheet revealed the facility admitted her on 07/02/2020 with diagnoses including but not limited to cerebrovascular disease, Alzheimer's Disease with late onset, and idiopathic neuropathy.Review of the comprehensive care plan for R16 revealed she was initially care-planned for pain on 11/14/2022 related to history of hip fracture, decreased range of motion, arthritis, and weakness. Interventions included administering medications as ordered, as well as evaluating the effectiveness of pain interventions. Further review of the care plan revealed an additional pain problem added on 04/27/2025, stating, [R16] is receiving opioid medication related to CVA and muscle weakness. The long-term goal, with target date of 07/13/2026, stated, [R16] will not have complication related opioid use and interventions included medications / treatments as ordered, as well as reviewing pain as needed.Review of R16's MAR, dated, 04/01/2026 - 04/30/2026, revealed no documented administration of Hydrocodone-Acetaminophen 5-325 milligram tablets. Per the MAR, this medication was ordered to be administered every six (6) hours as needed for pain. Review of the Medication Monitoring / Control Record for this medication revealed five (5) tablets were removed for R16 from 04/01/2026 - 04/30/2026. Documentation of five (5) PRN doses were missing from the MAR, including a pain assessment and reevaluation of R16's pain before and after administering the medication.Review of R16's MAR, dated, 05/01/2026 - 05/31/2026, revealed one (1) documented administration of Hydrocodone-Acetaminophen 5-325 milligram tablets. Review of the Medication Monitoring / Control Record for this medication revealed nine (9) tablets were removed for R16 from 05/01/2026 - 05/31/2026. Documentation of eight (8) PRN doses were missing from the MAR, including a pain assessment and reevaluation of R16's pain before and after administering the medication.Review of R8's undated Resident Face Sheet revealed the facility admitted her on 01/20/2025 with diagnoses including but not limited to Type 2 Diabetes Mellitus with hyperglycemia, unspecified myalgia, and acquired absence of the left foot and right great toe.Review of the comprehensive care plan for R8 revealed she was initially care-planned for acute pain on 01/21/2025 related to amputation of right great toe. Interventions included administering medications as ordered, as well as a resident preference for Hydrocodone-Acetaminophen. Further review of the care plan revealed an additional pain problem added on 04/27/2025, stating, [R8] is receiving opioid related to acquired absences of right great toe. The long-term goal, with target date of 07/08/2026, stated, [R8] will not have complication related opioid use and interventions included medications / treatments as ordered, as well as reviewing pain as needed.Review of R8's Medication Administration Record (MAR), dated, 03/01/2026 - 03/31/2026, revealed no documented administrations of Hydrocodone-Acetaminophen 7.5-325 milligram tablets. Per the MAR, R8 could receive the medication every 8 hours as needed for pain. Review of the Medication Monitoring / Control Record for this medication revealed five (5) tablets were removed for R8 from 03/01/2026 - 03/31/2026. Documentation of five (5) PRN doses were missing from the MAR, including a pain assessment and reevaluation of R8's pain before and after administering the medication.Review of R8's MAR, dated, 04/01/2026 - 04/30/2026, revealed (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	four (4) documented administrations of Hydrocodone-Acetaminophen 7.5-325 milligram tablets, complete with pain assessments before and after administration. Review of the Medication Monitoring / Control Record for this medication revealed 16 tablets were removed for R8 from 04/01/2026 - 04/30/2026. Documentation of 14 PRN doses were missing from the MAR, including a pain assessment and reevaluation of R8's pain before and after administering the medication.Review of R8's MAR, dated, 05/01/2026 - 05/31/2026, revealed no documented administration of Hydrocodone-Acetaminophen 7.5-325 milligram tablets. Review of the Medication Monitoring / Control Record for this medication revealed seven (7) tablets were removed for R8 from 05/01/2026 - 05/31/2026. Documentation of seven (7) PRN doses were missing from the MAR, including a pain assessment and reevaluation of R8's pain before and after administering the medication.During an interview with Licensed Practical Nurse (LPN)1 on 05/28/2026 at 4:10 PM, she stated that she was aware that medications, including PRNs, are supposed to be documented. Additionally, she stated she realized she needed to be more diligent about her documentation and that she became lazy about it over time. She further stated that it would be possible to double down on someone's medication if it is not documented properly.During an interview with Certified Medication Technician (CMT)4 on 05/28/2026 at 11:10 AM, she stated if a PRN pain medication is needed, she notified the nurse to do an assessment and once they did their part, she took out the medication and documented it in the MAR. She further stated that the documentation of administration is not complete unless it was on the MAR. Additionally, she stated, if a narcotic is given but not documented in the MAR, it could lead to a potential overdose, medication reaction, or death if the same medication is unknowingly administered too soon.During an interview with LPN3 on 05/29/2026 at 11:20 AM, she stated, if an administered narcotic is not documented in the MAR it could lead to drug overdoses because the MAR prevented someone from giving the medication too soon.During an interview with the DON on 05/29/2026 at 3:40 PM, she stated that she did not perform audits of PRN medications specifically, only scheduled medications, and was unaware if the consulting pharmacy performed narcotic audits. She stated that due to the concerns brought forward by the State Survey Agency, she started the process of making sure every narcotic signed out was then documented on the MAR. She further stated that she would be responsible for doing those audits on an ongoing basis because it was her expectation for all medication administrations, including PRNs, to be documented accurately in the MAR.During an interview with the Administrator on 05/29/2026 at 4:15 PM, she stated there will be audits moving forward on PRN narcotic documentation to compare the Controlled Substance Records to the MARs. Additionally, she stated that the facility would provide education about ensuring that staff documented all medications in the MAR. She stated, her expectation was for all medication administrations to be documented in the MAR, including PRN pain medications.