STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185127	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Centre for Health & Rehabilitation	642 North Third Street Danville, KY 40422

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately consult with the resident's physician and notify the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status or a need to alter treatment significantly for 1 of 6 sampled residents, Resident (R) 1. The facility failed to administer R1's scheduled monthly invega sustenna injection (an antipsychotic medication used to treat schizophrenia) on 04/19/2026. Additionally, the facility failed to notify the resident's physician or guardian at the time of the missed medication. R1 had increased behaviors in April and May 2026, which resulted in multiple transfers to the local hospital, and an admission to the state psychiatric facility from 05/08/2026 until 05/21/2026. R1 was last admitted to the local hospital's behavioral unit related to psychotic behaviors and psychosis on 05/31/2026 and remained in the hospital during the Survey.The findings include:Review of the facility's policy titled, Notification of Change of Condition, reviewed 01/31/2026, revealed the facility must inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status or a need to alter treatment significantly. Further review revealed documentation of notification or notification attempts should be recorded in the resident's electronic medical record (EMR). Continued review revealed the resident and/or representative and medical provider should be notified of a change in condition and the medical provider would provide guidance related to the change in condition. Review of the facility's policy titled, Medication Administration, dated 07/2018, revealed medications were administered as prescribed in accordance with the manufacturers' specifications and good nursing principles and practices. Further review revealed medications were to be administered within 60 minutes of the scheduled time.Review of R1's Face Sheet, located in the electronic medical record (EMR), revealed the facility admitted the resident on 08/06/2021 with diagnoses which included schizoaffective disorder, dementia with behavioral disturbance, and cognitive communication disorder. Review of R1's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/20/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status of five out of 15 indicating severe cognitive impairment.Review of R1's Physician's Orders, dated 04/2026, revealed orders for invega sustenna 234 milligrams (mg) (the maximum dosage) once monthly. This medication was initiated 09/19/2025.Review of the website:www.mentalhealthdaily.com, revealed quitting invega cold turkey might leave the person's neurotransmission and nervous system in a state of chaotic disarray. Additional review revealed possible withdrawal symptoms included agitation, anger, anxiety, confusion, hallucinations, hot flashes, irritability, memory problems, mood swings, and sweating. Review of R1's Comprehensive Care Plan Communication, dated 05/05/2025, revealed a focus area that R1 was under state appointed guardianship and required notification to the guardian for decision-making. Further review revealed a goal to maintain effective communication with the state guardian for guardianship notification to promote the resident's well-being. Continued review revealed approaches which included to notify the resident's medical guardian with change in condition.Review (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 0580 Level of Harm - Actual harm Residents Affected - Few	of R1's Medication Administration Record (MAR), dated April 2026, revealed the facility scheduled R1's monthly dose of invega sustenna for 04/19/2026. Licensed Practical Nurse (LPN) 2 charted the medication was unavailable on that date. Further review of the MAR revealed there was no documented evidence the invega sustenna medication was administered during the month of April 2026.Review of the facility's investigation, undated, revealed the facility determined Licensed Practical Nurse (LPN) 2 did not administer R1's scheduled invega on 04/19/2026. Additional review revealed the facility did not administer R1's invega until 05/06/2026.Additional review of R1's Electronic Medical Record (EMR), revealed there was no documented evidence the facility notified the resident's guardian or physician that the invega sustenna medication was not administered as ordered.Review of R1's Progress Notes, dated 04/20/2026 at 1:55 PM, revealed LPN3 documented R1 refused his oral medications. Continued review revealed on 04/21/2026 at 12:46 AM, Registered Nurse (RN)3 documented R1 refused his bedtime medications. However, there was no documented evidence the physician or guardian was notified at the time, of the missed medication administrations. Review of R1's Progress Notes, dated 05/03/2026 at 12:13 AM, revealed LPN2 documented R1 had increased anxiety and agitation. However, there was no documented evidence LPN2 notified the physician or guardian.Review of R1's Progress Notes, dated 05/05/2026 at 7:06 PM, revealed the facility transferred the resident to the hospital as the resident was attempting to leave the unit and became physically aggressive with staff. Further review of R1's Progress Notes, dated 05/05/2026 at 11:18 PM, revealed R1 returned to the facility and was placed on 15-minute checks.Review of R1's Progress Notes, dated 05/06/2026 at 5:28 PM, written by Psychiatric Advanced Practice Registered Nurse (APRN) 2, revealed following medication review, it was noted R1 did not receive his invega injection for 04/19/2026 and suspect likely reason of behavioral change. Review of R1's May 2026 MAR, revealed the facility administered invega sustenna 234 mg to R1 on 05/06/2026, 17 days after it should have been administered.Review of R1's Progress Notes, dated 05/08/2026 at 7:58 AM, revealed the resident was verbally aggressive to staff, the Physician was notified. Orders were received to send R1 to the emergency room (ER).Review of R1's Progress Notes, dated 05/11/2026 at 8:45 AM, written by the Social Services Director (SSD), revealed R1 had been transferred to a state psychiatric facility related to behavioral health needs. Review of R1's Progress Notes, dated 05/21/2026 at 9:12 PM, revealed R1 returned to the facility at 9:00 PM.Review of R1's Progress Notes, dated 05/31/2026 at 10:19 AM, revealed R1 pushed a staff member through the secure unit exit and exited the unit into the lobby. The facility called 911 for assistance related to R1's behavior escalation and law enforcement arrived to talk with R1. R1 was transported to the hospital by Emergency Medical Service (EMS) for further evaluation.Review of R1's Progress Notes, dated 05/31/2026 at 12:41 PM, revealed R1 had been admitted to the local hospital's behavioral unit related to psychotic behaviors and psychosis.In an interview, on 06/01/2026 at 4:24 PM, R1's State Guardian (SG) stated she had been his guardian for approximately a year and a half. The SG stated the facility provided psychiatric services and started R1 on invega injections. The SG stated she did not receive a phone call when the facility did not administer R1's invega in April, nor did the facility notify her of any increased behaviors. In continued interview, on 06/01/2026 at 4:24 PM, R1's SG stated the first time she was made aware of any increased behavior was when the local hospital called asking her for permission to transfer R1 to a state psychiatric facility. She stated the state psychiatric facility asked the facility when the last dose was received and it was determined R1 did not receive the medication in April. The SG stated it was her understanding that missing the invega was likely the reason for R1's increased behaviors. Messages were left for LPN2, on 06/02/2026 at 8:04 AM and 06/03/2026 at 8:20 AM. However, no return calls were received from LPN2. During an interview, on 06/02/2026 at 2:51 PM, Unit Manager (UM) 1 stated she was unsure if anyone had notified the Physician that R1's invega sustenna was not administered on 04/19/2026. UM1 stated she would not typically notify the physician if medication was unavailable if the medication could be given within 24 hours.During an interview, on 06/02/2026 at 3:04 PM, the Director of Nursing (DON) stated R1 began (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	having increased behaviors and was transferred to the local hospital on [DATE] for evaluation. She stated R1 was later transferred to a state psychiatric facility. The DON stated LPN2 had not documented notification to the physician or guardian at the time of the missed invega sustenna medication.During an interview, on 06/03/2026 at 11:13 AM, APRN 1 stated R1 exhibited increased behaviors and aggression after missing his April Invega Sustenna injection. Additionally, APRN 1 stated it was her expectation the facility notify her of any missed medication. She stated she could not make any decisions regarding appropriate medication orders if she was unaware the medication was not administered.During an interview, on 06/03/2026 at 3:28 PM, the Medical Director stated he was not notified when R1 did not receive the invega sustenna medication. He further stated he was available 24 hours a day for calls, and it was his expectation the facility notify him or the APRN of any missed medications.During an interview, on 06/03/2026 at 8:05 AM, the Administrator stated he expected staff to follow all facility policies and procedures including notification of physicians and guardians.

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide routine drugs to its residents as ordered or obtain them for one (1) of six (6) sampled residents, Resident (R) 1. The facility failed to administer R1's scheduled monthly invega sustenna injection (an antipsychotic medication used to treat schizophrenia) on 04/19/2026 and did not promptly notify the pharmacy that the medication was unavailable. R1 did not receive his scheduled invega sustenna injection until 05/06/2026, 17 days later, resulting in increased behaviors in April and May 2026. R1 was admitted to the state psychiatric facility from 05/08/2026 until 05/21/2026. Additionally, on 05/31/2026, R1 was admitted to the local hospital's behavioral unit related to psychotic behaviors and psychosis and remained there during the Survey.The findings include: Review of the facility's policy titled, Medication Administration, dated 07/2018, revealed medications were administered as prescribed in accordance with the manufacturers' specifications and good nursing principles and practices. Further review revealed medications were to be administered within 60 minutes of the scheduled time. Review of the facility's policy titled, Ordering and Receiving Non-Controlled Medications, dated 01/2025, revealed all medication order changes must be communicated to the pharmacy timely, in order to provide the correct quantities and accurate labeling. Further review revealed a licensed nurse or appropriate personnel as required by law should promptly report any discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor. Review of R1's Face Sheet, located in the electronic medical record (EMR), revealed the facility admitted R1 on 08/06/2021. R1's diagnoses included schizoaffective disorder, dementia with behavioral disturbance, and cognitive communication disorder. Review of R1's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/20/2026, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 5 out of 15. This score indicated severe cognitive impairment. Review of R1's Comprehensive Care Plan, dated 01/30/2024, revealed a focus of at risk and/or active behavioral problems which included hallucinations, paranoia, and delusional behaviors at times. The goal stated the resident would have fewer episodes during the review period. Interventions included administering and monitoring the effectiveness and side effects of medications as ordered and intervening as needed to protect the rights and safety of others. Review of R1's Physician's Orders, dated 04/2026, revealed the physician ordered invega sustenna 234 milligrams (mg) (the maximum dosage) once monthly. This medication was first ordered 09/19/2025. Review of the website: www.mentalhealthdaily.com revealed quitting Invega cold turkey might leave the person's neurotransmission and nervous system in a state of chaotic disarray. Further review revealed possible withdrawal symptoms included agitation, anger, anxiety, confusion, hallucinations, hot flashes, irritability, memory problems, mood swings, and sweating. Review of R1's March 2026 Medication Administration Record (MAR), revealed the facility administered R1's monthly invega sustenna 234 mg dose on 03/19/2026. Review of R1's April 2026 MAR, revealed the facility scheduled R1 to receive his monthly dose of invega sustenna on 04/19/2026. However, Licensed Practical Nurse (LPN)2 documented on the MAR, that the medication was unavailable. Additional review of the MAR revealed there was no documented evidence the facility administered R1's invega sustenna during the month of April 2026. Review of R1's Progress Notes, dated 04/29/2026 at 4:14 PM, revealed the facility documented R1 had a reddened face, complained of being hot, and was noted to have delusions during the shift. Review of R1's Progress Notes, dated 05/03/2026 at 12:13 AM, revealed LPN2 documented R1 had increased anxiety and agitation. Review of R1's Progress Notes, dated 05/05/2026 at 7:02 PM, revealed the Director of Nursing (DON) documented R1 was transferred to the local hospital. Further review of R1's Progress Notes, dated 05/05/2026 at 7:06 PM, revealed the DON documented R1 was attempting to leave the unit and became physically aggressive with (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	staff. Further review revealed Advanced Practice Registered Nurse (APRN) 1 was notified with orders to send R1 to the local hospital via Emergency Medical Services (EMS) for evaluation. Review of R1's Progress Notes, dated 05/05/2026 at 11:18 PM, revealed Registered Nurse (RN)3 documented R1 had returned from the hospital. The facility placed R1 on every 15-minute checks. Review of R1's Progress Notes, dated 05/06/2026 at 5:28 PM, revealed Psychiatric APRN 2 documented that after a med review, it was noted R1 had not received his invega injection for 04/19/2026 and suspect likely reason of behavioral change. Review of R1's May 2026 MAR, revealed the facility administered the invega sustenna 234 mg to R1 on 05/06/2026. Further review revealed this was 17 days after it should have been administered. However, review of the invega sustenna package insert revealed if a maintenance dose of 234 mg was missed more than six (6) weeks, the injection should be restarted by giving an injection of 156 mg as soon as possible, followed by another 156 mg injection one week later. Continued review revealed there was no documented evidence the facility administered this dosage although it was 6 weeks and 6 days between R1's injections. Review of R1's Progress Notes, dated 05/08/2026 at 7:58 AM, revealed Unit Manager (UM) 1 documented R1 was verbally aggressive to staff. Further review revealed the physician was notified with an order to send R1 to the emergency room (ER). Review of R1's Progress Notes, dated 05/11/2026 at 8:45 AM, revealed the Social Services Director (SSD) documented R1 had been transferred to a state psychiatric facility related to behavioral health needs. Review of R1's Progress Notes, dated 05/21/2026 at 9:12 PM, revealed RN4 documented R1 had returned to the facility at 9:00 PM. Review of the state psychiatric hospital's Discharge Summary, dated 05/21/2026, revealed the hospital admitted R1 on 05/08/2026 and discharged him on 05/21/2026 with diagnoses which included major neurocognitive disorder and schizoaffective disorder by history. Further review revealed an order for invega sustenna 234 mg every 28 days, beginning on 06/04/2026, for psychosis. Continued review revealed R1 was admitted to the psychiatric facility on a 72-hour court order from the local hospital for increasingly violent behavior and threatening to kill and assaulting staff members at the local facility. Additionally, the local facility staff stated they had missed R1's 04/19/2026 Invega injection, caught it and gave it on 05/06/2026, but at that time he was already having symptom burden return (meaning the Invega needed to be received monthly for maximum symptom relief, and, since the medication was not given in over a month, R1's symptoms were beginning to return). Review of R1's Progress Notes, dated 05/31/2026 at 10:19 AM, revealed LPN4 documented R1 pushed a staff member through the secure unit exit and exited the unit into the lobby. Further review revealed the facility called 911 for assistance related to R1's behavior escalation and law enforcement arrived to talk with R1. Continued review revealed R1 was transported to the hospital by EMS for further evaluation. Review of R1's Progress Notes, dated 05/31/2026 at 12:41 PM, revealed LPN4 documented R1 had been admitted to the local hospital's behavioral unit related to psychotic behaviors and psychosis. Review of the facility's investigation, undated, revealed the facility determined Licensed Practical Nurse (LPN) 2 did not administer R1's scheduled invega medication on 04/19/2026, and corrective action was given regarding failure to follow policy. During an interview, on 06/01/2026 at 11:17 AM, the Assistant Director of Nursing (ADON) stated the facility's pharmacy delivered medications twice a day, and the pharmacy could deliver the medication within four (4) hours if they were needed between the twice daily deliveries. During an interview, on 06/01/2026 at 4:24 PM, R1's State Guardian (SG) stated she had been his guardian for approximately a year and a half. She further stated R1 started to have increased exit seeking behavior around Thanksgiving (November 2025) and thought the Federal Bureau of Investigation (FBI) was coming to get him. She stated the facility provided psychiatric services and had started R1 on invega injections. The SG stated it was her understanding that missing the invega was likely the reason for R1's increased behaviors. During an interview, on 06/02/2026 at 10:32 AM, Registered Nurse (RN)2 stated she typically worked on R1's unit. She further sated he had schizophrenia with delusional thinking, often geared toward women and things he heard on the television. RN 2 stated she had never seen R1 become aggressive and grab staff until (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	May 2026. She stated R1 had started to refuse medications which was not typical for him. During an interview, on 06/02/2026 at 2:51 PM, Unit Manager (UM) 1 stated R1 was not aggressive or did not attempt to elope until recently. She stated she thought the nurse (LPN2) tried to reorder R1's invega sustenna because it wasn't there, but it was not communicated to the team, that it needed to be reordered. Messages were left for LPN2, on 06/02/2026 at 8:04 AM and 06/03/2026 at 8:20 AM, to return the call to the State Survey Agency (SSA) Surveyor. Additionally, the SSA Surveyor asked the facility to reach out to LPN2. The Director of Nursing (DON) stated on 06/03/2026, she had talked with LPN2 and asked her to speak with the SSA. However, no return calls were received from LPN2. During an interview, on 06/02/2026 at 3:04 PM, the DON stated R1's April invega was marked unavailable on his MAR because pharmacy had not sent the medication, and it was not on the medication cart. She further stated R1 began having increased behaviors and was sent to the local hospital on [DATE] for evaluation. The DON explained R1 was later transferred to a state psychiatric facility who requested the date of R1's last invega injection. She stated the facility then began an investigation and found out the invega was not given in April. The DON stated she called LPN2 in and the nurse received disciplinary action. She stated staff should notify the pharmacy if a medication was unavailable to determine when it would be delivered. During an interview, on 06/03/2026 at 9:12 AM, Pharmacist1 stated the pharmacy had filled R1's invega sustenna on 04/07/2026, 05/04/2026, and 05/21/2026. He further stated the facility was supposed to reorder the medication as soon as it was administered in order for the facility to have the medication available when the next dose was due. Pharmacist1 stated he did not recall speaking with the facility regarding R1 not having the invega sustenna available. He stated the 04/07/2026 medication dose was refilled at 11 AM and shipped midday on 04/08/2026 to the facility. He stated he did not have a digital copy scanned into his system for the April invega sustenna medication to show it was delivered, although he did for the March and May medications. During an interview, on 06/03/2026 at 10:30 AM, the DON stated she had found an undated slip (believed by the facility to be 04/07/2026) of medications that were ordered, but never received from the pharmacy, including R1's invega sustenna. She stated the staff should have called the pharmacy when they realized the medication was unavailable to ensure it sent on the next shipment. During an interview, on 06/03/2026 at 11:13 AM, Advanced Practice Registered Nurse (APRN) 1 stated she was typically in the facility three (3) times per week. She further stated R1 typically had vocal behaviors but had increased behaviors and aggression since missing his April invega injection. Additionally, she stated best practice was to keep medications consistent, as missing medications could cause side effects and increased behaviors. She stated the facility's failure to administer R1's invega sustenna in April was likely a contributing factor for his increased behaviors. During an interview, on 06/03/2026 at 11:38 AM, the Pharmacy Director stated the pharmacy did not have a hard copy signed by the facility to show R1's April invega was delivered to the facility. He further stated there were no notes to indicate the facility contacted the pharmacy to notify them R1's invega was not available in April 2026. Additionally, he called the SSA Surveyor on 06/03/2026 at 1:24 PM, to state he had listened to the calls on 04/19/2026, and the facility did not call to notify the pharmacy that the invega sustenna was not available. During an interview, on 06/03/2026 at 8:05 AM, the Administrator stated medications should automatically be refilled monthly. The Administrator stated medications should arrive within a three (3) day window of the medication due date.