STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185133	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tradewater Pointe	100 West Ramsey Dawson Springs, KY 42408

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47567 Based on interview, record review, and review of facility policy, the facility failed to ensure an allegation of suspected abuse was reported in accordance with S42 CFR 483.12 (c)(1), for 1 of 12 sampled residents, (Resident (R)45). In interview, a Licensed Practical Nurse (LPN) and a Registered Nurse (RN) stated they reported to facility leadership an allegation of sexual abuse involving R44 and R45 in mid-December, 2024. However, per the facility's report, the abuse incident allegedly occurred on 12/31/2024, approximately 17 days after the nurses reporting the allegation. The findings include: Review of the facility policy titled, Resident Abuse, Neglect, and Exploitation, revised 11/26/2024, revealed the goal of the facility was to have a process in place to protect the health and welfare of each resident and assure each resident was free from verbal, sexual, physical, and mental abuse. Per policy review, all alleged violations and substantiated incidents were to be reported, and notification must be made to the appropriate reporting agencies within two hours, to include law enforcement. Further review revealed a written report of the investigation was to be prepared by the Administrator or designee and completed within five working days of the incident. Review of a progress note dated 12/14/2024 at 2:25 PM for R45, revealed the resident was being sent to the emergency room (ER) per the Medical Director related to increased agitation and change in mental status. Review revealed R45 had experienced multiple behavioral episodes that shift, and was unaware her actions were wrong. Further review revealed statements were given to administration, with an incident report in progress. Review of the facility's initial report dated 01/01/2025, for an alleged incident on 12/31/2024, revealed it had been reported to the former Administrator by a third party source there were rumors of some type of sexual act that occurred between two residents within the facility. Per review, the third party source communicated via telephone call that a staff member of the facility told them R45 had entered R44's room and performed a sex act on the resident while the door was closed. Continued review revealed the third party source did not identify the staff member who reported the incident to them. Review of the facility's initial investigation findings revealed the facility had determined those acts had not occurred as it was not able to verify the incident. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Final 5-day Report dated 01/09/2025, for a second investigation, revealed the former Administrator had not thoroughly investigated the reported abuse. Per review, the second investigation discovered R44 was the one who went into R45's room and not the reverse as the former Administrator had said. Continued review revealed staff members working that day (the alleged sexual abuse occurred) were never interviewed and noted those staff were never contacted by the former Administrator regarding the alleged sexual abuse incident. In addition, review revealed the former Administrator had not thoroughly investigated, or reported the incident within the mandated time frame. In interview with LPN 1 on 01/16/2025 at 2:53 PM, she stated the alleged abuse incident occurred in mid-December, and she stated it occurred on dayshift. She stated she notified the Administrator by phone immediately to report the alleged incident and to ask her how she wanted her to proceed with the matter. The LPN reported the Administrator told her and the other nurse working with her that day (RN 1) that they were not to document anything about it because it would need to be documented a certain way. She said during the phone call with the Administrator, RN 1 asked the Administrator if they needed to contact the resident's family and the Administrator told her, No, let me handle it. LPN 1 stated she documented the incident anyway and notified the Medical Director who gave orders to send R45 to the hospital that evening. She further stated the Administrator never said anything further regarding the incident and she assumed the matter had been taken care of. In interview with RN 1 on 01/22/2025 at 10:11 AM, she stated she recalled the alleged incident occurred on either 12/14/2024 or 12/15/2024 she could not remember the exact date. She said however, she remembered for sure it happened in the middle of December of 2024 on the weekend that she worked. RN 1 reported LPN 1 had called the Administrator to report the incident immediately after finding R44 and R45 together. Per the RN in interview, the residents were lying on the bed together, with the male resident with no pants on and only wearing his brief, and the female resident fully clothed lying across the male resident. She stated the Administrator advised them both to not document anything and not notify the family because she would handle all of it. RN 1 further stated she never heard any more about the alleged incident after that. In interview with the former Director of Nursing (DON) on 01/15/2025 at 3:28 PM, she stated she had been out on medical leave during the time the alleged abuse event occurred. She further stated she would take action to report any allegations of abuse or neglect to her Administrator immediately. In interview with the former Administrator on 01/14/2025 at 11:46 AM, she stated on 12/31/2024, another Administrator, who worked at their sister facility, reported she had received third party information, regarding an incident between R45 and R44 that allegedly occurred sometime in mid-December of 2024. She stated she had not learned of the alleged abuse incident until 12/31/2024. The former Administrator said she reported the alleged abuse as soon as she was made aware and began an investigation. She further stated she did not recall staff reporting anything to her (regarding the alleged abuse event) and had not been aware of any progress note documented prior to learning of the alleged incident from the third-party source.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47567 Based on interview, record review, and review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.1, the facility failed to ensure Minimum Data Set (MDS) Assessments accurately reflected the resident status for 3 of 12 sampled residents. (Residents (R)43, 31, and 13). Record review revealed R13, R31, and R43 did not have MDS Discharge Assessments completed as required upon being discharged from the facility. The findings include: Review of the CMS RAI 3.0 User's Manual Version 1.19.1, Chapter 2: Assessments for the RAI, revealed discharge assessments must be completed when a resident was discharged from the facility. 1. Review of R13's closed record revealed the facility admitted the resident on 03/27/2020, with diagnoses to include: Unspecified Dementia, Anxiety, and Stage 3 Chronic Kidney Disease. Closed record review further revealed R13 was discharged from the facility on 08/16/2024, with no documented evidence of a MDS Discharge Assessment having been completed as required. 2. Review of R31's closed record revealed the facility admitted the resident on 04/12/2023, with diagnoses to include: Vascular Dementia, Hemiplegia and Hemiparesis post cerebral infarction affecting the left non-dominant side, and Chronic Obstructive Pulmonary Disease (COPD). Closed record review further revealed R31 was discharged from the facility on 08/12/2024, with no documented evidence of a MDS Discharge Assessment having been completed as required. 3. Review of R43's closed record revealed the facility admitted the resident on 11/28/2023, with diagnoses to include: Cerebral Infarction, Type 2 Diabetes Mellitus with Diabetic Neuropathy, and Gastroparesis. Closed record review further revealed R43 was discharged from the facility on 08/14/2024, with no documented evidence of a MDS Discharge Assessment having been completed as required. In interview with the MDS Coordinator on 01/24/2025 at 5:51 PM, he stated MDS Discharge Assessments should be completed on the day a resident discharged from the facility. The MDS Coordinator stated on that day they opened up the MDS Discharge Assessment and had a 14 day window to complete the assessment. He said he had only been the MDS Coordinator since 11/01/2024. The MDS Coordinator reported prior to that dated, the facility had not had a MDS Coordinator. He further stated the MDS tasks had been outsourced to a third party service provider for a couple of months. The MDS Coordinator additionally stated the MDS Discharge Assessments should have been completed for R13, R31, and R43. An interview was attempted with the Third Party MDS Coordinator on 01/24/2025 at 3:25 PM; however, was unsuccessful with no return phone call received. In interview with the Director of Nursing (DON) on 01/24/2025 at 6:13 PM, she stated her expectations were for the MDS Assessments, including the Discharge Assessments, to be performed per the regulatory guidelines. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the Administrator on 01/24/2025 at 5:51 PM, she stated her expectations were for the MDS Assessments (to include the Discharge Assessments) to be completed timely with accuracy. She further stated she also expected the MDS Assessments to be updated to correlate to the nursing assessment of the resident.

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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. 47567 Based on observation, interview, record review, and review of facility policy, the facility failed to develop and implement a comprehensive care plan for 2 of 12 sampled residents, (Residents (R)30, and 45). Record review revealed R30 was care planned to have both a bed and chair alarm in place; however, observation on 01/23/2025 at 10:58 AM, revealed the chair and bed alarms were not visualized as in use. Additionally, record review revealed R45 was care planned for having difficulty finding her room and a name plate with a picture with a picture of her favorite animal was to be placed outside her room to make it easier for her to find her room consistently. However, observation on 01/08/2025 at 4:40 PM, and 01/09/2025 at 10:03 AM, revealed no name on R45's nameplate and no picture of a horse (her favorite animal) outside the resident's door as per her care plan. The findings include: Review of the facility policy titled, Comprehensive Care Plan, revised 01/11/2022, revealed it was the facility's policy for residents to receive care and treatment based on an assessment of their needs, the severity of their disease,condition, or impairment of disability. Further review revealed the comprehensive care plan would describe at a minimum resident specific interventions that reflected the resident's needs and preferences. 1. Record review revealed the facility admitted R45 on 11/20/2024, with diagnoses to include: Vascular Dementia, moderate with other behavioral disturbance; Cognitive Communication Deficit; and Type 2 Diabetes Mellitus. Review of R45's Discharge Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 12/18/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status score of 99 indicating the resident was unable to complete the assessment. Review of the Comprehensive Care Plan for R45 dated 12/06/2024, revealed the facility identified a problem for the resident related to disorientation to place, having difficulty finding her room, and wandering from room to room looking for her possessions. Per review, the interventions included R45 having an image of her favorite animal (a horse) and her name placed outside her room to make it easier for her to find the room consistently. Further review revealed additional interventions included staff assisting R45 out of other residents' rooms if she was observed wandering into others' rooms that she had not been invited into or requested to enter. Observation on 01/08/2025 at 4:40 PM and on 01/09/2025 at 10:03 AM, revealed no visual evidence of R45's name/signage or picture of a horse posted outside her door as per the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with Licensed Practical Nurse (LPN) 6 on 01/09/2025 at 10:05 AM, she stated the only reasons she could think of why a resident's name would not be on their room door was because there was either a room change or the room was for a new admission to the facility. She reported she did not know who was responsible for placing the residents' names on the room door nameplates. The LPN further stated she would use the resident's photo located in the facility's Electronic Medical Record (EMR) to identify them if there was not a name displayed on their room door. In interview with the Director of Nursing (DON) on 01/24/2025 at 6:00 PM, she stated the Activities Director made the door signs for R45; however, the resident was known to remove the signs quite frequently. She stated if the Activities Director was not at the facility there was no way to access her computer in order to make another door sign if the resident removed it. 50153 2. Record review revealed the facility admitted on R30 on 09/12/2019, with admission diagnoses that included: history of falling, need for assistance with personal care, Muscle Wasting and Atrophy, Schizophrenia and Bipolar Disorder. Review of the Quarterly MDS Assessment with an ARD of 12/03/2024, revealed the facility assessed R30 to have a BIMS score of 13 out of 15, indicating the resident was cognitively intact. Review of the Physician's orders for R30 revealed a Safety order initiated on 07/29/2024, that included a pressure alarm to bed and chair. Review of Comprehensive Care Plan for R30 revealed the facility identified the resident as at risk for falls related to history of falls, impaired balance, use of psychotropic med, muscle wasting, and abnormal gait, which was initiated 09/12/2019 and last revised 11/22/2021. Per review, the interventions included R30 to have an alarm on the bed and an alarm in place on the wheelchair. Observation on 01/23/2025 at 10:58 AM and 01/24/2025 at 10:40 AM, revealed however, no bed or wheelchair alarms in place as per R30's care plan In interview with LPN 1 on 01/24/2025 at 1:30 PM, she stated she thought R30's alarms had been discontinued since they did not show up on the resident's Treatment Administration Record (TAR). Review of R30's TAR revealed no documented evidence of an active order for the resident to have bed and chair alarms. In interview with the MDS Coordinator on 01/09/2025 at 2:15 PM, he stated his expectations were for care plan interventions to be followed through with by staff. In interview with the DON on 01/24/2025 at 1:45 PM and at 6:00 PM, she stated she expected an intervention on located in a resident's care plan to be in place and for staff to implement the residents' care plan interventions. In interview with the Administrator on 01/24/2025 at 6:40 PM, she stated her expectations were for staff to develop an appropriate care plan for residents' needs and follow the interventions on the residents' care plans.

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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. 50153 Based on observation, interview, and review of facility policy, the facility failed to store drugs in accordance with currently accepted professional practices for 1 of 2 medication carts audited out of a total of 2 medication carts and 1 of 1 audited medication rooms. Observation of the East Hall medication cart revealed 12 insulin pens not properly labeled for 8 of 15 residents. (Residents (R)32 32, 36, 17, 23, 15, 20, 35, and 5). Observation of the East Hall medication room revealed a vial of Tubersol solution (an injectable medication used to test for tuberculosis) not properly stored in the medication refrigerator. The findings include: Review of the facility policy titled, Medication Storage, revised 08/18/2017, revealed Medications. treatments, and biologicals are stored safely, securely, and properly following manufacturer's recommendations or facility policy. Further review of the policy revealed, medications would be dated at time of opening as appropriate (ie. insulin, tb solution, etc.). 1. Review of the manufacturer's recommendation for the Tubersol solution revealed once the vial had been entered, it was to be discarded after 30 days. Review further revealed the vial should not be used after the expiration date. Observation on 01/23/2025 at 3:19 PM, of the East Hall medication room revealed one opened, undated vial of Tubersol solution located in the medication refrigerator available for use. In interview with the Director of Nursing (DON) on 01/24/2025 at 1:45 PM, she stated she did not know if facility staff had been educated specifically about dating open medication vials since she became the DON last fall (2024). She verbalized that an opened vial should be dated with the open date and the expiration date on both the vial and the box once opened. 2. Review of the manufacturer's recommendations for insulin storage revealed Lantus, Novalog, and Lispro insulin pens, once opened, were beyond use, 28 days after opening when kept at room temperature. Further review revealed the pens should be replaced after 28 days. Observation of the East Hall medication cart on 01/23/2025 at 3:30 PM, revealed eight insulin pens prescribed for eight of the 15 residents (located on that hall) were not properly stored and labeled. Per observation, one vial of Lantus was not improperly labeled. Continued observation revealed one vial of Lantus and three insulin pens were dated; however, were available for use past the manufacturer's recommendations. Observation revealed the medications were prescribed for R32, R36, R17, R23, R15, R20, R35, and R5 and included the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(a) One unlabeled pen of Trulicity (injectable diabetes medication), 0.75 milligrams (mg) per 0.5 milliliters (ml), without a cap, resident name label, or opened date lying in the top drawer of the medication cart. (b) One unlabeled Lantus insulin pen, 100 units per ml, opened with no label indicating the resident's name and opened date, that was lying inside the top drawer of the medication cart. (c) R32's Lantus 10 ml vial with an opened date of 12/20/2024, available for use beyond the 28-day storage for Lantus; and a Novolog insulin pen dated with opened date; however, not labeled with the resident's name. (d) R36's Lantus 10 ml vial was not labeled with an opened date. (e) R23's Lantus pen with an opened date of 12/23/2024, available for use after the manufacturer's recommended beyond use date of 28 days when stored at room temperature. (f) A Lantus pen which was dated; however, not labeled with R15's name. (g) A Lispro (short acting insulin) pen, unlabeled, but dated with an opened date of 12/20/2024, available for use past the manufacturer's recommended 28 days from open date when stored at room temperature. (h) A Novolog (short acting insulin) pen labeled with R35's name and dated 12/21/2024, past the beyond use date, and one Novolog pen with an opened date, but not labeled with the resident's name. (i) A Basaglar (long acting) insulin pen opened and dated; however, was not labeled with R5's name. In interview on 01/23/2025 at 2:57 PM, Licensed Practical Nurse (LPN) 7, assigned to the East Hall medication cart, stated that there was risk of transmitting disease if insulin pens were shared between residents. The LPN said sharing pens between residents, even if the needle was changed, was not an acceptable practice. LPN 7 further stated insulin pens should be labeled with the residents' names to prevent cross contamination. In a phone interview on 01/23/2025 at 5:06 PM, the Pharmacist, from the supplying pharmacy, stated the pharmacy dispensed boxes of five insulin pens and labeled the box, but did not open the boxes and label each pen. He stated the beyond use date would depend on the type of insulin and according to the manufacturer's recommendation on the package insert. The Pharmacist reported Levemir could be in use out of the refrigeration for 42 days; Novolog for 28 days; and Lantus for 28 days. He further stated it would not be good practice to use insulin past the beyond use date. The Pharmacist additionally said it would not be acceptable to share insulin pens between residents due to the risk of disease transmission. In continued interview with the DON on 01/24/2025 at 1:45 PM, she stated insulin pens should be labeled and dated once opened with both the opened date and a disposal date that was 28 days after opening. She said it had not been the pharmacy's practice to label each insulin pen with the resident's names. The DON further stated insulin pens were not to be shared due to the risk for potential disease transmission. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the Administrator on 01/24/2025 at 6:38 PM, she stated medications should be stored according to manufacturer's recommendations. She further stated medications should also be refrigerated as appropriate, and labeled accordingly.

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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** 44370 Based on observation, interview and review of facility policy, the facility failed to establish and maintain an effective infection prevention and control program for 4 of 12 sampled residents (Resident (R)5, R10, R34, and R4). Observation of a cart located by the 100 hall nurse's station revealed no Personal Protective Equipment (PPE) gowns present in the cart. Observation of the cart on the 200 hall revealed no PPE gowns present in that cart. 1 (a). Observation revealed R34 had an indwelling catheter and the resident's room door had signage for enhanced barrier precautions (EBP). However, no Personal Protective Equipment (PPE) observed outside R4's door. R4, in interview, reported having a wound on his sacrum. (b). Observation of R10's room door had a sign for contact precautions; however, there was no PPE visible near the resident's door or in the hallway. R10, in interview, reported having wounds on her leg. (c). Observation of R4's room, revealed a sign on the door that read contact precautions. Observation also revealed two staff in R4's room at the resident's bedside without no PPE in place. An additional observation on another day revealed the Activity Director present in R4's room without any PPE in place. 2, Observation of Certified Medication Technician (CMT) 2 revealed she left the medication cart to go to the medication room to obtain a blood pressure cuff. The CMT was observed to return to the medication cart and continued with medication administration without sanitizing hands. CMT 2 was further observed to fail to disinfect the blood pressure cuff before using it on R5. The findings include: Review of the facility policy titled,Precaution for Managing Infections, revised on [DATE], revealed, all facilities would appropriately use standard precautions, transmission-based precautions, and resident placement to decrease/prevent the spread of infectious disease. Continued review revealed gowns were to be worn to protect the skin and prevent soiling of clothing during procedures and resident care activities that were likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or cause soiling of clothing. Further review revealed that contact precautions were to be used when transmission of disease can occur through direct and indirect contact. Direct contact transmission involves skin-to-skin contact and the physical transfer of microorganisms from a source person to a host. Gowns were to be worn when entering a resident's room if you anticipate substantial contact with the resident environmental services or items in the residents' room. Wear gloves when coming in direct contact with a resident. A red bio-hazard trash bag should be placed in the residents' room for disposal of contaminated material such as gloves, masks, and gowns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on [DATE] at 12:05 PM, a cart sitting at the 100 hall nurse's station. The State Survey Agency (SSA) Surveyor checked the cart for PPE, and when all drawers were opened there were no gowns observed present in the cart. The SSA Surveyor went to the 200 hall and checked the cart located there, and observed no gowns present in that cart. 1(a). Review of the Admission Record for R34 revealed the facility admitted the resident on [DATE], with diagnoses to include: acquired absence of left leg below the knee, acquired absence of right leg, above the knee, and pressure ulcer of right buttock, stage 2. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R34 to have a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating the resident was cognitively intact. Observation on [DATE] at 1:30 PM, of room [ROOM NUMBER] (R34's room) revealed signage on door for enhanced barrier precautions (EBP); however, no Personal Protective Equipment (PPE) was visible outside the door in the hallway. In interview with R34 on [DATE] at 1:33 PM, he stated staff did not wear gowns when providing care for his indwelling urinary catheter. The resident also stated he had a wound on his sacrum and staff did not wear gowns when providing his wound care. (b). Review of the Admission Record for R10 revealed the facility admitted the resident on [DATE], with diagnoses to include: chronic obstructive pulmonary disease, peripheral vascular disease, and type 2 diabetes mellitus. Review of the Significant Change in Status Assessment (SCSA) dated [DATE], revealed the facility assessed R10 to have a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Observation on [DATE] at 11:55 AM, of room [ROOM NUMBER] (R10's room) revealed a sign on the door for contact precautions. Further observation revealed no PPE visible near R10's room door or nearby in the hallway. In interview with R10 on [DATE] at 11:58 AM, she stated she had wounds on her leg. She said there used to be a door hanger on her door, that contained gowns and masks on it; however, staff had taken it down. R10 said the gowns were now located on a cart in the hallway. R10 further stated staff did not don PPE before entering her room or when they provided her care and wound care. In interview with Licensed Practical Nurse (LPN) 6, an agency nurse, on [DATE] at 10:25 AM, she stated she thought R10 was on contact precautions because she had wounds. The LPN said however, she did not know if there was an infection, and would have to ask someone. (c). Review of the Admission Record for R4 revealed the facility admitted the resident on [DATE], with diagnoses to include: Alzheimer's dementia, heart failure, and renal insufficiency. Review of the SCSA dated [DATE], revealed the facility assessed R4 to have a BIMS score of three out of 15, indicating the resident had severe cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185133	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tradewater Pointe	100 West Ramsey Dawson Springs, KY 42408

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on [DATE] at 12:10 PM, of room [ROOM NUMBER] (R4's room) revealed a sign on the door that read contact precautions. Continued observation revealed two staff in R4's room at the resident's bedside without PPE in place. At the time of observation, the SSA Surveyor asked Certified Nursing Assistant (CNA) 1 to read the sign on R4's door. In interview at the time of observation, CNA 1 stated he was not aware PPE was required when caring for R4. The CNA stated he did not know where PPE was located. CNA 1 asked Certified Medication Technician (CMT) 3 and the CMT told the CNA, PPE was located in the cart in the hall. Observation revealed CNA 1 went to the cart, opened four drawers, and found no gowns present in the cart. Observation on [DATE] at 10:33 AM, R4 remained on contact precautions, and the Activity Director present in R4's room without wearing PPE. In interview, at the time of observation, the Activity Director stated the sign on R4's door said contact precautions. The Activity Director said she should have put on a gown and gloves before entering the resident's room. In interview on [DATE] at 12:17 PM, Licensed Practical Nurse (LPN) 9, an agency nurse, stated it was her first day at the facility. When asked by the SSA Surveyor were PPE was located, LPN 9 stated she did not know the location of PPE. When the SSA Surveyor asked LPN 9 what the difference was in contact precautions and EBP, she stated she did not know the difference. 50153 2. Review of the facility policy titled, Medication Pass with a revision date of [DATE], stated the purpose of the policy is for medications to be administered in an appropriate and timely manner that upholds Nursing Standards of Practice and to always begin by first washing hands and using proper sanitary technique. Review of the policy titled, Infection Control Universal Precautions with a revision date of [DATE] stated that re-useable resident care equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed. Observation on [DATE] at 9:20 AM, revealed Certified Medication Technician (CMT) 2 left the medication cart to go into the medication room to obtain a blood pressure cuff. Per observation, CMT 2 returned to the medication cart and continued with medication administration without sanitizing her hands. Additionally, observation revealed the CMT failed to disinfect the blood pressure cuff before using it on R5. In interview with CMT 2 on [DATE] at 9:45 AM, she stated sanitizing one's hands, and disinfecting equipment was important in preventing the spread of infection. In interview with Licensed Practical Nurse (LPN) 1 on [DATE] at 4:28 PM, she stated disinfecting equipment and hand sanitizing would be indicated if she left the medication cart then returned to the cart, and before restarting medication administration to prevent the spread of infection. (continued on next page)

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	185133	A. Building B. Wing	01/24/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on [DATE] at 6:00 PM she stated the facility currently did not have an Infection Preventionist (IP) as her certification had expired. She stated she was currently taking classes to get it back. She stated the former DON was the last IP that the facility had. She stated she has been the DON at the facility since [DATE]. She stated she does not know of any corporate people who do IP for the facility. She stated she is currently responsible for training staff on infection control. The DON stated contact precautions were required for wounds with drainage or had something growing in the wound, Respiratory Syncytial Virus (RSV) or COVID infections. She stated enhanced barrier precautions (EBP) would be for residents if they had a feeding tube, indwelling catheter, or wounds. She stated she has not done any training on EBP or Contact Precautions with staff since she has been the DON. Stated she does not do onboarding training for new staff stated she doesn't know what the facility's annual training is. Stated she received some training when she came on as DON but not much. Interview with the Administrator on [DATE] at 6:40 PM, she stated that the DON had just informed her yesterday about the status of her IP training but as far as she was concerned she did not believe that the training expires at all. She stated when they facility does not have an in house IP person they will utilize the IP from the sister facility, consult with their in house legal nurse consultant or contact the local epidemiologist. She stated what the facility had been using was not the correct signage and that they corrected it yesterday and that the staff should be well aware.