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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2026
NAME OF PROVIDER OR SUPPLIER: Tradewater Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, it was determined the facility failed to provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks for one of 15 sampled residents (Resident (R) 31).The findings include:Review of the facility policy titled, Concord Health Systems, 03/31/2020, revealed nursing personnel will serve resident trays, checking the information on tray cards with the items on the trays prior to serving, and will help residents who require assistance with eating.Review of the Resident Face Sheet for R31 revealed the facility admitted the resident to the facility on [DATE], with diagnoses to include: chronic obstructive pulmonary disease (COPD), Alzheimer's, and dysphagia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R31 to have a Brief Interview for Mental Status (BIMS) score of thirteen out of fifteen, indicating the resident was cognitively intact.Review of the physician order for R31 dated 11/14/2025, revealed an order for the resident to have regular soft and bite size / nectar mildly thick liquids. Continued review of the order revealed R31 was to have a divided plate, nosey cup, weighted utensils, and suction bowls to increase overall self-feeding and increase intake.Review of R31's Comprehensive Care Plan dated 11/14/2025, revealed a focus for nutritional risk related to receiving a mechanically altered diet and a diagnosis of dysphagia and oropharyngeal phase. Continued review revealed interventions dated 11/14/2025, included providing diet as ordered; and providing a divided plate and spouted lid with meals.Observation on 03/26/2026 at 11:36 AM R31 was served a lunch tray by CNA 4. Observation of his meal card revealed the resident was not provided built up utensils. R31 stated during the observation that he was not able to grip utensils easily because the ones provided are not what he is used to. During an interview with Certified Nursing Aide (CNA) 4 on 03/26/2026 at 11:32 AM, she was observed at this time dropping off the lunch tray for R31. She stated the kitchen places the utensils on the tray. She stated she should have double checked the meal card before dropping off the tray to R31. CNA 4 went to the kitchen to retrieve utensils and drop them off to resident. Observation on 03/26/2026 at 12:03 PM, resident was observed using his built-up utensils after they had been dropped off by CNA4. R31stated the built-up utensils are better for him, especially when I am customed on handling the utensils. He stated that they forget his built-up utensils often. He stated the built-up utensils help with his grip, instead of the regular utensil rolling off his fingers. During an interview with the Dietary Manager on 03/27/2026 at 9:22 AM, she stated our dietary aide set up the tray, drinks, condiments, silverware, and desserts. She stated she printed off the meal card. Meal card updates are communicated through a communication slip from the nurses, and the order is updated via tray card system. The updates vary from resident to resident on new orders including resident likes and dislikes. She stated the resident being unable to feed himself with the required utensils is a concern. During an interview with LPN 2 on 03/27/2026 at 9:31 AM, she stated she helped by delivering food trays. Resident name, diet expirations, room numbers, likes and dislikes are always checked before dropping off the food tray to the resident. She stated before picking up 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

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	03/27/2026

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

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tray from the kitchen, she checked for the correct utensil, plate, and diet. If the resident was missing something from his tray, she stated she went back to the kitchen and kitchen staff swap it out. She stated a resident who required specialized equipment is at risk for a negative outcome if they are not provided. She added, the resident can struggle and it is also a dignity issue. She stated, they can drop their food, and it can be embarrassing for them. During an interview with CNA 5 on 03/27/2026 at 9:43 AM, she stated she assisted with delivering food trays, food carts, and feeding assistance. She stated she verified the meal card for the residents' diet, correct utensils, specialty plates, and cups. She stated she would take the incorrect utensils and replace them. She stated if the residents did not have the right utensils, this would cause a dignity concern and cause embarrassment because they would not be able to feed themselves. During an interview with CNA 6 on 03/27/2026 at 10:09 AM, she stated the meal task is divided up amongst CNAs to assist in the dining room and hallways. She stated she verified the ticket name, verified food items, and checked for the right utensils. She stated that staff that work here usually will know what their residents need. She stated if the resident had the wrong utensils and they were in the dining room; she would go to the kitchen to correct it. If she is working in the hallway, she would grab the charge nurse to help with getting the right utensils. She stated the resident would become frustrated if they didn't have the correct utensils. During an interview with the DON on 03/27/2026 at 10:52 AM, she stated she expected staff to know the mealtimes and verifying all residents have their assistive devices. This would fall under dignity concern if they were not provided what they need. She stated she expected staff to correct the issue immediately. During an interview with the Administrator on 03/27/2026 at 10:54 AM, she stated her expectation was for staff to correctly deliver the food tray by verifying the resident's meal card, and to make sure it was correct before serving. She expected for staff to address any issues with the kitchen if anything is missing off the resident's tray. She also added, the residents would feel undignified if they didn't have the correct utensils.