STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185148	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Health & Rehabilitation Center	287 North 11th Street Williamsburg, KY 40769

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to label and date food items in 2 (100 Unit and 300 Unit) of 3 unit refrigerators. This had the potential to affect all the residents who resided on 2 (100 Unit and 300 Unit) of 3 units in the facility.Findings included:An undated facility policy titled, Protocol for Foods Brought in From Family/Visitors, revealed, Policy: Recognizing that residents receiving foods brought in by family and friends has a positive association with their quality of life, we encourage family and friends to bring in items for their loved ones. Foods should be Checked In at Nurses' Station prior to delivering to the resident. The policy specified, The resident's nurse will label and date all home cooked food containers with the resident's name and date, if it is requested to be stored in the unit refrigerator. All items should be discarded at the end of the 3rd day by dietary personnel.During an interview on 12/09/2025 at 11:45 AM, the Dietary Manager (DM) stated that the dietary staff maintained the unit refrigerators, stocked them every day, and kept track of the items in the unit refrigerators.During interview and observation of the 300 Unit refrigerator on 12/09/2025 at 12:01 PM, two, unlabeled and undated plastic containers that contained homemade food was observed in the refrigerator. Licensed Practical Nurse (LPN) 2 stated she did not know who the plastic containers belonged to.During interview and observation of the 100 Unit refrigerator on 12/09/2025 at 12:06 PM, there were two, opened, unlabeled and undated plastic bottles of soda in the door of the refrigerator and one, unlabeled, undated, opened, almost empty bottle of ranch dressing. LPN 1 stated she did not know who the soda or ranch dressing belonged to, but she discarded the items.During a follow-up interview on 12/10/2025 at 9:28 AM, the DM stated the dietary staff checked the contents of the unit refrigerators three times a day. The DM stated her expectation was that the dietary staff were to look in the unit refrigerators and check to make sure food items were labeled with dates and resident names.During an interview on 12/10/2025 at 9:34 AM, Dietary Aide 3 stated she checked all the unit refrigerators on 12/09/2025 before 10:00 AM and did not remember if the refrigerators had any opened, unlabeled or undated food items.During an interview on 12/10/2025 at 9:48 AM, LPN 4 stated she knew the plastic containers observed in the 300 Unit refrigerator on 12/09/2025 belonged to two residents but did not know who the residents were. During an interview on 12/10/2025 at 10:37 AM, the Administrator stated the unit refrigerators were the responsibility of dietary; however, the families were instructed to give the food item to the charge nurse, and the charge nurse was to ensure the item was labeled with the resident's name and dated. The Administrator stated the charge nurse should check the unit refrigerators once a shift as well.

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
	185148	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Health & Rehabilitation Center	287 North 11th Street Williamsburg, KY 40769

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, record review, document review, and facility policy review, the facility failed to protect a resident's right to be free from verbal abuse by a staff member for 1 (Resident #65) of 1 sampled resident reviewed for abuse.Findings included: A facility policy titled, Abuse, Neglect, Misappropriation and Exploitation Policy, revised 07/2024, indicated, Our facility does not condone or tolerate resident abuse (this includes verbal abuse, sexual abuse, physical abuse and mental abuse), neglect, misappropriation or exploitation under any circumstances by anyone, including staff members, other residents, consultants, volunteers, staff of other agencies serving or visiting the resident, family members, legal guardians, sponsors, friends, or other individuals. The policy specified, Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to threats of harm, saying things to frighten a resident such as telling a resident that he/she will never be able to see his/her family again. An admission Record revealed the facility admitted Resident (R)65 on 07/16/2021. According to the admission Record, the resident had a medical history that included a diagnosis of Alzheimer's disease. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/25/2025, revealed R65 had a Brief Interview for Mental Status (BIMS) score 3, which indicated the resident had severe cognitive impairment. The facility Final Report/5 Day Follow Up dated 09/19/2025, indicated At approximately 7:20 pm on 09/13/25, State Registered Nurse Aide (SRNA) 6, and SRNA 5 were attempting to transfer resident 65 to his/her bed in their room when R65 became combative. R 65 pushed his/her walker over, almost causing SRNA 5 to fall. SRNA 6 stated that SRNA 5 said, my child doesn't' act this way, so you're not going to. SRNA 5 pushed R 65's wheelchair next to the bed in order to complete the transfer and when the bed was lowered, the rail was pushing R65's right knee. SRNA 6 told SRNA 5 to stop, that the rail was on the resident's knee. SRNA 5 moved the rail off the resident's knee and stated to R65, That's what your bratty [curse word] gets. R65 was transferred to bed and stated that their (the resident's) leg hurt and SRNA 5 stated, See R65, you lived. SRNA 6 then reported the incident to LPN (licensed practical nurse) Charge nurse. The Final Report/5 Day Follow Up revealed In conclusion, based upon interviews and witness statements to the alleged incident, the IDT (interdisciplinary team) feels that SRNA 5, responded in this interaction with resident, R65, with an inappropriate verbal response by stating, that's what your bratty [curse word] gets. During an interview on 12/08/2025 at 11:52 AM, R65 stated a staff member said something mean to them, but they could not remember what was said or who said it. During an interview on 12/10/2025 at 10:31 AM, SRNA 5 stated she did not recall saying anything inappropriate to R65 and that she was not mean to the resident. SRNA 5 denied verbally abusing R65. During an interview on 12/10/2025 at 9:27 AM, SRNA 6 stated SRNA 5 was upset because she almost fell over R65's walker. Per SRNA 6, SRNA 5 did not yell or raise her voice to R65, but she did get in R65's face after she got R65's leg out from under the bedrail. SRNA 6 stated it was then that SRNA 5 told R65 in a smart-alecky way, that's what your bratty [curse word] gets. SRNA 6 stated SRNA 5 sounded sarcastic and giggled when she told R65 that he/she would live. Per SRNA 6, what she witnessed would rise a little bit to verbal abuse. During an interview on 12/10/2025 at 12:13 PM, the Administrator stated the facility substantiated verbal abuse based on their abuse policy and SRNA 5 was terminated due to the incident.