STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185155	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Morehead	933 North Tolliver Road Morehead, KY 40351

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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 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. Based on interview, record review, and review of the facility's policy, the facility failed to provide the necessary activity of daily living, bathing, to maintain good personal hygiene for 1 of 27 sampled residents, Resident (R) 51. The findings include: Review of the facility's policy titled, Activities of Daily Living, last reviewed 09/10/2024, revealed the resident would receive assistance as needed to complete activities of daily living (ADL), and any change in the ability to perform ADLs would be reported to the nurse. Further review revealed ADLs included hygiene activities such as bathing, dressing, grooming and oral care. Review of R51's admission Record revealed the facility admitted her on 04/15/2025 with diagnoses including displaced trimalleolar fracture of right lower leg, difficulty in walking, and dysphagia. Review of R51's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/18/2025, revealed her Brief Interview for Mental Status [BIMS] score was 13 of 15, indicating her cognitive status was intact. The admission MDS also indicated the resident was dependent for showering and bathing. Review of R51's Point of Care charting since admission revealed she received bed baths on 04/24/2025, 05/06/2025, 05/09/2025, and 05/22/2025. In an interview on 05/20/2025 at 10:47 AM, R51 stated staff was always rushing through her care because there were not enough of them. She further stated she mostly received partial bed baths instead of full showers or full bed baths because the aides did not have enough time for a full shower. In additional interview with R51 on 05/22/2025 at 2:53 PM, she stated she had only been given one full bath and hair wash since admission, and that happened at 3:00 AM. She further stated she had received partial baths perhaps five times. She stated on those occasions, she was given a washcloth to wash her face, and the aide washed her arm pits, applied deodorant, and put a little lotion on her legs. She stated she felt embarrassed and that everybody was looking at her because she was not clean. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/21/2025 at 5:09 PM, Certified Nurse Aide (CNA) 6 and CNA7 stated they often worked with just the two of them as aides for [NAME] Hall, which had 34 residents. They stated those residents had a lot of care needs. Per interview, they stated 18 of the 34 residents were a two-person assist, so CNA6 and CNA7 worked as a team to provide care to these residents. They stated when there were only two aides for that hall, residents typically did not get full showers, only partial bed baths, and other aspects of their care were rushed. During interview with the Director of Nursing (DON) on 05/23/2025 at 2:44 PM, she stated aides would come to her if they could not give a shower, and she directed them to ask night shift to shower/bath the resident, but sometimes that did not get charted. She stated a bed bath included washing head to toe and nails trimmed, and the residents should be offered a wash-up with face, armpits, and skin folds every day. During interview with the Executive Director on 05/23/2025 at 3:27 PM, he stated his expectation was that staff got their tasks done, and if having issues, to let leaders know so they could help. He stated a resident should get their shower on their day, and they should get a bath and linen changed on their day.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, record review, review of the manufacturer's guidelines, review of a journal article, and review of the facility's policy, the facility failed to provide the services to prevent possible complications of enteral feeding including but not limited to diarrhea, vomiting, and dehydration for 1 of 2 residents sampled for tube feeding care, Resident (R) 244. The findings include: Review of the facility's policy titled, Enteral Nutrition Therapy (Continuous), revision date 09/10/2024, revealed the facility would provide continuous enteral nutrition therapy in accordance with Physician's Orders and professional standards of practice. The policy stated the [enteral feeding pump] proximal spike sets should be replaced once every 24 hours unless otherwise ordered. Per the policy, a resident who was fed by enteral means should receive appropriate treatment and services to prevent complications of enteral feedings including but not limited to aspiration (inhaling food or drink into airway), diarrhea, vomiting, dehydration, and metabolic abnormalities (ability of the body to convert food and drink into energy). Review of the formula company's recommendation, dated 12/14/2024, revealed precautions included: unless a shorter hang time was specified by the set manufacturer, hang product up to 48 hours, otherwise hang for no more than 24 hours. Review of R244's admission Record revealed the facility admitted the resident on 05/16/2025 with diagnoses to include dysphagia, diabetes, adult failure to thrive, and dependence on renal dialysis. Review of R244's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 05/20/2025, revealed the resident had a Brief Interview for Mental Status [BIMS] score of 10 out of fifteen 15, which indicated the resident had moderate cognitive impairment. Review of R244's Physician's Orders, dated 05/19/2025, revealed an active order for Nepro with Carb Steady (enteral formula) at 50 milliliters (ml) an hour with water flushes of 125 ml every four hours of purified water. Review of R244's Care Plan, dated 05/19/2025, revealed the resident required tube feeding related to a swallowing problem and not eating well. Further review revealed no interventions listed for how often to change the tube feeding closed set. Review of R244's Medication Administration Record (MAR) revealed, beginning the night shift on 05/16/2025 and through the day shift on 05/22/2025, it was initialed as tube feed being administered. Observation on 05/19/2025 at 4:56 PM revealed R244 had a tube feeding solution of Nepro 1.8 cal and water flush hanging on the pole with the tube feed pump and line primed, and both were dated for 05/16/2025. Further observation revealed neither the feeding solution or the water was hooked to the resident or infusing. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with Registered Nurse (RN) 2 on 05/19/2025 at 5:25 PM, she stated the tube feeding solution should be discarded after 24 hours. She stated if a resident was administered a solution that had been hanging for longer, the resident could possibly get sick. When asked if she was taking care of R244 today, she stated yes, but was not sure why the solution and water flush were dated for 05/16/2025. During interview with Licensed Practical Nurse (LPN) 3 on 05/19/2025 at 6:39 PM, she stated she had been the admitting nurse for R244 on 05/16/2025. When asked what the process was for continuation of orders, she stated the nurse got in touch with the provider to verify the orders, and she called the provider. When asked what the provider had ordered for R244's tube feedings, she stated he said to continue them. She stated that meant the feeding was to continue, but she was unsure of the rate. She stated she thought she remembered changing the solution over the weekend but could not recall if it was dated. She stated she thought the feeding solution was sent from the hospital but could not say for sure when asked why the solution and water flush were dated for 05/16/2025. The State Survey Agency (SSA) Surveyor attempted to reach the night shift nurse for 05/16/2025 by telephone on 05/19/2025 at 7:04 PM. However, there was no answer, and a voice message was left without response. During interview with LPN5 on 05/20/2025 at 8:50 AM, she stated the tubing feeding solution and the tubing should be changed every 24 hours. She stated it was important because there was a chance the solution could go bad, and the resident could possibly get food poisoning. During interview with RN8 on 05/22/2025 at 10:35 AM, she stated tube feedings should be discarded after 24 hours to prevent bacterial growth in the tubing and feeding solution. She stated if she found a feeding solution outdated and hanging, she would discard immediately and fill out an incident report. During interview with the Infection Preventionist Nurse on 05/23/2025 at 12:13 PM, she stated tube feeding solutions should be discarded after 24 hours. She stated it was important because if the feeding solution and set were left over the 24 hour limit, there was a chance of bacterial growth and that could increase the resident's risk of infection. She stated if staff found a feeding solution and set hanging and it was past the 24 hour limit, they should discard it, assess the resident, and immediately notify the provider. She stated an incident report (IR) should be made, but she was not aware of R244's outdated solution. During an interview with the Director of Nursing (DON) on 05/22/2025 at 3:25 PM, she stated if feeding solutions were hanging longer than 24 hours, the solution could clabber and make a resident sick. She stated the tubing and solution were supposed to be changed every 24 hours. She stated she had not been made aware R244's feeding solution was outdated and still hanging in the resident's room. During an interview with the Executive Director on 05/22/2025 at 4:20 PM, he stated his tasks were to offer oversight for the building to assure safety of the residents. Further, the Executive Director stated it was his expectation that staff would follow the facility's policies and procedures.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide effective pain management for 2 of 5 residents investigated for pain management, Resident (R) 5 and R59. The findings include: Review of the facility's policy, Nursing Documentation, dated [DATE], revealed the facility implemented interventions to prevent or manage each individual resident's pain, beginning at admission. Review of the facility's policy, Administration of Medications, dated [DATE], revealed the facility would ensure medications were administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. 1. Review of the Closed Record revealed the facility admitted R59 on [DATE] at approximately 5:30 PM from the hospital to recover from a fall at home that resulted in a right hip fracture. Further review of the Closed Record revealed diagnoses to include peripheral vascular disease and diabetes. Review of the admission Minimum Data Set Assessment with an ARD date of [DATE] revealed the facility assessed R59 as having a Brief Interview of Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Review of the physician orders dated [DATE] revealed an order for Oxycodone 30 mg to be given every 6 hours as needed for pain. Review of progress note effective date [DATE] at 1:15 AM written by Licensed Practical Nurse (LPN) 6 revealed R59 was complaining of pain in the right hip. LPN6 wrote R59 was aware they were waiting on the pain medication to be delivered from the pharmacy. Further review revealed LPN6 administered acetaminophen 650 mg at 1:15 AM. Review of progress note effective date [DATE] at 02:08 AM written by LPN6 revealed R59 requested pain medication. LPN6 informed R59 that she would notify pharmacy and have the medication sent stat. LPN6's next sentence stated she notified the pharmacy of urgent need for medications to be delivered and the pharmacy stated they would have the medications sent by 6:00 AM or 6:30 AM. LPN 6 documented at 3:08 AM spoke with Director of Nursing (DON), informed her of what was going on. Review of progress note effective date [DATE] at 3:50 AM written by LPN6 revealed R59 was yelling out requesting pain medications. R59 was informed that the medications still had not arrived. LPN6 offered to send R59 to the emergency room (ER) for pain evaluation. R59 requested to be sent to the ER. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with LPN6 on [DATE] at 7:55 AM, she stated the facility admitted R59 and she could not get his pain medication because there was not another nurse in the facility with a code to access the facility's emergency medication system, so she sent him to the emergency room (ER). She further stated the Oxyconde 30 mg was available in the emergency medication system but there was not another nurse in the facility that had the code to obtain the medication and it took two nurses to enter the codes to get in the secured system. During a post-survey interview with the contracted pharmacy, on [DATE] at 2:55 PM, the pharmacist stated Oxycodone was available in the emergency medication system. During interview with the Director of Nursing (DON) on [DATE] at 10:32 AM, she stated the emergency medication system required two nurses to enter a code in order to remove medications from the system and she said the process for giving the nurses codes to access the emergency medication system was to contact the pharmacy by way of electronic mail (e-mail). She stated the pharmacy issued the codes, and any new nurse or any nurse who had an expired code was given a new code. She stated she tried to look at the list of nurses' codes and their expiration date monthly, but she was not always able to review it. She stated the importance of the codes was so nurses could access medications that were not in the medication cart. She stated, to her knowledge, there had always been two nurses in the facility who had codes to the emergency medication system. She stated, if there were not two nurses in the facility who had a code, the nurses should contact her, and she would come to the facility. 2. Review of R5's admission Record revealed the facility admitted the resident on [DATE] with diagnoses to include acquired absence of left great toe, chronic kidney disease, and type two diabetes with polyneuropathy (disorder of the peripheral nerves). Review of R5's CCP, dated [DATE], revealed the facility assessed the resident as at risk for pain in her wrist and leg related to diabetes complications. Further review revealed the facility included interventions such as administering controlled medications as ordered and providing nonpharmacologic treatments for pain. Further review of the CCP, dated [DATE], revealed the facility assessed the resident as at risk for needing more medications to achieve adequate pain relief and included interventions such as administering analgesic (pain relief) medicine as ordered and reviewing when the medication regimen was not followed as ordered. Review of R5's significant change MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of 14 out of 15, indicating the resident was cognitively intact. Further review revealed the facility noted R5 received scheduled and as needed pain medications. Review of R5's Medication Administration Record (MAR), dated 01/2025, revealed the physician ordered 300 mg of gabapentin (a medication for nerve pain) to be administered three times per day for leg pain. Further review revealed the facility failed to administer 14 doses of gabapentin from [DATE] to [DATE], and R5 did not receive any additional pain medication during this time. Review of R5's Progress Notes, dated [DATE] at 1:54 PM, revealed Registered Nurse (RN) 5 documented sending a request for a refill for R5's gabapentin because it was running low. Per review, RN5 called the physician and the pharmacy, and the pharmacy told her the prescription was not sent in. She did not remember specifically if she followed-up after the calls because this had happened so many times. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R5's Progress Note dated [DATE] at 7:32 AM, revealed RN5 documented R5 was out of gabapentin, even though the prescription was requested on [DATE]. In an interview on [DATE] at 3:48 PM, R5 stated she recalled the facility running out of her gabapentin in 01/2025. She stated staff told her the pharmacy had not refilled her medicine, and it took days to get it fixed. R5 stated she was in pain, and she felt a shooting sensation down her leg. Per the interview, R5 did not want to complain to the nurses because she knew they were trying, but her pain was increased while she was not receiving her gabapentin. Additionally, R5 stated no staff member had suggested heat, ice, or different positions to relieve her pain. In an interview on [DATE] at 6:37 PM, RN5 stated she recalled R5 running out of gabapentin on more than one occasion, including in 01/2025. She further stated she had notified the pharmacy a week prior, when she noticed the resident's medication supply was low. Per the interview, R5's dose of gabapentin was not available in the emergency medication system. RN5 stated she did not recall R5 complaining of additional pain during that time, but the resident had received other pain medications, which helped prevent the resident's pain from getting out of control. Additionally, she stated it was important to manage the resident's pain because no one wanted to be in pain. During a post-survey interview with the contracted pharmacy, on [DATE] at 2:55 PM, the pharmacist stated gabapentin was available in the emeregency medication system. In an interview on [DATE] at 10:25 AM, the DON stated the facility's process for obtaining medication refills included faxing a refill reminder sticker to the pharmacy, submitting a request on the electronic health record, and having cycle fills of routine medications that were refilled automatically. She stated the facility had issues with getting routine medications and narcotics from the pharmacy in a timely manner. Per interview, the pharmacy the facility was currently using was new to them and they had problems with miscommunication with them. Additionally, the DON stated the facility did not have a 24-hour pharmacy in town to use as a back-up if the main pharmacy failed to deliver a medication. In an interview on [DATE] at 3:46 PM, the Executive Director (ED) stated he expected the facility to have medications available for residents as much as possible. He further stated if something happened that resulted in the medication not being available, he expected staff to call the physician and the pharmacy and get either a rush delivery or a code to obtain the medication out of the emergency medication system. He stated staff should also let the DON and himself know about the situation. The ED stated he expected residents to receive their pain medication as ordered so that their pain did not rise to uncontrollable and intolerable levels. Per the interview, the ED was not aware of R5 missing 14 doses of gabapentin in late 01/2025 and could not explain how the process failed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview, record review, and review of the facility's policy, the facility failed to provide pre-and post-dialysis communication documentation for 1 of 6 dialysis residents, Resident (R) 42. The findings include: Review of the facility's policy titled, Area of Focus: Dialysis, revision date 11/19/2024, revealed instructions for day of dialysis included to check medications especially blood pressure and cardiac medications and to initiate the Pre/Post Dialysis Communication Form to be sent to the dialysis clinic with the resident, ensure transportation was scheduled, and send snack/lunch with the resident. Further review revealed the treatment, upon the resident's return to the facility, included to obtain vital signs and monitor vascular access site. Per the policy, staff was to complete the Pre/Post Dialysis Communication Form, transcribe any orders sent from the dialysis clinic, and maintain the dialysis transfer form in the resident's medical chart. Review of R42's Face Sheet revealed the facility admitted the resident on 02/27/2025 with diagnoses to include diabetes, chronic kidney disease stage five (5), and dependence on renal dialysis. Review of R42's quarterly Minimum Data Set [MDS] with an Assessment Reference Date (ARD) of 04/02/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, which indicated the resident was cognitively intact. Review of R42's Physician's Orders dated 11/07/2024, revealed an active order for the resident to receive dialysis every Monday, Wednesday, and Friday related to chronic renal failure. Review of R42's Care Plan, initiated on 11/11/2024, revealed a focus included hemodialysis related to renal failure. Goals included the resident would have no signs and symptoms of complications from dialysis. However, interventions did not include initiation, completion, and documentation of the Pre/Post Dialysis Communication Form. Review of the facility's blank document Pre/Post Dialysis Communication Form revealed sections titled Pre-Dialysis and Post-Dialysis, including if a meal was given to the resident to take to the dialysis center, were to be completed by the Skilled Nursing Facility (SNF). Further review included a section for the dialysis center to complete prior to the resident's return to the facility. Review of R42's hemodialysis treatment records received from the dialysis center revealed R42 received eight hemodialysis in-center treatments from 05/02/2025 through 05/19/2025. Review of R42's hard copy medical chart revealed the Pre/Post Dialysis Communication Form was not located for the 05/02/2025 through 05/19/2025 dialysis treatments. Review of R42's electronic medical record (EMR) revealed no Pre/Post Dialysis Communication Form was located or assessments charted as performed for the 05/02/2025 through 05/19/2025 dialysis treatments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with R42 on 05/19/2025 at 5:50 PM, he stated he had just returned from dialysis and was doing well. When asked if he took any papers with him to the center earlier today or brought any back, he stated he really could not remember. During interview with Registered Nurse (RN) 8 on 05/22/2025 at 10:35 AM, she stated dialysis residents were supposed to be assessed pre- and post-dialysis treatment, findings placed on the communication form, the form given to the resident to take to the dialysis center, and the form completed by the dialysis center and returned to the facility with the resident. However, she stated there were times this process was not followed. When asked if the information was charted elsewhere, RN8 stated staff was supposed to chart the pre- and post-dialysis assessments in the progress notes. She stated the form, when and if returned from the dialysis center, was placed on a clip board at the nurse's station, but the dialysis center seldom sent it back to the facility. When RN8 was asked what process was followed if the form was not returned, she stated staff called the dialysis center and requested the form be faxed. She stated completion of the form was important to know the pre- and post-baseline of the resident to detect any change in condition. Review of the clip board documents during interview revealed no dialysis forms. During continued interview with RN8, she stated medical records staff picked up the forms that were placed on the clip board. During interview with Medical Records (MR) staff on 05/22/2025 at 10:55 AM, she stated she did pick up the dialysis forms and scanned them into the EMR, but they were not always on the clip board. During interview with Licensed Practical Nurse (LPN) 2 on 05/22/2025 at 1:47 PM, she stated she thought vital signs and a weight were to be taken on a resident prior to them going to dialysis, and a weight was supposed to be obtained upon return, but she did not send that many residents to dialysis. When asked why it would be important for pre- and post-dialysis assessments to be completed and charted, she stated to know the baseline so the resident could get the best care. During interview with the Director of Nursing (DON) on 05/22/2025 at 3:25 PM, she stated the dialysis forms should be completed and returned to the facility so staff could monitor the resident pre- and post-dialysis for any changes. During interview with the Executive Director on 05/23/2025 at 4:46 PM, he stated staff completing the Pre/Post Dialysis Communication Form was important because it determined the status of the resident pre- and post-dialysis to assure the safety of the resident.

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F 0755 Level of Harm - Minimal harm or potential for 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** 1. Review of R50's admission Record revealed the facility admitted R50 on 07/08/2024 with diagnoses including [NAME]-[NAME] syndrome (a rare, autoimmune disorder in which the immune system attacked the neuromuscular junctions), type 2 diabetes, and carcinoma-in-situ of the lung. Review of R50's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating her cognitive status was intact. Review of R50's Physician Orders, initiated on 12/13/2022, revealed an order for Pyridostigmine Bromide ER(used to improve muscle strength in patients with certain muscle diseases), 180 milligrams (mg) daily by mouth. Further review revealed it was ordered to manage the effects of [NAME]-[NAME] syndrome. Review of R50's Medication Administration Record [MAR] for April 2025 revealed she missed the dose of Pyridostigmine Bromide ER on [DATE]. Review of R50's Administration Note, dated 04/03/2025, revealed pharmacy cancelled the order for Pyridostigmine Bromide ER the previous night after Licensed Practical Nurse (LPN)1 had reordered it. Further review of the note revealed LPN1 had requested the medication be sent that day. Review of R50's MAR for May 2025 revealed she missed the doses of Pyridostigmine Bromide ER on [DATE] and 05/19/2025. Review of R50's Administration Note, dated 05/18/2025, revealed the medication was out of stock in the cart and had been reordered from pharmacy. Review of R50's Administration Note, dated 05/19/2025, revealed the medication was on order. Review of the facility's Pharmacy Calls/Notifications log revealed a call on 04/02/2025 at 9:36 AM regarding R50's missing Pyridostigmine Bromide, and the result was that the medication required Prior Authorization (PA) from the insurance company. Further review revealed a call on 05/19/2025 at 10:00 AM, with indicated response that the missing medication would be sent that evening. Continued review revealed a call on 05/20/2025 at 9:15 AM regarding the Pyridostigmine Bromide, with indicated response that it would be sent on the first run that date. Observation on 05/20/2025 at 1:58 PM, revealed R50 in bed and looking weak with a flat affect. During interview with R50 on 05/20/2025 at 1:58 PM, she stated she was very concerned about a needed medication she had not received for three days. She stated she understood the problem, and it had something to do with insurance and that it had happened before. She stated the medication was for an autoimmune condition that left her weak and unable to stand without it. Observation on 05/23/2025 at 11:46 AM revealed R50 with a much brighter affect and feeling better after the Pyridostigmine Bromide ER had been restarted. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Morehead	933 North Tolliver Road Morehead, KY 40351

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with R50 on 05/23/2025 at 11:46 AM, she stated she felt much better today. She stated the medicine was for [NAME] syndrome, and it affected her muscles and made her not be able to stand up. She stated with the medicine her muscles worked better, and without the medicine, she was so weak she could not get up and get around. She stated she typically could get up and move with a walker but could not if she was without her medicine. She stated she had a harder time talking when she was without the medicine. She stated she felt much better today. During interview with LPN1 on 05/21/2025 at 5:22 PM, she stated the problem was the medication required a Prior Authorization (PA). She stated the facility received nine of 30 ordered pills the previous afternoon, 05/20/2025. She stated when she returned from vacation on 05/19/2025, R50 was out of the medication, so she called the pharmacy and requested a stat (immediate) delivery, but they did not send it. She also stated a PA was supposed to go to the doctor's office for them to send to the pharmacy for refilling the medication. She stated when she spoke to the pharmacy, they would tell her they needed a PA and sent the request to the physician and to the facility. In the meantime, she stated, staff had requested from the Administrator or Director of Nursing (DON) to pay for the short-term refill pending the authorization being approved. LPN1 stated they normally ordered refills directly through the electronic heath record (EHR). But for this medication, she stated the pharmacy notified the provider but would call the facility if the PA was not received. She stated sometimes pharmacy sent that to the facility as well, and those would be taken to the DON. During interview with LPN6 on 05/22/2025 at 8:24 AM, she stated if a medication was not stocked in the cart, she ordered it right then through point-click-care (PCC), a software the facility used. However, she stated when she ordered at night, then it still might not be in when she returned to work, and she had to call again. She stated the facility had a telephone log for pharmacy calls so anybody who followed the nurse who ordered a given medication could see it on the computer, and it should have been on the log. During interview with LPN2 on 05/22/2025 at 1:21 PM, she stated when R50's Pyridostigmine Bromide ER was received, the manifest indicated the pharmacy sent nine pills, and owed 21. She stated she ordered medicines directly through PCC, and also took the sticker off the medication box and added that to a list of stickers on a paper form, and then faxed it to the pharmacy. She stated she usually ordered refills three to four days out from being out of the medication. LPN2 stated, if knowing from the past that a medication was difficult to get, she would order earlier. She stated if a medication required a PA, she might not be aware of that as those were managed on day shift, but if alerted for such, the day nurse called the doctor for that. She stated when putting in orders, the only alert from the screen were possible interactions. She stated there was not an alert if the medication required a PA, and that information would come from a pharmacist. LPN2 also stated she knew at least two other nurses who used the added step of faxing the stickers. During additional interview with LPN1 on 05/22/2025 at 5:26 PM, she stated the facility had received the remainder of ordered pills for R50. She stated PAs were previously not a problem, and a PA was in effect for a year. However, she stated after 01/01/2025, that had changed, and now a PA was required every month. She stated the pharmacy had reported they had sent the PA to the physician, but the facility had not received a response. She also stated she started having more problems with this in April 2025, and the facility had paid for the medicine since then. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the Staff Development Coordinator (SDC) on 05/22/2025 at 2:39 PM, she stated the facility provided education on medication management if there was a complaint. For example, she stated if there was a complaint that came up at the morning staff meeting, the DON asked for education for that issue, then she would develop a review with the policy for the staff. She stated staff nurses kept up with medication management. She stated she did not do specific education on reordering, that came with assistance from their preceptor. During interview with the contracted Pharmacist on 05/22/2025 at 10:08 AM, he stated Pyridostigmine Bromide orders required a PA. He also stated there was an attempt to refill on 05/18/2025, and the non-covered authorization form was completed. He stated this form was necessary because insurance would not pay, so either the facility could pay or work to get an alternate medication. He stated the medication was not covered, but he did not know why and could not say if this was a permanent issue. He stated all he could say was a PA was required as evidenced by a PA documented as requested on 05/13/2025. He stated the methods to pursue included using an interface from another pharmacy for review of issues. He stated he had been working on the communication process. He stated the pharmacy's Clinical Intervention Center generated the PA, which then went to the physician or facility per the facility's preference. He stated for this facility, he could not say the process but agreed to reach out to the Clinical Intervention Center and request they call. During additional interview with the Pharmacist on 05/23/2025 at 9:01 AM, he stated for this facility, PA notifications went to an interface from another pharmacy, and also generated a fax to the facility. He further stated the PA could go to the provider if a facility chose. For this facility, he stated, a PA went to a fax number in the facility but was changed to a different fax number last week per request of the DON. The Pharmacist stated R50's medication was ordered on 05/13/2025, kicked to the Clinical Intervention Center due to the PA and nonpayment without it. In turn, he stated it generated a notice of the needed PA to OCC, which the facility could have access to, and generated a fax to the selected number. He stated the facility could see OCC with their own login, so a nurse or manager would have to do that manually on that website. He stated the website could have alerts sent via email, but the alerts could not be seen in PCC. During interview with the DON on 05/23/2025 at 10:19 AM, she stated when she talked to the pharmacist last week, she learned when a medication required a PA, if the pharmacy would notify the facility, the facility would pay for a short supply pending the PA approval. She stated the current strategy was for the pharmacy to notify the facility of a PA by fax. In the past, she stated the pharmacy had a staff member who included PA notices on paper on the midnight delivery, so the facility would have it in hand the following morning. She stated the paper PA notices stopped maybe six months ago, but she was not sure of the exact timeframe. She stated she had an in-person meeting with the Pharmacist, when they went over the interface from another pharmacy together, but the links did not take them to relevant information or the system crashed. Since then, she stated the pharmacy had been sending the notices by fax. She also stated the facility had only a few residents who were taking medications which required a PA, such as something insurance would not cover, so the facility paid for those. She further stated the pharmacy sent the PA, and the DON completed the form. She stated, then Medical Records staff took the PA to the provider or they obtained the signature when the provider was in the building. Then, she stated the facility sent the PA back to the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During additional interview with the DON on 05/23/2025 at 2:44 PM, she stated she called the pharmacy when she was no longer receiving PA notices on paper. She stated the pharmacy told her those staff members were no longer there, and they did not offer an explanation or how they were to transmit those. After that, she stated a notice would show up on a random basis, and she assumed there was nobody on a medication that required a PA. She stated she and another nurse manager were the only ones who had access to the interface from another pharmacy, but the floor nurses did not and would not have received the notices. During interview with the Executive Director on 05/23/2025 at 3:11 PM, he stated if there were problems with getting residents' medications, he expected staff to alert the provider and work with pharmacy. He stated, if the issue was still not resolved, he expected staff to contact him or the DON, and they could contact the Regional Pharmacist directly. He stated he expected if those actions did not resolve the problem, then the facility could source the medication from a retail pharmacy.2. Review of R5's admission Record revealed the facility admitted the resident on 01/25/2023 with diagnoses at time of survey including acquired absence of left great toe, chronic kidney disease, and type two diabetes with polyneuropathy (disorder of the peripheral nerves). Review of R5's significant change MDS, with an ARD of 04/16/2025, revealed the facility assessed the resident to have a BIMS score of 14 out of 15, indicating the resident was cognitively intact. Further review revealed the facility noted R5 received scheduled and as needed pain medications. Review of R5's MAR, dated 01/2025, revealed the physician ordered 300 mg of gabapentin (a medication for nerve pain) to be administered three times per day for leg pain. Further review revealed the facility failed to administer 14 doses of gabapentin from 01/12/2025 to 01/30/2025. Review of R5's Progress Note, dated 01/10/2025, revealed Registered Nurse (RN) 5 documented sending a request for a refill for R5's gabapentin because it was running low. Per review, RN5 called the physician and the pharmacy, and the pharmacy told her the prescription was not sent in. Review of R5's Progress Note, dated 01/17/2025, revealed RN5 documented R5 was out of gabapentin, even though the prescription was requested on 01/10/2025. In an interview on 05/23/2025 at 3:48 PM, R5 stated she recalled the facility running out of her gabapentin in 01/2025. She stated staff told her the pharmacy had not refilled her medicine, and it took days to get it fixed. R5 stated she was in pain and felt a shooting sensation down her leg. Per interview, R5 did not want to complain to the nurses because she knew they were trying, but her pain was increased while she was not receiving her gabapentin. In an interview on 05/23/2025 at 6:37 PM, RN5 stated she recalled R5 running out of gabapentin on more than one occasion, including in 01/2025. She further stated she had notified the pharmacy a week prior, when she noticed the medication supply was low. Per interview, R5's dose of gabapentin was not available in the facility's emergency medication system. In continued interview, RN5 stated on multiple occasions, she had notified the physician of the need for a refill prescription and would call the pharmacy to follow up on a refill. She stated the pharmacy would tell her they did not have it, even though the physician told her they sent it in. Additionally, RN5 stated a delivery requested as STAT (as quickly as possible; high priority) would often not arrive for 10 hours from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a post survey interview with the contracted pharmacy, on 06/10/2025 at 2:55 PM, the pharmisist stated that gabapentin was available in the emergency medication system at the facility. In an interview on 05/22/2025 at 10:25 AM, the Director of Nursing (DON) stated the facility's process for obtaining medication refills included faxing a refill reminder sticker to the pharmacy, submitting a request on the electronic health record, and having cycle fills of routine medications that were refilled automatically. She further stated staff could request a rush delivery from the pharmacy or pull the medication from the emergency medication system with an access code from pharmacy. In continued interview, the DON stated the facility had issues with getting routine medications and narcotics from the pharmacy in a timely manner. Per interview, the pharmacy the facility was currently using was new to them, and they had problems with miscommunication with them. Additionally, the DON stated the facility did not have a 24-hour pharmacy in town to use as a back-up if the main pharmacy failed to deliver a medication. In an interview on 05/23/2025 at 3:46 PM, the Executive Director stated he expected the facility to have medications available for residents as much as possible. He further stated if something happened that resulted in the medication not being available, he expected staff to call the physician and the pharmacy and get either a rush delivery or a code to obtain the medication out of the emergency medication system. In continued interview, he stated the facility noted the communication barriers with pharmacy on 05/12/2025 around admission and readmission, as well as not receiving refills. Per interview, he stated he was not aware of R5 missing 14 doses of gabapentin in late 01/2025. Based on observation, interview, record review, and review of the facility's policies, the facility failed to provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement. The facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 5 residents investigated for pharmacy services, Resident (R) 5 and R50. The findings include: Review of the facility's policy, Reordering, Changing, and Discontinuing Medication Orders, revision date 7/01/2024, revealed facilities are encouraged to reorder medications electronically or by fax whenever possible staff may use electronic orders. Facility staff [the pharmacy's software program, secure web portal for pharmacy management, communication, and reporting] log in [the pharmacy's software program] to access medication, order status, payment and more. [The pharmacy's software program] should be restricted by assigned user identification and password and should be controlled by the Director of Nursing or designee. Further review revealed facilities were encouraged to reorder medications electronically or by fax whenever possible, and the reorders would be written and submitted on the pharmacy's Refill Order Form and would be faxed to the pharmacy, if permitted by applicable law. Continued review revealed authorized facility staff would use the software to electronically reorder resident medications, and staff should review the transmitted reorders for status and potential issues and pharmacy response. Review of the facility's policy titled, Nursing Documentation, reviewed 09/05/2024, revealed the facility implemented interventions to prevent or manage each individual resident's pain, beginning at admission. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Administration of Medications, reviewed 09/16/2024, revealed the facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 review of the facility's policies, the facility failed to store food in accordance with professional standards for food service safety. This had the potential to affect 87 of 90 residents who consumed food from the kitchen and snacks from the North and South Units. The findings include: Review of the facility's policy titled, Safe Food Handling, revised 04/20/2025, revealed thawing some foods at room temperature might not be acceptable because it might be within the danger zone for rapid bacterial proliferation. Further review revealed the recommended methods to safely thaw frozen foods included thawing in the refrigerator in a drip proof container and in a manner that prevented cross contamination, thawing the item in a microwave oven, or thawing as part of a continuous cooking process. Continued review revealed frozen food must be thawed under refrigeration or in the cooking process. Additional review revealed snacks and other food items sent from the food service department were handled safely related to temperature, labeling, and storage. Review of the facility's policy titled, Nourishment and Snacks, revised 05/08/2025, revealed nourishment and snacks would be prepared and stored using food safety guidelines. Further review revealed resident nourishments and snacks could be prepared in advance and stored in the nourishment room refrigerator/freezer outside of the food service department to be served by nursing staff. Continued review revealed the nourishment/snack refrigerators should be clean and free of non-resident food items, and items stored in the units should adhere to safe food handling and food safety, specifically labeling and dating. Observation of the kitchen on 05/19/2025 at 2:45 PM revealed five rolls of frozen ground beef thawing at room temperature in a bin resting on a rolling cart . Further observation revealed a commercially prepared container of sliced meat in the reach-in refrigerator that was unlabeled and undated. Continued observation revealed a 12-ounce can of soda that was unlabeled and undated. Observation on 05/21/2025 at 6:15 PM revealed snacks in a bin, already placed on top of the North Unit nurse's station counter, ahead of the 8:00 PM snack distribution time, including meat sandwiches and milk, which were not in the refrigerator. Observation of the North Unit nourishment refrigerator on 05/22/2025 at 4:26 PM revealed one box from a fast food restaurant with no label for the intended resident or date. The observation further revealed a lunch box containing two energy drinks and without a label or date. Observation of the South Unit nourishment refrigerator on 05/22/2025 at 5:03 PM revealed a shopping bag containing fruit and crackers belonging to Certified Nurse Aide (CNA) 15, who retrieved it and stated there was a staff refrigerator in their break room where staff was expected to place their own food items. Observation also revealed a shopping bag containing apples and a carton of chocolate milk, unlabeled and undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview with Cook/Dietary Aide (DA) 1 on 05/19/2025 at 2:45 PM, she stated she believed the commercially prepared meat in the reach-in refrigerator was leftover from a prior activity. She further stated she thought the soda might belong to a staff member, and prepared snacks were taken to the units at about 2:30 PM and about 7:00 PM each day. She stated the ground beef was thawing and would go into the walk-in refrigerator later in the afternoon to finish thawing to be used the following day. During interview with Cook/DA2 on 05/21/2025 at 8:16 AM, she stated when thawing meats, they removed the meats from the walk-in freezer, placed a label with the pull date and use by date on the packaging, placed the meat in a pan and allowed it to begin thawing, and then later placed the pan in the bottom shelf of the walk-in refrigerator. During interview with Licensed Practical Nurse (LPN) 6 on 05/21/2025 at 6:15 PM, she stated nighttime snacks were often delivered directly to the nurse's station, not to the nourishment refrigerator, around shift change. During telephone interview with Registered Nurse (RN) 5 on 05/21/2025 at 8:02 PM, she stated the nighttime snacks arrived about the time night shift arrived around 6:00 PM or 6:30 PM. She stated snacks were placed on the nurse's station counter and not in the refrigerator. She stated the aides started night shift by feeding those residents who might still need assistance, collect trays, round, and then pass snacks with their ice pass. During interview with LPN2 on 05/22/2025 at 1:39 PM, she stated the kitchen delivered a box of snacks to the nurse's station while shift change staff was in report. She stated sometimes she put the box in the refrigerator later, after shift report, or the aides would distribute after they passed the resident's ice. During interview with the Registered Dietician (RD) on 05/22/2025 at 2:18 PM, she stated best practice was to put frozen meats from the freezer to the refrigerator at least 24 hours in advance of preparing the meal. Further, she stated it was best practice to avoid putting meat on the counter to thaw at room temperature. During interview with the admission Coordinator on 05/22/2025 at 4:26 PM, she stated the reason it was important to label and date stored items in the Nourishment Room was so residents did not get food that was spoiled. She stated food should be labeled if it was something brought in for a specific resident. During interview with the Certified Dietary Manager (CDM) on 05/23/2025 at 1:37 PM, she stated to thaw meat, the expectation and policy was to take the meat straight from the freezer, place it in a pan, and label and date the item. She further stated all meat and poultry would go to the bottom shelf of the walk-in refrigerator. She stated the sliced ham in the refrigerator was left from a prior activity and kept for resident snacks. She stated it should have been labeled and dated. She stated the nourishment refrigerators on the units should only hold resident items, and those should be labeled and dated. She stated staff snacks or lunches should not be in the nourishment refrigerators. She stated she had educated dietary staff to remove unlabeled items from the refrigerators. The CDM stated the kitchen staff delivered snacks at around 10:00 AM, 3:00 PM, and 8:00 PM. She stated staff should not have delivered at 6:00 PM because that was too early for nighttime snacks. She stated they typically delivered to the nurse's stations. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview with the Director of Nursing on 05/23/2025 at 2:44 PM, she stated staff drinks or snacks should be stored in the break room, and putting those in a nourishment refrigerator for residents was not acceptable. During interview with the Executive Director on 05/22/2025 at 4:32 PM, after he observed the lunch bag found in a nourishment refrigerator, he stated he had not identified the owner of the lunch bag. He further stated it was important to label and date items in the refrigerator so that the right resident received them and so they did not distribute food that might be spoiled. During another interview with the Executive Director on 05/23/2025 at 3:11 PM, he stated his expectation was that all the food was stored correctly, and he relied on the CDM and the RD to assure staff followed the prescribed policies. He further stated if they had problems, they notified him. He stated if snacks were not passed in a timely fashion, they should be stored in the refrigerator. He stated all items in the nourishment refrigerator must be labeled and dated, and it was not acceptable for staff to keep personal items in a nourishment refrigerator.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the glucometer's (device used to calculate a finger-stick blood glucose level) manufacturer's instructions, review of disinfectant wipe instructions, review of the Centers for Disease Control and Prevention (CDC) document, and review of the facility's policies, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent and control the development and transmission of communicable diseases and to implement interventions to protect the residents. The deficient practice had the potential to affect 34 of 34 residents, to who received fingersticks for blood glucose testing, with observations to include (Resident (R)7, R45, R37, and R244). Additional observations of deficient practice revealed they affected 4 of 27 sampled residents (R13, R27, R70, and R72). Observations revealed Registered Nurse (RN)1, Licensed Practical Nurse (LPN)1, and LPN3 failed to properly clean and disinfect shared glucometers after obtaining blood glucose measurements. Review of the manufacturer's recommendations revealed the staff was to use specific wipes validated by the manufacturer. Further review revealed staff was to use two wipes, one for cleaning and one for disinfecting, leaving the surface wet for a specific amount of time for the wipe, which the staff failed to do. Review of the product information for Sani-Cloth Bleach wipes, which the facility used to clean and disinfect glucometers, revealed its Environmental Protection Agency (EPA) number was not listed by the manufacturer as approved for the glucometer. Further review revealed the incorrect wipe had a dwell time of four minutes. Review of the facility's list of residents with bloodborne illnesses revealed one resident, Resident (R) 45, with human immunodeficiency virus (HIV), and the resident received blood glucose checks using the facility's shared glucometers. Immediate Jeopardy (IJ) was identified on 05/22/2025 and was determined to exist on 05/21/2025, in the area of 42 CFR 483.80 Infection Control, F880, at a Scope and Severity (S/S) of an K. The facility's Executive Director was notified of the IJ on 05/22/2025. The facility provided an acceptable Immediate Jeopardy Removal Plan, on 05/23/2025, alleging removal of the IJ on 05/23/2025. The State Survey Agency (SSA) determined the IJ was removed on 05/23/2025, prior to exit on 05/23/2025, with remaining non-compliance at an S/S of an E while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's policy titled, Infection Control, revision date 03/21/2024, revealed the facility was to provide a comprehensive infection control program involving all departments to prevent and control infections acquired or brought into the facility. Review of the facility's policy titled, Standard Precautions, revision date 07/05/2022, revealed standard precautions were used as the first line of defense against preventing transmission of microorganisms. The policy stated the procedure included to utilize personal protective equipment (PPE), and resident care items for multiple residents were disinfected between uses with the approved disinfectant. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Morehead	933 North Tolliver Road Morehead, KY 40351

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the CDC's document Standard Precautions for All Patient Care, Infection Control Basics, Health Care Providers, dated 04/03/2024, revealed hand hygiene meant cleaning hands with water and soap (e.g., plain soap or with an antiseptic) or antiseptic hand rub (alcohol-based foam or gel hand sanitizer); immediately before touching a patient [resident]; before performing an aseptic task such as placing an indwelling device or handling invasive medical devices; before moving from work on a soiled body site to a clean body site on the same patient [resident]; after touching a patient [resident] or patient's [resident's] surroundings; after contact with blood, body fluids, or contaminated surfaces; and immediately after glove removal. It also stated gloves were not a substitute for hand hygiene, and if the task required gloves, perform hand hygiene before donning (putting on) gloves and touching the patient [resident] or the patient's [resident's] surroundings. Further review of the CDC's document, dated 04/03/2024, revealed staff should always clean hands after removing gloves. Per the document, it stated to wear gloves when coming in contact with blood or other infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment. Additionally, the document stated to change gloves and clean hands if gloves became damaged or soiled with blood or body fluids after a task; if moving from work on a soiled body site to a clean body site on the same patient [resident]; if moving from care on one patient [resident] to another patient [resident]; if they looked dirty or had blood or body fluids on them after completing a task; and before exiting a patient's [resident's] room. Review of the facility's glucometer manufacturer's instructions for cleansing the machine to reduce the risk of transmission of blood-borne pathogens, revised 04/2021, revealed it was to be cleaned and disinfected after each use on each patient [resident] using standard precautions and the manufacturer's disinfection procedures. Per the policy, the procedure included to clean the glucometer with the approved wipe (Super Sani-Cloth, EPA number 9480-4, purple top) with a contact time of two minutes before its next use. The instructions stated to use two wipes, one for cleaning and one for disinfecting, wiping the surface of the meter three times vertically and three times horizontally. Review of Super Sani-Cloth (EPA number 9480-4), the approved wipe for the glucometer utilized by the facility, revealed the instructions for cleaning and disinfecting was to clean with one wipe and disinfect with the second wipe allowing the surface to remain wet for two (2) minutes and allowing to air dry. Review of the facility's list for residents with Blood Borne Illnesses, dated 05/19/2025, revealed one resident, R45, diagnosed with Human Immunodeficiency Virus (HIV) Disease. Review of the facility's Midnight Census Report, dated 05/19/2025, listed the census with 34 residents receiving fingersticks for blood glucose testing, including R45. 1 a. Review of R45's admission Record revealed the facility admitted R45 on 01/19/2019 with diagnoses to include diabetes, encephalopathy,high blood pressure, and Human Immunodeficiency Virus (HIV). Review of R45's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 05/20/2025 revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of two out of 15, which indicated the resident was severely cognitively impaired. Review of R45's Physician's Orders, revealed an active order set, dated 03/20/2024, for a fingerstick to be obtained one time a day to check for blood glucose level. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. Review of R7's admission Record revealed the facility initially admitted the resident on 02/22/2021 with diagnoses including diabetes, cerebral vascular accident, and pneumonia. Review of R7's annual MDS, with an ARD of 04/25/2025, revealed the facility assessed the resident to have a BIMS score of 14 out of 15, indicating intact cognition. Further review revealed the resident received five insulin injections during the last seven days. c. Review of R58's admission Record revealed the facility initially admitted the resident on 05/26/2020 with diagnoses including stroke, dementia, and atrial fibrillation. Review of R58's quarterly MDS, with an ARD of 03/24/2025, revealed the facility assessed the resident to have a BIMS of 12 out of 15, indicating moderate cognitive impairment. Observation on 05/21/2025 at 10:00 AM on the [NAME] Hall revealed RN1 checked R7's glucose. RN1 removed the glucometer from Medication Cart 2. The glucometer was in the top drawer, it was not in a container or a bag, and there was another glucometer in the same spot touching the other glucometer. RN1 put on gloves without sanitizing her hands and performed the glucometer check on R7. She then went to R7's roommate's bed (R58) and placed the glucometer on his bedside table. She talked with R58, picked up the glucometer, and placed it on the top of the medication cart. She removed her gloves and did not sanitize her hands. She opened the bottom right drawer of the medication cart and wiped the glucometer from 10:07:01 AM to 10:07:010 AM, nine seconds. After wiping the glucometer, she placed the glucometer back on the top of the medication cart, without using a barrier. RN1 left the glucometer on the top of the cart and went to give medications. Observation of the Sani-Cloth Bleach Germicidal Disposable Wipes RN1 used for R7's glucometer disinfection revealed its EPA number was 9480-8 (unapproved, orange top), and it was to remain visibly wet with the disinfectant for four minutes. During interview with RN1 on 05/21/2025 at 10:26 AM, she stated the facility's policy instructed to wipe all sides of the glucometer. She stated she always did three swipes on each side with a Sani-cloth wipe. She stated she thought she should wipe the glucometer and let it dry. She stated she did not think there could be any contamination because she wiped all sides of the glucometer. She said it was just an oversight that she did not let the glucometer stay wet for four minutes. She stated she had two glucometers, and she switched them for use. Per the interview, the RN revealed she was not aware the glucometers needed to be wet for four minutes. d. Review of R244's admission Record revealed the facility admitted the resident on 05/16/2025 with diagnoses to include dysphagia, diabetes mellitus, adult failure to thrive, and dependence on renal dialysis. Review of R244's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 05/20/2025, revealed the resident had a Brief Interview for Mental Status [BIMS] score of 10 out of fifteen 15, which indicated the resident had moderate cognitive impairment. Further review revealed the resident received four insulin injections during the last seven days. Review of R244's Physician's Orders, dated 05/16/2025 revealed a verbal order was given for fingerstick blood sugars four times a day for diabetes mellitus. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 05/21/2025 at 11:50 AM revealed Licensed Practical Nurse (LPN) 3, prior to performing a fingerstick on R244, removed the glucometer which was lying on top of the South Hall Medication Cart without a barrier underneath. LPN3 entered R244's room, placed the glucometer on the overbed table, and donned PPE. After cleansing R244's right middle finger with an alcohol pad, LPN3 lanced R244's finger and obtained blood for checking the glucose level. After administering medications and insulin, LPN3 removed PPE and put on different gloves, picked up the glucometer, and placed it on top of the medication cart without a barrier underneath. LPN3 wore the same gloves, opened the bottom drawer of the medication cart, and removed a container of Sani-Cloth Bleach wipes, which was not the acceptable wipe. She removed one cloth and wiped the front and back of the glucometer for approximately four to five seconds with the one cloth and placed the glucometer on top of the medication cart without a barrier underneath. During interview with LPN3 at the time of the observation, on 05/21/2025 at 11:52 AM, she stated she did not have another resident to check for a glucometer check at that time. When asked about the dwell time for the disinfectant wipe for the glucometer, she stated, I don't know, probably two to three minutes. LPN3 further stated she did not know if the glucometer was clean when she used it, but she guessed it was. She stated it was important to clean and disinfect equipment properly to prevent spreading germs from resident to resident. e. Review of R37's admission Record revealed the facility initially admitted the resident on 10/21/2016 with diagnoses of diabetes, anemia, and coronary artery disease. Review of R37's annual MDS, with an ARD of 04/24/2025, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating intact cognition. Further review revealed the resident received seven insulin injections during the last seven days. Observation on 05/21/2025 at 3:42 PM revealed LPN1 prepared to check R37's glucose. She opened the top drawer of Medication Cart 2 on the North Hall. She took one of two glucometers that were not in containers and lying next to each other. She did not sanitize her hands, and she put on gloves. She performed the glucose check on R37 and placed the glucometer without a barrier underneath on the top of the medication cart. She removed her gloves and did not sanitize her hands. She took out her keys and opened the bottom right drawer of the medication cart. She took out the Sani-Cloth Bleach Germicidal Disposable Wipes container. She removed a wipe and wiped the glucometer from 3:44:40 to 3:44:50 (10 seconds). She then put the glucometer in a cup and set it on top of the medication cart, started the timer for five minutes, and left. During interview with LPN1 at the time of the observation, on 05/21/2025 at 3:50 PM, she stated she was taught to wipe the glucometer three times each way and then let it dry for five minutes with the orange top sani-wipes. She stated she did not know to use the purple top sani-wipes. Further, she stated she had received training from the staff development coordinator in cleaning the glucometer a few months ago. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interview with the Infection Preventionist on 05/21/2025 at 3:20 PM, she stated each medication cart had two glucometers, and the process was for staff to wipe down the glucometer, using the proper wipe, set to the side, and use the other glucometer while the first was drying. Observation revealed two medication carts on the South Hall, and each had two glucometers which were lying in the top drawer of each medication cart side-by-side. When asked if there was a concern if staff did not follow the proper cleaning procedure, she stated it would cause cross contamination, and she would be concerned for the spread of bloodborne pathogens. During interview with the Director of Nursing (DON) on 05/22/2025 at 4:00 PM, she stated her expectation was for staff to follow guidelines to properly clean glucometers with the orange top wipes. She stated her concern would be if they did not follow the process, infection could be spread throughout the residents. Review of the facility's policy titled, Enhanced Barrier Precautions, revision date 04/22/2025, revealed staff providing high-contact care activities for residents in EBP isolation included dressing, bathing/showering, transferring, providing hygiene, linen or brief change, medical care device use, wound care, and assisting with toileting. It stated, during these high-contact care activities, staff was to wear PPE and follow EBP signage. Review of the facility's EBP signage (procedure to be used), posted on residents' doors in EBP, revealed everyone was to clean hands before entering and leaving the room. The signage revealed providers and staff must also wear gloves and a gown for high-contact resident care activities. Review of the facility's list of residents on EBP, dated 05/19/2025, revealed there were 24 residents listed, including R13, R27, R70, and R72. 2. a. Review of R27's admission Record revealed the facility initially admitted the resident on 06/08/2024 with diagnoses including respiratory failure, protein-calorie malnutrition, and diabetes. Review of R27's significant change in status assessment MDS, with an ARD of 03/25/2025, revealed the facility assessed the resident to have a BIMS score of four out of 15, indicating the resident had severe cognitive impairment. Further review revealed the resident had one stage 2 pressure ulcer and one stage 3 pressure ulcer. Observation on 05/19/2025 at 4:08 PM revealed Certified Nurse Aide (CNA)2 placed herself partially in Resident (R)27's bed and hugged the resident while she was in the bed without wearing a gown or gloves. Additional observation revealed R27's room door had signage placed for Enhanced Barrier Precautions (EBP) with Personal Protective Equipment (PPE) hanging on the back of the door. Further observation revealed R27 had an indwelling urinary catheter to bedside drainage. During interview with CNA2 on 05/20/2025 at approximately 12:00 PM, she stated she had received training on infection control and isolation procedures. When asked when staff should put on PPE if a resident was in EBP isolation, she stated anytime there was direct resident care or touching a resident to prevent germs from spreading. During continued interview with the Infection Preventionist (IP) on 05/21/2025 at 3:20 PM, she stated R27 was in EBP for a urinary catheter and wounds. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. Review of R13's admission Record revealed the facility admitted the resident on 01/28/2025 with diagnoses to include zoster encephalitis, malignant neoplasm of the brain, and infection with multidrug resistant organisms (MDRO). Review of R13's quarterly MDS, with an ARD of 03/24/2025, revealed the facility assessed the resident to have a BIMS score of 12 out of 15, which indicated the resident had moderate cognitive impairment. Observation on 05/19/2025 at 5:20 PM revealed RN1 went into R13's room to give an injection. R13 was in EBP due to infection with Multi Drug Resistant Organisms (MDRO). RN1 was only wearing gloves. She opened the left side of the brief and gave the injection. RN1 then left the room and went to the medication cart still wearing the same gloves. She took the keys out of her pocket and opened the drawer and removed an alcohol pad. RN1 returned to R13's room and went to the right side of the bed. She opened the right side of the resident's brief and gave the injection in the right hip, exited the room with her contaminated gloves on, and obtained ice without taking her gloves off. She removed her gloves and put them in the trash can, moving the can with ungloved hands. She did not sanitize or wash her hands. During immediate interview with RN1 after the observation, on 05/19/2025 at 5:30 PM, she stated she could not remember when she was trained in infection control. She stated she had received so much training she could not remember if she had infection control training. She stated she should have sanitized her hands before putting on her gloves and after removing the gloves, she just forgot. c. Review of R72's admission Record revealed facility admitted the resident on 03/01/2025 with diagnoses to include diabetes, stroke, and heart disease. Review of R72's quarterly MDS, with an ARD of 04/10/2025, revealed the facility assessed the resident to have a BIMS score of nine out of 15, which indicated the resident had moderate cognitive impairment. Review of R72's Progress Note, dated 05/12/2025 and untimed, revealed the resident had a stage 3 pressure wound to her lower sacrum. During interview with R72 on 05/19/2025 at 3:50 PM, she stated she had a sore on her butt, which was getting better, and the nurses were putting something on it to take care of it. Observation on 05/21/2025 at 8:05 AM revealed CNA5 entered R72's room without wearing a gown or gloves after the resident requested help to reposition. Additional observation revealed R72's door had signage for EBP. During immediate interview with CNA5 after exiting R72's room at 8:10 AM, she stated she had helped the resident to reposition and had not donned Personal Protective Equipment (PPE), but she should have to prevent the spread of germs. d. Review of R70's admission Record revealed the facility admitted the resident on 12/02/2022 with diagnoses which included unspecified protein-calorie malnutrition, unspecified dementia, and acute ischemic heart disease. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R70's significant change in status assessment MDS, with an ARD of 03/20/2025, revealed the facility assessed the resident to have a BIMS score of five out of 15, which indicated severe cognitive impairment. Review of R70's Wound Assessment, dated 04/17/2025 revealed the resident had an acute Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer acquired on 02/10/2025 and has received a status of Not Healed. Initial wound encounter measurements were 1cm [centimeter] length x 1. 5cm width with no measurable depth, with an area of 1.5 sq cm [square centimeter]. There was a Moderate amount of purulent drainage noted. Observation on 05/22/2025 at 1:15 PM revealed there was EBP signage on R70's door. Continued observation of R70's dressing change by LPN7 revealed LPN7 did not follow EBP. The LPN did not wear a gown during this high-contact activity, and the wound cleaner container was hung on the scrub pocket with the spray tip touching the scrubs. During interview with LPN7 on 05/20/2025 at 8:50 AM, she stated it was important to wear proper PPE each and every time direct care was provided to a resident in EBP to prevent the spread of infection and germs. During interview with RN2 on 05/19/2025 at 5:25 PM, she stated if a resident was on EBP, staff should put on PPE prior to touching the resident for prevention of spreading germs. During continued interview with the Infection Preventionist (IP) on 05/21/2025 at 3:20 PM, she stated anytime there was high-contact care given that involved touching a resident, PPE should be put on correctly. She stated hand hygiene audits were performed randomly with yearly training. She stated staff was trained to use soap and water after providing care to a resident with diagnoses of C-difficile or Noravirus (gastrointestioanl infection characterized by diarrhea, vomiting, and stomach pain) but was allowed to use hand sanitizer other times. Review of the facility's policy titled, Cleaning and Disinfection of Non-Critical Patient [Resident] Care Equipment, revision date 08/22/2022, revealed non-critical reusable patient [resident] care equipment was cleaned daily and before and after reuse with an approved disinfectant based on manufacturer guidelines or Environmental Protection Agency (EPA)-registered hospital disinfectant. 3. Observation on 05/19/2025 at 4:10 PM, 05/20/2025 at 11:20 AM, and 05/22/2025 at 12:18 PM, revealed the Hoyer lift (mechanical lift used to transfer residents from one surface to another) on the South 2 Hall had drops of a brown-colored substance on the base of the lift. During interview with CNA5 on 05/21/2025 at 8:10 AM, she stated the entire Hoyer lift should be cleaned after each use. During continued interview with the DON on 05/22/2025 at 4:00 PM, when asked how often the Hoyer lifts should be cleaned, she stated after each use, including the base of the lift. During interview with the Executive Director on 05/22/2025 at 4:20 PM, he stated his tasks included oversight of the building and assuring the needs and safety of the residents and staff were met. The Executive Director revealed he expected staff to follow the infection control policies and procedures for the prevention of spreading infection throughout the facility. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility provided an acceptable IJ Removal Plan on 05/23/2025 verbatim: 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 5/22/25, the Director of Nursing (DON) removed the Orange topped Sani-Cloth Bleach wipes from the North Unit medication carts #1 and #2 and replaced with the Purple topped Sani-Cloth Germicidal Disposable wipes which Environmental Protection Agency (EPA) number is listed by the manufacturer as approved for the glucometer. On 5/22/25, the Director of Nursing (DON) removed the Orange topped Sani-Cloth Bleach wipes from the South Unit medication carts #1 and #2 and replaced with the Purple topped Sani-Cloth Germicidal Disposable wipes which Environmental Protection Agency (EPA) number is listed by the manufacturer as approved for the glucometer. On 5/22/25, the Director of Nursing (DON) removed the Orange topped Sani-Cloth Bleach wipes from the [NAME] Unit medication carts #1 and #2 and replaced with the Purple topped Sani-Cloth Germicidal Disposable wipes which Environmental Protection Agency (EPA) number is listed by the manufacturer as approved for the glucometer. On 5/22/25, the Director of Nursing (DON) provided Resident (R) 45 with his own personal glucometer device to be kept in his room to ensure his glucometer device is to be used for his own personal use and not shared with other residents. The Executive Director, Director of Nursing and Interdisciplinary Team completed a Root Cause Analysis (RCA) on 5/23/2025. 2. How facility will identify other residents having the potentlal [sic] to be affected by the same deficient cract1ce [sic]? All residents receiving finger stick blood glucose checks have the potential to be affected. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 5/22/2025, the Regional Director of Clinical Services provided education to the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator and Infection Preventionist Nurse on the following: o Blood Glucose Monitoring Policy o Assur Prism multi® Blood Glucose Monitoring System Reference Manual (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Glucometer Cleaning and Disinfecting-Quick Reference Guide o [NAME] Glucometer Assure Quality Control Checks and Cleaning Procedures o [NAME] Skills Checklist-Cleaning and Disinfecting the Meter Any associate who has not completed training by 5/23/2025 will not be allowed to provide direct resident care until training is completed. The Director of Nursing (DON), Staff Development Coordinator (SOC), Infection Prevention Nurse and/or Regional Nurse will provide education to all new associates upon hire during orientation. [The facility's name] does not utilize agency staffing. As of 5/23/25, the facility has educated 23 out of 26 licensed nurses. On 5/23/25, the Director of Nursing (DON) placed a copy of the Omnicare Glucometer Cleaning poster and the Quick Reference Guide for glucometer cleaning on each medication cart as a guide to ensure the facility follows standard precautions during the performance of routine testing of blood glucose and ensure proper cleaning and disinfecting of the shared glucometer monitors that are used for more than one resident. The Medical Director reviewed and agreed with this plan of removal on 5/22/2025 with a copy provided to him on 5/23/25. AD Hoc QAPI meeting was held on 5/23/2025 regarding this plan of removal. Attendees were Executive Director, Medical Director, Director of Nursing, Staff Development Director, Infection Preventionist, Activity Director, Social Service Director, Health Information Manager, MOS Coordinator, Director of Rehabilitation, and Dietary Manager. A second AD Hoc OAPI [sic] meeting will be conducted on 5/23/25 to review audit tools that were completed to identify any deficient practice and provide re-education as indicated. 4. How the facilitv [sic] clans [sic] to monitor its oerformance [sic] to make sure that solutions are sustained. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SOC), Infection Prevention Nurse and or Regional Nurse will conduct [NAME] Skills Checklist-Cleaning and Disinfecting the Meter for one nurse per unit per shift (dayshift & nightshift), seven (7) days a week until IJ removal and then five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then one (1) time a week for four (4) weeks. The Director of Nursing and/or Regional Director of Clinical Services will Audit (Audit #4 A Skills Checklist- Cleaning and Disinfecting the Meter) the skills checklists to ensure the facility follows proper cleaning and disinfecting of the shared glucometer monitors that are used for more than one resident. If any non compliance is identified, a licensed nurse will provide re-education. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185155	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Morehead	933 North Tolliver Road Morehead, KY 40351

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SOC), Infection Prevention Nurse and or Regional Nurse will conduct a visual observation and complete [NAME] Blood glucose monitoring, long-term care skills checklist for one nurse per unit, seven (7) days a week until IJ removal, then five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then one (1) time a week for four (4) weeks. The Director of Nursing and/or Regional Director of Clinical Services will Audit (Audit #4 B Skills Checklist- Blood Glucose Monitoring) the skills checklists to ensure the facility follows standard precautions during the performance of routine testing of blood glucose. If any non-compliance is identified, a licensed nurse will provide re-education.