STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and review of facility policies, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs, that were identified in the comprehensive assessment for 1 of 19 sampled residents, Resident (R) 1.The facility admitted R1 on 01/05/2026 with a documented diagnosis of post-traumatic stress disorder (PTSD); however, the facility failed to include trauma-informed care and interventions for that care on R1's care plan. The findings include:Review of the facility's policy titled, Comprehensive Care Plans and Conferences, reviewed 08/29/2025, revealed the comprehensive care plan is developed within seven days of the completion of the initial comprehensive assessment and reviewed and revised following each assessment, thereafter.Review of R1's admission Record revealed the facility admitted the resident on 01/05/2026 with diagnoses including fracture of left femur, PTSD, and acute respiratory failure.Review of R1's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 02/16/2026, revealed the resident had a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating the resident was cognitively intact. Further review revealed R1 was assessed for an active diagnosis of PTSD.Review of R1's Comprehensive Care Plan revealed PTSD and/or trauma-informed care were not addressed.Review of R1's hospital discharge paperwork, dated 01/05/2026, revealed documentation showing the resident had a diagnosis of PTSD.Review of R1's Order Summary Report revealed PTSD listed as an active diagnosis. Further review revealed no active or standing orders for psychiatric care.Review of R1's Trauma Informed Care Assessment, dated 01/12/2026, revealed the resident indicated he had experienced personal trauma related to a transportation accident. Further review revealed R1 specified he experienced the following over the past month: repeated and disturbing dreams of the stressful event; feeling very upset when reminded of the stressful event; having physical reactions when reminded of the event (heart pounding, sweating, trouble breathing); avoiding memories or feelings related to the stressful experience; trouble remembering important parts of the experience; blaming self or someone else; and having strong negative feelings such as fear, horror, guilt, anger, or shame.In an interview with R1 on 03/17/2026 at 12:09 PM, he stated he was at the facility for therapy because he fell and broke his leg, but his goal was to return home. When asked about his past trauma, R1 declined to discuss anything related to the event.In an interview with State Registered Nurse Aide (SRNA) 5 on 03/19/2026 at 9:38 AM, she stated she determined a resident's care when she received report and from the Kardex. She further stated each resident's abilities and interventions were listed on the Kardex. SRNA5 stated it was important to know a resident's needs, so they were given proper care. Additionally, SRNA5 stated it was hard to provide assistance if she did not know what a resident's needs were. In an interview with Licensed Practical Nurse (LPN) 3 on 03/19/2026 at 9:49 AM, she stated R1 did not share much information with staff related to his trauma. She stated she was not aware of any specific triggers related to the resident's trauma. LPN3 further stated she made herself available if R1 wanted to talk and she provided him with encouragement. LPN3 stated it was important PTSD was listed on R1's care plan because it was hard to meet his (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Morehead		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needs if she did not know what they were.In an interview with the Social Services Director (SSD) on 03/19/2026 at 10:01 AM, she stated R1 was admitted to the facility for rehab following a fall that resulted in a broken leg. The SSD stated she addressed PTSD with R1 when he was admitted and he told her he was involved in a very terrible accident, but declined any further discussion related to specific triggers or the accident itself. When asked how needs were met when triggers were not readily identified, the SSD stated she monitored behavior changes such as increased isolation, depression, or aggression. The SSD stated it was important that staff were aware of R1's PTSD diagnosis and any known triggers so he received resident-centered care and was not re-traumatized. She said it was important that PTSD was listed on R1's care plan so staff were aware of his diagnosis, and he could be monitored for changes.In an interview with the MDS Coordinator on 03/19/2026 at 10:23 AM, she stated when she gathered information for the initial MDS and for each review, she looked at diagnoses, reviewed discharge summaries, interviewed residents/family, and talked to nursing. The MDS Coordinator stated the purpose of a care plan was to let staff know what a resident needed for his/her care. When the MDS Coordinator was asked to review R1's care plan, she stated PTSD was not included and there were no interventions that addressed the resident's trauma. She further stated it was somehow missed but should have been on R1's care plan.In an interview with the Director of Nursing (DON) on 03/19/2026 at 12:42 PM, she stated it was her expectation residents with PTSD received trauma-informed care, and it should be included in their care plan. She further stated quality care could not be provided if staff were not aware when residents had PTSD. The DON stated that even if R1's specific triggers were not known, there should have been interventions in place so R1 could be monitored for changes in behavior.In an interview with the Executive Director (ED) on 03/19/2026 at 1:08 PM, he stated it was his expectation that any resident with trauma or a diagnosis of PTSD felt safe, secure, and comfortable in the facility. He stated he expected PTSD to be included in R1's care plan because that was how staff identified his needs.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, record review, and review of facility policy, the facility failed to ensure residents who were trauma survivors received trauma-informed care based on professional standards and residents' experiences to eliminate or lessen triggers that could cause re-traumatization for 1 of 1 resident sampled for trauma informed care, Resident (R) 1.The facility admitted R1 on 01/05/2026 with a documented diagnosis of post-traumatic stress disorder (PTSD); however, the facility failed to include trauma-informed care and interventions for that care on R1's care plan. The findings include:Review of the facility's policy titled, Trauma-Informed Care, revised 01/06/2026, revealed the facility ensures residents who are diagnosed with mental disorder and psychosocial adjustment difficulty, or who have a history of trauma and/or post-traumatic stress disorder, receive treatment and services in accordance with professional standards of practice, and has a comprehensive person-centered care plan that reflects the resident's goals to eliminate or mitigate triggers that may cause re-traumatization of the resident. Additional review revealed in situations where a trauma survivor is reluctant to share his or her story, the facility should still attempt to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.Review of R1's admission Record revealed the facility admitted the resident on 01/05/2026 with diagnoses including fracture of left femur, PTSD, and acute respiratory failure.Review of R1's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 02/16/2026, revealed the resident had a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating the resident was cognitively intact. Further review revealed R1 was assessed for an active diagnosis of PTSD.Review of R1's Comprehensive Care Plan revealed PTSD and/or trauma-informed care were not addressed.Review of R1's hospital discharge paperwork, dated 01/05/2026, revealed documentation showing the resident had a diagnosis of PTSD.Review of R1's Order Summary Report revealed PTSD listed as an active diagnosis. Further review revealed no active or standing orders for psychiatric care.Review of R1's Trauma Informed Care Assessment, dated 01/12/2026, revealed the resident indicated he had experienced personal trauma related to a transportation accident. Further review revealed R1 specified he experienced the following over the past month: repeated and disturbing dreams of the stressful event; feeling very upset when reminded of the stressful event; having physical reactions when reminded of the event (heart pounding, sweating, trouble breathing); avoiding memories or feelings related to the stressful experience; trouble remembering important parts of the experience; blaming self or someone else; and having strong negative feelings such as fear, horror, guilt, anger, or shame.In an interview with R1 on 03/17/2026 at 12:09 PM, he stated he was at the facility for therapy because he fell and broke his leg, but his goal was to return home. When asked about his past trauma, R1 declined to discuss anything related to the event.In an interview with Licensed Practical Nurse (LPN) 3 on 03/19/2026 at 9:49 AM, she stated R1 did not share much information with staff related to his trauma. She stated she was not aware of any specific triggers related to the resident's trauma. LPN3 further stated she made herself available if R1 wanted to talk and she provided him with encouragement. LPN3 stated it was important that staff knew when residents had a history of trauma so they were able to meet their needs.In an interview with the Social Services Director (SSD) on 03/19/2026 at 10:01 AM, she stated R1 was admitted to the facility for rehab following a fall that resulted in a broken leg. The SSD stated she addressed PTSD with R1 when he was admitted and he told her he was involved in a very terrible accident, but declined any further discussion related to specific triggers or the accident itself. When asked how needs were met when triggers were not readily identified, the SSD stated she monitored behavior changes such as increased isolation, depression, or aggression. The SSD stated it was important staff were aware of R1's PTSD diagnosis and any known triggers so he received resident-centered care and was not re-traumatized.In an interview with the Director of Nursing (DON) on 03/19/2026 at 12:42 PM, she stated it was her (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation residents with PTSD received trauma-informed care. She stated residents with past trauma received a PTSD assessment at admission to help determine possible triggers. She further stated, in situations where triggers were not easily identified, she expected that staff anticipated a resident's needs, when possible, looked for changes in behavior, and provided support and encouragement.In an interview with the Executive Director (ED) on 03/19/2026 at 1:08 PM, he stated it was his expectation that any resident with trauma or a diagnosis of PTSD felt safe, secure, and comfortable in the facility. He stated every resident with a known history or diagnosis of PTSD received a trauma assessment, and if specific triggers were not identified at that time, he expected that all staff monitored the resident for changes or new behaviors.