STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185164	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barbourville Health and Rehabilitation Center	65 Minton Hickory Farm Road Barbourville, KY 40906

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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 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 facility policy review, the facility failed to ensure food items were discarded when required, milk received from a vendor had a legible expiration date, food items in the walk-in freezer and dry storage room were stored appropriately, and the room temperature of the dry storage room did not exceed 70 degrees Fahrenheit (F). These deficient practices had the potential to affect all 114 residents who received food from the kitchen. Findings included: An undated facility policy titled, Food Storage, indicated, 2. Dry storage rooms must be well ventilated and illuminated, with adequate temperature and humidity controls to prevent condensation of moisture and growth of mold. The storeroom temperature should be 50 [degrees] to 70 [degrees] F. The policy specified, b. Food should be dated as it is placed on the shelves if required by state regulation. c. Date marking should be visible on all high-risk food to indicate the date ready-to-eat or TCS [time/temperature control food] food should be consumed, sold or discarded. Per the policy, All foods should be covered, labeled, and dated and routinely monitored to assure that foods will be consumed by their safe use by dates, or frozen, or discarded. During a concurrent interview and observation of the walk-in refrigerator with the Dietary Manager (DM) on 08/25/2025 at 9:47 AM, the surveyor noted there were three 16-ounce containers of fresh strawberries with hair-like white and green fuzzy growth that the DM described as mold. There were 57 8-ounce cartons of milk stored in crates without a date of storage, use-by-date (UBD), or legible expiration date by the facility or manufacturer. The DM stated the molded strawberries should have been discarded. Per the DM, she could not read the manufacturer expiration date stamp on the cartons of milk and some cartons did not record a date of expiration. The DM stated she expected staff to monitor food in cold storage for quality and freshness. The DM stated she expected when staff received food from the vendor to make sure items received recorded a manufacturer expiration date or notify her so that she could contact the vendor to clarify the expiration date. During a concurrent interview and observation of the walk-in freezer with the DM on 08/25/2025 at 9:50 AM, the surveyor noted the following:- there were two 8-ounce packages of frozen blueberries stored in clear plastic containers with holes. The blueberries were exposed to air and there was no date of storage recorded. - a clear plastic bag that contained food identified by the DM as steak fries was stored in an opened package that was not sealed. - a clear plastic bag that contained food identified by the DM as chicken nuggets was stored in an opened package that was not sealed. - a clear plastic bag that contained food identified by the DM as onion rings was approximately half full, sealed with a rubber band, and did not record a date of storage. - a clear plastic bag with food identified by the DM as breaded chicken patties, with approximately two patties remaining, was stored without a date of storage. The DM stated the all food items in the freezer should be stored in closed containers and opened foods should include a date of storage. During an observation of the dry storage room on 08/26/2025 at 9:50 AM, the surveyor noted a thermostat was mounted on the wall that indicated a room temperature of 77 degrees F. In the dry storage room, there was one case of fresh bananas, two cases of fresh sweet potatoes, and two cases of fresh white potatoes stored each in a box on the bottom shelf. The box of white potatoes indicated the manufacturer recommendations for storage was 45 degrees F. During a telephone (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview on 08/27/2025 at 5:42 PM, the Registered Dietitian (RD) stated she provided support to the DM and completed monthly sanitation checks. The RD stated she was not aware until 08/25/2025 that milk was delivered by the vendor to the facility that did not have a manufacturer date stamp. The RD stated if staff received milk without a manufacturer date stamp, she expected them to notify the DM, and would expect the DM to contact the vendor for clarification of the expiration dates. The RD stated the DM should obtain clarification of the expiration dates before the milk was served to residents. The RD stated she expected staff to monitor cold/frozen storage for expired items and remove any items that were expired. The RD stated anytime staff returned food to cold, frozen, or dry storage, she expected them to label each item with the date the item was placed in storage and with the UBD. The RD stated she expected staff to monitor food storage for any expired items not labeled, dated, or not stored in a closed container. The RD stated the dry storage room temperature should be around 60-70 degrees F. During an interview on 08/28/2025 at 9:20 AM, the Administrator stated she expected staff to check the recommendation and store food items based on how the product should be stored and follow the policy on how items should be stored. During an interview on 08/28/2025 at 10:19 AM, the Director of Nursing (DON) stated her expectation that food received from the vendor should be received with an accurate expiration date and received in good quality. The DON stated staff should follow facility policies related to food storage and safety. The DON stated staff should return food items to storage according to the facility policy on how foods should be stored and include a UBD or best-by date.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview, and facility policy review, the facility failed to honor a resident's right to have a personal fan in their room for 1 (Resident 3) of 2 sampled residents reviewed for personal property.Findings included: A facility policy titled, Resident Rights, revised 12/2022, recorded, Purpose: To protect and promote the rights of each resident. The policy specified the resident had the right to u. To be able to retain and use personal possessions as space permits. An admission Record revealed the facility admitted Resident #3 on 06/17/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease and anxiety disorder. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/24/2025, indicated Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. During a concurrent observation and interview on 08/25/2025 at 11:11 AM, Resident #3 stated Registered Nurse (RN) #7 took their personal black fan on 08/25/2025 that they had in their room since admission to the facility. Resident #3 stated they were not asked if the fan could be removed, but rather RN #7 just took it. Resident #3 stated it upset them that their fan was taken and they wanted it back. The surveyor noted there was not a personal fan in the resident's room. During an interview on 08/25/2025 at 11:17 AM, RN #7 stated she removed a personal fan from the room of Resident #3 on 08/25/2025 as directed by her supervisor, Clinical Coordinator (CC) #4. RN #7 stated she thought residents could not have personal fans in their rooms that were plugged into the wall outlet, so she took the fan out of the resident's room and told the resident they could not have the fan. During an interview on 08/25/2025 at 11:41 AM, CC #4 stated she directed RN #7 to remove the personal fan from Resident #3's room on 08/25/2025. CC #4 stated it was her fault as she thought personal fans had to be battery operated. CC #4 stated when she heard a surveyor questioned the resident why their personal fan was removed, CC #4 stated she found out that Resident #3 could have a personal fan plugged into the wall, so she told staff to give the fan back to the resident. During an interview on 08/28/2025 at 9:43 AM, the Administrator stated personal fans were allowed if the fan was plugged into the wall outlet and should be inspected by the Maintenance Director before use to make sure the fan did not pose a safety concern to that resident or another resident. The Administrator stated she could not explain why the fan was removed from the resident's room on 08/25/2025, but the fan should not have been removed. During an interview on 08/28/2025 at 10:35 AM, the Director of Nursing (DON) stated she was aware of an issue with a personal fan for Resident #3 and that as a team the facility thought personal fans had to be battery operated, but then determined fans were allowed if the fan was plugged directly into the wall outlet. The DON stated the personal fan for Resident #3 should not have been removed from the resident's room.

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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 observation, interview, record review, and facility policy review, the facility failed to provide nail care for 1 (Resident #122) of 4 sampled residents reviewed for activities of daily living (ADL) care.Findings included: An undated facility policy titled Protocol for Nail Care, indicated, Nail care for all residents that do not have a diagnosis of Diabetes will have nail care provided weekly per Nurse Aide staff as needed and will document on the NA [nurse aide] flow sheets. An admission Record indicated the facility admitted Resident #122 on 08/22/2025. According to the admission Record, the resident had a medical history that diagnoses of B-cell lymphoma, restless leg syndrome, hyperlipidemia, and osteoarthritis. Resident #122's Brief Interview for Mental Status [BIMS] revealed the resident had a BIMS score of 5, which indicated the resident had severe cognitive impairment. Resident #122's 48 Hour Baseline Care Plan indicated the resident required assistance of two staff for hygiene, bathing, dressing, and grooming. During an observation on 08/25/2025 at 10:35 AM, Resident #122 was noted with long nails that were dirty and jagged in places. During an observation on 08/26/2025 at 2:00 PM, Resident #122 was noted with long, jagged nails with visible blackish, brownish materials beneath them. During a concurrent observation and interview on 08/27/2025 at 9:05 AM, State Registered Nurse Aide (SRNA) #5 stated staff trimmed residents' nails every Sunday and whenever staff noticed a resident's nails were long. SRNA #5 stated she had not worked with Resident #122 yet on 08/27/2025 and she did she see the resident the last time she worked. SRNA #5 observed Resident #122's nails and confirmed the resident's nails were long, jagged, and dirty. During an interview on 08/27/2025 at 9:45 AM, Clinical Coordinator (CC) #4 confirmed that Resident #122's nails were long and dirty, and they were going to be trimmed. She stated staff should trim a resident's nails on their shower and skin audit days, unless the resident refused. During an interview on 08/28/2025 at 10:31 AM, the Administrator stated nail care should be performed on a resident's shower days and if SRNAs noted a resident had long nails, they should offer that care. She did not know why that was missed for Resident #122. During an interview on 08/28/2025 at 11:20 AM, the Director of Nursing (DON) stated SRNAs should perform nail care if they noticed a resident's nails being long, unless the resident preferred long nails. The DON stated she was not sure why the SRNAs did not provide that care for Resident #122.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's bi-level positive airway pressure (BiPAP) mask was stored when not in use for 1 (Resident #15) of 2 sampled residents reviewed for respiratory care.Findings included: An undated facility policy titled Protocol for CPAP [continuous positive airway pressure/BiPAP Machines, did not specify how respiratory equipment should be stored when not in use. An admission Record revealed the facility admitted Resident #15 on 06/10/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD) and chronic respiratory failure with hypoxia. Resident #15's Care Plan Report included a focus area initiated 07/05/2025, that indicated the resident was at risk for alteration in respiratory status due to COPD with chronic supplemental oxygen use and had a BiPAP machine that was ordered for nighttime use. Resident #15's physician orders included an order dated 08/08/2025, for the resident to wear the BiPAP as needed during the daytime and all the time during the night. During a concurrent observation and interview on 08/25/2025 at 10:40 AM, Resident #15's BiPAP mask was noted on the resident's bedside table, next to the BiPAP machine, and the mask was opened to air and was not stored in a bag. Resident #15 stated their BiPAP mask was never stored in a bag when not in use. During an observation on 08/26/2025 at 3:12 PM and 08/27/2025 at 4:40 PM, Resident #15's BiPAP mask was noted on the resident's bedside table, next to the BiPAP machine, and the mask was opened to air and not stored in a bag. During an interview on 08/27/2025 at 4:40 PM, Licensed Practical Nurse #2 stated a resident's BiPAP mask should be stored in a bag when not in use. During an interview on 08/28/2025 at 11:38 AM, the Director of Nursing (DON) stated staff needed to make sure that after a BiPAP mask was used it was placed in a bag so the mask would not be exposed to the environment. The DON stated it was her expectation that masks would be placed in a bag when not in use. During an interview on 08/28/2025 at 11:55 AM, the Administrator stated her expectation was that BiPAP masks be stored when not in use to prevent an infection control issue.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and facility policy review, the facility failed to ensure the medication rate was 5 percent (%) or less. The facility had 2 medication errors out of 29 opportunities, which yielded a medication error rate of 6.90 % for 2 (Resident #10 and Resident #45) of 7 residents observed for medication administration. Findings included: A facility policy titled, Administering Medications Policy, dated 03/2024, revealed, Medications are to be administered by licensed medical or nursing personnel as prescribed. Medications shall be administered accurately and timely. 1. An admission Record revealed the facility admitted Resident #10 on 02/04/2016. According to the admission Record, the resident had a medical history that included a diagnosis of atherosclerotic heart disease. Resident #10's Order Summary Report, that contained active orders as of 08/25/2025, revealed an order dated 06/30/2023, for potassium chloride extended release (ER) oral tablet 10 milliequivalents, give one tablet by mouth twice a day for supplement. The Full Prescribing Information for potassium chloride ER revised 04/2018, indicated Swallow tablets whole without crushing, chewing or sucking. During medication administration observation on 08/26/2025 at 7:08 AM, Registered Nurse (RN) #1 crushed the potassium chloride ER oral tablet and administered the medication to Resident #10. During an interview on 08/26/2025 at 2:13 PM, RN #1 stated the potassium chloride ER tablet was crushed because the physician's order did not include instructions not to crush the medication. During an interview on 08/26/2025 at 3:02 PM, the Infection Preventionist/Staffing Coordinator (IP/SC) stated potassium chloride ER tablet was usually not crushed, and the medication administration record (MAR) should indicate when medications should not be crushed. The IP/SC confirmed the MAR for Resident #10 did not indicate the medication should not be crushed. During an interview on 08/27/2025 at 2:07 PM, the Director of Nursing stated she was aware potassium chloride was crushed and it should not have been crushed. During an interview on 08/28/2025 at 10:29 AM, the Administrator stated medications were expected to be administered accurately. 2. An admission Record revealed the facility admitted Resident #45 on 02/02/2016. According to the admission Record, the resident had a medical history that included a diagnosis of hyperlipidemia (high cholesterol). Resident #45's Order Summary Report that contained active orders as of 08/25/2025, revealed an order dated d 02/12/2024, for fenofibrate oral tablet 160 milligrams, give one tablet by mouth in the morning for dyslipidemia (abnormally elevated cholesterol or fats in the blood). The Full Prescribing Information for fenofibrate revised 06/2025, indicated Do not crush, break, dissolve, or chew tablets. During medication administration observation on 08/26/2025 at 7:19 AM, Registered Nurse (RN) #1 crushed fenofibrate and administered the medication to Resident #45. During an interview on 08/26/2025 at 2:13 PM, RN #1 stated the fenofibrate tablet was crushed because the physician's order did not include instructions not to crush the medication. During an interview on 08/27/2025 at 2:07 PM, the Director of Nursing stated she was aware medications were crushed for Resident #45 that should not have been crushed. During an interview on 08/28/2025 at 10:29 AM, the Administrator stated medications were expected to be administered accurately.