STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Crossing, LLC	1101 Lyndon Lane Louisville, KY 40222

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, the facility failed to ensure a comfortable, sanitary environment free from odors. The Men's Unit of the facility had ongoing, unpleasant odors of stale urine on all four days of the survey. In additions, feces and/or blood was observed to be smeared on different surfaces on one of the four days of the survey. The failure to maintain a comfortable, sanitary environment which was free from odors, had the potential to affect any of the 23 residents living on this locked unit, as well as staff and the public/visitors in the area.The findings include:Review of the facility policy titled, Safe and Homelike Environment, reviewed/revised 02/16/2024, revealed The facility will provide a safe, clean, comfortable and homelike environment. Per the policy, Environment refers to any environment in the facility that is frequented by residents including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas .and activity areas. The policy noted that orderly is defined as an uncluttered physical environment that is neat and well-kept. 'Sanitary' includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean .Resident care equipment includes, but is not limited to equipment used in the completion of the activity of daily living. The policy also noted that Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment .Minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to Housekeeping Department.1. Observations including, but not limited to, on 01/06/2026 at 9:35 AM, 01/07/2026 at 9:43 AM, 01/08/2026 at 9:04 AM, 9:25 AM, 11:30 AM, 4:30 PM, and 01/09/2026 at 7:00 AM, 7:45 AM, 9:00 AM. 9:05 AM, 9:09 AM, 9:13 AM, 9:28 AM, 10:25 AM, 11:44 AM, 12:25 PM, 1:45 PM, 3:29 PM, 3:38 PM, 3:55 PM, and 4:40 PM revealed a strong odor, indicative of stale urine, was present and pervasive on the Men's locked dementia unit. The odor was present and immediately noticeable when entering through the locked doors that led into the unit. In each observation, the odor was strongest in and around the common day room area where residents were sitting on chairs and/or a couch. The odor lessened in intensity, but was still present, as one left the common area and moved down the adjacent halls. Routine housekeeping services and/or resident toileting/incontinence care was noted throughout the day on 01/09/2026. Although fresh odors were noted to lessen after these services, the underlying odor indicative of stale urine remained present and was noted during each observation.Interview on 01/09/2026 at 9:00 AM with Housekeeper 1 revealed she was aware of the odor on the unit and identified it as urine. Housekeeper 1, who spoke limited English, showed the products on her cleaning cart and indicated that she used Bioenzymatic Odor Eliminator spray and disinfectant when cleaning.Interview on 01/09/2026 at 9:05 AM with the Housekeeping Manager confirmed the strong odor of urine was present, adding, It's all day long over here .We all smell it. She offered several possible reasons for the ongoing odor, noting that there were multiple male residents on the dementia unit who were incontinent, and/or had behaviors, including refusals of showers. The Housekeeping Manager also stated that the furniture could be contributing to the odors and added that staff used the Bioenzymatic product once a week to kill bacteria on the chairs used by the residents in the common (continued on next page)

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

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	area. Further interview with the Housekeeping Manager revealed that although she did not know the root cause, she also thought the ventilation system could be contributing to the problem. The Housekeeping Manager stated the Administrator was aware of the odors and would tell her when there were complaints, and they needed to clean.During interview with the Director of Nursing (DON) on 01/09/2026 at 11:48 AM, she stated that the odors were occurring after care and housekeeping staff was constantly on it. She acknowledged that there were men on the dementia unit who refused to bathe, as well as men on the unit who urinated in inappropriate locations, such as on the floor. The DON was unaware that, per the Housekeeping Manager's statement, the chairs on the unit were only being sprayed once per week. She stated that the chairs should be sprayed/disinfected each time immediately after a chair was contaminated due to urine.Interview on 01/09/2026 at 12:25 PM with Social Services (SS) 1, whose office was on the locked unit, revealed he was aware of issues with the urine odor. He stated there were multiple residents on the unit who were frequent wetters. He stated that he had identified that part of the issue was that the material on some of the chairs in the day room was fabric and could not be easily cleaned/disinfected. SS1 added that he himself, routinely cleaned soiled chairs with the Bioenzymatic spray, and had thrown aware at least three fabric chairs that were too urine-soaked to be cleaned/disinfected. He noted that he had discussed the issue with the Administrator, who was talking with corporate staff about replacing them with chairs covered in a vinyl-type (rather than cloth) material which could be cleaned/disinfected. However, the replacement of all chairs had not yet occurred. Observation of the common day room on 01/09/2025 at 1:45 PM confirmed SS1's statement that not all seating in the area had a surface material that could be readily cleaned/disinfected, with a resident sitting in a cloth-covered chair.A second interview with the Housekeeping Manager on 01/09/2026 at 12:35PM revealed she wished to clarify her initial statement. She explained that in addition to the weekly use of the Bioenzymatic product, staff will also clean a chair when it is soiled. However, she continued, this did not always happen as some of the residents stayed in the chairs all day long, so they could not immediately be cleaned/disinfected at the time it was needed. An additional interview with the Housekeeping Manager on 01/09/2026 at 4:40 PM confirmed SS1's statement that the cloth-covered chairs could not be thoroughly cleaned/disinfected, pointing out a cloth recliner in the day room.During an interview with the Minimum Data Set (MDS) Coordinator on 01/09/2026 at 2:30 PM, she described the bathroom on the locked unit as having a foul odor. The MDS Coordinator noted a lot of residents on the unit refused care or showers. She added that housekeeping staff only works during the day, and the aides are responsible for clean-up at night. Observation on 01/09/2026 at 3:30 PM revealed the MDS Coordinator's office was in the portion of the facility where the Men's locked unit was located and access to her office was past the bathroom which was located off of the common day area. During interview with the Administrator on 01/09/2026 at 4:50 PM, he stated, There are occasions when there are odors, but it is not pervasive. He added that if there were odors in the facility, they were on the Men's dementia unit, adding that there were residents on this unit who urinated and defecated in inappropriate places, such as the floor or flowerpots. He confirmed that there were no housekeeping staff working in the evening, adding that if cleaning was needed at that time, the aides working on the unit were responsible and had access to housekeeping supplies. The Administrator initially stated that no one on staff had talked to him about any ideas to reduce/relieve odors. However, when asked about SS1's statement that he had spoken to him, the Administrator confirmed that SS1 had told him about the problem related to cleaning/disinfecting cloth-covered chairs. He stated that a request for replacing the chairs was in the quarterly budget; however, corporate approval had not yet been granted. Further interview with the Administrator revealed that he thought that all cloth chairs were removed from the unit and was unaware that this had not yet occurred.2. a. In addition to the urine odor, observation also revealed a strong odor of feces was present on the Men's locked dementia unit on 01/09/2026 at 7:45 AM, 9:00 AM, 9:05 AM, and 9:09 AM. Observation at 9:09 AM revealed that the odor of feces was strongest around Shower room [ROOM NUMBER]. Observation of Shower room (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[ROOM NUMBER] at this time with the Housekeeping Manager revealed that there was feces smeared down the left outer side of the toilet bowl. Soiled resident clothing was also noted on the floor at this time. The Housekeeping Manager revealed she was unaware of the condition of the room prior to surveyor intervention, adding That's what's causing the smell in here. It needs to be cleaned up. Additional observation of Shower room [ROOM NUMBER] on 01/09/2026 at 9:28 AM revealed that staff had just finished helping a resident with toileting. Although the soiled clothing was gone from the floor, observation revealed the outside of the toilet remained smeared with feces. In addition, blood was noted on the lip of the sink in the room. b. Observation on 01/09/2026 at 9:13 AM, prior to entering Shower room [ROOM NUMBER], (which was on a different wing of the locked unit), also revealed a strong odor of feces. Upon entry to this room with the Housekeeping Manager, observation revealed multiple streaks of feces on the floor in front of the toilet, the sink, and on the floor of the shower area. At this point, the Housekeeping Manager noted that she was also unaware of the condition of the shower room prior to surveyor intervention, adding, This one needs to be cleaned, too. Further interview with the Housekeeping Supervisor revealed that there was no set schedule as to when the Shower rooms (which were also used for toileting residents) were to be cleaned, as housekeeping staff were also responsible for cleaning administrative offices and resident rooms.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one (Resident (R) 3) of 26 sampled residents had an admission Minimum Data Set (MDS) assessment completed within 14 days of admission. R3 was admitted on [DATE], and the MDS V200B date, signifying completion of the assessment, was not completed until 11/05/2025.The findings include:Review of R3's Census tab in the electronic medical record (EMR) revealed the resident was admitted on [DATE]. The review of the admission MDS, with an Assessment Reference Date (ARD) of 10/21/2025, revealed that V200B date, signifying completion of the Care Area Assessment (CAA) Process, was not signed by the MDS Coordinator until 11/05/2025, the 22nd day of admission.Interview with the MDS Coordinator on 01/09/2026 at 3:30 PM revealed that she was the Registered Nurse (RN) responsible for signing R3's admission MDS as complete. She confirmed that R3's admission MDS was due to be completed no later than 10/28/2025, the 14th day of admission to the facility. She stated that the delay in completing the resident's admission MDS occurred because she was waiting for Social Services (SS) staff to complete various portions of the assessment. Review of assessment documentation with the MDS Coordinator confirmed that data for which SS staff was responsible was not locked in the computer system until 11/03/2025, and she, herself, did not sign V200B, signifying completion of the CAA process portion of the MDS until 11/05/2025. Further interview with the MDS Coordinator revealed that sometimes SS falls behind and there had been other assessments which were late, due to untimely completion of the sections assigned to SS staff. Interview with SS1 on 01/09/2026 at 3:55PM revealed that SS2, who was not present, was the SS staff responsible for R3's admission MDS. He reviewed the EMR and stated that SS2's portion of the MDS assessment was opened on 10/27/2025 and signed on 11/03/2025. SS1 explained that the total MDS could not be completed and locked until all portions were done, confirming that the MDS Coordinator did not sign the MDS as complete until 11/06/2025, three days after SS2 completed his portion. Further interview with SS1 revealed that it was possible that SS2 had actually completed the assessment on time but then failed to lock the work timely so that the information in the assigned sections could populate and MDS Coordinator could sign the total MDS document as complete. SS1 stated he was aware of times when this occurred, adding, I have had to go on and lock behind him.Interview with the Director of Nursing (DON), on 01/09/2026 at 4:09 PM, revealed that she was unaware of any issues with late MDS assessments or issues with SS staff not completing and/or locking their portions of the assessment process in a timely manner. Additional interview with the DON on 01/09/2025 at 5:21 PM revealed that the facility did not have a specific policy regarding time frames for MDS assessments, and instead, followed the requirements of the Resident Assessment Instrument (RAI) manual. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 October 2025, revealed that for admission assessments, the CAA(s) Completion Date (Item V0200B2) must be no later than review of the 14th calendar day of the resident's admission (admission date + 13 calendar days).Interview with the Administrator on 01/09/2026 at 4:50 PM revealed that his expectation was that MDS assessments were submitted timely for a multitude of reasons and he was unaware of any late assessments prior to surveyor intervention.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, record, review, and review of facility policy, the facility failed to ensure that one (Resident (R) 38) of 26 sampled residents had a thorough, complete medical record which reflected the care that was provided. R38 had no documentation of medication administration or multiple contacts with the physician in accordance with physician orders.The findings include:Review of the facility policy, titled, Timely Administration of Insulin, reviewed/revised 02/14/2024, revealed the procedures included, Document on the medication administration record the time and location of the insulin injection. Review of the facility policy, titled, Medication [sic] Administration, reviewed/revised 02/14/2024, revealed staff are to obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. Sign MAR [Medication Administration Record] after administered. For those medications requiring vital signs, record the vital signs on the MAR.Review of the facility policy, titled, Notification of Change, reviewed/revised 03/20/2025, revealed the facility must consult with the resident's physician when there are circumstances that require a need to alter treatment, including, but not limited to, exacerbation of a chronic condition. Review of these policies revealed they did not address the need for accurate, complete documentation (including documentation of physician notification, documentation of orders given, and documentation of medication administration in response) when physician notification was required due to vital signs outside established parametersReview of R38's Census tab in the electronic medical record (EMR) revealed the facility admitted the resident on 12/22/2025. Per the Medical Diagnosis tab, R38's diagnoses included diabetes mellitus Type 2. Review of R38's care plan, initiated 12/23/2025, revealed the Resident has Diabetes Mellitus. Per the care plan, interventions to minimize the risk of complications for diabetes included, Administer medications as ordered, and Obtain blood sugars as ordered, notify MD [physician] of abnormal results as indicated.Review of the resident's physician orders, dated 12/23/2025, revealed they included insulin Lispro, 16 units (U) three times a day, insulin Glargine 30U once per day, and dapagliflozin 10 milligrams each day. In addition, physician orders included sliding scale insulin twice a day, based on blood sugar (BS) readings. Review of the sliding scale order revealed that the order only went as high as 351- 400, which would require 20U of insulin. Per the order, staff were to contact the physician for blood sugar readings over 400, with no specific sliding scale dose established.Review of R38's 12/2025 Medication Administration Record (MAR) revealed that on five instances in 12/2025, R38's blood sugar reading was greater than 400.a. 12/26/2025 Bedtime (HS) - BS = 525. Review of the MAR revealed the nurse coded 9, which per the legend, meant Other/See Nurse Notes. Review of Nurse's Notes for 12/26/2025 at 10:17 PM revealed R38's ACC [Accu-Chek used to measure blood sugar] was 525. NP [Nurse Practitioner Name] was notified ordered that 20 Unit is [sic] be administered. Further review of the note revealed that although the nurse documented the NP gave an order, there was no evidence that the insulin was actually given.b. 12/27/2025 HS - BS = 537. Per the MAR, the nurse again coded 9, indicating the need to refer to Nurse Notes. Review of the Nurse Notes for 12/27/2025 at 8:11 PM revealed Resident ACC was 537. NP ordered prescribed dose. However, review of the note, as well physician orders revealed that there was no dose prescribed for BS of greater than 400; only the order to call the doctor if the BS were higher than 400. There was no evidence as to the amount that the NP ordered at this time, or what amount (if any), the nurse administered.c. 12/28/2025 Morning - BS = 410. Per the MAR, the nurse coded 13, which, per the legend meant No insulin required. Review of R38's progress notes for the day revealed no evidence that the nurse followed the order and contacted the physician when the resident's blood sugar was over 400.d. 12/29/2025 Morning- BS 401. Per the MAR, the nurse again coded 13, indicating No insulin required. Review of R38's progress notes for the day revealed no documentation that the nurse informed the physician the resident's blood sugar was over 400.e. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/29/2025 HS - BS = 465. Per the MAR, the nurse coded 9, which per the legend, meant Other/See Nurse Notes. An Administration Note, on 12/29/2025 at 11:31 PM repeated the sliding scale order which had been in place since 12/23/2025. However, there was no evidence that the nurse followed the order and contacted the physician when the resident's blood sugar was over 400.During an interview with a family member of R38 (FM38) on 01/08/2026 at 1:54 PM, he expressed concerns about the resident having elevated blood sugars and delays in insulin administration.Interview on 01/09/2026 at 10:30 AM with the Registered Nurse (RN) East Unit Manager (UM) revealed that neither of the two nurses who were responsible for these five instances were working. The RN East UM reviewed R38's MAR and notes and confirmed the above record review, including that there was no documentation that the dose ordered on 12/26/2025 was, in fact, given. In response to the 12/27/2025 HS reading, she stated, I can't see what was given. The RN East UM stated that there was no order for set sliding scale order for blood sugars over 400, and she could not tell, by reviewing the documentation what order the NP gave or what the nurse, in fact, administered. Further interview with the RN East UM revealed that there was no evidence that the physician/NP was notified of the 12/28/2025 and 12/29/2025 readings greater than 400.During an interview with the Director of Nursing (DON) on 01/09/2026 at 11:48 AM, she reviewed the MAR and notes. The DON stated that at that time she could not confirm what happened, based on the documentation and would do further investigation.A second interview was conducted with the DON on 01/09/2026 at 3:40 PM. The DON stated that, after investigation, it appears it's a documentation error, indicating that the nurses needed training. She stated that she had contacted both nurses, and believed that the care was provided as ordered, but the record did not include documentation of their actions. She stated that for the 12/26/2025 instance, the nurse stated she had given the 20U of insulin; however, she failed to document its administration. The DON continued that the nurse told her than the note on 12/27/2025 that the NP ordered prescribed dose meant that the NP ordered the same 20 U that she had also ordered the previous day. However, the DON confirmed, there was no documentation to verify this. She stated that although there was no documentation for the other three instances, she also contacted the NP, who told her she was notified about each of the elevated BS readings. The DON noted that Clearly, education re documentation is needed.Interview with the NP by telephone on 01/09/2026 at 4:12 PM revealed that she was aware that R38 had elevated BS readings during the last week of 12/2025. She stated that she could not remember being contacted every time it occurred, but knew she had talked to staff and, in response to the elevated BS, had tapered R28's prednisone (a potent synthetic corticosteroid medication which increases blood sugar.)Interview with the Administrator on 01/09/2026 at 4:50 PM revealed that, as an attorney, Documentation is key to me. He stated that both his and the DON's expectation regarding documentation was that it be accurate and complete.