STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185173	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Nursing and Rehabilitation Center	200 Norfleet Drive Somerset, KY 42501

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure that one resident (Resident (R) 6), who was unable to carry out activities of daily living (ADLs), out of a total sample of 21 sampled residents, received the necessary services to maintain good grooming and personal hygiene. R6 failed to receive nail care as needed, and was noted with long, dirty nails on multiple occasions. The findings include: Review of the facility policy Activities of Daily Living Tasks, dated 01/012001, revealed, Any resident that has a deficit that keeps them from doing any kind of ADL's will be helped with whatever need they have. Per the policy, Nails should be observed daily and cut when appropriate. Review of the electronic medical record revealed R6 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and cerebrovascular accident (CVA) with left-sided weakness. Review of R6's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/06/2025, revealed a Brief Interview for Mental Status (BIMS) score of 6/15, indicating R6 was severely cognitively impaired. Review of R6's comprehensive care plan, last revised 02/03/2025, revealed the resident will have fingernails and toenails trimmed by staff to maintain adequate personal grooming health. Observation on 04/22/2025 at 9:14AM revealed R6 was sitting in her wheelchair. The resident's nails were observed to be approximately ½ inch long with an unidentified black substance (which appeared to be grime/dirt) underneath eight out of 10 nails. On 04/22/2025 at 12:18PM, R6 was observed in the dining room, eating her lunch. R6 was eating spaghetti and garlic bread, and she was seen licking her fingernails. The resident still had a black substance present underneath eight of the 10 nails. Interview with R6's family member (FM6), on 04/22/2025 at 4:18 PM, revealed she was not happy with how her mother's nails currently looked, adding that normally the facility was good about keeping her nails trimmed and 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 with State Registered Nurse Aid (SRNA) 1 on 04/23/2025 at 9:13AM, she stated that residents' nails were examined daily and cleaned if needed. SRNA1 stated that nail care was done at the same time that residents received showers. SRNA1 added that long nails could lead to dirt or grime getting under the nail and the resident could potentially put that in their mouth, which could cause them to become sick. During this interview, SRNA1 stated she gave R6 nail care on 04/22/2025 (the prior day), before she left her shift. However, observation on 04/23/2025 at 8:42AM, revealed R6, who was in her wheelchair on the C hallway, continued to have a black unidentified substance underneath eight out of 10 nails. The resident's nails were still ½ inch long and in need of care. Review of shower sheets (where staff documented when the resident was bathed/showered) revealed that the sheets also included a place for staff to document nail care. Review of shower sheets revealed that the last nail care documented for R6 (prior to the initial observation on 04/22/2025) was 03/28/2025. In an interview with Registered Nurse (RN)1 on 04/23/2025 at 9:41AM, she stated that it was up to the SRNA's and nurses to check residents' nails daily and give them care if needed. RN1 stated that the SRNA's look at the residents when they are in the shower, and then tell the nurse if they provided nail care or they need the nurse to provide nail care to the resident. RN1 noted that it was up to the nurse to check to make sure this is getting done though. She stated it was important to cut the residents' nails because long nails can hold dirt and bacteria and could be harmful to residents. In an interview with the Director of Nursing (DON) on 04/23/2025 at 12:20PM, she stated I expect my nurses and my aides to check on residents daily and to provide them the appropriate care needed for their ADL's. She further stated, I guess I need to be more proactive and get out on the floor more. Interview with the Administrator on 04/23/2025 at 1:44 PM revealed that she expects all residents' nails to be properly trimmed and clean at all times. The Administrator stated, I expect my nurses and aides to keep all of our residents' nails clean and trimmed. We have some residents that like to put their fingers in their mouth, and this is especially important for them to not get sick. Long dirty nails are sources of bacteria. We want our residents to be as clean as possible at all times.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and facility policy review, it was determined the facility failed to provide housekeeping services to ensure a clean and sanitary environment for four (Resident (R) 6, R7, R64, and R37) of 21 sampled residents. Each of these resident rooms, as well as all four of four shower rooms used by residents, were noted to need cleaning, with a black, fuzzy-appearing substance (which had a strong odor), growing around sinks, in bathrooms, on tiles, and high moisture areas. The findings include: Review of the undated facility policy titled, Resident Rights, revealed the resident had a right to a safe, clean, comfortable and homelike environment. A policy for housekeeping titled Housekeeping Daily Duties, dated 12/2001, revealed a schedule of what housekeeping would do on each day of the week. The policy states All corners and along all baseboards must be dust mopped to prevent buildup. When water pushes dust into corners, problems occur. 1. Observation during a tour of the A, B, C, and D-Hall shower rooms on 04/23/2025 revealed that all four shower rooms had a black substance with a fuzzy-like texture, that was observed on the ceramic tile in the shower. The substance, which smelled very earthy and was potentially indicative of mold, was all over high moisture areas in the showers and bathrooms. The observations in these areas included: a. At 9:08AM, observation of the C-hall shower room revealed the black substance on the ceramic tile in the shower. In addition, a cracked piece of ceiling tile was observed to be laying over the tub with remnants/particles of tile all over the shelving, in the tub, and on the floor of the room. b. At 9:28AM, observation of the D-hall shower room revealed the black substance on the ceramic tile in the shower, as well as on the bottom of the lid of the shower chair. c. At 9:42AM, observation of the A-hall shower room revealed the black substance was on the sink of the faucet and on the ceramic tile in the shower. d. At 9:58AM, observation of the B-hall shower room revealed a bag of garbage laying in the floor of the shower. The black substance was observed in the ceramic tile in the shower. 2. On 04/22/2025 at 10:14AM, observation of R6's room revealed the black substance was growing on tiles under the sink and in the bathroom, and a strong odor was noted. Continued observation of R6's room revealed three tiles were cracked in R6's bathroom close to the base board. The overbed table was observed to have the rubber piece around the edge missing, which exposed wood that had a sharp edge on it. 3. On 04/22/2025 at 10:31AM, observation of R7's room revealed the black substance on the baseboard of the bathroom. The bathroom had a brown substance on the commode lid that appeared to be feces, which had a foul odor emitting from it. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. On 04/22/2025 at 10:54AM, observation of R64's room revealed a black substance on the baseboards. Two tiles in the resident's bathroom were cracked. 5. On 04/22/2025 at 11:08AM, observation of R37's room revealed a black substance on the baseboards of the resident's room. Interview with the resident revealed that staff come in the room every day and clean, but the black substance remains. Interview with the Maintenance Assistant on 04/23/2025 at 11:42AM, revealed that the black substance seen throughout the facility was a housekeeping issue. In an interview with the Director of Nursing (DON) on 04/23/2025 at 12:13PM, she stated that she was unaware of any black substance on the walls or baseboards of any of the resident rooms or shower rooms. The DON further stated that if there was something like that growing on the walls and baseboards, housekeeping should notify her, and they would have someone come in and look at it and find out what it is and how to treat it. During an interview with the Housekeeping Manager on 04/23/2025 at 1:12PM, she stated, Every resident room gets a deep clean once a week and on the days we don't deep clean, we spot clean. She confirmed the multiple areas where the black, foul-smelling substance was observed, saying, I was not aware of this black substance, but I see what you are talking about. We will have to use some bleach and try to clean them up. Interview with Administrator on 04/23/2025 at 1:15PM revealed that housekeeping services were contracted out and they were supposed to be making sure that all areas were clean and sanitary. Further interview with the Administrator on 04/23/2025 at 1:44PM revealed that she relied on maintenance and housekeeping to keep the floors and shower rooms clean at all times. She stated she did not have any knowledge of a black substance growing on any surface of the facility and added that having a black substance growing in high moisture environments could be mold, which could create a bad outcome for the residents of the facility.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. Based on observation, interview, record review, and policy review, the facility failed to ensure that two of four corridors were equipped with firmly secured handrails on each side of the hallway. Failure to have firmly secured handrails could affect residents' ability to safely ambulate down the hallways. The findings include: Review of an undated facility policy titled Resident Rights, revealed residents have a right to a safe environment. No specific policies related to maintenance or inspection of handrails were provided during the survey. Observation during a tour of the A and B Halls on 04/22/2025, initiated at 11:46 AM, revealed the following: 1. The handrail outside of resident room A7 was loose and shifted when light pressure was applied. 2. A corner joint was missing from the handrail outside of resident room A8 with a blunt end exposed. 3. The handrail outside of resident room A10 was missing screws that connected it to the support brackets, allowing the handrail to be easily moved when pressure was applied. 4. The handrail outside of resident room B2 did not have screws securing it to support brackets, allowing the handrail to be easily moved when light pressure was applied. 5. The handrail outside of resident room B3 was missing screws and easily moved when pressure was applied. 6. The handrail outside of resident room B4 had loose screws and was not securely connected to the support brackets. 7. The handrail outside of resident room B5 was loose and not securely fastened to the support brackets. Review of the logs from the facility's TELS system (used to report and track maintenance issues) revealed no evidence of reports or work orders related to handrails. In an interview on 04/24/2025 at 9:15 AM, the Assistant Director of Maintenance confirmed that the handrails noted above were loose. He stated that he was responsible for checking the handrails and did checks every time he walked up and down the halls. He further stated that he did not have any current work orders for the handrails and that he had just done a facility walkthrough with the Administrator, and they did not have any concerns with the handrails. The Assistant Director of Maintenance stated that having handrails that were loose and not securely connected to the support brackets could create a fall risk for residents. Further interview with the Assistant Director of Maintenance revealed that he was currently in charge of facility maintenance, as the previous Maintenance Director walked out after the survey was initiated. (continued on next page)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/24/2025 at 9:55 AM, Restorative Nurse 1 stated that she was aware of loose handrails on the A and B halls. She added that she noticed the loose rails within the last three months. Restorative Nurse 1 further stated that residents could fall and get hurt if they tried to use a handrail because it was not securely mounted to the wall, and she should have reported the loose railing, but did not. In an interview on 04/24/2025 at 10:20AM, the Housekeeping Supervisor stated that the housekeepers clean the handrails in the facility; however, they but do not inspect them to ensure they are safely mounted to the wall, as that would be up to the maintenance department. In an interview on 04/24/2025 at 1:36 PM, the Administrator stated that it was her expectation for all staff to report any maintenance related issues to her. She stated that she was not aware of any issues with the handrail but added that the facility did not have any lists or checkoff sheets to monitor their condition. The Administrator noted that with a building as old as theirs, there was always something going on, and they had just missed the rails being loose/in poor repair. The Administrator confirmed that she and the Assistant Director of Maintenance had recently done a walkthrough of the facility together; however, she continued, they had not looked at the rails during this walkthrough. The Administrator further stated that residents could be cut or have their fingers get stuck in the handrail with the missing corner piece.