STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185174	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Florence Park Care Center	6975 Burlington Pike Florence, KY 41042

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 Centers for Disease Control and Prevention (CDC) guidelines, review of the glucometer's (used to measure blood glucose values) directions for use, review of the facility's disinfection wipes' directions for use, 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 for 3 of 29 sampled residents who required blood glucose monitoring, Resident (R) 67, R70, and R41; for 1 of 31 sampled residents for indwelling catheter collection bag resting on the ground, R8; for 3 of 31 sampled residents where staff did not wear appropriate personal protective equipment (PPE) or perform required hand hygiene for residents who were required to be in Enhanced Barrier Precautions (EBP), R67, R81, and R129; and for all 130 current residents due to the facility's unsanitary laundry practices and lack of a documented water management plan to reduce the risk of Legionella in the facility's water system. The facility's failure to have an effective system in place to ensure residents had blood glucose finger sticks performed using a clean and disinfected glucometer has caused or is likely to cause serious injury, harm, impairment, or death to a resident.Immediate Jeopardy was identified on 01/13/2026 and was determined to exist on 01/13/2026 in the area of 42 CFR 483.80 Infection Control at a Scope and Severity (S/S) of an L. The facility was notified of the Immediate Jeopardy (IJ) on 01/13/2026. The findings include:Review of the facility's policy titled, Standard Precautions, reviewed 08/2025, revealed standard precautions were infection prevention measures that applied to the care of all residents, regardless of suspected or confirmed infection status in any setting where healthcare was provided. The policy further stated hand hygiene must be performed before and after resident contact, and after removing gloves.Review of the CDC's guidelines Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 04/12/2024, revealed staff should ensure the proper selection and use of personal protective equipment (PPE) based on isolation precautions and potential for exposure to respiratory secretions and infectious materials.Review of the facility's policy titled, Glucometer Cleaning, revised 11/2024, revealed glucometers must be cleaned and disinfected after each use to prevent infection transmission. Per the policy, clean the glucometer after each use with a disinfectant recommended by the manufacturer or other Environmental Protection Agency (EPA) registered disinfectant that was effective against bloodborne pathogens and allow the appropriate wait time that was indicated on the disinfectant guidelines. Per the policy, that would be performed after each use of the glucometer.Review of the [Facility Used] Blood Glucose Monitoring System User's Guide, revised 03/2024, revealed cleaning and disinfecting was accomplished according to manufacturer's guidelines with an EPA registered disinfectant or germicide that was approved for a health care setting.Review of the directions for use for Microdot Kill Germicidal Bleach Wipes, undated, revealed the product required gross soil to be removed prior to disinfection. After pre-cleaning, staff was to wipe the surface to be disinfected with the pre-saturated wipe ensuring the entire surface remained visibly wet for the required dwell (contact) time of three minutes. 1. During observation on 01/13/2026, starting at 7:51 AM, Registered Nurse (RN) 4 entered (continued on next page)

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	procedure.During an interview on 01/13/2026 at 1:00 PM, LPN6 stated the glucometer should not have been placed next to clean supplies while wrapped in a used disinfectant wipe, and gloves should have been removed with hand hygiene performed between dirty and clean tasks. When asked about the importance of cleaning glucometers properly after use and between residents, LPN6 stated he thought he had grabbed the bleach wipes.During an interview with the Infection Preventionist/Minimum Data Set (IP/MDS) Nurse on 01/14/2026 at 10:10 AM, she stated all staff members were trained in IPCP. The IP/MDS Nurse stated the facility followed CDC guidelines to prevent the spread of infection. She further stated the facility had a specific policy addressing shared equipment, and clinical staff members were trained to clean multiuse or shared equipment, including vital sign equipment and glucometers after each use. The IP/MDS Nurse stated glucometers were to be cleaned with Microdot Kill Germicidal Bleach Wipes, which were the facility's designated disinfectant wipes per the manufacturer's instructions. She stated the wipes should be kept on each medication and treatment cart. During an interview with the Director of Nursing (DON), on 01/13/2026 at 4:05 PM, she stated there were inconsistencies in the availability of Microdot Kill Germicidal Bleach Wipes on the medication and treatment carts. She further stated all carts should contain the Microdot Kill Germicidal Bleach Wipes for cleaning and disinfecting shared glucometers. Further, she stated the glucometers should be correctly disinfected after each use for infection control.Review of the facility's policy titled, Enhanced Barrier Precautions [EBP], reviewed 04/01/2024, revealed enhanced barrier precautions (EBP) were infection control interventions used with standard precautions to reduce transmission of multidrug-resistant organisms (MDRO). Per the policy, EBP signage should be posted on the resident's door and should ensure gowns and gloves were readily available. The policy also required staff to perform hand hygiene after providing care to a resident. EBP applied to residents with indwelling medical devices (e.g., central lines, peripherally inserted central catheter (PICC), urinary/suprapubic catheters, hemodialysis catheters) and needed to be implemented for high contact activities.3. Review of R67's admission Record revealed the facility admitted the resident on 01/23/2025 with diagnoses to include type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF).Review of R67's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/11/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating the resident was cognitively intact.Review of R67's Comprehensive Care Plan [CCP], dated 12/29/2025, revealed a focus dated 12/05/2025 to use EBP due to active or colonized infection and/or wounds and/or indwelling medical device with potential for cross-contamination, which would be contained with the use of EBP. Interventions dated 12/08/2025, revealed instructions to use gown and gloves when providing high-contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care/use/maintenance, and wound care requiring dressings.Review of R67's Order Summary Report, dated 01/2026, revealed on 05/28/2025 the physician ordered Humalog injections (insulin to reduce blood glucose levels) per sliding scale (the amount given depended on the blood glucose result). Further review revealed orders dated 12/05/2025, for the resident to be placed in Enhanced Barrier Precautions related to peripherally inserted central catheter (PICC). Further review revealed an order, dated 01/13/2026, to change PICC line transparent dressing and needleless connector.Observation on 01/13/2026 at 8:53 AM, revealed RN7 entered R67's room designated as EBP, without donning (putting on) gown and gloves. RN7 provided direct patient care by changing a peripherally inserted central catheter (PICC) dressing. Further observation revealed RN7 did not wear a mask while changing the dressing, even though the dressing change kit contained exam gloves and a mask. The SSA Surveyor observed there was signage above the resident's bed which stated, Enhanced Barrier Precautions.During an interview on 01/14/2026 at 9:47 AM, with R67, she stated she returned to the facility with the PICC from the hospital on [DATE] to have intravenous (IV) antibiotics administered.During an interview on 01/13/2026 at 9:21 AM, with RN7, she stated she did not know (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	(RDM), on 01/15/2026 at 9:37 AM, he stated the To Do list, found in the Maintenance binder, which outlined Maintenance tasks such as flushing, routine ice machine filter maintenance, and checking and flushing the facility's eye wash stations, served as the facility's WMP. The RDM stated the facility did not have a Legionella policy. Furthermore, he stated he was not aware of a designated WMT. The RDM further stated he was not familiar with the CDC's Legionella toolkit. He stated if there was a case of Legionella, he would follow the local health department guidelines.During interview with the DON, on 01/15/2026 at 4:10 PM, she stated the WMP was the responsibility of the Administrator and the Maintenance Director, and she did not manage the water program. She stated she was not aware of a Legionella policy or if the facility had completed a Legionella risk assessment. The DON stated she would ask the Administrator for details to avoid providing inaccurate information. Additionally, the DON stated it was her expectation for staff to follow the facility's infection prevention and control program (IPCP), which included current standards, policies, and procedures based on CDC recommendations. She stated this was important to prevent the spread of disease and to ensure a safe and comfortable environment for residents, staff, and visitors.During an interview with the Administrator, on 01/15/2026 at 4:10 PM, she stated the Maintenance Director completed routine water management activities (e.g., flushing rounds). She stated the facility worked closely with the state health department in response to any Legionella concern. She further stated she was not aware of a Legionella policy, plan, or if the facility had completed a Legionella risk assessment. The Administrator stated it was her expectation for staff to follow the facility's policies and procedures related to infection control. She stated this was important to prevent the spread of infection.During an interview with the Medical Director on 01/08/2026 at 10:50 AM, he stated all staff should follow IPCP to prevent the spread of infection in the facility and to ensure the safety and well-being of residents and staff.The facility provided an acceptable credible Removal of Immediacy Plan on 01/14/2025 that alleged removal of the Immediate Jeopardy (IJ) on 01/15/2026. Review of the IJ Removal Plan revealed the facility implemented the following:Concern:On 01/13/2026 at approximately 8:00 AM, staff member RN4 completed blood sugar testing for R70. RN 4 failed to clean the glucometer after use and then proceeded to complete blood sugar testing for R67.On 01/13/2026 at 8:55 AM, the RDCO (Regional Director of Clinical Operations) completed education and blood sugar competency with RN4 on glucometer cleaning procedure.On 01/13/2026 at approximately 11:00 AM, LPN6 completed blood sugar testing for R41 and placed the glucometer on the bedside table without cleaning the surface or establishing a clean barrier. After completing the blood sugar testing LPN6 continued wearing the same gloves and cleaned the glucometer with a Sani-cloth wipe, exited R41's room wearing the same gloves and placed the glucometer wrapped in Sani-cloth wipe on the medication cart next to clean supplies while wearing the same gloves.On 01/13/2026 at 11:30 AM, the DON completed education and blood sugar competency with LPN6 including placing the glucometer on a clean surface or barrier, removing gloves after obtaining blood sugar, and cleaning the glucometer with the Micro-kill bleach wipes.On 01/13/2026 at 3:15 PM, R41 and R67 were assessed by the DON and residents at baseline, with no negative effects.On 01/13/2026 at 3:30 PM, the DON notified the Medical Director that RN4 completed blood sugar testing for R70 and failed to clean the glucometer after use, then proceeded to complete blood sugar testing for R41. LPN 6 completed blood sugar testing for R41and cleaned the glucometer with a Sani-cloth wipe, and with the same gloves wrapped the glucometer in the Sani-cloth wipe, on the medication cart next to clean supplies. No new orders from Medical Director.Other residents at risk:On 01/13/2026 at 4:00 PM, the DON informed the Medical Director that 29 residents currently have orders for routine blood sugar monitoring and no residents with orders for blood sugar monitoring have a communicable blood borne pathogen. Medical Director gave directions to complete glucometer cleaning education with nurses. No new orders.On 01/13/2026 at 6:40 PM, the Nurse Managers assessed the other 27 residents at risk. All residents at baseline. No negative effects.Education:On 01/13/2026 at 5:45 PM, the RDCO verified the DON was educated on glucometer cleaning procedure, including utilizing clean surface/barrier, utilizing (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	micro-kill bleach wipes, and removing gloves, and clean storage of the glucometer.On 01/13/2026 at 6:00 PM, the DON initiated education and blood sugar competency via return demonstration with all licensed nurses present in the facility on glucometer cleaning pr[

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review, review of the controlled substance log titled Individual Patient Controlled Substance Administration Records [IPCSAR], and review of the facility's policies, the facility failed to ensure the proper documentation of controlled substances in accordance with professional standards of practice when nursing staff did not accurately complete and reconcile controlled narcotic record sheets at the time of removal for the A, B, and C Hall medication carts. In multiple instances, the IPCSAR sign out time, which should reflect the actual time the narcotic was removed from the narcotic bubble pack, instead reflected the ordered time and did not correlate with the medication administration time documented on the Medication Administration Record [MAR]. These repeated omissions demonstrated ongoing noncompliance with the required narcotic documentation practices and created an unacceptable risk for diversion and inaccurate medication records and comprised resident safety for 11 of 11 sampled residents, Resident (R) 2, R17, R20, R23, R31, R37, R42, R68, R73, R122, and R127. Additionally, medications were given late, past the scheduled administration time and the parameters for medication administration for 10 of 11 sampled residents, R2, R17, R20, R23, R31, R42, R68, R73, R122, and R127.The findings include:Review of the facility's policy titled, Controlled Substances, revised 11/2024, revealed when a licensed nurse removed a controlled substance for administration, the removal must be documented on the controlled substance record at the time of removal, including the date, time, and amount removed for that resident.Review of the facility's policy titled, Administering Medications, reviewed 04/28/2025, revealed medications were to be given as ordered, including any specified administration times. The policy further stated scheduled medication should be administered within one hour of the scheduled administration time (SAT), unless the prescriber specified a different time frame.1. Observation of the A Hall medication cart with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) 3 on 01/07/2026 at 10:36 AM, revealed LPN3 did not sign out R122's 8:00 AM gabapentin dose at the time it was removed from the bubble pack.During continued observation on 01/07/2026 at 10:48 AM, LPN3 returned to the medication cart and informed the DON she needed to sign R122's IPCSAR. LPN3 stated the medication had been administered at 10:20 AM, and she was only then returning to complete the required sign out documentation.During an immediate interview with LPN3, when questioned by the State Survey Agency (SSA) Surveyor regarding why she did not sign out the medication per policy at the time it was removed from the bubble pack, she stated, I'm signing it out now. When educated by the DON on facility policy, LPN3 did not provide any further explanation and responded by shaking her head and nodding in agreement.Review of the admission Record found in R122's electronic health record (EHR), revealed the facility admitted the resident on 06/18/2021 with diagnoses to include traumatic subdural hemorrhage, muscle wasting and atrophy, and chronic pain.Review of the quarterly Minimum Data Set [MDS], found in R122's EHR with an Assessment Reference Date (ARD) of 12/26/2025, 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 in the pain assessment interview the resident indicated she had frequent pain and was taking an opioid for pain.Review of the Order Summary Report, dated 01/2026 and found in R122's EHR, revealed on 04/18/2022 the physician ordered gabapentin capsule 300 milligrams (mg), give one capsule per mouth, three times a day related to pain.Review of the IPCSAR and MAR for gabapentin 300 mg one capsule by mouth three times daily at 8:00 AM, 2:00 PM, and 8:00 PM revealed repeated instances where the IPCSAR was not signed, the sign out time did not correlate with the MAR administration time, and multiple doses were administered outside the appropriate timeframe. Those incidents were on 01/02/2026, the 8:00 PM dose was signed out at 8:00 PM but administered at 10:48 PM, two hours and 48 minutes past the SAT; on 01/04/2026, the 8:00 AM dose was signed out at 8:23 AM but administered at 10:44 AM, two hours and 44 minutes past the SAT; on 01/06/2026, the 8:00 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	AM dose was signed out at 9:30 AM but administered at 1:04 PM, five hours and four minutes past the SAT; and the next scheduled dose (ordered every eight hours) was given at 2:17 PM, only one hour and 13 minutes later, shortening the ordered eight hour dosing interval by six hours and 47 minutes. Additionally, on 01/06/2026, the 8:00 PM dose was signed out at 8:00 PM but administered at 11:42 PM, three hours and 42 minutes past the SAT. On 01/07/2026, documentation indicated a dose at 10:20 AM; however, there was no corresponding IPCSAR sign out. Continued review of the MAR documentation revealed no corresponding note to indicate the physician was notified the medication was administered outside the acceptable administration time frame of one hour before and one hour after the schedule administration time.During an interview with R122 on 01/07/2026 at 11:16 AM, she stated her pain was frequent and her pain medications were often not administered on schedule, particularly when certain nurses were working, but she could not recall specific staff names. She stated delayed doses caused her pain to worsen. She further stated she often waited a long time for her medications.2. Review of the admission Record found in R2's EHR, revealed the facility admitted the resident on 12/23/2025 with diagnoses to include chronic respiratory failure, generalized anxiety disorder, and chronic pain.Review of the quarterly MDS, found in R2's EHR with an ARD of 12/29/2025, revealed the resident had a BIMS score of 14 out of 15, indicating the resident was cognitively intact. Further review revealed in the pain assessment interview the resident indicated she had frequent pain and was taking opioids (pain reliever), antianxiety, and antipsychotic medications.Review of the Order Summary Report, dated 01/2026 and found in R2's EHR, revealed on 12/23/2025, the physician ordered lorazepam 1 milligram (mg), give one tablet per mouth, every eight hours related to generalized anxiety disorder. The medication was scheduled for 6:00 AM, 2:00 PM, and 10:00 PM.Review of R2's lorazepam 1 mg IPCSAR and corresponding MAR documentation revealed multiple discrepancies between medication administration times and controlled substance sign out documentation and administration outside the SAT. Those incidents were on 01/04/2026, the lorazepam was documented as signed out at 6:00 AM, but MAR documentation indicated it was administered at 5:44 AM, prior to being signed out; on 01/04/2026, MAR documentation indicated the 10:00 PM dose was administration at 11:21 PM, one hour and 21 minutes past the SAT, with no corresponding documented IPCSAR sign out; on 01/05/2026, MAR documentation indicated the 2:00 PM dose was administered at 5:36 PM, three hours and 36 minutes past the SAT, with no corresponding documented IPCSAR sign out; on 01/06/2026, the 10:00 PM dose was documented as signed out at 8:00 PM, but MAR documentation indicated administration at 10:44 PM; and on 01/07/2026, MAR documentation indicated administration at 5:15 AM, prior to the medication being signed out, and administration at 10:10 PM, with no corresponding documented IPCSAR sign out. Continued review of the MAR documentation revealed no corresponding note to indicate the physician was notified the medication was administered outside the acceptable administration time frame.3. Review of the admission Record found in R17's EHR, revealed the facility admitted the resident on 07/11/2025 with diagnoses to include chronic obstructive pulmonary disease (COPD), respiratory failure, and chronic pain.Review of the quarterly MDS, found in R17 's EHR with an ARD of 09/26/2025, revealed the resident had a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Further review revealed in the pain assessment interview the resident indicated he had frequent pain and was taking opioids for pain.Review of the Order Summary Report, dated 01/2026 and found in R17's EHR, revealed on 07/14/2025 the physician ordered gabapentin 100 mg, give 100 mg by mouth, three times per day related to chronic pain. The medication was scheduled for 8:00 AM, 2:00 PM, and 8:00 PM.Review of R17's gabapentin 100 mg MAR documentation revealed on 01/05/2026 the 8:00 PM dose was administered at 10:12 PM, two hours and 12 minutes past the SAT. Also, on 01/06/2026, the 8:00 AM dose was given at 10:21 AM, two hours and 21 minutes past the SAT. Continued review of the MAR documentation revealed no corresponding note to indicate the physician was notified the medication was administered outside the acceptable administration time frame.4. Review of the admission Record found in R20's EHR, revealed the facility admitted the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident on 05/25/2023 with diagnoses to include acute kidney failure, anxiety disorder, and unspecified dementia.Review of the quarterly MDS, found in R20's EHR with an ARD of 09/26/2025, revealed the resident had a BIMS score of zero out of 15, indicating the resident had severe cognitive impairment. Further review revealed that R20 was taking antianxiety medication.Review of the Order Summary Report, dated 01/2026, and found in R20's EHR, revealed on 12/19/2025 the physician ordered lorazepam 0.5 mg, give 1 by mouth, two times a day related to anxiety. The medication was scheduled for 9:00 AM and 9:00 PM.Review of R20's lorazepam 0.5 mg IPCSAR and corresponding MAR documentation revealed on 01/01/2026, the 9:00 AM dose was documented as signed out at 1:28 PM, and MAR documentation indicated it was administered at 1:28 PM, four hours and 28 minutes past the SAT. The next scheduled dose (ordered every 12 hours) was given at 9:18 PM, only seven hours and 50 minutes later, shortening the ordered 12-hour dosing interval by 4 hours and 10 minutes. Continued review of the MAR documentation revealed no corresponding note to indicate the physician was notified that the medication was administered outside the acceptable administration time frame.5. Review of the admission Record found in R23's EHR, revealed the facility admitted the resident on 06/30/2025 with diagnoses to include diffuse traumatic brain injury, muscle wasting and atrophy, and hemiplegia.Review of the quarterly MDS, found in R23 's EHR with an ARD of 12/28/2025, revealed the resident had a BIMS score of nine out of 15, indicating the resident had moderate cognitive impairment and was taking opioids for pain.Review of the Order Summary Report, dated 01/2026 and found in R23's EHR, revealed on 09/19/2025 the physician ordered morphine sulfate oral solution 20 mg/milliliter (mL), give 0.25 mL three times a day for pain related to muscle wasting and atrophy. The medication was scheduled for 8:00 AM, 2:00 PM, and 8:00 PM.Review of R23's morphine sulfate oral solution 20 mg/mL IPCSAR and corresponding MAR documentation revealed multiple discrepancies between medication administration times and controlled substance sign out documentation for the 8:00 AM dose. On 12/28/2025, it was signed out on the IPCSAR at 8:00 AM, but the MAR indicated the medication was not administered until 10:25 AM, two hours and 25 minutes past the SAT; on 12/29/2025, it was signed out on the IPCSAR at 8:15 AM, but the MAR indicated the medication was not administered until 10:36 AM, two hours and 36 minutes past the SAT; on 12/31/2025, it was signed out on the IPCSAR at 8:30 AM, but the MAR indicated the medication was not administered until 11:18 AM, three hours and 18 minutes past the SAT; and on 01/02/2026, it was signed out on the IPCSAR at 8:30 AM, but the MAR indicated the medication was not administered until 10:04 AM, two hours and four minutes past the SAT. Further review revealed for the 2:00 PM dose, on 12/31/2025, it was signed out on the IPCSAR at 3:30 PM, but the MAR indicated the medication was administered at 5:33 PM, three hours and 33 minutes past the SAT. Continued review of the MAR documentation revealed no corresponding note to indicate the physician was notified that the medication was administered outside the acceptable administration time frame.6. Review of the admission Record found in R31's EHR revealed the facility admitted the resident on 10/27/2021 with diagnoses to include cerebral infarction, chronic obstructive pulmonary disease (COPD), and chronic pain.Review of the quarterly MDS, found in R31 's EHR with an ARD of 12/28/2025, revealed the resident had a BIMS score of nine out of 15, indicating the resident had moderate cognitive impairment. Further review revealed R31 was taking antipsychotics and opioids.Review of the Order Summary Report, dated 01/2026 and found in R31's EHR, revealed on 11/24/2025 the physician ordered hydrocodone-acetaminophen 5-325 mg tablet, give one tablet by mouth every six hours. The medication was scheduled for 2:00 AM, 8:00 AM, 2:00 PM, and 8:00 PM.Review of R31's hydrocodone-acetaminophen 5-325 mg IPCSAR and corresponding MAR documentation revealed multiple discrepancies between medication administration times and controlled substance sign out documentation and administration past the SAT. Those instances, for the 8:00 dose, were on 01/01/2026, it was documented as administered at 11:42 AM, three hours and 42 minutes past the SAT; on 01/04/2026, it was documented as administered at 11:10 AM, three hours and 10 minutes past the SAT; and on 01/06/2026, it was documented as administered at 10:34 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	AM, two hours and 34 minutes late, while the IPCSAR reflected a sign out at 7:00 AM. For the 2:00 PM dose, on 01/01/2026, it was documented as administered at 3:47 PM, one hour and 47 minutes past the SAT, and there was no provided IPCSAR sign out for that dose; and on 01/04/2026, it was documented as being administered at 7:00 PM, five hours past the SAT. Also, on 01/04/1026, the 8:00 PM dose was documented as administered at 8:40 PM, one hour and 40 minutes from the previously documented dose. On 01/05/2026, the 8:00 PM dose was documented as administered at 10:07 PM, two hours and seven minutes past the SAT. Continued review of the MAR documentation revealed no corresponding note to indicate the physician was notified that the medication was administered outside the acceptable administration time frame.7. Review of the admission Record found in R37's EHR revealed the facility admitted the resident on 04/24/2025 with diagnoses to include Alzheimer's disease, chronic kidney disease stage 3, and muscle wasting and atrophy.Review of the quarterly MDS, found in R37's EHR with an ARD of 12/27/2025, revealed the resident had a BIMS score of five out of 15, indicating the resident had severe cognitive impairment. Further review revealed that R37 was taking opioids.Review of the Order Summary Report, dated 01/2026 and found in R37's EHR, revealed on 05/23/2025 the physician ordered hydrocodone-acetaminophen 5-325 mg tablet, give one tablet by mouth every six hours. The medication was scheduled for 6:00 AM, 12:00 PM, 6:00 PM, and 12:00 PM.Review of R37's hydrocodone-acetaminophen 5-325 mg IPCSAR and corresponding MAR documentation revealed multiple discrepancies between medication administration times and controlled substance sign out documentation. On 01/01/2026, 01/04/2026, and 01/05/2026, the 6:00 AM doses were all documented on the IPCSAR at 6:00 AM after the medication had already been administered, indicating late controlled substance documentation rather than real time sign out. Additionally, on 01/01/2026, the 6:00 PM dose was administered at 5:02 PM but was not signed out on the IPCSAR until 6:00 PM, reflecting delayed controlled-substance documentation.8. Review of the admission Record found in R42's EHR, revealed the facility admitted the resident on 12/01/2025 with diagnoses to include hemiplegia, type 2 diabetes with diabetic neuropathy, and unspecified pain.Review of the quarterly MDS, found in R42's EHR with an ARD of 12/07/2025, revealed the resident had a BIMS score of 12 out of 15, indicating the resident had moderate cognitive impairment. Further review revealed in the pain assessment interview, the resident indicated she had frequent pain.Review of the Order Summary Report, dated 01/2026 and found in R42's EHR, revealed on 12/01/2025 the physician ordered gabapentin oral tablet, give 300 mg by mouth two times a day related to pain. The medication was scheduled for 8:00 AM and 8:00 PM.Review of R42's gabapentin 300 mg oral tablet IPCSAR and corresponding MAR documentation revealed multiple late medication administrations. The instance for the 8:00 AM dose was on 01/07/2026, when it was administered at 11:24 AM, three hours and 24 minutes past the SAT and signed out on the IPCSAR at 11:00 AM. Instances for the 8:00 PM dose were on 01/03/2026, when it was documented as administered on 01/04/2026 at 1:21 AM, five hours and 21 minutes past the SAT, leaving an approximate six and one-half hour window between the next scheduled dose, and a corresponding IPCSAR was not provided; on 01/04/2026, it was documented as administered at 11:24 PM, three hours and 24 minutes past the SAT, and signed out on the IPCSAR at 11:00 PM; and on 01/07/2026, it was administered at 10:42 AM, two hours and 42 minutes late past the SAT and signed out at 10:42 PM. Continued review of the MAR documentation revealed no corresponding note to indicate the physician was notified that the medication was administered outside the acceptable administration time frame.9. Review of the admission Record found in R68's EHR, revealed the facility admitted the resident on 07/24/2024 with diagnoses to include end stage renal disease (ESRD), pain in left ankle and joints of the left foot and shoulder pain, and Achilles tendinitis.Review of the quarterly Minimum Data Set [MDS], found in R68 's EHR with an ARD of 12/16/2025, revealed the resident had a BIMS score of 11 out of 15, indicating the resident had moderate cognitive impairment. Further review revealed in the pain assessment interview, the resident indicated she had frequent pain and was taking opioids (pain reliever) for pain.Review of the Order Summary Report, dated 01/2026 and found in R68's EHR, revealed on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10/10/2025 the physician ordered pregabalin capsule 100 mg, give one capsule per mouth, two times a day every Monday, Wednesday, and Friday at 9:00 AM and 9:00 PM, related to low back pain. In 12/2024 she was ordered oxycodone-acetaminophen 5-325 mg, give one tablet by mouth at 6:00 AM and 2:00 PM and oxycodone-acetaminophen 5-325 mg, give two tablets by mouth at bedtime (scheduled for 9:00 PM). Those orders were discontinued on 01/08/2026. A new order was received, dated 01/09/2025, for oxycodone-acetaminophen 5-325 mg, give two tablets by mouth at bedtime (scheduled for 10:00 PM). Additionally, R68 had an order for alprazolam 1 mg, give one tablet twice daily, at 9:00 AM and 9:00 PM.Review of the MAR, dated 12/2025 and found in R68's EHR, revealed her ordered pregabalin 100 mg capsule for 9:00 AM was administered on 12/29/2025 at 10:53 AM, one hour and 53 minutes past the SAT. Further review revealed her 2:00 PM dose for oxycodone-acetaminophen 5-325 mg tablets was administered on 12/27/2025 at 4:11 PM, two hours and 11 minutes past the SAT; and on 12/29/2025 it was given at 6:14 PM, four hours and 14 minutes past the SAT. Further review revealed R68's 9:00 AM dose for alprazolam 1 mg, on 12/22/2025, was given at 11:52 AM, two hours and 52 minutes past the SAT; on 12/29/2025, it was given at 10:54 AM, one hour and 54 minutes past the SAT; and on 12/30/2025, it was given at 11:22 AM, two hours and 22 minutes past the SAT. Continued review of the MAR documentation revealed no corresponding note to indicate the physician was notified that the medication was administered outside the acceptable administration time frame.During an interview with R68 on 01/13/2026 at 9:10 AM, she stated her medications were frequently administered late. R68 stated that delays in her pain and anxiety medications led to a return of pain and escalation of anxiety. She stated, once her medications were not given on time, it was hard for her symptoms to settle back to a tolerable level. She further stated, recently, there were several incidents when her pain and anxiety medication were not given at the ordered time. She stated, although she could not recall the specific dates or times, delayed doses increased her anxiety and made it harder to cope with her chronic pain.10. Review of the admission Record found in R73's EHR, revealed the facility admitted the resident on 07/22/2024 with diagnoses to include chronic pain syndrome, peripheral vascular osteomyelitis, and peripheral disease. Review of the quarterly MDS, found in R73's EHR with an ARD of 12/23/2025, revealed the resident had a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Further review revealed in the pain assessment interview, the resident indicated he had pain almost constantly and was taking opioids (pain reliever) for pain.Review of the Order Summary Report, dated 01/2026 and found in R73's EHR, revealed on 11/14/2025 the physician ordered gabapentin capsule 300 mg, give one capsule per mouth, three times a day related to peripheral vascular disease and oxycodone HCL oral tablet, 15 mg, give by mouth every four hours as needed for pain related to chronic pain syndrome.Review of the MAR, dated 01/2026 and found in R73's EHR, revealed his ordered gabapentin 300 mg capsule for the 8:00 AM dose was administered on 01/03/2026 at 11:17 AM, three hours and 17 minutes past the SAT; on 01/04/2026, it was given at 10:45 AM, two hours and 45 minutes past the SAT; on 01/05/2026, it was given at 9:52 AM, one hour and 52 minutes past the SAT; and on 01/09/2026, it was given at 11:25 AM, three hours and 25 minutes late. Continued review of the MAR documentation revealed no corresponding note to indicate the physician was notified that the medication was administered outside the acceptable administration time frame.During an interview with R73 on 01/13/2026 at 9:20 AM, he stated there had been several times when his medications had not been administered on schedule during the last couple weeks. He stated, when his pain medications were given late, his pain intensified and required significant time to return to baseline. He further stated it was more common than not for his pain medications to be administered late. Additionally, he stated he typically waited at least one hour past the scheduled administration time and sometimes, on occasion, he waited two hours or longer.During an interview with LPN1 on 01/14/2026 at 3:30 PM, she stated the medication window was one hour before and one hour after the scheduled ordered time. She stated staff was taught to sign out medications when removed from the cart and complete remaining medication administration record documentation after administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When asked why several of R73's gabapentin 300 milligrams, ordered three times a day, were administered outside the facility's administration window during her medication administrations, LPN1 stated interruptions and short staffing could cause some medication administration to run late. She further stated documentation could be delayed, and there were too many medications assigned to one cart. LPN1 stated it was important to follow the resident's plan of care and provide ordered medication on schedule to ensure timely administration and documentation to prevent the residents from experiencing prolonged or increased pain. 11. Review of the admission Record found in R127's EHR, revealed the facility admitted the resident on 01/02/2025 with diagnoses to include chronic pain syndrome, Parkinson's disease, anxiety and panic disorder, and pain.Review of the quarterly MDS, found in R127's EHR with an ARD of 10/11/2025, revealed the resident had a BIMS score of 11 out of 15, indicating the resident had moderate cognitive impairment. Further review revealed in the pain assessment interview, the resident indicated she had pain frequently and was taking antianxiety medications and opioids for pain.Review of the Order Summary Report, dated 01/2026, and found in R127's EHR, revealed on 01/02/2025 the physician ordered clonazepam (brand name Klonopin) oral tablet 1 mg, give one tablet every 12 hours related to anxiety disorder and hydrocodone-acetaminophen (brand name Norco) 5-325 mg oral tablet, give one tablet by mouth every 12 hours for pain management.Review of the MAR, dated 12/2025 and 01/2026 and found in R127's EHR, revealed, for the hydrocodone-acetaminophen 5-325 mg oral tablet for 8:00 AM, on 01/04/2026, it was given at 10:25 AM, two hours and 25 minutes past the SAT; and on 01/11/2026, it was administered at 10:19 AM, two hours and 19 minutes past the SAT. Further review revealed for the hydrocodone-acetaminophen 5-325 mg oral tablet for 8:00 PM, on 12/31/2026, it was given at 10:30 PM, two hours and 30 minutes past the SAT; on 01/01/2026, it was given at 12:39 AM, the following day, four hours and 39 minutes past the SAT; and on 01/04/2026, it was given at 10:00 PM, two hours past the SAT. Review of the MAR, dated 01/2026 and found in 127's EHR, revealed, for the clonazepam 1 mg tablet 9:00 AM dose, on 01/01/2026, it was administered at 12:33 PM, three hours and 33 minutes past the SAT; and on 01/05/2026, it was administered at 10:13 AM, one hour and 13 minutes past the SAT. For the 9:00 PM dose, on 01/02/2026, it was administered at 10:03 PM, one hour and three minutes past the SAT; and on 01/04/2026, it was administered at 10:10 PM, one hour and 10 minutes past the SAT. Continued review of the MAR documentation revealed no corresponding note to indicate the physician was notified that the medication was administered outside the acceptable administration time frame.During an interview with R127 on 01/12/2026 at 12:50 PM, she stated she received routine pain medication. However, she stated her medications were late yesterday morning (01/11/2026). R127 stated she was supposed to receive her medications at 9:00 AM, but it was close to 10:25 AM before she received them yesterday.During an interview with State Trained Nurse Aide/Kentucky Medication Aide (STNA/KMA) 14 on 01/15/2025 at 2:12 PM, when asked about delayed medication administration for R127's Norco and Klonopin on 01/01/2026, scheduled for 9:00 AM but documented as administered at approximately 12:33 PM, she stated she did not recall specific circumstances that caused the delay. STNA/KMA14 initially stated the unit was well staffed. However, she stated later she took over the medication cart two hours into her shift due to a nurse call-in. When asked about notifying the physician, she stated KMA's typically did not have access to the facility application used for provider communications. She stated it would be the supervisor's responsibility to notify the on-call provider if needed.During an interview with Licensed Practical Nurse (LPN) 6 on 01/08/2026 at 1:30 PM, he stated nursing staff was not to sign out medications early or late, and documentation must reflect the actual administration process. He stated the concern with failure to document in real-time was that it resulted in errors, raised concern whether the medication was actually administered to the resident, and created potential for diversion. He stated inaccurate documentation was not legal and was not consistent with standard nursing practice.During an interview with LPN14 on 01/08/2026 at 1:55 PM, she stated real-time documentation ensured residents received medications correctly and at the appropriate time. She (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated if she observed documentation suggesting a medication scheduled at 8:00 AM was documented as removed at 12:00 PM and the next scheduled dose was due at 2:00 PM, she would follow the chain of command by notifying the Unit Manager or Director of Nursing (DON), hold the dose, and contact the physician for guidance because the doses would be too close together.During an interview with LPN16 on 01/08/2026 at 2:20 PM, she stated nursing staff should sign out controlled medications on the MAR and the IPCSAR at the same time the medication was administered.During an interview with Nurse Supervisor/LPN13 on 01/08/2026 at 2:20 PM, she stated she was the nurse supervisor responsible for building oversight, staffing, walkthroughs, and monitoring resident care. She stated the controlled narcotic sheet [IPCSAR] and MAR audits were typically completed by the DON and were not usually part of her role. She stated her expectation was that medications be removed, administered, and documented at the time of administration. She further stated, if a dose was administered beyond the one-hour allowance, staff should notify the physician for direction and notify the DON.During an interview with LPN5 on 01/09/2026 at 10:15 AM, she stated the expected process was to verify the correct medication, sign out the controlled substance at the time it was removed [on the IPCSAR], administer it to the resident, and document administration on the MAR. She stated any significant delay or discrepancy between sign out and administration should be reported to the physician and explained in a nurse's note. She stated accurate documentation was necessary to prevent missing narcotics and support timely medication administration.During an interview with the contracted pharmacy's Registered Pharmacist (RPh) on 01/10/2026 at 1:50 PM, he stated nursing staff should administer medications according to physician orders and within the required administration window, so doses were appropriately spaced, and therapeutic levels were maintained. He stated, A medication's half-life is the time it takes for the amount of the drug in the body to decrease by 50 percent and giving a dose late can result in residual medication still present when the next scheduled dose is due, increasing risk for unintended dose stacking, accidental double dosing or overdose. The RPh further stated the physician should be notified when a medication was administered late because some drugs, including gabapentin, have an elimination half-life of approximately five to seven hours in residents with normal kidney function. He stated, in residents with decreased renal function, the half-life could be significantly prolonged, which increased the risk of accumulation and adverse effects when doses were given late or too close together.During an interview with the DON on 01/15/2025 at 4:10 PM, she stated she reviewed only a limited sample of IPCSAR sheets and did not reconcile the IPCSAR sign-out times with the corresponding MAR administration times. She stated her review was limited to IPCSAR completion, and as a result, she was not aware of the extent of the inconsistencies. The DON stated it was her expectation that nursing staff complied with the facility policy requiring medications to be administered within the one-hour medication administration window. Additionally, she stated it was her expectation that nursing staff signed the IPCSAR at the time the controlled substance was removed from the bubble pack and administered promptly, then documented appropriately. During an interview with the Administrator on 01/15/2025 at 4:10 PM, she stated licensed clinical staff was expected to follow facility policies, administer medications timely, and communicate delays appropriately. The Administrator stated she could not speak to each specific late administration event without reviewing the details and whether legitimate circumstances were present. The Administrator stated controlled substance documentation and medication administration practices had improved significantly, stating the facility went from a high percentage of incorrect signatures/documentation to substantially fewer errors. The Administrator clarified prior monitoring was limited (e.g., auditing a limited number of individuals per medication cart), and the facility was now auditing all staff by pulling MARs and comparing medication administration details across shifts.During continued interview with the Administrator on 01/15/2025 at[TRUNCATED]

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, interview, document review, review of the Quality Assurance/Quality Assurance and Performance Improvement (QA/QAPI) Committee minutes, review of the facility's Plan of Correction (PoC), and review of the facility's policy, the facility failed to implement and sustain its Plan of Correction (PoC) related to monitoring of the narcotic sign-out sheets and timely administration of pain medications, as evidenced by the facility not thoroughly performing an audit process, and the QA/QAPI/ Committee failing to provide effective oversight and follow-up of identified concerns. This deficient practice limited the facility's ability to identify, correct, and prevent recurrence of narcotic medication timing and documentation concerns and ensure pain management was provided to residents who required such services, through a functioning QAPI/QAA monitoring and governance system.See F697 and F755The findings include:Review of the facility's policy titled, Quality Assurance and Performance Improvement [QAPI], revised 04/28/2025, indicated the facility would develop, implement and maintain an ongoing facility wide QAPI program designed to actively pursue quality of care. The policy stated the program's primary purpose was to establish data-driven processes to improve the residents care, quality of life, and clinical outcomes. The policy also described governance and leadership input and stated performance improvement projects were initiated when problems were identified, and root cause analysis was used to evaluate whether issues were related to how care and services were organized or delivered.Review of the facility's PoC, dated 12/15/2025, indicated the Director of Nursing (DON) would ensure ongoing monitoring of one to two Individual Patient Controlled Substance Administration Record [IPCSAR], a narcotic proof of use sheet, from each medication cart during a nurse medication administration two times a week for four weeks to monitor that medications were being signed out at the time they were pulled starting on 11/21/2025. The results of the audits were referred by the Administrator to the QA/QAPI Committee to determine if additional actions were needed. Additionally, the facility's PoC indicated an audit was completed by the DON and/or Nursing Manager on all residents' pain assessments on 11/24/2025, and all nursing staff was in-serviced on assessing and documenting pain and effectiveness of pain management. The QA/QAPI committee included: the Medical Director, Director of Nursing, Administrator, Infection Preventionist, Social Service Director, and Minimum Data Set (MDS) Coordinator.1. Observation of the A Hall medication cart with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) 3 on 01/07/2026 at 10:36 AM, revealed LPN3 did not sign out R122's 8:00 AM gabapentin dose at the time it was removed from the bubble pack. During continued observation at 10:48 AM, LPN3 returned to the medication cart and informed the DON she needed to sign R122's IPCSAR. LPN3 stated the medication had been administered at 10:20 AM, and she was only then returning to complete the required sign out documentation.Review of the IPCSARs for the A, B, and C Hall medication carts, conducted on 01/07/2026, 01/08/2026, and 01/09/2026, revealed a repeated pattern of failure by nursing staff to accurately document controlled substance removal and administration. In multiple instances, the narcotic medication sign out time reflected the ordered time and did not correlate with the medication administration time documented on the Medication Administration Record [MAR]. Additionally, throughout the survey, review of residents' IPCSARs identified repeated occurrences where nursing staff failed to complete the controlled narcotic record sheet at the time of removal for 11 of 11 sampled residents. 2. Review of the electronic health records of Resident (R) 68, R73, R122, and R127 revealed they were care planned for pain medication for comfort as ordered. However, review of their MARs and from their interviews, R68, R73, R122, and R127 had multiple instances in the past three weeks of medications being administered late, sometimes more than three hours past the scheduled administration time and the facility's window for medication administration, and the delay caused them to experience worsening pain. Review of the QAPI Committee meeting sign-in sheet and minutes, dated 11/25/2025, revealed the Medical Director, Director of Nursing, Administrator, Infection Preventionist, Social Service Director, and MDS (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Coordinator were in attendance. The committee discussed deficiency tags, audit results, and training of staff.Review of the QAPI Committee meeting minutes, dated 12/23/2025, revealed the committee discussed audit results, training of staff, and the PoC related to narcotic medication administration and documentation and pain management. The Medical Director, Director of Nursing, Administrator, Infection Preventionist, and Human Resource Director were in attendance.During an interview with the DON on 01/08/2026 at 10:17 AM, she stated she only conducted live audits, meaning she stood and watched a nurse pull and sign out controlled medications in real-time. She stated she did not verify whether the medication sign-out time matched the actual administration time and did not reconcile her live audit observations with the MAR. She further stated she did not conduct random audits across all shifts. The DON stated prior auditing was limited to a small sample per cart and, as a result, discrepancies were not identified. The DON stated she had since expanded the audit process to include comparing narcotic sheets, IPCSAR, to the MAR and conducting a more comprehensive review of medication administration timing entries. The DON stated a pain-related audit was due around the time of the survey week/holiday period, and it was not completed as scheduled due to competing demands. However, she stated that it was a process that would normally help identify concerns.During an interview with the Administrator on 01/15/2026 at 4:11 PM, she stated the QA/QAPI Program Committee met at least quarterly and described data collection/monitoring including falls, infections/labs, therapy input, human resources/new hires, agency usage, turnover, and admissions (including source of admissions). The Administrator stated the committee discussed the November 2025 complaint survey, stating the pharmacy services tag involved medication diversion by an agency nurse. The Administrator stated that monitoring/audits were due around the time the survey occurred and indicated auditing had not been completed during the holiday period due to workload demands. Furthermore, the Administrator stated nursing staff was expected to administer pain medications as ordered and follow facility policies, including timely administration. She stated, Things happen, but the key issue was communication and documentation when medication timing fell outside the facility's expected window.During an interview with the Medical Director on 01/08/2026 at 10:50 AM, he stated he attended the 11/25/2025 and 12/23/2025 QAPI meetings regarding the PoC. He stated the meetings included discussion of removing medications as indicated, sign-in procedures, and counting narcotic drugs. He stated the committee discussed pain assessments, timely administration of narcotic pain medication, and accurate narcotic documentation. He stated nursing staff had contacted him regarding resident pain concerns, and he had received several calls related to pain management. He stated there was a concern with administering medications late or too close to the next scheduled dose, and it could result in double dosing. He stated if medications were not received as ordered, it could impact pain relief and contribute to anxiety and behaviors.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on interview, record review, and review of the facility's policies, the facility failed to have an effective system in place to ensure pain management was provided to residents who required such services. The facility failed to ensure pain medications were administered timely to residents in accordance with the physician orders and the comprehensive care plan (CCP) for 4 of 8 sampled residents, Resident (R) 68, R73, R122, and R127. The findings include:Review of the facility's policy titled, Policy and Procedure for Pain Management, reviewed 01/2024, revealed the facility would ensure pain management was provided to residents, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences.Review of the facility's policy titled, Care Planning - Interdisciplinary Team Policy Statement, reviewed 04/28/2025, revealed the facility must develop an individualized, comprehensive care plan for each resident within seven days of completing the comprehensive assessment. The care plan was based on a comprehensive assessment and developed by the care planning interdisciplinary team.Review of the facility's policy titled, Administering Medications, reviewed 04/28/2025, revealed medications were to be given as ordered, including any specified administration times. The policy further stated scheduled medications should be administered within one hour of the order time [scheduled administration time], unless the prescriber specified a different time frame.1. Review of the admission Record found in R68's electronic health record (EHR) revealed the facility admitted the resident on 07/24/2024 with diagnoses to include end stage renal disease (ESRD), pain in left ankle and joints of the left foot and shoulder pain, and Achilles tendinitis.Review of the quarterly Minimum Data Set [MDS], found in R68 's EHR with an Assessment Reference Date (ARD) of 12/16/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 11 out of 15, indicating the resident had moderate cognitive impairment. Further review revealed on the pain assessment interview, the resident indicated she had frequent pain and was taking opioids (narcotic pain reliever) for pain.Review of the CCP, dated 01/02/2026 and found in R68's EHR, indicated the resident was care planned for potential for comfort alteration related to chronic pain, with interventions to include administer analgesics as ordered by the physician.Review of the Order Summary Report, dated 01/2026 and found in R68's EHR, revealed on 10/10/2025 the physician ordered pregabalin capsule 100 milligrams (mg), give one capsule per mouth, two times a day every Monday, Wednesday, and Friday at 9:00 AM and 9:00 PM, related to low back pain. In 12/2025, she was ordered oxycodone-acetaminophen 5-325 milligrams (mg), give one tablet by mouth at 6:00 AM and 2:00 PM, and oxycodone-acetaminophen 5-325 mg, give two tablets by mouth at bedtime (scheduled for 9:00 PM). These orders were discontinued on 01/08/2026. A new order, dated 01/09/2026, was for oxycodone-acetaminophen 5-325 mg, give two tablets by mouth at bedtime (scheduled for 10:00 PM).Review of the Medication Administration Record [MAR], dated 01/2026 and found in R68's EHR, revealed the pregabalin 100 mg capsule for 9:00 AM on 12/29/2025 was given at 10:53 AM, one hour and 53 minutes past the scheduled administration time (SAT). Further review revealed R68's oxycodone-acetaminophen 5-325 mg tablets 2:00 PM dose on 12/27/2025 was given at 4:11 PM, two hours and 11 minutes past the SAT; and on 12/29/2025 was given at 6:14 PM, four hours and 14 minutes past the SAT.During an interview with R68 on 01/13/2026 at 9:10 AM, she stated her medications were frequently administered late. R68 stated delays in her pain medications led to a return of pain. She stated, once her medications were not given on time, it was hard for her symptoms to settle back to a tolerable level. She stated there were several incidents recently when her pain medication was not given at the ordered time. Although she could not recall the specific dates or times, she stated delayed doses made it harder to cope with her chronic pain.2. Review of the admission Record found in R73's EHR, revealed the facility admitted the resident on 07/22/2024 with diagnoses to include chronic pain syndrome, peripheral vascular osteomyelitis, and peripheral disease.Review of the quarterly MDS, found in R73's EHR with an ARD of 12/23/2025, revealed the (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident had a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Further review revealed on the pain assessment interview, the resident indicated he had pain almost constantly, and R73 was taking opioids for pain.Review of the Order Summary Report, dated 01/2026 and found in R73's EHR, revealed on 11/14/2025 the physician ordered gabapentin capsule 300 mg, give one capsule per mouth, three times a day related to peripheral vascular disease; and oxycodone HCL oral tablet, 15 mg, give 15 milligrams (mg) by mouth every four hours as needed for pain related to chronic pain syndrome.Review of the CCP, dated 11/03/2025 and found in R73's EHR, indicated the resident was care planned on 07/23/2024 for potential for comfort alteration related to chronic pain, with interventions to include administer pain medications as ordered.Review of the MAR, dated 01/2026 and found in R73's EHR, revealed his gabapentin 300 mg for 8:00 AM on 01/03/2026 was given at 11:17 AM, three hours and 17 minutes past the SAT; on 01/04/2026 was given at 10:45 AM, two hours and 45 minutes past the SAT; on 01/05/2026 was given at 9:52 AM, one hour and 52 minutes past the SAT; and on 01/09/2026 was given at 11:25 AM, three hours and 25 minutes past the SAT.During an interview with R73 on 01/13/2026 at 9:20 AM, he stated there had been several times when his medications had not been administered on schedule during the last couple weeks. He stated when his pain medications were given late, his pain intensified and required significant time to return to baseline. He further stated it was more common than not for his pain medications to be administered late. Additionally, he stated he typically waited at least one hour past the scheduled administration time, and sometimes on occasions, he waited two hours or longer.During an interview with Licensed Practical Nurse (LPN) 1 on 01/14/2026 at 3:30 PM, she stated the medication window was one hour before and one hour after the scheduled ordered time. When asked why she had administered several of R73's gabapentin 300 mg capsules outside the facility's administration window, LPN1 stated interruptions and short staffing could cause some medication administrations to run late. She further stated there were too many medications assigned to one cart. LPN1 stated it was important to follow the resident's plan of care and provide ordered medication on schedule to ensure timely administration to prevent residents from experiencing prolonged or increased pain.3. Review of the admission Record found in R122's electronic health record (EHR), revealed the facility admitted the resident on 06/18/2021 with diagnoses to include traumatic subdural hemorrhage, muscle wasting and atrophy, and chronic pain.Review of the quarterly MDS, found in R122's EHR with an ARD of 12/26/2025, revealed the resident had a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Further review revealed in the pain assessment interview the resident indicated she had frequent pain and was taking an opioid for pain.Review of the Order Summary Report, dated 01/2026 and found in R122's EHR, revealed on 04/18/2022 the physician ordered gabapentin capsule 300 milligrams (mg), give one capsule per mouth, three times a day related to pain.Review of the CCP, dated 11/06/2025 and found in R122's EHR, indicated the resident was care planned on 06/21/2021 for potential for comfort alteration related to right shoulder and right knee osteoarthritis and history of hip replacement, with interventions to include administer pain medications as ordered.Review of the MAR, dated 01/2026 and found in R122's EHR, revealed the 8:00 AM dose of gabapentin 300 mg, on 01/04/2026 was given at 10:44 AM, two hours and 44 minutes past the SAT, and on 01/06/2026 was given at 1:04 PM, five hours and four minutes past the SAT. Further review revealed the 8:00 PM dose of gabapentin 300 mg on 01/02/2026 was given at 10:48 PM, two hours and 48 minutes past the SAT, and on 01/06/2026 was given at 11:42 PM, three hours and 42 minutes past the SAT. During an interview with R122 on 01/07/2026 at 11:16 AM, she stated her pain was frequent and her pain medications were often not administered on schedule, particularly when certain nurses were working, but she could not recall specific staff names. She stated delayed doses caused her pain to worsen. She further stated she often waited a long time for her medications.4. Review of the admission Record found in R127's EHR revealed the facility admitted the resident on 01/02/2025 with diagnoses to include long-term (current) use of opiate analgesic, unspecified abdominal pain, pain in unspecified joint, and pain in right shoulder.Review of the (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	quarterly MDS, found in R127's EHR with an ARD of 10/20/2025, revealed the facility assessed the resident to have a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Review of the Order Summary Report, dated 12/2025 and 01/2026, and found in 127's EHR, revealed an order for Norco, a Schedule II pain reliever combining the opioid hydrocodone 5 milligrams (mg) and acetaminophen 325 mg, every 12 hours for pain.Review of the CCP, initiated on 01/03/2025 and found in R127's EHR, revealed a focus of comfort, which indicated pain would be managed with current medications and nursing interventions. An intervention, dated 01/03/2025, was to administer pain medications as ordered.Review of R127's December 2025 MAR revealed Norco 5/325 mg was to be given at 9:00 AM and 9:00 PM. Further review revealed the resident received Norco on 12/30/2025 at 10:59 AM, outside the acceptable administration times of 8:00 AM to10:00 AM for morning doses. Review of R127's January 2026 MAR revealed Norco 5/325 mg was to be given at 9:00 AM and 9:00 PM. Further review revealed the resident received Norco outside the acceptable administration times on six occasions: 1) 01/01/2026, R127 received her AM dose at 12:34 AM, three hours and thirty-four minutes past the SAT; 2) 01/02/2026, the resident received her PM dose at 10:04 PM; 3) 01/04/2026, the resident received her AM dose at 10:23 AM; 4) 01/04/2026, the resident received her PM dose at 10:10 PM; 5) 01/05/2026, the resident received her AM dose at 10:12 AM; and 01/11/2026, the resident received her AM dose at 10:19 AM.During an interview with R127 on 01/12/2026 at 12:50 PM, she stated she received routine pain medication. However, she stated her medications were late yesterday morning (01/11/2026). R127 stated she was supposed to receive her medications at 9:00 AM, but it was close to 10:25 AM before she received them yesterday. During an interview on 01/14/2026 at 2:12 PM with State Tested Nurse Aide (STNA) 14, also a Kentucky Medication Aide (KMA), she stated she arrived at the facility at 7:00 AM on 01/01/2026, working as an STNA. She stated a nurse called off, and staff was not certain who was going to work the medication cart. She stated she was scheduled to transition to the duties of the medication cart, administering medications, at 6:00 PM but was assigned the medication cart at 9:30 AM. She stated she began morning medication administration at that time. She stated normally it would not be an issue giving 9:00 AM medications before 10:00 AM. However, she stated that because she was assigned the medication cart late, medications were administered late. She stated, as medication administration was running late, residents were going about their daily routine, and she had to track some down and administer morning medications as residents were available.During an interview with the Medical Director on 01/08/2026 at 10:50 AM, he stated it was his expectation that all nursing staff verified and followed the physician's orders as written, as those orders were based on the resident's plan of care. He further stated medications should be administered according to the physician's order to maintain therapeutic dosing. He stated doses given late or too close together might allow symptoms to return or increase the risk of side effects. Furthermore, the Medical Director stated late administration might result in missed pain relief or symptom control and attempts to catch up could lead to doses being administered too close together. He stated timely administration helped prevent prolonged pain.During an interview with the Director of Nursing (DON) on 01/14/2026 at 2:20 PM, she stated there was more than one sick call-off on 01/01/2026. She stated, on 01/01/2026, if there had been another call-off, a supervisor would have been called in. She stated normally the supervisor would take the duties of the medication cart if there was a call-off, but that did not happen. She stated the supervisor should have called the Medical Director or Nurse Practitioner to get their guidance on how to proceed because medication administration times were missed. During additional interview with the DON on 01/15/2026 at 4:10 PM, she stated it was her expectation that nursing staff complied with the facility policy requiring medications to be administered within the one-hour medication administration window. She stated timely administration of pain medications as ordered by the physician was essential to maintain safety and effectiveness, avoid the risk of double dosing, and support consistent therapeutic drug levels.During an interview with the Administrator on 01/15/2026 at 4:10 PM, she stated it was her expectation for nursing staff to follow physician orders (continued on next page)

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	185174	A. Building B. Wing	01/15/2026

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Florence Park Care Center	6975 Burlington Pike Florence, KY 41042

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the facility's policy related to the administration of pain medications. The Administrator further stated it was important for the resident's health and well-being.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of the facility's policies, the facility failed to ensure medications were properly stored, labeled, secured, and maintained in accordance with acceptable standards of practice for 2 of 3 Medication Rooms.Observation on 01/14/2026 of Unit A and Unit B Medication Rooms revealed numerous medications from other facilities that residents brought with them upon admission were stored with clean supplies. In addition, on Unit A, an opened bottle of tuberculosis (TB) serum was not dated or labeled. On Unit B, an opened insulin pen was not dated or labeled.The findings include:Review of the facility's policy titled, Administering Medications, dated 04/28/2025, revealed medications were to be administered in a safe and timely manner. The policy revealed that when staff opened a multi-dose medication container, the date opened must be recorded on the container. The policy also required insulin pens to be clearly labeled with the resident's name or other identifying information.Review of the facility's policy titled, Medication Storage, undated, revealed that medications were to be stored in the original, labeled containers received from the pharmacy. The policy further revealed that expired or contaminated medications were to be removed from the medication storage area and disposed of in accordance with facility policy.Review of the facility's policy titled, Medication Disposal/Destruction, undated, revealed the facility would maintain a record of all discontinued medications for record-keeping purposes for a period of three years.1. Observation, with the Director of Nursing (DON), on 01/14/2026 at 1:40 PM of the Unit A Medication Room revealed numerous medications from other facilities that residents had brought with them upon admission comingled with clean supplies and overstock medications. Further observation revealed an opened bottle of tuberculosis (TB) serum that was not dated or labeled to indicate the date opened. 2. Observation, with the DON, on 01/14/2026 at 2:00 PM of the Unit B Medication Room revealed numerous medications from other facilities that residents had brought with them upon admission, comingled with clean supplies and overstock medications. Further observation revealed an opened insulin (lowered blood glucose levels) pen that was not dated at the time of opening. The insulin pen did not have a pharmacy label identifying the resident's name or providing pharmacy directions.During an interview on 01/15/2026 at 12:00 PM with Pharmacy Client Services staff, he stated the facility had an abundance of medications from other facilities that were still on-site.During an interview with the DON on 01/13/2026 at 1:40 PM, she stated the facility did not maintain records of discontinued medications unless they were controlled medications. The DON stated she expected staff to date medications when opened to prevent the administration of expired medications. She stated all medications should have a pharmacy label, so staff knew which resident the medication belonged to and how it was to be administered.During an interview with the Administrator on 01/15/2026 at 4:30 PM, she stated she expected nursing staff to follow the facility's medication policies to ensure safe medication administration and storage.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and review of the facility's policies, the facility failed to ensure that a resident was supported in exercising their right to self-determination, including choices related to personal care, to maintain their autonomy and dignity for 2 of 31 sampled residents, Resident (R) 53 and R1. The findings include:Review of the facility's policy titled, Policy and Procedure for Resident Rights and Advance Care Planning, dated 08/2026, revealed that employees shall treat all residents with respect, dignity, and full recognition of each resident's rights. The policy further revealed the facility would make every effort to assist residents in fully exercising their rights.Review of the facility's policy titled, Dignity, dated 08/2021 and reviewed on 04/28/2025, revealed the facility would treat each resident with respect and dignity and care for each resident in a manner and environment that promoted maintenance or enhancement of quality of life. The policy revealed the facility would protect and promote resident rights by assisting residents in dressing in their own clothes, appropriate to the time of day and individual preferences, and residents' private space and personal property would be respected. 1.Review of R53's admission Record revealed the facility admitted the resident on 02/16/2024 with diagnoses including degenerative disease of the nervous system, need for assistance with personal care, and muscle weakness.Review of R53's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/02/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 13 of 15, indicating the resident was cognitively intact.Review of R53's Care Plan Report, revised on 01/02/2026, revealed the resident was at risk for a deficit in activities of daily living (ADL) self-performance related to decreased mobility. Interventions indicated the resident required supervision for lower body dressing and total staff assistance for putting on and removing footwear.Observation on 01/12/2026 at 2:40 PM revealed R53 seated in his wheelchair in his room wearing a t-shirt and an adult incontinence brief, with no pants covering his lower body.In an interview with R53 with the observation, he stated he wanted a pair of pants and had asked multiple staff throughout the day. However, he stated staff told him he did not have any. R53 stated he felt embarrassed and reported he went without pants daily.Observation on 01/13/2026 at 9:40 AM and 12:35 PM revealed R53 seated in his wheelchair wearing a shirt and an adult incontinence brief. In interviews with both observations, R53 stated staff told him he had no clean pants.Observation on 01/14/2026 at 12:30 PM revealed R53 seated in his wheelchair wearing a shirt with a sheet draped over his legs in place of pants. In an interview with the observation, R53 stated, I would rather have a pair of pants, but at least they gave me something to cover up with today.In an interview on 01/12/2026 at 3:00 PM with State Tested Nurse Aide (STNA) 14, she stated R53 did not have clean pants due to an incontinence episode. STNA14 stated she did not offer a gown or blanket because she assumed it was his preference. She stated she did not ask the resident about his preference.In an interview on 01/12/2026 at 4:00 PM with Licensed Practical Nurse (LPN) 13, she stated R53 frequently went without pants following incontinent episodes. LPN13 stated she did not offer alternative clothing or coverings and did not ask the resident if he preferred pants.In an interview on 01/13/2026 at 2:00 PM with the Director of Nursing (DON), she stated R53 should have been appropriately covered, and staff was expected to provide residents with proper clothing to prevent embarrassment.In an interview on 01/15/2026 at 4:30 PM with the Administrator, she stated R53 should have been provided pants. Further, she stated staff was expected to notify the DON or Administrator if a resident lacked appropriate clothing.2. Review of R1's admission Record revealed the facility admitted the resident on 07/13/2023 with diagnoses including cerebral infarction, chronic kidney disease stage 3, major depressive disorder, and anxiety disorder.Review of R1's quarterly MDS, with an ARD of 11/16/2025, revealed that the facility assessed the resident's BIMS score as 15 out of 15, indicating the resident was cognitively intact.Review of R1's Care Plan, initiated on (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/06/2025, revealed a focus on making R1's stay at the facility easier. Goals included honoring the resident's preferences as much as possible and ensuring that R1 would express satisfaction with her environment.Further review of R1's Care Plan, revealed an intervention, initiated on 11/25/2025, to engage R1 in independent activities in her room, including reading, gadget games, and watching television. However, R1's belongings were not moved with her on 12/20/2025. Further review of R1's Care Plan, revised on 11/26/2025, revealed a focus of potential for impaired adjustment related to disability and the need for long-term care. Interventions included establishing a daily routine and providing a safe, non-threatening environment.Review of R1's electronic health record (EHR) revealed the facility failed to document the date, reason, or duration of R1's room change. However, a review of the EHR for R1's roommate revealed the roommate tested positive for COVID-19, and R1 was moved from her room on 12/30/2025. Further review revealed the roommate was removed from contact and droplet isolation on 01/07/2026. Despite the discontinuation of isolation precautions, R1 was not returned to her original room until 01/12/2026. There was no documented evidence the facility assessed or justified the continued room change. Observation on 01/12/2026 at 3:15 PM revealed R1 was lying in bed watching television. In an interview at the time of observation, R1 stated her roommate had COVID-19, and she was temporarily moved to another room on 12/30/2025. R1 stated that, with the move, her personal belongings were left in her original room, and another COVID-19-positive resident was placed in her room, with her belongings still present. R1 stated, I am missing them terribly. R1 further stated that the room she was moved into contained a television and refrigerator that did not belong to her, which she pointed out to the State Survey Agency (SSA) Surveyor.Observation on 01/13/2026 at 9:30 AM revealed R1 was back in her original room. During the observation, R1 stated, I'm so happy to be back home with my stuff.In an interview on 01/12/2026 at 3:24 PM, STNA11 stated that R1 had been moved to another room and that her belongings were left behind. STNA11 stated that staff retrieved items for R1 upon request. STNA11 stated that it was a common facility practice referred to as a soft move, defined as a temporary move for isolation.During an interview conducted on 01/15/2026 at 10:35 AM, the Housekeeping Supervisor stated the housekeeping department typically completed room changes. She stated that during a soft move, all resident belongings were moved with the resident, and the room was cleaned after the belongings were removed. If the room change occurred after housekeeping hours, then the resident's belongings were moved the next morning. She further stated that she thought R1's belongings had been moved with her on 12/30/2025.In an interview on 01/12/2026 at 4:00 PM, Licensed Practical Nurse (LPN) 13 stated R1's roommate was removed from isolation on 01/07/2026. She stated she was unsure why R1 had not yet returned to her original room.In an interview on 01/14/2026 at 2:15 PM, the Director of Nursing (DON) stated that, during a soft move for isolation precautions, the resident's belongings were not moved, but staff retrieved items as requested. The DON further stated that even when another isolation resident was placed into the original room, belongings were not moved. In an interview on 01/15/2026 at 4:30 PM, the Administrator stated that when a resident changed rooms, all personal belongings should be moved with the resident, and another resident should not be placed into a room containing someone else's belongings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and review of the facility's documents and policies, the facility failed to provide a resident environment that was consistently clean, comfortable, and home-like for 1 of 31 sampled residents, Resident (R) 2. The findings include:Review of the facility's policy titled, Policy and Procedure for Residents Rights and Advance Care Planning, dated 08/2016, revealed employees shall treat all residents with respect, dignity, and with full recognition of each resident's rights. Per the policy, the facility would make every effort to assist residents in fully exercising those rights.Review of the facility's policy titled, Dignity, dated 08/2021 and reviewed on 04/28/2025, revealed the facility would treat each resident with respect and dignity and provide care in an environment that promoted maintenance or enhancement of quality of life. Review of R2's admission Record revealed the facility admitted the resident on 12/23/2025 with diagnoses of chronic obstructive pulmonary disease (COPD), schizoaffective disorder bipolar type, and depression. Review of R2's admission Minimum Data Set [MDS], dated 01/06/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, indicating the resident was cognitively intact. Review of R2's Care Plan, dated 01/13/2026, revealed refusal of care was not identified as a concern and was not included as a care planned behavior. Observation of R2 on 01/12/2026 at 12:53 PM revealed the resident's shirt and pants were stained with what appeared to be coffee or coke and some kind of food. The shirt was stained down the front and the pants on the thigh area of the leg. Observation of R2 on 01/13/2026 at 8:21 AM revealed the resident remained in the same stained clothing that the resident wore on 01/12/2026. Observation of R2's room on 01/13/2026 at 8:34 AM, revealed spilt food on the floor, and follow-up observation at 10:22 AM revealed food remaining on the floor, which consisted of cheerios, a plate with unknown food items, and a container that had held an opened package of graham crackers, now scattered on the floor. The breakfast tray was sitting on the bedside table, covered and untouched. Observation of R2 on 01/14/2026 at 8:50 AM revealed the resident remained in the same stained clothing that the resident wore on 01/12/2026 and 01/13/2026. In an interview with Family Member (FM) 2 on 01/14/2026 at 10:12 AM she stated her sister, along with her, visited R2 twice a week. FM2 stated when she mentioned concerns to staff, the nurse stated, I'm agency. FM2 stated Hospice came to the facility to see R2 and would help with bathing and activities of daily living. In an interview with State Tested Nurse Aide (STNA) 16 on 01/14/2026 at 3:11 PM, she stated both shifts were responsible for ensuring residents were dressed in clean clothing. She stated it was expected for residents' clothing to be changed daily. She stated she was unaware R2 had been wearing the same clothing for multiple days. STNA16 stated she would not consider R2's room to be a clean, home-like environment. In an interview with Licensed Practical Nurse (LPN) 7 on 01/14/2026 at 3:19 PM, she stated it was her expectation that residents' clothing was changed daily. She stated it was not appropriate for a resident to wear the same clothing for multiple consecutive days. In an interview with the Director of Nursing (DON) on 01/15/2026 at 12:57 PM, she stated she expected that residents' clothing be changed daily.In an interview with the Administrator on 01/15/2026 at 12:58 PM, she stated she expected residents' clothing to be changed daily.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's documents and policy, the facility failed to notify the resident and the resident's representative of the bed hold notice and the transfer or discharge and the reasons for the move in writing and in a language and manner they understood as soon as practicable for 2 out of 7 residents investigated for transfer and/or discharge, Resident (R) 8 and R24. The findings include:Review of the facility's policy titled, Transfer and Discharge [including (Against Medical Advice) AMA], dated 04/28/2025, stated, The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. 1. Review of R8's admission Record revealed the facility admitted the resident on 03/24/2025 with diagnoses of diabetes, cognitive communication deficit, and dementia.Review of R8's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/12/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating R8 was cognitively intact.Review of R8's document Emergency Transfer to Hospital Notice, dated 08/22/2025, revealed the notice was sent with the resident to the hospital, with reason for transfer on the notice. The notice also documented paperwork for R8's representative was sent with the resident to the hospital.Review of R8's Activity Report, dated 08/23/2025, revealed the Business Office Manager (BOM) hand carried R8's Bed Hold Notice to the resident but nothing was documented about sending it and information about the transfer or discharge and the reasons for the move in writing to the resident's representative. 2. Review of R24's admission Record revealed the facility admitted the resident on 03/14/2023 with diagnoses of metabolic encephalopathy, acute kidney failure, and chronic kidney disease stage four.Review of R24's quarterly MDS, with an ARD of 12/09/2025, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Review of R24's Census List revealed, since the date of admission [DATE]), the resident had experienced a total of 17 hospital transfers. Review of R24's Bed Hold Notice, dated 10/28/2025 and signed by R24 on 11/04/2025 with the reason for the transfer, revealed it was for R24's hospitalization on 10/27/2025. Further review revealed the facility did not provide written notification to the resident's representative regarding the notice, the transfer or discharge, or the reasons for the move. Review of R24's Bed Hold Notice, dated 12/09/2025 and signed by R24 on 12/15/2025 with the reason for the transfer, revealed the facility did not provide written notification to the resident's representative regarding the notice, the transfer or discharge, or the reasons for the move. Review of R24's Bed Hold Notice, dated 12/18/2025, with the reason for the transfer, revealed the facility did not provide written notification to the resident's representative regarding the notice, the transfer or discharge, or the reasons for the move. The State Survey Agency (SSA) Surveyor attempted to contact the resident's representative on 01/13/2026 at 4:12 PM by telephone. However, the attempt was unsuccessful.During an interview on 01/13/2026 at 2:50 PM with the Business Office Manager (BOM), she stated bed holds were done face to face, or the bed hold form was sent via certified mail to the representative when the resident was not their own person. During continued interview on 01/14/2026 at 9:53 AM with the BOM, she stated she did not notify the residents' representatives of bed hold notices or reason for transfers, in writing, if the resident was their own person.During an interview on 01/14/2026 at 10:35 AM with the Director of Nursing (DON), she stated nursing did not do bed hold notification and reason for transfer notifications. She stated that it was done by the BOM.During an interview on 01/15/2026 at 4:36 PM with the Administrator, she stated it was her expectation that bed holds and reason for transfer notifications were sent to the resident or the resident's representative. She stated when the notification was done, she would expect it to be documented at least once.

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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 the facility's policy, the facility failed to develop and implement a comprehensive person-centered care plan to address the residents' medical needs for 1 of 31 sampled residents, Resident (R) 28. The findings include:Review of the facility's policy titled, Care Planning-Interdisciplinary Team Policy Statement, reviewed 04/28/2025, revealed the facility must develop an individualized, comprehensive care plan for each resident within seven days of completing the comprehensive assessment. Per the policy, the care plan was based on a comprehensive assessment and developed by the care planning interdisciplinary team (IDT), but it did not address staff implementing or following a resident's care plan.Further review of the facility's policy titled, Care Planning-Interdisciplinary Team Policy Statement, reviewed 04/28/2025, revealed the policy referenced a related document, Care Plans, Comprehensive Person-Centered. The State Survey Agency (SSA) Surveyor requested that additional care plan policy from the Director of Nursing on 01/14/2026 at 2:20 PM and on 01/15/2026 at 4:10 PM. However, that policy was not provided. Review of the admission Record found in R28's electronic health record (EHR), revealed the facility admitted the resident on 05/12/2025 with diagnoses to include dysphagia, moderate protein-calorie malnutrition, and hemiplegia.Review of the quarterly Minimum Data Set [MDS], found in R28's EHR with an Assessment Reference Date (ARD) of 12/23/2025, revealed the resident had a Brief Interview for Mental Status [BIMS] score of zero out of 15, indicating the resident had severe cognitive impairment. Further review revealed 51 percent of R28's total calories were received through parenteral or tube feeding.Review of the Order Summary Report, dated 01/2026 and found in R28's EHR, revealed on 10/29/2025 there was a physician ordered enteral feed order every day and night shift for Two-cal HN at 50 ml/hr continuous.Review of the Comprehensive Care Plan [CCP], no date, found in R28's EHR, indicated the resident was care planned 05/13/2025 for tube feeding related to dysphagia, poor oral intake, and refusal of meals with an intervention initiated 05/13/2025 to follow physician orders for current feeding orders. The goals included the resident would remain free of complications related to tube feeding.Observation on 01/12/2026 at 12:25 PM revealed R28 was receiving an enteral nutrition via g-tube (Two-Cal HN) infusing via pump at 65 mL/hr. The enteral feeding container was labeled for 50 mL/hour and documented as hung on 01/12/2026. However, the time and initials of the nurse were illegible.Observation on 01/13/2026 at 8:23 AM revealed R28 was receiving an enteral nutrition via g-tube (Two-Cal HN) infusing via pump at 65 mL/hr. The enteral feeding container was labeled for 50 mL/hour and documented as hung on 01/12/2026. However, the time and initials of the nurse were illegible.The SSA Surveyor, during the observations on 01/12/2026 and 01/13/2026, attempted to interview the resident but was unsuccessful due to the resident's cognition.During an interview with Licensed Practical Nurse (LPN) 10 on 01/13/2026 at 8:25 PM, she stated the expectation was that nurses followed the physician's orders and care plan as written to ensure the resident received the ordered amount of nutrition.During an interview with the Registered Dietician on 01/15/2026 at 2:58 PM, she stated it was her expectation that staff provided the residents with nutritional intake as prescribed to ensure the resident received optimum nutritional benefit.During an interview with the Minimum Data Set/Infection Prevention (MDS/IP) Nurse on 01/14/2026 at 1:16 PM, she stated it was her expectation that nursing staff followed R28's care plan for enteral feedings. She stated it was important to ensure the resident received adequate nutrition. During an interview with the Director of Nursing (DON) on 01/15/2025 at 4:10 PM, she stated it was her expectation for clinical staff to follow the resident's care plan to prevent complications related to enteral feeding and maintain adequate nutrition. During an interview with the Administrator on 01/15/2025 at 4:10 PM, she stated it was her expectation for nursing staff to follow physician's orders and the plan of care related to tube feeding and nutrition. She stated it was important for the resident's health and well-being.During an interview with the Medical Director on 01/08/2026 at 10:50 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Florence Park Care Center	6975 Burlington Pike Florence, KY 41042

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, he stated it was his expectation that all nursing staff verified and followed the physician's orders as written because the orders were based on the resident's plan of care. He stated over infusion of enteral feeding could cause an aspiration risk, nausea, vomiting, and/or diarrhea.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's Fall Investigation, and review of the facility's policy, the facility failed to ensure a resident was free from accidents and received adequate supervision and an assistive device to prevent accidents for 1 of 31 sampled residents, Resident (R) 14. The findings include:Review of the facility's policy titled Falls and Falls Risk Management, revised 04/28/2025, revealed that staff would identify and implement relevant interventions to minimize serious consequences of falling. The policy further stated that staff would monitor residents' responses to interventions intended to reduce falls or the risks of falling.Review of R14's admission Record revealed the facility admitted the resident on 12/02/2021 with diagnoses that included Alzheimer's disease, type 2 diabetes mellitus, cerebral infarction, dependence on a wheelchair, and difficulty walking.Review of R14's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 10/13/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of three out of 15, indicating severe cognitive impairment. Further review revealed R14 was totally dependent on staff for chair/bed transfers.Review of R14's Care Plan for the activities of daily living (ADL) self-care performance deficit revealed interventions of Hoyer lift (mechanical lift where a supportive sling was placed under the resident, and the resident did not have to stand or bear weight) with full-length Hoyer sling for transfers, initiation date documented as 12/05/2024; mechanical lift required for all transfers, initiated 05/13/2025 and revised 01/09/2026; and Hoyer lift to be used for all transfers, initiated 08/25/2025. Review of R14's Physical Therapy [PT] Treatment Encounter Note, dated 08/28/2025, revealed PT recommended a Hoyer lift for all transfers due to the resident's inability to safely use a sit-to-stand lift.Review of R14's Physician Orders, dated 08/29/2025, revealed a Hoyer lift was required for all transfers. Review of R14's State Tested Nurse Aide (STNA) Kardex, undated, revealed all transfers were to be completed using a Hoyer lift.Review of the facility's Fall Investigation, dated 01/07/2026, revealed, under the incident description, that staff members were attempting to transfer R14 from a wheelchair to a bed using a sit-to-stand mechanical lift when R14 slid out of the chair onto the floor while standing. Per the investigation, R14 had no injuries. During an interview on 01/12/2026 at 1:00 PM, Family Member (FM) 5 stated, My husband fell because the staff was using the wrong mechanical lift. FM5 further stated the sit-to-stand lift was used to transfer the resident from the chair to the bed today. During an interview on 01/13/2026 at 1:30 PM, STNA4 stated R14 primarily used the sit-to-stand mechanical lift until he fell on [DATE]. STNA4 further stated staff only used the Hoyer lift when R14 was fatigued and unable to stand on his own because R14 preferred the sit-to-stand lift. During an interview on 01/13/2026 at 2:30 PM, the Director of Nursing (DON) stated staff members were expected to use the Hoyer lift for all transfers of R14. The DON further stated it was important for staff to follow the physician's orders regarding transfers to prevent injury. During an interview with the Administrator on 01/15/2026 at 4:30 PM, she stated she expected staff to follow the facility's policies and the physician's orders for transferring residents to prevent injuries.

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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, and record review, the facility failed to ensure residents received appropriate treatment and services to prevent complications of enteral feeding for 1 of 2 sampled residents reviewed for tube feeding, Resident (R) 28.The findings include:The State Survey Agency (SSA) Surveyor requested the facility's enteral feeding policy from the Administrator on 01/13/2026 at approximately 9:30 AM and on 01/23/2026 at 3:34 PM via email. The policy was not provided.Review of the admission Record found in R28's electronic health record (EHR), revealed the facility admitted the resident on 05/12/2025 with diagnoses to include dysphagia, moderate protein-calorie malnutrition, and hemiplegia.Review of the quarterly Minimum Data Set [MDS], found in R28's EHR with an Assessment Reference Date (ARD) of 12/23/2025, revealed the resident had a Brief Interview for Mental Status [BIMS] score of zero out of 15, indicating the resident had severe cognitive impairment. Further review revealed R28 was dependent (helper did all of the effort) for activities of daily living (ADL) and required substantial/maximal assistance (helper did more than half the effort) for mobility in bed.Review of the Order Summary Report, dated 01/2026 and found in R28's EHR, revealed on 10/29/2025 the physician ordered enteral feed every day and night shift, Two-cal HN at 50 ml/hr continuous. Additionally, there was an order dated 09/12/2025 for 250 mL free water flush five times a day per tube feeding.Review of the Comprehensive Care Plan [CCP], no date, found in R28's EHR, indicated the resident was care planned on 05/13/2025 for tube feeding related to dysphagia, poor oral intake, and refusal of meals. An intervention, initiated on 05/13/2025, was to follow the physician's orders for the current feeding orders. The goals included the resident would remain free of complications related to tube feeding.Review of R28's weights, found in the resident's EHR, of the weight history over 180 days, revealed the resident weighed 140.6 pounds (lbs.) on 07/10/2025 and 153.1 lbs. on 01/05/2026, representing an 8.89 percent increase. Review of the 30-day weight history revealed the resident's weight was 147.0 lbs. on 12/16/2025 and 153.0 lbs. on 01/05/2026, representing a 4.08 percent increase.Observation on 01/12/2026 at 12:25 PM revealed R28 resting with his eyes closed in bed; the head of the bed was elevated. The resident was receiving an enteral nutrition via g-tube (Two-Cal HN) infusing via pump at 65 mL/hr. The enteral feeding container was labeled for 50 mL/hour and documented as hung on 01/12/2026. However, the time and initials of the nurse were illegible. Attempts to interview the resident were unsuccessful due to the resident's cognition.Observation on 01/13/2026 at 8:23 AM revealed R28 resting in bed; the head of the bed was elevated. The resident was receiving an enteral nutrition via g-tube (Two-Cal HN) infusing via pump at 65 mL/hr. The enteral feeding container was labeled for 50 mL/hour and documented as hung on 01/12/2026. However, the time and initials of the nurse were illegible. During an interview with Licensed Practical Nurse (LPN) 10 on 01/13/2026 at 8:25 PM, she stated the evening nurse hung the enteral feed and would have programmed the feeding pump. LPN10 stated she did not realize the pump had been programmed to infuse a higher volume rate of enteral feed than what was ordered. She further stated she had not yet looked at the pump that morning. However, she stated she would go into the resident's room to check the pump, verify the current physician orders, and change the pump's programming to match the order as needed. Additionally, LPN10 stated she had not yet seen the resident, and the facility did not conduct beginning of the shift rounding or bedside shift report at the start of the shift where concerns could be identified. Furthermore, LPN10 stated the expectation was that nurses followed the physician's orders as written and verified the enteral feeding pump was programmed correctly, including confirming the correct rate volume per the current order to ensure the resident received the ordered amount of nutrition.During an interview with the Registered Dietitian on 01/15/2026 at 2:58 PM, she stated it was her expectation that staff provided the residents' nutritional intake as prescribed to ensure the resident received optimum nutritional benefit. The RD further stated ordered meals and supplements should be offered and (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered according to the nutritional care plan. She stated extra volume added up quickly and, over multiple days, could significantly increase total intake, which could lead to feeding intolerance, aspiration risk, and fluid overload. She stated the facility process and staff should ensure the resident received the full ordered intake unless the resident refused or there was a documented clinical reason the intake could not be provided.During an interview with the Director of Nursing (DON) on 01/15/2026 at 4:10 PM, she stated it was her expectation the clinical staff would have followed the physician orders when administering enteral feedings via a g-tube. She also stated staff should ask for assistance if they did not know how to operate the pump or were unsure how to implement the order. When asked who was responsible to ensure the order was correct, the DON stated the nurse on duty was expected to check the pump and tube feeding rate to ensure it was correctly set and administered per the order. She stated it was important to prevent complications related to enteral feeding and maintain adequate nutrition.During an interview with the Administrator on 01/15/2026 at 4:10 PM, she stated it was her expectation for nursing staff to follow physician orders and the resident's plan of care related to tube feeding and nutrition. She stated it was important for the resident's health and well-being.During an interview with the Medical Director on 01/08/2026 at 10:50 AM, he stated it was his expectation that all nursing staff verified and followed the physician's orders as written because the orders were based on the resident's plan of care. He stated over infusion of enteral feeding could cause an aspiration risk, nausea, vomiting, and/or diarrhea.

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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 documents and policy, the facility failed to ensure residents who required dialysis services received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 out of 2 residents sampled for dialysis services, Resident (R) 10 and R24. The findings include:Review of the facility's policy titled, Dialysis Care, dated 08/2021 and last reviewed 04/24/2025, revealed, Facilities shall use a form to communicate between the dialysis center with each visit.1. Review of R10's admission Record revealed the facility admitted R10 on 09/05/2025 with diagnoses of congestive heart failure (CHF), dementia, chronic kidney disease stage three, and diabetes mellitus.Review of R10's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/09/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of three out of 15, indicating R10 had severe cognitive impairment. Review of R10's Care Plan, dated 09/11/2025, revealed R10 was care planned for receiving hemodialysis on Monday, Wednesday, and Friday related to end stage renal disease (ESRD).Review of R10's Order Details revealed R10 had orders for off-site hemodialysis services three days per week, dated 09/08/2025. Review of R10's Dialysis Center Communication Record revealed three incomplete forms, dated 01/07/2026, 01/09/2026, and 01/12/2026. In addition, further review of R10's electronic health record revealed zero completed forms for Dialysis Center Communication Record since R10's admission. The State Survey Agency (SSA) Surveyor attempted to interview R10 on 01/12/2025 at 3:00 PM. R10 was sitting in his wheelchair in his room and was not able to state his name. When asked if he received dialysis, R10 stated, No. R10 was corrected by his roommate that R10 did receive dialysis. 2. Review of R24's admission Record revealed the facility admitted the resident on 03/14/2023 with diagnoses of metabolic encephalopathy, acute kidney failure, and chronic kidney disease stage four. Further review revealed R24 was diagnosed with ESRD and dependence on renal dialysis on 05/23/2024. Review of R24's quarterly MDS, with an ARD of 12/09/2025, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Review of R24's Order Details, dated 09/12/2025, revealed the resident received hemodialysis services three days per week. Review of R24's Care Plan, revealed R24 was care planned for dialysis, dated 01/12/2026. Review of the facility's document for R24 Dialysis Center Communication Record, dated 01/03/2026, 01/06/2026, 01/08/2026, 01/10/2026, and 01/13/2026 revealed four of the five documents reviewed were incomplete. Dialysis communication forms from prior dialysis dates were not received. During an interview on 01/15/2026 at 1:29 PM with the dialysis center's Administrator, she stated, We are supposed to receive a dialysis communication form, but very rarely do we get it. They just call asking for our records.During an interview on 01/13/2026 at 6:02 PM with the Director of Nursing (DON), she stated the facility only kept three months of records on the physical chart, and the rest was sent to medical records. She stated she would check with medical records to see if they had hemodialysis (HD) records. However, in follow-up, the DON stated medical records did not have any HD communication forms. During an interview on 01/14/2026 at 9:38 AM with License Practical Nurse (LPN) 14, she stated she sent the Dialysis Center Communication Record with residents that went to the dialysis clinic. However, she stated the dialysis clinic did not return it. She stated when that happened, she was to call the clinic and request it to be faxed. She stated the dialysis clinic usually faxed the post summary report. During additional interview on 01/14/2026 at 9:45 AM with the DON, she stated she educated nurses on the morning of 01/14/2026 to call the dialysis clinics and request the form to be faxed back when it was not returned with the resident. In additional interview on 01/14/2026 at 10:35 AM with the DON, she stated it was her expectation that the Dialysis Center Communication Record be completed. She stated that it was important to know how the resident was doing and for communication. During an interview on 01/15/2026 at 4:36 PM with the Administrator, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she stated it was her expectation for staff to follow all of the facility's policies. She stated, It's extremely important to communicate back and forth with dialysis.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, record review, and review of the facility's documents and policy, the facility failed to maintain an effective pest control program, so the facility was free of pests and rodents for 2 out of 31 sampled residents, Resident (R) 2 and R53. The findings include:Review of the facility's policy titled, Resident Environmental Quality, dated 08/2023, revealed the policy stated, It is the policy of this facility to be designed, constructed, equipped and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The policy also stated, The facility shall maintain an effective pest control program, so the facility is free of pests and rodents. Review of the facility's Pest Control Agreement, with the contracted pest control company, revealed it stated, This agreement covers only the pest specified. Should the customer request services for pests other than those specified, additional charges will be made for the additional services. Review of the pest specified within the agreement included general pests, ants, crickets, mice, millipedes/centipedes, spiders, pill/sowbugs, and German roaches. Review of the Maintenance logbook, containing work orders for the proceeding 30-day period, revealed no documented reports or issues related to gnats. Review of the pest control Invoices, dated 10/30/2025, 11/26/2025, and 12/22/2025, revealed no documented reports or issues related to gnats. 1. Review of R2's admission Record revealed the facility admitted the resident on 12/23/2025 with diagnoses of chronic obstructive pulmonary disease (COPD), schizoaffective disorder bipolar type, and anxiety. Review of R2's admission Minimum Data Set [MDS], dated 01/06/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, indicating the resident was cognitively intact.Observation of R2 on 01/12/2026 at 12:53 PM revealed gnats on the resident and in the resident's room.Observation on 01/13/2026 at 8:21 AM revealed the persistent presence of gnats in the room and on the resident.Observation on 01/14/2026 at 8:50 AM again revealed the persistent presence of gnats in the room and on the resident. Observation on 01/14/2026 at 2:19 PM revealed cleaned nebulizer parts on a napkin next to the sink, with gnats present on and around the equipment. The State Survey Agency (SSA) Surveyor attempted to interview R2 on 01/12/2026 and again on 01/13/2026. However, the resident's eyes were closed and appeared to be sleep. The resident could not participate in an interview.In an interview with Family Member 2 on 01/14/2026 at 10:12 AM she stated, Me and my sister visit twice a week. The facility does not communicate with me, or my sister, and staff are not friendly. Family Member 2 stated when she had brought up concerns about the gnats, the nurse stated, I'm agency. In an interview with State Trained Nurse Aide (STNA) 16 on 01/14/2026 at 3:11 PM, she stated if she observed gnats in a resident's room, it was her expectation that the area be cleaned and treated, and she would notify housekeeping or maintenance. STNA16 stated she would not consider R2's room to be a clean, home-like environment.In an interview with the Housekeeping Supervisor on 01/14/2026 at 2:13 PM, she stated the daily housekeeping staff hours are 8:00 AM to 4:30 PM. She stated, There is a housekeeper assigned to each hall, every day. If pests are observed or suspected, then the staff report it to the housekeeping supervisor, and she will report it to maintenance. The expectation is that staff will clean rooms daily and report any issues, and staff have not reported any issues regarding gnats. The Housekeeping Supervisor stated she would not consider R2's room to be a clean, home-like environment.2. Review of R53's admission Record revealed the facility admitted the resident on 02/16/2024 with diagnoses including chronic diastolic heart failure, dementia, and degenerative disease of the nervous system.Review of R53's admission MDS, with an ARD of 01/02/2026, revealed the facility assessed the resident to have a BIMS score of 13 of 15, indicating the resident was cognitively intact and able to express concerns regarding the environment.Observation on 01/14/2026 at 12:30 PM revealed R53 seated in his wheelchair in his room, eating lunch, with multiple gnats flying around and landing on the resident's food tray. In an immediate interview at the time of the observation, R53 stated bugs landing on his food was gross, (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and he had asked STNA4 to bring him something else to eat.In an interview on 01/14/2026 at 1:30 PM with STNA 4, she stated she provided R53 with additional food. She further stated she would request different food if a bug had landed in her food as well. In an interview on 01/14/2026 at 3:19 PM with Licensed Practical Nurse (LPN) 7, she stated the presence of gnats in a resident's room did not constitute a home-like environment, and if observed, gnats should be reported to housekeeping and maintenance for treatment.In an interview on 01/15/2026 at 4:30 PM with the General Manager of contracted pest control company, he stated the agreement with the facility stated the company would come to the facility twice a month to treat the common areas and up to five resident rooms. He stated, We will treat up to four times a year for the outside. When treating common areas, we are treating pests, including gnats. Gnat treatment alone will not fully resolve the issue, as gnats are linked to sanitation issues. Additionally, the General Manager stated the facility had not made them aware of any issues concerning gnats. He stated, The service technician checks with staff and reviews the maintenance log upon arrival for any reported concerns. In an interview on 01/15/2026 at 12:57 PM with the Director of Nursing (DON), she stated the presence of gnats in a resident's room did not meet the expectation of a home-like environment. She stated, Gnats should be reported to maintenance as soon as they are noted, and that needed to be addressed immediately. In an interview on 01/15/2026 at 12:58 PM with the Administrator, she stated the presence of gnats in a resident's room did not meet the expectation of a home-like environment. She stated, Gnats should be reported to maintenance soon as they are noted, and they needed to be addressed immediately. Staff can address pest concerns in the maintenance book that is located at the front desk. Maintenance reviews the book multiple times a day addressing the concerns noted. In an additional interview on 01/15/2026 at 5:03 PM with the Administrator, she stated, I was unaware of any gnats until this week. The Administrator reported there had been a gnat issue approximately six months prior, in the same room, at which time the room was treated, and no further presence of gnats was noted. She stated, I would check the room about once a day to verify that gnats were no longer present. However, I may have slacked (checking the room) around 12/23/2025. She stated she did not think the issue with gnats was a result of a sanitation issue. She stated, I don't think the drain was treated when the room was previously treated for the gnats.