STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185228	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western State Nursing Facility	2400 Russellville Road Hopkinsville, KY 42240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 20Number of residents cited: 2The facility failed to provide a dignified existence for two residents by not ensuring lap covering for two residents, R35 and R18. Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to treat each resident with respect, dignity, and care for each resident in a manner and an environment that promotes maintenance or enhancement of his/her quality of life, recognizing each resident's individuality for two (2) of twenty (20) sampled residents (Resident 18 and 35). The findings include: Review of facility policy dated October 2000, item 21 titled Dignity revealed, the facility must promote care for residents in a manner that maintains or enhances each individual's dignity and respects his or her dignity.A review of MDS information revealed R35 was admitted on [DATE] with a diagnosis of unspecified symptoms and signs involving cognitive functions and awareness and does not have a BIMS score and is not interviewable. R18 was admitted on [DATE] with a diagnosis of schizophrenia and psychotic disorder, and has a BIMS score of 99 and is not interviewable. An observation at 12:45 PM on 12/08/2025, Resident (R)18 and R35 are sitting in the hallway outside their rooms in wheelchairs. Each was wearing only a short gown with underwear and no pants. R18 was playing with her gown's tail and exposing herself. There were no lap covering or blanket on R18 or the floor near the Broda chair.An observation at 2:20 PM on 12/08/2025 revealed that R35 was sitting in a wheelchair in the hall with her legs exposed, wearing only a gown and underwear without pants and no lap cover or blanket around. An interview with CNA#2 on 12/10/2025 at 3:43 PM revealed that R18, who was sitting in the hall in a wheelchair, throws her blanket off her and that she likes to flash at times. CNA#2 also stated that an intervention for her is to put pants on her and blankets, but she does not like those. No blanket or lap covering was covering R18, who was in the hall at that time.In an interview with LPN #1 on 12/10/2025 at 3:50 PM, it was revealed that they put a blanket on R18 in the past to help cover her, but she doesn't keep a blanket on her, and they must continually cover her back up to maintain privacy. In an interview with the ADON on 12/10/2025 at 6:30 PM, she revealed that she expected residents in gowns to have their legs covered with a lap cover or blanket while in the hall.In an interview with the DON on 12/10/2025 at 6:40 PM, she revealed that her expectations were that the staff monitor the residents in the hall and that they be covered by a blanket, and depending on the time of day, the resident should be dressed to avoid a privacy or dignity issue.In an interview with the Administrator on 12/10/2025 at 7:00 PM, she revealed that she expected residents to be covered for dignity and privacy while in the hall. Her expectation for a resident with behavioral difficulty is to maintain dignity and privacy, to redirect the resident, and if behavior persists, to remove the resident to their room.

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and review of facility policy, the facility failed to follow standard precautions to be followed to prevent the spread of infection. Appropriate infection prevention and control practices were not implemented during medication administration. Hand hygiene was not performed while administering medications to one of two residents, Resident (R) 28. The findings include:Review of facility policy, titled Psychobiological/Pharmacological Interventions Medication Administration and Documentation, revised January 2023, revealed all medication will be prepared and administered as per manufacturer's specifications and accepted professional standards.Review of facility policy, titled Infection Prevention and Control, revised October 2022, revealed Western State Nursing Facility will maintain an Infection Prevention and Control Program intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/29/2025 revealed the facility admitted R28 on 03/27/2013 with the primary reason for admission of non-traumatic brain dysfunction. Diagnoses active within seven (7) days of the ARD included cancer, anemia, Parkinson's Disease, and schizophrenia. A Brief Interview for Mental Status (BIMS) of 99 indicated the interview for R28 could not be completed.Observation of medication administration with Registered Nurse (RN) 1 on 12/10/2025 at 9:15 AM revealed RN1 wearing gloves while preparing medications for R28 at the medication cart. Wearing the same pair of gloves, RN1 placed a finger inside the medication cup prior to placing medication in the same cup, she typed on the computer keyboard and handled the drawers of the cart. Continuing to wear the same pair of gloves, RN1 entered R28's room and picked up the fall mat from the floor and placed it against the wall, she then used the bed control to adjust height of the bed. While still wearing the same pair of gloves, she moved the blanket away from R28's face and began to administer medications. Because she had a question regarding the need to thicken liquid medications, RN1 exited the resident's room, returned to the medication cart computer, and then went to the end of the hall to add thickener to the liquid medication. Upon return to the medication cart, RN1 removed her gloves, used hand sanitizing gel, and re-gloved before typing on the computer keyboard then knocking on resident's door, adjusting the bed height, administering the liquid medication and wiping R28's face. She then replaced the fall mat, exited the room, and returned to the medication cart to type information into the computer before removing her gloves.In an interview with RN1 on 12/10/2025 at 9:40 AM, she stated nothing should be inside a medication cup and she was unaware she had placed a finger inside the cup. She further stated it is the facility policy to wear gloves during medication administration so that the meds are not touched. I guess we need to figure it out because there are no gloves or hand sanitizer in the resident rooms and that would be a lot of in and out of a room she stated regarding wearing gloves and the lack of hand hygiene.In an interview on 12/10/2025 at 6:38 PM with Assistant Director of Nursing (ADON), she stated that she was not sure it was in the policy for nurses to wear gloves while administering medication. She further stated that a lot wear them and change in between residents. If gloves are worn, staff are to remove and perform hand hygiene between residents. Additionally, she stated that touching multiple objects, including a fall mat on the floor and the resident's face, while wearing the same gloves was not appropriate. Staff is educated that hand hygiene should be performed prior to and after the administration of medications. She stated that possible negative outcomes of a lack of hand hygiene could be that residents become sick or the possibility of spreading anything after touching so many things. In an interview with Director of Nursing (DON) on 12/10/2025 at 6:55 PM, she stated it was not policy for staff to wear gloves while administering oral medication, but they should perform proper hand hygiene between residents. Additionally, she stated that staff is educated on hand hygiene. She added that the educator left back in June so herself and the ADON have educated new staff on hire and others annually and as needed. She stated that she saw no concerns with the morning medication pass because RN1 did not touch (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medicine. She expected staff to wash hands between residents and that there could be a potential for illness or something could happen to make the residents sick if proper hand hygiene was not performed. In an interview with Administrator on 12/10/2025 at 7:11 PM, she stated she had a social work background but was familiar with hand hygiene. She would not expect gloves to be worn for oral medication administration. She knows some may prefer to wear gloves. She would expect that if something was touched that was contaminated, hands would be washed prior to administering medication. Administrator stated that she did not believe that the morning's medication administration was appropriate. A potential negative outcome could be infection.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 20Number of residents cited: 1The facility failed to ensure that one resident could access the call light R46. Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure the call system was accessible to residents while in their bed, chair, or other sleeping accommodations for one (1) of twenty (20) sampled residents (R46). The findings include: Review of MDS information on 12/08/2025 revealed that R46 was admitted on [DATE] and had a BIMS of 99 with a diagnosis of schizophrenia and is not interviewable. Review of functional abilities (GG0130A1) shows partial to moderate help needed for using eating utensils. Review of care plan dated 10/20/2025, an intervention for high risk of fall was to ensure the call light is within reach. An observation made on 12/08/2025 at 2:00 PM revealed that Resident 46 was sitting in a Broda chair 2 feet from her bed with a call light wedged behind the recliner at the foot of her bed. An observation made on 12/10/2025 at 3:33 PM revealed that R46 was sitting in a Broda chair with the call light on the floor between the recliner and the bed, out of reach. In an interview, CNA#2 on 12/10/2025 at 3:43 PM, she revealed that R46 will hold her drinking cups and can use a call light. In an interview, LPN #1 on 12/10/2025 at 3:50 PM, she revealed that R46 can operate a call light and, at times, feed herself. In an interview with the ADON on 12/10/2025 at 6:30 PM, she revealed that they trained all staff to place the call light on the resident's lap when they do not see it within reach. In an interview with the DON on 12/10/2025 at 6:40 PM, she revealed that the expectation was that all residents who can use call lights have them. In an interview with the Administrator on 12/10/2025 at 7:00 PM, she expected the call light to be within the reach of all residents, and if a resident cannot operate a call light, that it be recorded and addressed in the care plan. If the resident cannot push a button, they would receive a pressure pad alternative.