STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chautauqua Health and Rehabilitation	1205 Leitchfield Road Owensboro, KY 42303

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety which had the potential to affect all residents who consumed meals from the kitchen. The findings include:1). Review of the facility's policy titled, Food Storage, dated 10/2019, revealed the Dietary Manager was to ensure all food items were stored properly in covered containers. Further review revealed the containers were to be labeled, dated, and arranged in a manner to prevent cross-contamination.Observation of the kitchen, on 05/05/2026 at 11:05 AM, revealed a dessert cart with 20 cups of chocolate trifle stored uncovered and undated in the freezer. Observation of the dry pantry storage revealed one large 6.61-pound canned peaches, two large 6.61-pound canned mandarin oranges, and three large 6.38-pound stewed tomatoes were dented but stored in active rotation to serve to residents. Chicken soup base was stored in the 1.25-pound original container with the lid lying on top, unsealed, and had an open date of 12/30/2025 but no use-by date. 2). Review of the facility's policy titled, Staff Attire, dated 10/2019, revealed all dining service staff were to wear approved attire for the performance of their duties. Further review revealed all staff members would take their hair off their shoulders, confine it in a hair net or cap, and facial hair was to properly restrained. Observation of Assistant Dietary Manager (ADM), on 05/05/2026 at 11:20 AM, revealed her hairnet was improperly worn and exposed approximately 2.5 inches of hair on her right side and 1.5 inches of hair on the left side and had receded 1-2 inches above her hairline on her forehead. In an interview with the ADM, on 05/05/2026 at 11:30 AM, she stated she did not realize her hair was exposed but stated she had a lot of hair and the hairnet had slipped off sometimes. She was aware that not properly wearing a hairnet was a concern and hair should always be covered to prevent hair from falling into the resident's food. 3). Review of the facility's policy titled, Record of Food Temperature, dated 01/02/2020, revealed food temperatures were to be verified using a clean, sanitized, and calibrated thermometer to ensure accuracy. Observation of the kitchen on 05/06/2026 at 11:45 AM, revealed the ADM used a thermometer to check the temperature of hamburger patties, but failed to clean the thermometer before taking the temperature (temping) the pureed corn. Further observation revealed the ADM used an ice cream scoop to remove the area of the pureed corn she had touched with the thermometer; however, did not discard the pureed corn.In interview with the ADM on 05/06/2026 at 11:55 AM, she stated she realized her mistake. She reported she should have discarded the pureed corn because it had become contaminated after the thermometer was used on the hamburger patties and was not sanitized prior to using on the corn.In interview with Dietary Manager (DM), on 05/08/2026 at 4:00 PM, she stated expectations for the dietary staff to follow facility's polices and procedures. She said all staff were aware of wearing hairnets and the importance of keeping all hair covered. The DM reported she would not want resident's served food contaminated with hair and residents would not be happy to find hair in their food. She explained when checking temperatures of food, her expectations for all dietary staff was to ensure thermometers were sanitized between each food item to prevent cross contamination and allergy concerns. The DM said if staff used the same thermometer in two different food items, the (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	contaminated food item should be discarded. She stated all staff were trained on food safety, and the ADM would be completing courses through Servsafe (a nationally recognized food safety training program) to be certified in food safety and the registered dietician would proctor her training. Additionally, she stated expectations were for all staff, including dietary staff, was to ensure residents were provided with meals that were healthy and safe. In interview with the Administrator on 05/08/2026 at 5:52 PM, she stated her expectations for all dietary staff was for them to follow the facility's policies and procedures for food safety. She said all dietary staff should be wearing hairnets properly covering all visible hair to prevent food contamination. The Administrator reported staff were in-serviced by the Registered Dietician (RD). She explained she had performed audits in the kitchen to ensure safety processes were being followed. The Administrator further stated if staff were not following policies and procedures there was a potential for cross contamination and foodborne illnesses. In addition, she said if policies and procedures were not followed it could be worse for those with allergies if sanitation practices were not followed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document and policy review, the facility failed to report all alleged violations of abuse to the State Agencies (including the State Survey Agency (SSA) for 1 of 1 residents sampled for sexual abuse out of the total sample of 25 residents, (Resident (R)61).The findings include:Review of the facility policy titled, Abuse, Neglect and Exploitation, last reviewed 04/2026, revealed, under section II Employee Training, new employees were to be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation and existing staff to receive annual education through planned in-services and as needed. Continued review under section VII Reporting/Response, the facility was to have written procedures that included reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes. Further review revealed for allegations involving abuse or that resulted in serious bodily injury, the allegations were to be reported immediately, but not later than two hours after the allegation was made.Review of the Resident Face Sheet revealed the facility admitted R61 on 07/12/2024, with diagnoses which included stage four pressure ulcer of sacral region, non-pressure chronic ulcer of skin of other sites with necrosis of muscle, and anxiety disorder. Review of the Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 03/29/2026, revealed the facility assessed R61 to have a Brief Interview for Mental Status (BIMS) of 14 out of 15, which indicated intact cognitive function. Additionally, review of the Annual MDS Assessment revealed the facility identified no behaviors for R61.Review of the facility's grievance log from 01/01/2026 through 05/07/2026, revealed no documentation of grievances filed either from or on behalf of R61.Review of the Facility Investigation for R61 in February revealed a written statement noted by the Assistant Director of Nursing (ADON), dated 02/12/2026, which documented, Resident reported to this nurse that she did not want Licensed Practical Nurse (LPN 1), to work with her any longer. Per review of the ADON's statement, R61 said she felt like she had concerns with LPN 1 doing her treatment and she shouldn't have to spend so long cleaning and doing her treatment. Continued review revealed the ADON noted R61 said she did not particularly like LPN 1 and did not want her to take care of her any longer. Further review revealed the ADON documented explaining to R61 it was her right to prefer other caregivers, and the facility would accommodate her request, and the resident voiced no further complaints.Review of Facility Investigation for R61 in February revealed a statement from the Administrator, dated 02/12/2026, which stated On 02/12/2026 R61 voiced concerns related to LPN1 doing her wound care. R61 was interviewed by ADON on 02/12/2026. ADON reported during interview R61 stated she did not like LPN1 and no longer wanted her as her nurse because it took too long to do her treatment. ADON reported R61 stated she felt safe in the facility. LPN1 was removed from R61 care per resident request. Residents with a BIMS of eight or greater were interviewed on 02/12/2026 who were assigned to LPN1 as a precautionary measure, no complaints or concerns were voiced. Residents with a BIMS below eight head to toe skin assessments were completed as a precautionary measure, no concerns identified. Additional review of the February Facility Investigation revealed documentation noting skin assessments performed of residents with a BIMS score below eight, as well as interviews of residents with BIMS scores of eight or higher performed with no concerns noted.During interview on 05/05/2026 at 10:04 AM, R61 stated LPN 1 had been removed from this floor because of me. R61 stated she was recovering from flesh eating bacteria and said, They had to move my urethra to my vagina; my anatomy doesn't look like a normal female. She reported LPN 1 stuck her finger inside me and told her, Oh, you are so tight now. Like a virgin again. R61 explained Certified Nurse Aide (CNA) 8 overheard LPN 1 make that remark and got the ADON so I could tell her what happened. She said the Administrator got involved and removed LPN 1 from her care. R61 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, I'm not devastated or anything but just floored that it had happened. She reported being concerned for other residents who could not speak up for themselves, as LPN 1 was now on an all-female dementia unit. R61 further stated she was told it was, not sexual assault, it was just inappropriate behavior; however, did not remember who had told her that. She additionally stated, This all happened about 3 months ago or so.During telephone interview on 05/06/2026 at 5:20 PM, CNA 8 stated she helped nurses with peri-care and wound care for R61. She reported on one occasion while assisting LPN 1 with R61's care, she observed LPN 1, after removing the wound packing, to stick her fingers inside the resident's vagina. CNA 8 said she had never seen other nurses do anything like that before. She stated, LPN 1, while moving her fingers clockwise in R61's vagina, said, [NAME] R61, it's getting tighter. Like a born-again virgin. If your husband was alive, he would like that. Some people pay for this. CNA 8 reported R61, CNA 6 (who was also assisting) and herself, all looked at each other like, what just happened? Did she really say that? The CNA said she knew that was wrong. She stated after completing R61's peri-care and wound care, all three staff members left the room. CNA 8 further stated she went back later to check on R61 and asked if she was okay, and the resident told her what LPN 2 had done, made her feel very uncomfortable. In addition, the CNA said she told R61 she needed to file a grievance about what LPN 1 had done. In an additional interview with CNA 8, on 05/07/2026 at 3:42 PM, she stated she had not reported the incident involving what LPN 1 had done to R61, as the resident asked her not to. During a phone interview on 05/06/2026 at 6:25 PM, with CNA 6, she stated that sometime near the end of January or in February she was assisting LPN 1 and CNA 8, with providing care for R61. She reported while LPN 1 had her fingers inside R61, the LPN said, you are getting tighter. It's like you are a born again virgin. If your husband was alive, he would have paid for this. CNA 6 said after R61's care was completed, all of the (the staff) left R61's room. She stated she did not believe R61 ever said anything about the interaction or reported it to anyone. The CNA further stated she was never questioned by anyone regarding the incident. During an additional interview on 05/07/2026 at 3:32 PM, with CNA 6, she stated did not report the incident to her leadership, but now regretted not doing so. She stated she wished she would have; however, then again I felt like no one would have taken it seriously. During interview on 05/07/2026 at 9:35 AM, CNA 10 stated she had worked at the facility since October 2025, mostly on the facility's Memory Care (dementia) unit. She said she received abuse training during orientation, and had no concerns of fellow co-workers mistreating or abusing residents. CNA 10 further stated however, if she ever had such concerns, she would report them to the facility's abuse coordinator. During interview on 05/07/2026 at 9:40 AM, CNA 11 stated she started at the facility in January and had always worked on the Memory Care unit. She said she had abuse training in orientation, and had no concerns of any staff mistreating a resident. CNA 11 further stated she would notify the (facility's) abuse coordinator or the Administrator of any concerns.During interview on 05/07/2026 at 9:50 AM, LPN 1, who was working at the time, stated she worked at the facility for about two and a half years. She said the staff received abuse training all the time, practically monthly. LPN 1 explained she had worked all the units in the facility; however, the Memory Care unit was her favorite. When the SSA Surveyor asked if LPN 1 had ever witnessed or been concerned about staff abusing a resident, she replied they got rid of someone who was snappy with a family member that very night. During a phone interview on 05/07/2026 at 7:20 PM, CNA 19 stated she had not been an eyewitness to the incident involving LPN 1 and R61. She stated however, when she entered R61's room later on, the resident looked really upset and asked if she could talk to her (CNA 19) about something. CNA 19 reported R61 then told her that during her peri-care, LPN 1 told her, You're a new, born-again virgin, and also expressed concern LPN 1 was re-opening wounds that had closed. She explained R61 told her she did not want her (LPN 1) in here because of that. CNA 19 said she tried to convince R61 to report that information, but the resident told her she was afraid of retaliation. The CNA stated she reported what R61 had told her to the ADON, and the ADON and Social Services (SS) talked to R61 and she (CNA 19) witnessed their conversation. She stated a few days later, R61 asked her if she heard anything about what was being (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	done about LPN 1, and she told the resident no, but she would find out for her (R61). CNA 19 further stated she went to the ADON and asked about the progress of the investigation and was told by the ADON, there is an active investigation going and that is all I can say. Additionally, CNA19 stated she felt terrible, like she had let her resident down because she had not put anything in writing, saying, I trusted them and this was what it had led to.During interview on 05/08/2026 at 10:13 AM, CNA 3 stated on unknown date, R61 informed her she was uncomfortable with LPN 1 providing her care. She reported R61 told her LPN 1, touched her more than she should. CNA 3 stated R61 told her not to tell but said, of course I did. She explained she told the Social Services (SS) Worker what R61 had told her right then because SS happened to be on the resident's hall, and that was who they were supposed to go to about residents' behaviors.During interview on 05/08/2026 at 4:55 PM, the Director of Social Services (SS) stated she did not remember being told of concerns related to inappropriate touching of R61 by LPN 1. She said it was possible she was told, but had forgotten as she was dingy and if she did not write things down, she often forgot them. The Director of SS reported if the incident (involving LPN 1 and R61) occurred while the previous Administrator had been here, she could believe that Administrator had, swept it under the rug. She further stated LPN 1 was, rough as a cob and you never know what will come out of her mouth, but I have never known her to be intentionally mean to a resident.During interview on 05/07/2026 at 1:46 PM, the Administrator started in her position at the facility on 02/09/2026, and it had been maybe her third day here when she became aware of R61 requesting that LPN 1 not provide her care any longer. She said R61 voiced concerns about LPN 1 taking too long to do a dressing change and that she didn't really want that nurse to take care of her anymore. The Administrator explained LPN 1 was moved to another hall in the facility. She stated as she was still learning staff and residents, it had been her decision to re-assign LPN 1 to another unit. The Administrator said Interviews of interviewable residents, and skin assessments on other residents were performed just to make sure things were covered. She reported based on the concern presented she did not feel it had been necessary to interview R61 or the nurse involved as part of the facility's investigation. The Administrator stated the incident had been the only complaint like this she had experienced in her time at the facility, and if there were to be additional such incidents she would save a folder. She said there had been no additional concerns with R61 or LPN 1 since that time. The Administrator further stated there had been no reason to report the incident / complaint to the SSA because it had been related to resident care. Additionally, the Administrator said she had performed the interview with R61 and saw the resident for several days afterwards.During interview on 05/07/2026 at 2:13 PM, the ADON stated R61 had been in her care for a long time and she was a generally pleasant person. She said R61 had people she liked and those she did not like and there was no rhyme or reason for that. The ADON explained the only concern she remembered involved a nurse that R61 did not want taking care of her anymore. She stated, She (R61) didn't want LPN1 to care for her anymore. She said something about her treatment, and it took her (LPN 1) too long to do. The ADON said it was normal to move a nurse if the facility was able to accommodate a resident's wishes. The ADON reported she had never heard R61 make any accusations against anyone about sexually inappropriate behavior, and R61 had only told her she did not like her, but never gave a reason why. She stated it was normal to make a file if a resident complained as, We were told to cover all bases. The ADON further stated she would take an accusation of that nature very seriously; however, based on the concern reported to her, there had been no reason to report that information.

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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 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 2 of 5 residents, sampled for medication observation out of the total sampled 25 sampled residents, (Resident (R)46 and R75). The findings include: Review of the facility policy titled, Infection Prevention and Control Program, last revised 01/2025, revealed the facility established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Additionally, all staff were to assume all residents were potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Review of the facility policy titled, Medication Administration, last reviewed 04/2026, revealed staff were to wash hands prior to and after administering medication.During observation of medication pass on the facility's 500- Hall on 05/05/2026 at 12:00 PM, Certified Medication Aide (CMA)1 failed to perform hand hygiene prior to administering medication to R46 and between administering medication to R46 and R75. Per observation, there was a stack of medication cups and a stack of water cups placed upside down on top of the medication cart. CMA 1 was observed to touch the rim of the water cups and medication cups, as well as the inside of the medication cups when obtaining the medication from the medication cards and carrying water to the resident. Continued observation revealed, after donning a glove and obtaining another glove from the Personal Protective Equipment (PPE) holder on R75's door, the CMA sorted through the medication cart contents. Observation revealed CMA 1 then, without changing gloves or performing hand hygiene, opened a gabapentin (an anticonvulsant medication) capsule in order to empty its contents into a medication cup. Further observation revealed the Assistant Director of Nursing (ADON) witnessed CMA 1 emptying the capsule with the contaminated gloves on. In addition, observation revealed the ADON addressed and educated CMA 1 at that time.During interview with CMA 1 on 05/05/2026 at 12:10 PM, she stated she had to get a glove from the PPE holder because there were no more gloves on the medication cart. She additionally stated she had not thought about what she was touching and had just forgotten to perform the necessary hand hygiene. During interview with the ADON on 05/05/2026 at 12:12 PM, she stated she would further educate CMA 1. She further stated she would conduct additional observations of CMA 1 administering medications later to ensure her compliance with standard precautions.