STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185242	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mt. Sterling Health & Rehab, LLC	125 Sterling Way Mount Sterling, KY 40353

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 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 observation, interview, record review, review of the facility's job description, and review of the facility's policies, the facility failed to provide adequate supervision and an environment free of accident and hazards for 3 of 5 sampled residents, Resident (R) 10, R82, and R60. Review of R82's electronic medical record (EMR) revealed on 05/19/2025 R82 was left unsupervised in the bathroom and fell. Review of R10's EMR revealed on 09/15/2025 R10 was sitting in a chair in the television area and fell while attempting to self-transfer. The resident sustained a fractured nose, abrasion to the right eyebrow, and complained of pain in the right shoulder.Observation on 03/03/2026 of R60 revealed a medication cup containing crushed medication mixed in pudding, with a spoon inside, was left on the bedside table in front of R60, who was awake and sitting in her wheelchair.The findings include:Review of the facility's policy titled, Fall Prevention Program, undated, revealed each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risks to minimize the likelihood of falls. The policy listed the definition of fall as an unintentional change of position. Further review revealed the facility utilized a standardized risk assessment to determine fall risk, and the nurse would refer to high, or low/moderate risk when determining primary interventions. Per the policy, if a resident was identified as high risk, the resident would be placed on the Fall Prevention Program, which identified the risk on the care plan, and an indicator of the high fall risk (a star or colored sticker) would be placed on the resident's name plate and wheelchair. Further review revealed when a resident fell, the facility would assess, complete the post fall assessment, and complete an incident report. Further review revealed the facility should notify the physician and family, review the care plan and update as indicated, document all assessments/actions, and obtain witness statements in case of injury.Review of the facility's policy titled, Conducting Internal Incident/Accident Investigations, undated, revealed the policy was to establish procedures to conduct investigations of internal incidents and accidents. Per the policy, the procedure was to include in the investigation, the root cause analysis, which included care plan interventions and corrective action. Further review revealed there would be a Quality Improvement Review with a review of the Quality Assurance and Performance Improvement (QAPI) process to identify trends and opportunities for improvement.Review of the facility's policy titled, Safe Resident Handling/Transfers, undated, revealed all residents required safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. Furthermore, the policy stated staff would perform resident transfers, in accordance with the minimum degree of assistance indicated on the care plan. The provision of more assistance than specified is the only permissible deviation from the resident care plan pertaining to transfer practice. Review of the facility's undated policy titled, Accidents and Supervision, revealed the facility was responsible for maintaining an environment as free of accident hazards as possible and providing adequate supervision to prevent accidents. The policy further indicated staff was responsible for observing and identifying potential hazards.1. Review of the admission Record, found in R82's electronic medical record (EMR), revealed the facility admitted the resident on 10/22/2024 with (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Mt. Sterling Health & Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Sterling Way Mount Sterling, KY 40353	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses of other intervertebral disc degeneration lumbar region with discogenic back pain only, extrapyramidal and movement disorder unspecified, and cardiomegaly. Review of the quarterly Minimum Data Set [MDS], found in R82's EMR and with an Assessment Reference Date (ARD) of 12/9/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 13 out of 15, indicating the resident was cognitively intact. Review of the Comprehensive Care Plan [CCP], found in R82's EMR and dated 12/06/2024, revealed the resident was dependent on two staff members to move between surfaces and as necessary. It also stated the resident was to be supervised when toileting. Review of the facility provided job description titled, Certified Nursing Assistant, dated 2023, revealed major duties and responsibilities were assisting residents with or performing activities of daily living for the residents in accordance with care plans and established policies and procedures and assisting nursing staff in carrying out toileting program activities. Review of the Morse Fall Scale evaluation done before the fall, dated 04/15/2025, revealed R82 scored 75.0, indicating she was at high risk for falling.Review of the Morse Fall Scale evaluation done after the fall on 05/19/2025 and dated 05/19/2025, revealed R82 scored 80.0, indicating she was at high risk for falling. During an interview with Nurse Aide State Registered ([NAME]) 7 on 03/05/2026 at 3:48 PM, she stated she transferred R82 to the bathroom commode by herself on 05/19/2025. She stated she was told the resident was a one-person assist. She stated she placed R82 on the bathroom commode, told the resident to pull the call light when she was done using the restroom, and then proceeded to leave the resident on the bathroom commode as she went to the nurse's station to tell a co-worker something. She stated she was gone for only two minutes, and when she returned to the bathroom, R82 was on the floor beside the commode in the bathroom. She stated R82 stated, I guess I thought I could do it by myself, but I guess not. During an interview with the MDS Coordinator on 03/05/2026 at 10:07 AM, she stated R82 was now a two-person assist but she was unsure of the date that became effective. She stated the night of the fall, on 05/19/2025, she was the Unit Nurse that evening. She stated she re-educated staff about R82 being a two-person assist due to weakness in her legs. During an interview with the Director of Nursing (DON) on 03/05/2026 at 3:58 PM, she stated R82 required two staff members to assist her due to false accusation she made against staff members. She stated through fall incident reports she had been informed of two reports of one aide transferring the resident. She stated currently all staff was fully aware the resident was a two-person assist with transfers. 2. Review of the admission Record, found in R10's EMR, revealed the facility admitted the resident on 06/11/2025 with diagnoses to include acute respiratory failure, dementia, and anxiety.Review of the quarterly MDS, found in R10's EMR and with an ARD of 01/22/2026, revealed the facility assessed the resident to have a BIMS score of seven out of 15, which indicated the resident was severely cognitively impaired. Review of R10's Morse Fall Scale, dated 09/14/2025 (prior to fall) and 09/16/2025 (post fall) revealed both scored 55, indicating a high risk for falling.Review of R10's CCP, with an initiation date of 06/11/2025, identified R10 as a risk for falls related to gait and balance and a revision date of 06/18/2025 with the goal of being free of minor injuries. Further review of the CCP revealed interventions of assistance to toilet and to bed and bed in low position, with the date initiated on 09/16/2025. Further review revealed no interventions were added for supervision while in the common area or up in a chair. Additional review of the CCP revealed R10 had a focus of Activities of Daily Living (ADL) deficit with initiation date of 06/11/2025 and the goal of improvement of function for transfers to bed and chair. Further review revealed interventions were initiated on 06/11/2025 for two staff to move resident between surfaces with a revision date of 06/22/2025. No updates were located for after the fall on 09/15/2025. Further review revealed a focus of R10 as having impaired cognition and impaired thought processes with the goal of being able to communicate basic needs on a daily basis. Interventions included to cue, to reorient, and to supervise the resident as needed with initiation date of 09/11/2025. However, the CCP was not updated after the fall on 09/15/2025.Review of the facility's document Unwitnessed Fall, dated 09/15/2025 at 8:20 PM, revealed a nurse heard the resident (R10) yelling for help, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Mt. Sterling Health & Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Sterling Way Mount Sterling, KY 40353	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upon observation, the nurse found R10 face down in front of a chair in the common area. Injuries documented included a moderate amount of bleeding from the nose, a new laceration over the right eyebrow, and the nose swollen and bruised. Further review revealed R10 had right shoulder pain, and vital signs were obtained. The document stated the resident's predisposing factors included gait imbalance, incontinence, confusion, and impaired memory. Also, the document stated the predisposing situation factors included transferring without assistance and improper footwear.Review of the facility's document Fall Investigation, dated 09/15/2025 at 8:20 PM, revealed R10 had an unwitnessed fall from a Broda chair while in the common area and sustained a closed fracture to the nose with abrasion and bruising to the face and was transferred to the emergency room. Further review revealed the Quality Assurance Performance Improvement (QAPI) Root Cause Analysis determined R10 was getting up without assistance due to confusion from short- and long-term memory loss with weakness and limited mobility. Further review revealed the action plan included more frequent hourly checks and resident up in chair at the nurses' area when awake. The document stated the care plan was updated on 09/16/2025 when R10 returned from the hospital with the intervention of to offer to assist to toilet and to bed. However, the care plan was not updated with more frequent hourly checks.Review of R10's Progress Note, dated 09/15/2025 at 9:23 PM and written by Licensed Practical Nurse (LPN) 10, revealed she heard R10 yelling for help, and upon observation, she found R10 face down in front of her chair in the TV area. The note stated the resident's nose was swollen and bleeding, there was a new skin abrasion over the right eyebrow, and R10 complained of increased pain to right shoulder. Review of R10's Progress Note, dated 09/16/2025 at 1:40 AM and written by LPN10, revealed R10 returned from the hospital with a diagnosed closed fracture of the nasal bone. Observation on 03/03/2026 at 10:00 AM revealed R10 in bed. An attempt was made to interview the resident, but she was not interviewable. The bed was in low position, and the call light was within reach. During an interview with Nurse Aide State Registered ([NAME]) 10 at 11:20 AM on 03/05/2026, she stated the facility did have a lot of falls but there had not been an increase in falls. She stated she was not familiar with R10.During an interview with NASR12 at 8:23 AM on 03/05/2026, she stated her [NAME] tasks included meeting the care needs of residents. She stated she had received training for fall prevention. When asked if a resident was a fall risk how would she know, she stated staff normally had it on the Group/Assignment sheet, and the on-coming staff did walking rounds with the off-going staff. She stated she looked at the care plan sometimes but not always.During an interview with LPN4 on 03/05/2026 at 11:10 AM, she stated the facility did have more falls than they should, but she could not pinpoint a specific reason. She stated she did not recall R10 sustaining a fall, but she was not familiar with the resident. She stated she had received fall prevention training and in services. During an interview with LPN10 (nurse providing care for R10 the date of the incident) on 03/06/2026 at 11:11 AM, she stated she had picked up an extra shift and was in the middle of administering medications down the hallway. She stated she heard R10 yell, and when she got there, R10 was face down and bleeding from the nose. She stated she contacted the provider and the family, and the resident was sent to the local emergency room (ER). When asked if she had any training for assessing a resident for risk of falls, she stated, I don't think so. She stated she did receive training after the incident from the Director of Nursing (DON) because the DON at that time was the Staff Development Coordinator (SDC). When asked if R10 had experienced other falls, she stated she did not think so. In an interview with the Minimum Data Set (MDS) Coordinator on 03/06/2026 at 10:26 AM, she stated one of her tasks included to view the progress notes and orders to identify anything new and to place that information on the care plan. She stated she usually would view every 48 hours to assure interventions were placed. She stated a care plan guided the care of a resident, and that was why it was so important.During an interview with the Director of Nursing (DON) on 03/06/2026 at 12:08 PM, she stated she had been DON for about three weeks and was Staff Development Coordinator (SDC) at the time of R10's fall. She stated she was not that familiar with the event. She stated it was her expectation that staff looked at care plans each and every day, so (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Mt. Sterling Health & Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Sterling Way Mount Sterling, KY 40353	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they knew how to provide the correct care to residents. She stated if they were not doing that, they might not be the safest person to be providing care to residents. She stated that it would be a concern not only for R10 but for all the residents. During an interview with the Administrator on 03/06/2026 at 11:26 AM, he stated his tasks included providing oversight of the facility. When asked if that included the clinical side of the operation, he stated yes. He stated all the department heads were present in the daily stand-up meetings to identify and discuss concerns. When asked if resident falls was a topic discussed he stated yes. He stated the process was for nurses to follow up with newly identified problems from the fall and place new interventions to the care plan to help prevent another fall. He stated a care plan's purpose was so staff would know what care to provide to keep residents safe and have a positive outcome. The Administrator stated falls had been discussed in the quality improvement meetings, and there had been improvements. He stated his expectations were for all staff to follow the facility's policies and procedures.Review of the facility's undated policy titled, Medication Storage, revealed medications were required to remain under the direct observation of the staff member administering them during medication administration or be secured in the medication cart or designated medication storage area.Review of the facility's undated policy titled, Medication Administration, revealed medications must be administered in accordance with physician orders, and staff must observe a resident's consumption of the medication.3. Review of the admission Record found in R60's EMR, revealed the facility admitted the resident on 04/05/2024 with diagnoses to include unspecified atrial fibrillation, expressive language disorder, and gout.Review of the quarterly MDS, found in R60's EMR and with an ARD of 04/05/2024, revealed the facility assessed the resident to have a BIMS score of six out of 15, indicating the resident had severe cognitive impairment. Review of the Comprehensive Care Plan [CCP], dated 02/09/2026, found in R60's EMR, revealed the resident was not assessed to self-administer her medications. Review of the Medication Administration Record [MAR], dated 03/2026, found in R60's EMR, revealed the resident was scheduled to receive the following medications during the 9:00 AM medication administration and were documented as given at 9:00 AM by Kentucky Medication Aide (KMA) 3: amlodipine besylate tablet 2.5 milligrams (mg), give one tablet by mouth one time a day for hypertension; aspirin oral capsule 81 mg, give one tablet by mouth one time a day related to atrial fibrillation; cholecalciferol tablet 1000 units (u), give two tablets by mouth one time a day for vitamin D deficiency; docusate sodium oral tablet 100 mg, give one tablet by mouth one time a day for constipation; methenamine hippurate oral tablet 1 gram (g), give one tablet by mouth one time a day for urinary tract infection prevention; metoprolol tartrate oral tablet 25 mg, give one tablet by mouth one time a day related to atrial fibrillation; and acetaminophen oral tablet 500 mg, give two tablets by mouth three times a day for chronic pain.Observation of R60 on 03/03/2026 at 9:45 AM revealed she was seated in her wheelchair in front of her bedside table. She was holding a baby doll in her lap. There was a medication cup containing multiple crushed medications mixed in pudding, with a spoon inside the cup, left unattended on the bedside table in front of R60. The resident was unable to be interviewed due to impaired cognition.During an interview with KMA3 on 03/03/2026 at 9:49 AM, she stated the medication cup was from last night. She stated she did not remove it when she entered the room earlier to administer morning medications to R60 because she wasn't thinking. KMA3 quickly disposed of the cup, and as she did, she retrieved an empty medication cup from the trash. She stated this was the cup she used to administer R60's morning medication. The cup did not contain any pudding or pill residue. KMA3 stated it was important to remove medications after administration for resident safety and to prevent another resident from accessing or ingesting the medication. During an interview with Licensed Practical Nurse (LPN) 5 on 03/03/2026 at 9:55 AM, she stated she had not been in R60's room that morning and did not observe the medication cup on the bedside table because she had not completed her rounding on all her residents. LPN5 stated medications should be removed and disposed of to prevent accidental ingestion by another resident. She stated R60 could not self-administer her medications. She stated it was important to stay with R60 to ensure the resident received all her (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Mt. Sterling Health & Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Sterling Way Mount Sterling, KY 40353	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered medications.During an interview with the Assistant Director of Nursing/Infection Preventionist (ADON/IP) on 03/06/2026 at 9:39 AM, she stated medications should not be left at the bedside due to the risk of residents or others taking medications incorrectly or failing to take prescribed medications. The ADON/IP stated if medications were observed unattended, staff should address the issue immediately.During continued interview with the DON on 03/06/2026 at 12:08 PM, she stated medications should not be left unattended at the resident's bedside. She stated if she observed a medication cup with pills at the bedside, she would immediately investigate the situation by speaking with the nurse or KMA involved. She stated medications should never be left unattended because another resident could take the medications or the intended resident might not take the medications creating a safety risk. Additionally, she stated leaving medications unattended at the bedside could result in the resident not receiving the medications as ordered. The DON stated it was her expectation that nursing staff administered medications as ordered and ensured unused medications would be disposed of to maintain resident safety.During an interview with the Administrator on 03/06/2026 at 11:27 AM, he stated medications should not be left unattended at the resident's bedside due to the potential risk of accidental ingestion or misuse. He stated it was his expectation that nursing staff administered medications as ordered and ensured unused medications would be disposed of to maintain resident safety.During a telephone interview with the Medical Director on 03/06/2026 at 12:53 PM, she stated it was her expectation that licensed clinical staff administered medication as ordered. The Medical Director stated medication should not be left at the bedside unless the resident was care planned to self-administer. She stated it was important for staff to follow the facility's policies to ensure resident safety and prevent avoidable accidents.During an additional interview with the Administrator on 03/05/2026 at 2:01 PM, he stated he expected leadership to make sure care plans were correct in point click care (the facility's software). He stated the MDS Coordinator reviewed the care plans daily, and when the care plan was correct it should be communicated to floor staff so residents could get the proper care. He stated when care plans were not correct or floor staff chose not to follow the resident's individual care plan, it could have a negative impact on the residents. He stated his expectation was for all staff to always follow a resident's care plan.