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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview, record review, review of the facility's admission Packet, and review of the facility's policy, the facility failed to ensure residents were provided the right to formulate an advance directive for 12 of 19 sampled residents, Resident (R) 1, R2, R4, R6, R8, R10, R22, R37, R38, R54, R56, and R60. Seven residents had a Health Care Decision Making form on file, with six indicating they had advance directives. However, review of the documentation did not meet the requirements for advance directives. The findings include:Review of the facility's policy titled, Residents' Rights Regarding Treatment and Advance Directives, not dated, revealed the facility would support and facilitate a resident's right to formulate an advance directive. The policy stated if requested, the facility would provide the resident or resident's representative information about the right to formulate an advance directive, and if a resident had an advance directive on admission, copies would be placed in the chart.Review of the facility's admission Packet revealed a form, Health Care Decision Making, that asked if residents had an advance directive, and if so, asked what documentation it consist of, with possibilities being a living will, a health care surrogate, durable power of attorney for health care, court appointed guardian for person, court appointed guardian for property, or other. There was also a question at the end asking if residents wanted to proceed further with Social Services (SS). In the body of the form, it stated facility staff would not act as a witness to signing any forms or documents concerning health care decision making and would not notarize such documents. 1. Review of R1's admission Record revealed the facility admitted the resident on 08/05/2021 with diagnoses to include congestive heart failure (CHF), hypertensive heart disease with heart failure, and dependence on supplemental oxygen. R1's responsible party completed a Health Care Decision Making form on 08/09/2021 indicating R1 did not have an advance directive. However, R1's document does not answer the question of whether or not the resident wanted to proceed further with SS.2. Review of R2's admission Record revealed the facility admitted the resident on 10/20/2022 with diagnoses to include demyelinating disease of central nervous system, posterior reversible encephalopathy syndrome, and acute and chronic respiratory failure. No Health Care Decision Making form was on file. Further review revealed guardianship documentation on file. However, that documentation did not delineate responsibility for health care decision making. 3. Review of R4's admission Record revealed the facility admitted the resident on 09/29/2025 with diagnoses to include chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and stage 4 chronic kidney disease. Further review revealed a Health Care Decision Making form completed by R4's responsible party on 09/30/2025 that indicated the resident had an advance directive, specifically a durable power of attorney for healthcare. However, review of the document revealed a general power of attorney on file, which did not address health care decision making.4. Review of R6's admission Record revealed the facility admitted the resident on 03/25/2025 with diagnoses to include COPD, hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left dominant side, and chronic respiratory failure. A Health Care Decision Making form completed by R6's responsible party on 03/25/2025 indicated the resident had an advance directive and did not want to proceed further with SS. However, review of R6's document revealed a general power of attorney on file which did not (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	address health care decision making. 5. Review of R8's admission Record revealed the facility admitted the resident on 05/08/2024 with diagnoses to include atherosclerotic heart disease of native coronary artery without angina pectoris, hypertensive heart disease with heart failure, and acute kidney failure unspecified. A Health Care Decision Making form completed on 05/09/2024 indicated R8 had an advance directive, a durable power of attorney for health care, and did not want to proceed further with SS. However, review of the document revealed only a general power of attorney on file which did not address health care decision making. 6. Review of R10's admission Record revealed the facility admitted the resident on 06/11/2025 with diagnoses to include acute respiratory failure with hypoxia, COPD, and acute kidney failure unspecified. A Health Care Decision Making form completed on 01/09/2024 indicated the resident had an advance directive, a durable power of attorney for health care, and did not want to proceed further with SS. However, no further documentation was on file. 7. Review of R22's admission Record revealed the facility admitted the resident on 01/09/2024 with diagnoses to include heart failure unspecified, hypertensive heart disease with heart failure, and unspecified atrial fibrillation. There was no Health Care Decision Making form, and a general power of attorney was on file which did not address health care decision making. 8. Review of R37's admission Record revealed the facility admitted the resident on 12/11/2025 with diagnoses to include metabolic encephalopathy, acute respiratory failure with hypoxia, and repeated falls. A Health Care Decision Making form dated 12/11/2025 indicated the resident had an advance directive, specifically a durable power of attorney for health care, and did not want to proceed further with SS. However, continued review revealed only a general power of attorney on file which did not address health care decision making. 9. Review of R38's admission Record revealed the facility admitted the resident on 06/20/2022 with diagnoses to include metabolic encephalopathy, COPD, and end stage renal disease. No Health Care Decision Making form was on file, nor any advance directive. 10. Review of R54's admission Record revealed the facility admitted the resident on 01/15/2025 with diagnoses to include cerebral infarction unspecified, dysphagia following cerebral infarction, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. No Health Care Decision Making form was on file, nor any advance directive. 11. Review of R56's admission Record revealed the facility admitted the resident on 03/25/2025 with diagnoses to include metabolic encephalopathy, quadriplegia unspecified, and chronic combined systolic and diastolic heart failure. No Health Care Decision Making form was on file. An order for emergency guardianship was on file; however, this did not address advance directives. 12. Review of R60's admission Record revealed the facility admitted the resident on 04/05/2024 with diagnoses to include unspecified atrial fibrillation, expressive language disorder, and essential (primary) hypertension. A Health Care Decision Making form dated 04/05/2024 indicated the resident had an advance directive and did not want to proceed further with SS. However, there was only a general power of attorney on file which did not address health care decision making. During an interview with the Admissions Coordinator (AC) on 03/05/2026 at 2:20 PM, she stated she had been in that position for five years and had limited training with the prior AC. She stated she reviewed with residents and/or resident representatives on admission the Health Care Decision Making form that asked if they had an advance directive. She stated an advance directive was a choice that a resident made regarding whether or not they wanted any lifesaving or life prolonging care, and was usually a living will, a health care surrogate, or a power of attorney for health care. The AC stated when she went over the admission packet, she asked if residents had advance directives, and if they say no, she asked if they would be interested and documented that on the question and whether they wanted to proceed further with SS. She stated if they had an advance directive, she asked for a copy, and followed up with residents and families in order to get a copy. She stated no one had ever expressed an interest in following up with SS regarding advance directives, but if they did she would pass that on to the social worker. The AC stated it was important for the facility to have advance directive paperwork in case something was to happen, so the facility would know what a resident wished and (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff was able to follow those wishes, which would be especially important for residents with no power-of-attorney (POA). During an interview on 03/05/2026 at 4:01 PM with the Social Services Director (SSD), she stated she had been in her position almost 10 years, and no resident or the resident's representative had expressed an interest in an advance directive. She stated if anyone did, she would provide them with information on living wills. After review of some of the residents identified as having an advance directive in medical records but not having appropriate paperwork on file or having non-appropriate paperwork, she stated it looked like residents or families were not educated on the purpose and elements of an advance directive. She stated resident wishes regarding code status and advance directives were discussed during the quarterly care plan meetings. During an interview with the Director of Nursing (DON) on 03/06/2026 at 12:17 PM, she stated she expected everyone's advance directives to be followed, and if at any time a resident wanted to talk about advance directives or change them, the facility got the appropriate people to assist them. She stated her expectation when residents were admitted was that staff discussed the differences in each level of resuscitation, and what they expected of the facility's staff and what the facility's expected of them. She stated, if there was confusion about what an advance directive was, staff should discuss that with them. During an interview with the Administrator on 03/06/2026 at 11:36 AM, he stated when a resident was admitted , advance directives were discussed with the resident or the resident's representative. He stated, if a resident had an advance directive, the facility's staff asked for a copy. He stated, if a resident did not have an advance directive and was interested, the facility's staff offered them assistance. He stated the facility's social worker had resources to help facilitate obtaining an advance directive. He stated resident wishes for code status as well as advance directives were reviewed quarterly at their care plan meeting. He stated when discrepancies were brought up between what was documented on the Health Care Decision Making form and what was actually on file, he thought there might be some confusion on what constituted an advance directive. He stated, if the resident's representative or family brought in what they thought was an advance directive but it was not, the expectation was that SS would work with them to explore how they would like to proceed. He stated advance directives were important so that the facility followed the wishes of residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's policies, the facility failed to label drugs and biologicals in accordance with currently accepted professional principles and include the appropriate expiration date when applicable for 3 out of 8 medications carts, the Wisteria Unit medication cart 1 and medication cart 2 and the Lakeview Unit medication cart 1.Observations on [DATE] revealed three expired and/or undated eye drops in the Wisteria Unit's medication cart 1; seven expired and/or undated eye drops in the Wisteria Unit's medication cart 2; and one expired eye drop in the Lakeview Unit's medication cart 1.The findings include:Review of policy titled Storage of Medication Requiring Refrigeration not dated, revealed The facility will ensure that all drugs and biologicals used will be labeled in accordance with professional standards, including expiration dates (when applicable) and with appropriate accessary and precautionary instructions (such as shake well, take with meals, do not crush, special storage instructions).Review of policy titled Medication Storage not dated, revealed Unused medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels.Observation on [DATE] at 8:46 AM of the Wisteria Unit's medication cart 1 revealed one bottle of Systane (an eye lubricant) eye drops for Resident (R) 7 was opened and dated [DATE]; one bottle of Lumigan (generic bimatoprost, a prescription medication used to lower high eye pressure) eye drops for R105 was opened and dated [DATE]; and one bottle of Refresh (an eye lubricant) eye drops for R105 was opened and not dated. Observation on [DATE] at 8:55 AM of the Wisteria Unit's medication cart two revealed one bottle gentamycin (an antibiotic) prescription eye drops for R86 was opened and dated [DATE]; one bottle of Systane eye drops for R86 was opened and not dated; one bottle of Systane eye drops for R125 was opened and dated [DATE]; one bottle of polyvinyl alcohol (an eye lubricant) eye drops for R114 was opened and dated [DATE]; one bottle of bimatoprost eye drops for R130 was opened and not dated; one bottle of tobramycin (an antibiotic) prescription eye drops for R60 was opened and dated [DATE]; one bottle of tobramycin eye drops for R60 was opened and dated [DATE]; and one tube of erythromycin (an antibiotic) prescription eye ointment for R60 was opened and not dated. Observation on [DATE] at 9:16 AM of the Lakeview Unit's medication cart 1 revealed one bottle of brimonidine (used to lower high eye pressure eye drops for R14 was opened and dated [DATE]. During an interview on [DATE] at 9:00 AM with Kentucky Medication Aide (KMA) 2, she stated her process was to date and initial medications when they are opened. She stated she looked for the date to ensure it was not expired so she knew when to dispose of the medications. She stated she was not sure when the eye drops were to be discarded and would find out. She then returned and stated the Director of Nursing (DON) told her she thought 30 days from opening. She stated she had not worked the Wisteria Unit recently and had not had to access or administer any drops this shift. During an interview on [DATE] at 2:59 PM with the Pharmacy Consultant, she stated eye drops should be dated when they were opened, and most were to be discarded 28 to 30 days after opening. She stated she did not have a list of eye drops and when to discard them. During an interview on [DATE] at 10:04 AM with the Assistant Director of Nursing (ADON), she stated eye drops should be dated when they were opened, and they were usually good for about a month. She stated it was her expectation that all dates were being checked prior to administration by the nurses and KMAs. She stated she would expect them to notify pharmacy if needed for clarification. She stated if mediations were not dated or dated prior to 30 days, then the medication should be discarded and reordered if the resident still needed it. She stated if a medication was expired then it might not be as potent or work correctly which could worsen a resident's condition. During an interview on [DATE] at 9:17 AM with the DON, she stated she believed eye drops (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were to be discarded after 30 days, but she would call the pharmacy to confirm and get back to me. During an additional interview with the DON on [DATE] at 11:28 AM, she stated she called their pharmacy consultant who stated all eye drops should be discarded after 30 days of opening date unless the expiration date was extended by the manufacturer. During an additional interview with the DON on [DATE] at 12:19 PM, she stated eye drops should be dated correctly so the staff knew they were still effective. She stated the nurses and KMAs on the floor should be checking for dates daily, if not weekly, and always prior to administering medications. During an interview on [DATE] at 11:26 AM with the Administrator, he stated it was his expectation that medications were stored according to policy and discarded appropriately to achieve positive outcomes for the residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, and review of the facility's policy, 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. The facility failed to implement its infection prevention and control policies and procedures and identify and correct problems relating to infection prevention practices for 6 out of 10 sampled residents, Resident (R) 11, R18, R38, R113, R122, and R133, who were cared for by staff who had not performed the required hand hygiene. The findings include:Review of the Centers for Disease Control and Prevention (CDC) guidelines Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 04/12/2024, revealed hand hygiene should be performed immediately before providing resident care and after care was completed. According to the guidelines, staff should ensure the proper selection and use of PPE based on the nature of the patient interaction and potential for exposure to blood, body fluids, and/or infectious materials. Review of the facility's policy, Infection Prevention and Control Program, revised 05/2025, revealed the purpose of the policy was to ensure the facility provided a safe and comfortable environment to prevent infections, according to accepted national standards and guidelines. According to the policy, hand hygiene was a component of standard precautions and was required to prevent the transmission of infectious organisms during the provision of resident care. The policy stated staff was to use personal protective equipment (PPE) according to facility policy. Additionally, the policy stated staff received infection control education and training related to their job duties.1 a. Observation on 03/04/2026 at 9:30 AM revealed Nurse Aide State Registered ([NAME]) 5 exited room [ROOM NUMBER] wearing gloves and holding a plastic trash bag containing soiled briefs. NASR5 opened the laundry cart and disposed of the bag inside. He then removed his contaminated gloves and did not perform hand hygiene before he donned a new pair of gloves and entered R113's room. NASR5 was subsequently observed exiting the resident's room and again did not perform hand hygiene. He removed his gloves, donned a new pair of gloves and entered R122's room.b. Observation on 03/04/2026 at 11:50 AM revealed NASR5 exited R11's room after transferring the resident with a mechanical lift into his Broda (as specialized wheelchair) chair. NASR5 was observed wearing gloves as he exited the room. During an interview with NASR5 on 03/03/2026 at 11:58 AM, he stated PPE should be removed inside the resident's room and hand hygiene should be performed prior to exiting to prevent the spread of the infection between residents. NASR5 further stated he could not explain why he failed to remove his gloves inside the resident's room or perform hand hygiene after providing resident care, before and after donning and doffing (putting on and taking off) PPE, and before entering another resident's room to provide care during his rounds. The [NAME] stated he had received education and training on hand hygiene and PPE use.2. Observation on 03/04/2026 at 9:40 AM revealed NASR1 passing ice and water to residents. NASR1 filled a cup obtained from R38's room by holding it over the open ice chest. She placed the scoop inside the chest, entered R38's room, and placed the cup on the resident's bedside table. NASR1 exited the room and did not perform hand hygiene. She entered R18's and R133's room. Again, she filled both cups while holding them over the ice. The scoop was placed on top of the ice. NASR1 delivered R18 and R133 their ice cups. She exited the room, did not perform hand hygiene, and proceeded to the next resident's room.During an interview with NASR1 on 03/04/2026 at 9:40 AM, when asked by the State Survey Agency (SSA) Surveyor why it was important to place the ice scoop in its holder and not back on top of the ice, she stated, I didn't put it on the ice. However, when the SSA Surveyor asked NASR1 to open the ice chest, the scoop was observed resting directly on top of the ice. NASR1 further stated she performed hand hygiene between residents while passing ice. The [NAME] was unable to explain the importance of performing hand hygiene between resident contacts (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or the need to store the scoop in the designated holder. Furthermore, after the question was asked, the nurse aide did not respond to the question and ended the interview. During an interview with the Assistant Director of Nursing/Infection Preventionist (ADON/IP) on 03/06/2026 at 9:39 AM, she stated staff should perform hand hygiene when entering and exiting resident rooms and before and after providing resident care. She stated hand hygiene should also be performed after removing gloves, and gloves were not a substitute for proper hand hygiene. The ADON/IP further stated staff should use PPE equipment when indicated and remove the equipment prior to leaving the resident's room. Additionally, she stated proper handling of ice was important to prevent contamination. She stated the ice scoop should not be stored inside the ice container and cups should not be filled while held directly over the ice bin. She stated these practices were necessary to prevent contamination of the ice supply and reduce the risk of spreading germs that could impact the residents' health and safety. The ADON/IP stated it was her expectation for staff to follow all infection control policies. She stated it was important to prevent the spread of microorganisms between the residents staff, and the environment and helped to protect the health and safety of the residents.During an interview with the Director of Nursing (DON) on 03/06/2026 at 12:08 PM, she stated it was her expectation that staff followed infection control policies and procedures when providing resident care. She stated staff was expected to perform hand hygiene before and after resident contact and after removing gloves. She further stated PPE should be worn when indicated and removed prior to leaving the residents' rooms. The DON stated staff should not wear contaminated gloves in the hallway, and the wearing of gloves did not replace the need for hand hygiene. Additionally, the DON stated staff should maintain sanitary practices when passing ice. She stated the ice scoop should be stored in the designated holder and not placed inside the ice bin. She further stated cups should not be held over the ice container while being filled. She stated following those practices were necessary to prevent contamination of the ice supply and reduce the potential spread of germs to residents. Furthermore, the DON stated it was her expectation that staff followed infection control policies and procedures when providing resident care. She stated following infection control practices was important to prevent the spread of infection and protect the health and safety of residents and staff.During an interview with the Administrator on 03/06/2026 at 11:27 AM, he stated it was his expectation that nursing staff followed the facility's infection control policies and procedures when providing resident care. He stated following CDC guidelines and the facility's policies helped reduce the risk of infection transmission.During a telephone interview with the Medical Director on 03/06/2026 at 12:53 PM, she stated it was her expectation that staff followed the facility's infection control policies and adhered to CDC guidelines when providing care for residents. She stated following these practices, including proper hand hygiene and use of personal protective equipment, was important to prevent the spread of infection and protect the health and safety of the residents.

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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 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 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, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policies, the facility failed to ensure that a resident who needed respiratory care was provided with such care, consistent with physician orders and professional standards of practice for 2 out of 3 sampled residents, Resident (R) 11 and R93.1. Observation on 03/03/2026 revealed R11's oxygen was set at 4.5 liters per minute (LPM) when his physician order was for continuous oxygen at 4.0 LPM. Further observation on 03/03/2026 and 03/05/2026 revealed the resident was not wearing his oxygen tubing and not receiving oxygen, and staff did not return to R11's room to place the oxygen back on the resident. 2. Observation on 03/03/2025 revealed R93's oxygen was set at 2 LPM and observation on 03/04/2026 revealed R93's oxygen was set at 3.5 LPM when her physician order was for continuous oxygen for 14 hours or more at 3.0 LPM via nasal cannula.The findings include:Review of the facility's undated policy titled, Oxygen Administration, revealed the purpose of the policy was to ensure oxygen was administered to residents who required it in accordance with professional standards of practice, physician orders, and the care plan. The policy stated staff was expected to set and maintain the oxygen equipment at the prescribed flow rate ordered by the physician. Further review of the policy revealed staff was to maintain infection control measures.Review of the facility's undated policy titled, Oxygen Concentrator, revealed the purpose of the policy was to establish responsibilities for the care and use of the concentrators. The policy stated the nurse should [NAME] the physician's orders for the prescribed oxygen flow rate.1. Review of the admission Record found in R11's electronic medical record (EMR), revealed the facility admitted the resident on 07/04/2024 with diagnoses to include chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypercapnia, and myocardial infarction.Review of the quarterly Minimum Data Set [MDS], found in R60's EMR with an Assessment Reference Date (ARD) of 07/04/2025, 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 the Comprehensive Care Plan [CCP], dated 12/25/2025 and found in R11's EMR, revealed a focus for COPD with interventions to include oxygen at 5 liters per minute (LPM) via nasal cannula.Review of the Order Review Report, dated 03/2026 and found in R11's EMR, revealed an order dated 10/23/2025 for oxygen at 4 LPM via nasal cannula every day and night shift related to chronic obstructive pulmonary disease in chronic respiratory failure with hypercapnia.Observation of R11 on 03/03/2026 10:58 AM revealed he was sitting up in bed with the head of the bed elevated and was not wearing oxygen. The oxygen concentrator was on, and the flow rate was set at 4.5 LPM. The nasal cannula and tubing were on the floor and were out of reach of the resident. Observation on 03/05/2026 at 10:58 AM, revealed R11 was seated in his chair. The resident's oxygen tubing had been removed during transfer from the bed to the chair per the resident. The resident's nasal cannula remained on the bed and was not within reach of the resident. The oxygen concentrator was placed behind the resident's chair and out of view. Staff did not return to the room during the observation period to replace the oxygen on the resident. During an interview with R11 on 03/05/2026 at 10:58 AM, he stated his oxygen flow rate was supposed to be 4 liters per minute. He stated he could not adjust the set due to limited mobility. He further stated he was unsure how often staff checked the oxygen concentrator to ensure the correct flow rate. R11 stated staff transferred him from his bed to his Broda chair and removed his oxygen during the transfer. During an interview with Licensed Practical Nurse (LPN) 3 on 03/05/2026 at 11:00 AM, she stated R11 was on continuous oxygen and should be wearing his nasal cannula. She stated it was important for staff to ensure residents wear their oxygen and maintain the correct flow as prescribed to maintain oxygen levels to prevent shortness of breath. 2. Review of the admission Record found in R93's EMR, revealed the facility admitted the resident on 01/22/2025 with diagnoses to include unspecified atrial fibrillation, expressive language disorder, and gout.Review of the annual MDS, found in R93's EMR (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with an ARD of 02/01/2026, revealed the facility assessed the resident to have a BIMS score of 10 out of 15, indicating the resident was moderately impaired. Review of the CCP, dated 02/09/2026, found in R93's EMR, revealed a focus for COPD with an intervention initiated on 01/22/2025 to include oxygen at 2 LPM via nasal cannula.Review of the Order Review Report, dated 03/2026 and found in R93's EMR, revealed an order dated 01/26/2026 for oxygen at 3 LPM via nasal cannula every day and night shift related to COPD.Observation of R93 on 03/03/2025 at 2:43 PM revealed she was lying in bed with the head of the bed slightly elevated and wearing a nasal cannula which delivered oxygen from her oxygen concentrator. Observation of the oxygen concentrator revealed the flow rate was set at 2 LPM. Additional observation of R93 in her room on 03/04/2026 at 10:52 AM revealed R93's oxygen was set at 3.5 LPM.During an interview with the Assistant Director of Nursing/Infection Preventionist (ADON/IP), on 03/06/2026 at 9:39 AM, she stated nurses were responsible to ensure oxygen was administered according to physician orders. She stated staff should verify the oxygen concentrator was set to the ordered liters per minute during resident assessments. She further stated staff was instructed to read the oxygen flow meter at eye level and ensure the center of the ball aligned with the ordered liter flow. The ADON/IP stated following oxygen orders was important to ensure residents received the correct oxygen therapy and to prevent respiratory distress.During an interview with the Director of Nursing (DON) on 03/06/2026 at 12:08 PM, she stated staff should follow physician orders for oxygen therapy. She stated staff was educated on the proper use of oxygen equipment to ensure residents received the ordered oxygen therapy. The DON stated it was her expectation that nursing staff administered medications as ordered, including oxygen therapy. She stated it was important to ensure the resident received the prescribed oxygen for their overall health and well-being. During an interview with the Administrator on 03/06/2026 at 11:27 AM, he stated it was his expectation that nursing staff administered medications as ordered 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. She stated administering oxygen as ordered was important to ensure the resident received adequate oxygenation to prevent respiratory distress and decreased oxygen saturation or a complication related to excess oxygen.

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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 policy, the facility failed to provide residents who required dialysis services an ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility for 1 of 1 sampled resident who received dialysis services, Resident (R) 38.Record review revealed R38 received hemodialysis three times a week on Monday, Wednesday, and Friday. However, the facility provided incomplete documentation for pre-and-post dialysis assessments on the following dates: 02/04/2026, 02/05/2026, 02/16/2026, 02/23/2026, and 02/25/2026. Also, the facility did not provide ongoing assessment and monitoring for the months of January 2026 or March 2026.The findings include:Review of the facility's undated policy titled, Hemodialysis, revealed the facility would ensure each resident's care and services included an ongoing assessment and oversight of the resident before, during, and after treatments, including monitoring for complications and ongoing communication and collaboration with the dialysis facility. Review of the admission Record found in R38's electronic medical record (EMR), revealed the facility admitted the resident on 10/02/2020 with diagnoses to include dependence on renal dialysis, type 2 diabetes mellitus, and metabolic encephalopathy.Review of the quarterly Minimum Data Set [MDS], found in R38's EMR with an Assessment Reference Date (ARD) of 10/02/2020, 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], dated 03/05/2025, found in R38's EMR, revealed a focus initiated on 05/12/2025 which identified the resident required hemodialysis related to renal failure. The CCP included goals to ensure the resident would have no complications from dialysis.Review of the Order Review Report, dated 03/2026, found in R38's EMR, revealed an order, dated 01/28/2026, for dialysis three times weekly on Monday, Wednesday, and Friday. Further review revealed an order to monitor the insertion site related to mild bleeding from the site post dialysis and an order for a renal, regular texture diet with liquid protein supplement of 30 milliliters twice a day, dated 01/28/2026.Review of R38's Windsor Care Dialysis Communication Form [DCF], no date, and found in R38's Dialysis Folder, revealed multiple prefilled DCFs with the resident's name, physician, current renal diet order, fluid restriction of 1500 milliliters (mL), and pre-signed by Licensed Practical Nurse (LPN) 4. Further review of the resident's dialysis communication folder revealed no additional dialysis communication forms or documentation for dialysis treatments during 01/2026, 02/2026, or 03/2026 beyond the dates listed above.At the request of the State Survey Agency (SSA) Surveyor, the facility was asked to provide dialysis communication documentation for the months of 01/2026, 02/2026, and 03/2026. The facility provided dialysis communication forms for the following dates: 02/05/2026, 02/06/2026, 02/16/2026, 02/23/2026, and 02/25/2026. The facility also provided nursing notes corresponding to dialysis treatments dated 02/16/2026, 02/18/2026, and 02/23/2026. However, no additional dialysis communication documentation was provided for the requested months.Review of R38's DCF, dated 02/04/2026, revealed several sections of the facility's information were left blank. Vital signs were taken on 02/04/2026 at 6:00 AM. The date and time of the resident's last meal was not documented. Documentation indicated the resident's current diet order was a regular diet. The section titled Important information for dialysis nurse to know contained no entries. Additionally, the section for facility nurse name/signature, phone number, and extension was not completed. Review of the dialysis communication section revealed it was dated 02/05/2026 at 10:30 AM. The result section contained no documentation. The dialysis nurse signature, phone number, and extension were not documented. Review of R38's DCF, undated, revealed several sections of the facility's information were left blank. Vital signs were taken on 02/05/2026; however, no time was documented. Review of the dialysis communication section revealed it was dated 02/06/2026 at 6:45 AM. The position of the resident when vital signs were taken was not documented. The oxygen saturation (SpO2) was left blank. The time of discharge was not (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented. The results section contained no documentation. The dialysis nurse's name was signed but no contact information was provided. Review of R38's DCF, dated 02/16/2026, revealed several sections of the facility's information were left blank. Vital signs were taken on 02/16/2026 at 5:00 AM; however, the pulse, respirations, and SpO2 fields were blank. Documentation indicated the resident's current diet order was a regular diet. The section titled Important information for dialysis nurse to know contained no entries. Additionally, the section for facility nurse name/signature, phone number, and extension was not completed. Review of the dialysis communication section revealed it was dated 02/16/2026 at 6:30 AM. The SpO2 was left blank. The results section contained no documentation. The dialysis nurse's name was signed but no contact information was provided. Review of R38's DCF, dated 02/23/2026, revealed the resident received her last meal at 5:30 AM, and it was documented as a regular diet. The section titled Important information for dialysis nurse to know contained no entries. Additionally, the section for facility nurse name/signature, phone number, and extension was not completed. Review of the dialysis communication section revealed it was dated 02/23/2026 at 6:30 AM. It was noted R38 did not receive a meal or snack during treatment. The results section contained no documentation. Further documentation requested the facility remove R38's bandage prior to sending the resident to dialysis, as the bandage prevented access to the site. The note further indicated the resident should eat prior to leaving for dialysis because once the fistula was accessed, the resident could not move her right arm. It was also documented that sending the resident's meals tray with her was not appropriate. The dialysis nurse's name was signed but no contact information was provided. Review of R38's DCF, dated 02/25/2026, revealed several sections of the facility's information were left blank. Vital signs were taken on 02/25/2026 at 5:30 AM. Documentation indicated the resident's current diet order was a regular with thin liquids. The section titled Important information for dialysis nurse to know contained no entries. Additionally, the facility phone number, and extension fields were not completed. Review of the dialysis communication section revealed the entire section was left blank. During an interview with Licensed Practical Nurse (LPN) 4 on 03/05/2026 at 9:50 AM, she stated dialysis communication forms were kept at the nurse's station in a binder. She stated the binder accompanied the resident when the resident was transported to and from the dialysis clinic. LPN4 stated the dialysis communication form should be completed prior to the resident leaving the facility. She stated the form should include complete documentation. She further stated the nurse completing the form should document the nurse's name, signature, and contact information on the form. LPN4 stated the dialysis clinic nurse was expected to complete the dialysis portion of the form and return the form with the resident. She stated the dialysis clinic staff should document information including dialysis treatment details and any issues that occurred during dialysis.During the continued interview with LPN4 on 03/05/2026 at 9:50 AM, she stated the resident should be monitored for complications after returning from dialysis and any complications should be documented. She stated a nurse's note should also be entered into the resident's medical record following the resident's return from dialysis. LPN4 stated she did not know why dialysis communication forms in Resident 38's dialysis binder had been copied and pre-filled with her name. She stated information should not be pre-filled on the dialysis communication form because the resident's condition and clinical information could change, and the form should reflect the resident's current and most up-to-date information at the time the resident was sent to dialysis.During an interview with the Assistant Director of Nursing/Infection Preventionist (ADON/IP), on 03/06/2026 at 9:39 AM, she stated the facility's process for residents receiving dialysis treatment included use of a dialysis communication form that was sent with the resident to the dialysis center. She stated the form contained sections for both the facility and dialysis staff to complete. She stated the facility's portion of the form should be completed prior to the resident leaving the facility, and the dialysis clinic was expected to complete its portion before the resident returned. The ADON/IP further stated the nurse was expected to document a nursing note upon the resident's return from the dialysis clinic and contact the dialysis provider if any information was missingDuring an interview (continued on next page)

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the Director of Nursing (DON) on 03/06/2026 at 12:08 PM, she stated the facility used a dialysis communication form that accompanied the resident to the dialysis clinic. She stated the facility's nurse was expected to complete the facility's portion on the form prior to the resident leaving for dialysis, and the dialysis clinic was expected to complete the dialysis communication section and return the form with the resident. The DON stated nurses should review the dialysis communication form upon the resident's return and document a nurse's note regarding the dialysis treatment. She further stated if the form was incomplete or information was missing, nursing staff was expected to contact the dialysis provider to obtain the missing information.During an interview with the Administrator on 03/06/2026 at 11:27 AM, he stated it was his expectation that nursing staff followed the facility's policies and procedures when providing resident care. The Administrator stated staff members were expected to carry out their assigned responsibilities so residents received appropriate care to ensure the residents' safety and well-being.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 followed the facility's policies and procedures when providing resident care. She stated it was important to ensure residents received appropriate medical care and treatment and to protect the residents' health and overall well-being.