STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185259	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivers Edge Rehabilitation and Healthcare Center	6301 Bass Road Prospect, KY 40059

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to store food in a sanitary manner. Specifically, the facility failed to ensure refrigerators were clean, and food items were labeled and dated prior to storage in a nutrition refrigerator located at the nurse's station. These failures had the potential to affect all residents who received meals and snacks from the facility. The findings included:Review of facility policy, Monitoring of Cooler/Freezer Temperature, revised 09/01/2024, indicated, It is the policy of this facility to maintain temperatures of coolers and freezers at the appropriate temperature to promote food safety. This policy also addresses refrigerated storage. The policy further indicated, 1. Logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the freezer or refrigerator unit. a. Temperatures will be checked and logged at least twice per day by designated personnel. The policy continued, 11. Refrigerated food shall be labeled, dated, and monitored so that is issued by the use by date, frozen, or discarded, whichever is applicable. Review of facility policy, Sanitation Inspection, revised 09/01/2024, indicated, It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. The policy continued, 1. All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. The policy continued, 4. Sanitation inspections will be conducted in the following manner: a. Daily: Food service staff shall inspect refrigerators/coolers, freezers, storage area temperatures, and dishwasher temperatures daily. b. Weekly: The dietary manager shall inspect all food service areas weekly to ensure the areas are clean and comply with sanitation and food service regulations.5. Inspections will be conducted but not limited to the following areas: a. Dry storage b. Freezer c. Refrigerator d. Dish room e. Pot wash f. Main production area g. Food preparation area h. General dietary observations. During an observation of the kitchen and concurrent interview on 03/09/2026 at 9:12 AM, the kitchen's walk-in refrigerator was observed to have a thick black and gray matter build-up around the ceiling inside the refrigerator radiating out from the dual fans. The Dietary Manager (DM) stated that the black and gray matter build-up was dust and that the refrigerator should have been cleaned weekly. During an observation on 03/11/2026 at 3:41 PM, the nutrition refrigerator revealed a temperature log that was missing temperatures for 03/10/2026 and there were no temperature measurements for the freezer compartment. Inside the freezer compartment there was a frozen, sticky, tan residue and ice packs in plastic bags were stuck to the surface inside the freezer compartment. There were two 48 fluid ounce (a unit of measure) tubs of rainbow sherbet, a popsicle box, and a bag of popsicles that were unlabeled and undated. During an interview on 03/13/2026 at 10:10 AM, the Maintenance Director (Maint. Dir.) stated housekeeping was responsible for cleaning the nutrition refrigerator weekly on Thursdays. The Maint. Dir. stated that the kitchen and nursing staff were responsible for logging temperatures. During an interview on 03/13/2026 at 11:23 AM, Licensed Practical Nurse (LPN) #3 stated housekeeping was responsible for cleaning the nutrition refrigerator every Thursday. LPN #3 stated temperature logs should have been updated, and any food items inside the nutrition refrigerator should have been labeled with names and dates. LPN #3 stated (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	food items without labels were discarded. LPN #3 stated it was important to keep the nutrition refrigerator clean, and the temperature monitored and logged daily to ensure residents did not get sick from spoiled foods. During an interview on 03/11/2026 at 3:51 PM, the DM stated she was responsible for recording and updating the temperature logs and that she did not record the temperature on 03/10/2026. The DM stated foods inside the refrigerator and the freezer compartment should have been labeled with names and dates or should have been discarded if they were not labeled. During an interview on 03/13/2026 at 8:39 AM, the Director of Nursing (DON) stated kitchen staff were responsible for cleaning the kitchen refrigerator, and housekeeping was responsible for cleaning the nutrition refrigerator. The DON stated she expected the refrigerators to be cleaned weekly and temperature logs to be taken and updated daily for all refrigerator compartments. The DON stated it was important to keep the refrigerator and freezer compartment clean, and temperatures monitored, so food did not spoil and potentially cause harm to the residents. During an interview on 03/13/2026 at 9:04 AM, the Administrator stated all refrigerators should have been cleaned. The Administrator stated housekeeping was responsible for cleaning the nutrition refrigerator, and kitchen staff were responsible for the kitchen refrigerator. The Administrator further stated she expected temperatures to be taken daily for the refrigerator and freezer compartments. The Administrator continued, stating it was important to keep refrigerators and freezers clean, and temperature logs updated to ensure food did not pose a risk for bacterial growth. Additionally, the Administrator stated that food stored inside the refrigerator should have been labeled.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview, record review, and facility policy review the facility failed to develop a care plan to address the tracheostomy (an opening in the neck to facilitate breathing) care for 1 (Resident #5) of 1 sampled residents reviewed for respiratory care. The findings included: Review of the facility's undated policy titled, Comprehensive Care Plans, indicated, It is the policy of this facility to develop and implement a comprehensive-person centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The policy further indicated, 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. and 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. Review of facility policy, Tracheostomy Care, reviewed 12/31/2024, indicated, The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards or practice, the comprehensive person-centered care plan and resident goals and preferences. The policy further continued, 4. Based upon the resident assessment, attending physician's orders, and professional standards of practice, the facility in collaboration with the resident/resident's representative will develop a care plan that includes appropriate interventions for respiratory care. Review of the facility's admission Record indicated the facility admitted Resident (R) #5 on 01/12/2026. According to the admission Record the resident had a medical history that included diagnoses of cerebral infarction (stroke) due to thrombosis (blood clot) of unspecified cerebral artery, chronic obstructive pulmonary disease (a lung condition that makes it hard to breath), chronic respiratory failure with hypoxia (low oxygen levels), and tracheostomy status. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/18/2026, revealed the facility assess Resident #5 with a Brief Interview for Medical Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed that the Resident received respiratory treatments that included oxygen therapy, suctioning, and tracheostomy care while a resident and within the last 14 days of the assessment period. Review of the facility's Care Plan Report, for R5 included a focus area initiated 01/25/2026 that indicated the resident had difficulty in communication related to the resident's tracheostomy. Interventions directed staff to allow the resident adequate time to respond and repeat as necessary, to face the resident and make eye contact, use simple, brief, consistent words, and use alternative communication tools as needed. There was no focus area that addressed the resident's tracheostomy care or respiratory services. Review of Resident #5's Order Summary Report, with active orders as of 03/10/2026, contained an order dated 01/22/2026 to cleanse tracheostomy site and perform tracheostomy care every shift. During an interview on 03/13/2026 PM at 2:14 PM, Licensed Practical Nurse (LPN) #2 stated that the MDS nurse was responsible for updating residents' care plans. LPN #2 stated she did not see a care plan specifically addressing Resident #5's tracheostomy, and that a care plan was essential to ensure nursing staff were informed on proper tracheostomy care and remained current with prescribed interventions. During an interview on 03/13/2026 at 11:07 AM, the Director of Nursing (DON) stated Resident #5 did not have a care plan specifically for tracheostomy and that her expectation was that Resident #5's care plan address the tracheostomy. The DON further stated that care plans were essential, as their absence could impact the quality and consistency of care provided and fail to guide staff in the proper management of the tracheostomy. During a subsequent interview on 03/13/2026 at 2:50 PM, the DON stated that Resident #5 should have had a care plan that was specific for the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tracheostomy, containing the size of the tracheostomy, oxygen flow rates, and specific care required for the tracheostomy. During an interview on 03/13/2026 at 9:29 AM, the Administrator stated care plans should have been done appropriately for Resident #5.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility document and policy review, the facility failed to maintain infection control practices during tracheostomy care for 1 (Resident #5) of 1 resident observed during tracheostomy care. Specifically, staff failed to maintain a sterile field and use proper hand hygiene during tracheostomy care. The findings included: Review of facility policy titled, Tracheostomy Care, dated 12/31/2024, indicated, The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences, The Policy further indicated, 6. Procedure with Use of Reusable Cannula: a. Explain the procedure to the resident and screen for privacy. b. Perform hand hygiene per facility policy. c. Put exam gloves on both hands; masks and eye wear should be worn if there is a likelihood of splashes and splattering. d. Suction tracheostomy per facility policy. e. Remove old dressing; pull soiled glove down over the hand, and the soiled dressing, and roll the glove over dressing; Discard both in appropriate receptacle. Perform hand hygiene. f. Prepare equipment on bedside table. g. Open and set up the sterile tracheostomy care kit and apply sterile gloves. n. Dispose of equipment and perform hand hygiene Review of a facility policy titled, Hand Hygiene, dated 09/01/2024, indicated, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. The policy further indicated, 6. Additional considerations: - a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the facility's undated policy, Tracheostomy Care packet, indicated, Tracheostomy Suctioning Procedure, that included, 2. Wash hands and don gloves and other PPE. The education packet continued, 7. Open sterile suction kit and fill container with saline. Be sure to set up sterile container touching only the outside surface. 8. Put on sterile gloves. The dominant hand remains sterile and the non-dominant hand is nonsterile. Review of the facility document, admission Record indicated the facility admitted Resident #5 on 01/12/2026. According to the admission Record, the resident had a medical history that included diagnoses of cerebral infarction (stroke) due to thrombosis (blood clot) of unspecified cerebral artery, chronic obstructive pulmonary disease (a lung condition that makes it hard to breath), chronic respiratory failure with hypoxia (low oxygen levels), and tracheostomy status. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/18/2026, revealed the resident received respiratory treatments that included oxygen therapy, suctioning, and tracheostomy care while a resident and within the last 14 days of the assessment period. Review of the facility's Care Plan Report, for Resident (R) #5 included a focus area initiated 01/25/2026 that indicated the resident had difficulty in communication related to the resident's tracheostomy. Interventions directed staff to allow the resident adequate time to respond and repeat as necessary, to face the resident and make eye contact, use simple, brief, consistent words, and use alternative communication tools as needed. There was no focus area that addressed the resident's tracheostomy care or respiratory services. Review of Resident #5's Order Summary Report, with active orders as of 03/10/2026, contained an order dated 01/22/2026 to cleanse tracheostomy site and perform tracheostomy care every shift. During an observation on 03/10/2026 at 11:08 AM, Licensed Practical Nurse (LPN) #2 entered Resident #5's room to perform tracheostomy care. LPN #2 set up a sterile field and prepared suctioning supplies. LPN #2 picked up a sterile glove with her bare hands from the sterile field; she then returned the sterile glove back onto the sterile field, stating she had to go obtain another sterile glove as there was only one. LPN #2 left the resident's room, returned, did not perform hand hygiene, applied sterile gloves, donned (put on) a gown, and performed suctioning of Resident #5's tracheostomy. LPN #2 then threw away the used supplies, doffed (removed) the gown and gloves, and performed hand hygiene. LPN #2 donned a new gown (but did not tie the neck and waist tie strings), (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	donned gloves, set up a new sterile field, and opened the new cannula and collar supplies. As LPN #2 opened the sterile supplies and dropped them onto the sterile field, LPN #2's loose gown was observed touching the sterile field. LPN #2 then reached behind her neck and back, tied the gown's neck and waist tie strings, and continued opening the sterile supplies without performing hand hygiene. During an interview on 03/10/2026 at 11:50 AM, LPN #2 stated that a sterile field was an area where there were no infectious organisms that could cause infections. LPN #2 stated nothing was to touch the sterile field except sterile supplies. LPN #2 stated she contaminated the sterile field when she did not wash her hands, picked up the sterile glove and put it back down onto the sterile field, and when her untied gown came into contact with the sterile field. During an interview on 03/12/2026 at 10:05 AM, the Infection Prevention (IP) nurse stated that sterile technique was important to prevent the introduction of microorganisms to a resident. The IP nurse stated that tracheostomy care was a sterile procedure, and LPN #2 did not follow sterile technique. During an interview on 03/12/2026 at 11:00 AM, the Director of Nursing (DON) stated that tracheostomy care was a sterile procedure and said that LPN #2 should have started a new sterile field when she contaminated the original sterile field. During an interview on 03/12/2026 at 11:35 AM, the Administrator stated it was important to follow sterile technique during tracheostomy care.