STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185287	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrodsburg Health & Rehabilitation Center	853 Lexington Road Harrodsburg, KY 40330

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, review of the Serve Safe flyer, and review of the facility's policies, the facility failed to prepare and serve food under sanitary conditions. Observations during the lunch meal service on 02/24/2026 revealed staff pulled gloves out of his pocket, the cleaning cloth was not kept in the sanitizer bucket, and the soiled sheet pans and pots were stacked over the food production table. Additional observation on 02/25/2026 again revealed soiled sheet pans and pots were stacked over the food production table. These deficient practices had the potential to affect the current 87 residents who received food from the kitchen.The findings include: Review of the facility's policy titled, Food Preparation, dated 02/2025, revealed all staff would practice proper hand-washing techniques and glove use. Review of the facility's policy titled, Manual Ware Washing, 3-Compartment Sink, dated 01/2024, revealed all cookware, dishware, and service ware that was not processed through the dish machine would be manually washed and sanitized. The policy stated before processing any dishware, service and /or cookware, it was best practice to set up the three compartment sink. Review of the Serve Safe flyer Cleaning and Sanitizing Practices that will Prevent Cross Contamination, dated 09/2021, revealed pathogens could spread to food if equipment had not been cleaned and sanitized correctly. The flyer stated that it could happen by the use of equipment and utensils that were not washed, rinsed, or sanitized between uses; by wiping clean but not washing, rinsing, and sanitizing food-contact surfaces; by the use of wiping clothes that were not stored in a sanitizer solution between uses; and by the use of sanitizing solutions that were not at the required levels to sanitize objects. Observation on 02/24/2026 at 11:33 AM during the lunch tray line revealed soiled baking sheets and pots stacked on the left side of the three-compartment sink which hung over one opened number 10 can of vanilla pudding and one opened number 10 can of fruit cocktail with clean plastic dessert bowls on a tray by the soiled side of the pans. Further observation revealed there was no detergent in the first sink, water for rinse in the second sink, and no sanitizer in the third sink. Observation of [NAME] 1 on 02/24/2026 at 11:35 AM revealed the cook used a cloth from the pot and pan sink, rinsed off the cleaning cloth under the faucet, and wrung the cloth out to clean the food production table by the robe coupe. The food production table had crumbs which appeared to be mechanical soft meat. [NAME] 1, using the cleaning cloth, brushed off the crumbs onto the rack of scoop plates behind the machine. The cleaning cloth was not kept in the sanitizer bucket and was left in the empty sanitizer sink. Further observation revealed the sanitizer bucket was located underneath the stack of soiled pots and sheet pans on the left side of the pot and pan sink. Then, [NAME] 1 removed a pair of gloves from his pocket and put them on his hands. Observation on 02/25/2026 at 8:30 AM revealed the soiled pots and sheet pans were stacked on the left side of the pot and pan sink overhanging the food production table. In an interview with [NAME] 1 on 02/25/2026 at 3:09 PM, he stated he changed gloves when he changed tasks. He stated the gloves pulled from his pocket could have bacteria or other items from his pocket with a potential for cross contamination. He stated food on the production table near the soiled pots and pans hanging over from the pot and pan sink could cause cross contamination. He stated the cleaning cloth should have been in the sanitizer bucket instead of using water to rinse and wring it out. He stated using the (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	unsanitized cleaning cloth to wipe the tables could cause cross contamination. In an interview with the Account Manager (Dietary Manager) on 02/25/2026 at 3:31 PM, she stated [NAME] 1 wearing gloves taken from his pocket could cause cross contamination. She stated using cleaning cloths that were not kept in the sanitizer bucket would cause the surfaces wiped to not be disinfected. She also stated the soiled pots and sheet pans hanging over the food production table could cause cross contamination. In an interview with the Director of Nursing on 02/26/2026 at 10:30 AM, she stated she expected gloves to be stored and used appropriately to prevent cross contamination. She also stated she expected staff to follow infection control practices in the kitchen. In an interview with the Administrator on 02/26/2026 at 10:45 AM, she stated she expected gloves not to be put into pockets, cleaning cloths to be put in the sanitizer bucket, and clean and soiled dishes separated to prevent the potential for cross contamination.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to notify the resident and the resident's representative of the resident's transfer or discharge and the reasons for the move in writing and in a language and manner they understood as soon as practicable. The facility failed to ensure the notice included the reason, date, and location for the transfer, as well as a statement of the residents' appeal rights and the contact information for the state Long-Term Care Ombudsman. The deficient practice was identified for 1 of 20 residents reviewed for transfer and/or discharge practices, Resident (R) 68. The findings include:Review of the facility's policy titled, Facility Bed-hold, revised 02/02/2025, revealed the facility would notify the resident and or resident's representative of the facility's bed hold policy at admission and anytime a resident was transferred to the hospital or went out on therapeutic leave. Per the policy, the facility would also notify the resident and or resident's representative in writing of the reason for the transfer or discharge to another legally responsible institution or non-institutional setting, and the resident's right to appeal the transfer or discharge. Review of the facility's provided Grievance Log, dated 12/2025, revealed the Minimum Data Set (MDS) Coordinator documented a grievance concern, Family was not notified resident was taken to the ER [Emergency Room]. Review of R68's Face Sheet revealed the facility admitted the resident on 08/06/2023 with diagnoses of type 2 diabetes mellitus with no proliferative diabetic retinopathy without muscular edema bilateral, cerebrovascular disease, and cerebral infarction (stroke). Further review of R68's medical record revealed on 11/03/2025, R68 was sent to the hospital emergency department for evaluation.Review of R68's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/23/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 6 of 15, indicating she was severely cognitively impaired.During an interview with R68's family member (FM) on 02/26/2026 at 10:48 AM, she stated she had come to the facility to visit R68, when she overheard a nurse say to R68, How have you been feeling since you got back? Per the interview, the FM stated to the nurse, I was not aware my mother had been sent out. During an interview with the MDS Coordinator on 02/26/2026 at 2:15 PM, she stated she was unaware the FM was not called or given a written bed hold notice when R68 was sent to the hospital on [DATE]. She stated it was not a good standard to send residents out of the facility with family representatives not notified. She stated R68 had a low BIMS score, and she was left alone at the hospital because of the failure to notify family representatives. During an interview with the Director of Nursing (DON) on 02/26/2026 at 2:42 PM, she stated she was unaware the facility sent R68 to the hospital and her FM was not called. She stated it was not how the facility normally operated and was unsure how it happened. She stated moving forward and to have a good standard of practice at the facility, the resident and family representatives should be notified immediately if their loved one was being sent out of the facility. During an interview with the Administrator on 02/26/2025 at 2:57 PM, she stated she was not aware the family was not called or mailed a bed hold for R68 on 11/03/2025. She stated when residents were sent out of the facility for a medical emergency or a facility outing, the facility staff members called to inform the family. She stated with R68 having a low BIMS score, it would be imperative that she have someone with her.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure residents received treatment and care in accordance with the physician's orders and the comprehensive person-centered care plan for 1 of 20 sampled residents, Resident (R) 87.Review of R87's Orders revealed orders for the dressing to the right foot to be changed daily and for the central line dressing to be changed every 72 hours.However, during an interview on 02/24/2026 with R87, she stated there were orders for daily dressing changes to her right foot, and the dressing was not changed by staff on 02/16/2026, 02/17/2026, and 02/18/2026. R87 also stated her central line dressing had not been changed since 02/15/2026, which observation on 02/24/2026 verified. The findings include:Review of the facility's policy titled, Non-Tunneled Central Catheter, dated 10/2024, revealed it did not address care of the catheter.Observation on 02/24/2026 at 10:38 AM of R87's central line dressing revealed it had a date written on it of 02/15/2026, written in pink ink. Further observation of R87's right heel dressing revealed it did not have a date written on it.Review of R87's Face Sheet revealed the facility admitted R87 on 02/06/2026 with diagnoses of chronic obstructive pulmonary disease (COPD), acute osteomyelitis of the right ankle and foot, and chronic kidney disease.Review of R87's admission Minimum Data Set [MDS], with an Assessment Reference Date of 02/10/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, which indicated the resident was cognitively intact.Review of R87's Orders, revealed an order for the central line dressing change to be done every 72 hours, dated 02/06/2026. Further review revealed an order to apply betadine-soaked gauze to the right heel, cover with an abdominal (ABD) pad (a large, thick, highly absorbent pad with multiple layers used for heavily draining wounds), wrap with Kerlix (cotton gauze roll used to protect wounds), and then wrap with Coban (a self-adherent wrap used to protect the wound dressing) once a day. The order's start date was 02/11/2026, and the end date was 02/19/2026. On 02/19/2026, the same right heel wound dressing order was increased to every shift.Review of R87's Care Plan revealed, Resident has surgical wound to right heel related to wound requiring surgical intervention prior to admission to facility, dated 02/13/2026. The intervention for the right heel wound was treatment per order, dated 02/13/2026. Further review revealed a focus for central line to right chest, with the intervention of dressing changes as ordered.Review of R87's Medication Administration Record [MAR] revealed Licensed Practical Nurse (LPN) 2 documented treatment to the right heel was done on 02/16/2026 and 02/18/2026. Further review revealed LPN3 documented treatment was done on 02/17/2026. Continued review revealed the central line dressing was documented as done on 02/18/2026 by LPN2; and the central line dressing was documented on 02/21/2026 as not done by LPN4. Further review revealed the central line dressing was documented on 02/24/2026 as being completed by LPN5.During an interview on 02/24/2026 at 10:38 AM with R87, she stated her central line dressing was supposed to be changed every Sunday, but it had not been changed since the previous Sunday, 02/15/2026. She stated the dressing to her right foot was not done several days the previous week from Monday, 02/16/2026, to Thursday, 02/19/2026. She stated she usually had the right heel dressing changed on Tuesdays by her podiatrist. However, she stated last Tuesday, 02/17/2026, the facility did not arrange transport to her appointment, so it had to be cancelled.The State Survey Agency (SSA) attempted to interview LPN2, but she was out-of-state and unreachable.During an interview on 02/25/2026 at 3:07 PM with LPN1, she stated dayshift staff usually did the dressing changes, and she did not have an answer as to why dressing changes were not done as ordered for R87. She stated wound care staff made rounds on Tuesdays, and they did the dressing changes to R87's right heel. She stated LPNs were not allowed to change central line dressings, and the Assistant Director of Nursing (ADON) or (Infection Prevention) IP Nurse usually did them. However, she stated it was the nurses' responsibility to make them aware. She stated she thought central line dressings were to be changed once a week and was not aware R87's order was for every 72 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours.During an interview on 02/25/2026 at 3:10 PM with LPN3, she stated the Registered Nurse (RN) on duty would be the one changing central line dressings. She stated that it was important to prevent infections. She stated she did not remember if she changed R87's foot dressing, and she just signed it off on the [MAR] on 02/17/2026 because she thought it was being done by wound care staff during their rounds.During an interview on 02/25/2026 at 3:45 PM with the Director of Nursing (DON), she stated if an LPN was checked off to change central line dressings, then they were allowed to do so. However, she stated she was not sure which LPNs were competent and would need to check and get back to me. She stated staff should not document tasks being done if they did not complete them. She stated it was her expectation that staff followed care plans and orders to ensure proper care was given.During an interview on 02/26/2026 at 10:30 AM with the Administrator, she stated it was her expectation that all staff should be following the residents' orders to follow directions from the provider. She stated it was her expectation that staff followed the residents' care plans because they were put in place for each resident to ensure they were getting the correct care.