STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185293	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Laurel Creek Rehabilitation and Nursin	1033 North Highway 11 Manchester, KY 40962

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy, the facility failed to develop and implement a baseline care plan which included instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care for one (1) of 23 sampled residents, Resident (R) 339. R339 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), encounter for orthopedic aftercare, and presence of right artificial hip joint. However, the facility failed to complete a baseline care plan to provide effective care within 48 hours of admission.The findings include: Review of the facility's Baseline Care Plans policy, undated, revealed a baseline plan of care to meet the resident's immediate needs should be developed for each resident within 48 hours of admission. Further review revealed a base line care plan included initial goals on admission orders and physician orders. Continued review revealed the resident and their representative would be provided a summary of the baseline line care plan which included the initial goals of the resident and a summary of the resident's medications. Review of R339's Face Sheet revealed the facility admitted the resident on 06/24/2025 with diagnoses encounter for other orthopedic aftercare, presence of right artificial hip joint, history of malignant neoplasm of ovary, and osteoarthritis. Review of R339's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/29/2025, revealed it was still in progress and had not been completed. Review of R339's Comprehensive Care Plan, dated 07/01/2025, revealed the resident was at risk for pain related to depression and a recent medical procedure. Further review revealed a goal that the resident would report satisfaction with her pain medication regime. Continued review revealed interventions to administer medications as ordered and a pain assessment as needed. Review of R339's Physician Orders revealed an order, dated 06/24/2025, for Oxycodone 10 milligrams (mg) every 4 hours as needed for severe pain. However, there was no evidence the facility care planned the resident's need for pain medication within 48 hours. During an interview, on 07/01/2025 at 1:20 PM, R339 stated she had received Oxycodone 10 mg as ordered from 06/24/2025 until 07/01/2025 when the nurse told her she only had a three-day order and would not give her the medication. She further stated she had been on the Oxycodone prior to the hip replacement, and it had been ordered by her oncologist when she was fighting cancer. She continued to state she was only in the facility for short-term rehabilitation following a hip replacement and she was unable to go to therapy on 07/01/2025 because of the pain.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** The facility failed to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three of 23 sampled Residents (R) (23, 20, 85).The findings include: Review of the facility’s policy, “Oxygen Administration,” undated, revealed steps in providing safe oxygen administration included to turn on the oxygen at the number of liters per minute as ordered by the physician/practitioner, be sure there was water in the humidifying jar with water level high enough the water bubbles as oxygen flows through, and periodically re-check the water level in the humidifying jar. Review of R85’s Medication Administration Record (MAR) revealed a physician's order for oxygen administration at two liters per minute. Review of R20’s Medication Administration Record (MAR) revealed a physician's order for oxygen administration at two liters per minute. Observation, on 06/29/2025 at 11:10 AM, revealed R85's oxygen concentrator set on three liters per nasal cannula with an empty water container, and nebulizer tubing attached to a nebulizer at the resident’s bedside which was not bagged while not in use. Observation, on 06/29/2025 at 11:30 AM, revealed R20’s oxygen concentrator set on four liters per nasal cannula with no water container, and nebulizer tubing attached to a nebulizer at the resident’s bedside which was not bagged while not in use. During an interview, on 06/29/2025 at 11:10 AM, R85 stated the facility adjusted her oxygen levels and she was unaware her water container was empty. During an interview, on 06/29/2025 at 11:30 AM, R20 stated the facility adjusted her oxygen levels. She further stated she didn’t know “anything” about the water container. During an interview, on 06/30/2025 at 4:05 PM, Licensed Practical Nurse (LPN) 3 stated R20 and R85 were ordered for oxygen at two liters per minute. During an interview, on 06/30/2025 at 4:10 PM, Registered Nurse (RN) 1 stated nurses check the oxygen settings and tubing at least every shift. He further stated if the oxygen is set at a higher rate than ordered, it could cause residents to become hypoxic and have a risk for the resident to stop breathing. He continued to state the water container was changed and filled weekly by the central supply staff. RN1 stated if the oxygen did not have humidity, it could cause irritation to the resident’s nasal passages. During an interview, on 07/02/2025 at 2:00 PM, the Infection Preventionist stated all oxygen and nebulizer tubing should be bagged when not in use to prevent the spread of germs because if it was not bagged it would be touching surfaces that had been touched by multiple people. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 07/02/2025 at 3:00 PM, the Director of Nursing stated it was her expectation staff followed physician orders and administered oxygen per stated orders. Observation on 06/29/2025 at 10:50 AM and at 12:00 PM revealed Resident 23 (R23) who was ordered to receive Oxygen (O2) therapy via a nasal cannula and was observed to have the nasal cannula on. However, the tubing was disconnected from the concentrator and lying in the floor. When staff was made aware, LPN 2 picked up the tubing from the floor and connected it to the concentrator without cleaning, sanitizing or changing the tubing.Review of the facility policy titled Oxygen Administration undated, revealed the purpose was to provide guidelines for safe oxygen administration.Review of Resident 23's face sheet revealed he was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, and Diabetes.During an interview on 06/29/2025 at 12:05 PM with LPN2, she stated she should have obtained a new tubing for R23 due to potential contamination from lying in the floor. LPN2 further stated the Resident could be at risk for respiratory issues due to the oxygen and or contaminates going directly into the respiratory system. During an interview on 06/30/2025 at 4:10 PM with Registered Nurse (RN)1 he stated the oxygen saturation, the oxygen setting, and the tubing should be checked every shift by the nurse.During an interview on 07/02/2025 at 3:00 PM with the Director of Nursing (DON) she stated her expectation was for staff to follow the Oxygen policy.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure pain management was provided as ordered for one of 23 sampled, Resident (R) 339. The findings include:Review of the facility's policy, Pain Management, undated, revealed the organization would ensure pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.Review of the facility's policy, Medication and Treatment Orders, undated, revealed medications would be administered upon the written order of a person duly licensed and authorized to prescribe such medications. Further review revealed drug orders must be recorded on the physician's order sheet in the resident's medical record.Review of R339's Face Sheet revealed the facility admitted the resident on 06/24/2025 with diagnoses encounter for other orthopedic aftercare, presence of right artificial hip joint, history of malignant neoplasm of ovary, and osteoarthritis.Review of R339's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/29/2025, revealed it was still in progress and had not been completed.Review of R339's Comprehensive Care Plan, dated 07/01/2025, revealed the resident was at risk for pain related to depression and a recent medical procedure. Further review revealed a goal that the resident would report satisfaction with her pain medication regime. Continued review revealed interventions to administer medications as ordered and a pain assessment as needed.Review of R339's physicians orders revealed an order for Oxycodone 10 milligrams (mg) every four hours as needed for severe pain.Review of R339's June 2025 Medication Administration Record (MAR) revealed the resident had an Oxycodone documented as given on 06/30/2025 at 1:18 PM and no further pain medication was documented on the June 2025 or July 2025 MAR prior to 07/01/2025 at 1:20 PM.Review of R339's Controlled Drug Receipt/Record/Disposition Form for Oxycodone 10 mg revealed the medication was signed out on 06/30/2025 at 6:30 PM and 10:30 PM, and on 07/01/2025 at 3:30 AM and 2:00 PM.Observations on 06/29/2025 and 06/30/2025 revealed R339 up in room in cheerful mood with no complaints voiced. Observation, on 07/01/2025 at 1:20 PM, revealed resident was sitting on side of bed tearful.During an interview, on 07/01/2025 at 1:20 PM, R339 stated she had been told she could not have her pain medication because it was only a three-day order and she was trying to get in touch with her doctor to get a refill. She further stated she could not attend therapy on 07/01/2025 because she was in too much pain.During an interview, on 07/01/2025 at 1:30 PM, with the Unit Manager who was R339's primary nurse, she stated the resident only had an order for Oxycodone for three days, which had ended, and she messaged the doctor regarding the order. She further stated R339 was drug seeking.During an interview, on 07/01/2025 at 4:15 PM, R339 stated the nurse had given her a pain pill this afternoon and pain had improved. She further stated she was able to attend physical therapy after receiving the pain medication.During an interview, on 07/01/2025 at 4:20 PM, the Unit Manager stated she had called the physician and received permission to give the resident one pain pill until the physician came to the building to see her tonight.During an interview, on 07/02/2025 at 11:45 AM, the Unit Manager stated R339's Oxycodone order had no stop date, and she wanted to clarify with the physician if R339 could continue the medication. During an interview, on 07/02/2025 at 3:00 PM, the Director of Nursing stated nurses should follow physician orders and assess the resident's pain as needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** §483.45(g) Labeling of Drugs and Biological's and §483.45(h) The facility failed to ensure that all drugs and biologicals used in the facility are labeled in accordance with professional standards, including expiration dates and with appropriate accessory and cautionary instructions for one of five sampled residents. Resident (R)#1. On [DATE] the Licensed Practical Nurse (LPN) 2 administered Med-Pass to R1 that had expired per manufacturers recommendations. The findings include: Observation on [DATE] at 12:10 PM revealed Licensed Practical Nurse (LPN) # 2 poured Med-Pass 2.0 (a nutritional shake) from a multi-dose carton, which had an open date of [DATE]. Resident # one, (R1) was handed the Med-Pass in a cup to drink. Review of the facility policy titled, Medication Storage, not dated, revealed no instructions pertaining to labeling of nutritional supplements. However, review of the Med-Pass 2.0 manufacturer's direction on the carton revealed after opening, the product should be consumed in four days if properly refrigerated, or within 4 hours if not refrigerated. Review of R1's Face Sheet revealed resident was admitted to the facility on [DATE] with diagnoses of Intellectual Disabilities, Atrial Fibrillation, and Postural Kyphosis. Review of R1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed the Brief Interview for Mental Status (BIMS) could not be administered due to the resident's poor cognitive status. Interview on [DATE] at 12:25 PM with LPN 2 revealed she wasn't sure of when the Med-Pass should be discarded, she thought it was 30 days after opening. LPN2 further stated she normally uses the entire container during the medication pass but had run out during this medication pass and obtained the opened/dated carton from the refrigerator. She further stated the Med-Pass should have been disposed of on [DATE]. LPN 2 stated she receives education monthly from the facility as well as online. She further stated giving expired Med-Pass to the resident could cause gastrointestinal issues. During an interview with the Director of Nursing on [DATE] at 3:00 PM she stated her expectation was for the staff to follow the policy as well as the manufacturers' recommendations regarding storage and disposal.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and review of the facility 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 the development and transmission of communicable diseases and infections for all residents, staff, volunteers, visitors and other individuals providing services. The sample census was 23.The findings include: Review of the facility’s “Infection Control Program”, signed 03/10/2025, revealed the facility had an infection control program and committee that addressed the surveillance, prevention, and control of disease and infection consistent with the guidelines from the Centers for Disease Control (CDC) and the federal Occupational Safety Hazard Agency (OSHA) blood borne pathogens regulations. Review of the facility’s “Hand Hygiene” policy, undated, revealed all staff were responsible for hand hygiene procedures after contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident and before and after wearing gloves. Observation, on 06/30/2025 during the lunch meal, revealed HK1 with her cleaning cart cleaning the residents’ hallway when meal trays arrived. The facility staff opened the tray cart and began passing lunch trays to residents. HK1 pushed her cart down the hallway to the closet and parked the cart in the hallway while she opened the closet door with a key. Facility staff were noted to push the tray cart next to the cleaning cart and open the cart door to get more trays off the cart and take to residents. HK1 then pushed the cleaning cart into the closet, disposed of her gloves in the trash bin on the cart, then closed the closet door and walked down the hallway (past the nurse’s station) to the doorway of a resident room to retrieve a wet floor sign, without hand hygiene. During an interview, on 06/30/2025 at 12:45 PM, HK1 stated she had worked in the facility for 5 months and was aware the cleaning cart needed to be put up when resident trays were out so they wouldn’t be running into each other, and she was supposed to have the cart off the floor before trays arrived. She continued to state it could be an infection control issue with the items she had on her cart encountering the residents’ meal trays. She further stated she should have performed hand hygiene when she took her gloves off to prevent the spread of germs. During an interview with the Infection Preventionist, on 07/02/2025 at 2:00 PM, she stated staff received training on proper hand hygiene and the facility monitored for proper hand hygiene through Ambassador rounds daily. She further stated cleaning carts should be off the floor at mealtime because they contained dirty items and garbage, as well as supplies that should not be out close to residents’ meal trays. She continued to state staff not performing proper hand hygiene could lead to the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/01/2025 at 9:38 AM of Resident (R) 43 being transferred from his bed to the wheelchair revealed the use of a Hoyer lift. Upon completion of the R43 being transferred to his wheelchair, from the Hoyer Lift. The Hoyer lift was removed from the room and placed across the hall in a dayroom. No cleaning was noted of the Hoyer lift before or after the use of the lift.Review of the facility policy titled Cleaning and Disinfecting Resident Care Items and Equipment dated 10/01/2021, revealed, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA bloodborne pathogens standard. Furthermore, reusable items were to be cleaned and disinfected or sterilized between residents (e.g. stethoscopes, and durable medical equipment).Review of the facility policy titled Enhanced Barrier Precautions (EBP) Policy dated 03/28/2024 revealed the purpose of the policy was to outline the guidelines for implementing EBP to reduce the transmission of multi drug-resistant organisms (MDROs) within the facility. EBP was to be used in conjunction with standard precautions to provide targeted gown and glove use during high-contact resident care activities. Further review of the policy revealed if a resident had a wound or indwelling medical device EBP were to be utilized during high-contact resident care activities such as transferring the resident.Review of Resident 43's Face Sheet revealed he was admitted to the facility on [DATE] with a diagnoses of Hemiplegia following Cerebral Infarction affecting right side, contractures of right upper and lower extremities. During an interview on 07/01/2025 at 10:07 AM with Certified Nursing Assistant (CNA) #9 she stated after using the Hoyer Lift, it is placed in the breakroom until used again. She further stated there is a storage area where they are also placed. CNA9 further stated the Hoyer Lifts are cleaned at the end of the day and the lift pads are cleaned after the resident is put back to bed. CNA 9 continued to state there was no need to clean the Hoyer lift between residents as the residents didn't come in contact with the other areas of the lift, but only the lift pad that was under the resident during transfer. During an interview on 07/02/2025 at 2 PM with the Infection Preventionist she stated her expectation was to follow the infection control policy regarding multi-use devices cleaning.