STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185302	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hardinsburg Nursing and Rehabilitation Center	101 Fairgrounds Road Hardinsburg, KY 40143

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to ensure the environment was free of accident hazards for 1 of 2 sampled residents reviewed for accidents, Resident (R)39. Based on observation, interview, record review, and review of facility policy, the facility failed to ensure the environment was free of accident hazards for 1 of 2 sampled residents reviewed for accidents, Resident (R)39. FindingsCollapse[NAME]'s FindingsWriting Complete | Last Updated by [NAME] 07/25/2025 12:01 PM | The findings include: Review of the facility policy titled, Medication Administration Standard of Practice, dated 10/2020, revealed, Medications will be administered in a safe and timely manner, and as prescribed. Review of R39's admission Face Sheet indicated the facility admitted the resident on 11/26/2024. According to the admission Face Sheet, the resident had a medical history that included a diagnosis of low back pain. Review of R39's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/25/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had occasional pain. Review of R39's Care Plan, included a problem area dated 06/26/2025, that indicated the resident had a recent surgery and had an incision. Interventions directed staff to administer medication as ordered, monitor effectiveness, and encourage the resident to verbalize the need for pain medication and/or pain-relieving measures (initiated 06/26/2025). Review of R39's Physician's Order Form for orders as of 07/09/2025, revealed an order started on 06/20/2025, for acetaminophen (Tylenol) 325 milligrams (mg) (medication used to treat mild to moderate pain), one tablet by mouth every four hours as needed, not to exceed 3,000 mg daily from all sources. There was no documented evidence of an order to keep the medication at the resident's bedside. During an observation on 07/07/2025 at 11:00 AM, a bottle of Tylenol 500 mg and a tube of cream was observed at R39's bedside. During an observation on 07/08/2025 at 1:10 PM, a one-ounce tube of bacitracin zinc ointment (a medication used on the skin to prevent infection) and a bottle of Tylenol 500 mg was observed on R39's bedside table. During an interview on 07/08/2025 at 1:10 PM, R39, stated the Tylenol and bacitracin zinc ointment was brought to the facility upon admission after a medical appointment with the urologist, approximately two to three weeks prior to 07/08/2025. Further interview revealed R39 applied the ointment and took two to four Tylenol from the bottle, daily, as needed without staff monitoring. R39 stated staff had not talked about the resident self- administering the medications, and R39 did not think Tylenol was a medication the nurse had to monitor. R39 opened the Tylenol bottle and stated there were six pills left in the bottle. During an observation on 07/09/2025 at 9:40 AM, Tylenol and bacitracin zinc continued to be on R39's bedside table. During an interview on 07/09/2025 at 10:12 AM, Registered Nurse (RN) 1 stated, Tylenol nor any type of ointment should be left at a resident's bedside without a doctor's order and an assessment to determine whether it was safe to leave medications at the bedside. Per RN1, if the resident had a Tylenol limit, it would be hard to monitor the amount the resident took if the resident had Tylenol at the bedside. During an interview on 07/09/2025 at 3:16 PM, the Director of Nursing (DON) stated she expected staff to report if there were any medications at a resident's bedside. The DON stated Tylenol usage should be monitored for side effects and if a resident wanted to self-administer a medication, the facility needed to conduct an assessment and speak to the doctor. During an interview on 07/09/2025 at 3:39 PM, the Administrator stated he expected staff to notify the nurse if they saw any medications at a resident's bedside.

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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. Based on observation, interview, and record review, the facility failed to follow physician's orders for the administration of supplemental oxygen for 1 of 3 sampled residents reviewed for respiratory care, Resident (R)9. The findings include: Review of R9's admission Face Sheet revealed the facility admitted the resident on 05/02/2025. According to the admission Face Sheet, the resident had a medical history that included diagnoses of heart failure and pulmonary hypertension. Review of R9's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2025, revealed the facility assessed R9 as having a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. Review of R9's Care Plan indicated a problem area initiated 05/26/2025, revealing the resident had a self-care deficit as evidenced by the need for moderate assistance with activities of daily living due to chronic obstructive pulmonary disease, diabetes, and generalized weakness. Interventions directed staff to give supplemental oxygen as ordered (initiated 05/26/2025). Review of R9's Physician Order Form for active orders as of 07/08/2025, revealed an order started on 05/04/2025, for supplemental oxygen at 2 liters per minute (LPM) per nasal cannula (NC) every shift. During an observation on 07/07/2025 at 10:55 AM, R9 was lying in bed with supplemental oxygen per NC. The supplemental oxygen concentrator flow rate was observed to be set at 3 LPM. During an interview on 07/09/2025 at 10:26 AM, Licensed Practical Nurse (LPN)2 stated it was the responsibility of the nurse to make sure a resident's supplemental oxygen concentrator was set at the LPM prescribed by the physician. LPN2 stated if the supplemental oxygen was set too high, the resident could retain too much carbon dioxide. LPN2 further stated R9's supplemental oxygen concentrator was set at 3 LPM. LPN2 reviewed the resident's physician orders and stated R9 should receive supplemental oxygen at 2 LPM by way of a NC. LPN2 stated she was unsure why the resident's supplemental oxygen was set at 3 LPM. During an interview on 07/10/2025 at 9:23 AM, the Director of Nursing (DON) stated the facility did not have a policy for oxygen administration. During an interview on 07/10/2025 at 11:12 AM, R9 stated staff had not adjusted the flow rate on the oxygen concentrator. R9 stated, I don't know nothing about that thing. During an interview on 07/10/2025 at 1:51 PM, the Staff Development Coordinator (SDC) stated supplemental oxygen initiation and oxygen flow rate adjustment were included in the nurses' competencies. The SDC stated she taught each staff member, documentation should be made in real time as much as possible and before checking the box on the Medication Administration Record (MAR), the nurse was expected to verify the oxygen flow rate. During a follow-up interview on 07/09/2025 at 3:03 PM, the DON stated the nurses were expected to check the resident's supplemental oxygen setting every shift and document the accuracy of the LPM on the MAR. The DON stated she expected the nurses to follow the physician's orders, and if the resident had a change in condition that required the resident's supplemental oxygen to be increased, she expected the nurse to call the physician to obtain a new supplemental oxygen order. During an interview on 07/10/2025 at 10:38 AM, the Medical Director stated he expected the nurses to monitor the residents' supplemental oxygen concentrator to ensure it was on the correct flow rate. The Medical Director stated it was important residents receive supplemental oxygen based on the order, because if the supplemental oxygen was not set as ordered the resident could become hypoxic (insufficient oxygen in the body). During an interview on 07/10/2025 at 11:32 AM, the Administrator stated he expected the nurses to follow orders from the physician for supplemental oxygen administration. The Administrator stated if the wrong amount of supplemental oxygen was delivered, the resident could become dependent upon the increased amount. The Administrator stated he was unsure whether R9 could change the supplemental oxygen setting and he had received no reports about the resident adjusting their flow rate.