STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185330	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbellsville Nursing and Rehabilitation Center	1980 Old Greensburg Road Campbellsville, KY 42718

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 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, and review of facility policy, the facility failed to ensure staff adhered to infection prevention and control practices, including hand hygiene and cleaning and disinfection of resident care equipment, to prevent the transmission of infections. The failure had the potential to affect all residents. The findings include: Review of the facility's policy titled, Infection Control Program Standard of Practice, revised 11/2017, revealed the purpose of the facility's infection control program was to prevent the spread of infection. In addition, review revealed the purpose also included providing appropriate education for staff and residents concerning infection control and to monitor infections and facility areas of infection. Continued review revealed hand washing, clinical equipment disinfecting, and isolation guidelines were included and intended to meet the Centers for Disease Control and Prevention (CDC) guidelines for long-term care and regulatory requirements. Further review revealed all isolation precautions and hand washing techniques for staff and residents were to follow the CDC long-term care guidelines. Additionally, the facility's infection control program was to be guided by recommendations via the CDC website. 1). Review of the facility's policy titled, Enhanced Barrier Precautions Standard of Practice, revised 04/2024, revealed enhanced barrier precautions (EBP) were additional infection control measures that might be implemented as needed as part of the facility's infection control practices to help prevent and manage the transmission of diseases and infections. Continued review revealed EBP might be implemented during high-contact care activities for residents with chronic wounds, indwelling medical devices, and/or residents with identified targeted multidrug-resistant organisms when contact precautions did not apply. Further review revealed when a resident was placed on EBP the facility was to determine the process for resident identification to alert staff when high-contact activities might require additional infection control measures, including the use of gown and gloves. Review of the facility's enhanced barrier tracking log, undated, revealed facility documentation identified 13 residents had been placed on EBP for conditions requiring additional infection control measures such as, wounds, indwelling medical devices, dialysis shunts, Foley catheters, and surgical incisions. Observation on 01/04/2026 at 10:20 AM, at the time of the State Survey Agency (SSA) entry, revealed EBP signage posted outside of some residents' room doors. Review of the EBP signage revealed instructions for everyone to clean their hands before entering and when leaving those rooms. Continued observation revealed the signage instructed providers and staff to wear gloves and a gown for high-contact resident care activities, including dressing, bathing or showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use, and wound care. Further observation revealed the signage instructed staff not to wear the same gown and gloves for the care of more than one resident. 1a). Observation on 01/04/2026 at 10:40 AM, revealed signage indicating the need for EBP precautions posted above and below the room number placard for resident room [ROOM NUMBER] (where Resident(R)9 and R55 resided) on the East Wing. Per observation, the signage instructed staff to clean their hands before entering and when leaving the room. Continued review of the EBP signage indicated both residents in resident room [ROOM NUMBER] were on EBP. Observation revealed State Registered Nurse Aide (SRNA) 1 entered without performing the required (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185330	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbellsville Nursing and Rehabilitation Center	1980 Old Greensburg Road Campbellsville, KY 42718

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand hygiene prior to entry and exited the room without performing necessary hand hygiene. Review of R9's medical record revealed the resident had been on EBP since 11/27/2025, due to the presence of a dialysis shunt. Review of R55's medical record revealed the resident had been on EBP since 12/01/2025, due to a neck dressing. In interview with SRNA 1, on 01/04/2026 at 10:40 AM, she said she entered resident room [ROOM NUMBER], which had residents on EBP, and failed to perform hand hygiene after exiting the room. She stated she did not believe hand hygiene was required because she had only provided the resident with water. SRNA 1 reported she had not performed hand hygiene because she had forgotten. She further stated not practicing proper hand hygiene as required could spread illness to other residents allowing them to get sick. 1b). Observation on 01/04/2026 at 10:44 AM, revealed Kentucky Medication Aide (KMA) 1 entered R9's and R55's room without performing hand hygiene prior to entering the room. Per observation, KMA 1, while in R9's and R55's room, removed oxygen tubing from an oxygen machine and discarded the tubing in the garbage. Continued observation revealed KMA 1 then exited R9's and R55's room without performing hand hygiene and proceeded to resident room [ROOM NUMBER] (where R5 resided) on the East Wing without performing hand hygiene. Observation revealed R5 was on EBP due to the presence of a Foley catheter. Review of R5's medical record revealed the resident had been on EBP since 11/16/2024.A telephone (phone) interview was attempted with KMA 1 on 01/04/2026 at 10:44 AM; however, the KMA stated she was not working at the time and declined to speak with the State Survey Agency (SSA) Surveyor. In interview on 01/04/2026 at 11:00 AM, R55 stated KMA 1 came in her room, and did something with her oxygen tubing. The resident further stated KMA 1 then threw the oxygen tubing in the garbage beside her bed. 1c). Observation on 01/04/2026 at 11:20 AM, revealed SRNA 2 entered resident room [ROOM NUMBER] (R9's and R55's room) without performing hand hygiene. Per observation, SRNA 2 exited resident room [ROOM NUMBER] without performing hand hygiene, proceeded to an office area to obtain personal scissors, and returned to resident room [ROOM NUMBER] to cut oxygen tubing. Continued observation revealed SRNA 2 discarded oxygen tubing in the garbage. Further observation revealed however, SRNA 2 failed to perform hand hygiene before or after handling the oxygen equipment or when exiting resident room [ROOM NUMBER]. In interview with SRNA 2 on 01/04/2026 at 11:20 AM, she stated when she entered and exited resident room [ROOM NUMBER] on the East Wing, she had not thought about performing hand hygiene. She said she had not looked to see if the residents were on any type of precautions before entering the room. SRNA 2 reported she had been asked to change the resident's oxygen tubing and had been in a hurry at the time. She further stated she should have washed her hands for the safety of the residents and to prevent the spread of germs. 1d). Observation on 01/04/2026 at 3:53 PM, revealed SRNA 6 exited resident room [ROOM NUMBER] (where R24 resided) on the [NAME] Wing without performing hand hygiene. Per observation, while in the room, SRNA 6 changed the resident bed linens without wearing a gown or gloves. Review of R24's medical record revealed the resident had been on EBP since 01/02/2026 due to a wound dressing. In interview with SRNA 6 on 01/04/2026 at 3:53 PM, she stated she entered resident room [ROOM NUMBER] on the [NAME] Wing and had not paid attention to the posted EBP signage. She reported she should have performed hand hygiene and worn the appropriate PPE. She acknowledged her failure to do perform hand hygiene could result in contamination to herself or the spread of germs that could make residents sick. In interview with Registered Nurse (RN) 1, on 01/04/2026 at 10:51 AM, she stated she was responsible for resident room [ROOM NUMBER] on the East Wing; however, said she was not aware if the residents assigned to that room were on EBP. She reported her expectations for staff entering resident room [ROOM NUMBER], were for the staff to follow Personal Protective Equipment (PPE) 1 requirements regardless of whether they were on the clock or not. RN 1 further stated failure to follow PPE protocols could result in the spread of germs and illness to other residents. In interview with the Infection Preventionist (IP) on 01/06/2026 at 10:02 AM, she stated it was important for staff to follow the posted EBP signage for residents' safety. She said proper hand hygiene was the first line of defense to prevent the spread of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185330	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbellsville Nursing and Rehabilitation Center	1980 Old Greensburg Road Campbellsville, KY 42718

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	germs. The IP reported it was her expectation for all staff to follow proper infection prevention protocols for the safety of residents and to prevent the spread of germs. In interview with the Administrator on 01/06/2026 at 1:11 PM, she stated it was her expectation for staff, regardless of whether they were clocked in for work or not, to follow the EBP signage for the safety of residents. 2). Review of the facility's policy titled, Homelike Environment Standard of Practice, reviewed 04/2025, revealed residents were to be provided a safe, clean, comfortable, and homelike environment. Continued review revealed the facility was to maintain cleanliness and order throughout the environment. Further review revealed overall cleanliness was maintained to promote resident comfort and safety. Review of the facility's, Night Shift CNA Chore Sheet document revealed it outlined the routine cleaning and handling of resident care equipment and supplies. Per review, the Chore Sheet did not include instructions or expectations for the cleaning or disinfection of shower chairs used for resident bathing. Observation on 01/04/2026 at 12:24 PM, in the East Wing shower room revealed a shower chair used for resident showers with a dark, mold-like substance present on multiple surfaces. Per observation, the substance was on the fabric seat sling, along the seams of the sling material, and on the white plastic frame of the shower chair, including areas near joints, bolts, and tubing connections. Further observation revealed the dark residue was also on the lower portions of the chair frame and around the wheels. In interview with SRNA 4 on 10/05/2026 at 9:17 AM, she stated the shower chair located on the East Wing was not clean presently. She reported the shower chair had not been cleaned in at least seven months. SRNA 4 said she would not want residents' skin to come into contact with the mold-like substance present on the chair due to health concerns. She stated such contact could cause infections to residents. SRNA 4 further stated she would not sit in the shower chair herself and would not want her loved ones to have to sit on it. In interview with SRNA 5 on 01/05/2026 at 9:22 AM, she stated residents could get sick from sitting on the shower chair in its present condition. She reported she would not sit on the chair herself, nor would she want her loved ones to have to sit on it. SRNA 5 further stated the shower chair should be cleaned before being used for residents. In interview with the Director of Nursing (DON) on 01/05/2026 at 10:06 AM, she stated the SRNAs were responsible for cleaning the shower chairs. She said that task was included on a nightly chore list completed by the SRNAs. The DON stated licensed nurses reviewed and checked off on the chore list and she or the Assistant Director of Nursing (ADON) provided oversight to ensure the tasks were completed as required. She further stated however, she did not know the last time she or the ADON had checked the shower room chairs to verify they were being cleaned. In interview with the ADON on 01/05/2026 at 10:25 AM, she stated she and the DON had oversight responsibility to ensure shower chairs were being cleaned and were safe for resident use. She reported the mold-like substance observed on the shower chair appeared to have been present for a long time. The ADON said she could not identify the last time the shower chairs had been cleaned or inspected. She stated residents could experience skin issues or other complications if the mold-like substance contacted their skin, or if they had an open wound. The ADON further stated exposure to the mold-like substance could also result in respiratory issues for residents. In interview with Licensed Practical Nurse (LPN) 2 on 01/05/2026 at 10:34 AM, she stated the shower chair located in the East Wing shower room was filthy. LPN 2 stated the black matter present on the chair appeared to be mold-like and said she would not sit in that chair herself nor want a loved one to sit on it. She further stated she was concerned about cross-contamination and potential respiratory issues for residents. LPN 2 additionally stated she was concerned that steam from the showers could allow the mold-like substance to spread throughout the shower room. In interview with the DON on 01/05/2026 at 11:50 AM, she stated she reviewed the night shift chore sheet and determined cleaning of the shower chairs was not included on the chore list. She said that had been an oversight on her part. The DON further stated she could not identify when the shower chairs had last been cleaned. In continued interview with the Administrator on 01/06/2026 at 1:11 PM, she stated it was her expectation for staff to ensure all equipment used for residents to be clean and maintained in a clean condition to ensure resident safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185330	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbellsville Nursing and Rehabilitation Center	1980 Old Greensburg Road Campbellsville, KY 42718

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 - Few	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 review of facility policies, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety.The findings include: 1). Review of the facility policy titled, Staff Attire HCSG Policy 024, revised 01/2025, revealed all staff members were to have their hair off their shoulders and confined in a hair net or cap, with facial hair properly restrained. Further review revealed all staff members were to store all personal belongings, including cell phones, in designated areas away from food preparation or food and supply areas. Observation, on 01/04/2026 at 10:35 AM, revealed [NAME] 1 and Dietary Aide (DA) 1 preparing residents' lunches without hair nets in place as per the policy. Per observation, [NAME] 1 was wearing a headband that covered her ears; however, which was completely open on top with her ponytail on top of her head. Further observation revealed DA 1 had no a hair net or hair covering on. Observation, on 01/04/2026 at 11:33 AM, revealed [NAME] 1 took a phone out of her back pocket to answer a call during the lunch tray line. Continued observation revealed [NAME] 1 placed the phone back in her pocket and continued plating residents' food without performing hand hygiene and donning new gloves. Observation, on 01/05/2026 at 11:56 AM, revealed [NAME] 1 left the steam table with her gloves on to go to the microwave to heat up cheese on a burger. Continued observation revealed [NAME] 1 then returned to the steam table without removing the gloves, performing hand hygiene and donning new gloves. Observation, on 01/05/2026 at 12:06 PM, revealed [NAME] 1 leaned her gloved hands on the top of the steam stable sneeze guard for several minutes. Continued observation revealed [NAME] 1 then continued scooping chicken pot pie from its tin container onto a resident's plate and putting a hamburger from one plate to another with her gloved hands. Per observation, additional observation the Regional Dietary Manager (RDM) came into the kitchen with no beard cover in place, and without performing hand hygiene, to go to the dishwasher side of the kitchen. Further observation revealed the RDM then left the kitchen area. During interview, on 01/05/2026 at 3:03 PM, Cook1 stated she thought she could wear a cap instead of a hair net. [NAME] 1 stated she could see how, by not wearing a hair net, hair could fall into the residents' food. She reported by not performing hand hygiene and changing gloves that could contaminate the food and cause a resident to get sick. [NAME] 1 further stated she had received some training related to dietary sanitation; however, could not recall when she received that training. During interview, on 01/05/2026 at 3:00 PM, the Dietary Account Manager stated [NAME] 1 usually wore a hair net under her other head coverings. She said she was aware anyone entering or being in the kitchen was to wear a hair net per the facility policy. The Dietary Account Manger reported proper hand hygiene was expected of staff serving food on the tray line and in the kitchen in general. Additionally, she further stated the kitchen was short staffed and was not sure how to correct that. During interview, on 01/05/2026 at 2:30 PM, the RDM stated all dietary staff needed to wear a hair net or a hat, and if they had a beard, they were to wear a beard net. He said hand hygiene was expected to be performed whenever hands became soiled. The RDM reported it was his expectation for residents' food to be prepared and served in a sanitary manner to prevent cross contamination. He further stated he would be ensuring dietary staff were trained on kitchen expectations, hand hygiene and sanitation. During an interview, on 01/06/2026 at 9:55 AM, the Administrator stated it was her expectation dietary staff wore hair nets or hats and wore beard guards when necessary. Further, she stated when dietary staff were working behind the steam table, and moved to another part of the kitchen, they were to wash their hands and don new gloves prior to working at the steam table again. The Administrator stated dietary staff were to follow facility dietary policies and regulations related to storing, preparing, and serving food. The Administrator continued to state that it was ultimately her responsibility for the kitchen staff and how it was run. 2). Observation, on 01/05/2026 at 3:05 PM, of the facility's emergency food supply revealed it included expired food items that included four bags of rice cereal with an expiration of 12/05/2025; two cases (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185330	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbellsville Nursing and Rehabilitation Center	1980 Old Greensburg Road Campbellsville, KY 42718

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 - Few	of apple juice with an expiration of 06/11/2025; and one case of chocolate chip cookies that expired on 07/01/2025. During continued interview, on 01/05/2026 at 2:30 PM, the RDM stated it was his expectation for food to be stored in a safe and sanitary manner, to include no expired food, to prevent cross contamination. He said it was his expectation that staff followed the dietary policies. He further stated he was aware that more kitchen staff were needed and will be working on that in the future.