STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185334	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Nursing & Rehab Center, Inc	1595 S US Highway 231 Beaver Dam, KY 42320

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, document review, and facility policy review, the facility failed to ensure staff consulted the Registered Dietician (RD) before they substituted pureed mashed potatoes for pureed tomatoes for 4 residents of 4 sampled residents (Resident (R) 15, 16, 41 and R49) ordered a pureed diet. The findings include: Review of a facility policy titled, Menus, revised 10/2017, indicated, policy statement menus were developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. The policy further specified the dietitian would review and approve all menus.Review of the facility menu for the dinner meal on 04/20/2026 indicated the following would be served: macaroni & cheese, stewed tomatoes, carrots, baked apples. Review of the facility Resident Summary Report dated 04/22/2026, revealed four residents R15, R16, R41, and R49 were ordered a puree texture diet. During a concurrent interview and dinner meal tray line observation on 04/20/2026 at 4:55 PM, the surveyor noted the Dietary Services Director (DSD) plate puree mashed potatoes on the dinner meal tray of residents ordered a puree texture diet. The DSD stated mashed potatoes were a substitution for the puree tomatoes. During an interview on 04/20/2026 at 5:09 PM, the DSD stated the dietary department stopped serving puree tomatoes because staff were unable to get the seeds in the tomatoes to a puree consistency. The DSD stated she contacted the RD prior to the dinner meal on 04/20/2026 to obtain permission to serve mashed potatoes instead of puree stewed tomatoes. During an interview on 04/21/2026 at 3:00 PM, the RD stated the menu should be followed and she was not notified that mashed potatoes would be served instead of puree stewed tomatoes. The RD stated she would expect a vegetable substitution for the stewed tomatoes that was not a starchy vegetable like mashed potatoes since the macaroni and cheese were high in carbohydrates. The RD stated tomatoes had fewer calories and more vitamin C than potatoes. The RD stated she would not expect potatoes to be served with a high carbohydrate entree like macaroni and cheese. During an interview on 04/22/2026 at 9:10 AM with the Chief Executive Officer (CEO) / Administrator and the Clinical Operations Officer (COO), the CEO / Administrator stated he expected staff to follow the menu. The COO stated she had the same expectation for staff to follow menus, spreadsheets, policies, and procedures for following the menu.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, document review, and facility policy review, the facility failed to ensure staff performed a safety check before insulin was administered which resulted in 3 medication errors out of 32 opportunities, which yielded a medication error rate of 9.38% for two residents (Resident 5 and Resident 7) of eight residents observed for medication administration. The findings include: Review of a facility policy titled, Administering Medications, revised 04/2019, indicated medications were administered in a safe and timely manner, and as prescribed.Review of the Lantus SoloStar pen manufacturer information with a copyright date of 2022, indicated Step 3, Perform a Safety Test. Dial a test dose of 2 units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after your perform the test. If no insulin comes out, repeat the test 2 more times. If there is still no insulin, coming out, use a new needle and do the safety test again. Always perform the safety test before each injection. The undated Novolog pen manufacturer information indicated Get your pen ready 1. Wash and dry your hands well. 2. Remove the pen cap. 3. Look at the insulin in the pen to make sure the liquid is clear and has no color and no specks. Only use the pen if the liquid is clear, had no color and no specks in it. It's normal to see air bubbles. 4. Wipe the rubber end of the pen with an alcohol swab. 5. Remove the paper seal from the new pen needle. Carefully screw the pen needle onto the end of the pen. 6. Remove the outer needle cap and set it aside. Remove the inner needle cap and throw it away. 7. Turn the knob on the pen to dial up a dose of 2 units. 8. Hold the pen with the needle pointing straight up. Gently tap the side of the pen to get rid of any large air bubbles. You may still see some small bubbles. This is normal. 9. Push the injection button until you see 0 (zero) in the dose window. You should see a drop of liquid at the end of the needle. This means your pen is ready to use. 10. If you can't see a drop of liquid, repeat steps 7 to 9. Do this until you see a drop of medicine. 1. Review of R5's admission Record revealed the facility admitted the resident on 02/17/2026. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus with hyperglycemia. Review of R5's Order Summary Report with active orders as of 04/22/2026, revealed an order dated 02/17/2026, for Lantus SoloStar subcutaneous solution pen-injector 100 units per milliliter inject 50 units subcutaneously one time a day for diabetes. During medication administration observation on 04/22/2026 at 6:17 AM, Licensed Practical Nurse (LPN) 4 without performing a safety test, attached a new needle to the Lantus pen, dialed it to 50 units, cleaned R5's abdominal area with an alcohol pad, then injected 50 units of Lantus insulin into the resident's abdominal area. During an interview on 04/22/2026 at 6:54 AM, LPN4 stated she never primed the insulin pens and was unsure what that meant. During an interview on 04/22/2026 at 12:19 PM, the Clinical Operations Officer stated her expectation would be for the nurse to prime the insulin pen. During a telephone interview on 04/22/2026 at 3:23 PM, the Consultant Pharmacist stated her expectation for insulin pens would be for the nurses to be consistent and prime them with the 2 units of insulin to make sure the pens did not have any air bubbles. 2. Review of R7's admission Record revealed the facility admitted the resident on 02/14/2025. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus with hyperglycemia. Review of R7's Order Summary Report with active orders as of 04/22/2026, revealed an order dated 10/03/2025, for Lantus SoloStar subcutaneous solution pen-injector 100 units per milliliter (unit/mL) inject 48 units subcutaneously one time a day for diabetes and an order dated 07/25/2025, for Novolog flex pen subcutaneous solution pen-injector 100 unit/mL inject 3 units if the resident's blood glucose level is between 151 milligrams per deciliter (mg/dL) and 200 mg/dL. During medication administration observation on 04/22/2026 at 6:32 AM, LPN4 without performing a safety test, attached a new needle to the Lantus pen, dialed it to 48 units, cleaned R7's abdominal area, and (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injected 48 units of Lantus into the resident's abdominal area. LPN4 then checked R7's blood glucose level and it was noted to be 170 mg/dL. LPN4 did not perform the safety test before she injected 3 units of Novolog into the resident's abdomen. During an interview on 04/22/2026 at 6:54 AM, LPN4 stated she never primed the insulin pens and was unsure what that meant. During an interview on 04/22/2026 at 12:19 PM, the Clinical Operations Officer stated her expectation would be for the nurse to prime the insulin pen. During a telephone interview on 04/22/2026 at 3:23 PM, the Consultant Pharmacist stated her expectation for insulin pens would be for the nurses to be consistent and prime them with the 2 units of insulin to make sure the pens did not have any air bubbles.

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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 policy review, the facility failed maintain infection control practices to ensure staff did not reach into their pockets with a gloved hand to retrieve medical supplies during medication administration for two of eight residents observed for medication administration (Resident (R) 5 and R7). The findings include: Review of a facility policy titled, Infection Prevention and Control Program, revised 10/2018, revealed an infection prevention and control program was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.1. Review R5's admission Record revealed the facility admitted the resident on 02/17/2026. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus with hyperglycemia. Review of R5's Order Summary Report with active orders as of 04/22/2026, revealed an order dated 02/17/2026, for Lantus SoloStar subcutaneous solution pen-injector 100 units per milliliter inject 50 units subcutaneously one time a day for diabetes. During medication administration observation on 04/22/2026 at 6:17 AM, Licensed Practical Nurse (LPN) 4 placed her gloved left hand in the pocket of her jacket and removed a packaged disinfectant wipe to clean R5's glucometer before she placed the glucometer in the resident's bedside table. During an interview on 04/22/2026 at 6:54 AM, LPN4 stated she did not realize she put her gloved hand back in her pocket to get the disinfectant cloth. LPN4 stated it was her process to keep the disinfectant packages in her pocket. During an interview on 04/22/2026 at 12:19 PM, the Clinical Operations Officer stated she would expect the nurse to perform hand hygiene at the appropriate times. 2. Review of R7's admission Record revealed the facility admitted the resident on 02/14/2025. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus with hyperglycemia. Review of R7's Order Summary Report with active orders as of 04/22/2026, revealed an order dated 10/03/2025, for Lantus SoloStar subcutaneous solution pen-injector 100 units per milliliter (unit/mL) inject 48 units subcutaneously one time a day for diabetes and an order dated 07/25/2025, for Novolog flex pen subcutaneous solution pen-injector 100 unit/mL inject 3 units if the resident's blood glucose level is between 151 milligrams per deciliter (mg/dL) and 200 mg/dL. During medication administration observation on 04/22/2026 at 6:32 AM, LPN4 placed her gloved left hand in the pocket of her jacket and removed a packaged disinfectant wipe to clean R7's glucometer before she placed the glucometer in the resident's bedside table. During an interview on 04/22/2026 at 6:54 AM, LPN 4 stated she did not realize she put her gloved hand back in her pocket to get the disinfectant cloth. LPN4 stated it was her process to keep the disinfectant packages in her pocket. During an interview on 04/22/2026 at 12:19 PM, the Clinical Operations Officer stated she would expect the nurse to perform hand hygiene at the appropriate times.