STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185337	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Care & Rehabilitation Center	246 East Main Street Beattyville, KY 41311

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted from 12/16/2025 - 12/18/2025, the facility failed to maintain a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Multiple ongoing environmental concerns were identified that had the potential to negatively impact the health, safety, and quality of life of residents, staff, and the public. These issues were noted throughout resident rooms and common areas. These findings demonstrated a failure to routinely monitor, identify, and address environmental concerns to maintain the facility in safe and good repair. Review of the facility's policy titled Resident Rights, last revised 01/31/2025, revealed all residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life. However, observations, interviews, and record review revealed the facility did not consistently maintain the physical environment in accordance with this policy.Review of the facility's maintenance request logs revealed multiple environmental concerns identified during the survey, including damaged wall surfaces, broken or deteriorated tiles, rusted fixtures, and other structural concerns in resident rooms and common areas, were not consistently documented in the maintenance tracking system prior to surveyor observation. Maintenance requests for several of these concerns were entered into the log on or after 12/17/2025 and 12/18/2025, following identification during the survey. This indicated the facility did not have an effective system in place to routinely identify, document, and track maintenance concerns to ensure the physical environment was maintained in safe and good repair.Observation on 12/17/2025 at 3:35 PM in the C Wing shower room revealed environmental conditions that were not maintained in a safe and sanitary manner. Two cracked tiles were observed at the corner of the shower. A black, mold-like substance was observed underneath the blue cushion of a resident mobile shower chair. In addition, a wad of hair, debris, and loose hair were observed underneath the blue cushion and on the surface beneath the cushion of the mobile shower bed.Observation on 12/17/2025 at 3:55 PM in the B Wing shower room revealed a rusted air vent located within the shower area, two broken tiles noted on the corner of the shower entrance, and multiple floor tiles observed separating from the corner wall. Additionally, a mobile shower chair stored in the shower room was observed with a mold-like substance present on its surface and wheel wells. Observations during a facility tour conducted on 12/18/2025 beginning at 8:56 AM revealed multiple areas within resident use and common areas that were not maintained in a safe, functional, and sanitary manner. In the dining room, six ceiling tiles were observed with brown staining, black substance was noted on ceiling tiles located directly outside of the kitchen area, and multiple drop ceiling clips exhibited visible rust. A section of baseboard was missing from a dining room wall. On the ramp leading to the dining room, ceiling tiles were observed to be sagging, including two tiles with brown staining and one tile with a broken corner. The door frame leading to the nurses' station on B Wing was observed to be rusted, and paint was noted to be scratched and missing from the wall between resident rooms B12 and B13. The door to resident room B10 was missing a section of paneling and paint. Additional observations included a scuffed and rusted door frame leading to the utility room on B Hall, a scuffed and rusted door frame leading to the restroom in resident room B2, (continued on next page)

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

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and a scuffed and rusted door frame leading to resident room A4. A four-inch area of paint was observed to be chipped off the wall outside of resident room A5. In addition, the light panel at the C Wing nurses' station was observed to be broken, and the wall corner guard located across from the C Wing nurses' station was observed to be broken and separated from the wall. These conditions demonstrated a lack of routine environmental monitoring and maintenance, resulting in multiple deteriorated surfaces and fixtures present thought-out resident-use and common areas. Interview with Resident (R21) on 12/16/2025 at approximately 11:11 AM stated he had a hole in the ceiling of his room that had been present for several weeks and stated no one had come to assess or repair it. R21 further stated he had observed brown stains on the ceiling in the dining room and noticed cracked tiles and broken ceiling tiles in the shower room. He further stated that since residing at the facility, no one had addressed the rust present around the entryway to his room or in the bathroom. R21 stated he would like these concerns repaired and indicated that if he were able to do so himself at home, the repairs would have already been completed.Interview with State Registered Nurse Aide (SRNA) 1 on 12/17/2025 at 11:30 AM stated she had been employed by the facility for approximately one month and stated that the door paneling to resident room B10 had been missing for the duration of her employment. SRNA 1 further stated that she had not reported the missing paneling to supervisory or maintenance staff for repair, although she acknowledged that it should have been reported. SRNA 1 stated the facility serves as the residents' home and that maintaining the physical environment in good repair was important to promote resident safety and comfort.Interview with the District Manager for housekeeping services on 12/17/2025 at 4:00 PM stated mobile shower chairs and mobile shower beds were expected to be cleaned by either nursing staff or housekeeping staff after each resident use to promote resident safety and reduce the risk of infection transmission. The District Manager further stated that damaged wall tiles and deteriorated surfaces within resident shower areas were hazardous, as broken or sharp edges could result in residents sustaining cuts or other injuries during use of the bathing area.Interview with the Housekeeping Supervisor on 12/17/2025 at 4:06 PM stated neither she nor her housekeeping staff routinely cleaned mobile shower devices after each use. The Housekeeping Supervisor acknowledged that ensuring resident safety was important and further stated that the wheel wells of the mobile shower chair were not routinely cleaned. She indicated that failure to remove mold-like substances from shower equipment could potentially place residents at risk for respiratory issues and other health concerns. Interview with Housekeeper 2 on 12/18/2025 at 9:25 AM stated she had observed multiple environmental concerns within resident rooms and common areas, including brown stains and broken ceiling tiles, scuffed flooring, and rust present on door frames leading to resident rooms. Housekeeper 2 stated that she had not reported these concerns to the maintenance department but should have. She further stated she did not routinely report environmental concerns she considered to be cosmetic in nature. Housekeeper 2 stated it was important to report all environmental concerns, so residents did not feel like they lived in a broken facility. Interview with the Maintenance Director on 12/18/2025 at approximately 3:00 PM stated he conducted facility rounds on a weekly basis to identify areas in need of repair and maintenance; however, he stated that he relied on all facility staff to report environmental concerns as they were identified. The Maintenance Director stated that he was not aware of a hole in the wall of resident room [ROOM NUMBER] on the B Wing at the time of interview. He further stated the maintenance department consisted of one Maintenance Director, one full-time maintenance employee, and one additional staff member who assisted as needed. The Maintenance Director stated that during the week of the survey, more maintenance work was completed than at any other time since he assumed the role due to having additional staff onsite to help.Interview with the Regional Plant Operations Manager on 12/18/2025 at 3:05 PM stated the facility needed to establish a plan to ensure the physical environment was maintained in good repair. He further stated that maintaining the physical environment was important to ensure resident safety and comfort.Interview with the Administrator on 12/18/2025 at 3:20 PM stated it was her expectation that environmental concerns and items in need (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of repair were identified and corrected in a timely manner. The Administrator stated all staff were expected to report environmental issues to the maintenance department to ensure repairs were completed and resident safety was maintained.Interview with State Registered Nurse Aide (SRNA) 2 on 12/18/2025 at 3:30 PM, stated she was aware of environmental concerns within the facility, including cracked tiles in resident shower areas and a rusted air vent located in the shower room, but had not reported them to anyone. SRNA 2 stated these areas had been present for an extended period and had not been repaired. SRNA 2 further stated she had utilized the mobile shower chair during resident care and acknowledged that she had not ever cleaned the wheel wells of the mobile shower chair after use. She stated environmental conditions, and equipment should be maintained in a clean and safe condition, as residents rely on staff to ensure bathing areas and equipment do not pose a safety or health concern.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and review of facility's policy, the facility failed to protect resident rights to privacy related to electronic medical records (EMRs). The computer located on top of the medication cart, contained confidential resident information and was observed to be left open and viewable to visitors, residents, and staff in the hallway on 12/16/2025 at 10:34AM,10:40AM and at 11:05AM. The findings include: Review of the facility admission packet under title Resident Records, Duties of facilities effective June 20, 2005, section 7 revealed all residents' shall be provided with confidential treatment of their medical and personal records. Review of the facility admission packet under title Federal- Resident Rights -privacy and confidentiality revealed the resident has the right to personal privacy and confidentiality of his/her personal and medical records, and the right to refuse the release of personal and medical records in accordance with state laws. This included privacy and confidentiality in his /her accommodations, medical treatment, written and telephone communications, personal care, visits and meetings with family and residents' groupsObservation of the medication/treatment cart located at the B Wing nurses' station, on 12/16/2025 at 10:34AM, 10:40AM and at 11:05AM, revealed the computer was left open with residents' information in public view. Residents and staff were observed in the hallway during all three observations. Further observation of the computer screen revealed a resident picture in the upper left-hand corner. On 12/16/2025 at 10:42AM the Director of Nursing (DON) was walking down the hall and saw the computer left open with residents' information in clear view of anyone in the hall. The DON stated in an interview that it was a violation of privacy, and that the computer screen should be minimized before staff walked away from the medication cart.During an interview on 12/16/2025 at 10:45AM RN 1 stated leaving the computer open with resident information visible to anyone was a violation of the resident's privacy. On 12/16/20025 at 11:05AM RN1 was observed to prepare medication for a resident and RN1 walked away from the B Wing medication cart with the computer screen open and resident information in full view of anyone one in the hallway.During an interview on 12/17/2025 at 11:40 AM, the Administrator, stated the computer screen should be minimized or closed for resident privacy before staff walk away from the medication cart.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan was accurate, person-centered, and reflective of the resident's assessed needs and preferences for one of 27 sampled residents (R21). Review of R21's behavioral care plan revealed it was updated to include the statement I have a history of refusing showers and medications at times; however, the care plan did not include any corresponding interventions to address the identified behaviors. Interview with R21 revealed he did not refuse showers. Additionally, interview with the Medical Records Nurse revealed R21 did not have a history of refusing medications and stated this information should not have been included in the care plan. This resulted in a care plan that contained inaccurate information and failed to provide individualized interventions to guide staff in meeting the resident's needs.Review of the facility's policy titled Resident Assessment, last reviewed on 01/31/2025, revealed the facility was responsible for conducting comprehensive, accurate, and standardized assessments of each resident using multiple sources of information, including resident interview, medical record review, observations, and input from interdisciplinary staff, to ensure assessment data accurately reflected the resident's status. The policy further required if assessment data was conflicting, inaccurate, or requires clarification, the Minimum Data Set Coordinator was responsible for verifying the information with the resident and appropriate staff and correcting the documentation accordingly. Additionally, the policy required any identified inaccuracies be clarified and corrected through appropriate documentation to ensure the resident's care plan accurately reflected the resident's needs, preferences, and behaviors.Review of the facility's policy titled Resident Rights, last reviewed 01/31/2025, revealed all residents have the right to be treated with respect and dignity and to receive care in a manner and environment that promotes maintenance or enhancement of quality of life. The policy further stated residents have the right to participate in decisions regarding their care and care planning and to review their care plan, including the right to be informed of and participate in decisions affecting their treatment. Additionally, the policy emphasized respect for the resident's individuality and self-determination, requiring that care planning accurately reflected the resident's preferences, needs, and choices.Review of the facility's policy titled Behavioral Health, last reviewed 09/13/2024, revealed the facility was responsible for providing necessary behavioral health care and services in accordance with each resident's comprehensive assessment and plan of care to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The policy further stated behavioral health care was to be based on a comprehensive resident assessment, and person-centered approaches must be implemented according to the resident's interests, preferences, and choices. Additionally, the policy required staff remain alert to the effectiveness and accuracy of care plan interventions, and the care plan be reviewed and revised as necessary to reflect the resident's current status and needs.Review of the facility's policy titled Quality Assurance/Performance Improvement (QAPI) Program Policy, last reviewed on 2/3/2025, revealed the facility was responsible for conducting an ongoing, systematic Quality Assurance and Performance Improvement program designed to monitor, evaluate, and improve the quality and appropriateness of resident care. The policy stated QAPI activities were to examine both processes and outcomes, identify problem areas, and implement corrective actions when care practices place resident outcomes at risk. The policy further required the QAPI Committee to review identified concerns, conduct audits and assessments, and develop improvement plans when care processes, including care planning and assessment accuracy, fail to meet standards or negatively affect resident care.Review of the facility's Abuse, Neglect and Misappropriation of Property policy, last reviewed 1/31/25, revealed the facility was responsible for the ongoing identification, assessment, care planning, and monitoring of residents' needs and behaviors to prevent harm, neglect, and unmet (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosocial needs. The policy stated residents were to be monitored for changes in condition, care planning was to include appropriate interventions based on identified needs, and residents' physical, mental, and psychosocial well-being were to be addressed through assessment, care planning, and ongoing monitoring. The policy further required identified resident needs and behaviors be addressed through appropriate interventions to ensure residents received care and services consistent with their assessed needs.Review of the facility's policy titled Comprehensive Care Plans, last reviewed on 1/31/2025, revealed the facility was responsible for developing and implementing a comprehensive, person-centered care plan for each resident based on a thorough assessment of the resident's medical, nursing, mental, and psychosocial needs. The policy required the Interdisciplinary Team to develop and maintained a care plan that incorporated identified problem areas and associated risk factors, including measurable objectives, and to ensure the care plan was revised as necessary when changes occur. The policy further stated residents and/or their representatives were encouraged to participate in the development and review of the care plan, and the comprehensive care plan was designed to address identified problems through individualized interventions to assist in preventing or reducing declines in the resident's physical and psychosocial well-being.Review of Resident 21's behavioral care plan, start date 11/20/2025, revealed it had been updated to include the statement the resident has a history of refusing showers and medications at times. Further review revealed the care plan did not include any identified interventions, approaches, or strategies to address the identified behaviors. The care plan lacked documentation supporting the inclusion of these behaviors and did not reflect individualized, person-centered interventions related to bathing or medication administration. The inclusion of unsupported behavioral concerns without corresponding interventions indicated the care plan was not based on an accurate and comprehensive assessment of the resident's needs and did not demonstrate an individualized approach to care planning.Review of Resident 21's Nurse Aide Care Plan revealed an entry dated 12/15/2025 indicating leave and return; however, the documentation did not include any clarification regarding the purpose of the leave, the duration, or specific instructions identifying when or how the information was to be applied to the resident's care. Further review revealed the entry lacked accompanying guidance or direction for nursing staff or nurse aides to ensure continuity and consistency of care following the resident's return. Additionally, the entry was not signed or initialed by the individual who entered the information. The absence of clear instructions and staff authentication indicated the Nurse Aide Care Plan did not provide sufficient, individualized guidance to direct staff in meeting the resident's care needs.Review of R21's Resident Face Sheet revealed R21 was admitted to the facility on [DATE] following a hospital stay with diagnosis including cerebral infarction with left sided hemiplegia (damage to the right side of the brain, causing paralysis on the body's left side.)Review of R21's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/2025 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact.The MDS Nurse 1 stated in interview on 12/17/2025 at 2:45 PM upon review of Resident 21's care plan, the resident did not have any interventions in place related to a behavioral concern of refusing showers or medications. MDS Nurse 1 stated if a behavior was identified and entered onto a care plan, corresponding interventions should be implemented immediately to address the behavior. MDS Nurse 1 further stated she reviewed the care plan at the time of the interview and was unable to locate any interventions addressing refusal of showers or medications, indicating the care plan did not provide guidance to staff regarding the identified behavior.Interview with MDS Nurse 2 on 12/17/2025 at 2:45 PM stated the resident did not have a documented history of refusing showers or medications and no interventions addressing refusal of showers or medications were present on the care plan. MDS Nurse 2 stated when behaviors were added to a care plan, it was expected that individualized interventions were developed to ensure staff have clear direction on how to meet the resident's needs. MDS Nurse 2 further stated staff received routine training, including pre- and post-testing, to promote understanding of care planning (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectations; however, the resident's care plan did not reflect interventions aligned with those expectations.The Medical Records Nurse stated in interview on 12/17/2025 at 3:15 PM she was responsible for entering the behavioral information onto Resident 21's care plan. The Medical Records Nurse stated when a behavioral concern was identified, the care plan should be updated immediately with person-centered interventions to guide staff in addressing the behavior; however, she stated she had forgotten to update the care plan with interventions for R21's behaviors. The Medical Records Nurse further acknowledged that although the behavioral concern had been added to the care plan, corresponding interventions were not entered at that time. She additionally stated a care plan entry had previously been made indicating the resident refused medications; however, upon later review, it was determined the resident did not have a history of refusing medications, and the care plan was subsequently updated to remove the incorrect behavior from R21's care plan.Interview with the Administrator on 12/17/2025 at 3:50 PM stated it was her expectation when a behavior was identified and added to a resident's care plan, the care plan would be updated immediately to include appropriate interventions. The Administrator further stated nurse aides were expected to reference the Nurse Aide Care Plan for direction regarding resident care and this document was intended to guide nurse aides in how care was to be provided to the resident. (The Nurse Aide Care Plan was used by nurse aides for day-to-day care direction, whereas the comprehensive care plan reflected the resident's overall care needs and required nursing interventions.)State Registered Nurse Aide (SRNA) 3 stated in interview on 12/18/2025 at 10:13 AM she had worked at the facility for more than three years; however, she did not understand what the notation leave and return on Resident 21's Nurse Aide Care Plan meant. SRNA #3 stated she would need to ask a nurse for clarification regarding the instruction.Registered Nurse (RN) 2 stated in interview on 12/18/2025 at 10:15 AM the leave and return notation on the Nurse Aide Care Plan should have included clearer instructions for staff, like when the directive applied, what services it applied to, and how it was expected to be used by nurse aides. RN 2 further stated the entry should have been signed or otherwise identified by the individual who entered it so staff would know who to contact for clarification if additional information was needed.During an interview with State Registered Nurse Aide (SRNA) 4 on 12/18/2025 at 10:20 AM she stated she did not understand what the leave and return notation on Resident 21's Nurse Aide Care Plan meant. SRNA #4 stated the entry should have been signed or initialed by the individual who added it to the care plan so nursing assistants would know who to ask for clarification.R21 stated in interview on 12/18/2025 at 12:35 PM that he has never refused showers or medications. R21 further stated when personal care services were not provided in a timely manner, he felt unclean and uncomfortable, which made him more likely to request hygiene care rather than refuse it. R21 stated due to these feelings, he would not refuse showers and did not understand why the facility would have care planned for refusals or behaviors he has not demonstrated.The Director of Nursing (DON) stated in interview on 12/18/2025 at 2:04 PM it was her expectation that when a behavior was entered into a resident's care plan, nursing staff update the care plan at that time to include appropriate interventions. The DON stated nursing staff were responsible for ensuring the care plan accurately reflected the resident's current needs and provided clear guidance for staff.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure one out of 27 sampled resident's (R21) basic hygiene needs were met by not providing routine nail care as needed. The failure to provide routine nail care resulted in long unclean nails, placing the resident at risk for discomfort, skin integrity issues, and infection.Review of the facility's policy titled Resident Rights, last revised 01/31/2025, revealed all residents would be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life. Additionally, the stakeholders would respect the resident's individuality and value their input by providing a dignified existence, through self-determination and communication with and access to persons and services inside and outside the facility.Review of the facility's policy titled Abuse, Neglect, and Misappropriation of Property, last revised 09/15/2023, revealed neglect was defined as the failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress.Review of R21's Resident Face Sheet revealed R21 was admitted to the facility on [DATE] following a hospital stay with diagnosis including cerebral infarction with left sided hemiplegia (damage to the right side of the brain, causing paralysis on the body's left side.), dysphagia (difficulty swallowing), and chronic respiratory conditions.Review of R21's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/2025 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact.Review of R21's Behavioral Care Plan, problem start date 11/20/2025, revealed R21 had a history of self-inflicted scratching and bruising to the left side of his nose, with nursing interventions documented to address hygiene and reduce the risk of complications. Observations conducted on 12/16/2025 through 12/18/2025 revealed R21's fingernails were long and visibly soiled on each day. R21's nails extended beyond the fingertips and contained dark debris underneath all fingernails. The condition of R21's fingernails remained unchanged throughout the observation period.During an interview conducted with R21 on 12/16/2025 at 11:11 AM, R21 stated his fingernails had not been cut in over a month. R21 reported he had asked facility staff on multiple occasions to trim his fingernails but felt his requests were ignored. R21 further stated if he were able to trim his fingernails himself, he would do so. R21 expressed not having his fingernails trimmed in the manner he preferred made him feel dirty.During an interview conducted with State Registered Nurse Aide (SRNA) 4 on 12/18/2025 at 10:05 AM, SRNA 4 stated she did not bring R21's shower documentation sheet with her during the resident's shower care and therefore did not document the observations related to R21's skin or nail care. SRNA 4 stated nail care was typically addressed during the shower routine; however, she did not verify whether R21 was a diabetic prior to initiating the shower. SRNA 4 stated if a resident was a diabetic, nail care must be completed by a licensed nurse and documented accordingly. SRNA 4 further stated she did not complete R21's shower documentation sheet at the time of care, explaining she became sidetracked and left the form incomplete along with other residents' documentation. Additionally, SRNA 4 stated documenting observations during shower care was intended to alert licensed nursing staff to residents' additional care needs, including nail care.During an interview conducted with Registered Nurse (RN) 2 on 12/18/2025 at 10:15 AM, RN 2 stated shower documentation sheets were intended to be reviewed to identify residents who require nail care. RN2 stated that SRNA's were expected to complete the shower documentation sheets and provide them to licensed nurses for review so that any additional care needs, including nail care, could be addressed. RN2 further stated SRNA's should verify whether a resident was diabetic prior to providing nail care, as nail care for diabetic residents must be completed by a licensed nurse, with podiatry providing toenail care as indicated. RN2 stated that completion and review of the shower documentation sheets was essential, as there was no designated location within the Electronic Health Record (EHR) to document nail care. Additionally, RN2 sated that failure to identify and follow (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up on nail care needs may result in routine hygiene care not being provided as intended.During an interview conducted with Director of Nursing (DON) on 12/18/2025 at 2:04 PM, the DON stated trimming residents' nails was a responsibility of the nursing staff and part of providing routine personal care. The DON stated it was her expectation that nursing staff listen to residents when they communicate care needs or requests and take appropriate action to address those needs. The DON further stated that if R21 had been requesting nail care, his nails should have been trimmed.During an interview conducted with the Administrator on 12/18/2025 at 2:30 PM, the Administrator stated the shower documentation sheets were not the only method for staff to communicate residents' care needs and that staff could also verbally communicate identified needs to licensed nursing staff. The Administrator stated it was her expectation that staff communicate resident care needs through appropriate channels and follow through to ensure those needs were addressed. The Administrator did not identify any additional system used to track or ensure follow-up of verbally communicated care needs.

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	185337	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Care & Rehabilitation Center	246 East Main Street Beattyville, KY 41311

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 - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and review of 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 1 of 27 sampled residents, (Resident (R)59). The findings include:Review of the policy titled Infection Control Infection Prevention Measure, undated, section 3.2 Needleless Connectors, revealed Needless connectors were to be vigorously scrubbed with an antiseptic wipe before accessing. Needless connectors must be swabbed between each entry into the connector, including attaching syringes of flush solution or attaching the administration set. On 12/16/2025 at 11:05AM Registered Nurse (RN) 1was observed to administer intravenous (IV) Vancomycin (an antibiotic) to resident (R) 59. RN1 did not place a barrier on the bed before laying the tubing from the IV with open ports on R59's bedsheets. Further observation revealed that RN1 did not wipe the ends of the port from R59s wrist with an alcohol swab or the end of the IV tubing before connecting them to administer R59's medication. During an interview, on 12/16/2025 at 11:10AM, RN1 stated it was not necessary to wipe the IV tubing ports as the bed had the resident's flora and cleanliness was not an issue. During an interview on 12/17/2025 at 11:34AM the Staffing Procurement Registered Nurse (SPRN) stated IV tubing should not have been placed on R59's bed without a barrier underneath as it could become contaminated. The SPRN further stated that she would have expected the tubing to have been put on a clean surface. The Administrator stated in an interview on 12/17/2025 at 11:40AM she expected RN1 to have used a barrier under R59s IV tubing and that the IV ports were required to be wiped with an alcohol swab prior to being connected. During an interview on 12/17/2025 at 11:45AM with the Director of Nursing (DON), the DON stated she expected RN1 to have used a barrier to lay the IV tubing on and to have wiped the IV ports before connecting. The DON further stated the facility did not have competency training for regular IV administration such as antibiotics.