STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185338	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Heights Nursing and Rehabilitation Cente	124 West Nashville Street Pembroke, KY 42266

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, the facility failed to protect residents from misappropriation of property (medication) for 1 of 9 sampled residents observed during medication administration, Resident (R)38. The findings include: Review of the facility policy, titled Abuse Prohibition Standard of Practice, revised 07/2022, revealed the definition of misappropriation of resident property was the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of the resident's belongings or money without the resident's consent. Further review revealed all new and current team members would receive education/training at the time of employment/initial orientation, annually, and through on-going in-service programs to include prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation; and identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property. Review of R38's Face Sheet, revealed the facility admitted the resident on 10/14/2020 with diagnoses including chronic obstructive pulmonary disease (COPD), chronic pain syndrome, dysphagia and essential hypertension. Review of R30's Face Sheet, revealed the facility admitted the resident on 02/28/2020 with diagnoses including COPD, schizophreniform disorder, anxiety disorder and essential hypertension. Observation of medication pass, on 03/26/2026 at 9:15 AM, on Hall 2, revealed R30 was out of Metoprolol succinate extended release (ER) 25 milligram (mg) tablets (Medication used to treat high blood pressure, and angina). Registered Nurse (RN)1 locked the cart, closed the computer and went to Hall 1. She stopped to get the medication cart keys from Kentucky Medication Aide KMA3. Further observation revealed RN 1 went to the medication cart on Hall 1 and pulled a tablet of Metoprolol succinate ER 25 mg from R38's medication card and placed the tablet in the cup of medication for R30. After closing and locking the medication cart, RN1 went back to Hall 2 and administered the medication to R30. In an interview, on 03/26/2026 at 9:20 AM with RN1, she stated if someone was out of a medication, it was normal practice to just get it from another resident. RN1 further stated, when the resident that loaned the medicine ran out of medication, then she would just borrow medication from another resident. In an interview, on 03/26/2026 at 5:50 PM, with the Director of Nursing (DON), she stated she was aware of the incident of misappropriation which occurred earlier in the day. She stated Borrowing medication from another resident was not normal practice. She further stated, RN1 was a new nurse and was nervous. In addition, she stated RN1 was originally from [NAME] and there was a slight understanding barrier. Further, the DON stated RN1 received education after the incident, and the facility planned to do re-education with all staff related to what to do if a resident runs out of medication. In continued interview with the DON, on 03/26/2026 at 5:50 PM, she stated if it was discovered a resident was out of a medication, nursing staff should first check the Pyxis (Automated medication dispensing system using secure computerized cabinets to store and dispense medication). She stated if the medication was not in the Pyxis, the dose would not be administered and would be documented as such. In continued interview, she stated if a dose of medication was missed, the nurse should notify the physician. Also, the DON stated there was a refill button in the Medication Administration Record (MAR) section of Visual (the electronic medical record system the facility utilized) to request a refill of medication. Further, she stated the pharmacy (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	delivered medications at least twice a day. In an interview, on 03/26/2026 at 4:08 PM, with the Administrator, he stated he had been made aware of the medication misappropriation that occurred this morning. He stated the practice of borrowing medication from one resident for another was absolutely not approved by the facility. He further stated RN 1 was a brand new nurse and after the incident, the nurse was educated on the process of what to do when a resident runs out of medication.

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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 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. Based on observation and interview, the facility failed to store drugs under proper temperature controls, and failed to provide separately locked, permanently affixed compartments for storage of controlled drugs. This affected Resident (R)29. The findings include: Observation of the facility's only medication storage room was conducted on 03/26/2026 at 4:20 PM, with the Director of Nursing (DON). The Pixis system (Automated medication dispensing system using secure computerized cabinets to store and dispense medication) and three unlocked refrigerators were observed on the shelves of the medication storage room. Temperature logs for the refrigerators were checked with no concerns noted. However, there was no controlled substance affixed lock box present inside the refrigerators. Also, there were no controlled drugs in the refrigerators. The DON stated R29 had new comfort measures and was prescribed Ativan (Medication used for short term relief of severe anxiety). The DON further stated R29's Ativan was kept on the medication cart as the medication did not require refrigeration. Observation of Hall 2's Medication Cart 1's controlled substance drawer, on 03/26/2026 at 4:25 PM, revealed a zip-lock bag with a bright pink label stating Refrigerate, which contained a single 30 milliliter bottle of oral Ativan in its carton prescribed to R29. The carton was labeled on the front to store between two and eight degrees Celsius. Registered Nurse (RN) 1, who was assigned to the medication cart stated she was uncertain whether oral liquid Ativan required cold storage after opening. Interview was conducted on 03/26/2026 at 6:11 PM, with the Administrator to address earlier findings. He stated medication should be refrigerated as specified on the storage instructions.