STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185341	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Acres Healthcare	402 W. Farthing Street Mayfield, KY 42066

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure resident(s)had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three of 12 sampled residents (Resident (R) 11, 12, and R38).The findings include: Review of the facility's policy titled Resident Rights, dated 06/2025, revealed that residents had the right to receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents. Further review of the policy revealed that the resident had a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.Review of the facility's policy titled Call Lights: Accessibility and Timely Response, reviewed 06/2025, revealed that staff should ensure the call lights were within reach of the resident and secured, as needed. Further, the call system should be accessible to residents while in their bed or other sleeping accommodations within the resident's room.1. Review of R11's face-sheet revealed the facility admitted R11 on 01/28/2022 with diagnoses which included chronic obstructive pulmonary disease, Alzheimer's disease, and essential hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that R11 had a Brief Interview of Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. Further review of the MDS Assessment revealed that R11 was dependent on staff for all activities of daily living, toileting, and mobility.Observations of R11 on 08/12/2025 at 10:27 AM, in room [ROOM NUMBER]-A, revealed R11 was sitting in wheelchair and the resident's call light was clipped to the privacy curtain, not within reach of the resident.2. Review of R38's face-sheet revealed the facility admitted the resident on 10/24/2018 with diagnoses which included unspecified dementia, unspecified convulsions, and unspecified intellectual disabilities. Review of the quarterly MDS assessment dated [DATE], revealed R38 was rarely/never understood. Further review of the MDS assessment revealed that R38 was dependent on staff for activities of daily living, toileting, and mobility. Observations of R38 on 08/12/2025 at 10:28 AM, revealed she was lying in bed asleep. Further observation revealed that R38 had a touch pad call light at the foot of her bed and not within her reach.3. Review of R12's face-sheet revealed the facility admitted the resident on 02/05/2021 with diagnoses which included acute pulmonary edema, type 2 diabetes, and heart failure. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 8 out of 15, indicating R12 had moderate cognitive impairment. Further review of the MDS assessment revealed that R12 was dependent on staff for activities of daily living and using wheelchair. Observations of R12 on 08/12/2025 at 12:13 PM, revealed he was sitting in his wheelchair with his arms crossed over his chest. Further observation revealed his call light was under his bed linens and not within his reach. During an interview with R12 on 08/12/2025 at 12:15 PM, he stated that he did not know where his call light was and he was not able to roll himself in his wheelchair.Observations of R12 on 08/13/2025 at 8:44 AM, revealed he was sitting in his wheelchair facing the television and away from the bed. Further observation revealed the call light cord and button were located under his bedding.During an interview with Registered Nurse (RN)2 on 08/13/2025 at 3:16 PM, she stated to (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure the resident's safety before exiting their room, staff should make sure their bed was in the proper position, call light was in a position where they could reach it. She further stated if the resident was sitting in a wheelchair in their room, staff should ensure they can reach the call light. RN2 stated that there could be negative outcomes if a resident were to fall and not able to reach their call light to call for assistance. During an interview with Licensed Practical Nurse (LPN)1 on 08/14/2025 at 8:55 AM, she stated that before exiting a resident's room, staff were to make sure their floor is dry and not cluttered and make sure their call light was within reach. She stated that if the resident was sitting in a wheelchair in their room, she would make sure they could reach their call light. LPN1 stated that some residents want the call lights clipped to them so they can get to it. During an interview with Certified Nurse Aide (CNA)4 on 08/15/2025 at 9:50 AM, she stated that before exiting a resident's room, to ensure the resident's safety she would make sure there was nothing the resident could trip on, and make sure their call light was within reach. She stated that if the resident was not mobile, she would make sure their call light was within reach. CNA4 stated that for a resident that was not mobile, the call light being placed at the foot of the bed would not be considered to be within reach and she did not know why R38's call light was placed at the foot of her bed. She stated that for residents who are sitting in their wheelchair, she would make sure the call light was clipped to their side. CNA4 further stated that bed linens should not be placed over the call light. She stated she was unsure how or why the bed linens were placed over R12's call light. During an interview with CNA5 on 08/15/2025 at 9:57 AM, she stated that before leaving a resident's room she would make sure she put the bed down, make sure the resident was not near the edge of the bed, make sure the call light was within reach if they are in bed. She stated that if the resident were up in the wheelchair, she would clip their call light to their shirt or somewhere where they can reach it. She stated that she was unsure how the call light got clipped to R11's privacy curtain and should not have been, because it was out of reach. She stated that if the resident is in bed, the call light being placed at the foot of the bed would not be considered in reach. She stated that the bed linens should not be made over the call light. She stated that possible negative outcomes of the resident not being able to reach their call light could be that the resident could not get help and die, the resident could be unconscious or be sitting in a wet or dirty brief for an extended period of time, and the resident could fall if trying to get up and reach the call light.During an interview with the Director of Nursing (DON) on 08/15/2025 at 11:50 AM, she stated that she expected nursing staff to follow the facility's policy and procedures regarding call light placement and keeping resident's safe. She stated that the call light would not be in the resident's reach if it was placed at the foot of the resident's bed. The DON further stated the call light was essentially the resident's lifeline to staff. She stated that negative outcomes could be they would need something and not be able to contact staff and other safety concern. During an interview with the facility's Administrator on 08/15/2025 at 11:58 AM, she stated that her expectations of staff for keeping residents safe was keeping their call light within reach. She stated that if the resident was in bed, the call light should be within their reach. She stated that if they were in a wheelchair, it would need to be in the wheelchair with them. The Administrator further stated that if a resident needed to call for help and their call light was not within reach, there could be a negative outcome.

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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. Based on interview, record review, and facility policy, it was determined the facility failed to ensure that the required care plan meetings were conducted quarterly for reviewing and revising care plans by the interdisciplinary team after each quarterly review assessments for two of twelve sampled residents (Resident (R) 11 and R33). The findings include: Review of the facility's policy titled, Comprehensive Care Plans, revised 03/03/2025, revealed the facility was to develop and implement a comprehensive person-centered care plan for each resident to meet a resident's medical, physical, mental, and psychosocial needs. Further review revealed the comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment. Review of facility's job description titled, Social Service Director, dated 10/2022, revealed essential duties and responsibilities included to provide timely and accurate completion of the social services portion of the MDS, resident assessment protocols, resident care plan, and progress notes. 1.Review of R33's Electronic Health Record (EHR) revealed the facility admitted the resident on 11/02/2021 with diagnoses which included vascular dementia, psychotic disturbance, mood disturbance, and anxiety. Review of R33's EHR revealed the last care plan meetings was conducted 02/13/2025. Further review revealed a quarterly care plan meeting should have been conducted in 05/2025, and the next quarterly care plan meeting would have been due 08/2025. Review of R33's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) date of 05/06/2025, revealed the facility assessed the resident with the Brief Interview of Mental Status (BIMS) of 05, which indicated severely impaired. Review of Resident (R)33's, Care Conference Report, dated 06/13/2024 through 06/10/2025, revealed missing quarterly assessments in 09/2024 and 05/2025, the notes on 06/10/2025 were added after the initial review of the resident's EHRs on 08/14/2025. In an interview with Family Member (F)1, on 08/13/2025 at 2:37 PM, he stated the facility had generally called him about care plan meetings, but he had not recalled hearing anything from them in a long while. He stated he lived out of state with spouse of R33 but had participated with the care planning via phone. 2. Review of R11's face sheet revealed the facility admitted the resident on 01/28/2022 with diagnoses which included chronic obstructive pulmonary disease, Alzheimer's disease, and essential hypertension. Review of the quarterly Minimum Data Set (MDS) assessment with an ARD date of 08/10/2025, revealed that R11 had a Brief Interview of Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. Review of R11's EHR revealed the last care plan meeting was conducted on 10/22/2024. Further review revealed quarterly care plan meetings should have been conducted on 01/2025, 04/2025, and 07/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R11's Care Conference Report, dated 06/29/2023 through 10/22/2024, revealed missing quarterly care conferences in 01/2024, 04/2025, and 07/2025. During an interview with F2 on 8/12/2025 at 3:54 PM, she stated that the only care conference that the facility had discussed was when the resident was declining and they were discussing the residents code status. She stated that she could not remember the exact date, but it was not this year. In an interview with the Social Services Director (SSD), on 08/14/2025 at 3:34 PM, she stated she had worked as the SSD for a year. She stated all care conferences were conducted quarterly, and she had been responsible to ensure that the residents and representative were contacted. She stated contacts were made via phone and if that was unsuccessful a letter would be sent. The SDC stated if a representative was unable to be in the facility they had participated by phone. She further stated that all call conference meeting notes should be entered right after the meeting had occurred. She stated it was her responsibility to ensure that the required care conference meetings were being conducted quarterly and documented. She could not recall any specific reason as to why R33 or R11 had missing care plan meetings. In an interview with the Director of Nursing (DON), on 08/15/2025 at 11:55 AM, she stated based on the facility's policy and procedures the care meetings were conducted quarterly. She stated if the resident or representative were notified of the care plan conference it would be documented in the progress notes. The DON further stated residents could be affected if care plan meeting were not conducted as required regarding their care. In an interview with the Administrator, on 08/15/2025 at 12:05 AM, she stated the SSD was responsible for ensuring the quarterly care plan meetings were conducted and the resident and representative were notified. She stated those meetings were important and reviewed areas of communication, medications, care plan revisions, behaviors, therapy, and goals. Additionally, the Administrator stated there were potentially negative outcomes for residents regarding the best quality of care if the care plan meetings were not conducted timely and as required and updated as necessary.