STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185378	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Grove Senior Living LLC	711 Frankfort Road Shelbyville, KY 40066

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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined 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 and control the development and transmission of communicable diseases and to implement interventions to protect facility residents. The deficient practice had the potential to affect the entire facility census of 68.Observations during initial tour on 01/13/2026 revealed no isolation signage or signage indicating Enhanced Barrier Precautions at the entrance or on the door for rooms 402-A, 407-A, or 433-A. Observation on 01/14/2026 revealed housekeeping staff collecting garbage from residents' rooms without donning gloves prior to collecting garbage or practicing hand hygiene after completing task. Additionally, interviews and record review revealed the facility failed to establish written standards and procedures for a documented water management program based on nationally accepted standards.The findings include: Review of facility policy Infection Prevention and Control Program revised 10/2018, revealed an infection and control program (IPCP) 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. Implementation included the program was developed to address the facility's specific infection control needs with the program being based on accepted national infection prevention and control standards. Further review revealed the IPCP was facility wide involving all disciplines and individuals; and prevention of infections included implementing appropriate isolation precautions when necessary following established guidelines sign as those of Centers for Disease Control (CDC).Review of facility policy titled Policies and Practices-Infection Control revised 10/2018, revealed the facility's infection control policies and practices were intended to maintain a safe, sanitary and comfortable environment and prevent and manage diseases and infections. Added review revealed the objectives of the program were to prevent, detect, investigate, and to control infections in the facility.1(a). Review of facility signage Enhanced Barrier Precautions (EBP) indicated everyone must clean hands upon entering and exiting room. Further review of signage revealed providers, and staff must also wear gloves and a gown for high contact resident care activities which included dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs and or toileting. Added review of signage revealed providers and staff must wear gloves and gowns for residents with devices to include feeding tube and resident with any skin opening requiring a dressing.Review of facility policy titled Handwashing/Hand Hygiene revised 08/2019 revealed the facility considered hand hygiene to be primary means to prevent the spread of infections.Review of R4's face sheet revealed the resident was admitted to the facility on [DATE]. Diagnoses included diabetes with foot ulcer, peripheral vascular disease, vascular dementia, and kidney disease.Review of R4's physician's orders revealed an order for EBP placed on 01/13/2026 related to wound.Review of R4's comprehensive care plan (CCP) dated 01/16/2025 revealed focus was for the resident to be in EBP related to wound requiring dressing. Further review revealed interventions included the use of gown and gloves for high contact care activities and when providing wound care.Review of wound care notes dated 01/13/2026 revealed a wound to left medial foot with (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	duration of greater than 186 days. Further review of wound physician notes revealed diabetic wound to left medial heel with duration greater than ten days.Observation on 01/13/2026 at 11:22 AM revealed R4 was not in the room. Added observation revealed a heel lift bootie was lying on bed. Further observation revealed a laminated Stop sign saying to see nurse before entering room was posted on wall outside R4's room, no signage for EBP or Personal Protective Equipment (PPE) bin noted.During an interview with Certified Nurse Aide (CNA)7 on 01/14/2026 at 3:30 PM she stated R4 has had a wound ever since she has worked here which was one year today.1(b). Review of R5's face sheet revealed the resident admitted to facility on 11/21/2021. Diagnoses included vascular dementia, reflux disease, and gastroparesis (delay in gastric emptying).Review R5's order set revealed order was placed on 10/27/2024 for EBP for infection control due to ostomy.Observation on 01/13/2026 at 11:45 AM revealed a laminated Stop sign posted on door frame of room [ROOM NUMBER] that stated to see nurse before entering. Further observation revealed there was a PPE bin hanging on the door into the room and the door was open.During an interview with the Infection Prevention Nurse on 01/13/2026 at 11:46 AM she stated the stop sign meant that R5 was in EBP due to having a feeding tube in place.1(c) Review of R8's face sheet revealed resident was admitted to facility on 03/20/2021. Diagnoses included heart failure, vascular dementia, peripheral vascular disease, and pressure ulcer to left heel.Review of R8's order set revealed order was placed on 01/13/2026 for EBP related to wound.Review of R8's CCP dated 10/05/2025 revealed EBP-Infection Control was identified as focus related to Stage 3 pressure ulcer to left heel. Further review revealed interventions placed included the use of gown and gloves for high contact care activities and wound care.Review of wound therapy note dated 01/13/2026 revealed wound to left lateral heel had a duration of greater than seventy-nine (79) days.Observation of R8's room on 01/13/2026 at 11:50 AM revealed a bin containing PPE was hanging on the bathroom door however, no isolation signage was posted on wall outside room or room door.During an interview with Certified Nurse Aide (CNA)7 on 01/14/2026 at 3:30 PM she stated R4 has had a wound ever since she has worked here which was one year today. She stated R8 developed a wound to foot about 6 months ago and the nurses do the treatment, and the resident is turned every 2 hours unless she refuses. She stated she has had training on infection control and knew to wear PPE if having contact with the resident during care for prevention of spreading germs.During an interview with Registered Nurse (RN)2 on 01/15/2026 at 2:15 PM she stated she has had training on infection control and signage should be placed at room entrance so staff would know what to wear prior to entering the room. She stated EBP precautions are placed for residents with different conditions and did include having a feeding tube and wound. She stated PPE should be worn for any high touch resident care.During an interview with the Unit Manager on 01/15/2026 at 2:34 PM he stated if the proper signage is not posted at the room needing isolation his concern would be the staff may not know what PPE to wear. He added if the proper PPE is not worn the bacteria or germs could spread, impacting the residents.2. Observation on 01/14/2026 at 8:43 AM revealed Housekeeper (HK)1 rounding on the 400 hall. Further observation revealed she entered rooms [ROOM NUMBER] emptying trash into a larger bag she was carrying without donning gloves or practicing hand hygiene upon entry to rooms or exiting the rooms.During an interview with Housekeeper (HK)1 on 01/14/2026 at 2:54 she stated her tasks included cleaning resident rooms. HK1 stated she has had training on infection control, and she should wear PPE when performing cleaning tasks, including emptying garbage to not spread germs and keeping the residents safe.3. Review of facility policy Legionella Water Management Program revised 07/2017, revealed the facility was committed to the prevention, detection and control of water-borne contaminants, to include Legionella. Further review revealed the purposes of the water management program were to identify areas in the water system where Legionella bacteria can grow and spread; and to reduce the risks of Legionnaire's disease and was based on the Centers for Disease Control and Prevention, and American Society of Heating and Air-Conditioning Engineers (ASHRAE) recommendations for developing a Legionella water management program. The policy also stated the program would (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	include a detailed diagram and description of the water system, identify areas in system that encourage the growth and spread of waterborne bacteria which included water tanks, water heaters, filters, and medical equipment to include C-pap machines. Added review revealed that the water program included a process that identified situations that could lead to Legionella growth which included construction, water main breaks, water temperature, pressure, stagnation, and inadequate disinfectants. Further review of policy revealed the programs would include a plan for when control limits were not met and/or effective with the water management program reviewed annually.Review of facility documents titled Water System Flush revealed initials next to the dates on 10/20/2025 and on 12/18/2025 indicating the water system had been flushed; however, no specifics were included in documentation including areas and time of flushes.Review of a hand drawn diagram on notebook paper titled Masonic Homes Shelbyville revealed a diagram indicating areas of water intake to boiler and water tanks, however no diagram was given for entire water system in building.Review of document titled Lab Sample ID 482676 with collection date of 05/12/2025 from an outside lab company, revealed Legionella was not detected in potable and non-potable water.During an interview with Plant Operation Director (POD) on 01/15/2026 at 4:50 PM when asked if he had a risk assessment to identify where Legionella or any other water borne germs could grow, he stated he did not really know what that was and has not had any training on Legionella. When asked the process and how often he assessed the facility water system for any stagnant water, water leaks inside and outside he stated he walked through sometimes just checking everything but did not really have a scheduled time. When asked if the water was checked for chlorine levels, he stated he was unsure and did not know if the water company provided those levels to facility. He stated there was no diagram of the facility water system at this time with exception of a drawing for the water tanks in basement. He stated the last time there was a water line break was about 2-3 weeks ago but was unsure if the lines had been flushed after repair and was unsure of water used by residents. When asked if facility had areas for dead legs (areas where low flow occur due to lines capped or not in use) he stated he did not think so but could not say for sure. He stated facility had no decorative fountains or hot tubs, but facility did have two cooling towers. When asked how the cooling towers were monitored or chemicals added, he stated an outside company checked them and was pretty sure they (the outside company) added chemicals. He stated the facility checked water for Legionella yearly and the last time was last year sometime. When asked about monitoring water temperatures for proper levels to kill Legionella, he stated the water tanks/boiler are set to one hundred twenty (120) degrees Fahrenheit (F). However, when asked for documentation of temperature checks of the tanks, the POD stated there were none. When the POD was asked what control measures were used to monitor for prevention of waterborne illnesses, he stated he did not really know.During an interview with the Infection Preventionist (IP) nurse on 01/15/2026 at 10:36, she stated the facility Maintenance was responsible for the water plan and there had been no cases of Legionella in facility. She stated she trained staff on infection control, and her expectation was for staff to follow their training and follow signage. She stated if a resident had a wound or on a tube feed, the resident should be in EBP and there should be appropriate signage placed at the entrance to the room. During an interview with the Director of Nursing (DON) on 01/15/2026 at 10:36 AM she stated if someone was emptying garbage, they should be wearing gloves and practicing hand hygiene to prevent possible infection.The Director of Nursing (DON) in additional interview on 01/15/2026 at 4:43 PM stated her tasks included oversite of the clinical operation of facility and operation of building, adding she depended on department heads to keep her updated of any concerns. She stated as the DON it was her expectation for all staff to follow their infection control training to prevent transferring germs and bacteria between residents and staff. She added proper signage should be placed when needed and staff should be practicing hand hygiene and donning gloves when needed.During an interview with Administrator on 01/15/2026 at 5:23 PM she stated her tasks included oversight of daily operations of the facility and she depended on the DON for the clinical part and other department managers in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	other areas. She stated it was her expectation for all staff to follow their infection control training to protect the residents. When asked if gloves should be worn by staff when emptying garbage, she stated yes to prevent risk of infection. She stated the facility had no water diagram. She stated the facility has had no cases of Legionella, but her concern was for residents' safety if the water system was not being monitored properly.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately, but not later than 2 hours after the allegation was made for 1 of 1 resident files investigated for abuse, Resident 16. On 01/09/2026, Resident (R)16 alleged to Certified Nurse Aide (CNA)6 and Licensed Practical Nurse (LPN)2 that she had been raped by an unidentified man. CNA6 and LPN2 failed to report the allegation to administration and the allegation was not reported to the State Survey Agency until 01/12/2026.The findings include:Review of facility policy titled Abuse Prevention Program, dated 12/2016, revealed the facility required staff training and orientation which included abuse prevention, identification, and reporting. Further review revealed the policy of the facility was to report any allegations of abuse within timeframes as required by federal requirements.Review of facility policy titled Abuse Investigation and Reporting, dated 07/2017, revealed an alleged abuse should be reported immediately, but not later than two hours.Review of facility self-reported incident form, Initial Report, revealed an allegation of sexual abuse was reported to staff by R16 on 01/09/2026 at 11:54 PM and was not reported by the staff. Further review revealed the allegation was identified through a medical record review on 01/12/2026 at 1:00 PM. Facility investigation was initiated and required notifications were made.Review of facility self-reported incident form, Final Reports/ 5 Day Follow-Up revealed the alleged incident occurred on 01/09/2026 and Administrator was notified on 01/12/2026 at 1:00 PM. An assessment and interview with R16 revealed no physical injuries, no psychosocial or emotional distress, and denial of any sexual abuse or mistreatment. Interviews were conducted with pertinent staff. All residents were either interviewed or had skin assessments that did not result in any findings of abuse, all staff received mandatory education on abuse prevention, identification, and reporting. Conclusion of the facility investigation resulted in allegation not supported by evidence.Review of R16's admission Record revealed the facility admitted her on 05/29/2024 with diagnoses of neoplasm of pituitary gland, chronic pain syndrome, blindness, insomnia, hoarding disorder, and psychotic disorder with delusions.Review of R16's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating significant for intact cognitive function. Section E-Behavior listed delusions for potential indicator of psychosis.Review of R16's Electronic Medical Records (EMR) revealed a Behavior Note dated 01/09/2026 at 11:57 PM documented by Licensed Practical Nurse (LPN)2, indicating R16 reported a camera was in the ceiling and that whoever had put it there had raped her. Further review revealed LPN2 documented R16 was lying in bed covered, without any signs or symptoms of pain or discomfort and would continue to monitor.In interview with R16 on 01/13/2026 at 11:52 AM, she stated she recalled making the allegation of sexual abuse but now believed it was only a dream. R16 stated she had a nightmare and when she awoke, she believed the rape was occurring, so she reported it to the staff that was working. R16 further stated that, when she reported it, a nurse came in and asked her questions and she realized it was only a dream, did not believe she was raped, and felt safe at the facility.Interview with Certified Nursing Assistant (CNA) 6 on 01/15/2026 at 4:46 PM, revealed on 01/09/2026 she answered R16's call light and when she entered the room R16 alleged being videotaped while raped. CNA6 stated she asked R16 where and when it occurred and she pointed to the sprinkler on the ceiling, she told her she needed to report it to the nurse, left the room and told LPN2. CNA6 stated she returned to R16's room with LPN2, who again reported the same allegation, and neither herself nor LPN2 reported the allegation. Lastly, CNA6 stated she had training on abuse that included reporting but did not report it because R16 had a brain tumor that caused hallucinations, and she believed the rape hadn't occurred. Interview with LPN2 on 01/15/2026 at 11:22 AM, stated CNA6 reported R16 had made an allegation of rape, and they both went to the resident's room. LPN2 stated R16 pointed to a sprinkler in the ceiling, told him it was a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	camera, people were watching her, and stated she had been raped. He stated he re-oriented her, told her it was a sprinkle in case of a fire, and she was safe. Based on prior education for abuse, LPN2 stated he knew the expectation was to report allegations immediately, however due to R16 having a history of delusions, and no signs of an assault, he documented the behavior but did not report it.Interview with North Unit Manager on 01/15/2026 at 5:07 PM, revealed R16 had a history of delusions, had reported to staff she had been raped, and they did not report it per facility policy. He stated the facilities policy and procedure was to report any allegation of abuse immediately, and proper procedure would have been to notify the on-call manager so the investigation and notifications could be made within the required two hours.In interview with Director of Nursing (DON) on 01/15/2026 at 4:24 PM, the DON stated every Monday the management team pulled the previous 72 hours of charting and performed a review. The DON stated a progress note for R16 identified an allegation of sexual assault had been made but no report had been received. She stated she called CNA6 and LPN2 and they both reported R16 had made the allegation, however based on her history of delusions neither staff believed it had occurred and did not report it. DON stated the expectation was that all staff were to report any allegation of abuse made by any resident, regardless of their diagnoses or past history of allegations. Interview with Administrator on 01/15/2026 at 4:35 PM stated the weekend report had been reviewed, a progress note identified an allegation of abuse was made to staff and they failed to report it to management. Administrator stated R16 was immediately assessed, notifications were made, and an investigation started. She stated during interviews with CNA6 and LPN2 they both believed the allegation had not occurred, they assessed her safety and did not feel they had any further obligation to report. Administrator stated the policy, and expectation was that all staff would report any allegation of abuse immediately to management, regardless of the reporting sources history or mental status.