STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185383	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlandspring of FT Thomas	960 Highland Avenue Fort Thomas, KY 41075

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of the facility's policies, the facility failed to store food under sanitary conditions. Observations of the kitchen on 02/08/2026 revealed undated cans on the rack, four packages of vanilla wafers out of the box and not dated, a large clear plastic container with the appearance of white rice not labeled or dated, and one undated bag of chocolate chips out of the box. Continued observation on 02/08/2026 revealed three of five clear plastic covered cereal containers with no label or date in the second floor serve kitchen. Also, observation on 02/09/2026 in the kitchen revealed the bucket sanitizer had no documentation of the date or time the sanitizer was checked or changed. The deficient practice had the potential to affect all 136 current residents.The findings include:Review of the facility's policy titled, Food Storage, not dated, revealed it was the policy of the facility that food storage areas be maintained in a clean, safe, and sanitary manor. Food storage areas shall always be clean. All opened, potentially hazardous food items would be labeled, dated, covered, and discarded within seven days. Review of the facility's policy, untitled and dated 09/2023, revealed the facility used Quat Sanitizer Solution to sanitize kitchen surfaces, using the manufacturer's directions for preparation, which stated the sanitizing solution should be made fresh daily and as needed. Per the policy, prior to its use, testing of the sanitizing solution should be done using the appropriate test strips that were not outdated or expired. Observation on 02/08/2026 at 11:27 AM during the initial tour of the kitchen revealed the dry storage can rack contained number 10 cans, with no visible expiration dates on the bottom or top of the cans. Observation on 02/08/2026 at 3:36 PM of the second floor serve kitchen revealed three of five large clear plastic covered cereal containers with a blue lid which had no date or label. Return observation on 02/08/2026 at 3:48 PM of the second floor serve kitchen again revealed three of five large clear plastic covered cereal containers with a blue lid which had no date or label.Observation on 02/08/2026 at 3:55 PM on the return tour of the kitchen dry storage room revealed a four-pound package of mini semi-sweet chocolate chips with no date, four vanilla wafers out of the box in the packaging without a date, and a large clear lidded bin of breadcrumbs (with the appearance of white rice) with no date or label.Observation on 02/09/2026 at 8:28 AM with the Chef revealed the sanitizer bucket had no documentation of the date or time the sanitizer was changed. In an interview with the Chef on 02/09/2026 at 8:28 AM, she stated they did not document when the sanitizing solution was changed in the sanitizer bucket. She stated the cook checked and changed the solution after each food prep, and the diet aides changed the sanitizing solution after meals. She stated she expected the sanitizing solution to be changed every two hours or if became soiled. She stated food should be labeled and dated with the date received if taken out of the box, the opened date, and the date of expiration. In an interview with the Director of Nursing (DON) on 02/11/2026 at 9:30 AM, she stated she completed a walk through in the kitchen weekly and looked for cleanliness and that cans were dated. She stated she expected dietary staff to follow the facility's policy and procedure for properly dating and labeling stored food.In an interview with the Administrator on 02/11/2026 at 10:48 AM, she stated she expected the food to be labeled and dated and the sanitizer regularly changed.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describe the services to be furnished to attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being for 2 of 27 sampled residents, Resident (R) 52 and R79.The facility admitted R52 and R79 with known histories of Post-Traumatic Stress Disorder and histories of known triggers. However, in the residents' admission care plans, no interventions were in place to prevent potential adverse behaviors.The findings include: Review of the facility's policy titled, Quality of Care-Care Planning, dated 10/2022, revealed the facility would provide resident centered care with the aim of providing individualized Comprehensive/Interdisciplinary Care Plans for each resident. Per the policy, the facility would incorporate trauma-informed care into the person-centered, culturally competent plan of care for each resident to ensure their needs were met. The policy defined trauma informed as a means of recognizing that people often had many different types of traumas in their lives, and people who had been traumatized needed support and understanding from those around them. Per the policy, often trauma survivors could be inadvertently re-traumatized by caregivers and visitors. The policy revealed the process to address past trauma was based on assessment, identifying the trauma type and triggers, and care planning to address past trauma. 1. Review of the admission Record for R52 revealed the facility admitted the resident on 12/08/2025 with multiple co-morbidities, including hemiplegia and hemiparesis because of a stroke that affected his left, non-dominant side, major depressive disorder, anxiety, insomnia, and post-traumatic stress disorder (PTSD). Further review revealed R52 was discharged from the facility on 02/08/2026 and admitted to an acute care hospital for observation and treatment related to an acute behavioral episode. The State Survey Agency (SSA) Surveyor was unable to make a direct observation of this resident. Review of R52's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/19/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, indicating his cognition was intact. It also revealed his functional abilities were limited to one side, and he utilized a wheelchair for assisted mobility. PTSD was listed as an active diagnosis. Review of R52's Social Services admission Assessment, dated 12/08/2025 and performed by the Social Worker, revealed a Trauma Informed Care Assessment was included. Further review revealed a PTSD diagnosis was listed with the triggers noted only as loud. No further information was provided. Review of Resident 52's Comprehensive Care Plan [CCP], dated 12/08/2025, revealed no documented evidence that any care planned interventions had been formulated for the resident's diagnosis of PTSD since admission. Review of R52's hospital records from the emergent admission on [DATE] revealed the resident had no acute infections that might have caused the adverse behaviors. Psychiatric Consult records indicated the resident had a diagnosis of PTSD, and his reported baseline anger issues had worsened (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	since returning from the Vietnam War. Per the Psychiatric Consult, the right-sided stroke that occurred in 2022 likely contributed to his worsened emotional management status. Per the record, R52 was admitted to intensive care for psychiatric care. During an in-person interview on 02/08/2026 at 1:38 PM with R52's family member (FM), he stated R52 had an anger management issue. He stated he was not free to discuss it further at that time. During a follow-up interview with R52's FM via telephone on 02/09/2026 at 1:16 PM, he stated R52 had always been very rigid and temperamental. He stated his family was the typical 1950's family that did not share personal information or go to a therapist. He stated he did not think R52 had ever been treated for any psychological issues. He stated R52 had served in two or three tours of Vietnam and had experienced angry outbursts for as long as he could remember. He stated, historically, it was loud noises that triggered R52, but R52's temperament was always an issue. During an interview on 02/11/2026 at 8:50 AM with R52's primary care Nurse Practitioner (NP), she stated she was aware of his diagnosis of PTSD but was not aware of specific triggers for him. She stated she was unaware of any physiological causes for his current behaviors, such as an acute urinary tract infection. She stated it was her understanding that R52 was currently in restraints at the hospital and was admitted for psychiatric care. During an interview on 02/10/2026 at 1:35 PM with the Psychiatric Nurse Practitioner, he stated PTSD symptoms were often lifelong and required treatment or intervention. He stated identified triggers could create distress at any point in the future. He stated he had not received a request to consult with R52 since his admission, but requests were often made when he was in the building, and he had been out sick for a couple of weeks. He stated there were always on-call psychiatric services available for urgent needs. During an interview on 02/09/2026 at 2:11 PM with the Director of Physical Therapy, he stated R52 was limited in his mobility but could push himself short distances, such as out of the dining room. He stated that it was likely his new baseline. He stated he had personally never seen the resident physically aggressive. He stated he was unaware of any specific triggers regarding the PTSD diagnosis. During an interview on 02/09/2026 at 11:10 AM with the Social Services Director, she stated she spoke with R52 upon admission, and it was her understanding that loud noises were no longer a trigger for his diagnosed PTSD. She stated the resident told her if it was a concern, he would let her know. She stated she was unaware if symptoms of PTSD were ever cured or absolved. She stated if loud noises continued to be a trigger for R52, it could result in resident distress and anxiety. During an interview on 02/11/2026 at 9:30 AM with the Director of Nursing (DON), she stated she was aware of the PTSD diagnosis for R52. However, she stated she was unaware of the resident's history of adverse behaviors, as his FM relayed in his interview with the SSA Surveyor. She stated she felt certain that this specific outburst was not related to his diagnosis of PTSD or a trigger such as a loud noise, although she was not present during that episode. 2. Review of Resident 79's admission Record revealed the facility admitted the resident on 10/29/2024 with diagnoses of PTSD, anxiety, and type 2 diabetes mellitus. Review of R79's admission MDS, with an ARD of 11/04/2024, revealed the facility assessed Resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	79 to have a BIMS score of 15 out of fifteen 15, indicating she was cognitively intact. Continued review revealed R79 triggered for PTSD. Review of R79's CCP, dated 10/29/2024, revealed no documented evidence of a care plan formulated for the resident's PTSD upon admission and for over a year. However, on 11/05/2025, a focus of stress was added because the resident had a diagnosis of PTSD due to sexual assault from her stepfather, and loud voices could be triggering. The goal, with a target date of 04/30/2026, was R79 would receive as much social support as wanted. Interventions/tasks, initiated 11/05/2025, were coordination of resources to address social needs, education about breathing techniques, and education about mindfulness-based stream reduction program. Review of R79's quarterly Social Service Assessment and History, dated 05/02/2025 and 08/13/2025, both revealed the resident had anxiety disorder, unspecified; conversion disorder with seizures or convulsions; depressive disorders; and PTSD. During an interview with R79 on 02/11/2026 at 10:44 AM, she stated she made her preference and request for female caregivers upon admission. During an interview with State Registered Nurse Aide (SRNA) 4 on 02/11/2026 at 9:16 AM, she stated R79 preferred female staff for care and did not like loud noises. She stated she did not know why and did not know if R79 had PTSD. During an interview with the NP on 02/11/2026 at 9:05 AM, she stated she was aware of R79's PTSD, and the resident had a compulsive nature. During additional interview with the Social Services Director on 02/11/2026 at 10:24 AM, she stated she was responsible for updating the care plans and creating the base line care plan. She stated the comprehensive care plan changes could be made by other staff. She stated she had team discussions with staff members about the needs of the residents. She stated care plan interventions carried over to the State Registered Nurse Aide (SRNA) Kardex. During an interview on 02/11/2026 at 9:30 AM with the Director of Nursing (DON), she stated clinical staff was educated about the care needs of a resident based on the care plan. She stated, in the absence of complete information and/or interventions in a care plan, staff would not be aware of how to best care for residents. During an interview with the Administrator on 02/11/2026 at 10:51 AM, she stated Social Services was responsible for residents' care plans and would talk to the resident and/or family to identify any triggers related to the diagnosis of PTSD. Then, she stated information relayed by Social Services would be discussed in the Interdisciplinary Team (IDT) meetings to develop or add to the care plan. She stated specific triggers on the care plans identified what the staff was reviewing concerning residents' care, and care plans would be how interventions were communicated. She stated staff used the interventions to provide the most accurate care for residents. She stated the admission assessments carried to the care plan.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and review of the facility's documents, the facility failed to make the location of the results of the State Inspection book available to residents without asking. In an interview with the Resident Council members on 02/09/2026, they stated they did not know the state survey results were available for their review and did not know the location of the survey results without asking. This deficient practice had the potential to affect all 136 current residents.The findings include: Review of the facility's document Federal Resident Rights, not dated and found in the admission Agreement packet, revealed reports of the facility's survey certifications, complaint investigations, and plans of correction made during the three preceding years be available for any individual to review upon request. Review of the facility's document State Resident Rights, not dated and found in the admission Agreement packet, revealed a resident had the right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. Per the document, the results shall be posted by the facility in a place readily accessible to residents. Review of the facility's handbook titled, Skilled Nursing Facility Handbook, dated 2018, revealed nursing facility patients were granted specific rights under both State and Federal law. The handbook stated copies of these laws could be found with the resident's admission documentation, as well as requested from the front office at any time. In an interview during the Resident Council meeting on 02/09/2026 at 10:30 AM, residents stated they did not know about the survey book, location of the survey book, and the survey findings. Observation on 02/09/2026 at 3:15 PM and 3:18 PM on the first and second floors in the living rooms revealed the state survey results were kept on each floor in the bookcase on the shelf labeled Family Resident Handbook. In an interview with the Director of Nursing (DON) on 02/11/2026 at 9:37 AM, she stated the survey book was kept in the living room areas. She stated residents were told about the survey book upon admission, and if they asked a question about the survey, they would inform the family/resident about the survey book location. In an interview with the Administrator on 02/11/2026 at 10:48 AM, she stated information about the location of the survey book was posted by the front door of the facility. In resident council, she stated, residents were informed of the location of the survey book in each unit's living room. She also stated residents were provided the survey information upon request.