STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185437	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village of Lebanon	105 Village Way Lebanon, KY 40033

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and facility policy review, the facility failed to ensure staff transported 1 (Resident #31) of 4 residents in their geriatric chair in a forward-facing position to promote dignity. Findings included: A facility policy titled, Promoting/Maintaining Resident Dignity, revised 10/01/2024, indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. An admission Record indicated the facility admitted Resident #31 on 03/14/2025. According to the admission Record, the resident had medical history that included diagnoses of dementia, anxiety disorder, adult failure to thrive, need for assistance with personal care, and major depressive disorder. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/20/2025, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was dependent on staff for transfers. Resident #31's Care Plan Report included a focus area revised on 06/24/2025 that indicated the resident had an activities of daily living (ADL) self-care performance deficit related to dementia. Interventions initiated 06/24/2025 directed staff to utilize a geriatric (Geri) chair when the resident was out of bed. An observation on 08/11/2025 at 12:40 PM revealed Certified Nursing Assistant (CNA) #1 transported Resident #31 from the dining room in a rear facing position in a Geri chair. During an interview on 08/11/2025 at 1:20 PM, CNA #1 stated that transporting a resident in a rear facing position could be disrespectful and go against the resident's dignity. CNA #1 stated she transported the resident out of habit and she knew better than to pull any resident in a rear facing position. CNA #1 stated she had been trained to transport all residents in a forward-facing position. An attempt was made to interview Resident #31 on 08/11/2025 at 1:30 PM, but the resident was non-interviewable. During an interview on 08/12/2025 at 1:25 PM, CNA #2 stated that to transport a resident in their wheelchair or Geri chair, they should always be transported in a forward motion. She that that otherwise it would be a dignity issue for the resident. During an interview on 08/15/2025 at 11:35 AM, the Director of Nursing (DON) stated she expected staff to always transport the residents in a forward-facing position to promote dignity. During an interview on 08/15/2025 at 12:55 PM, the Administrator expected staff to transport residents in a forward-facing position because it could be a dignity issue for the resident.

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, review of facility records, and policy review, the facility failed to provide incontinence care in such a manner as to reduce the risk of a urinary tract infection for 1 (Resident #47) of 2 residents whose incontinence care was observed.Findings included: A facility policy titled, Perineal Care, revised 10/01/2024, indicated, If perineum is grossly soiled, turn resident on side, remove any fecal material with toilet paper, then remove and discard. A. Cleanse buttocks and anus, front to back; vagina to anus in females, scrotum to anus in males, using a separate washcloth or wipes. An admission Record revealed the facility admitted Resident #47 on 01/01/2023. According to the admission Record, the resident had a medical history that included urinary tract infection, Stage 4 (severe) chronic kidney disease, chronic systolic (congestive) heart failure, and unspecified cardiomyopathy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/05/2025, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff for toileting hygiene. The MDS revealed Resident #47 was frequently incontinent of bladder and occasionally incontinent of bowel. The MDS indicated Resident #47 had a urinary tract infection within the previous 30 days and had taken an antibiotic. Resident #47's Care Plan Report included a focus area initiated 01/30/2024 that indicated Resident #47 had a history of recurrent urinary tract infections and was at risk for complications. Interventions directed staff to perform incontinence care with each incontinence episode (initiated 01/30/2024). A urology consultant note dated 07/03/2025 revealed a facility certified nursing assistant (CNA) present for the appointment and Resident #47 informed the urologist that the resident keeps a UTI [urinary tract infection]. The note indicated the CNA informed the urologist that when the resident had a UTI, the resident's urine became almost brown and was foul smelling. The note indicated under Plan details that Resident #47 was being seen for urinary hesitancy, incontinence, and possible incomplete bladder emptying. The note indicated the resident had been referred to the urologist when the UTIs became more frequent. The note also revealed a cystoscopy (a medical procedure to examine the bladder) that had been completed in 2023 that indicated Resident #47 retained debris in the bladder. Review of a note from Resident #47's primary care physician (PCP), dated 07/25/2025, revealed the resident had acute recurrent cystitis (a type of UTI caused by a bacterial infection). The note indicated Resident #47 had a neurogenic bladder (a bladder condition caused by nerve damage) with persistent and recurrent pyuria (a condition where the urine contains high levels of white blood cells or infection) requiring systemic antibiotics. The note indicated intermittent catheterization had been discontinued at the resident's request. The note indicated Resident #47 had acute recurrent cystitis without hematuria (blood in the urine) secondary to incomplete bladder emptying and neurogenic bladder secondary to a stroke that influenced secondary, recurrent, and frequent UTIs. Resident #47 was interviewed on 08/11/2025 at 12:55 PM and stated they currently had a UTI, and they had problems with recurrent UTIs. The resident stated they had a bowel movement (BM), and the BM had oozed out of the brief. Resident #47 stated they were unsure if staff were providing adequate care after incontinence. At 12:59 PM, Resident #47 activated the call light. The resident stated the BM had occurred during the lunch meal, but they had not called for anyone to change them. The Administrator answered the resident's call light and responded she would find someone to assist the resident. An observation began on 08/11/2025 of CNA #2 and CNA #3 assisting Resident #47 with incontinence care. The resident had a large amount of BM covering them. CNA #2 was observed wiping the resident from back to front as she tried to remove the BM from the resident. CNA #2 was stopped and stated she had been taught to always wipe from front to back and added she was aware she had wiped Resident #47 from back to front. CNA #2 then told Resident #47 that may be the reason the resident had so many UTIs. CNA #2 stated she was aware that cleaning the resident from back to front may introduce (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bacteria into the resident's urinary system but stated she had just been trying to get the BM off the resident. Registered Nurse (RN) #4 was interviewed on 08/13/2025 at 2:48 PM. RN #4 functioned as the Staff Development Coordinator (SDC) and the facility's Infection Preventionist (IP). RN #4 stated the CNAs were taught to wipe residents from front to back when providing incontinence care to prevent the introduction of bacteria into the urinary tract system. The RN stated UTIs caused by Escherichia coli (E. coli - a type of bacteria) was caused when feces was introduced into the urinary tract system during incontinence care. RN #4 stated she was unaware that Resident #47's recent UTIs had been caused by E. coli. RN #4 stated Resident #47's PCP had stated that Resident #47 was colonized and would continue to have UTIs due to the chronicity of the resident's diseases. RN #5, who was assigned to care for Resident #47, was interviewed on 08/14/2025 at 10:37 AM. RN #5 stated E. coli UTIs were caused from fecal matter introduced into the urinary tract system due to poor incontinence care. RN #5 stated Resident #47 had frequent UTIs, was on a fluid restriction, and was followed by a urologist. RN #5 stated Resident #47 had a diagnosis of neurogenic bladder that held urine. RN #5 stated that during incontinence care, the resident should be cleaned from front to back to minimize the risk of introducing bacteria into the resident's urethra and causing a UTI. The Director of Nursing (DON) was interviewed on 08/15/2025 at 12:26 PM. The DON stated that when the CNA provided perineal care, the CNA should clean the residents front to back. The DON stated the procedure was important to avoid introducing bacteria into the urinary system. The DON stated wiping the resident from back to front would introduce E. coli into the urinary system. The DON stated Resident #47's PCP had told her the resident's bladder did not empty completely, and the resident was colonized with bacteria. The DON stated other contributing factors included the resident used powder and had declined the in-and-out catheterization recommended by the physician. The Administrator was interviewed on 08/15/2025 at 1:10 PM and stated she expected the nurses and nursing assistants to follow the facility policy when providing incontinence care to residents so that UTIs may be avoided.Resident #47's PCP was unavailable for interview due to a medical procedure.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, review of manufacturer's instructions for medication administration, and review of the facility policy, the facility failed to maintain a medication error rate of less than 5 percent (%). Three medication errors were observed during 27 medication error opportunities, for a medication error rate of 11.11%, which affected 2 (Resident #41 and Resident #47) of 3 residents observed during medication pass.Findings included: A facility policy titled, Medication Administration, revised 08/01/2025, indicated, 11. Review the MAR [Medication Administration Record] to identify medication to be administered. 12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. 17. Administer medication as ordered in accordance with manufacturer specifications. 1. An admission Record indicated the facility admitted Resident #41 on 01/14/2015 and most recently readmitted the resident on 02/05/2024. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus without complications; generalized anxiety disorder; recurrent major depressive disorder, unspecified; bipolar disorder, unspecified; and insomnia, unspecified. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/09/2025, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had diagnoses that included diabetes mellitus, depression, bipolar disorder, and anxiety. Additionally, the MDS indicated Resident #41 had received insulin injections on each of the last seven days of the assessment look-back period and had received antianxiety medications, antidepressants, and hypnotic medications during the seven-day assessment look-back period. Resident #41's Care Plan Report included a focus area initiated on 02/20/2024 that the resident had the potential for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) related to diabetes. Interventions directed a nurse to give diabetes medications as ordered (revised on 05/16/2024). The care plan report also included a focus area that indicated Resident #41 received hypnotic medication related to insomnia (revised on 02/28/2024). Interventions directed staff to administer hypnotic medication as ordered (revised on 05/16/2024). An Order Summary Report, with physician's active orders effective for the timeframe ending 08/12/2025, indicated Resident #41 had orders for zolpidem tartrate (a sedative-hypnotic medication) oral tablet, 5 milligrams (mg) to be given one time a day for insomnia (order date 12/23/2024) and Humalog mix 75/25 subcutaneous suspension 100 units per milliliter (ml) for 40 units to be given after supper for diabetes mellitus (order date 04/04/2025). The manufacturer's instructions for the Humalog Kwik Pen injection, dated 2023, indicated, Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. An observation, beginning on 08/12/2025 at 4:00 PM, was made of Licensed Practical Nurse (LPN) #6 preparing medication for Resident #41. LPN #6 took a card of zolpidem tartrate oral tablet, 5 mg out of a locked narcotic drawer, removed a tablet from the blister pack, placed the tablet in the medication cup, and returned the zolpidem medication card to the narcotic drawer. LPN #6 then took the zolpidem tartrate card out again and removed another tablet from the medication card and placed the tablet in the medication cup. The surveyor stopped LPN #6 and stated the second tablet was supposed to be Xanax (an antianxiety medication). The nurse then turned the dial on the insulin pen to 40 units and gave the insulin into the resident's right lower abdomen. LPN #6 did not prime the insulin pen before dialing up the dose of insulin. LPN #6 was interviewed on 08/12/2025 at 4:29 PM. The LPN stated she had popped out two zolpidem tartrate and placed them in the medication cup because she was nervous. The LPN stated the manufacturer's instructions did not give directions to prime the pen before giving the insulin, and she stated she had not been taught to prime the pen at any time. LPN #6 stated the only time she primed the insulin pen was if she saw air in the insulin pen. Registered Nurse (RN) #4 was interviewed on (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/13/2025 at 2:48 PM. RN #4 functioned as the Staff Development Coordinator (SDC) for the facility. RN #4 stated nurses were taught to prime the insulin pens before each use and added priming the pen was important for the resident to receive an accurate amount of insulin and to expel any air from the pen. RN #4 stated she taught all nurses the six rights of medication administration, which included the right resident, right medication, right dose, right time, right route, and the right documentation. A telephone interview was held with the Consultant Pharmacist (CP) on 08/14/2025 at 2:07 PM. The CP stated priming an insulin pen was important before using the pen for the first time, but she was unsure about priming the insulin pen before subsequent uses. The CP stated she needed to review the manufacturer's instructions. The CP stated priming the insulin pen before the first use was important to make sure insulin was in the needle. She stated if the correct dosage of insulin was dialed on the pen, then Resident #41 should have received the correct dosage. The CP stated LPN #6 placed two zolpidem tartrate in the medication cup due to nerves. The CP stated she expected all nurses to follow the six rights of medication administration and pay more attention to what medications were placed in the medication cup for administration. The CP stated getting an extra zolpidem once may have made Resident #41 more sleepy than usual but would have had no harmful effects. The Director of Nursing (DON) was interviewed on 08/15/2025 at 12:35 PM. The DON stated when nurses gave medication, she expected them to follow the rights of medication administration including right resident, right time, right dose, and right medication. The DON stated she would have expected the nurse to check the medication label and the MAR before removing the second zolpidem into the medication cup. The DON stated LPN #6 was expected to prime the insulin pen before each use to make sure the correct dosage of insulin was given. The DON stated Resident #41 could have received too much insulin or not enough insulin. The DON stated she had spoken to LPN #6, who confirmed to her that she never primed the insulin pen even before using it for the first time. The Administrator was interviewed on 08/15/2025 at 1:09 PM and stated she expected the nurses to give the right medication in the right dosage to the right resident and follow any special instructions on the medication label. 2. An admission Record revealed the facility admitted Resident #47 on 01/01/2023. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD) with exacerbation and acute and chronic respiratory failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/05/2025, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident was able to hear without difficulty, had clear comprehension, and was able to understand verbal content. The MDS indicated the resident had a diagnosis of asthma, COPD, or chronic lung disease. Resident #47's Care Plan Report included a focus area revised on 02/08/2023 that indicated the resident had congestive heart failure and was at risk for complications. Interventions directed a nurse to administer inhalers (revised on 04/26/2024). A focus area, revised on 07/15/2025, revealed the resident had COPD and was at risk of developing complications. Interventions directed a nurse to give aerosol or bronchodilators as ordered and to monitor for side effects and effectiveness (initiated on 07/15/2025). An Order Summary Report for Resident #47, with physician's orders effective for the timeframe ending 08/13/2025, included an order for Trelegy Ellipta Inhalation Aerosol Powder Breath Activated (an inhaler that contained a steroid medication) 100-62.5-25 microgram (mcg) per actuation. The instructions were to take one puff orally one time a day for congestion related to COPD with exacerbation. The manufacturer's instructions for the Trelegy inhaler, revised 01/2019, indicated under the warnings and precautions section, Candida albicans [yeast infection or thrush] infection of the mouth and pharynx may occur. Monitor patients periodically. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk. An observation began on 08/13/2025 at 8:50 AM of Registered Nurse (RN) #5 preparing and administering medications to Resident #47. The label for the Trelegy inhaler revealed instructions to RINSE MOUTH & [and] SPIT AFTER EACH USE was documented on the label. The observation revealed that RN #5 handed the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident the Trelegy inhaler and instructed the resident on how to inhale to get the most benefit from the medication. After administration of the inhaler, RN #5 did not give Resident #47 instructions to rinse their mouth and spit out the water. RN #5 was interviewed on 08/13/2025 at 9:02 AM. RN #5 reviewed the label for the inhaler and acknowledged the label clearly gave instructions to rinse after each use. RN #5 stated this was to avoid the development of oral thrush. RN #5 confirmed she had not asked Resident #47 to rinse their mouth after the use of the inhaler. The RN stated she had been speaking to Resident #47 about asking the physician for a spacer (a device that makes the inhalation of medication more effective) and had forgotten to ask the resident to rinse. RN #4 was interviewed on 08/13/2025 at 2:48 PM. RN #4 was the Staff Development Coordinator (SDC) for the facility. She stated the nurses were taught to have residents rinse their mouth and to read the directions on the medication labels for specific instructions about individual inhalers. RN #4 stated rinsing after the use of an inhaler was important to decrease the risk of thrush in the resident's mouth. A telephone interview was held with the Consultant Pharmacist (CP) on 08/14/2025 at 2:07 PM. The CP stated rinsing after using inhalers that contained a steroid was important to prevent fungal infections and thrush. The CP stated that if rinsing after the use of an inhaler was required, the information was printed on the medication label. The Director of Nursing (DON) was interviewed on 08/15/2025 at 12:35 PM. The DON stated that when nurses were giving medication, she expected them to follow the rights of medication administration including the right resident, right time, right dose, and right medication. The DON stated that after an inhaler that contained a steroid was used, the resident's mouth should be rinsed. She stated that it was important to prevent oral thrush. The DON stated Resident #47 had not had any episodes of oral thrush. The DON stated that she had received a pharmacy recommendation to add instructions to rinse after use of an inhaler to each resident's Medication Administration Record (MAR) but had not completed the task. The Administrator was interviewed on 08/15/2025 at 1:09 PM and stated she expected the nurses to give the right medication in the right dosage to the right resident and follow any special instructions on the label.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility policy review, the facility failed to ensure 1 of 2 medication carts were locked when unsupervised. Findings included: A facility policy titled, Controlled Substance Administration & Accountability, revised on 06/01/2025, indicated, It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion, or accidental exposure. An observation on 08/12/2025 from 3:18 PM to 3:26 PM revealed an unlocked/unsupervised medication cart outside room [ROOM NUMBER] with no staff present. During the observation, the nurse came out of a resident's room (the door was closed) and walked past the unlocked cart and went on to the nursing station. Registered Nurse (RN) #7 locked the cart when she returned at 3:26 PM. During an interview on 08/12/2025 at 3:28 PM, RN #7 stated she knew better than to leave the medication cart unlocked. RN #7 stated the risk of leaving carts unlocked/unsupervised was because someone, including any wandering residents, could get into the medication carts and get medications that did not belong to them. RN #7 stated it was no excuse, but she was in a resident's room providing a breathing treatment to a resident. RN #7 stated the cart was not in her line of sight when she was in the resident's room. During an additional observation on 08/12/2025 at 4:26 PM to 4:32 PM, the same medication cart was observed again to be unlocked and unsupervised. During this observation, no residents or staff were observed near the unlocked cart. During this observation, the location of the nurse was not known until the nurse came out of a resident's door into the hallway. The nurse came to the unlocked cart at that time and locked the medication cart. During an interview on 08/12/2025 at 4:32 PM, RN #7 stated she had no excuse why she had left the cart unlocked and unsupervised. She said it was a bad habit. She knew better, and she had received training on the importance of keeping medications safe and under locked carts. RN #7 stated that the risk of an unlocked cart was that a resident or visitor could get into the cart and get into the medication. RN #7 stated that both times the carts had been found to be unlocked they were not within her line of sight, and the carts were not supervised by any other staff. During an observation on 08/15/2025 from 10:48 AM to 10:53 AM, one medication cart was found to be unlocked/unsupervised outside of room [ROOM NUMBER]. During this observation, no residents or staff were present. LPN #8 was behind a resident's closed door at that time of this observation and returned to the unlocked cart and locked the cart. During an interview on 08/15/2025 at 10:55 AM, Licensed Practical Nurse (LPN) #8 stated she knew better than to leave the cart unlocked/unsupervised. LPN #8 stated the risk was someone like a resident, visitor, or even staff could get into the unlocked cart and have access to the residents' medications. LPN #8 stated she knew better and had been previously in-serviced on the importance of locking the medication carts. During an interview on 08/15/2025 at 11:35 AM, the Director of Nursing (DON) stated she expected the staff to keep the medication carts locked at all times. The DON stated the risk of unlocked/unsupervised medication carts was residents, visitors, or other staff getting into the carts. During an interview on 08/15/2025 at 12:55 PM, the Administrator stated she expected staff to keep the medications safe at all times.