

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Bluegrass Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3576 Pimlico Parkway Lexington, KY 40517	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview, record review, review of Mosby's Clinical Nursing Skills and Techniques, 11th edition, review of Kentucky Board of Nursing (KBN) standards, and review of the facility's documents and policies, the facility failed to ensure services provided met professional standards of practice for 1 of 26 sampled residents, Resident (R) 133. The facility discharged R133 on 12/30/2025, and R133 was given a medication that belonged to a different resident, R71. The findings include: Review of the facility's policy titled, Discharge Medication, last revised 04/14/2024, revealed a physician's order was required to discharge a resident with medications before they would be dispensed. Per the policy, the licensed nurse would reconcile the resident's pre-discharge medications with his/her post-discharge medications prior to the resident leaving the facility. Further review revealed a licensed nurse shall review medication instructions with the resident and/or representative as applicable before the resident left the facility. Review of the facility's policy titled, Medication Administration, dated 01/2025, revealed, Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurses contacts with the prescriber for clarification are documented in the nursing notes and elsewhere in the medical record as appropriate. The policy also revealed, Medications supplied for one resident are never administered to another resident. Review of www.KBN.ky.gov website's Accountability and Responsibility of Nurses in Accordance with Kentucky Revised Statute (KRS) 314.021(2) revealed, Nurses are responsible and accountable for making decisions that are based upon the individuals' educational preparation and current clinical competence in nursing and requires licensees to practice nursing with reasonable skill and safety. Nursing practice should be consistent with the Kentucky Nursing Laws, established standards of practice, and be evidence based. Review of Mosby's Safe Medication Administration Guide, from Mosby's Clinical Nursing Skills and Techniques, 11th edition at www.elsevier-elibrary.com, revealed, Always adhere to the 5 rights of medication administration when transcribing, preparing, administering, and documenting medications: Right patient, Right drug, Right route, Right dose, and Right time. 1. Review of R133's Face Sheet revealed the facility admitted R133 on 12/29/2025 with a primary diagnosis of atherosclerotic heart disease of native coronary artery status post-surgical intervention. Review of R133's discharge Minimum Data Set [MDS], dated 12/30/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating R133 was cognitively intact. Review of the facility's Summary of Investigation, dated 12/30/2025, revealed R133 was discharged on 12/30/2025, and R133's grandson arrived for the discharge and told staff he was in a hurry being on his lunch break. Per the investigation, Licensed Practical Nurse (LPN) 2 gathered medications from Kentucky Medication Aide (KMA) 3 to put in R133's belongings bag. It further stated LPN2 was obtaining (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 185446	If continuation sheet Page 1 of 3

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	paperwork to go over with the resident and family, but they left before LPN2 could review the paperwork with the resident and grandson. The investigation revealed R133 was sent home with her medications as well as Keppra (seizure medication) that belonged to R71. Per the investigation, R133 reported ingesting the medication that belonged to R71, thinking it was hers. The investigation stated R71 was reimbursed for the medication. Review of LPN2's Witness Statement, dated 12/31/2025, revealed LPN2 was preparing to discharge R133 and asked KMA3 to place medications in a bag for R133 to take home. Per the statement, that bag was handed to R133's grandson. Further review revealed LPN2 was going around the desk at the nurse's station to print the discharge summary, and R133 and her grandson left the facility before LPN2 could complete the discharge. Review of KMA3's Witness Statement, dated 12/31/2025, revealed LPN2 asked her for R133's medications. Further review revealed she opened the medication cart and handed R133's medications to LPN2 over the medication cart. Review of R133 Orders revealed she had no order for Keppra. Furthermore, R133 had no orders for medications to be sent home with her upon her discharge (per facility policy). 2. Review of R71's Face Sheet revealed the facility admitted R71 on 06/01/2023 with a diagnosis of nontraumatic acute subdural hemorrhage, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and epilepsy. Review of R71's Orders revealed an order for Keppra 1000 milligrams (mg) to be administered twice a day for epilepsy. During an interview on 07/13/2026 at 11:00 AM with the Ombudsmen, she stated R133's family called her after they had gone home with the medication. The Ombudsman stated they told her the resident had taken one of the pills that did not belong to her. She stated they told her they called the facility, and the facility asked them to bring it back. However, stated she instructed them not to. She stated she never saw the medication and was unsure how it was packaged. She stated R133 did not have any ill effects from taking the Keppra. During an interview on 07/14/2026 at 3:30 PM with LPN2, she stated R133's discharge was so fast because the family member picking up the resident was in a hurry. LPN2 stated the KMA bagged up the medications and gave them to the resident while she was trying to get the paperwork together. She stated the resident left before she had a chance to go over paperwork and verify the medications. LPN2 stated medications were usually double checked by another nurse before they were given to the resident, however, that time they were not. During an interview on 07/14/2026 at 3:34 PM with the Social Services Director (SSD), she stated R133 had a planned discharge, and she arranged the follow-ups. However, she stated she had no part in the medications being given to the resident. She stated the resident left fast, and she was made aware of the wrong medication being given to the resident the following day. During an interview on 07/15/2026 at 9:25 AM with R133 and R133's representative, they stated R133's grandson came to get her, and he was rushed because he had just started a new job and could not be late. R133 stated she did not remember any names of staff, but she saw one girl obtain her medication from the medication cart and hand it to another girl. She stated that girl then handed them to her grandson. She stated no one went through the medications with her or her grandson to ensure they were the correct medications. R133 stated she assumed they were all hers and took her doses later that day once she returned home. She stated she realized she had a skid, (a prepackaged sealed blister pack with individual doses) with another resident's name (R71) after she had already taken the medication. She stated she made her daughter aware, and they then called the facility and spoke to the unit manager that night (12/30/2030) to make them aware. They stated someone from the facility called them the following day to ask them to return the medications. However, they refused. R133's representative stated they called R133's primary care provider and made them aware, and they just had to monitor for any side effects at home. R133 and her representative stated R133 did not suffer from any adverse effects from taking the wrong medication. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R133 stated she never took a picture of the medication she received and just recently discarded it all. During an interview on 07/15/2026 at 10:00 AM with the former Assistant Director of Nursing (ADON), she stated (from what she remembered) the resident left with her grandson before the discharge was completed. She stated she was made aware of the situation the following day, on 12/31/2025, and she called to follow up with the resident. She stated she asked them to bring the medications back to the facility, however they would not. She stated she then offered to come to the residents' home, and R133 refused for them to do that also. The former ADON stated she ended up sending R133's discharge paperwork to R133 via certified mail. She stated she was unsure who handed the medications to the resident's grandson, but she thought the KMA did this while LPN2 was working on the discharge paperwork. The State Survey Agency (SSA) Surveyor left a message for KMA3 on 07/15/2026 at 10:37 AM to contact her. However, KMA3 did not return the call, and KMA3 was out of the facility. During an interview on 07/16/2026 at 3:34 PM with the Director of Nursing (DON), she stated she started working at the facility in May 2026 and did not know any details regarding this incident. She stated she was not sure what the process was for residents discharging with their medications from the facility. She stated she would expect residents to be given the correct medications. During an interview on 07/16/2026 at 4:26 PM with the Administrator, she stated R133 wanted to go home. She stated Physical Therapy's evaluation found R133 was very high functioning and safe to discharge home. The Administrator stated R133 called for a family member to come and pick her up. She stated the family member who came to get her had been at work, came on a break, and was in a rush to get the resident home and get back to work. The Administrator stated LPN2 was working to get her paperwork completed, and another staff member was working to get the medications. She stated medications were not normally sent home with the resident upon discharge because they got called into the resident's pharmacy. However, the Administrator stated since the discharge was not originally planned, and the medications had not been sent to the pharmacy, the medications were sent with the resident so she would not miss any doses. She stated it was her expectation that KMAs did not leave the medications with the resident and/or their representatives before the nurse had verified the medications were correct. The Administrator stated it was important to ensure the right medications were given to the correct resident and to ensure the resident understood their discharge instructions.		