STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185447	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villaspring of Erlanger	4220 Houston Road Erlanger, KY 41018

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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 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 facility policy review, the facility failed to prepare food in accordance with professional standards for food safety. This had the potential to affect 131 of 132 current residents that received food from the kitchen.The findings include:Review of the facility's policy titled, Uniform - Dress Code, revised 01/2024, revealed hair and beard nets must be worn by kitchen staff.1. Observation on 09/09/2025 at 9:28 AM revealed Food Service Worker (FSW) 1 had both sides of her hair, approximately three inches, not contained in the hairnet.During an immediate interview with FSW1 at the time of the observation she stated she received education involving how to wear hairnets and all hair was to be covered.2. Observation on 09/09/2025 at 9:47 AM revealed the Executive Chef had her front bangs, approximately two inches, not contained in the hairnet.During an immediate interview with the Executive Chef at the time of the observation she stated the facility policy was all hair should be covered. She stated her front bangs were not covered because she was rushed.During an interview on 09/11/2025 at 10:38 AM with the Dietitian, she stated all the residents in the facility received food from the kitchen except one, who had an order stating nothing was allowed by mouth and received artificial nutrition.During an interview on 09/11/2025 at 10:18 AM with the Director of Nursing (DON), he stated he expected the kitchen staff to follow facility policies and to wear hairnets when preparing food.During an interview on 09/11/2025 at 10:32 AM with the Administrator, she stated she occasionally went into the kitchen to monitor staff for proper hygiene, and she expected staff to wear hairnets that completely covered all hair.

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 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, record review, review of the facility's policies, and review of the Centers for Disease Control and Prevention (CDC) guidlines related to enhanced-barrier precautions (EBP) and transmission-based precautions (TBP), 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 for 4 out of 27 sampled residents (Residents (R) 5, R20, R65, and R86) 1. Observation on 09/09/2025 revealed the Medical Records Supervisor failed to remove her gloves or perform hand hygiene before leaving a resident's room after handling trash and walked through the hallway with gloved hands and opened the dirty utility room door with contaminated personal protective equipment (PPE).2. Observation on 09/09/2025 revealed State Registered Nurse Aide (SRNA) 3 entered room [ROOM NUMBER], an EBP room, then exited the room without performing hand hygiene.3. Observation on 09/09/2025 revealed the Nurse Practitioner (NP) entered the dining room and used a blood pressure cuff, digital thermometer, oxygen saturation monitor, and stethoscope to provide care to R20 in the dining room without disinfecting any of the equipment used.4. Observation on 09/10/2025 revealed Kentucky Medication Aide (KMA) 1 did not remove her gloves or perform hand hygiene prior to exiting room [ROOM NUMBER]. She walked through the hall wearing the gloves and opened the door to the dirty utility room with her contaminated gloved hand.5. Observation on 09/10/2025 revealed Licensed Practical Nurse (LPN) 1 took vital signs on R5, however the LPN did not clean and sanitize the shared equipment before performing a vital sign assessment on patient R65.6. Observation on 9/11/2025 revealed LPN2 entered the dining room holding a glucometer with a test strip inserted and was not wearing gloves and a glucose fingerstick on R86 without performing hand hygiene. LPN2 put on gloves and completed the fingerstick then placed the contaminated glucometer with the test strip in place on top of the medication cart and removed her gloves.The findings include:Review of the CDC Guidelines titled, Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 04/12/2024, revealed hand hygiene should be performed immediately before providing resident care and after care was completed. It stated staff should ensure the proper selection and use of PPE based on the nature of the patient interaction and potential for exposure to blood, body fluids, and/or infectious materials.Review of the facility's policy titled, Standard Precautions, revised 09/2025, revealed standard precautions will be used in the care of all residents regardless of their diagnosis or suspected or confirmed infection status. Further review of the policy revealed hand hygiene is required after removing gloves and other PPE. According to the policy, reusable shared equipment is not used for the care of another resident until it has been appropriately cleaned and disinfected.Review of the facility's policy titled, Nursing Standards of Practice for Bedside Blood Glucose Testing with the EvenCare G3 Blood Glucose Monitor, revised 1/2023, revealed standard precautions are used while providing blood glucose testing. Furthermore, nursing staff should disinfect glucose monitors between patient use.Review of R20's admission Record revealed the facility admitted the resident on 12/07/2022 with diagnoses of Alzheimer's disease, unspecified, anxiety disorder, unspecified, and depression, unspecified.Review of R20's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 09/03/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of five out of 15, indicating R20 was severely cognitively impaired.Review of R5's admission Record revealed the facility admitted the resident on 02/03/2023 with diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, and congestive heart failure.Review of R5's quarterly MDS, with an ARD of 08/15/2025, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating R5 was cognitively intact.Review R65's admission Record revealed the facility admitted the resident on 04/07/2023 with diagnoses of chronic venous hypertension, type 2 diabetes mellitus, and chronic (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	kidney disease.Review of R65's quarterly MDS, with an ARD of 08/22/2025, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating R65 was cognitively intact.Review of R86's admission Record revealed the facility admitted the resident on 12/30/2023 with diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, and atherosclerotic heart disease.Review of R86's quarterly MDS, with an ARD of 08/27/2025, revealed the facility assessed the resident to have a BIMS score of 15 out 15, indicating R86 was cognitively intact.1. Observation of the Medical Records Supervisor on 09/09/2025 at 10:10 AM revealed she gathered trash from a resident's room. The supervisor wore gloves but failed to remove her gloves or perform hand hygiene before leaving the resident's room and after handling trash. She walked through the hallway with gloved hands and opened the dirty utility room door with contaminated PPE.During an immediate interview at the time of the observation, the Medical Records Supervisor stated she was unaware she needed to remove her gloves and perform hand hygiene before leaving the room if she needed to carry trash to the dirty utility room. She stated she did not normally assist on the floor other than to monitor as needed. She further stated following infection control practices was important to prevent the spread of infection due to cross-contamination.2. Observation of SRNA3 on 09/09/2025 at 10:29 AM revealed she entered room [ROOM NUMBER], an EBP room, and did not perform hand hygiene upon entry. SRNA3 then exited the room without performing hand hygiene.During an interview with SRNA3 on 09/09/2025 at 10:40 AM, she stated she performed hand hygiene before leaving the room. When questioned further regarding the observation of not following hand hygiene protocols, she stated, I can't say I do it all the time. SRNA 3 stated following infection prevention and control policies (IPCP) was important to prevent the spread of infection due to cross-contamination. 3. Observation of the NP on 09/09/2025 at 1:05 PM revealed she entered the dining room wearing a blood pressure cuff on her right forearm. She approached R20 and applied the cuff to R20's right forearm without first cleaning and disinfecting the shared equipment, then measured the resident's blood pressure. After taking the measurement, she placed the cuff on the dining table. The NP took a digital thermometer out of her pocket to check R20's temperature and returned it to her pocket without disinfecting it. She then used an oxygen saturation monitor on R20's index finger, putting it back in her pocket without cleaning it afterward. Next, she listened to R20's heart and breath sounds using her stethoscope, again without disinfecting the equipment. Finally, the NP returned the blood pressure cuff to her forearm and left the dining room.During an interview with the NP on 09/09/2025 at 1:26 PM, she stated she did not work for the facility but provided services under contract. She stated she did not wipe off the blood pressure cuff after using it on a resident. She stated she usually cleans and disinfects shared equipment after using it a few times on residents. The NP stated there was a possibility of transmission of microorganisms to other residents when staff did not clean and disinfect shared equipment after use. She further stated infection control was important for the safety and well-being of residents.4. Observation of KMA1 on 09/10/2025 at 9:29 AM revealed she did not remove her gloves or perform hand hygiene prior to exiting room [ROOM NUMBER]. She walked through the hall wearing the gloves and opened the door to the dirty utility room with her contaminated gloved hand.During an interview with KMA1 on 09/10/2025 at 9:41AM, she stated she should have doffed (taken off) her gloves and PPE before exiting the resident's room. KMA1 stated she wanted to continue wearing gloves while transporting the heavily soiled trash and linen but stated she should have double bagged the items instead. She stated hand hygiene, and the removal of contaminated PPE was important to prevent cross contamination. 5. Observation of LPN1 on 09/10/2025 at 10:04 AM revealed she conducted a vital sign assessment on patient R5. However, after taking the vital signs, she did not clean and sanitize the shared equipment before performing a vital sign assessment on patient R65. Additionally, instead of cleaning and sanitizing the shared equipment after the second assessment, she pushed the vital sign machine into the hallway and left it there as she walked away.During an interview with LPN1 on 09/10/2025 at 10:24 AM, she stated according to facility policy any shared equipment should be cleaned and disinfected using the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	appropriate disinfecting wipes immediately after use on a resident. She stated she usually cleaned and disinfected the vital sign machine. She stated it was important to prevent the spread of infection and for the safety and well-being of the residents. 6. Observation of LPN2 on 09/11/2025 at 7:50 AM revealed she entered the dining room holding a glucometer with a test strip inserted and was not wearing gloves. She approached resident R86 and began to perform a glucose fingerstick. Upon noticing the State Survey Agency (SSA) surveyor, she stopped and moved the resident into the hallway near the medication cart. Without performing hand hygiene, she donned gloves and completed the fingerstick. LPN2 placed the contaminated glucometer with the test strip in place on top of the medication cart and removed her gloves. She pulled out the test strip, rolled it into her gloves, and disposed of them. She did not clean or sanitize the glucometer and did not perform hand hygiene immediately after the procedure.During an interview with LPN2 on 09/11/2025 at 10:41 AM, she stated she had never intended to perform R86's fingerstick in the dining room but only took all the supplies in there to get the resident to take her to her room. She stated she did perform hand hygiene when donning and doffing her gloves. She stated further that she cleaned the glucometer before she stored it in the medication cart. LPN2 could not articulate why it was important to use a barrier when placing the contaminated glucometer down on top of the medication cart with other supplies. During an interview with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) on 09/11/2025 at 3:18 PM, she stated it was her expectation for all staff to follow the infection prevention and control practices within the facility. She stated staff were required to follow CDC guidelines as posted on EBP and TBP signs located on resident's doors. She further stated the purpose of these signs was to ensure that staff use the correct PPE and perform hand hygiene to prevent the spread of infection. The ADON/IP stated all vendors, including the providers, are expected to follow facility IPCP policies to prevent the spread of infection and for the safety of all residents, staff, and visitors.During an interview with the Administrator on 09/11/2025 at 3:49 PM, she stated it was her expectation that staff follow all infection prevention and control practices. She stated nursing leadership should make routine observations to ensure staff followed protocol. The Administrator stated the importance of infection prevention and control was to prevent the spread of infection between residents, staff, and visitors, and she further stated infection prevention and control was essential for the safety and well-being of everyone in the facility.

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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, record review, and facility policy review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 27 sampled residents (Resident (R) 2 and R20).Observation during lunch service on 09/09/2025 revealed the Occupational Therapy Assistant (OTA) was standing between R2 and R20 while assisting them with eating lunch.Additional observation during lunch service on 09/09/2025 revealed the Nurse Practitioner (NP) approached R20, who was seated at a table eating lunch with R20, to obtain vital signs from the resident while she was eating. The findings include:Review of facility policy titled, Resident Rights, undated, revealed the resident shall be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs. 1. Review of R2's admission Record revealed the facility admitted the resident on 03/10/2023 with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphasia, pharyngoesophageal phase, and type II diabetes mellitus with hyperglycemia.Review of R2's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 08/28/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 99, indicating R2 was unable to complete the interview.Review of R2's Comprehensive Care Plan, dated 09/10/2025, revealed the resident was identified as having an activities of daily living (ADL) self-care performance deficit. R2 was totally dependent on staff for eating and required a feeding tube related to dysphagia.Observation of lunch service in the dining room on 09/09/2025 at 12:57 PM revealed R20 was sitting in a Broda chair positioned in the back corner of room. R2 was positioned in a Broda chair directly across from R20, and the OTA was standing in between the residents, assisting both residents with eating lunch.During an interview on 09/09/2025 at 1:22 PM with the OTA, she stated she was trying to feed R2 while keeping an eye on the other resident. She was not aware she was supposed to sit with R2 when assisting her with eating, and stated it was hard to sit because R2 was in a Broda chair, and it was hard to reach her mouth.2. Review of R20's admission Record revealed the facility admitted the resident on 12/07/2022 with diagnoses of Alzheimer's disease, unspecified, anxiety disorder, unspecified, and depression, unspecified.Review of R20's quarterly MDS, with an ARD of 09/03/2025, revealed the facility assessed the resident to have a BIMS score of five out of 15, indicating R20 was severely cognitively impaired.Review of R20's Comprehensive Care Plan (CCP), dated 09/10/2025, revealed the resident was identified as having an ADL self-care performance deficit. Interventions included R20 needed assistance with eating in set-up then supervision (helper provides verbal cues and/or touching as resident completes activity). Observation of lunch service in the dining room on 09/09/2025 at 1:05 PM revealed the NP brought a blood pressure cuff wrapped around her wrist into the dining room and proceeded to apply the blood pressure cuff to R20's right wrist, while the resident was eating, and she obtained additional vital signs for R20.During an interview on 09/09/2025 at 1:29 PM with the NP, she stated she was unaware of the requirement allowing residents to eat meals without being interrupted. She stated she was trying to obtain R20's vital signs and knew about infection control, but she was attempting to visit all her patients before leaving to travel to another facility.During an interview on 09/11/2025 at 5:00 PM with the Director of Nursing (DON), he stated it was his expectation that staff assisting residents with eating would sit next to the resident and not stand. He stated it was his expectation for staff or contract employees to respect the privacy of residents and not try to obtain vital signs while residents were eating.During an interview on 09/11/2025 at 4:47 PM with the Administrator, she stated it was her expectation that staff would take a food tray to a resident in the dining room and would expect staff to sit next to the resident when assisting residents with eating. She stated it was her expectation that staff would not interrupt (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents to obtain vital signs while residents were dining, and residents should be allowed to dine without being disturbed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review, and facility policy review, the facility failed to establish a system of records of receipts and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and failed to determine drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 out of 27 sampled residents (Resident (R) 101). Review of the Controlled Drug Receipt Record/Disposition Form for the 2100 Hall medication cart on 09/11/2025 revealed an incorrect count for R101's pregabalin 50 milligram (mg) capsules.Review of the Narcotic Shift Count sheet for the 2200 Hall medication cart on 09/11/2025 revealed Licensed Practical Nurse (LPN) 4 failed to sign the Narcotic Shift Count sheet as the oncoming nurse. Review of the Narcotic Shift Count sheet for the 2100 Hall medication cart on 09/11/2025 revealed LPN3 failed to sign the Narcotic Shift Count sheet as the oncoming nurse. The findings include:Review of the facility's policy titled Controlled Drug Reconciliation, revised 06/2025, revealed the licensed nurse/medication aide counts all controlled medications at every change of shift and during the hand-off of narcotic keys. According to the policy, a reconciliation is performed by both the outgoing and incoming licensed nurse/medication aide. The outgoing nurse/medication aide reads the quantity of narcotics listed on the proof of use sheet, while the incoming nurse/medication aide verifies the medication packaging to ensure it matches the recorded number of narcotics. A physical count reconciliation of controlled substances, along with the identification of the individuals conducting the medication reconciliation, is documented on the proof of use sheets for every shift-to-shift count.1. Review of R101's admission Record revealed the facility admitted the resident on 07/15/2025 with diagnoses of lumbosacral spondylopathies, chronic pain syndrome, and type 2 diabetes.Review of R101's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 09/05/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating R101 was cognitively intact.Review of R101's Order Summary, dated 09/2025, revealed on 07/15/2025 the physician prescribed pregabalin oral capsule 50 mg, give one capsule by mouth two times a day for pain.Review of the Medication Administration Report [MAR], dated 09/2025, revealed documentation on 09/08/2025 that R101 was given one pregabalin oral capsule 50 mg at 9:00 PM.Review of the 2100 Hall medication cart's Narcotic Count Sheets, on 09/11/2025 at 11:36 AM, revealed the count of R101's scheduled 9:00 PM dose of pregabalin 50 mg (a medication used to treat pain or nerve pain in individuals with diabetes) and classified as a Schedule 5 controlled substance (the lowest category for abuse potential), was inaccurate. The records indicated there were 17 capsules remaining; however, only 16 capsules were counted in the medication card. Furthermore, documentation showed that R101's scheduled 9:00 PM dose of pregabalin 50 mg on 09/08/2025 had not been signed out as administered.Review of the 2100 Hall medication cart's Controlled Drug Receipt Record/Disposition Form, for R101's pregabalin 50 mg capsules, with a received date of 09/03/2025, revealed the resident received one pregabalin 50 mg capsule by mouth twice daily for pain. The quantity received from the pharmacy was 30 capsules. On 09/08/2025, one capsule was signed out at 9:00 AM as given, leaving 22 pills. There was no 9:00 PM dose documented as given. The count on 09/11/2025 was 17.On 09/11/2025 at 11:40 AM, the State Survey Agency (SSA) surveyor requested the name and contact information for the nurse on duty on 09/08/2025, during the evening shift, who was responsible for administering R101's medications. This information was not provided by the facility during the survey.During an interview with Unit Manager (UM)/Registered Nurse (RN) 2 on 09/11/2025 at 11:41 AM, she stated nurses and medication aides were required to sign the narcotic count sheet at the end of the shift reconciliation period and staff must count at the beginning and end of each shift, ensure the count is accurate, and complete documentation. She stated R101's 9:00 PM dose of pregabalin 50 mg on 09/08/2025 was not signed out, however, based on the medication card count, the dose was given. UM/RN2 stated nursing staff (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have identified and reported the inconsistency immediately and were expected to follow established narcotic count protocols to prevent incorrect counts and diversion.2. Review of the Narcotic Shift Count sheet for the 2200 Hall medication cart on 09/11/2025 at 11:17 AM revealed LPN4 had not signed the sheet as the oncoming nurse. During an immediate interview, LPN4 stated she completed a narcotic card count with the outgoing nurse at shift change earlier that morning. However, she stated she forgot to sign the Narcotic Shift Count sheet. LPN4 stated it was important to follow the facility's procedures and document correctly to prevent the diversion of scheduled narcotics.3. Review of the Narcotic Shift Count sheet for the 2100 Hall medication cart on 09/11/2025 11:36 AM revealed LPN3 had not signed the sheet as the oncoming nurse. During an immediate interview, LPN3 stated she completed the count with the outgoing nurse at shift change, but stated I must have forgot to sign the sheet. LPN3 stated it was important to follow policy to prevent diversion of narcotic drugs.During an interview with the Assistant Director of Nursing (ADON) on 09/11/2025 at 3:18 PM, she stated licensed nurses/medication aides should follow facility policy related to medication storage and should follow established protocols for counting narcotics. She stated nurses were to maintain the cart according to policy and must follow the process for the cart count. She stated it was her expectation that both the outgoing and incoming nurse/medication aide count the cart together. She further stated they should be counting the medication pack as well as the count sheet. The ADON stated the incorrect count should have been identified immediately during the next shift count. She stated following narcotic count protocols was important to help prevent diversion of narcotics from occurring.During an interview with the Director of Nursing (DON) on 09/11/2025 at 3:42 PM, he stated licensed nurses and medication aides were expected to maintain the medication cart in accordance with facility policy and follow established procedures for completing the narcotic count. The DON stated it was his expectation for both the outgoing and incoming nurse or medication aide to conduct the narcotic medication count together. He further stated the incorrect count should have been identified immediately and the discrepancy should not have taken three days to discover, and the error should have been detected immediately if the counts were performed correctly. The DON stated staff must follow facility policy and protocols for counting narcotics, which included signing the narcotic count sheet and completing counts at the beginning and end of each shift. He stated following proper narcotic count procedures was important to ensure accuracy and to prevent opportunities for diversion.During an interview with the Administrator on 09/11/2025 at 3:49 PM, she stated it was her expectation that staff follow all established protocols for counting narcotics. She stated it was important for the well-being and safety of the residents to ensure accuracy of the narcotic count and to safeguard against potential diversion.

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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. Based on observation, interview, record review, and review of the facility's policies, the facility failed to label and store medications in accordance with currently accepted professional principles for 2 out 27 sampled residents (Resident (R) 94 and R103).During an observation of the 1300 Hall medication cart on 09/11/2025, a medicine cup containing R94's opened medications was found in the drawer. The medications were documented as given.During an observation of the 2100 Hall medication cart on 09/11/2025, a medicine cup containing R103's opened medications was found in the drawer. The medications were documented as given. The findings include:Review of the facility's policy titled, Administration Oral Medication, revised 11/2024, revealed the facility ensured residents were given medications per the physician's orders. The policy stated medications are given at the time ordered.Review of the facility's policy titled, Medication Storage, revised 04/2024, revealed medications and biologicals for each resident are stored in the containers in which they were originally received.1. Review of R94's admission Record revealed the facility admitted the resident on 07/11/2025 with diagnoses of type 2 diabetes mellitus, malignant meal plans, and in chronic pain.Review of R94's admission Minimum Data Set [MDS], with an assessment reference date (ARD) of 07/17/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating R94 was cognitively intact.Review of the Medication Administration Report [MAR], dated 09/2025, revealed on 09/11/2025 all of R94's 9:00 AM medications were documented as given by Licensed Practical Nurse (LPN) 2.Observation of the 1300 Hall medication cart on 09/11/2025 at 10:50 AM revealed an unlabeled medicine cup containing the medications for R94, scheduled for 9:00 AM, was found in a medication drawer. Medications found were cholecalciferol 50 micrograms (mcg) oral tablet, pantoprazole sodium 40 milligrams (mg) oral tablet, pioglitazone HCL 15 mg oral tablet, metformin 1000 mg oral tablet, ferrous sulfate 325 mg oral tablet, and lisinopril 10 mg oral tablet. All the medications had been documented on the MAR as administered to R94.During an immediate interview with LPN2, she stated she prepared the 9:00 AM medications and took them to R94's room; however, the resident did not want to take them at that time and stated she would take them after her physical therapy session. LPN2 stated she marked the medications as given but should have discarded them and marked them as refused. She stated opened and unlabeled medications should not be stored in the medication cart. LPN2 stated following facility policy for medication storage was important for the safety of the residents and she should not have marked the medications as given since they were not actually administered.2. Review of 103's admission Record revealed the facility admitted the resident on 08/13/2025 with diagnoses of pleural effusion, malignant neoplasm of the breast, and anemia.Review of R103's quarterly MDS, with an ARD of 08/17/2025, revealed the facility assessed the resident to have a BIMS score of 13 out of 15, indicating R103 was cognitively intact.Review of the MAR, dated 09/2025, revealed on 09/11/2025 all of R103's 9:00 AM medications were documented as given by LPN3.Observation of the 2100 Hall medication cart on 09/11/2025 at 11:17 AM revealed an unlabeled medicine cup containing the medications for R103, scheduled for 9:00 AM, was found in the medicine drawer. Medications found were Eliquis 2.5 mg oral tablet, doxycycline 100 mg oral tablet, mucus relief D 600 mg oral tablet, oxybutynin extended relief 10 mg oral tablet, pantoprazole sodium 40 mg oral tablet, pravastatin 20 mg oral tablet, probiotic 250 mg oral tablet, and metoprolol extended release 200 mg oral tablet. All the medications had been documented on the MAR as administered to R103. During an immediate interview with LPN3, she stated R103 refused her 9:00 AM medications, but she was going to try to get the resident to take them at a later time. She stated it would be too late to give them to the resident now as it was past the one hour after window. LPN3 marked the medications as given but stated she should have marked them as refused because the resident did not take them. Further (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185447	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villaspring of Erlanger	4220 Houston Road Erlanger, KY 41018

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview revealed LPN3 stated opened or unlabeled medication should not be kept in the medication cart. She stated it was important to follow facility protocols for storage to ensure resident safety.During an interview with Unit Manager (UM)/Registered Nurse (RN) 2 on 09/11/2025 at 11:41 AM, she stated staff must follow the facility's policies for medication storage to ensure the safety of residents and to prevent errors. She stated any opened or unlabeled medications pose a safety risk and must be discarded according to policy. She further stated the nurse responsible for the medication pass should not have marked the medications as given when they were not administered but should have instead documented them as refused and discarded the medications.During an interview with the Assistant Director of Nursing (ADON) on 09/11/2025 at 3:18 PM, she stated it was her expectation that nursing staff adhere to the facility policy for proper medication storage as it was important to protect residents from harm. She stated opened or unlabeled medications created a safety risk and must be discarded immediately. The ADON further stated medication should never be documented as given if they were not administered and staff were required to document the dose as refused.During an interview with the Director of Nursing (DON) on 09/11/2025 at 3:42 PM, he stated according to facility policy staff should not keep opened or unlabeled medications in the medication cart as it places residents at risk. The DON stated staff were required to discard such medications immediately. He stated medications must not be signed out as administered if they were not given and staff should instead document the doses as refused in accordance with the policy. The DON stated it was his expectation all nursing staff follow the facility policies and procedures for safe medication storage and administration. He further stated it was important that resistant residents receive their medications as ordered by their physician to ensure safe and effective treatment.During an interview with the Administrator on 09/11/2025 at 3:49 PM, she stated it was her expectation that staff follow all established protocols for medication storage and administration. She stated it was important for the well-being and safety of the residents and to ensure they receive their medication as ordered by the physician.