STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185463	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Premier Nursing & Rehab	2770 Palumbo Drive Lexington, KY 40509

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview, and review of the facility's policies, the facility failed to provide the residents or family group with a private space to have a monthly scheduled Resident Council meeting. Observation and resident interviews on 08/05/2025, during the Resident Council meeting, revealed the meeting's designated space to be a non-private area of the dining room accessed by nursing staff to communicate with kitchen staff.The findings include:Review of the facility's policy titled, Resident Rights, undated, revealed the resident had a right to personal privacy which included meetings with family and the resident group.Review of the facility's policy titled, Facility Responsibilities, undated, revealed the facility must ensure that the resident could exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. Per the policy, the facility must provide a resident or family group, if one existed, with private space, and take reasonable steps, with the approval group, to make residents or family members aware of the upcoming meetings in a timely manner.Observation on 08/05/2025 at 10:30 AM revealed the Resident Council (resident group) meeting was held in the dining hall that employees walked through to have access to the kitchen. Further observation revealed the meeting location was not a private space, as employees entered and exited without acknowledging the residents' right to meet in a private space. During an interview with Resident (R) 5 on 08/05/2025 at 11:12 AM during the Resident Council meeting, she stated the Resident Council meetings were held in the dining hall, and staff walked in, disrupting the meeting by being loud and noisy.During an interview with R8 on 08/05/2025 at 11:18 AM during the Resident Council meeting, she stated the Resident Council meetings were held in the dining hall, and staff was constantly walking through the meeting trying to access the kitchen. She stated staff had another door they could use to access the kitchen that would not cause them to interfere with the Resident Council meeting. During an interview with R14 on 08/05/2025 at 11:43 AM during the Resident Council meeting, he stated he attended the Resident Council meetings every month. He stated every time there was a meeting it was held in the dining hall, and employees came in to pass to the kitchen or just came in and sat in the meeting without getting the residents' approval. He stated employees entered the meeting at their own pleasure, disregarding the residents' right to meet in a private space. During an interview with the Activities Director on 08/06/2025 at 9:12 AM, he stated he held Resident Council meetings for the residents once a month. He stated at one time the Resident Council meetings were going to be held in what now was his office. He stated due to the facility having limited space, it had been an ongoing issue to find a private space for residents to meet monthly. He stated finding the residents a private space to express their concerns was important and should be treated as so. He stated residents not having a private space to discuss concerns with one another could result or lead to frustrations within residents. He stated he would continue to advocate for residents to have a private space to enjoy the company of their fellow residents and provide them with a private space to express concerns. During an interview with the Director of Nursing (DON) on 08/06/2025 at 11:00 AM, she stated she was unaware Resident Council meetings were being disrupted by staff. She stated she thought signs were posted on the doors to inform staff the Resident Council meeting was in progress. She stated she could communicate with and educate staff on not to walk through or cause any unnecessary disruption while the Resident Council meeting was being held in the dining hall. She (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated it was important for residents to feel respected while they were here at the facility, as this was their home, and staff wanted them to reside in a home like environment. During an interview with the Administrative Assistant on 08/07/2025 at 4:22 PM, he stated he was unaware of the Resident Council not having a private space to meet for their monthly meetings. He stated now that he was aware of a private area being requested from the residents for the Resident Council meeting, he would ensure it was provided. He stated the facility did not have a lot of space, especially for those residents in wheelchairs, but he would do his best, even if he must monitor the dining hall entrance to ensure staff did not interrupt. During an interview with the Chief Executive Officer (CEO) on 08/06/2025 at 10:33 AM, he stated he was unaware of residents requesting to meet in a private space for their monthly Resident Council meetings. He stated if the residents were requesting a private space to meet, then the facility should provide the residents a space where they could feel safe and have privacy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents had a right to a safe, clean, comfortable and homelike environment. Observations on 08/04/2025 and 08/07/2025 of three areas of the facility revealed stained and unraveled carpet. The findings include:The State Survey Agency (SSA) Surveyor requested an environmental policy from the Director of Nursing (DON) on 08/08/2025 at 8:46 AM; however, the only documents provided were blank cleaning logs.Observation upon the initial entry to the facility on [DATE] at 3:00 PM revealed the carpet in the front lobby was overall dirty, visibly stained in multiple areas, and unraveling near the front reception desk.Observation on 08/04/2025 at 3:19 PM revealed the carpet on the North Hall was visibly stained in multiple areas throughout the unit. Observation on 08/07/2025 at 3:57 PM revealed the carpet on the South Hall was visibly stained in multiple areas throughout the unit. During an interview with Registered Nurse (RN) 4 on 08/08/2025 at 9:59 AM, she stated it was important the carpets were clean in the facility, so dust and dirt were eliminated; and it was just overall unhealthy. RN4 further stated it made a bad first impression when people walked into the facility, and the first thing they noticed were visibly stained and dirty carpets.During an interview with the Assistant Director of Nursing (ADON) on 08/08/2025 at 10:04 AM, she stated it was important the facility and the carpets were clean because the facility was home for the residents, and it should be clean. Additionally, she stated it left a bad impression when visitors or family walked into the facility, and the first thing they noticed were the carpets needed to be cleaned. During an interview with the Administrative Assistant (AA) on 08/08/2025 at 11:48 AM, he stated the facility's carpets should be clean, as well as the entire facility for resident safety related to infection prevention concerns. During an interview with the Chief Executive Officer (CEO) on 08/06/2025 at 10:33 AM, he stated he was not clinical and was unaware of any standard practices for infection control. He stated he had recently replaced carpeting in the resident rooms, but the entire carpet replacement was a two-phase project that had not yet been completed due to the facility's financial trouble when he took over leadership a few years ago. The CEO further stated he had received three or four quotes from different companies to replace the carpet at the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, record review, and review of the facility's policy, the facility failed to provide food and drink that was palatable and at a safe and appetizing temperature. Observation on 08/06/2025 at 8:15 AM of the breakfast test tray on the South 200 Unit revealed the food at point of service was at unappetizing temperatures. The findings include:Review of the facility's policy titled, In-Room Dining, dated 2020, revealed hot foods served on room trays were preferred to be at 120 degrees Fahrenheit (F) or greater to promote palatability for the resident. Review of the facility's Food Temperature Chart, dated 08/06/2025, revealed cooked cereal had a temperature of 184 degrees (F) initially and continued to a temperature of 180 degrees (F) at the conclusion of the tray line. Further review revealed eggs had a temperature of 179 degrees F and continued to a temperature of 176 degrees F at the conclusion of the tray line. Further review revealed sausage had a temperature of 179 degrees F initially and continued to a temperature of 177 degrees at the conclusion of the tray line.Observation on 08/06/2025 of the breakfast service on the South 200 Unit revealed a trolley of 20 trays and a smaller cart with six trays arrived at 7:55 AM. Staff was observed to deliver trays to residents, with the last tray delivered at 8:15 AM. Further observation revealed the Dietary Manager (DM) at 8:15 AM, took the temperature of food items, with a sausage patty measuring 77 degrees F, cheesy eggs measuring 104 degrees F, and oatmeal measuring 144 degrees F. Additional observation revealed, with tasting by the State Survey Agency (SSA) Surveyor, the sausage was not warm enough to be palatable, the cheesy eggs would have tasted better if warmer, and the oatmeal was palatable. Observation on 08/06/2025 at 10:45 AM of the kitchen during meal preparation revealed the plate warmer in the kitchen was overflowing with plates. Further observation at 11:00 AM revealed the Dietary Manager (DM) attempted to close the plate warmer and was able to close one side with effort, but the other side was too full to close. During interviews as part of the Resident Council meeting on 08/05/2025 at 10:30 AM, residents stated food items were sometimes cold when delivered to rooms, with breakfast cited as cold more often than the other meals.During interview with the DM on 08/06/2025 at 8:42 AM, he stated everything coming out of the kitchen was hot for breakfast, with temperatures taken of the food items when placed on the tray line and temperatures taken again at the completion of the tray line to ensure temperatures held. He stated the kitchen had plate warmers, and the bottom plate holder was insulated. He stated when the cooks arrived in the morning, they turned on the plate warmer and coffee pot first thing. He stated there were more residents in the facility than there was room for plates in the plate warmer. The DM stated his expectation was that temperatures be no less than 105 degrees F at the point of service, and if he went into a restaurant and his sausage was served at 80 degrees F, he would be upset.During interview with the Director of Nursing (DON) on 08/07/2025 at 9:27 AM, she stated when a resident complained about food temperatures, staff immediately alerted the DM and the Administrator. The DON stated the plate warmer in the kitchen was purchased by a recent Administrator to help ensure food was warm at point of service.The DON stated her expectation was when food was delivered to the floor, floor staff delivered trays as soon as they arrived to ensure they were distributed quickly. She stated her expectation was that food was at the correct temperature when residents received it. During interview on 08/08/2025 at 10:10 AM with the Administrative Assistant (AA), he stated he had been acting as the temporary Administrator for two months. The AA stated he grew up knowing breakfast was the most important meal of the day, and his expectation was that food temperatures would be warm enough, so residents enjoyed their meals.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, record review, review of the Centers for Medicare & Medicaid Services (CMS) Center for Clinical Standards and Quality/Quality, Safety & Oversight Group's QSO-21-19-NH Memo, and review of the facility's policy, the facility failed to maintain documentation of screening, education, offering, and current Coronavirus Disease 2019 (COVID-19) vaccination status for 5 of 5 sampled staff, Registered Nurse (RN) 2, Licensed Practical Nurse (LPN) 2, State Registered Nurse Aide (SRNA) 10, SRNA11, and SRNA12.The findings include:Review of the CMS Center for Clinical Standards and Quality/Quality, Safety & Oversight Group's QSO-21-19-NH Memo, dated 05/01/2021, revealed Long-term Care (LTC) facilities must offer staff vaccination against COVID-19 when vaccine supplies were available to the facility. LTC facilities must screen staff prior to offering the vaccination for prior immunization, medical precautions, and contraindications to determine whether they were appropriate candidates for vaccination. Per the guidance, the vaccine might be offered and provided directly by the LTC facility or indirectly, such as through an arrangement with a pharmacy partner, local health department, or other appropriate health entity.Review of the facility's policy titled, Infection Control, revised 09/2021, revealed the facility would plan control activities and manage potential outbreaks of disease. The facility did not provide a COVID-19 Immunization Policy.1. Review of RN2's employee file revealed no documented evidence noting RN2 was offered the COVID-19 vaccination. Additionally, there was no documentation that education regarding the benefits, risks, and potential side effects of the vaccine was provided to the employee. RN2 was unavailable for interview.2. Review of LPN2's employee file revealed no documented evidence the facility had provided LPN2 with education regarding the benefits, risks, and potential side effects of the COVID-19 vaccination. LPN2 was unavailable for interview.3. Review of SRNA10's employee file revealed no documented evidence the facility had provided SRNA10 with education regarding the benefits, risks, and potential side effects of the COVID-19 vaccination. During an interview with SRNA10 on 08/07/2025 at 10:53 AM, he stated he had not been educated about or asked regarding his COVID-19 vaccination status. The SRNA further stated he had not signed any forms related to this issue and was not required to present a COVID-19 vaccination card or sign any documentation.4. Review of SRNA11's employee file revealed no documented evidence the facility had provided SRNA11 with education regarding the benefits, risks, and potential side effects of the COVID-19 vaccination. During an interview with SRNA11 on 08/07/2025 at 10:53 AM, he stated he had not been educated about or asked regarding his COVID-19 vaccination status. The SRNA further stated he had not signed any forms related to this issue and was not required to present a COVID-19 vaccination card or sign any documentation.5. Review of SRNA12's employee file revealed no documented evidence the facility had provided SRNA12 with education regarding the benefits, risks, and potential side effects of the COVID-19 vaccination. SRNA12 was unavailable for interview.During an interview with the Human Resources Director (HRD) on 08/07/2025 at 2:56 PM, she stated the facility did not provide COVID-19 vaccinations in-house. Instead, she stated, the facility would offer information on external resources for obtaining vaccines. She stated the facility would provide educational materials to staff, utilizing the CDC's Vaccine Information Statement (VIS) dated January 2025. Additionally, she stated the facility did not require employees who chose to decline the vaccine to submit a declination form. During an interview with the Infection Preventionist (IP) on 08/07/2025 at 4:00 PM, she stated the facility did not have a COVID-19 Immunization Policy. The IP further stated she could not provide documentation to support staff signature on declination forms and education related to the COVID-19 vaccine. She stated the facility followed the Infection Control policy and CDC guidelines to prevent the spread of infection and disease. During an interview with the Director of Nursing (DON) on 08/08/2025 at 10:05 AM, she stated the facility followed the recommendation of the CDC for all (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	immunizations and vaccines but had not provided education regarding the benefits, risks, and potential side effects associated with the COVID-19 vaccine immunization education to its employees. Furthermore, she stated she did not have documentation for the staff regarding the employee's COVID-19 vaccine education. The DON stated it was important for the facility to educate staff about and offer the COVID-19 vaccine. Additionally, the DON stated the facility should maintain documentation of each staff member's immunization status or their decision to decline the vaccine in their personnel files. She stated the importance of adhering to the CDC's guidelines for infection prevention and control was to help prevent the spread of diseases and infections within the facility.During an interview on 08/08/2025 at 10:10 AM with the Administrative Assistant (AA), he stated he had been acting as the interim Administrator for two months. The AA stated it was important that the facility maintained the appropriate documentation to reflect that it provided the required COVID-19 vaccine education to employees to comply with CDC recommendations and adhere to the facility's infection control program. He further stated that following policy and CDC guidelines was important for the safety of residents and staff.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, record review, and review of the facility's policies, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs for 1 of 4 sampled residents, Resident (R) 54. The findings include: Review of the facility's policy titled, Call Lights: Accessibility and Timely Response-Physical Environment, dated 01/2024, revealed with each interaction in the resident's room or bathroom, staff would ensure the call light was within reach of the resident and secured, as needed. Review of the facility's policy titled, Facility Responsibilities, dated 01/2024, revealed the resident had a right to a dignified existence, self-determination, and communication and access to persons and services inside and outside the facility. Review of R54's admission Record revealed the facility admitted the resident on 02/20/2024 with diagnoses including acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and age-related cognitive decline. Review of R54's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 03/07/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, which indicated the resident was cognitively intact. Observation on 08/04/2025 at 4:29 PM revealed R54 lying in bed in her room. Further observation revealed R54's call light was located on the floor on the right side of the bed and out of the resident's reach. During an interview with State Registered Nurse Aide (SRNA) 10 on 08/07/2025 at 10:53 AM, he stated call lights were always placed within a resident's reach, and the resident should be aware of the call light's location. SRNA10 further stated it was important residents were able to always reach the call light, so they could contact staff when they needed help. During an interview with SRNA7 on 08/08/2025 at 8:55 AM, she stated the facility's call light policy was to answer lights as soon as possible, even if the resident was not assigned to that staff member. SRNA7 further stated she ensured the call light was within a resident's reach before she left a room, and it should not be located on the floor. SRNA7 stated if a resident needed help or had an emergency, they could not call for help if their call light was on the floor. During an interview with SRNA18 on 08/08/2025 at 9:01 AM, she stated call lights and television remotes were placed within a resident's reach before she left a room. She stated it was important for residents to be able to reach staff if they required assistance. During an interview with SRNA19 on 08/08/2025 at 9:08 AM, she stated call lights were answered as soon as possible so residents' needs were addressed. SRNA19 stated call lights were located within a resident's reach and never on the floor. She further stated residents depended on their call lights as a form of communication so staff could be reached when needed. During an interview on 08/08/2025 at 9:35 AM, Registered Nurse (RN) 3 stated she rounded on residents in between SRNA rounds. She further stated she expected residents' call lights were always accessible. RN3 stated it was important residents were able to reach their call light when they needed staff assistance. During an interview on 08/08/2025 at 10:04 AM, the Assistant Director of Nursing (ADON) stated it was her expectation residents were able to always reach their call light, so residents had access to staff when needed. During an interview on 08/08/2025 at 10:56 AM, the North Unit Manager (UM) stated it was her expectation that residents' call lights were in their reach always and/or pinned to their clothing or bed linens. The North UM stated it was important staff ensured call lights were in reach, so resident needs were met when they required assistance. During an interview on 08/08/2025 at 11:08 AM with the Director of Nursing (DON) and the Administrative Assistant, the DON stated the purpose of the call light was so residents had access to staff when they needed assistance, and it was her expectation a resident's call light was always within their reach and not located on the floor.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview, record review, and review of the facility's policy, the facility failed to provide documentation they notified the resident and/or the resident's representative in writing of the reason for the transfer/discharge to the hospital or of the facility's bed hold policy, including reserve bed payment. Additionally, the facility failed to notify or send a copy of the notice to the ombudsman for 3 of 4 sampled residents, Resident (R) 9, R37 and R54. The findings include:Review of the facility's policy titled, Transfer and Discharge from the Facility, dated 01/2024, revealed the resident and representative would receive timely notification, adequate preparation, orientation, and information about the transfer as orderly and safely as possible, and the notice contained information about the transfer and information about the resident's right to appeal. Further review revealed the facility forwarded a copy of all discharge notices to the Office of the State Long-Term Care Ombudsman and required state agencies. Additional review revealed the facility must notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood. Review of R9's, R54's, and R37's electronic health record (EHR), on 08/06/2025, revealed there was no documentation in the residents' EHR that the facility notified the residents and/or the residents' representatives of the reason for the transfer/discharge to the hospital or of the facility's bed hold policy, including reserve bed payment. Additionally, the facility failed to notify the residents and/or the residents' representatives in writing of the reason for the transfer/discharge to the hospital or send a copy of the notice to the ombudsman. 1. Review of R9's admission Record revealed the facility admitted the resident on 08/16/2024 with diagnoses including Parkinson's disease, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF).Review of R9's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 07/29/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 11 out of 15, indicating the resident was moderately cognitively impaired. Review of R9's, Progress Note, dated 07/31/2025, revealed the resident was sent to an outside hospital for evaluation following complaints of abdominal pain on that date.2. Review of R54's admission Record revealed the facility admitted the resident on 02/20/2024 with diagnoses including acute and chronic respiratory failure with hypoxia, COPD, and age-related cognitive decline. Review of R54's quarterly MDS, with an ARD of 03/07/2025, revealed the facility assessed the resident to have a BIMS score of 14 out of 15, which indicated the resident was cognitively intact. Review of R54's Progress Note, dated 05/17/2025, revealed the resident was sent out to the hospital due to altered mental status and decreased urine output on that date. 3. Review of R37's admission Record revealed the facility admitted the resident on 09/09/2022 with diagnoses including hemiplegia and hemiparesis following a cerebral infarction, dementia, and pneumonia. Review of R37's significant change in status MDS, with an ARD of 05/20/2025, revealed the facility assessed the resident to have a BIMS score of eight out of 15, which indicated the resident was moderately cognitively impaired.Review of R37's Progress Note, dated 05/06/2025 at 4:27 AM, revealed R37 was sent out by emergency services for a possible stroke. According to the progress note, the nurse assessed the resident and found her to have droop to the left side and slurred speech. Per the progress note, the nurse gave report to the local emergency department. Review of R37's Progress Note, dated 05/17/2025, revealed the resident was sent to the hospital due to altered mental status and decreased urine output on that date. During a telephone interview with R37's legal guardian on 08/07/2025 at 1:10 PM, she stated she was assigned to the resident on 07/31/2025. She stated the resident's files indicated that R37 had been hospitalized ; however, she could not confirm whether the communication regarding this was written or verbal. The guardian also stated there was an after-hours hotline available where messages could be left, but the guardian's office and ombudsman required written documentation. She stated to her knowledge, the state guardian's office had not received any written notification, bed hold, or reason (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for R37's transfer from the facility. During an interview on 08/07/2025 at 10:28 AM with the Administrative Assistant (AA), he stated bed hold information was provided to the resident and the resident's representative in the admission packet. The AA stated when a resident was sent to the hospital, their representative was notified the following day via telephone, the bed hold was discussed, and the representative was mailed a copy of the bed hold information. He further stated he thought the transfer/discharge summary information was part of the bed hold form. During an interview on 08/07/2025 at 3:32 PM, Licensed Practical Nurse (LPN) 12 stated the nurses filled out the transfer/discharge information that went with the resident when they were transferred or discharged to the hospital, and their representative was notified by telephone. During an interview on 08/08/2025 at 9:35 AM, Registered Nurse (RN) 3 stated the resident was given a copy of the transfer/discharge summary at the time of their transfer or discharge. She stated transfer/discharge information went with the resident to the hospital and included a Situation, Background, Assessment, Recommendation (SBAR) form, a demographics sheet, medication list, advance directive, pertinent progress notes or labs, and a medication administration record (MAR). During a follow-up interview with the AA on 08/08/2025 at 11:48 AM, he initially stated that both the discharge/transfer and bed hold information was mailed out to the resident's representative. The AA stated family was notified by phone that day or the following morning and asked about the bed hold, and the bed hold information was mailed to the representative. When asked again about the discharge/transfer summary, the AA stated he was uncertain about the discharge/transfer summary, and the Director of Nursing (DON) should be contacted for that information. On 08/08/2025 at 12:09 PM, the State Survey Agency (SSA) Surveyor requested proof from the DON that the facility sent written notification to the resident, resident's representative, and the ombudsman when a resident was transferred or discharged ; that information was not received.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Premier Nursing & Rehab	2770 Palumbo Drive Lexington, KY 40509

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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. Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 24 sampled residents, Resident (R) 76.R76 was prescribed scheduled narcotics for pain but did not have a care plan developed for effective pain management. The facility failed to create a care plan to address the resident's chronic pain with assessment-based goals and interventions.The findings include:Review of the facility's policy titled, Care Plan Process, revised 09/2019, revealed the facility was to develop and implement a comprehensive person-centered care plan for each resident to meet the needs as identified in the comprehensive assessment to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Review of R76's admission Record, found in R76's electronic health record (EHR), revealed the facility admitted the resident on 08/22/2022 with diagnoses to include unspecified dementia, severe, with other behavioral disturbance; chronic obstructive pulmonary disease (COPD); and dysphagia following cerebral infarction. Review of R76's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/30/2025, revealed the resident was not assessed by the facility for the Brief Interview for Mental Status [BIMS] due to issues with both long and short-term memory, as well as difficulties in being understood.Review of R76's Comprehensive Care Plan [CCP], revised 06/24/2025, and found in the resident's EHR, revealed the facility did not care plan the resident for pain based on her assessment to address the resident's chronic pain, including goals and interventions for pain management.Review of R76's Pain Evaluation, dated 07/09/2025, and found in the resident's EHR, revealed the resident expressed pain non-verbally. R76's pain was rated as hurts even more on the Wong-Baker Faces Pain Rating Scale. The assessment noted several nonverbal indicators of pain, including moaning and grimacing facial expressions. It was assessed that the resident's pain increased with movement during care and dressing changes. According to the evaluation, pain medications effectively relieved the discomfort. Per the evaluation, the current pain management regimen included narcotics, and the plan of care indicated that satisfactory pain management was achieved with narcotics.Review of R76's Physician Orders, found in the resident's EHR, revealed an order, dated 04/25/2025, instructing staff to observe the resident for any signs or complaints of pain. According to this order, all instances of pain must be addressed with appropriate interventions, and any uncontrolled pain should be reported to the physician during each shift. Additionally, there was an order, dated 08/05/2025, for oxycodone (narcotic pain reliever) 10 milligrams (mg) to be given four times a day for pain. Furthermore, R76's orders included an order, dated 04/24/2025, for acetaminophen (pain reliever) 500 mg tablet, give two tablets by mouth two times a day for pain. R76 was also prescribed acetaminophen 325 mg, to be taken as two tablets by mouth every four hours as needed for pain relief.Review of R76's Medication Administration Record [MAR], for 08/05/2025, found in the resident's EHR, revealed R76 received one oxycodone 10 mg and two tramadol (pain reliever) 50 mg tablets at 8:00 AM, as ordered. Further review of the MAR and narcotic count sheets revealed the resident received her medications as ordered. Observation of R76 on 08/05/2025 at 9:15 AM revealed she was lying in bed in her room. R76 displayed non-verbal signs of pain, including intermittent crying and moaning. Further observation revealed facial expressions indicative of discomfort; R76 was grimacing and had a furrowed brow. Additionally, she exhibited protective body movements, such as bracing with her arms, and frequently changed her position, moving her head back and forth. R76 was unable to participate in an interview and could not express her needs. There were noticeable signs of discomfort.Observation of R76 on 08/05/2025 at 9:38 AM revealed she was lying in bed in her room, and she continued to cry out and moan. The State Survey Agency (SSA) Surveyor requested that the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit manager check on the resident. Both Licensed Practical Nurse (LPN) 1 and the South Unit Manager (SUM) attended to the resident. During an interview with LPN1 on 08/05/2025 at 9:55 AM, he stated he and the SUM repositioned the resident, and he administered as needed (PRN) pain medication at 9:45 AM. He stated the resident was non-verbal, but staff could ask questions, and R76 would respond by nodding. He stated the resident was assessed as having pain, and she received scheduled and PRN pain medications as ordered. He stated he left a message with the provider to discuss R76's pain.During an interview with the SUM, she stated pain medications were administered to the resident. The SUM also stated the facility had requested that the State Guardian place the resident in Hospice, due to her recent decline. The SUM stated the facility had not heard back from the State Guardian. Resident 76 was non-interviewable due to severe cognitive impairment. During an interview with R76's appointed State Guardian on 08/08/2025 at 10:06 AM, she stated she had recently been assigned to R76. She stated she was not yet familiar with all aspects of the resident's case and was not aware of the request for a Hospice consultation. She stated she would immediately advance the request to the department's nurse navigators for review. She further stated she would call the facility and discuss current plans of care. During an interview with the Director of Nursing (DON) on 08/08/2025 at 10:05 AM, she stated R76 should have a care plan for pain management, as the resident had displayed behaviors indicating discomfort, occasionally crying out or moaning. She stated care plans must be based on the resident's assessment to address chronic pain, including specific goals and interventions for pain management. Furthermore, the DON stated staff should respond to the resident's non-verbal cues and assess for non-pharmacological interventions promptly. She stated it was her expectation that State Registered Nurse Aides (SRNA) inform the nurse about observations indicating pain. She stated nurses needed to assess pain effectively. The DON stated pain medication should be administered as ordered and promptly. During an interview on 08/08/2025 at 10:10 AM with the Administrative Assistant (AA), he stated he had been acting as the interim Administrator for two months. The AA stated it was his expectation that a comprehensive person-centered care plan was developed for each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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 observation, interview, review of the facility's job description, and review of the facility's policy, the facility failed to ensure nursing staff followed the standard of care for medication administration for 1 of 4 sampled residents, Resident (R) 57. Observation on 08/07/2025 revealed the North Unit Nurse Manager prepared medications for R57. She then transferred the cup of pills to Licensed Practical Nurse (LPN) 2, who administered the medications to the resident. The findings include: Review of the facility's policy titled, Medication Administration by Route or Dosage Form, undated, revealed no specific guidelines for more than one nurse administering medications to a single resident. Review of the facility's job description Licensed Practical Nurse (LPN), undated, revealed LPNs were expected to only administer medications personally prepared and did not leave medications at the bedside without an order to do so.Observation of medication administration with the North Unit Manager (UM) on 08/06/2025 at 8:30 AM revealed she prepared 14 medications for R57. R57's assigned staff nurse, LPN2, walked to the storage room twice during this time to obtain a nutrition supplement. After the North Unit UM had placed the pills in the medication cup, she handed it to LPN2, who had returned to the room entrance and immediately administered the medications to the resident, who was sitting just inside the door to the room. During interview with the North Unit UM on 08/06/2025 at 8:41 AM, she stated she would have to check the policy to determine whether one nurse preparing medications to be administered by another nurse was appropriate. During interview with LPN6 on 08/07/2025 at 8:50 AM, she stated it was not the acceptable standard of care to prepare medication and hand it to another staff to give or to administer medications prepared by another nurse. During interview with LPN10 on 08/07/2025 at 10:00 AM, she stated it was never an accepted standard of practice to prepare medications and hand them to someone else to give. She stated it was also unacceptable for staff to give medications they did not prepare because they did not know what was in the cup if they did not prepare the medications. She stated that was not a safe practice.During interview with LPN12 on 08/07/2025 at 10:45 AM, she stated it was not accepted practice to prepare and then hand medications to someone else to give due to safety issues.During a joint interview with the Director of Nursing (DON) and the Administrative Assistant (interim Administrator) on 08/08/2025 at 1:45 PM, the DON stated her expectation was that nursing staff would prepare and administer medications to residents individually and would not hand medications to another staff member to give to a resident. She stated if a nurse received medications prepared by someone else, it was not safe because they would not know if it was the right medication for the right resident. The Administrative Assistant stated his expectation was that staff would follow the facility's policies.

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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, review of the Food and Drug Administration's document, review of the facility's job descriptions, and review of the facility's policy, the facility failed to correctly label opened medications and dispose of expired medications and supplies to prevent resident use for 1 of 3 medication rooms and 3 of 8 medication and treatment carts.Observation of the Rehab Unit Medication Room and Treatment Cart on 08/06/2025 revealed expired medications and supplies available for resident use.Observation of North Unit Medication Cart 3 on 08/07/2025 revealed a vial of insulin with no opened date on the box or the vial and available for resident use.Observation of South Unit Medication Cart 3 on 08/07/2025 revealed an expired inhaler was on the cart and available for resident use.The findings include:The State Survey Agency (SSA) Surveyor made a written request to the Director of Nursing, on 08/06/2025 and 08/07/2025, for the facility's policy on medication storage. A written response was received that medication storage was included as part of the Medication Administration policy. Review of the facility's policy titled, Medication Administration, undated, revealed no details of medication storage requirements.Review of Licensed Practical Nurse (LPN) and Registered Nurse (RN) job descriptions, both undated, revealed job duties included to dispose of drugs appropriately, to check in medications when delivered, to order medications in a timely manner, to restock medication carts, to maintain clean and orderly medication rooms, and to maintain proper storage of medications.Review of the document Food and Drug Administration's Expiration Dates - Questions and Answers, most recent update 01/21/2025, found on the website www.fda.gov, revealed the importance of drug expiration dates was they reflected the time period during which the product had been shown to remain stable, such that it retained strength, quality, and purity when stored in accordance with labeled conditions. Further review revealed the risk of taking an expired medicine or one that might have degraded because it was not stored according to the labeled conditions. Per the document, if a drug had expired or degraded, subsequent review revealed it might not provide the intended benefit because it had a lower strength than intended. Observation of the Rehab Unit Medication Room on 08/06/2025 at 12:40 PM revealed expired medications and supplies as follows: one Biopatch (a wound dressing), expired 3/31/2024; 31 lubricating jelly, 0.9 ounce, expired 10/28/2023; one box of Surgilube lubricant 0.9-ounce, expired June 2023; and nine DermaFoam dressings, 4-inch x 4.25-inch, expired 02/20/2024.Observation of the Rehab Treatment Cart on 08/06/2025 at 1:34 PM revealed Resident (R) 88's 30-gram tube of Santyl ointment for wound care, expired 05/2025; one Hydrocellular Foam Dressing, 6-inch x 6-inch, expired 06/2020; and one nonbordered Mepilex dressing, 8.3-inch x 8.3-inch, expired 04/01/2023.Observation of the North Unit Medication Cart 3 on 08/07/2025 at 3:04 PM revealed an opened vial of Admelog insulin, 100 unit/milliliter, with no opened date on the box or vial.Observation of the South Unit Medication Cart 3 on 08/07/2025 at 3:47 PM revealed one opened Ellipta inhaler, 100/25 micrograms (mcg), with an opened date of 03/17/2025 and noted to discard after six weeks.During an interview with LPN6 on 08/06/2025 at 12:48 PM, she stated the pharmacy consultant audited the medication carts, and nursing staff and Kentucky Medication Aides (KMA) audited at least once per week. She stated medication rooms were audited weekly. She stated it was important to discard items/medications before expiration because they might not be safe and effective. During an interview with LPN11 on 08/07/2025 at 3:17 PM, he stated the pharmacy conducted medication storage audits, and the Unit Manager did audits, but he did not know the frequency.During an interview with the Rehab Unit Manager on 08/06/2025 at 12:51 PM, she stated it was important not to use medications after expiration because they might not be effective. During a joint interview with the Director of Nursing (DON) and the Administrative Assistant (interim Administrator) on 08/08/2025 at 1:45 PM, the DON stated her expectation was that the nursing staff would ensure appropriate labeling with medications, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and discarded medications would be returned to pharmacy or discarded. The Administrative Assistant stated his expectation was that staff would follow the facility's policies.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 bleach germicidal wipe instructions, review of the facility's job descriptions, review of the facility's policies, and review of the Centers for Disease Control and Prevention (CDC) document and signage 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 3 out of 24 sampled residents, Resident (R) 16, R28, and R32. 1. Observation on 08/04/2025 revealed Licensed Practical Nurse (LPN) 2 performed a blood sugar fingerstick for R28, then went to perform a fingerstick on R32. LPN2 failed to follow infection control practices while performing the procedure and failed to put on the appropriate personal protective equipment (PPE) for the resident under EBPs. Further observation revealed LPN2 failed to properly clean and disinfect the blood glucose meter (used to obtain blood sugar results) before storage. 2. Observation on 08/04/2025 revealed R16 was under Contact precautions due to colonization from carbapenem-resistant acinetobacter baumannii ([NAME]). Staff interviews revealed they were unaware of the reasons for the TBP. Further observation on 08/05/2025, revealed staff members entered the room without first donning (putting on) required PPE. The findings include:Review of the CDC's document Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms [MDROs], updated 04/22/2024, revealed due to the increase in MDRO transmission in skilled nursing facilities, EBPs were indicated for nursing home residents. EBPs were an infection control intervention designed to reduce transmission of MDROs, which employed targeted gown and glove use during high contact resident care activities to include: 1) wounds or indwelling medical devices, regardless of MDRO colonization status; and 2) infection or colonization with an MDRO. Review of the CDC's signage on Contact Precautions, undated, revealed everyone must clean their hands before entering and when leaving the room. Additional instructions for providers and staff were to put on gloves and gown before room entry, and discard gloves and gown before room exit, not wearing the same gown and gloves for the care of more than one person. In addition, the signage stated to clean and disinfect reusable equipment before use on another person. Review of the facility's policy titled, Infection Control, revised 09/2021, revealed the facility would plan infection control activities and manage potential outbreaks of disease. Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 01/2024, revealed resident-care equipment, including reusable items and durable medical equipment, would be cleaned and disinfected according to current CDC recommendations for disinfection. Review of the facility's policy titled, Isolation-Categories of Transmission-Based Precautions, revised 01/2024, revealed EBP was an infection control measure that reduced the transmission of resistant organisms by requiring gowns and gloves during high-contact resident care. Additionally, staff would also follow standard precautions for all residents, regardless of infection or colonization status. According to the policy, staff should wear a gown and gloves to provide high-contact resident care. Review of the facility's policy titled, Infection Control Standard Precautions- Handwashing, revised 01/2024, revealed the facility considered hand hygiene the primary means to prevent the spread of infection. Further review revealed all personnel would follow the hand-hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.Review of the MicroKill bleach germicidal wipes instructions, Cleaning and Disinfecting Recommendations, no date, revealed to thoroughly clean the glucometer surface then wrap the glucometer with a bleach wipe, covering all surfaces of the glucometer, and ensure the surface remained wet for the entire contact time. Per the instructions, These wipes are EPA-registered and effectively eliminate Clostridium difficile spores in just 3 minutes and Candida auris in 2 minutes.Review of the Certified Nursing Assistant/State Registered (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Aide (SRNA) job description, undated, revealed aides were expected to conduct proper hand hygiene and use of PPE and sanitize surfaces when needed.Review of the Licensed Practical Nurse (LPN) job description, undated, revealed LPNs were expected to conduct proper hand hygiene and use of PPE and sanitize surfaces when needed. Review of the Registered Nurse (RN) job description, undated, revealed RNs were expected to conduct proper hand hygiene and use of PPE and sanitize surfaces when needed.Review of R16's admission Record found in R16's electronic health record (EHR), revealed the facility admitted the resident on 08/02/2023 with diagnoses to include dementia, dysphagia, and [NAME].Review of R16's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/29/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of eight out of 15, indicating the resident was moderately cognitively impaired.Review of R28's admission Record found in R28's EHR, revealed the facility admitted the resident on 07/11/2024 with diagnoses to include type 2 diabetes, cancer, and neurogenic bladder. Review of R28's quarterly MDS, with an ARD of 04/16/2025, revealed the facility assessed the resident to have a BIMS score of 10 out of 15, indicating the resident was moderately cognitively impaired.Review of R32's admission Record found in R32's EHR, revealed the facility admitted the resident on 10/31/2024 with diagnoses to include congestive heart failure, type 2 diabetes, and convulsions.Review of R32's quarterly MDS, with an ARD of 06/26/2025, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating the resident was cognitively intact. 1. Observation of LPN2 on 08/04/2025 at 6:25 AM revealed he performed a blood sugar fingerstick for R28. LPN2 entered the room and did not don the appropriate PPE for R28 who was in EBP. Furthermore, LPN2 did not perform hand-hygiene prior to entering the room. LPN2 then came out of the room holding a contaminated glucometer. He then entered R32's room with the glucometer in his hand and without performing hand-hygiene. LPN2 then exited R32's room and went back to the medication cart, where he placed the contaminated glucometer down without a barrier cloth. When asked by the State Survey Agency (SSA) Surveyor what the facility policy was regarding the cleaning and disinfection of shared equipment, he pulled out disinfectant wipes and wiped the glucometer for 15 seconds and placed it back down on the medication cart without a barrier.During an interview with LPN2 on 08/04/2025 at 6:36 AM, he stated glucometers were cleaned after each use to prevent the spread of blood-borne pathogens. He further stated he should have performed hand-hygiene before and after providing R28's care. Additionally, he stated he should have worn the appropriate personal protective equipment (PPE) when providing direct care to a resident under enhanced-barrier precautions (EBP). Further discussion with LPN2 revealed he was unable to articulate what dwell-time meant or the required dwell-time for the disinfecting wipes he used to clean the glucometer. During an interview with R28 on 08/04/2025 at 7:06 AM, he stated staff rarely put on a gown or gloves to provide his care. He stated he did not want to make waves so he did not say anything when staff failed to follow infection control procedures such as washing their hands or putting on a gown and gloves.During an interview with the North Unit Manager on 08/04/2025 at 10:25 AM, she stated staff should follow CDC guidance for residents under EBP if they provided direct care to the resident. She stated PPE for EBP rooms were inside the room. She stated hand-hygiene was done when entering and exiting a resident's room. She stated nursing staff should follow the disinfecting wipes manufacturer's instructions for proper cleaning and disinfection of all shared equipment. She further stated it was her expectation that all staff followed facility polices to prevent the spread of disease and infection. 2. Observation of R16's room on 08/04/2025 at approximately 3:45 PM revealed the resident was placed under Contact isolation precautions. CDC signage on the door provided detailed instructions for staff regarding appropriate PPE, supplies, and the necessary actions while providing care to R16. During an interview with SRNA1 on 08/04/2025 at 4:05 PM, she stated she did not know the source of R16's infection. She stated she did not receive that information in shift report. Additionally, SRNA1 stated staff entered R16's room without donning the appropriate PPE. Observation of R16's room on 08/05/2025 at 8:47 AM revealed Housekeeping 1 entered the room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and did not don (put on) gloves or gowns. During an immediate interview with Housekeeping 1, she stated she had not been trained to don gloves and a gown when entering R16's room, and she did not know anything about precautions for R16. During an interview with SRNA15 on 08/07/2025 at 8:30 AM, she was able to explain when hand hygiene was necessary, such as when entering and exiting resident rooms, and when it was required to wash with soap and water. SRNA15 stated she followed the guidelines for PPE use for contact precautions based on the instructions posted on the signage at the resident's doors. Additionally, the SRNA stated she understood the importance of following EBP as indicated by the signage, particularly for residents who had a catheter or a feeding tube.During an interview with SRNA16 on 08/07/2025 at 8:35 AM, she stated the importance of hand hygiene when entering and exiting resident rooms, as well as when passing out meal trays. SRNA16 stated staff was to wash hands with soap and water after providing personal care or if hands became soiled for any reason. Additionally, she stated that residents with any type of TBP isolation had signage indicating the appropriate PPE required, and staff should strictly adhere to these guidelines.During an interview with LPN12 on 08/07/2025 at 10:15 AM, she stated she was R16's assigned nurse. She stated she believed R16's isolation was due to having a catheter port. However, LPN12 was unsure why that would require contact precautions. According to LPN12, contact precautions required staff to wear gowns and gloves, but she was uncertain about EBPs related to R16's isolation precautions. LPN12 stated she did not receive information about the resident's isolation precautions during the shift report.During an interview with the South Unit Manager on 08/07/2025 at 10:25 AM, she stated the reason for R16's isolation was due to [NAME] colonization, which was a multi-drug resistant organism. She stated staff was educated regarding isolation precautions and updated daily in report. During an interview with the Infection Preventionist (IP) on 08/07/2025 at 2:06 PM, she stated the facility provided generalized education related to isolation precautions. She stated staff received infection prevention and control training upon hire and periodically thereafter. The IP stated it was important for staff to know about the resident's condition. She stated her expectation was for staff to follow the posted CDC signage. She stated all staff should follow the facility's policies and procedures related to infection control to provide a safe and healthy environment for residents, staff, and visitors. She stated staff was trained to clean and disinfect all shared equipment between residents. She stated nurses were educated on the proper cleaning and disinfection process for shared glucometers to prevent the spread of blood-borne pathogens. Additionally, she stated it was her expectation that all nurses cleaned, disinfected, and stored shared glucometers according to the manufacturer's instructions. She stated the dwell time for MicroKill germicidal bleach wipes was three minutes. She stated the glucometer must remain wet for the full three minutes to ensure complete disinfection, and after cleaning and disinfection, the glucometer should be stored in a container to keep it clean.During an interview with the Director of Nursing (DON) on 08/05/2025 at 9:00 AM, she stated R16 had been under Contact precautions since staff learned, after admission, he was colonized with [NAME]. She stated it was her expectation that staff members who cared for a resident understood the type of infection the resident had and the reasons for enhanced or transmission-based precautions.During an additional interview with the DON on 08/08/2025 at 10:05 AM, she stated the facility followed the recommendations of the CDC for isolation precautions and for shared equipment cleaning and disinfection. She stated her expectation was for staff to adhere to posted signage when entering an EBP or TBP isolation room. Additionally, the DON stated it was her expectation that staff cleaned and disinfected shared equipment according to the facility's policy and manufacturer's guidelines. The DON stated it was important to follow infection prevention and control guidelines and policies to prevent the spread of infection and disease to residents, staff, and visitors. During an interview with the Administrative Assistant (AA) on 08/08/2025 at 10:10 AM, he stated he had been acting as the interim Administrator for two months. The AA stated it was his expectation that staff adhered to the facility's policies related to infection control. He stated that was important to ensure the safety and health of the residents.