STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185467	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cardinal Hill Skilled Rehabilitation Unit	2050 Versailles Road Lexington, KY 40504

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, review of a document from the Food Safety and Inspection Service of the United States Department of Agriculture, and review of the facility's policy, the facility failed to prepare, store, and serve food under sanitary conditions. Observations on 08/12/2025 and 08/13/2025 revealed incorrect storage of equipment, food items not labeled or dated, and food temperatures taken incorrectly.The findings include:Review of the facility's policy titled, Food Storage, last review date 09/23/2024, revealed all food would be clearly labeled for identification. Review of a document from the Food Safety and Inspection Service of the United States Department of Agriculture Using a Food Thermometer, updated 03/21/2025, revealed the food thermometer should be placed in the thickest part of the food, away from bone, fat, or gristle; for thin foods, the food thermometer should be inserted through the side until it reached the center of the food. Observation on 08/12/2025 at 11:00 AM revealed fry pans and pots turned up and an opened bin of scoops on the bottom shelf of the equipment stand turned up and not turned down. Observation of the kitchen area on 08/12/2025 at 11:05 AM revealed a large colander, mixing bowl, and a steam table pan turned up on the bottom shelf in the production area. Also, two hand sifters were opened on both ends, under the same production table with no covering. Further observation revealed commonly used food products stored on a shelf with a clear lid canister which had no date or label and other food products wrapped up in plastic with no date or identification visible. Observation on 08/12/2025 at 4:19 PM revealed the hand sink behind the production area had a cleaning cloth left in the sink. Staff could have deposited the used cleaning cloth into the soiled barrel located two to three feet from the hand sink behind a short divider wall.Observation on 08/12/2025 at 4:23 PM of [NAME] 1 revealed he opened the convection oven doors and pushed the thermometer through the foil on the pan.In an interview with [NAME] 1 on 08/13/2025 at 2:50 PM, he demonstrated how he took temperatures of food by placing the thermometer through the lid of macaroni with cheese. He stated he had not been instructed not to put the thermometer through the lid or foil. In an interview with the Services Manager and General Manager of Food and Nutrition on 08/14/2025 at 1:07 PM, the Manager stated the facility's expectations were for the equipment not to be turned up to prevent the collection of dust and debris; all foods to be labeled and dated; all cleaning cloths to be properly stored after use or placed into the soiled barrel; and staff to use the food thermometer correctly. In an interview with the Director of Nursing (DON) of the Skilled Unit on 08/14/2025 at 2:25 PM, she stated she would address the areas of concern on the plan of correction.In an interview with the Administrator of the Skilled Unit on 08/14/2025 at 2:31 PM, he stated his expectation was for staff to provide nutrition to residents with safe, quality foods.

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 - Some	Provide and implement an infection prevention and control program. Based on observation, interview, review of the Centers for Disease Control and Prevention's (CDC) Enhanced Barrier Precautions poster, review of the manufacturer's directions for use, and review of the facility's policy and procedure, the facility failed to maintain infection control for 7 of 17 residents sampled for infection control by not wearing appropriate personal protective equipment (PPE) for residents on Enhanced Barrier Precautions (EBP), Resident (R) 75 and R76, and by not properly disinfecting glucometers (used to measure blood sugar from finger sticks) or following infection control guidelines when performing finger sticks for R46, R73, R76, R77, and R78. Observation on 08/13/2025 revealed Registered Nurse (RN) 2 performed wound care on R75's right foot. She wore only gloves, no gown. Observation on 08/13/2025 revealed State Registered Nurse Aide (SRNA) 1 assisted R76, who was on EBP, in pulling up her brief. She wore only gloves, no gown. Observations on 08/13/2025 and 08/14/2025 revealed the glucometer case and/or glucometer for R46, R73, R76, R77, and R78 was placed in an unclean spot prior to each glucose check. Further, the glucometer was not cleaned according to the facility's policy and manufacturer's instructions.Observations on 08/13/2025 and 08/14/2025 revealed glucometer strips were stored in staff's pockets, and a shared rolling cart with glucometer supplies was taken in residents' rooms.The findings include:Review of the facility's procedure guide titled, Enhanced Barrier Precautions (EBP), dated 2024, revealed, for patients with infection/colonization with a Centers for Disease Control and Prevention (CDC)-targeted multidrug resistant organism, providers and staff must wear gloves and a gown for the following high-contact resident care activities: changing briefs or assisting with toileting and wound care for any skin opening requiring a dressing. Review of the CDC's Enhanced Barrier Precautions poster (signage), undated, revealed all persons must clean their hands before entering and when leaving the room. Further review revealed providers and staff must also wear gloves and a gown for the following high-contact resident care activities, which included: dressing, bathing/showering, transferring, changing linens, providing hygiene, and changing briefs or assisting with toileting. The poster also stated other high-contact activities were device care or use, such as a central line, urinary catheter, and tracheostomy; and wound care for any skin opening requiring a dressing. Further review revealed the poster stated not to wear the same gown and gloves for the care of more than one person.Review of the facility's policy titled, Disinfection and Sterilization, effective date 03/26/2025, revealed cleaning of semi-critical equipment should be done at the point of use immediately after each procedure to prevent drying of excretions, secretions, or blood on the instrument. Per the policy, disinfectant wipes must remain on surface areas for a specified period to be effective. The policy stated this time was two minutes for purple top germicidal wipes and four minutes for orange top bleach wipes but refer to the label. Per the policy, all equipment must be disinfected prior to use, between patients, and after use. Review of the facility's glucometer manufacturer's cleaning instructions, undated, revealed to wipe to clean by gently wiping the outside of the meter and carefully wipe around the test strip port area, making sure no liquid entered the test strip port and then wipe dry with a tissue. Then, the cleaning instructions stated to dry the meter thoroughly with a dry cloth or gauze, and ensure the meter was thoroughly dried after cleaning. Review of the facility's glucometer manufacturer's disinfecting instructions, undated, revealed to gently wipe the outside of the meter three times horizontally and three times vertically, and carefully wipe around the test strip port area. Per the disinfecting instructions, allow the surface of the meter to remain damp with the recommended disinfecting solution, and the meter surface should stay moist for the entire contact time. Review of the purple top Super Sani-Cloth Germicidal Disposable Wipes, undated, revealed the contact time was two minutes. 1. a. Observation on 08/13/2025 at 4:14 PM revealed Registered Nurse (RN) 2 removed the dressing on R75's right foot, while wearing only gloves and no gown. Further observation revealed at 4:19 PM, RN2 cleaned R75's wound while wearing only gloves and no gown.In an interview with RN2 immediately after the observation, she stated she forgot (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to put on a gown.b. Observation on 08/13/2025 at 4:39 PM revealed State Registered Nurse Aide (SRNA) 1 assisted R76, who was on EBP, to the toilet wearing only gloves. She assisted R76 in pulling up her brief.During interview with SRNA1 immediately after the observation, she stated she was nervous and did not think to put on a gown.2. a. Observation on 08/13/2025 at 4:47 PM revealed SRNA1 prepared to check R77's glucose. She placed the glucometer case on top of the dirty linen cart and then placed a glucometer on R77's bedside table, without using a barrier. She held the glucometer with her right hand against her front and reached into her left pocket. She pulled out a blue glove with wipes inside. She wiped the glucometer from 4:51:22 PM to 4:51:42 PM, 20 seconds. She then went to the glucometer case on top of the dirty linen cart. She opened the case and pulled out another glucometer. She put the used glucometer in the case and placed the wipe on top of the glucometer. The wipe did not cover the whole top of the glucometer. During interview with SRNA1 at the time of the observation, she stated the wipes came from the purple top container. She then left the room.b. Observation on 08/13/2025 at 4:56 PM revealed SRNA1 prepared to check R76's glucose. She checked the glucose and placed the glucometer on R76's abdomen. She then pulled a blue glove with wipes inside from her left pocket. She wiped the glucometer from 4:58:12 PM to 4:58:22 PM, 10 seconds. She then took the glucometer that was in the case out, put the used glucometer in the case, and placed the wipe on top of the glucometer. The wipe did not totally cover the glucometer. She then removed her gloves and washed her hands. c. Observation on 08/13/2025 at 4:58 PM revealed SRNA1 prepared to check R46's glucose. She pulled the glucose strips out of her right pocket; she then placed the glucometer and a single use glucose needle on R46's bed and took out a glucose strip. She did the fingerstick glucose check and pulled a wipe out of her left pocket that was in a blue glove. She wiped the glucometer from 4:59:10 PM to 4:59:25 PM, 15 seconds. She then went to the glucometer case lying on the dirty linen cart. She took the glucometer in the case out and put the used glucometer in the case and covered it with the wipe which did not cover the glucometer. She then removed her gloves and washed her hands.d. Observation on 08/13/2025 at 5:14 PM revealed SRNA1 prepared to check R78's glucose. She placed the glucometer case in the chair next to R78's bed on top of a cloth bag. She removed the glucometer on the top of the case, reached into her right pocket, and removed the glucometer strips. She opened the case and removed an alcohol wipe. She cleaned R78's finger and performed the glucose check. She then removed a wipe from her left pocket that was in a blue glove. She wiped the glucometer from 5:15:15 PM to 5:15:25 PM, 10 seconds. She picked up the other glucometer from the case and put the used glucometer in the case and placed the wipe on top of the glucometer. She closed the case and put the other glucometer on top of the case. She then took off her gloves and washed her hands. She then tossed two of R78's pillows on top of the glucometer case. She assisted R78 up in bed. She picked up the pillows that were on top of the glucometer case and put them under R78's head. She then picked up the glucometer case with the other glucometer on top and went to the nurse's station. She took the blue glove from her left pocket and placed it on the counter next to the sink. She pulled out all the wipes from the blue glove and wiped the glucometer that was on top of the case and put it in the charger. She threw the blue glove and used wipes in the trash. She then took the other glucometer out of the case and put it in the charger. There were three chargers with glucometers. She then removed her gloves and washed her hands. In an interview with SRNA1 on 08/13/2025 at 5:20 PM, she stated she had received education in infection control. The interview was interrupted as documented in the next observation.e. Observation on 08/13/2025 at 5:21 PM revealed RN2 approached SRNA1 in the nurse's station and asked her for the glucometer strips. SRNA1 took the strips out of her right pocket and handed them to RN2. RN2 put the glucometer on top of the rolling cart along with the glucose strips and went into R76's room to check her glucose. However, R76 stated her glucose had already been checked. RN2 then gave R76 two medications and left the room.In the continued conversation with SRNA1 on 08/13/2025 at 5:32 PM, she stated she did not remember what she was taught in infection control. She stated that information was in the computer. She stated when she performed a glucose check, she put on gloves; scanned the resident's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	arm band; wiped the resident's finger with an alcohol pad that she got from the glucometer case; performed the check; removed her gloves; and washed her hands. She stated she kept the wipes in a glove in her pocket because the container was too big to carry.f. Observation on 08/14/2025 at 8:00 AM revealed SRNA6 in the nursing station. SRNA6 stated he was looking for wipes to clean the glucometer. He left the nurse's station and came back with a purple top container of wipes. He put the container of wipes on the counter. He put a container of glucose strips, a single use glucose needle, and an alcohol pad in a cup. He cleaned the glucometer with a purple top wipe. He went outside of R73's room and placed the glucometer on a rail outside the room with the cup on top of the meter. He put on a gown, sanitized his hands, and put on gloves. He then picked up the glucometer and cup and went into the room. He placed the glucometer on R73's bedside table touching her belongings on the table. He also placed the glucose strips on the table. He performed the glucose check and put the glucometer and the cup with the strips inside on top of the dirty linen cart. He removed his gown, gloves, and washed his hands. He picked up the glucometer from the top of the dirty linen cart and left the room holding the cup in one hand and the glucometer against his chest. In an interview with SRNA6 immediately after the glucose check, he stated he usually worked downstairs, but often floated to different units, and he had been at the facility about two years. He stated he was last trained in infection control about one month ago. He stated he was taught about the purple wipes, to clean the machine after each use with purple wipes and to let the meter stay wet for two minutes. He stated he should have but did not time the meter when he wiped it this morning. He stated the importance of cleaning the meter was to make sure infections were not transmitted. He stated he was not taught to put a paper towel down on a surface prior to placing the glucometer on a surface. g. Observation on 08/14/2025 at 11:57 AM revealed SRNA1 put on Personal Protective Equipment (PPE) and went into R77's room. She rolled a cart containing glucose supplies into the room. She picked up the glucometer and scanned R77's arm band. She performed the glucose check. She placed the glucometer on the top of the cart, removed her PPE, and washed her hands. She put on gloves and took a wipe out from a purple top container which was on the bottom of the cart. She then opened a 4 x 4 gauze pad and placed it on top of the cart. She used the wipe on the glucometer for 30 seconds, dried the glucometer with the gauze pad, and put the glucometer on top of the cart, resting on a clipboard. She then cleaned the left side of the cart. She did not disinfect the glucometer.h. Observation on 08/14/2025 at 12:07 PM revealed SRNA1 prepared to check R76's glucose. She pushed the cart with the supplies into R76's room. She performed the glucose check and placed the glucometer on the clipboard on top of the cart. She removed her gloves and washed her hands. She cleaned the glucometer for 22 seconds and then wiped it with a 4 x 4 gauze pad and placed it on top of the cart. She did not disinfect the glucometer.i. Observation on 08/14/2025 at 12:15 PM revealed SRNA1 prepared to check R46's (R76's roommate) glucose. After checking the glucose, she placed the glucometer on top of the cart with the edge touching the clipboard. She washed her hands and put on clean gloves. She got a wipe from the purple top container and wiped the glucometer for 30 seconds. She then placed the glucometer on top of the cart. In an additional interview with SRNA1 immediately after the observation, she stated she was taught to clean the glucometer and let it sit for two minutes. She stated sometimes she got lax, and she was told she could not get lax in infection control. She stated she made mistakes. She stated she was nervous yesterday, but she felt better today because she was able to use the cart. In an interview with the Hospital Clinical Educator on 08/14/2025 at 10:05 AM, she stated staff was trained in orientation on EBP, and all types of infection control precautions. She stated training was based on the Centers for Medicare and Medicaid Services (CMS) guidelines and was done in orientation and annually. She stated the clinical education on EBP included everything on the EBP poster, placed on EBP residents' doors. Concerning glucometer cleaning and disinfection, she stated the training did not go into details on how to time while cleaning/disinfecting the glucometers. She stated staff was taught to clean/disinfect the glucometers for two minutes using the purple top wipes. In an interview with the Infection (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Preventionist (IP) on 08/14/2025 at 10:12 AM, she stated she taught staff on EBP in orientation. She stated she explained that EBP was a little different than Transmission Based Precautions. She stated staff was taught to wear gown and gloves and perform hand hygiene prior to caring for a resident in EBP. She stated staff was trained in orientation and annually. She stated she performed environment of care rounds to make sure staff was wearing the appropriate PPE when going into EBP rooms. She stated she was not sure if there had been any audits. She stated she taught staff to clean the glucometers before and after each resident with the purple top wipes. She stated, after a glucometer check, staff was taught to turn off the meter, place it on a flat surface to clean, wring out excess cleaning solution, and dry thoroughly after cleaning. She stated staff was then taught to disinfect the glucometer by wiping all sides three times and the glucometer must stay wet for two minutes. She stated staff was then to dry it prior to putting the glucometer on the charging base. She stated she also included observing that on environment of care rounds to make sure staff was cleaning/disinfecting the glucometers correctly, and she was not sure if there had been any audits. She further stated staff was not trained to place a barrier down prior to putting the glucometer on a flat surface.In an interview with the Director of Nursing (DON) on 08/14/2025 at 9:29 AM, she stated she had been at the facility about one year. She stated she was trained in infection control on the computer. She stated she expected staff to wear the appropriate PPE when assisting residents who were on EBP. She further stated staff should clean/disinfect the glucometers for two minutes between each resident. She stated she expected staff to wipe the whole glucometer and then use another wipe to clean it again on all surfaces. She stated she would look at the training to see if staff was taught how to time the glucometers. She stated she monitored to assure staff was doing that by checking the glucometers to make sure they were clean with no blood. She stated there was no regular audit to observe staff cleaning/disinfecting glucometers.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to report misappropriation within 24 hours for 1 of 2 sampled residents investigated for misappropriation, Resident (R) 74.It was reported on 11/09/2024 at 7:05 PM per e-mail to the Director of Nursing (DON) and the Administrator that R74 reported missing money from his wallet. However, the Administrator did not report the incident to the required entities until 11/11/2024. The findings include:Review of the facility's policy titled, Allegations of Abuse/Neglect, effective date 06/11/2025, revealed all alleged incidents involving mistreatment, neglect, or abuse including injuries of unknown origin and misappropriation of resident's property would be reported immediately to the facility Administration, and appropriate state agencies would be notified by the facility's Administration within two hours.Review of R74's admission Record revealed the facility initially admitted the resident on 09/21/2024 with diagnoses which included atrial fibrillation, osteoarthritis, and congestive heart failure. He was admitted to the hospital on [DATE] for altered mental status and shortness of air. Per the record, the facility readmitted R74 on 10/31/2024.Review of R74's admission Minimum Data Set [MDS], with an Assessment Reference Date of 09/23/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, indicating intact cognition.Review of the Belongings Section, of R74's electronic health record, dated 09/23/2024, revealed no mention of money.Review of the e-mail from Registered Nurse (RN) 1 to the Director of Nursing and the Administrator on 11/09/2024 at 7:05 PM revealed a nurse notified her that R74 reported he was missing money from his wallet. In an interview with R74 on 08/13/2025 at 12:56 PM, he stated he did not remember the details, but he did have money missing from his wallet while he was admitted to the facility. He stated he reported it to the nurse and had not heard anything about the issue.The State Survey Agency (SSA) Surveyor attempted to reach RN1 for a telephone interview on 08/13/2025 and left a voice message for a return call. However, RN1 did not return the call.In an interview with the Director of Nursing (DON) on 08/13/2025 at 1:35 PM, she stated when the facility admitted a resident, the nurse could either enter the resident's belongings in the computer or put the information on a paper list. She stated if the nurse documented the belongings on paper, it was scanned into the resident's chart. The DON further stated when there was misappropriation of property, it should be reported as quickly as possible. However, she stated she did not know the timeframe for the report. She stated she was not part of the on-call process. She stated the Administrator was responsible for reporting any allegation of abuse.In an interview with the Administrator on 08/13/2025 at 2:04 PM, she stated the process for reporting misappropriation of property on the weekends was to report to her as soon as possible. She stated she was not sure what the regulations stated about the time for reporting misappropriation of property, but she thought it was 24 to 48 hours. She stated she reported the incident as soon as she was made aware. She stated she remembered the case and could not validate that anyone took R74's money. She stated she also had all the residents in the area questioned, and no other resident reported missing money.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview, medical record review, and facility policy review, the facility failed to provide education regarding the benefits and potential side effects of pneumococcal immunizations for 1 of 6 residents investigated for pneumococcal vaccines, Resident (R) 44. The findings include:Review of the facility's policy titled, Influenza and Pneumococcal Immunization, last reviewed 12/19/2024, revealed the resident's medical record included documentation that indicated, at a minimum the following: each resident and/or the resident's representative received education regarding the benefits and potential side effects of the pneumococcal immunization.Review of R44's admission Record, in R44's electronic health record (EHR), revealed the facility admitted the resident on 08/02/2025 with diagnoses including anemia, congestive heart failure, and protein-calorie malnutrition. Review of R44's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 08/09/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 12 out of 15, indicating moderate cognitive impairment.Further review of the EHR revealed R44 refused the pneumococcal vaccine, and there was no documentation of education regarding the benefits and potential side effects of the pneumococcal immunization.In an interview with the Infection Preventionist (IP) on 08/14/2025 at 10:12 AM, the IP stated the facility checked the residents on Respiratory Syncytial Virus (RSV), influenza, and Covid-19. However, she stated she did not specifically train the staff to educate the residents on the benefits and risks of the vaccines.