| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185476 | A. Building<br>B. Wing | 11/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Coldspring Transitional Care Center | 300 Plaza Drive<br>Cold Spring, KY 41076 |

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) |
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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on interview, record review, review of the facility's investigation, review of the nursing guidebook of professional standards, review of the Kentucky Board of Nursing (KBN) standards, and review of the facility's policies, the facility failed to ensure nursing services provided met professional standards of practice for 1 out of 12 sampled residents, Resident (R) 1.R1 was administered incorrect medications on 09/10/2025, which caused her to be sent to the hospital for further evaluation on 09/10/2025.Based on review of the facility's plan of correction (PoC) and validation through observation, interviews, and record reviews, the facility had implemented corrective actions with a compliance date of 09/18/2025, before survey entrance. Therefore, the deficient practice was past noncompliance.The findings include: Review of the facility's policy titled, Identification of the Resident Prior to Medication Administration, revised 12/2021, revealed, Prior to administering medication, the nurse/medication aide identifies the recipient of the medication by: asking the resident his/her name, if appropriate with diagnosis. Checking wristband. Comparing resident with picture in EMAR [electronic medication administration record]. If still in doubt, the nurse/medication aide must verify identity by conferring with facility staff member who is familiar with the resident.Review of the facility's policy titled, Administration Oral Medications, revised 11/2024, revealed, The medication name, dosage, and interval are to be read from the medication administration record. The policy also revealed, To assure administration accuracy, the nurse/medication aide cross checks the following reference points: physician's order, Medication administration record [MAR], and label on drug container.Review of the website, www.KBN.ky.gov revealed, Accountability and Responsibility of Nurses in accordance with KRS 314.021(2), nurses are responsible and accountable for making decisions that are based upon the individuals' educational preparation and current clinical competence in nursing and requires licensees to practice nursing with reasonable skill and safety. Nursing practice should be consistent with the Kentucky Nursing Laws, established standards of practice, and be evidence based.Review of Mosby's Safe Medication Administration Guide, undated, from www.elsevier-elibrary.com, revealed, Always adhere to the 5 rights of medication administration when transcribing, preparing, administering, and documenting medications: Right patient, Right drug, Right route, Right dose, and Right time.Review of R1's incident investigation IDT [Interdisciplinary Team] Follow up Note, dated 09/11/2025, revealed the incident was reported and documented on 09/10/2025 at 6:45 AM. The note revealed, On the AM of 09/10/2025 resident received the following medications oxycodone-acetaminophen 5/325 mg [milligrams] one tablet [an opioid pain medication], clonazepam 0.5 mg one tablet [an anti-anxiety medication], nifedipine ER 30 mg one tablet [a cardiac medication], vitamin B12 1000 mcg [micrograms] one tablet, iron 325 mg one tablet, and omeprazole [a medication to reduce stomach acid] 40 mg one capsule. Resident's vitals were checked. Resident with altered mental status. Vital signs 148/90, pulse 62, respirations 20, temp 97.6 axillary, oxygen 88% room air. Oxygen applied, Narcan x 1. O2 sats increased to 96%. MD was notified with orders to send to ER [emergency room] for further eval [evaluation]. Son also notified. Resident was admitted to hospital r/t pneumonia and CHF.Review of R1's Face Sheet revealed the facility admitted R1 on 03/08/2021 with diagnoses which included Alzheimer's disease, chronic pain, anxiety, atrial fibrillation, and hypertension.Review<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of R1's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 07/28/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 13 out of 15, indicating intact cognition.During an interview on 10/21/2025 at 7:07 PM with Registered Nurse (RN) 1, she stated during morning medication administration, she was preparing medications for a different resident, R2, when R1, who was a couple of rooms down the hall, began yelling. She stated simultaneously another resident started yelling, and she went to check on R1 to make sure she was okay. She stated she had already pulled R2's medications and had them in a cup, so she placed them in her medication cart and locked it before walking away. She stated she then went to check on R1 who wanted her shoes on and her morning medications. She stated she helped R1 with her shoes and then gave R2's medications to R1 by mistake, since R1 was ready for her medications. She stated she realized what she had done right away and reported it. She stated she made the Director of Nursing (DON), Physician, and R1's son aware. She stated she obtained baseline vitals, and R1 was not as responsive to her. She stated, because of this, a dose of Narcan was given. She stated she received education, provided by the DON and Administrator. She stated she was observed administering medications correctly prior to her being allowed to return to work and administer medications unsupervised. She stated a plan of action was made to scan every medication. She stated, at the time R1 was yelling, she was safe. Therefore, RN1 stated she should have continued with R2's medication administration since they were already prepared. She also stated she should have made R1 wait until she was finished administering R2's medications.During an interview on 10/22/2025 at 11:21 AM with R1's representative, he stated the facility called him that morning and reported to him they had mistakenly given R1 the wrong medications. He stated they also told him R1 was being sent to the emergency room (ER) for further evaluation and monitoring. He stated he went to the ER, and his mother was tired, but she seemed okay. He stated R1 was very coherent. He stated R1 had never been given the wrong medications before, and he felt safe with R1 remaining in the facility.The facility provided an acceptable plan of correction (PoC) on 10/21/2025 alleging past non-compliance of the deficient practice and a date of compliance of 09/18/2025, with corrective actions as follows:Review of the Quality Assurance and Performance Improvement [QAPI] Plan of Correction [PoC], dated 09/12/2025, revealed the topic reviewed was medication errors. Corrective actions included assessing R1 on 09/10/2025, notifying the DON on 09/10/2025, notifying the physician and R1's son on 09/10/2025, review of R1's medical record, including medications administered on 09/10/2025. The PoC also revealed the DON completed a medication administration check-off and provided immediate education regarding the six rights of medication administration with RN1 on 09/12/2025. The DON completed medication administration audits with each licensed nurse working. The DON completed an audit of all medications carts to ensure medications were not pre-pulled, and there was no evidence of medications not administered per physician order, as well as reviewed the narcotic count sheets to ensure medications were administered as ordered, dated 09/10/2025. Head to toe assessments, including vital signs, were completed on all residents on the 2100 and 2400 Halls on 09/10/2025.Further review of the QAPI PoC, dated 09/12/2025, revealed measures to be put into place to ensure deficient practice did not recur included additional in-service education would be given to all licensed nurses by the DON by 09/12/2025. This would be monitored by a PI [Performance Improvement] Audit Worksheet, completed by the DON to verify residents' medications were administered per physician's orders. The PI was being completed by the DON daily for seven days, twice weekly for two weeks, weekly for two weeks, and then monthly. The results would be reviewed by the QAPI team. The Lifelong Learning Attendance Sheet revealed medication error education was given to all licensed nurses and medication aides to include medication policies; ensure medications were administered according to physician's orders; prepare only one resident's medications at a time and as soon as they were prepared; and administer medications according to the six rights (right resident, right medication, right dose, right time, right route, right documentation). Fifty-one signatures were on the sign-in sheet. The Medication Administration Observation revealed<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the DON observed RN1 administer 26 medications to a total of 13 different residents with zero errors on 09/12/2025. Review of the Quality/Continuity of Care PI Worksheet revealed audits were done on 09/12/2025, 09/13/2025, 09/14/2025, 09/15/2025, 09/16/2025, 09/17/2025, 09/18/2025, 09/19/2025, 09/20/2025, 09/21/2025, 09/25/2025, 09/26/2025, 09/30/2025, 10/01/2025, 10/03/2025, 10/04/2025, 10/07/2025, 10/10/2025, 10/17/2025, 10/18/2025, and 10/21/2025.The State Survey Agency (SSA) validated the facility's PoC for past noncompliance which determined the facility had corrected the deficient practice for F658 on 09/18/2025 as alleged.Record review of R1's incident report, internal investigation, and the medication administration record (MAR) revealed R1 was immediately assessed post incident by RN1, who noted altered mental status. RN1 notified all appropriate staff members as well as R1's son.The records of nine additional residents identified as potentially at risk to be affected were reviewed, R2, R3, R4, R6, R7, R8, R9, R10, and R11. This review identified no deficiencies.Observation of all eight medications carts on 10/21/2025, revealed no pre-pulled medications.During an interview on 10/21/2025 at 1:50 PM with Licensed Practical Nurse (LPN) 7, she stated she was new to the facility and had received education regarding medication administration and storage. She stated she had not had any errors to her knowledge, but if she discovered one, she was to access the resident, document the incident, and notify leadership.During an interview on 10/21/2025 at 3:27 PM with LPN1, he stated medications were in blister packs from the pharmacy and were never prepared for medication administration then placed in the cart. He stated he identified residents by scanning their bracelets, if they were wearing one, or by the picture in the facility's system. He stated he had received medication error education recently, and it was provided by the DON.During an interview on 10/21/2025 at 3:30 PM with Registered Nurse (RN) 2, she stated they were taught not to prepare resident medications and then place them back into the medication carts. She stated she had received education about medication administration recently by the DON.During an interview on 10/21/2025 at 3:31 PM with RN3, she stated medications were never pre-pulled and placed back into the medication carts. During an interview on 10/21/2025 at 3:34 PM with LPN2, he stated medications were administered as they were prepared. He stated he scanned the resident's bracelet to verify it was the correct resident. He stated he had received medication education within the past month. During an interview on 10/21/2025 at 3:37 PM with LPN3, she stated she never pre-pulled medications and had never witnessed that occurring in the facility. During an interview on 10/21/2025 at 3:40 PM with LPN4, he stated he had never pre-pulled medications, and he had received medication education recently. He stated his scanner on his computer was currently broken; however, information technology (IT) was aware. He stated IT was usually fast with fixing their equipment. He stated the other ways he could identify a resident was by their picture or asking another staff member who might be familiar with the resident.During an interview on 10/22/2025 at 9:02 AM with LPN5, she stated she never pre-pulled medications, and she administered medications to one resident at a time. She stated the DON had provided education regarding medication errors. During an interview on 10/22/2025 at 9:19 AM with LPN6, she stated if medications were not administered after being prepared, then staff was to dispose of them. During an interview on 10/22/2025 at 11:00 AM with the DON, she stated she expected all staff who administered medications to follow the facility's policies. She stated that was important for resident safety. She stated if a medication error did occur, she expected to be notified immediately. |