

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185476	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Coldspring Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Plaza Drive 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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure the environment remained free of accident hazards as much as possible for 2 of 37 sampled residents, Resident (R) 54 and R116. Observation of the shared bathroom for R54 and R116 on 06/23/2026 at 11:43 AM revealed a white powdery substance in an unlabeled medication cup sitting on the bathroom sink. The findings include: Review of the facility's policy titled, Fall and Accident Management, revision date 06/2019, revealed the facility would identify patients at risk of falls and other accidents with implementations placed and evaluated to reduce risk of injuries, falls or other accidents. The policy stated the facility would work to identify hazards and risks to decrease the risk of injury. Further review revealed the facility would evaluate, analyze, implement interventions, monitor for effectiveness, and modify when needed. The State Survey Agency (SSA) Surveyor requested from the Director of Nursing (DON) on 06/23/2026 at 4:33 PM a policy for medication administration. However, one was not provided by exit on 06/26/2026. The SSA Surveyor requested from the DON on 06/26/2026 at 11:23 AM any and all additional policies for accidents. She stated the only one was the one already given that was primarily for falls. Observation on 06/23/2026 at 11:43 AM revealed a shared bathroom in the resident room where R54 and R116 resided. In the shared bathroom there was a medication cup (30 milliliters) sitting on the bathroom sink with a white powdery substance inside unlabeled. The SSA Surveyor immediately informed Licensed Practical Nurse (LPN) 2, and she discarded the cup and substance. During an immediate interview with LPN2, she stated she did not know what the substance was or where it came from. She stated R116 had an order for an antifungal powder and that could have been it. She stated she had not left the cup in the bathroom that day or any other day. When asked why the cup should not have been left in the bathroom, she stated because no one knew what it contained, and a resident could eat it and possibly be harmed. 1. Review of R54's admission Record revealed the facility admitted the resident on 06/10/2024 with diagnoses to include multiple sclerosis, heart failure, and high blood pressure. Review of R54's active Order Set did not include any powders or crush medication order. 2. Review of R116's admission Record revealed the facility admitted the resident on 02/03/2025 with diagnoses to include stroke, diabetes, and depression. Review of R116's active Order Set revealed an order placed on 06/22/2026 for tolnaftate antifungal external powder 1% to be applied under breasts and abdominal fold topically every day and night shift for moisture associated skin disorder (MASD) for 14 days. Review of R116's June 2026 Treatment Administration Record [TAR] revealed the antifungal powder had been applied for the day shift dose on 06/23/2026, initialed by LPN2. During an interview with Unit Manager 2 on 06/25/2026 at 3:13 PM, she stated her tasks included managing the floor, helping the nurses when needed, and having huddles with the Nurse Practitioner (NP). She stated she and the staff did daily walk-throughs for safety of the residents and their rooms and addressed issues as (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed. She stated, when asked about the medicine cup found in R54's and R116's shared bathroom, nothing had been found in the bathroom previously, and all the treatment carts and medication carts were locked. She stated her concern was that if a resident found the medicine cup, they could have ingested it, possibly causing harm. She stated her expectation was for staff administering medications to watch the resident take the medicine and apply all topicals. She stated she did not know what was in the cup. During an interview with LPN10 on 06/25/2026 at 6:21 PM, she stated she had provided care to R116 the night of 06/22/2026 and had not noticed any medicine cup sitting in R54's and R116's shared bathroom. She stated she had applied the antifungal powder to R116. She stated any confused resident could have entered that bathroom and ingested what was in the cup. She stated the facility provided training about not leaving medicine at the bedside. During an interview with the DON on 06/25/2026 at 8:45 AM, she stated her tasks included providing oversight of the nursing department, educating staff, and giving monthly in-services. When asked about finding the medication cup with the white powder in the shared bathroom, she stated it should not have happened. She stated she would be concerned about the safety of the residents and others in the building with that sitting out. She stated some of the residents were confused, and they could have gotten the cup and substance and ingested it. The DON stated staff was already doing daily walk-throughs to check all aspects of safety. She stated staff had been educated on not leaving items out, and she had no reports previously of any incidents where that occurred. During an interview with the Administrator on 06/25/2026 at 4:00 PM, he stated he had been the Administrator since 2018, and his tasks included oversight of the facility. He stated he was not clinical and relied on the DON for that side of operations. He stated his concern for having the substance found in the medicine cup in the shared bathroom was that any confused resident could have consumed it, and it could harm them.		