

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2026
NAME OF PROVIDER OR SUPPLIER Willowbrook Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2323 Concrete Road Carlisle, KY 40311	
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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure residents were free from physical restraints, failed to have documented evidence of assessments for the restraints, and failed to document ongoing re-evaluation of the need for the restraints when the use of restraints was indicated, for 3 of 3 sampled residents, Resident (R) 10, R38, and R41. Observations of R10, R38, and R41 on 05/26/2026 and 05/27/2026 revealed the residents sitting in their motorized wheelchairs with a restraint device on the residents. The findings include: Review of the facility's policy titled, Use of Restraints, revised December 2007, revealed restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Physical Restraints were defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual could not remove easily, which restricted freedom of movement or restricted normal access to one's body. The definition of restraint was based on the functional status of the resident and not the device. Per the policy, if the resident could not remove the device in the same way the staff applied it, given the resident's physical condition, and it restricted his/her typical ability to change positions or place, that device was considered a restraint. The policy stated restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or for the prevention of falls. Per the policy, prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. Per the policy, restraints shall only be used upon the written order of a physician after obtaining consent from the resident and/or resident representative. 1. Review of R10's Face Sheet revealed the facility admitted the resident on 09/12/2025 with hemiplegia and hemiparesis following cerebral infraction affecting left non dominant side, unspecified muscle spasm, and unspecified systolic (congestive) heart failure. Review of R10's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 03/09/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating he was cognitively intact. Review of R10's electronic health record (EHR) revealed there were not any assessments or re-evaluations related to restraint devices. Review of R10's Physician Orders revealed there was not an order for a self-releasing seat belt to be worn when the resident was in his motorized wheelchair. Observation on 05/26/2026 at 12:21 PM revealed R10 was sitting in his motorized wheelchair with a seat belt securing him to his motorized wheelchair. During an interview with R10 on 05/26/2026 at 12:23 PM, he stated he had a hard time using his left hand, and it could be difficult for him to remove the self-releasing seat belt on his motorized wheelchair. He stated staff removed the self-releasing seat belt attached to his motorized wheelchair at his request and when he was receiving care. He stated no one checked to see if he could fasten or unfasten his self-releasing seat belt. 2. Review of R41's Face Sheet revealed (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 185489	If continuation sheet Page 1 of 12

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility admitted the resident on 09/15/2025 with non-ST elevation (NSTEMI) myocardial infraction, muscle weakness, and primary osteoarthritis. Review of R41's quarterly MDS, with an ARD of 03/19/2026, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating he was cognitively intact. Review of R41's EHR revealed there were not any assessments or re-evaluations related to restraint devices. Review of R41's Physician Orders revealed there was not an order for a self-releasing seat belt to be worn when the resident was in his motorized wheelchair or the use of gait belts to be worn around his legs. Observation on 05/26/2027 at 12:32 PM revealed R41 was sitting in his motorized wheelchair with a seat belt securing him to his motorized wheelchair. During an interview with R41 on 05/27/2026 at 11:26 AM, he stated he could release the self-releasing seat belt on his chair, but sometimes he forgot how to unsnap the gait belt on his legs. He stated he was at a previous facility with R38 and asked her why she used the gait belt around her legs and feet. He stated R38 told him it helped her to keep her legs from dangling on the chair. He stated using the gait belt around his legs would also help him, and he just started using the gait belt. He stated he had never been assessed by a nurse or doctor for the use of the gait belt. 3. Review of R38's Face Sheet revealed the facility admitted the resident on 08/19/2025 with paraplegia unspecified, pain in left shoulder, and Alzheimer's disease unspecified. Review of R38's quarterly MDS, with an ARD of 02/09/2026, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating she was cognitively intact. Review of R38's EHR revealed there were not any assessments or re-evaluations related to restraint devices. Review of R38's Physician Orders revealed there was not an order for a self-releasing seat belt to be worn when the resident was in her motorized wheelchair or the use of gait belts to be worn around her legs and/or feet. Observation on 05/27/2026 at 10:30 AM, during Resident Council meeting, revealed R38 was sitting in her motorized wheelchair with one secured gait belt wrapped around her legs and one secured gait belt wrapped around both of her feet and the foot pedals of her motorized wheelchair. During an interview with R38 on 05/27/2026 at 11:15 AM, she stated she could remove the gait belt wrapped around her legs. She further stated she could not reach the gait belt strapped around her feet. She stated she started using the gait belts to secure her legs at another facility, and she just carried it over to the current facility. She stated she had never received an assessment or review from the doctor concerning the gait belt being wrapped around her legs and feet. During an interview with the Director of Nursing (DON) on 05/28/2026 at 10:45 AM, she stated the gait belts were not considered physical restraints. She stated she knew why the residents had chosen to wear gait belts, and the facility was not going around tying residents up in their wheelchairs. She also stated there were no assessments completed on the residents for wearing the gait belts around their legs and feet or the self-releasing seat belts on the motorized wheelchairs. She stated residents would need to be assessed by the rehabilitation department and the physician would need to determine the resident was safe to use the gait belts around their legs and feet and the self-releasing seat belt. During an interview with the Administrator on 05/28/2026 at 11:02 AM, he stated he was unsure of and not informed of residents wearing gait belts around their legs and feet or residents not being able to remove self-releasing seat belts on their motorized chairs. He stated he needed to discuss the issue with the DON.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, review of the American Diabetic Association's (ADA) document, review of manufacturer's guidelines, and review of the facility's policy, the facility failed to ensure all medications were stored in a manner that protected them from temperature changes, humidity changes, and exposure to light for 1 of 2 medication rooms, the North Hall medication room. The findings include: Review of the facility's policy titled, Storage of Medications, revised 04/2007, revealed nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Review of the CDC guidance, Storage Best Practices for Refrigerated Vaccines, dated [DATE], revealed vaccines/immunizations were not placed on door shelves or on the floor of the refrigerator because exposure to light could affect vaccine potency. Review of Ozempic's manufacturer prescribing guidelines, Instructions for Use, revised 06/2026, revealed new unused Ozempic pens were stored in the refrigerator between 36 degrees Fahrenheit (F) and 46 degrees F, away from the cooling element, away from heat, and out of the light. Review of the American Diabetes Association's (ADA) document Safe Storage of Insulin, undated, revealed exposure to extreme temperatures caused loss of effectiveness and recommended insulin be kept away from direct heat and out of direct light. Observation on [DATE] at 10:34 AM revealed the refrigerator in the North Hall medication room had one COVID-19 vaccine, one Solostar insulin pen, one Ozempic pen, one insulin glargine pen, and one vial of tuberculin (TB) serum all stored in the door of the refrigerator. During an interview with Kentucky Medication Aide (KMA) 1 on [DATE] at 3:30 PM, she stated medications were typically delivered to the facility from pharmacy in the evenings. She further stated nurses were responsible for ensuring the medications were put away, and that included the medications stored in the refrigerator. During an interview with Licensed Practical Nurse (LPN) 4 on [DATE] at 2:13 PM, she stated nurses managed the medication refrigerator, and dietary staff handled the nourishment refrigerator. LPN4 stated dietary usually checked the refrigerator weekly for cleanliness and expired items. She further stated nursing followed the same process with the medication refrigerator, and pharmacy audited both the carts and the medication rooms approximately once a month. LPN4 stated the refrigerator door was not a proper storage location for medications because of temperature changes and light exposure, which contributed to potential contamination or loss of effectiveness. Additionally, LPN4 stated medication that was contaminated or less effective presented unnecessary harm to residents. During an interview with the Director of Nursing/Infection Preventionist (DON/IP) on [DATE] at 2:32 PM, she stated she expected all medications to be properly stored based on the facility's policies. She further stated medications should not be stored in the refrigerator door because of unstable temperatures. The DON/IP stated the refrigerator door was constantly opened and closed, which affected the temperature of items stored in the door. The DON/IP also said the constant temperature fluctuations changed a medication's effectiveness which placed residents at risk. During an interview with the Administrator on [DATE] at 3:50 PM, he stated it was his expectation that medications were stored and dated properly. When asked if it was appropriate for medications to be stored in the refrigerator door, the Administrator stated it was not appropriate because of the potential for contamination and/or weakened efficacy. The Administrator further stated residents could be negatively affected if medications were improperly stored.		

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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. **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 notify the resident and the resident's representative(s) of the transfer to the emergency department and the reasons for the move in writing and in a language and manner they understood and provide written information to the resident or resident representative of the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility for 2 of 3 sampled residents, Resident (R) 6 and R7. On 4/30/2026, R7 was sent to the local emergency room due to her having an unwitnessed fall in the bathroom. R7 did not receive a bed hold/transfer notice prior to being sent out from the facility. During an interview with the Family Representative of R7, she stated she did not receive any documents by mail for a bed hold/transfer notice. On 05/25/2026, R6 was transferred to the local emergency room without receiving a bed hold or transfer notice. R6 was his own representative. Review of the facility's policy titled, Holding Bed Space, revised 2001, revealed the facility shall inform residents upon admission and prior to a transfer for hospitalization or therapeutic leave of the bed-hold policy. 1. Review of R6's Face Sheet revealed the facility admitted the resident on 09/15/2025 with diagnoses of type 2 diabetes mellitus with other specified complications and hyperlipidemia unspecified bladder disorder. Review of R6's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 03/10/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, indicating he was cognitively intact. Review of R6's electronic health record (EHR) in Point-Click-Care (PCC), a software documentation program, of R6's Profile Sheet, dated 09/15/2025, revealed R6 was his own representative. Review in the facility's documenting system, Point Click Care (PCC), revealed Registered Nurse (RN) 2 documented R6 had chest pains and decided he wanted to go the hospital on [DATE] at 5:04 PM. However, there is no documentation of the resident receiving a Bed Hold or Transfer Notice. During an interview with R6 on 05/27/2026 at 9:13 AM, he stated he was not given any papers when he decided to go the hospital on [DATE] for chest pain. 2. Review of R7's Face Sheet revealed the facility admitted the resident on 01/29/2026 with other displaced fracture of lower end of left humerus, subsequent encounter from fracture with routine healing, unspecified fall, and type 2 diabetes mellitus without complications. Review of R7's quarterly MDS, with an ARD of 03/26/2026, revealed the facility assessed the resident to have a BIMS score of three out of 15, indicating she was severely cognitively impaired. Review of R7's PCC revealed on 04/29/2026 at 10:02 PM, Licensed Practical Nurse (LPN) 5 was called to R7's room by staff. The resident's alarm was sounding, and the resident was found in the bathroom floor, lying on her right side and holding her left arm and wrist. The resident stated she fell and caught herself with her left arm, and she bent her left wrist back. Per the documentation, the resident's left wrist had swelling and pain when touched. During an interview with the Family Representative of R7 on 05/27/2026 at 3:16 PM, she stated she did not receive any documents by mail that was a bed hold/transfer notice for R7. During an interview with the Business Office Manager (BOM) on 05/28/2026 at 10:34 AM, she stated, after she reported in for her shift, she reviewed the dashboard/census to see what residents had transferred out to the facility overnight. She stated she followed up, after the morning meeting, to make sure she did not miss anything. She stated she used Document Management, a software program, to create the Bed Hold. She stated, if the resident understood the document, she would get the resident to electronically sign the document. However, she stated, if the resident was not (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitively intact, she called the family to inform them. She stated she emailed the Bed Hold/Transfer Notice to the family representative, or if the family came to the facility, she had them sign it as they visited the resident. During an interview with the Director of Nursing (DON) on 05/28/2026 at 10:45 AM, she stated she was not very well-versed with the Bed Hold or Transfer Notice. She stated families should be notified with all things concerning the residents, and the bed hold should be mailed. She stated residents should know they had a place to come back to. During an interview with the Administrator on 05/28/2026 at 11:02 AM, he stated the Bed Hold and Transfer Notice should be given to the residents as they were leaving the facility. He stated the family representatives should be mailed a copy of the forms, so they knew the resident had a bed to come back to at the facility.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's job description, the facility failed to ensure Minimum Data Set [MDS] assessments accurately reflected the residents' status for 3 of 17 sampled residents, Resident (R) 10, R38, and R41 for physical restraints. Refer to F604The findings include: Review of the facility's job description MDS Coordinator revealed the duties and responsibilities included scheduling, completing, and submitting MDS assessments in accordance with the Resident Assessment Instrument (RAI) Manual, and state and federal regulations. Review of the facility provided MDS, dated [DATE] at 10:57 AM revealed it did not have R10, R38, and R41 coded for physical restraints. During an interview with the Director of Nursing (DON) on 05/28/2026 at 10:45 AM, she stated R10, R38 and R41 would not have been coded for physical restraints, as they were not being restrained against their will. She stated the facility coded resident per the RAI manual, used for long-term care facilities participating in Medicare and Medicaid programs. During an interview with the Administrator on 05/28/2026 at 11:02 AM, he stated he had no idea why those residents would be considered having a physical restraint. He stated he was confident with his nursing staff and did not believe they would allow staff to practice physically restraining the residents. He stated his expectation would be for all residents to be assessed and coded correctly on the MDS.		

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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, review of a facility job description, and review of the facility's policy, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 35 sampled residents, Resident (R) 41. R41 was observed wearing a gait belt wrapped around his legs that was not ordered or addressed on the comprehensive care plan. The findings include: Review of the facility's policy titled, Care-Plans-Comprehensive, undated, revealed an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident. Per the policy, the facility's Care Planning/Interdisciplinary Team, in coordination with the resident and his or her family or representative, developed and maintained a comprehensive care plan for each resident that identified the highest level of functioning the resident might be expected to attain. Review of the facility's job description [Minimum Data Set] MDS Coordinator, undated, revealed the duties and responsibilities included scheduling, completing and maintaining resident care plans in a manner that was reflective of individualized assessments, needs, preferences, strengths and physician's order. Another duty listed was to communicate care plan schedules to appropriate departments to assure collaboration and timely completion of assigned sections and/or care plans. Review of R41's Face Sheet revealed the facility admitted the resident on 09/15/2025 with non-ST elevation (NSTEMI) myocardial infraction, muscle weakness, and primary osteoarthritis. Review of R41's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 03/19/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15, indicating he was cognitively intact. Observation on 05/26/2027 at 12:32 PM revealed R41 was sitting in his motorized wheelchair with a seat belt securing him to his motorized wheelchair. Review of R41's Care Plan, revealed he had not been care planned to wear the gait belt around his legs. Review of R41's Physician Orders revealed no physician's order for the resident to wear a gait belt around his legs. Review of R41's electronic medical record (EMR) revealed no documentation for skin assessments for the use of the self-releasing seat belt and gait belt. During an interview with the Director of Nursing (DON) on 05/28/2026 at 10:45 AM, she stated the gait belts should be added to R41's Care Plan, along with an assessment to ensure that was the correct alternative for him to use for his medical conditions. She stated R41 and all other residents using a gait belt around their legs and feet should have an order from a physician to use the gait belt. She stated she would not allow the resident to use a device if it was going to cause any hurt to the resident. During an interview with the Administrator on 05/28/2026 at 11:02 AM, he stated all residents that had a gait belt around their legs and feet should have a doctor's order to do so. He stated residents needed to be assessed to make sure the gait belt was a safe device for each resident to have and use daily.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review and review of the facility's policy, the facility failed to ensure residents receiving respiratory care was provided services in accordance with physician orders and the facility's protocol for 2 of 16 sampled residents, Resident (R) 52 and R8. Record review revealed R52 had an order for oxygen administration at two liters per minute (LPM) via nasal cannula. However, observations conducted on 05/27/2026 and 05/28/2026 revealed R52 was receiving oxygen via nasal cannula with the regulator set at two and one-half and three LPM, which was not consistent with the physician's order. Observation on 05/26/2026 at 1:29 PM revealed R8's oxygen tubing and the distilled water were not dated. The findings include: Review of the facility's policy titled, Long-Term Care Oxygen Policy, undated, stated oxygen shall be administered only with a physician/provider order and handled in accordance with the facility's policy for safety standards and manufacturer recommendations. Procedures on the policy included: ensuring oxygen flow rates match the physician/provider orders and inspecting tubing, concentrators, humidifiers, and oxygen delivery devices routinely. 1. Review of R52's admission Record revealed the facility admitted the resident on 05/16/2026 with diagnoses which included chronic obstructive pulmonary disease (COPD) and acute and chronic respiratory failure with hypoxia. Review of R52's Physician Orders, revealed the resident had an order for oxygen at two liters per minute (LPM) to be delivered by nasal cannula. Observation on 05/27/2026 at 11:37 AM revealed R52 was wearing oxygen per nasal cannula, and the oxygen concentrator was set at three LPM. Observation on 05/28/2026 at 10:05 AM revealed R52 was wearing oxygen per nasal cannula, and the oxygen concentrator was set at two and one-half LPM. During an interview with Licensed Practical Nurse (LPN) 3 at 11:03 AM on 05/28/2026 after the State Survey Agency (SSA) Surveyor showed LPN3 the oxygen concentrator, which was set at 2.5 liters, she stated, it's not that much over two liters. It says it's bubbling between a two and a three. LPN3 stated she did not know if there was a policy in place that determined how often nurses were supposed to check the oxygen concentrators. LPN3 stated residents might become hypoxic or experience hallucinations if getting too much or too little oxygen. During the interview, LPN3 changed the concentrator to reflect the correct order of two liters per nasal cannula. During an interview with LPN4 on 05/28/2026 at 11:29 AM, LPN4 stated the expectation was when a resident received oxygen, the nurse was to follow the order. LPN4 stated she was unaware if there was a policy in place that instructed nurses on how frequently to check the oxygen concentrator to ensure the set oxygen level was correct. LPN4 stated a resident might be at risk for carbon dioxide buildup if he/she received too much oxygen or become short of air if he/she received too little oxygen. LPN4 also stated it was very important to follow the doctor's order for oxygen. During an interview with the Administrator on 05/28/2026 at 10:55 AM, he stated he expected staff to follow physician orders. The Administrator stated he was unaware what the oxygen policy stated. 2. Review of R8's admission Record revealed the facility admitted the resident on 08/23/2025 with diagnoses which included COPD and coronary artery disease. Review of R8's Treatment Administration Record revealed the oxygen tubing was last changed on 05/06/2026. Observation on 05/26/2026 at 1:29 PM revealed R8's oxygen tubing and the distilled water were not dated. During an interview with R8 at the time of the observation, she stated the oxygen tubing was supposed to be dated, but it was not dated today. She stated the water bottle was changed when needed. During an interview with Licensed Practical Nurse (LPN) 1 on 05/26/2026 at 7:02 PM she stated she worked the night shift, and the oxygen tubing was to be changed weekly on Wednesday night. She further stated R8 was out on the day the tubing was to be changed. She stated she did not know when the water was to be changed. She further stated (continued on next page)		

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No. 0938-0391

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NAME OF PROVIDER OR SUPPLIER Willowbrook Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2323 Concrete Road Carlisle, KY 40311	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, for 1 of 5 staff members observed in the kitchen, Dietary Aide (DA) 2. The findings include: Review of the facility's policy titled, Food Preparation and Service, revised July 2014, revealed dietary staff shall wear hair restraints (hair net, hat, beard restraint) so that hair did not contact food. Observation on 05/26/2026 at 10:36 AM revealed Dietary Aide (DA) 2 had approximately four inches of hair hanging out of the hair net on both sides of the front of the head. DA2 was leaning over the steam table. During an interview with DA2 at the time of the observation, she stated, I'm sorry, I didn't know. She further stated hair could fall in the food. During an interview with the Dietary Manager (DM) on 05/26/2026, she stated the importance of keeping hair in the hair net was so hair did not get in the food. During an interview with the Administrator on 05/28/2026 at 10:57 AM, he stated he went in the kitchen daily. He stated he looked to assure the dietary staff's hair was fully covered with the hair net. He stated he expected dietary staff to have their hair completely covered.		

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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. Based on observation, interview, record review, and review of facility policies, the facility failed to follow infection prevention and control policies to help prevent the development and transmission of communicable diseases and infection for 3 of 17 sampled residents (R3, R16, and R47). The findings include: Review of the facility's policy titled, Infection Control Guidelines for Nursing Procedures, dated 2024, revealed employees must perform hand hygiene before and after every patient interaction, before performing any nursing procedure, after removing gloves, and after contact with potentially contaminated surfaces. Further review revealed staff must clean and disinfect all equipment and surfaces before and after resident use, including bedrails, tables, and reusable medical devices. Additionally, the policy stated staff must ensure all reusable equipment was properly cleaned and sterilized according to facility protocols. Review of the facility's policy titled, Hand Hygiene, undated, revealed an alcohol-based hand rub or soap and water were used before and after direct contact with residents, before preparing or handling medications, before handling clean or soiled dressings, gauze pads, etc., after handling used dressings or contaminated equipment, and after contact with objects in the immediate vicinity of the resident. Review of the facility's policy titled, Medication Pass, undated, revealed staff was not to touch anything with their bare hands that went into the resident's mouth (spoon, straw, pills). Additional review revealed hands should be washed following any direct patient contact. Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 10/2009, revealed reusable resident care equipment would be decontaminated and/or sterilized between residents according to manufacturers' instructions. 1. Review of R47's admission Record revealed the facility admitted the resident on 07/12/2025 with diagnoses including mild cognitive impairment, chronic kidney disease (CKD), and hyperlipidemia. Observation on 05/27/2026 at 8:05 AM revealed Kentucky Medication Aide (KMA) 1 entered R47's room and administered eye drops to the resident; however, continued observation revealed KMA1 neither performed hand hygiene nor donned gloves prior to administration. 2. Review of R3's admission Record revealed the facility admitted the resident on 10/03/2025 with diagnoses including type 2 diabetes, epilepsy, and autoimmune disorders. Observation on 05/27/2026 at 8:12 AM revealed KMA1 prepared R3's medications for administration and then obtained R3's blood pressure, which was out of the ordered parameters. Further observation revealed KMA1 poured all the medications from the cup into her ungloved hand, removed and discarded the blood pressure medication, placed the remaining medications back into the cup, and administered them to R3. During an interview with KMA1 on 05/27/2026 3:30 PM, she stated the facility policy required hand hygiene to be used between resident care. KMA1 further stated she should have sanitized her hands and donned gloves prior to administration of R41's eye drops because of infection control risks. Additionally, KMA1 stated when she dumped R3's pills into her ungloved hand, she contaminated them, which put the resident at risk for infection. KMA1 stated it was important for proper infection control and prevention procedures to be followed so residents were protected from infections. During an interview with Licensed Practical Nurse (LPN) 4 on 05/28/2026 at 2:13 PM, she stated staff received infection control education monthly at a minimum, and there was an infection control binder at the nurse's station they reviewed daily for updates or new in-services. LPN4 stated during medication administration, pills were not handled with a bare hand because of contamination risk, and gloves were worn when ophthalmic medications were administered to prevent transmission of bacteria. LPN4 stated it was important for the facility's infection control policies to be followed so residents were kept safe. During an interview with the Director of Nursing/Infection Preventionist (DON/IP) on 05/28/2026 at 2:32 PM, she stated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was responsible for infection control training for all staff in the building. The DON/IP stated she expected staff to know and follow the facility's infection control policies and procedures. The DON/IP stated when staff administered medications, it was her expectation they followed facility policy related to hand hygiene and proper handling of medications. She further stated gloves were worn if pills were handled, and gloves were worn when staff administered eye drops. The DON/IP stated it was important that staff followed infection control policies to prevent contamination, so infections were not spread and residents were protected. During an interview with the Administrator on 05/28/2026 at 3:50 PM, he stated it was his expectation staff used proper hand hygiene between resident care and when medications were administered. Additionally, he stated when medications were administered by ophthalmic route, he anticipated staff would wear gloves and any other required personal protective equipment (PPE). The Administrator stated he expected staff to be educated and to follow the facility's infection control policies and procedures. He further stated compliance was necessary, so residents were protected, and the spread of bacteria was prevented. 3. Observation on 05/27/2026 at 10:44 AM revealed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) finished applying a dressing on Resident (R) 16's left foot. She then picked up the scissors on the bedside table and washed them in the sink. She then picked up the tape used to secure the dressing from the bedside table. She placed the scissors and tape on top of the treatment cart, opened the top drawer, and put the scissors and tape in the top drawer. During an interview with the ADON/IP on 05/27/2026 at 2:07 PM, she stated she washed the scissors between each patient with soap and water. She stated soap and water possibly took care of the potential bacteria on the scissors, but I guess you could use a Sani-wipe. She stated she put the tape she used on the residents back in the treatment cart. When asked if this could potentially cause transmission of bacteria, the ADON/IP stated, So are we just supposed to throw the whole roll of tape away? Yes, usually we just put it back in the treatment cart. During an interview with the Director of Nursing (DON) on 05/27/2026 at 3:27 PM, she stated after using scissors, they should be cleaned with Sani-wipes. She stated tape should be thrown away if placed on the bedside table. She stated she expected staff to follow the infection control policy. During an interview with the Administrator on 05/27/2026 at 2:27 PM, he stated he had not discussed wound care in the morning meetings with clinical staff or the Quality Assurance Performance Improvement (QAPI) meetings. He stated there was a wound care doctor, who addressed wounds. He stated he expected staff to follow the policy and prevent transmission of infection. He stated staff had infection prevention education in orientation.		