STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN RIDGE HEALTH CAMPUS	6415 CALM RIVER WAY , LOUISVILLE, Kentucky, 40299

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 07/15/2025, it was determined the facility had achieved substantial compliance with Life Safety Code on 06/25/2025.	E0000		08/06/2025
K0000	INITIAL COMMENTS Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 07/15/2025, it was determined the facility had achieved substantial compliance with Life Safety Code on 06/25/2025.	K0000		08/06/2025

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0000	Initial Comments 42 CFR 483.73 Type of Structure: One (1) story, (2006), Type V (111), protected combustible construction with seven (7) smoke compartments and a complete automatic wet and dry sprinkler system. An Emergency Preparedness Recertification Survey was initiated on 06/04/2025 and concluded on 06/04/2025, in accordance with 42 Code of Federal Regulations, Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. During this Recertification Survey, Glen Ridge Health Campus was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	E0000		
K0000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 2006 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) story, (2006), Type V (111), protected combustible construction with seven (7) smoke compartments and a complete automatic wet and dry sprinkler system. A Life Safety Recertification Survey was initiated on 06/04/2025 and concluded on 06/04/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities.	K0000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

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K0000	Continued from page 1 During this Recertification Survey, Glen Ridge Health Campus was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K0000		
K0131 SS = F	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to provide separation from other occupancies in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect seven one (1) fire barrier wall, staff, and all residents. The facility had the capacity for 70 beds with a census of 67 on the day of survey.	K0131	1. On 6/17/2025 the Director of Plant Operations installed drywall patch to cover 12in hole and 8in hole that was revealed in the fire barrier wall located between the kitchen and dining room. Director of Plant Operations placed fire resistant caulk around patching. 2. All residents and staff had the potential to be affected by the deficient practice, no residents or staff were affected. 3. The Director of Plant Operations was notified on the requirements of NFPA 101 19.1.3.3 and the expectation to patch and seal openings on barrier wall. 4. As a quality measure the Director of Plant Operations will inspect all fire barrier walls for any holes or penetrations. 5. Compliance date 6/17/2025	06/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

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K0131 SS = F	Continued from page 2 The findings include: Observation, during the building inspection tour on 06/04/2025 at 11:38 AM, revealed the fire barrier wall located between the Kitchen and Dining Room, seperating the Skilled Nursing Facility from the Assisted Living, had a 12-inch by 12-inch hole and an eight (8) inch by eight (8) inch hole above the drop ceiling. Interview, on 06/04/2025 at 11:39 AM, with the Director of Plant Operations revealed the facility was not aware of the unsealed holes in the fire barrier wall. The findings were verified by the Director of Plant Operations at the time of observation and the Administrator at the exit conference on 06/04/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.1.3.5 Where separated occupancies provisions are used in accordance with either 19.1.3.3 or 19.1.3.4, the most stringent construction type shall be provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type shall be determined as follows: (1) The construction type and supporting construction of the health care occupancy shall be based on the story on which it is located in the building in accordance with the provisions of 19.1.6 and Table 19.1.6.1. (2) The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters of this Code. 8.2.1.3 Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on one of the following: (1) Separate buildings, if a 2-hour or greater vertically aligned fire barrier wall in accordance with	K0131		

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K0131 SS = F	Continued from page 3 NFPA 221, Standard for High Challenge FireWalls, FireWalls, and Fire BarrierWalls, exists between the portions of the building (2) Separate buildings, if provided with previously approved separations (3) Least fire-resistive construction type of the connected portions, if separation as specified in 8.2.1.3(1) or (2) is not provided Actual NFPA Standard: NFPA 221 Standard for High Challenge FireWalls, FireWalls, and Fire BarrierWalls, (2012) Table 4.8.2 Minimum Fire Protection Ratings for Opening Protectives in Fire Resistance-Rated Assemblies Fire Resistance Rating Fire Protection rating _____ _____ Walls and Fire Door Partitions Assemblies Fire Window Component	K0131		

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K0131 SS = F	Continued from page 4 (hr) (hr) Assemblies (hr) Elevator 2 1-1/2 NP Hoistways 1 1 NP Vertical 2 1-1/2 NP shafts (including stairways,	K0131		

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K0131 SS = F	Continued from page 5 exit, 1 1 NP and refuse chutes) — HC fire 4 See sections NP walls 5.8 and 6.10 and fire walls 3 3 NP	K0131		

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K0131 SS = F	Continued from page 6 2 1-1/2 NP Fire 4 3 NP barrier 3 3 NP 2 1-1/2 NP 1 ¾ 3/4 Horizontal	K0131		

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K0131 SS = F	Continued from page 7 2 1-1/2 NP Exit — Corridors, 1 1/3 3/4 exit access ½ 1/3 1/3 NP: Not permitted. Source: NFPA 5000: Table 8.7.2	K0131		
K0321 SS = D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved	K0321	1. On 6/17/2025, Schiller Door was dispatched to facility to install automatic self-closing device for the door in the copy room. Automatic self-closing door device was successfully installed. 2. 2 residents and 1 staff had the potential to be affected by the deficient practice, no residents or staff were affected.	06/17/2025

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K0321 SS = D	Continued from page 8 automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to provide separation of hazardous areas from other areas in the facility in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) room, staff, and two (2) residents. The facility had the capacity for 70 beds with a census of 67 on the day of the survey. The findings include: Observation, during the building inspection tour on 06/04/2025 at 12:14 PM, revealed the Copy Room was over 50 square feet, used for storing 15 boxes of	K0321	Continued from page 8 3. The Director of Plant Operations was notified on the requirements of NFPA 101 19.3.5.9 and the expectation to install self closer to copy room door. 4. As a quality measure the Director of Plant Operations will inspect affected room and confirm self closer was installed. 5. Compliance date 6/17/2025	

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K0321 SS = D	Continued from page 9 combustible paper supplies and had no automatic or self-closing device on the door as required. Interview, on 06/04/2025 at 12:15 PM with the Director of Plant Operations, revealed the facility was not aware the room was required to have a self-closing device due to the size and combustible storage in the room. The finding was verified by the Director of Plant Operations at the time of observation and the Administrator at the exit conference on 06/04/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1 19.3.2.1.3 The doors shall be self-closing or automatic closing. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1.) Boiler and fuel-fired heater rooms (2.) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3.) Paint shop. (4) Repair shops (5) Rooms with soiled linen in volume exceeding 64 gal (242 L) (6) Rooms with collected trash in volume exceeding 64	K0321		

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K0321 SS = D	Continued from page 10 gal (242 L) (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard	K0321		
K0921 SS = F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to establish policies for the Patient Care Related Electrical Equipment (PCREE) in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect all	K0921	1.The Director of Plant Operations has inspected, tested and documented the physical integrity, resistance, leakage current test for fixed and portable patient care related electrical equipment (PCREE). 2. This deficient practice had the potential to affect all residents and staff who use PCREE equipment, no residents were affected. 3. The Director of Plant Operations was educated by the Facilities Management Support on K921-Equipment-Testing and Maintenance Requirements, NFPA 101, 2012 Edition. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 103, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 4. Results of this inspection and daily audits will be presented Quality Assurance Performance Improvement committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	06/12/2025

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K0921 SS = F	Continued from page 11 PCREE, staff, and all residents. The facility had the capacity for 70 beds with a census of 67 on the day of the survey. The findings include: Record review, of the PCREE testing documentation on 06/04/2025 at 1:28 PM, revealed PCREE was in use throughout the facility and there were no policies or protocols for the type of test and intervals of testing for PCREE that the facility owned. Interview, on 06/04/2025 at 1:29 PM with the Director of Plant Operations, revealed the facility was not aware of the PCREE requirements. The finding was verified by the Director of Plant Operations at the time of record review and by the Administrator at the exit conference on 06/04/2025. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 3.3.137 Patient-Care-Related Electrical Equipment. Electrical equipment appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. 10.5.2.1 Testing Intervals. 10.5.2.1.1 The facility shall establish policies and protocols for the type of test and intervals of testing for patient care-related electrical equipment.	K0921	Continued from page 11 5. Compliance date: 6/12/2025	
K0923 SS = D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.	K0923	On 6/4/2025, the one (1) freestanding oxygen E tank that was unsecured on the floor located in the oxygen transfilling storage room was removed. Racks made more accessible for holding and sign placed to remind staff to have all tanks in holding racks. 2. 4 residents and staff had the potential to be affected by the deficient practice, no residents or staff were affected.	06/25/2025

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K0923 SS = D	Continued from page 12 >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined the facility failed to provide oxygen storage in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) oxygen storage room, staff, and four (4) residents. The facility had the capacity for 70 beds with a census of 67 on the day of the survey. The findings include: Observation, during the building inspection tour on 06/04/2025 at 12:35 PM, revealed one (1) freestanding	K0923	Continued from page 12 3. The Director of Plant Operations was notified on the requirements of NFPA 99 11.3.2.1 and the expectation to maintain secured oxygen tanks in secured holding racks. 4. As a quality measure the Director of Plant Operations will inspect oxygen transfilling rooms daily for 3 months starting 6/25/2025, then weekly for 3 months. 5. Compliance date 6/25/2025	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN RIDGE HEALTH CAMPUS	6415 CALM RIVER WAY , LOUISVILLE, Kentucky, 40299

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0923 SS = D	Continued from page 13 oxygen E tank unsecured on the floor located in the Oxygen Transfilling Storage Room. Interview, on 06/04/2025 at 12:36 PM with the Director of Plant Operations, revealed the facility was not aware the E tank was not in the rack. The finding was verified by the Director of Plant Operations at the time of observation and the Administrator at the exit conference on 06/04/2025. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1?2 hour 11.3.2. 4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.6.2.3 Cylinders shall be protected from damage by	K0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

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K0923 SS = D	Continued from page 14 means of the following specific procedures: (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device. (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts	K0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025

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K0923 SS = D		K0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	INITIAL COMMENTS A Desk Review Revisit Survey was initiated on 07/24/2025 and concluded on 08/06/2025. It was determined the facility had achieved substantial compliance on 07/08/2025 as alleged.	F0000		

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	INITIAL COMMENTS A Standard Recertification, COVID-19 Focused Infection Control and Abbreviated Survey investigating KY00045630 and KY00046075 concluded on 06/05/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. A defiency was related to KY00046075. No defiencies were issued related to KY00045630. Survey Dates: 06/02/2025 - 06/05/2025 Survey Census: 62 Sample Size: 16 Supplemental Residents: 0	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F0600	1. What corrective action(s) will be accomplished for those resident/patients found to have been affected by the deficient practice? Resident #214 was affected by the alleged deficient practice. Resident continued course of rehab stay without instance of abuse or neglect. Resident with no adverse side effects. Resident was discharged home with son on 4/24/2025 as planned. 2. How will you identify other residents/patients having the potential to be affected by the same deficient practice? All residents residing in facility had potential to be affected. Residents are to remain free from abuse and neglect while residing at facility. On 6/25/2025, all residents with a BIMS of 8 or greater were interviewed by Director of Health Services (DHS) and Assistant Director of Health Services (ADHS) to ensure residents	07/08/2025

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F0600 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility document and policy review, the facility failed to protect a resident's right to be free from mental abuse perpetrated by a staff member for 1 of 2 sampled residents reviewed for abuse, out of the total sample of 16. The findings include: Review of the facility policy titled, "Abuse and Neglect Procedural Guide," reviewed 08/29/2019, revealed the facility was to protect residents from abuse. Further review revealed "Mental/Emotional Abuse" was defined as the use of verbal or nonverbal conduct which caused or had the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Review of the "Resident Face Sheet" for Resident (R)214 revealed the facility admitted the resident on 03/11/2025, with diagnoses of emphysema, acute respiratory failure with hypoxia, acute kidney failure, and acute on chronic diastolic heart failure. Review of the Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 03/17/2025, revealed the facility assessed R214 to have a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated the resident had severe cognitive impairment. Review of the facility's "Final Report/5 Day Follow-Up" dated 04/18/2025, revealed in response to resident behaviors, Certified Resident Care Aide (CRCA) 6 directed an inappropriate hand gesture (middle finger gesture) toward R214. Per review, R214 reported the CRCA's action to the nurse on duty, who immediately obtained a statement from CRCA 6 and suspended the CRCA. Further review revealed after completion of its investigation, the facility determined, "Findings of the investigation were verified as employee admitted to the hand gesture toward resident." Continued review of the facility's investigation information revealed a "Statement of Witness Form,"	F0600	Continued from page 1 felt safe and are free from abuse and neglect. Residents with BIMS of less than 7 had skin assessments performed by DHS and ADHS to ensure residents were free from abuse and neglect. On 7/3/2025, the Director of Health Services (DHS) and Assistant Director of Health Services (ADHS) interviewed responsible parties/guardians/POAs of residents with BIMS less than 7 asking the following: Have they noticed any change in resident behavior that may include distress, fear, or discomfort? 3. What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? On 6/24/2025, all staff were educated by the Director of Health Services (DHS) and Executive Director (ED) on Abuse and Neglect with real time discussion and post test questions to ensure competency. Staff are to receive a 100% pass rate on post test to ensure staff retained education provided. Any newly hired staff will have education provided during new hire orientation by the Executive Director or designee. The campus does not use agency staff. 4. How the facility plans to monitor its performance to ensure that solutions are sustained? Beginning on 7/2/2025, the Director of Health Services (DHS) or Assistant Director of Health Services (ADHS) will conduct the following audits weekly for 1 month, every other week for 2 months, then monthly for 3 months: -Residents with BIMS score of 8 or greater: 3 residents will be randomly selected for interviews to assess for any concerns related to abuse, neglect or mistreatment. -Residents with a BIMS score of 7 or below: 3 residents will be randomly selected for a comprehensive skin assessment to identify any unexplained injuries or changes. Additionally, three responsible parties/guardians/POAs will be contacted to gather feedback regarding the resident's well-being and any concerns observed. As a quality measure, the DHS will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6	

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F0600 SS = D	Continued from page 2 from CRCA 6 dated 04/18/2025, which noted the CRCA admitted she "gave the middle finger" at R214 before turning to walk down the hallway, with the resident following behind her in his/her wheelchair. During interview on 06/04/2025 at 12:07 PM, CRCA 6 stated that although she knew the hand gesture could be perceived as abuse, she had not considered it in that manner at the time. During interview on 06/05/2025 at 4:30 PM, CRCA 7 stated she recalled being at the nurses' station with CRCA 6 when R214 activated his/her call light, and CRCA 6 went to answer it. She stated after a few minutes, CRCA 6 returned to the nurses' station, followed by R214. The CRCA reported R214 notified the Assistant Director of Health Services (ADHS) that CRCA 6 had demonstrated an inappropriate hand gesture at him/her. She explained that although she was not present when CRCA 6 made the gesture, she was present when CRCA 6 admitted to the ADHS that she made the gesture towards R214. During interview on 06/05/2025 at 10:43 AM, the ADHS stated she was on duty on the morning of 04/18/2025, when R214 approached the nurses' station and notified her that CRCA 6 made an inappropriate hand gesture towards him/her. The ADHS stated following R214's allegation, she questioned CRCA 6, who admitted making the hand gesture towards the resident. During interview on 06/05/2025 at 12:56 PM, the Director of Health Services (DHS) stated on 04/18/2025, around 3:00 AM, she received a telephone call from the ADHS who notified her that R214 alleged CRCA 6 made an inappropriate hand gesture towards him/her. She said the ADHS informed her CRCA 6 admitted to making the gesture towards the resident. The DHS further stated the hand gesture was inappropriate and was considered mental abuse. During interview on 06/05/2025 at 1:34 PM, the Executive Director (ED) stated CRCA 6's employment was terminated following R214's allegation, because the CRCA admitted the allegation had occurred.	F0600	Continued from page 2 months, if warranted, until 100% compliance is met. 5. Date of compliance 7/8/2025	
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F0609	1. What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?	07/08/2025

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F0609 SS = D	Continued from page 3 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility document and policy review, the facility failed to submit an initial report of an allegation of staff-to-resident abuse to the State Survey Agency (SSA) within two hours for 1 of 2 sampled residents reviewed for abuse (Resident (R)214). The findings include: Review of the facility policy titled, "Abuse and Neglect Procedural Guide," reviewed 08/29/2019, revealed "Mental/Emotional Abuse" was defined as using verbal or nonverbal actions which caused or had the potential to cause a resident to "experience humiliation, intimidation, fear, shame, agitation, or degradation." Review of the section of the policy titled, "Identification," revealed the Executive Director (ED) was responsible for notification to the State Department of Health (per State guidelines) and	F0609	Continued from page 3 Resident #214 was affected by by the alleged deficient practice. All abuse violations involving abuse, neglect, exploitations or mistreatment, mental anguish, exploitation, or mistreatment, are reported immediately, but not later than 2 hours after the allegation is made. 2. How will you identify other residents/patients having the potential to be affected by the same deficient practice? All abuse allegations are to be reported to the State Survey Agency, adult protective services, in accordance with State law through established procedures. All residents with abuse allegations have the potential to be affected by the deficient practice. All abuse allegations from 6/5/2025 through 7/5/2025 were reviewed for timely submission with no further findings of deficient practice. 3. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? On 6/24/2025, Clinical Support completed reeducation with Executive Director (ED), Director of Health Service (DHS) and Assistant Director of Health Services (ADHS) on reporting requirements, including ensuring any faxes submitted went through timely, within 2-hour time frame. On 6/24/2025, all staff were educated by the Director of Health Services (DHS) and the Executive Director (ED) on Reporting of Abuse allegations and reporting time frame to state agency with real time discussion and post test questions to ensure competency. Staff are to receive a 100% pass rate on post test to ensure staff retained education provided. Any newly hired staff will have education provided during new hire orientation by the Executive Director or designee. The campus does not use agency staff. 4. How the facility plans to monitor its performance to ensure that solutions are sustained? Beginning on 7/2/2025, the Director of Health Services (DHS) of Assistant Director of Health Services (ADHS) or Executive Director (ED) will interview 3 random staff members on policy/procedure of reporting abuse weekly x 1 month, every other week x 2 months, then monthly x 3 months.	

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F0609 SS = D	Continued from page 4 other agencies, which include the Ombudsman, Adult Protective Services (APS) and/or local law enforcement agencies, as indicated. Continued review of the policy revealed under the section titled, "Reporting/response," revealed the facility was to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately, but not later than two hours after the allegation was made if the event, that caused the allegation involved abuse or resulted in serious bodily injury. Further review revealed the alleged violation was to be reported to the Administrator of the facility and to other officials (including to the SSA and APS where state law provided for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of the "Resident Face Sheet" for R214 revealed the facility admitted the resident on 03/11/2025, with diagnoses of acute on chronic diastolic heart failure, acute respiratory failure with hypoxia, acute kidney failure, and type two diabetes mellitus. Review of the Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 03/17/2025, revealed the facility assessed R214 as having a Brief Interview for Mental Status (BIMS) score of seven out of 15, indicating the resident had severe cognitive impairment. Review of the facility's "Initial Report," dated 04/18/2025, revealed an initial report was submitted to the SSA related to an allegation of abuse involving Certified Resident Care Aide (CRCA) 6 having "made an inappropriate hand gesture" towards R214. Continued review of the Initial Report revealed the incident occurred on 04/18/2025 at 3:25 AM, and the ED was notified of the incident on 04/18/2025 at 3:42 AM. Further review revealed the facility had not submitted the report to the SSA until 7:48 AM on 04/18/2025, more than two hours after the allegation was reported. However, review of the facsimile (fax), "Communication Result Report," included with the facility's documentation of the allegation, revealed a fax transmission of the "Initial Report" was attempted on 04/18/2025 at 9:02 AM. Per review of the fax, the transmission had been unsuccessful, due to an error code of "E-3)," which indicated there was no answer. Continued review revealed comparison of the number	F0609	Continued from page 4 As a quality measure, the DHS will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6 months, if warranted, until 100% compliance is met. 5. Date of compliance 7/8/2025	

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F0609 SS = D	Continued from page 5 listed on the Communication Result Report to the fax numbers and contact numbers listed on the Initial Report revealed the facility attempted to submit a fax to a SSA telephone number, instead of a fax line number. Review of an electronic mail (email) correspondence from the ED to the SSA, dated 04/18/2025, revealed the initial report of the incident was submitted to the SSA on 04/18/2025 at 9:07 AM. In interview on 06/05/2025 at 4:30 PM, CRCA 7 stated she recalled being at the nurses' station with CRCA 6 when R214 activated their call light, and CRCA 6 left the nurses' station to answer the light. CRCA 7 stated few minutes later CRCA 6 returned to the nurses' station, with R214 following. The CRCA said R214 notified the Assistant Director of Health Services (ADHS) that CRCA 6 had demonstrated an inappropriate hand gesture towards him/her. In interview on 06/05/2025 at 10:43 AM, the ADHS stated the morning of 04/18/2025, R214 approached the nurses' station and notified her that CRCA 6 had made an inappropriate hand gesture towards him/her. The ADHS reported she immediately notified the Director of Health Services (DHS) via telephone call of the allegation and was instructed to suspend CRCA 6 pending an investigation of the allegation. In interview on 06/05/2025 at 12:56 PM, the DHS stated on 04/18/2025 around 3:00 AM, she received a telephone call from the ADHS who notified her R214 had alleged CRCA 6 made an inappropriate hand gesture towards him/her. The DHS said the ED was immediately notified. The DHS further stated she was aware the initial report of the incident "must" be submitted to the SSA within two hours. In interview on 06/05/2025 at 1:34 PM, the ED stated he was notified of R214's allegation made on 04/18/2025 between 3:45 AM and 4:00 AM. He said he was aware notification to the SSA "must" occur within two hours. After reviewing the initial report, the ED stated the report was submitted to the state on 04/18/2025, however, not within the required two hour timeframe. He further stated he was not aware the report had not been received by the SSA during the first transmission (fax) attempt or that the attempt had been made to fax the	F0609		

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F0609 SS = D	Continued from page 6 document to a telephone number instead of a fax number. The ED additionally stated he expected the initial report of an allegation to be sent to the SSA within the two-hour timeframe.	F0609		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of the Centers for Medicare and Medicaid (CMS) Long-Term Care Facility, Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure the accuracy of a Minimum Data Set (MDS) Assessment for 1	F0641	1. What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice? On 6/3/2025, Resident #54 was identified as having the potential to be affected by the cited deficiency. Resident was utilizing supplemental oxygen at night. This was not reflected on MDS assessment and was immediately corrected. The Minimum Data Set (MDS) must accurately reflect the resident's status. No adverse effects noted. 2. How will you identify other residents/patients having the potential to be affected by the same deficient practice? All residents on oxygen have the potential to be affected by the cited deficiency. On 6/26/2025, MDS assessments were reviewed by Clinical Support for accuracy on all residents receiving oxygen. No additional deficiencies were identified. 3. What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? On 6/9/2025, Assessment Support provided education to the MDS Coordinator on how to thoroughly review all relevant documentation and progress notes during assessment review date to ensure accurate assessment coding. 4. How the facility plans to monitor its performance to ensure that solutions are sustained? Beginning on 7/4/2025, the Director of Health Services (DHS) or Assistant Director of Health Services (ADHS) will audit the MDS assessments for all residents receiving oxygen therapy to ensure accuracy. Audits will be conducted weekly for one month, biweekly for 2 months, and then monthly for 3 months. As a quality measure, the DHS will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement	07/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0641 SS = D	Continued from page 7 of 16 sampled residents (Resident (R)54). The findings include: Review of the CMS Long-Term Care Facility RAI 3.0 User's Manual, Version 1.19.1, dated 10/2024, revealed under section "O0110: Special Treatments, Procedures, and Programs," "O0110C1, Oxygen therapy" specified, "Code continuous or intermittent oxygen administered via [by way of] mask, cannula, etc. [et cetera], delivered to a resident to relieve hypoxia in this item." Review of the "Resident Face Sheet" for R54 revealed the facility admitted the resident on 04/21/2025, with diagnoses to include pulmonary embolism, acute respiratory failure with hypoxia, pulmonary fibrosis, pulmonary hypertension, and atelectasis (complete or partial collapse of a lung or a lobe of a lung). Review of the Admission MDS Assessment, with an Assessment Reference Date (ARD) of 04/25/2025, revealed the facility assessed R54 with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. Further MDS review revealed the use of supplemental oxygen was not reflected under Section O0110 Special Treatments, Procedures, and Programs of the MDS. Review of the "Active Orders" for R54 revealed an order, dated 04/23/2025, for nursing to manage oxygen administration in coordination with physician to prevent respiratory acidosis. Further review of the Active Orders revealed however, no physician's order specifying when the supplemental oxygen should be administered or a prescribed supplemental oxygen flow rate. Review of a nursing "Progress Note," dated 04/22/2025 at 10:09 PM, revealed R54 had an oxygen saturation (O2 sat) level of 91 percent on room air. Further review revealed supplemental oxygen was administered to R54 at a rate of two liters per minute (2 LPM) by way of nasal cannula. Review of the physician "Progress Note," for R54 dated 04/23/2025 at 8:04 PM, revealed, "Assessment: "S/p	F0641	Continued from page 7 meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6 months, if warranted, until 100% compliance is met. 5. Date of compliance 7/8/2025	

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F0641 SS = D	Continued from page 8 [status post] acute hypoxia respiratory failure, on oxygen." Further review of the physician Progress Note revealed the "Plan" was to "Continue oxygen." During interview on 06/04/2025 at 8:59 AM, R54 stated he/she used supplemental oxygen at night because his/her oxygen level dropped whenever he/she laid down. R54 further stated he/she had used the supplemental oxygen every night since his/her admission to the facility. During interview on 06/03/2025 at 2:32 PM, Licensed Practical Nurse (LPN) 1 stated R54 wore supplemental oxygen at nighttime. During interview on 06/04/2025 at 9:53 AM, LPN 2 stated R54 wore supplemental oxygen at nighttime. During a telephone (phone) interview on 06/04/2025 at 1:01 PM, LPN 4 stated she worked on the nightshift and had taken care of R54 several times. LPN 4 said she had observed the resident wearing supplemental oxygen. She further stated R54 had been wearing oxygen at night since his/her admission to the facility. During interview on 06/05/2025 at 9:22 AM, the MDS Coordinator stated when gathering data for an MDS Assessment, she looked at the resident's orders, progress notes, observations, events, therapy notes, and the initial admission assessment. She reported the oxygen administration for R54 should have been "caught" in the many audits that had been done; however, it had not been. The MDS Coordinator further stated that had been an error on the resident's MDS Assessment. During interview on 06/04/2025 at 3:11 PM, the Director of Health Services (DHS) stated her expectation was that MDS assessments were completed accurately and timely. During interview on 06/05/2025 at 11:02 AM, the Executive Director (ED) stated his expectation was for staff to use the audits the facility had in place and to be thorough in completing the residents' MDS Assessments.	F0641		
F0695 ~~SS = D~~	Respiratory/Tracheostomy Care and Suctioning	F0695	1. What corrective action(s) will be accomplished for	07/08/2025

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F0695 SS = D	Continued from page 9 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility standard operating procedure review, the facility failed to obtain orders for supplemental oxygen use for 1 of 1 resident reviewed for respiratory care, out of the 16 total sampled residents (Resident (R)54). The findings include: Review of the facility's standard operating procedure (SOP) titled, "Administration of Oxygen," last reviewed 12/13/2024, revealed, "OVERVIEW Guidelines to properly Administering Oxygen and any Respiratory procedure. SOP DETAILS 1. Verify physician's order for the procedure." Review of R54's "Resident Face Sheet" revealed the facility admitted him/her on 04/21/2025, with diagnoses to include: pulmonary embolism, acute embolism and thrombosis of unspecified deep veins of left lower extremity, acute respiratory failure with hypoxia, atelectasis (complete or partial collapse of a lung or a tobe of a lung), pulmonary fibrosis, and pulmonary hypertension. Review of the Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 04/25/2025, revealed the facility assessed R54 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. Review of R54's "Care Plan," revealed the facility identified included a problem, dated 04/30/2025, that indicated the resident had the potential for shortness of breath while lying flat. Further review revealed the	F0695	Continued from page 9 those residents/patients found to have been affected by the deficient practice? Resident #54 was identified as having the potential to be affected by the cited deficiency. Orders were obtained for resident's home regimen of 2L oxygen via nasal cannula at bedtime at bedtime. Resident had no adverse side effects related to cited deficiency and oxygen levels ranged from 92-100%. Resident was discharged home on 6/16/2025 as planned. 2. How will you identify other residents/patients having the potential to be affected by the same deficient practice? All residents on supplemental oxygen had the potential to be affected. All residents on supplemental oxygen will have MD orders in place per Hospital Discharge Summary or with respiratory change of condition. On 6/24/2025, all residents on supplemental oxygen were visualized by Director of Health Services (DHS) and orders were reviewed to ensure Medical Director orders were in electronic health record. No additional deficiencies were identified. 3. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? On 6/24/2025, all licensed nursing staff were educated by Director of Health Services (DHS) on Use of Oxygen and to obtain oxygen orders on admission, per resident home regimen as requested and with any change of respiratory condition with real time discussion and post test questions to ensure competency. Staff are to receive a 100% pass rate on post test to ensure staff retained education provided. Any newly hired licensed nursing staff will have education provided during new hire orientation by their nurse preceptor/mentor. The campus does not use agency staff. 4. How the facility plans to monitor its performance to ensure that solutions are sustained. Beginning 7/2/2025, the Director of Health Services or Assistant Director of Health Services will visualize and review residents on supplemental oxygen to ensure Medical Director orders are in place weekly x1 month, every other week x 2 months, then monthly x 3 months. As a quality measure, the DHS will review any findings	

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F0695 SS = D	Continued from page 10 interventions directed staff to administer supplemental oxygen per physician's order and as needed (dated 04/30/2025). Review of R54's "Active Orders" revealed an order dated 04/23/2025, for nursing to manage the resident's oxygen administration in coordination with the physician to prevent respiratory acidosis. Review of the Active Orders further revealed however, no physician's order specifying when R54's supplemental oxygen was to be administered or a with a prescribed supplemental oxygen flow rate. In interview on 06/04/2025 at 8:59 AM, R54 stated he/she used supplemental oxygen at night as his/her oxygen level dropped whenever he/she laid down. The resident further stated he/she had used supplemental oxygen every night since being admitted to the facility. Review of the nursing "Progress Note," dated 04/22/2025 at 10:09 PM, revealed R54 had an oxygen saturation (O2 sat) level of 91 percent on room air. Review further revealed supplemental oxygen was administered to R54 at a rate of two liters per minute (2 LPM) by way of nasal cannula. Review of the physician "Progress Note" dated 04/23/2025 at 8:04 PM for R54, revealed under a section titled, "Assessment" it was noted the resident was status post (s/p) acute hypoxia respiratory failure, and was on oxygen. Review of the Progress Note further revealed under a section titled, "Plan," it was noted to "Continue oxygen." Review of the nursing Progress Notes, dated 04/27/2025, 05/02/2025, 05/04/2025, 05/05/2025, 05/08/2025, 05/12/2025, 05/14/2025, 05/15/2025, 05/19/2025, 05/20/2025, 05/21/2025, 05/29/2025, and 05/31/2025, revealed it was documented R54 used supplemental oxygen. Further review of those nursing Progress Notes revealed staff should refer to physician's orders for the oxygen flow rate and delivery method for R54. In interview on 06/03/2025 at 2:32 PM, Licensed Practical Nurse (LPN) 1 stated R54 wore supplemental oxygen at night. LPN 1 further stated there should have been an order for R54's supplemental oxygen	F0695	Continued from page 10 and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue beyond 6 months, if warranted, until 100% compliance is met. 5. Date of compliance 7/8/2025	

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F0695 SS = D	Continued from page 11 administration and a place to record the resident's oxygen saturation level. In interview on 06/04/2025 at 9:53 AM, LPN 2 stated R54 wore supplemental oxygen at night. She further stated there should have been an order for R54's supplemental oxygen. In a telephone (phone) interview on 06/04/2025 at 1:01 PM, LPN 4 stated she worked on the nightshift and had cared for R54 several times. LPN 4 further stated she had observed R54 wearing supplemental oxygen when she cared for the resident. In interview on 06/04/2025 at 3:11 PM, the Director of Health Services (DHS) stated a physician's order was needed for the administration of supplemental oxygen. The DHS said it was her expectation for nurses to obtain an order if a resident needed to use supplemental oxygen. She reported nurses could provide supplemental oxygen in an emergency situation and then immediately notify the physician for an order and parameters to follow. The DHS reviewed R54's physician orders and verified there was no order for supplemental oxygen for the resident. She further verified R54 wore supplemental oxygen nightly and had since being admitted to the facility.	F0695		
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, facility policy review, and review of manufacturer's information, the facility failed to ensure the medication error rate was less than 5 percent (%). The facility had 4 medication errors out of 26 total opportunities, affecting 2 of 3 residents reviewed during the medication administration task (Resident (R)54 and R58), which resulted in a medication (med) error rate of 15.38 %.	F0759	[No data entered]	07/08/2025

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F0759 SS = E	Continued from page 12 The findings include: Review of the facility policy titled, "Medication Administration - General Guidelines," revised 11/2018, revealed medications were to be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Continued review of the policy revealed, the "FIVE RIGHTS" for medication administration revealed the rights included: right resident; right drug; right dose; right route; and right time and were to be applied for each medication being administered. Per policy review, The policy medications were to be administered in accordance with written orders of "the prescriber." Further policy review revealed medications were to be administered within 60 minutes of the scheduled time, except before, with or after meal orders, which were "administered based on mealtimes." 1. Review of the "Resident Face Sheet" for R58 revealed the facility admitted the resident on 05/14/2025, with diagnoses that included gastrointestinal hemorrhage and constipation. Review of the Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 05/16/2025, revealed the facility assessed R58 to have a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated the resident had moderate cognitive impairment. Review of the "Active Orders" for R58 revealed an order dated 05/19/2025, for polyethylene glycol 3350 powder (a laxative) 17 grams (gms) per dose with instructions to administer one lid full in water twice a day between 6:00 AM and 10:00 AM and between 6:00 PM and 10:00 PM. Observation of medication administration on 06/03/2025 at 8:28 AM, revealed Licensed Practical Nurse (LPN) 1 removed the bottle top from the polyethylene glycol 3350 powder, poured the powder into the bottle top. Continued observation revealed LPN 1 then without placing the top of the bottle on a flat surface and measuring the medication with the provided measurement lines on the inside of the bottle top itself, poured the powder into a drinking glass. Further observation revealed LPN 1 then poured approximately four ounces of	F0759		

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F0759 SS = E	Continued from page 13 red juice into the cup, stirred it, and gave it to R58 with his/her other medications. During interview on 06/03/2025 at 2:24 PM, LPN 1 stated she did not know the proper way to measure the correct dosage of polyethylene glycol 3350 powder. During interview on 06/04/2025 at 9:53 AM, LPN 2 stated powdered medications, such as polyethylene glycol, usually came with a scoop. The LPN reported if the powdered medication did not have a scoop, "you" should fill the cap of the medication bottle. LPN 2 further stated to make sure the medication was measured correctly, "you" should shake the lid or tap it on top of the cart to see if it was level. During interview on 06/04/2025 at 10:12 AM, Registered Nurse (RN) 3 stated for powdered medications, such as polyethylene glycol, she used the clear medication cups for accuracy. RN 3 said if a staff member did not level the medication to ensure the correct amount was being administered, it would be a medication error. During interview on 06/04/2025 at 3:11 PM, the Director of Health Services (DHS) stated for a powdered medication, such as polyethylene glycol 3350 powder, there was a line in the bottle top that staff were to utilize when administering the medication. The DHS further stated the medication should be filled to that line and confirmed by the nurse by checking it at eye level. 2. Review of the "Resident Face Sheet" for R54 revealed the facility admitted the resident on 04/21/2025, with diagnoses that included diagnoses of hypokalemia (low potassium levels) and hypothyroidism (low thyroid levels). Review of the Admission MDS Assessment, with an ARD of 04/25/2025, revealed the facility assessed R54 to have a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of the "Active Orders" for R54 revealed the orders contained the following:	F0759		

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F0759 SS = E	Continued from page 14 - an order dated 04/21/2025 for calcium carbonate 500 milligrams (mg), one tablet once a day between 6:00 AM and 10:00 AM; - an order dated 04/21/2025 for "ferrous gluconate" 324 mg (38 mg of iron)" with instructions to administer with breakfast, once a day between 6:00 AM and 10:00 AM; - an order dated 05/10/2025 for levothyroxine 125 micrograms (mcg) once a day between 6:00 AM and 10:00 AM; and - an order dated 04/21/2025 for potassium chloride extended release 20 milliequivalents (mEq) with instructions to administer with meals, twice a day between 6:00 AM and 10:00 AM and between 4:00 PM and 6:00 PM. Review of the Manufacturer's "Prescribing Information" for levothyroxine sodium revealed the following instructions: "Take UNITHROID [levothyroxine sodium] on an empty stomach at least 30 minutes to 1 hour before eating breakfast or 3 or more hours after dinner or your last meal of the day." Review further revealed to wait "4 hours before or after taking calcium or iron supplements (including prenatal vitamins)." During observation of medication administration on 06/03/2025 at 8:42 AM, LPN 1 prepared R54's medications, including calcium carbonate 500 mg, ferrous gluconate 324 mg, levothyroxine 125 mcg, and potassium chloride 20 mEq, and placed them into one medication cup. Observation further revealed LPN 1 administered the medications to R54 with a 5-ounce glass of water. During interview on 06/03/2025 at 2:24 PM, LPN 1 stated medications that were to be administered with food should be given within 15 minutes of consuming food. She confirmed R54's potassium was ordered to be given with food and verified the breakfast trays had not been delivered to the hallway at the time of the medication pass observation. The LPN reported she had not provided food for R54 during the morning medication pass. LPN 1 stated she also administered R54's levothyroxine along with the residents' other morning medications, including his/her calcium and iron.	F0759		

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F0759 SS = E	Continued from page 15 During interview on 06/04/2025 at 9:53 AM, LPN 2 stated a medication that was to be given with food should be given within 30 minutes of the resident consuming food, or a snack could be provided to the resident. She further stated typically, thyroid medications (such as the resident's levothyroxine) were given an hour before all other medications. During interview on 06/04/2025 at 10:12 AM, RN 3 stated if medication was to be given with food, the resident had to be eating when the medication was given. The RN said she usually waited until the resident had eaten before she gave the medication to the resident. RN 3 reported if it was not mealtime, a snack, such as pudding or crackers, could be given with the medication. The RN further stated levothyroxine was a medication that was to be administered separately from other medications and was usually given at 5:00 AM. During interview on 06/04/2025 at 3:11 PM, the Director of Health Services (DHS) stated if medication was to be given with food. She said if a meal was not present at the time of the medication administration, the nurse should provide pudding or crackers during the medication pass to coat the resident's stomach. The DHS explained medications that were to be administered with food should be given to the resident with food. She reported levothyroxine was a medication that was to be given separately from other medications and on an empty stomach. The DHS confirmed R54 had not been asked if it was his/her preference to take all his/her medications together and there was no order for the levothyroxine to be given along with all the other medications. She stated her expectation was for the nurses to follow the physician's orders for medication administration. The DHS further stated all of the above discussed medication administration issues were medication errors. During interview on 06/04/2025 at 4:11 PM, Pharmacist 5 stated the recommendation for levothyroxine was to administer the medication an hour before all other medications and on an empty stomach for the best absorption. Pharmacist 5 said potassium should be given with food to prevent stomach upset and the physician's order should be followed. During interview on 06/05/2025 at 11:02 AM, the	F0759		

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F0759 SS = E	Continued from page 16 Executive Director stated his expectation was for the nurses to administer medications the proper way.	F0759		