STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(4) 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
)000	INITIAL COMMENTS Amended A Recertification and Abbreviated survey was conducted from 08/12/2025 through 08/15/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Immediate Jeopardy (IJ) was identified on 08/14/2025 and determined to exist on 04/09/2025 in the area of 42 CFR 483.80. The facility admitted Resident (R) 121 on 03/29/2025 without respiratory diagnoses. Review of the hospital record for R121 revealed, on 04/05/2025, R121 was admitted to the local hospital exhibiting a fever of 100.4° degrees Fahrenheit (F) and decreased oxygen saturation. Further review revealed R121 was admitted with diagnoses to include acute respiratory failure with hypoxia, suspect for pneumonia, and his urine antigen test, dated 04/05/2025, was positive for legionella. Per the record, R121 expired on 04/09/2025. Also, on 04/09/2025, the Local Health Department (LHD) informed the facility that R121 had been diagnosed with Legionnaire's disease while in the hospital. Testing conducted by a third-party water specialist revealed positive areas for legionella in the facility. On 04/14/2025 uncontrolled levels of growth were identified in the hot shower of Room 158 and in the cooling tower. Before this incident, there was no written water management program in place, and the facility was not actively flushing dead legs (an area of piping system where fluid flow was minimal or nonexistent) in the water system. On 08/14/2025 at 6:15 PM, the facility Administrator was informed of the IJ and was provided a copy of the CMS IJ Template and notified that the facility's failure to have a water management program to control for Legionella put residents at risk for Legionella pneumonia, including Resident 121, who expired on 04/09/2025 following becoming symptomatic for Legionnaires disease while a resident at the facility. The facility provided an acceptable plan for removal of the immediate jeopardy on 08/15/2025 at 1:35 PM. The survey team validated the immediate jeopardy was removed on 07/15/2025 prior to exit on 08/15/2025	F0000		09/03/2025

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other feguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 ys 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 lowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program rticipation.

ıBORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0000	Continued from page 1 following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at an "F," widespread with the possibility of more than minimal harm, following the removal of the immediate jeopardy. A deficiency was related to 715700 at F880. No deficiencies were issued related to 715694, 715695, 715696, 715697, 715698, and 715699. Survey Dates: 08/12/2025 to 08/15/2025 Survey Census: 99 Sample Size: 22 Supplemental Residents: 26	F0000		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident who was unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal and oral hygiene for 1 of 2 residents investigated for ADLs, Resident (R) 122. The findings include: Review of the facility's policy titled, "Activities of Daily Living (ADLs)," dated 10/23/2024, revealed, "The facility will provide care and services for activities of daily living including, bathing, dressing, grooming and oral care." Further review revealed, "A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene." Review of R122's "Admission Record" revealed the facility admitted the resident on 08/08/2025 with diagnoses including COVID-19 and syncope. Review of R122's admission "Minimum Data Set [MDS],"	F0677	Tag Cited: F-677 §483.24(a)(2) – Unable to Carry Out ADLs Issue Cited: "Facility failed to ensure a resident who was unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal and oral hygiene for 1 of 2 residents investigated for ADLs, (Resident (R) 122)" Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Immediate action(s) taken for the resident(s) found to have been affected include: -Resident 122 received immediate assistance with	09/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(4) 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
)677 S = D	Continued from page 2 with an Assessment Reference Date (ARD) of 08/15/2025, revealed the facility assessed to resident to have a "Brief Interview for Mental Status [BIMS]" score of 15 out of 15, which indicated the resident was cognitively intact. Further review revealed R122 required partial to moderate assistance with showering. Review of R122's "Comprehensive Care Plan," dated 08/08/2025, revealed a focus of impaired ADL function and need for assistance with self-care activities. Further review revealed an intervention for partial/moderate assistance with toileting, transfers, bathing, dressing, and grooming. Review of R122's "ADL Charting" revealed the section "Resident Received a Shower" was marked "Yes" for 08/11/2025. Observation on 08/12/2025 at 12:15 PM revealed signage outside of R122's room that indicated the resident was in droplet/contact precautions. During an interview with R122 on 08/12/2025 at 4:04 PM, she stated she was in isolation for an infection with COVID-19, and staff informed her they were not allowed to assist her with a shower in her room until her precautions were lifted. She further stated staff helped her clean up with wipes, but she wanted a shower because she came to the facility after a hospital stay. She further stated she had not had a shower in a while and needed one. During an interview with Family Member (FM) 9 on 08/14/2025 at 6:57 PM, she stated she was informed by Registered Nurse (RN) 4 that staff was unable to assist R122 with a shower until the resident came out of isolation. FM9 stated she did not quite understand, but when told it was the facility's policy, she accepted that. During an interview with State Tested Nurse Aide (STNA) 4 on 08/13/2025 at 3:29 PM, she stated R122 was on precautions for COVID-19, and she was not allowed to assist with showers when residents were on droplet precautions for COVID. STNA4 stated she was given that information by one of the nurses but was unable at the time to remember which nurse. STNA4 stated she helped R122 clean up with wet wipes. During a follow-up interview with STNA4 on 08/14/2025 at 11:29 AM, she stated she had not cared for a resident that was COVID positive and asked RN4 for guidance. STNA4 further stated RN4 informed her it was facility protocol that residents were not assisted with	F0677	Continued from page 2 grooming and oral hygiene on the date the deficiency was identified. Resident 122's care plan was reviewed and revised to reflect specific grooming and hygiene needs. Director of Nursing validated completion of grooming and oral care on the shift of correction. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. -A 100% audit of all residents requiring assistance with ADL's was conducted within 72 hours of deficiency identification to ensure grooming and hygiene needs were met. Audit completed by Nurse Managers. No resident was noted to be without appropriate grooming or oral care at the time of this audit. Audit results were documented and submitted to the Director of Nursing. Actions taken/systems put into place to reduce the risk of future occurrence include: -ADL policy reviewed by Director of Nursing, Corporate compliance, Administrator on 8/14/2025. -Direct care staff (STNA's, Nurses), were re-educated (with attendance documented) by the Director of Nursing, Nurse Managers and Staff Development Nurse on the ADL Policy and expectations for grooming and oral hygiene along with a post education test with 100% of the team completed by 8/21/2025. Mandatory Post Education Test score of 75% or higher. Staff were not permitted to return to work until education completed. Agency staff educated by Director of Nursing, Nurse Managers, and Staff Development Nurse prior to their next shift. Future Agency staff will be educated in the orientation packet. Education added to new employee orientation as of 9/1/25. -Initiation on 8/15/25 of STNA assignment tasks and care plans for all residents dependent with ADL's were reviewed and revised as indicated by licensed nurses within 7 days of admission to ensure grooming and oral hygiene needs are addressed. -Initiation on 8/15/25 of Nurse Managers to conduct daily visual audit of dependent residents for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0677 SS = D	Continued from page 3 showers until they were out of droplet precautions. During an interview with RN4 on 08/15/2025 at 9:03 AM, she stated the facility protocol for staff when they provided ADL assistance to COVID positive residents was to follow precautions and properly don (put on) and doff (remove) the appropriate personal protective equipment (PPE). RN4 stated, in the past, the facility protocol was staff provided bed baths instead of showers to residents who were COVID positive, particularly if they were symptomatic. RN4 further stated she had communicated that information to the aides because that was her understanding of the process. Also, she stated R122 was not symptomatic. During an interview with Licensed Practical Nurse (LPN) 1 on 08/13/2025 at 4:00 PM, she stated it was not the facility's policy that residents were given a bed bath only and no shower when they were on droplet precautions for COVID. During an interview on 08/15/2025 at 9:18 AM, the Infection Preventionist (IP) stated it was her expectation staff used a gown, mask, and gloves when they provided care to residents with COVID. Further, she stated there had been situations in the past where the doctors did not want the resident(s) to have a shower if the resident(s) was symptomatic. Further, she stated R122 was asymptomatic, and it was not applicable to her. During an interview at 08/15/2025 at 11:30 AM, the Director of Nursing (DON) stated it was his expectation that staff was familiar with each resident's care plan/Kardex, and staff followed those care guides and ensured residents' needs were met and ADLs completed. He further stated there was no specific policy for showers for residents with COVID, but rather a practice they instituted at the height of the COVID pandemic. However, he stated the practice addressed residents individually based on symptoms. He stated R122 should not have been denied a shower because she was asymptomatic. The DON stated he was not sure why the STNA told R122 she was unable to assist her with a shower. He stated it was possibly related to information provided to her by another staff member related to old COVID policies. During an interview on 08/15/2025 at 3:07 PM, the Medical Director stated she generally recommended that staff avoid showers for COVID residents, especially if they had an active cough or were otherwise symptomatic. She stated she still preferred the original CDC guidelines for COVID, but determinations were made on a	F0677	Continued from page 3 appropriate grooming and hygiene. Audits continue daily for 1 week, then weekly for 4 weeks. Results of audit will be presented to QAPI by the Director of Nursing and will continue based on QAPI recommendations. How the corrective action(s) will be monitored to ensure the practice will not recur: -Director of Nursing or Nurse Manager(s) to conduct random audit of 5 dependent residents per week for 12 weeks to verify grooming and oral hygiene care are completed and documented. This was initiated on 8/15/25. Audit tool will track compliance percentages. -Audit results will be reviewed monthly in QAPI presented by the Director of Nursing for 3 consecutive months. If 100% compliance is sustained for 3 months, audits will move to monthly random checks of 5 residents for ongoing monitoring. This plan of correction will be monitored at the Quality Assurance meetings until such time consistent substantial compliance has been determine to have been met. The Quality Assurance Committee is compiled of the Medical Director, Infection Preventionist, Administrator, Director of Nursing, Social Services and Staff Development Nurse. The Director of Nursing presented the first findings during a QAPI meeting held on 9/3/25. Those in attendance were the Medical Director, Infection Preventionist, Administrator, Director of Nursing, Dietary Manager, Medical Records, Admissions Coordinator, Nurse Managers, Therapy Director, MDS Nurses, Human Resource Manager, Maintenance Director, Activities Director, Business Office Manager, and Environmental Services Director. Completion date: 9/4/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

K4) ID REFIX 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
0677 S = D	Continued from page 4 case-by-case basis, and ultimately, the resident's wishes were honored at the facility. During an interview on 08/15/2025 at 2:29 PM, the Administrator stated she expected staff to provide ADL assistance to residents with COVID in a safe manner by wearing PPE. When asked if there were limitations on the type of assistance provided to COVID positive residents by staff, she stated it was decided on a case-by-case basis. She further stated the Medical Director typically did not want COVID positive residents showered. She stated the Medical Director's decision was based on the Centers for Disease Control and Prevention (CDC) recommendations during the COVID pandemic. The Administrator further stated the facility honored resident preferences, and if they wanted a shower, they were given a shower. The Administrator stated she was unaware that R122 requested a shower and was not given one.	F0677		
0761 S = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by:	F0761	Tag Cited: F-761 §483.45(h) – Storage of Drugs and Biologicals Issue Cited: "The facility failed to ensure medications were labeled to identify the specific resident and/or the date opened, failed to ensure medications were stored under proper environmental controls, and failed to ensure compounded medications were labeled appropriately, affecting 1 of 7 medication carts observed, 1 of 7 medication refrigerators, and 1 of 1 resident reviewed for compounded medications (Resident 56)." Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Immediate action(s) taken for the resident(s) found to have been affected include: -Resident 56's compounded medication bag was immediately discarded and reprepared with a proper pharmacy label including: resident name, contents,	09/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0761 SS = E	Continued from page 5 Based on observation, interview, and review of the facility's document and policies, the facility failed to ensure medications designed for multiple administrations were labeled to identify the specific resident for whom it was prescribed and/or the date the medication was opened in 1 of 7 sampled medication carts for the Maple Unit. Additionally, the facility failed to ensure the provision of appropriate environmental controls to preserve the integrity of medications in 1 of 7 sampled medication refrigerators, the Maple Unit medication storage refrigerator. Also, the facility failed to ensure when medications were prepared or compounded for use, a label containing the required information was attached to the compounded medication label for 1 of 1 sampled resident, Resident (R) 56 The findings include: Review of the facility's policy titled, "General Dose Preparation and Medication Administration," last revised date 11/15/2024, revealed staff should enter the date opened on the label of medications with shortened expiration dates. Additionally, staff should not administer a medication if the medication prescription label was missing or illegible. Review of the facility's policy titled, "Storage and Expiration Dating of Medication and Biologicals," last revised date 08/01/2024, revealed when an ophthalmic solution or suspension had a manufacturer shortened beyond use date once opened, staff should record the date opened and the date to expire on the container. Additional review revealed the facility should ensure medications and biologicals were stored at their appropriate temperatures according to the United States Pharmacopeia (USP) guidelines for temperature ranges and manufacturer guidance. Refrigeration parameters were documented as 36 to 46 degrees Fahrenheit (F). Review of the facility's document "Refrigerator/Freezer Temp Log" included directions to record temperatures at 6:00 AM and 6:00 PM upon shift change. 1. Observation on 08/13/2025 at 2:15 PM of the Dogwood Unit Medication Cart revealed opened medications of one Fluticasone nasal spray, one Lantus insulin pen, one Humalog insulin pen, one tube of Erythromycin 5 milligram per gram eye ointment, one bottle of Atropine 1% eye drops, one bottle of Brimonidine 0.2% eye drops, and one Albuterol inhaler. Those medications were not labeled to identify the specific resident for whom it was prescribed and/or the date the medication was opened.	F0761	Continued from page 5 dosage, beyond-use date, initials of compounder, and storage instructions. -All unlabeled medications observed on 8/13/2025 were immediately removed and replaced with properly labeled medications. -The Maple Unit medication refrigerator was adjusted to proper temperature (36-46 degrees Fahrenheit) on 8/14/2025, and contents were discarded if viability could not be assured. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents receiving medications requiring refrigeration have the potential to be affected. -A 100% audit of all medication carts and refrigerators was completed facility-wide within 72 hours. Any unlabeled, undated or improperly stored medication was discarded and replaced. -All residents requiring compounded medications were reviewed to ensure proper labeling and storage were in place. Actions taken/systems put into place to reduce the risk of future occurrence include: -Education: All licensed nursing staff and medication aides were re-educated by the Director of Nursing and Staff Development Coordinator initiated on 8/14/2025 addressing the facility policy regarding the proper storage of medications and including: -Labeling requirements for all multi-dose and compounded medications (resident name, date opened, beyond-use date, initials of staff). -USP and manufacturer guidelines for storage and temperature parameters. -Policy for discarding unlabeled or expired medications immediately. -Post Test with mandatory score of 75% or higher achieved by all staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(4) 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
)761 S = E	Continued from page 6 2. Observation on 08/14/2025 at 7:00 AM revealed the medication storage refrigerator on the Maple Unit's facility thermometer measured the temperature inside the refrigerator was 20 degrees Fahrenheit (F). One unopened bottle of Tuberculin purified protein derivative (PPD) was stored on the door shelf. Additionally, three unopened bottles of Latanoprost Ophthalmic Solution 0.005 % with fill dates of 3/23/2025, 06/05/2025, and 06/23/2025 were also stored in the refrigerator. However, review of the medication refrigerator temperature log revealed no temperature was documented for 08/14/2025 at 7:00 AM. During an interview on 08/14/2025 at 7:00 AM with Registered Nurse (RN) 3, she stated the refrigerator was "temperamental," and she would check it throughout the day. She stated she should have notified maintenance related to the refrigerator not working, but she did not. During an interview on 08/14/2025 at 10:27 AM with Kentucky Medication Aide (KMA) 8, she stated the nurses were responsible for logging the refrigerator temperatures. During an interview on 08/14/2025 at 6:25 AM with Licensed Practical Nurse (LPN) 7, she stated all the nurses were responsible for checking the medication refrigerator temperatures. LPN7 further stated on night shift, she usually checked the temperature around midnight after the residents were in bed, and things were quiet. LPN7 stated she did not know what nursing supervisor was responsible for managing the medication room and refrigerators. During an interview on 08/14/2025 at 10:26 AM, the Unit Manager (UM) stated she had been at the facility for 15 years and temperatures in the refrigerators on the unit were checked once a day by the nurses. The State Survey Agency (SSA) Surveyor showed the log to the UM with directions for twice a day, and she stated, "Oh." 3. Observation on 08/14/2025 at 10:28 AM of the Walnut Unit medication refrigerator revealed a 250-milliliter bag of normal saline labeled "mixed" in black marker but was unlabeled as to resident and what was "mixed" in the bag. During an interview On 08/14/2025 at 10:28 AM with LPN4, she stated the bag in the medication refrigerator on the Walnut unit marked "mixed" with black marker	F0761	Continued from page 6 - 100% compliance with education achieved by 8/25/25. Staff were not permitted to return to work until education completed. Agency staff educated by Director of Nursing, Nurse Managers, and Staff Development Nurse prior to their next shift. Future Agency staff will be educated in the orientation packet. Education added to new employee orientation as of 9/1/25. -Policy Reinforcement: Facility policies on 'General Dose Preparation and Medication Administration' and 'Storage and Expiration Dating of Medication and Biologicals' were reviewed and updated, with staff sign-off required. -Storage: Medication refrigerator logs were updated to require twice-daily temperature documentation on Day shift and on Night shift. Initiated on 8/15/25. -Responsibility Clarification: Nurse Managers will verify compliance daily, initiated on 8/15/25. Director of Nursing will ensure monthly review of temperature logs and random spot checks of carts/refrigerators, initiated on 8/15/25. How the corrective action(s) will be monitored to ensure the practice will not recur: -Director of Nursing and Nurse Managers will audit all medication carts and refrigerators weekly for 12 weeks, verifying labeling, dating, and storage compliance to ensure appropriate storage on an on-going basis, initiated on 8/15/25. -Compliance goal: 100% proper labeling and storage. -Audit results will be documented and reported monthly to QAPI Committee by the Director of Nursing for 3 months. If compliance remains at 100% for 3 consecutive months, audits will reduce to monthly random checks of 25% of carts/refrigerators. The Director of Nursing presented the first findings during a QAPI meeting held on 9/3/25. Those in attendance were the Medical Director, Infection Preventionist, Administrator, Director of Nursing, Dietary Manager, Medical Records, Admissions Coordinator, Nurse Managers, Therapy Director, MDS Nurses, Human Resource Manager, Maintenance Director, Activities Director, Business Office Manager, and Environmental Services Director. -Any noncompliance identified will result in immediate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0761 SS = E	Continued from page 7 belonged to Resident (R) 56 and contained the drug gentamycin which was used in his suprapubic catheter once a day. When asked how she knew what was contained in the unlabeled bag and who the unlabeled bag was for, she stated she had added the gentamycin to the bag that morning per pharmacy instructions. LPN4 further stated she and one other day shift nurse were the only nurses to instill the medication into the resident's bladder, and they both knew who the medication in the bag was for. LPN4 further stated a label for the medication came from pharmacy, but she did not place it on the bag after she mixed it, and she knew the medication was good for one week after mixed if kept in the refrigerator. LPN4 stated she could see if another nurse picked up the bag and did not see a label on it, that nurse would not know what was in the bag, which was not safe, and could cause a medication error. During an interview on 08/15/2025 at 9:45 AM with LPN6, she stated the instructions for mixing of R56's irrigation solution for his suprapubic catheter came on a label on the bag of the gentamycin vials. LPN6 stated there were several bottles within the bag, and she would not remove the label on that bag to place it on the mixed bag she prepared for R56. She stated she would create a separate label for the mixed bag with R56's name on it with the contents of the bag, the day and time she mixed it, and her initials. LPN6 stated if she came to work and found a bag in the refrigerator, unlabeled with the word "mixed" on it, she would not use it because that was not safe for the resident and could result in a medication error. During an interview on 08/15/2025 at 11:41 AM with the Staff Development Coordinator (SDC) she stated she educated nursing staff to the labeling of compounded medications in the annual Medication Administration skills fair. Per the interview, she stated any compounding education would have included the labeling of the compounded medication with the resident's name and room number, date of compounding, contents, dosing information, usage instructions and the initials of the person who compounded or mixed the medication. She stated the storage of an unlabeled compounded medication could lead to many things happening, and avoiding medication errors and resident safety should be the staff's first concern. During an interview on 08/14/2025 at 12:44 PM with the Pharmacist, he stated the gentamycin for R56 was delivered to the facility in two 40 milligram (mg) per milliliter (ml) per two ml vials and included directions for staff to mix 3 ml into a 250 ml bag of	F0761	Continued from page 7 removal of medication, staff re-education, counseling if recurrent. This plan of correction will be monitored at Quality Assurance meetings until such time consistent substantial compliance has been met. The Quality Assurance Committee is compiled of the Medical Director, Infection Preventionist, Administrator, Director of Nursing, Social Services and Staff Development Nurse. Responsible Party: The Director of Nursing, with oversight from the Administrator, is responsible for implementing and sustaining this Plan of Correction. Completion date: 9/4/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(4) 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
)761 S = E	Continued from page 8 0.9 Normal Saline (NS). The Pharmacist then stated the resulting drug mixture in the 250 ml bag would be stable at room temperature for 24 hours and stable in the refrigerator for seven days. The Pharmacist further stated since R56 received 60 ml of the medication from the 250 ml bag each day, the bag would be good for four days, and the remaining 10 ml in the bag would be discarded after the dose was delivered on the fourth day. Additionally, the Pharmacist stated the facility was responsible for monitoring and auditing the medication rooms and carts for expired or discontinued medications, as that task was not included in the contract the pharmacy had with the facility. During an interview on 08/14/2025 at 1:05 PM with the Director of Nursing (DON), he stated the responsibility for maintaining the cleanliness of the refrigerators, checking the temperatures of the refrigerators and the monitoring for the labeling of medications and the removal of expired and discontinued medication was whomever was assigned to the medication cart that day. The DON further stated the storage of medications in the refrigerator at the proper temperature, and the labeling of medications was important for the safety of the residents to avoid medication errors. During an interview on 08/15/2025 at 2:40 PM with the Administrator, she stated the floor nurses were responsible for the monitoring of the residents' medication and the residents' supplement refrigerators located in the unit medication rooms both for temperature and cleanliness. She stated the Nurse Manager on the unit was responsible for ensuring the temperature logs and the refrigerators were being maintained. The Administrator stated it was her expectation all medications that had been opened were labeled with an opened date to ensure they would be used and disposed of properly. Additionally, the Administrator stated she expected any mixed or compounded medication to be labeled with the resident's name, the name of the medication, and dosage. Finally, the Administrator stated her concern with undated and unlabeled medication was the possibility the medication would be ineffective or cause harm to the resident.	F0761		
)812 S = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	Tag Cited: F-812 §483.60(i)(2) – Food Safety Requirements Issue Cited: "Facility failed to ensure food items located in dry storage, the walk-in refrigerator, the	09/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0812 SS = F	Continued from page 9 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of facility policies, the facility failed to ensure food items located in dry storage, the walk-in refrigerator, the number five kitchen reach-in refrigerator, and unit nourishment refrigerators were properly labeled and dated, and that expired food items were discarded. This deficient practice affected all 99 current residents. The findings include: Review of the facility's policy titled, "Food and Supply Storage," revised 01/2024 revealed foods past the "use-by," sell-by," "best-by," or "enjoy-by" date should be discarded. Further review revealed unused portions and opened packages of food should be covered, labeled, and dated. Observation during an initial brief kitchen tour on 08/12/2025 at 10:53 AM revealed one pork ham with a discard date of 08/11/2025 located in the walk-in refrigerator; an undated, opened package of devil's food cake mix, an undated, opened 11 pound tub of chocolate fudge icing, and an expired loaf of bread located in dry storage; and an expired container of italian salad dressing located in the number five reach-in refrigerator. Observation of the Maple Unit nourishment refrigerator on 08/13/2025 at 2:02 PM revealed one container of yogurt with a "best-by" date of 08/06/2025.	F0812	Continued from page 9 number five kitchen reach-in refrigerator, and unit nourishment refrigerators were properly labeled and dated, and that expired food items were discarded." Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Immediate action(s) taken for the resident(s) found to have been affected include: -All expired, unlabeled and undated food items identified during the survey were immediately discarded on 8/13/2025. -All neighborhood walk in refrigerators, dry storage areas, and reach-in refrigerators were thoroughly inspected, cleaned, and sanitized by dietary staff under the supervision of the Culinary Manager on 8/14/2025. -All residents were monitored for potential signs or symptoms of foodborne illness, with no adverse outcomes identified. Registered Dietitian (RD) ran report within Point Click Care to review Health Status Report Notes on 8/14/2025. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents who consume food by mouth have the potential to be affected. -An immediate audit of all kitchen and nourishment refrigerators across all units was conducted on 8/14/2025 to ensure no other expired or unlabeled items were present. Ongoing audits by RD confirmed no other residents were affected. Actions taken/systems put into place to reduce the risk	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(4) 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
0812 S = F	Continued from page 10 Observation of the Dogwood Unit nourishment refrigerator on 08/13/2025 at 2:30 PM revealed one container of yogurt with an expiration date of 05/11/2025, one chocolate pudding cup with an expiration date of 08/03/2025, and one chocolate pudding cup that had burst opened and leaked out of the container. Observation of the Magnolia Unit nourishment refrigerator on 08/13/2025 at 2:38 PM revealed eight containers of gelatin with an expiration date of 10/2024, one container of gelatin with an expiration date of 01/2024, two containers of gelatin with expiration dates of 02/2025 and 07/2025, and one container of gelatin with an expiration date of 11/29/2023. Observation of the Walnut Unit nourishment refrigerator on 08/13/2025 at 2:49 PM revealed one bottle of french salad dressing with an expiration date of 05/2025, a four-serving snack pack of gelatin with an expiration date of 10/22/2024, and one bottle of mustard with a "best-by" date of 06/13/2024. Observation of the Hensley nourishment refrigerator on 08/13/2025 at 3:14 PM revealed three 4-ounce containers of orange juice with a "best-by" date of 08/09/2025. During an interview with Patient Server 1 on 08/13/2025 at 1:58 PM, she stated she had not been instructed to check nourishment refrigerators for expired items. During an interview with Dietary Checker 1 on 08/13/2025 at 2:02 PM, she stated it was primarily the responsibility of the Chef to ensure items were labeled and dated when received from the food truck. She further stated when items were received from the truck, they were marked with a sticker that contained the received date. She stated when items were opened, they were marked with a sticker that contained the opened date. Dietary Checker 1 stated any expired food items should be thrown away immediately to prevent residents from getting sick. During an interview with Dietary Runner 1 on 08/13/2025 at 2:05 PM, he stated he placed the meal trays in the boxes and delivered them to the floors. He further stated that on a typical day there were three runners, and one of those runners was designated to check the nourishment refrigerators on the units. Dietary Runner 1 stated if expired or unlabeled items were found in the refrigerators, they were immediately discarded, and the supervisor was notified. Dietary Runner 1 stated it was important expired food items were discarded and not	F0812	Continued from page 10 of future occurrence include: -Review of policy and procedure for Food Procurement, Storage and Labeling was completed by Culinary General Manager with re-education provided to all dietary staff effective 8/15/2025. -Unit nourishment refrigerators to be visually checked daily by the designated dietary runner, with a secondary verification by dietary manager at least three times per week, initiated on 8/14/25. -A "discard log" has been implemented as of 8/14/2025 requiring designated dietary runner to document (with supervision by Dietary Manager) all items discarded, including the reason (expired, unlabeled, damaged, etc.). -Nursing staff have been re-educated by Culinary General Manager and Staff Development Nurse to not store personal or unlabeled food items in unit refrigerators, initiated on 8/15/25 with 100% compliance as of 8/25/25. -All dietary staff have been in-serviced on the facility's policies and practice guideline for maintaining sanitation in food service by Dietary Managers. Re-education initiated on 8/15/25 with 100% compliance from dietary staff on 8/24/25. Post education test required with a score of 75% or higher. Staff were not permitted to return to work until education completed. Agency staff educated by Dietary Managers prior to their next shift. Future Agency staff will be educated in the orientation packet. Education added to new employee orientation as of 9/1/25. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Dining Services Director will complete a Food Storage and Labeling Audit Tool at least three times weekly for four weeks, then weekly for two months, and monthly thereafter, initiated on 8/14/25. The Dietary Manager will review all audit results and initiate immediate corrective action when non-compliance is identified. Dietary Manager will report audit findings to QAPI meeting. Validation checklists will be reviewed by the Dietary General Manager until such time consistent substantial	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0812 SS = F	Continued from page 11 served to residents to prevent sickness. During an interview on 08/13/2025 at 2:15 PM, the Executive Chef stated he unloaded the truck and was primarily responsible for ensuring items were labeled and dated, but every dietary staff member was responsible for ensuring expired food items were not left on the shelf. The Executive Chef stated everything that came off the truck was given a received date label unless it contained an expiration date. He further stated individual items were each labeled with an opened and a discard date. The Executive Chef stated checking for expired items in the kitchen was a shared responsibility, and the nutrition refrigerators on the units were checked at least once a week. He further stated out-of-date or expired items could potentially cause sickness to residents if they were ingested. During an interview on 08/13/2025 at 2:22 PM, the Culinary Manager stated when staff removed items from the delivery truck, the box or container was marked with a received date. She further stated when staff removed a food item from its case, the item was labeled with both an opened date and a discard date. The Culinary Manager stated that runners usually checked the unit nourishment refrigerators for expired items when they stocked them with new items, and dietary management checked them weekly. When asked about the number of expired items discovered, the Culinary Manager stated she was unsure how they were missed, but it was important the residents were not served outdated items because of the potential for food borne illnesses. During an interview on 08/15/2025 at 11:30 AM, the Director of Nursing (DON) stated he expected dietary staff was aware and observed that food items were labeled and dated appropriately and not kept past their expired date for both the kitchen and the unit nourishment refrigerators. The DON stated it was important the residents were not served expired foods for their health and wellness and for the prevention of sickness. During an interview with the Administrator on 08/13/2025 at 2:29 PM, she stated it was her expectation that all food items in the facility were properly labeled and dated and expired items were discarded. She further stated it was important expired foods were discarded and not served because of the possibility of food borne illness to the residents.	F0812	Continued from page 11 compliance has been achieved as determined by the committee. This plan of correction will be monitored at the Quality Assurance meetings until such time consistent substantial compliance has been met. The Quality Assurance Committee is compiled of the Medical Director, Infection Preventionist, Administrator, Director of Nursing, Social Services and Staff Development Nurse. The Director of Nursing presented the first findings during a QAPI meeting held on 9/3/25. Those in attendance were the Medical Director, Infection Preventionist, Administrator, Director of Nursing, Dietary Manager, Medical Records, Admissions Coordinator, Nurse Managers, Therapy Director, MDS Nurses, Human Resource Manager, Maintenance Director, Activities Director, Business Office Manager, and Environmental Services Director. Completion date. 9/4/2025	
F0880 SS = L	Infection Prevention & Control	F0880	Tag Cited: F-880	09/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(4) 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
0880 S = L	Continued from page 12 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must	F0880	Continued from page 12 §483.80 (a)(1)(2)(4)(e)(f) – Infection Prevention & Control Issue Cited: "Infection Prevention & Control" Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Immediate action(s) taken for the resident(s) found to have been affected include: All residents with pneumonia symptoms were tested via urine antigen testing for Legionella beginning 04/26/2025. No new positive cases were identified. Resident in Room 158 in Assisted Living was relocated, Room 158 showerhead replaced, and outlets flushed on 04/25/2025 by Facility Maintenance. Shared glucometers were immediately removed from use on 08/14/2025 until disinfected per manufacturer instructions. The nurse identified was immediately re-educated on the proper procedures for glucometer disinfection at of 8/14/25 (Exhibit A F880). Identification of other residents having the potential to be affected was accomplished by: A comprehensive risk assessment was completed by the Northern Kentucky Health Department to identify all residents, staff and visitors potentially exposed on 4/9/25. Water samples were collected from all facility units to determine the scope of contamination on 4/14/25 by Legionella Control Systems, Inc. The facility has determined that all residents requiring finger stick glucose monitoring have the potential to be affected. The facility has determined that all residents have the potential to exposure of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0880 SS = L	Continued from page 13 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) document, and review of the facility's documents, policies, and procedure, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for the total census of 99 residents. On 04/09/2025, the Local Health Department (LHD) informed the facility that Resident (R) 121 had been diagnosed with Legionnaire's disease while in the hospital. Testing conducted by a third-party water specialist revealed positive areas for legionella in the facility. On 04/14/2025 uncontrolled levels of growth were identified in the hot shower of Room 158 and in the cooling tower. Before this incident, there was no written water management program in place, and the facility was not actively flushing dead legs (an area of piping system where fluid flow was minimal or nonexistent) in the water system. The resident passed away at the hospital on 04/09/2025. Additionally, observation on 08/14/2025 of Registered Nurse (RN) 3 revealed she failed to clean and disinfect a glucometer according to the facility's policy, the	F0880	Continued from page 13 Legionella. All unit glucometers were audited on 08/14/2025 to ensure proper cleaning supplies and instructions were available at point of use. Actions taken/systems put into place to reduce the risk of future occurrence include: All licensed nursing staff were educated on the facility's Water Management Plan and Legionella (Exhibit B F880). Completed by 4/30/2025 and again on 8/15/2025 by Staff Development Nurse, Director of Nursing and Nurse Managers. Competency quiz (Exhibit C F880) completed by all nursing staff with 100% compliance on 8/20/2025. Staff were not permitted to return to work until education completed. Agency staff educated by Director of Nursing, Nurse Managers, and Staff Development prior to their next shift. Future Agency staff will be educated in the orientation packet. Water Management Program (WMP): A third-party water management consultant developed and implemented a WMP in July 2025, including schematic diagrams, flushing protocols, routine testing, and corrective action plans. The WMP team includes Administrator, Director of Nursing, Infection Preventionist (IP), Maintenance Director, Facility Maintenance, Medical Director, Director of Environmental Services (EVS), and consultant. A Legionella Surveillance Log was established on 4/10/2025 and will be monitored by the IP. Flushing Protocols: Facility-wide flushing schedules were implemented on 04/10/2025. Logs are maintained and reviewed weekly by the Maintenance Director and EVS. All licensed nursing staff were re-educated on the facility's Glucometer Disinfection policy and Practice Guideline as of 9/1/2025 by Staff Development Nurse, Director of Nursing and Nurse Managers (Exhibit D F880). Observation of each nurse performing the procedure using "Validation Checklist" was completed for each nurse to determine if the nurse was performing the procedure correctly (Exhibit E F880). Findings were reviewed with each nurse. Corrective action was provided as needed. Completed on 9/1/2025 by Staff Development Nurse, Director of Nursing and Nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(4) 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
)880 S = L	Continued from page 14 manufacturer's instructions, and the recommended dwell time for the sanitizing wipe. Immediate Jeopardy (IJ) was identified on 08/14/2025 and was determined to exist on 04/09/2025, in the area of 42 CFR 483.80 Infection Control, F-880 at a Scope and Severity (S/S) of an "L." The facility's Administrator was notified of the IJ on 08/14/2025. The facility provided an acceptable Immediate Jeopardy Removal Plan, on 08/15/2025, alleging removal of the IJ on 07/15/2025. The State Survey Agency (SSA) determined the IJ had been removed on 07/15/2025 as alleged, prior to exit on 08/15/2025, with remaining non-compliance at a S/S of an "F." The findings include: Review of the Centers for Disease Control and Prevention (CDC) document "Clinical Guidance for Legionella Infections," dated 06/09/2025, revealed minimizing Legionella growth in complex building water systems and devices was key to preventing infection. The CDC recommended healthcare facilities develop and implement comprehensive water management programs (WMPs). Review of the facility's policy titled, "Infection Prevention and Control Program," revised 11/09/2022, revealed the facility created and maintained an infection prevention and control program. Per the policy, the "Infection Prevention and Control Program [IPCP]" was designed to prevent the development and transmission of communicable diseases and infections, in accordance with national standards and guidelines. Review of the facility's policy titled, "Legionella Surveillance," revised 11/09/2022, revealed the facility would establish primary surveillance (approaches to prevent and control legionella infections with no identified cases). The primary surveillance strategies included routine maintenance of the cooling towers; however, the policy did not address routine flushing of empty rooms. According to the policy, legionella surveillance was one component of the facility's water management plan for reducing the risk of legionella and other opportunistic pathogens in the facility's water system. Review of sign-in sheets for staff education titled, "Legionella Awareness and Prevention," dated 12/18/2024, revealed staff was responsible for helping to prevent Legionella by following the facility water management plan and regularly running water at sinks	F0880	Continued from page 14 Managers. Staff were not permitted to return to work until education completed. Agency staff educated by Director of Nursing, Nurse Managers, and Staff Development prior to their next shift. Future Agency staff will be educated in the orientation packet. Education added to new employee orientation as of 9/1/25. Glucometer Disinfection: Reviewed Glucometer Disinfection Policy on 8/14/2025 by Administrator, Director of Nursing, Corporate Compliance and Infection Proventionist. All nursing staff were re-education initiated on 08/15/2025 with 100% compliance on 9/1/2025. Laminated quick-reference guides are posted on all carts as of 8/18/2025 (Exhibit F F880). Infection Prevention Program Strengthening: The Infection Preventionist received advanced training in Legionella management as of 4/9/2025 and now reports monthly and as needed to QAPI committee in regard to Legionella Surveillance, initiated on 4/9/2025 (Exhibit G F880). How the corrective action(s) will be monitored to ensure the practice will not reoccur: Infection Preventionist will continue to monitor the Legionella Surveillance Log (Exhibit H F880) and report those findings and water sample testing findings to the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee (Exhibit I F880). The facility will conduct an annual review of the water management program as part of the annual review of the infection prevention and control program, and as needed. The Director of Nursing, Staff Development Nurse and Nurse Managers, will complete random Validation Checklists of nurses performing glucometer disinfection to ensure nurses are performing the procedure in accordance with our facility's Practice Guideline and the resident's physician order and care plan. The Validation Checklists will be conducted daily for 1 week, weekly for 4 weeks, and monthly for 3 months. Validation Checklists were initiated on 8/15/25 by Staff Development Nurse, Director of Nursing, and Nurse Managers.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0880 SS = L	Continued from page 15 and showers in low-use rooms. 1. Review of an "Admission Record," found in R121's Electronic Medical Record (EMR), revealed the facility admitted Resident (R) 121 on 03/29/2025, with diagnoses to include unspecified cerebrovascular disease with aphasia, type 2 diabetes mellitus, and occlusion and stenosis of left carotid artery. Review of R121's hospital records revealed the resident was admitted to the local hospital on 04/05/2025, with diagnoses to include atrial fibrillation with rapid ventricular response, congestive heart failure, and acute respiratory failure with hypoxia. The resident's vital signs included a blood pressure reading of 80/70 millimeters of mercury (mm/Hg), temperature of 100.4 degrees Fahrenheit, and a peripheral capillary oxygen saturation (SpO2) of 87 percent. A chest radiography, dated 04/05/2025, revealed right peripheral infiltrate, suspect pneumonia. A urine antigen test, dated 04/05/2025, was positive for legionella. Review of the entry "Minimum Data Set [MDS]," found in R121's EMR with an assessment review date (ARD) of 04/05/2025, revealed staff did not assess R121's long- and short-term memory. The resident could not complete the "Brief Interview for Mental Status [BIMS]" and was documented as "99." Review of the "Care Plan Report," found in R121's EMR and dated 03/30/2025, revealed R121 was care planned to discharge from the facility to the community/private residence after skilled nursing services concluded. Additionally, the resident was care planned to be resuscitated in the event of cardiac arrest. Review of the hospital's "Critical Care Consult Note," dated 04/05/2025 to 04/09/2025, revealed R121 was admitted to the intensive care unit (ICU) on 04/05/2025 with diagnoses that included atrial fibrillation, acute hypoxic respiratory failure, and pneumonia complicated by sepsis and septic shock. According to the physician's notes, critical care was necessary because one or more vital organ systems were impaired, leading to a high probability of imminent or life-threatening deterioration in R121's condition. According to the notes, R121 was "critically ill with overwhelming infection." The resident transitioned to a do not resuscitate (DNR) code status on 04/06/2025, and R121 expired on 04/09/2025. Further review of hospital records revealed R121's chest radiograph, dated 04/05/2025, revealed the resident had right perihilar infiltrate, suspect of pneumonia, and R121's urine antigen test, dated 04/05/2025, revealed the resident	F0880	Continued from page 15 Validation Checklists will be reviewed and presented to the Risk Management/Quality Assurance Committee by the Director of Nursing until such time consistent substantial compliance has been achieved as determined by the committee. The Quality Assurance Committee is compiled of the Medical Director, Infection Preventionist, Administrator, Director of Nursing, Social Services and Staff Development Nurse. The Director of Nursing presented the first findings during a QAPI meeting held on 9/3/25. Those in attendance were the Medical Director, Infection Preventionist, Administrator, Director of Nursing, Dietary Manager, Medical Records, Admissions Coordinator, Nurse Managers, Therapy Director, MDS Nurses, Human Resource Manager, Maintenance Director, Activities Director, Business Office Manager, and Environmental Services Director. Completion date: 9/4/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(4) 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
)880 S = L	Continued from page 16 had tested positive for Legionella. During an interview with the Administrator on 08/13/2025 at 4:34 PM, she stated that prior to 04/09/2025 the facility did not have a WMP in place. She stated a plan was developed by the third-party contractor in late April 2025. During an interview with the Director of the Local Health Department (LHD) on 08/13/2025 at 4:17 PM, he stated the LHD was contacted by the local hospital regarding R121, who had tested positive for Legionnaire's disease on 04/05/2025. The Director stated, "We reached out to the facility" on 04/09/2025 to inform them of the positive findings. When asked about where R121 might have contracted the disease, he said, "He could have been exposed at the facility, adding, "I definitely wouldn't rule that out." The LHD did not identify any other potential exposures for R121. He stated the cooling tower could be a potential source, as it had shown positive results for legionella for the longest duration. He further explained that the mist from the cooling tower was released outside, creating a situation where staff and residents coming and going from the facility would have been exposed. He stated, under certain weather conditions, wind could carry aerosols, which could lead to exposure just by persons being in the vicinity of the cooling tower. During an interview with the Infection Preventionist (IP) on 08/12/2025 at 3:00 PM, she stated when the resident was sent to the local hospital's emergency room, he exhibited no respiratory issues; his primary concern was hypertension. The IP stated the facility did not diagnose him with pneumonia and noted the onset of symptoms was rapid. She stated the resident had been admitted to the facility from a local hospital and had only been at the facility for about a week. She stated on day four or five of his stay, he experienced a change in condition, presenting symptoms that included low blood pressure, an increased heart rate, and oxygen saturation levels that dropped to 87 percent. She stated the facility transferred the resident to the local hospital on 04/05/2025, and the local health department informed the facility that R121 had been diagnosed with Legionnaires' disease. She stated the health department also conducted a legionella risk assessment, which found the acidity (pH) and chlorine levels of the facility's water were not within normal limits. During continued interview on 08/12/2025 at 3:00 PM, the IP stated, on 04/14/2025, the facility hired a third-party contractor specializing in water testing to	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0880 SS = L	Continued from page 17 conduct facility-wide testing to identify any potential sources of Legionella bacteria within the facility. She stated the testing confirmed that the cooling tower and the hot shower in Room 158 tested positive for legionella pneumophila serogroup 1 (strain that causes Legionnaire's disease). The IP stated, on 04/25/2025, the facility conducted a video call with the local health department and a third-party contractor to discuss the results of testing. During the call, she stated, the facility received specific protocols to follow, which included guidelines for flushing procedures. She stated as part of the local health department guidelines she was trained on legionella through video instruction. She stated staff received general infection control, not just Legionella specific training annually and quarterly. She stated the last training specific to Legionella was in December 2024. When asked by the State Survey Agency (SSA) Surveyor as to what environmental controls the facility had in place to prevent the growth of Legionella before April 2025, she stated that prior to the local health department performing a Legionella Environmental Assessment Form (LEAF) assessment for the facility on 04/09/2025, the facility did not have a water management program (WMP) in place and had not completed the CDC's LEAF assessment. She stated maintenance was testing water temperatures, but she did not know if water flushing protocols were in place. During an interview with the Certified Legionella Expert (CLE) on 08/14/2025 at 8:48 AM, he stated the facility hired his company to investigate sources of Legionella. The CLE stated that he wrote the WMP, including a schematic of the water flow, for the facility in April 2025. He stated the facility did not have a WMP in place when he was brought in as a consultant. He stated he continued to provide consultation and water testing services. He stated he was a member of the facility's WMP team. Per the interview, he said he conducted water temperature checks and tested the facility's water every two weeks. In addition to the WMP, the CLE stated he conducted a LEAF assessment, which the CDC provided to help facilities gain a comprehensive understanding of their water systems and aerosolizing devices, assisting them in minimizing the risk of Legionnaires' disease. Additionally, the CLE stated samples taken on 04/14/2025, resulted in two positive findings of legionella pneumophila in the hot shower head of Room 158 and in the cooling tower. He stated the hot shower in Room 158 tested at 66 colony-forming units (CFUs), while the cooling tower tested at 1500 CFUs, which indicated uncontrolled legionella growth. The CLE stated while the cooling tower was being treated, two	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

K4) ID REFIX 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
0880 S = L	Continued from page 18 further treatments were required for proper remediation. According to the CLE, the latest testing, conducted on 08/05/2025, showed negative results for Legionella pneumophila. During an interview with the Maintenance Director on 08/14/2025 at 5:16 PM, he stated prior to the local health department informing the facility about a positive case of Legionella, there was no active water management plan (WMP) in place. He stated the facility hired a third-party contractor who provided a WMP in July 2025. Additionally, the Maintenance Director stated staff began flushing empty rooms after 04/09/2025, and the maintenance department continued to flush water in empty rooms. During an additional interview with the IP on 08/15/2025 at 10:10 AM, she stated the Legionella education in April 2025 consisted of slides and verbal education provided during a staff meeting. She stated no written tests were provided to gauge staff comprehension. However, she stated she had provided questions for group discussion. During an interview with Registered Nurse (RN) 6 on 08/15/2025 at 9:28 AM, he stated he provided education to staff regarding Legionella, including its symptoms, in April 2025. RN6 stated the IP and the Administrator educated him on the topic. He stated he was unsure when staff had received education specific to Legionella prior to 2025. During an interview with the Director of Nursing (DON) on 08/15/2025 at 2:10 PM, he stated the WMP was on the Quality Assurance and Performance Improvement (QAPI) Committee's agenda, but he had not had direct involvement with the WMP team. He stated the QAPI Committee met today for an ad-hoc meeting to discuss the latest Legionella test results. During an interview with the Administrator on 08/15/2025 at 3:08 PM, she stated she was concerned about the detection of Legionella in Room 158 and in the cooling tower, and once the facility was notified by the local health department, they hired a third-party contractor to assist with testing and to create a WMP. The Administrator stated after the WMP was fully implemented, in-house staff was assigned specific responsibilities to monitor water temperatures, flush unused lines, and maintain the cooling tower. She stated that adhering to infection control policies and guidelines was important for ensuring the safety and well-being of residents, staff, and visitors.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0880 SS = L	Continued from page 19 During a telephone interview with the Medical Director on 08/15/2025 at 2:59 PM, she stated she regularly attended QAPI meetings to address water quality. She stated it was her expectation that staff followed CDC guidelines and facility policies to prevent infections. The Medical Director stated the importance of infection control was to ensure the residents' health and safety. Review of the facility policy titled, "Blood Glucose Monitoring," dated 11/2024, revealed nurses were required to adhere to infection control practices to include cleaning and disinfection of the glucometer according to the manufacturer's instructions. Review of the facility's procedure titled, "Blood Glucose Monitoring Device Disinfection," reviewed 10/23/2024, revealed blood glucose monitoring devices would be disinfected according to the manufacturer's recommendations between uses. However, the procedure did not address the manufacturer's sanitation wipe recommendations for dwell time. 2. Observation and interview on 08/14/2025 at 6:35 AM on the Maple Unit revealed RN3 approached the nurses' desk and placed a contaminated glucometer down without using a barrier cloth to prevent contamination. She then took out a disinfectant wipe, cleaned the glucometer for approximately 30-seconds, and set it back down on the nurse's desk without placing it on a barrier cloth. When asked about the process for cleaning and disinfecting the glucometer, she stated she used a disinfectant wipe to clean it and then let it dry before putting it back in the medication cart. RN3 showed the SSA Surveyor a bleach wipe that had a three-minute kill time. However, when asked what "kill time" or "dwell time" meant, she was unable to answer. RN3 stated she did not realize the glucometer needed to remain wet for the entire three minutes to ensure proper disinfection. Additionally, she stated she was unaware she should place the glucometer on a barrier cloth to prevent cross-contamination. RN3 stated the glucometer was shared equipment and was available for any resident who required fingerstick testing for glucose. RN3 stated following IPCP guidelines was important to prevent disease and the spread of infection. During an interview with the Staff Educator (SE) on 08/15/2025 at 2:10 PM, she stated nursing staff was educated to properly clean and disinfect the blood glucose monitors according to manufacturer's instructions and according to the disinfectant wipe dwell-time. She stated staff was instructed to wipe the	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
0880 S = L	Continued from page 20 glucometer after each resident tested, ensuring that it was thoroughly wiped down, and then allow it to dry in place. She stated the equipment should be placed on a barrier cloth to prevent contamination and the spread of blood-borne pathogens. During an interview with the Director of Nursing (DON) on 08/15/2025 at 2:10 PM, he stated that following the guidelines of the IPCP was a "team effort." He stated it was his expectation for nursing staff to properly clean and disinfect the blood glucose monitors according to manufacturer's instructions and according to the disinfectant wipe dwell-time. The DON stated that was important to prevent the spread of blood-borne pathogens. During an interview with the Administrator on 08/15/2025 at 3:08 PM, she stated it was her expectation that staff followed the facility's infection control policies to prevent the spread of infection to residents and staff. The facility provided their Immediate Jeopardy (IJ) Removal Plan on 08/15/2025 verbatim: 1. Corrective Action for Residents Affected: • All residents with symptoms of pneumonia were tested via urine antigen test for Legionnaires' disease initiated 4/26/25. • No positive cases were identified at the time of testing. • Out of an abundance of caution, the resident in Room 158 Assisted Living was relocated to Room 157 Assisted Living on 4/26/25 related to a positive test result in the shower head in room 158 (See Exhibit A). Urine Antigen Test done and Respiratory Monitoring put into place (See Exhibit B). • Water outlets in Room 158 were flushed, and the showerhead was replaced on 4/25/25 (See Exhibit C). 2. Identification of Others at Risk: • A comprehensive risk assessment was completed by the Northern Kentucky Health Department to identify all residents, staff, and visitors potentially exposed on 4/9/2025 (Exhibit D). • Water samples were collected from all facility wings to determine the scope of contamination on 4/14/2025 by Legionella Control Systems, Inc. (Exhibit E).	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0880 SS = L	Continued from page 21 • Residents, families, and staff were notified and educated about signs, symptoms, and transmission risks of Legionella on 4/30/2025 (Exhibit F). 3. Systemic Changes to Prevent Reoccurrence: • 4/9/2025 -A Legionella Environmental Assessment Form (LEAF) Assessment was conducted in partnership with the Northern Kentucky Health Department. • 4/9/2025 - The facility's Infection Preventionist completed additional training on Legionella guidance (Exhibit 0). • 4/10/2025 - Flushing protocols were implemented facility-wide and are documented and monitored. (Exhibit I). A Legionella Surveillance Log was established and will be monitored by Infection Preventionist (Exhibit Z). • 4/14/2025 - Site visit conducted by Legionella Control Systems; Risk Assessment, Engineering Report, and on-site water testing performed (Exhibit G). • 4/25/2025 - Video Call with Legionella Control Systems to go over findings (Exhibit H). • 4/25/2025 - Positive Results BI 158 Hot Shower and Cooling Tower. Corporate Maintenance, Building Maintenance Director, Administrator, Director of Nursing, Infection Preventionist, Vice President Chief Operating Officer, Northern Kentucky Environmental Health Coordinator made aware (Exhibit E). • 4/25/2025-Notified ChemSearch of the need for inspection and evaluation of water safety procedures. • 4/28/2025 - ChemSearch added Bio-Xile and Chlorine Pellets to cooling tower (Exhibit J). • 4/28/2025 - Testing repeated (Exhibit K). • 4/28/25 - 12 month Surveillance Legionella started per Northern Kentucky Health Department. • 4/29/2025 - Staff Development provided education to staff including Legionella (Exhibit S). • 4/30/2025 - Staff Development continued education (Exhibit S). • 4/30/2025 - COO sent out message to staff, residents, families about Legionnaires' Disease (Exhibit Y).	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(4) 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
)880 S = L	Continued from page 22 • 5/1/2025 - Reported to Office of Inspector General via telephone. • 5/6/2025 - Positive Results Mech Room Tower. Relevant parties informed (Exhibit K). • 5/7/2025 - Corporate Maintenance contacted OBR Cooling Towers (OBR) to schedule a cleaning and sanitization of the cooling tower. • 5/8/2025 -Notified Solid Blend, a certified water management company, for consultation and services. • 5/8/2025 - Shower Head disinfecting put in place. Started by maintenance 5/12/2025, completed 6/11/2025. To be done every 6 months (Exhibit M). • 5/27/2025 - Solid Blend conducted a separate LEAF assessment and sampled water (Exhibit N). • 5/30/2025 - Kentucky Health Department came to facility to discuss risk assessment with Corporate Maintenance, Building Maintenance Director, Administrator, Director of Nursing, Infection Preventionist, Vice President Chief Operating Officer. • 6/2/2025 - LEAF Assessment Final Report shared Corporate Maintenance, Building Maintenance Director, Administrator, Director of Nursing, Infection Preventionist, Vice President Chief Operating Officer. (Exhibit N and H). • 6/5/2025 - Positive Result Cooling Tower Basin. Corporate Maintenance, Building Maintenance Director, Administrator, Director of Nursing, Infection Preventionist, Vice President Chief Operating Officer, Northern Kentucky Environmental Health Coordinator made aware (Exhibit Q). • 6/6/2025 - ChemSearch adjusted chemicals in cooling tower; chemical treatment changed to daily (Exhibit R). • 6/10/2025 - Water testing (Exhibit T). • 6/11/2025 - Building Maintenance added Float Chlorine to cooling tower. • 6/17/2025-Positive Results Cooling Tower Basin. Corporate Maintenance, Building Maintenance Director, Administrator, Director of Nursing, Infection Preventionist, Vice President Chief Operating Officer, Northern Kentucky Environmental Health Coordinator made aware (Exhibit T).	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
F0880 SS = L	Continued from page 23 • 6/18/2025 - Disinfectant concentration monitoring (Maintenance). • 6/24/2025 - Water testing (Exhibit U). • 7/2/2025 - Water management team reported to QAA committee. Committee members include the Medical Director, Administrator, Infection Preventionist, Social Services, Environmental Services Director, Building Maintanance [sic], Director of Nursing. Also present was Chief Operating Officer. • 7/3/2025 - Bioxide Added (Maintenance). • 7/4/2025 - Positive Results Water Tower. Corporate Maintenance, Building Maintenance Director, Administrator, Director of Nursing, Infection Preventionist, Vice President Chief Operating Officer, Northern Kentucky Environmental Health Coordinator made aware (Exhibit U). • 7/5/2025 - Call out to ChemSearch. • 7/8/2025 - Water Testing (Exhibit V). • 7/!5 [sic]/2025 -Negative Results. Corporate Maintenance, Building Maintenance Director, Administrator, Director of Nursing, Infection Preventionist, Vice President Chief Operating Officer, Northern Kentucky Environmental Health Coordinator made aware (Exhibit V). • 7/22/2025 - Water Testing (Exhibit W). • 7/29/2025 - Water Management Plan Completed. 7/31/2025 - Negative Results Corporate Maintenance, Building Maintenance Director, Administrator, Director of Nursing, Infection Preventionist, Vice President Chief Operating Officer, Northern Kentucky Environmental Health Coordinator made aware (Exhibit W). • 8/5/2025 - Water Testing (Exhibit X). • 8/15/2025 - Negative Results Corporate Maintenance, Building Maintenance Director, Administrator, Director of Nursing, Infection Preventionist, Vice President Chief Operating Officer, Northern Kentucky Environmental Health Coordinator made aware (Exhibit X). • 8/15/2025 -Ad Hoc QAPI meeting held with QAA	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SEASONS AT ALEXANDRIA	7341 E ALEXANDRIA PIKE , ALEXANDRIA, Kentucky, 41001

(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
0880 S = L	Continued from page 24 committee to discuss Water Sample results and Timeline. 4. Date of Compliance: IJ removal by: 07/15/2025	F0880		