STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185478	A. BUILDING 01 - FOREST SPRINGS .. B. WING	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Springs Health Campus	4120 Wooded Acre Lane , Louisville, Kentucky, 40245

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K0000 Bldg. 01	INITIAL COMMENTS Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 01/30/2026, it was determined the facility had achieved substantial compliance with Life Safety Code on 01/02/2026.	K0000		

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: 185478	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

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F0000	INITIAL COMMENTS A Recertification Survey and Abbreviated Survey, investigating KY715489, KY715492, KY715481, KY715493, KY715494, KY715498, KY715499, KY715501, KY2638859, and KY2866116 was concluded on 12/11/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. No deficiencies were issued related to KY715489, KY715492, KY715481, KY715493, KY715494, KY715498, KY715499, KY715501, KY2638859, KY2866116. Survey Dates: 12/09/2025 - 12/11/2025 Survey Census: 54 Sample Size: 16 Supplemental Residents: 7	F0000		
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of the facility policy it was determined that the facility failed to establish an antibiotic stewardship program that included a system to monitor antibiotic use. The findings include: Review of the facility policy titled, "Antibiotic	F0881	This plan of correction is to serve as Forest Springs Health Campus credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Forest Springs Health Campus or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find the plan of correction for Forest Springs Health Campus annual survey that was completed on 12/11/25. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is 1/6/26. We initiated immediate interventions when concerns were identified on this date. The facility respectfully requests from the department a desk review for substantial compliance. For information or paperwork, call (502) 243-5744. Sincerely, Mark Adkins	01/02/2026

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

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F0881 SS = D	Continued from page 1 Stewardship Guideline", reviewed 11/19/2025, revealed the purpose of the policy was to optimize the treatment of infections ensuring that residents who required an antibiotic were prescribed the appropriate antibiotic, to reduce the risk of adverse event, including the development of antibiotic resistant organisms from unnecessary or inappropriate antibiotic use encompass of facility wide system to monitor the use of antibiotics. Review of the facility's surveillance tracking for antibiotics revealed there was no surveillance of infections or antibiotic information available for review for November 2025. Further, the only information available for December was a list of prescribed antibiotics. The Executive Director verified the facility used McGreer's Criteria for prescribing antibiotics. An internet search revealed a chart listed under "McGreer et al infection surveillance chart," dated March, 2025, which listed various types of human body systems and possible infections for each system. The chart further listed various symptoms to observe prior to initiating antibiotic treatment. Further record review of facility provided printed documents revealed information was not provided as to if the prescribed antibiotic met the McGreer's established criteria. Additionally, there was no information documented on the organism/pathogen for an ordered culture and sensitivity. In an interview with the Director of Health Services (DHS) on 12/11/2025 at 6:25 PM, she stated the Assistant Director (AD) was previously the Infection Preventionist, but that person left the position in October. She stated currently there was no AD and that she (DHS) was responsible for infection surveillance in the facility. She stated infection tracking was behind for November and December. Interview with the Administrator on 12/11/2025 at 7:04 PM, she stated she expected the facility to follow the Infection Control Policy and to follow up with clinical support if they had questions. She stated the clinical team met each morning, and antibiotics were discussed. She stated ultimately the DHS would be responsible for ensuring infection control measures were in place. She stated she was not aware infection surveillance for antibiotics for November was not completed until this date. The Administrator stated that the surveillance of infections was important to identify trends and make any changes to help decrease infections.	F0881	Continued from page 1 Executive Director F881 – Antibiotic Stewardship Program (Corrective actions for identified resident(s) affected by the deficient practice). There were no residents identified as being adversely affected by the deficient practice. On 12/31/25, Trilogy's Campus Clinical Support Nurse reviewed Forest Springs's Infection Prevention and Control program from January 2025 – December 2025 to verify the presence of an antibiotic stewardship system. The review found no designated Infection Preventionist as required by CFR 483.80(b)(1)-(4), and the campus did not complete antibiotic surveillance tracking for November and December 2025. On 12/12/2025, the Director of Health Services appointed an Infection Preventionist /Admission Nurse. The Infection Preventionist provided education on CFR 483.80(b)(1)-(4), outlining her responsibilities, which include oversight of the campus's infection prevention and control program and the antibiotic stewardship program. This stewardship system is designed to optimize infection treatments, ensuring residents who need antibiotics receive the appropriate medication, minimizing the risk of adverse events such as the development of antibiotic-resistant organisms due to unnecessary or inappropriate antibiotic use. This was completed on 1/6/25. The Infection Preventionist/Admission Nurse completed CDC Infection Preventionist training modules assigned on 12/31/25 by 1/9/26. The Director of Health Services also finished the program by 1/9/25 as a backup. The Director of Health Services, Infection Preventionist, and Trilogy's Campus Clinical Support completed antibiotic surveillance tracking for November and December 2025 that was initiated on 12/31/25 and completed on 1/6/26. Findings and interventions were discussed with the IDT team and Medical Director at the Ad Hoc meeting on 1/6/2026 to help reduce unnecessary antibiotic use and resistant organisms. (Identification of other residents who may be affected by the deficient practice and corrective actions that	

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F0881 SS = D		F0881	Continued from page 2 will be put in place to ensure the deficient practice does not recur. All residents have the potential to be affected by the deficient practice. A one-time audit at Forest Springs Health Campus reviewed antibiotic use for residents with active infections from December 1, 2025 to December 31, 2025, ensuring compliance with McGeer Criteria. Conducted between 12/31/25 and 1/6/26, findings were discussed with the IDT team and Medical Director on 1/6/2026 to address unnecessary antibiotic use and resistance. (Measures put in place and systemic changes you will make to ensure that the deficient practice does not recur.) On 12/31/2025, Trilogy's Campus Clinical Support Nurse re-educated the Executive Director, Director of Health Services, Infection Preventionist/Admission Nurse, and Weekend Supervisor on McGeer's criteria, Antibiotic Stewardship, Infection Preventionist CFR 483.80(b)(1)-(4), and the Infection Control and Prevention Surveillance Program. After the Executive Director, Director of Health Services, Infection Preventionist/Admission Nurse, and Weekend Supervisor received training, all licensed nurses began the same program starting on 12/31/2025. The training was completed by 1/9/2026, and all post-tests were finished by that date as well. Every licensed nurse was required to achieve a 100% pass rate to confirm their understanding. Starting 01/09/2026, any licensed nurse who hasn't completed training will be educated before their shift. New hires receive orientation from DHS or the Infection Preventionist during onboarding. The campus does not employ agency staff. (Describe the Quality Assurance and Process Improvement Program An Ad Hoc Quality Assurance meeting was held on 12/31/25 with the following, Medical Director, Executive Director (ED), Social Services (SSD), MDS Coordinator, Infection Preventionist (IP), and Director of Health Services (DHS), regarding the above	

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F0881 SS = D		F0881	Continued from page 3 referenced deficiencies related to F881 Antibiotic Stewardship and F882 Infection Preventionist Qualifications Role to review the plan and corrective actions implemented. Audit #1 - Beginning 12/31/25, the IP/Admission Nurse or Director of Health Services will review residents with infections on antibiotics using the Facility Activity Report during daily Clinical Care Meetings (Monday–Friday), ensuring proper antibiotic use and reducing adverse events. Reviews will occur daily X 4 weeks, weekly X the next 4 weeks, then monthly X 5 months. Audit #2 – The Campus Clinical Support Nurse will verify that the campus has both a designated Infection Preventionist and a backup, ensuring compliance with CFR 483.80(b)(1)-(4) when the primary is unavailable. Reviews will occur daily X 4 weeks, weekly X the next 4 weeks, then monthly X 5 months. The second Ad Hoc Meeting on (insert Date) reviewed audit and education compliance with the Medical Director, ED, SSD, MDS Coordinator, IP, and DHS present. No new issues were found. The Findings of this audit will be presented to the Quality Assurance and Performance Improvement Committee (QAPI) consisting of Executive Director, Director of Health Services, and Medical Director monthly. The QAPI meetings will determine when compliance is achieved or if ongoing monitoring is required. 5) Alleged Compliance Date: 1/9/26 POC was put in attachments on 1/2/2026 at 4:24 PM on EPOC	
F0882 SS = D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;	F0882	This plan of correction is to serve as Forest Springs Health Campus credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Forest Springs Health Campus or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find the plan of correction for Forest Springs Health Campus annual survey that was completed on 12/11/25. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is 1/6/26.	01/02/2026

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F0882 SS = D	Continued from page 4 §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review it was determined the facility failed to designate one or more individual(s), with the certification as the infection preventionist(s) (IP)(s) responsible for the facility's infection prevention and control program. The findings include: Review of the facility policy titled, "Infection Prevention and Control Program," reviewed 12/17/2024, revealed the purpose of the policy established and maintained 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. Continued review revealed the campus would designate a member of the clinical team to monitor the campus's infection prevention and control program, to perform surveillance to identify, investigate, control, and prevent the spread of infection, and reporting for the infection prevention and control program. In review of facility documents provided to the State Survey Agency (SSA) at the entrance conference, no staff person was listed for the Infection Preventionist (IP) nor were training certificate(s) provided. Interview with the Executive Director (ED) on 12/09/2025 at 4:45 PM, he stated the previous IP was no longer working at the facility and the Director of Health Services (DHS) was completing those duties of the Infection Preventionist; however, she (DHS) had not received the specialized training. The regional nurse consultant was present and stated she oversaw the facility's Infection Control Program (ICP) but she was not at the facility daily. At approximately 5:00 PM on 12/09/2025. the ED provided a certificate and stated that the facility's Minimum Data Set (MDS) nurse had received the training.	F0882	Continued from page 4 We initiated immediate interventions when concerns were identified on this date. The facility respectfully requests from the department a desk review for substantial compliance. For information or paperwork, call (502) 243-5744. Sincerely, Mark Adkins Executive Director F882 – Infection Preventionist Qualifications/Role (Corrective actions for identified resident(s) affected by the deficient practice). There were no residents identified as being adversely affected by the deficient practice. On 12/12/2025, the Director of Health Services appointed an Infection Preventionist /Admission Nurse. The Infection Preventionist provided education on CFR 483.80(b)(1)-(4), outlining her responsibilities, which include oversight of the campus's infection prevention and control program and the antibiotic stewardship program. This stewardship system is designed to optimize infection treatments, ensuring residents who need antibiotics receive the appropriate medication, minimizing the risk of adverse events such as the development of antibiotic-resistant organisms due to unnecessary or inappropriate antibiotic use. This was completed on 1 The Infection Preventionist/Admission Nurse completed CDC Infection Preventionist training modules assigned on 12/31/25 by 1/9/26. The Director of Health Services also finished the program by 1/9/26 as a backup. (Corrective actions for identified resident(s) affected by the deficient practice). There were no residents identified as being adversely affected by the deficient practice. On 12/31/25, Trilogy's Campus Clinical Support Nurse reviewed Forest Springs's Infection Prevention and Control program from January 2025 – December 2025 to verify the presence of an antibiotic stewardship	

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F0882 SS = D	Continued from page 5 However, when asked if she (the MDS nurse) oversaw the ICP he stated that she did. The SSA requested a facility job description for the role of Infection Preventionist; however, the ED stated the facility did not have a job description as it was a designated position. In interview with the Director of Health Services (DHS) on 12/11/2025 at 6:25 PM, she stated she had been the DHC for six (6) months. The DHS stated the previous Assistant Director (AD) was the Infection Preventionist, but she had left the position in October. She stated she did not have an AD and that she was responsible for infection surveillance in the facility. She stated infection tracking was behind for November and December. Interview with the Executive Director on 12/11/2025 at 6:56 PM, he stated he expected staff to follow policies and procedures related to infections. He stated the facility did not have a job description for the Infection Preventionist, as it was a designation. He stated the Centers for Medicare and Medicaid Services (CMS) stated facilities have to have an IP not a particular position. He further stated the IP did not have a specific job list of duties.	F0882	Continued from page 5 system. The review found no designated Infection Preventionist as required by CFR 483.80(b)(1)-(4), and the campus did not complete antibiotic surveillance tracking for November and December 2025. The Director of Health Services, Infection Preventionist, and Trilogy's Campus Clinical Support completed antibiotic surveillance tracking for November and December 2025 that was initiated on 12/31/25 and completed on 1/6/26. Findings and interventions were discussed with the IDT team and Medical Director at the Ad Hoc meeting on 1/6/2026 to help reduce unnecessary antibiotic use and resistant organisms. (Measures put in place and systemic changes you will make to ensure that the deficient practice does not recur.) On 12/31/2025, Trilogy's Campus Clinical Support Nurse re-educated the Executive Director, Director of Health Services, Infection Preventionist/Admission Nurse, and Weekend Supervisor on McGeer's criteria, Antibiotic Stewardship, Infection Preventionist CFR 483.80(b)(1)-(4), and the Infection Control and Prevention Surveillance Program. After the Executive Director, Director of Health Services, Infection Preventionist/Admission Nurse, and Weekend Supervisor received training, all licensed nurses were trained regarding the above-mentioned education starting on 12/31/2025. The training was completed by 1/9/2026, and all post-tests were finished by that date as well. Every licensed nurse was required to achieve a 100% pass rate to confirm their understanding. Starting 01/09/2026, any licensed nurse who hasn't completed training will be educated before their shift. New hires receive orientation from DHS or the Infection Preventionist during onboarding. The campus does not employ agency staff. (Describe the Quality Assurance and Process Improvement Program An Ad Hoc Quality Assurance meeting was held on 12/31/25 with the following, Medical Director, Executive Director (ED), Social Services (SSD), MDS Coordinator, Infection Preventionist (IP), and Director of Health Services (DHS), regarding the above	

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F0882 SS = D		F0882	Continued from page 6 referenced deficiencies related to F881 Antibiotic Stewardship and F882 Infection Preventionist Qualifications Role to review the plan and corrective actions implemented. Audit #2 – The Campus Clinical Support Nurse will verify that the campus has both a designated Infection Preventionist and a backup, ensuring compliance with CFR 483.80(b)(1)-(4) when the primary is unavailable. Reviews will occur daily X 4 weeks, weekly X the next 4 weeks, then monthly X 5 months. A second Ad Hoc Meeting on 1/6/26 reviewed audit and education compliance with the Medical Director, ED, SSD, MDS Coordinator, IP, and DHS present. No new issues were found. The Findings of this audit will be presented to the Quality Assurance and Performance Improvement Committee (QAPI) consisting of Executive Director, Director of Health Services, and Medical Director monthly. The QAPI meetings will determine when compliance is achieved or if ongoing monitoring is required. 5) Alleged Compliance Date: 1/9/26 POC was added to attachments on 1/2/2026 at 4:34PM-Please check attachments.	