STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185478	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		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

(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
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 01 - FOREST SPRINGS .. B. WING	(X3) DATE SURVEY COMPLETED 12/10/2025

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

(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
K0000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 2015 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) story (2015), Type V (111), protected combustible construction with six (6) smoke compartments and a complete automatic wet sprinkler system. A Life Safety Code Recertification Survey was Initiated on 12/10/2025 and concluded on 12/10/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Forest Springs Health Campus was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K0000		01/19/2026
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips	K0920	The submission of this plan of correction does not indicate an admission by Forest Springs Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided and the living environment provided to the residents of Forest Springs Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. If there are any questions, please contact me at (502) 243-1643. Sincerely,-- Mark Adkins	01/02/2026

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	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - FOREST SPRINGS B. WING	12/10/2025

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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K0920 SS = E Bldg. 01	Continued from page 1 are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain power strips, extension cords and multiplug adapters in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect four (4) rooms, staff, and six (6) residents. The facility had the capacity for 58 beds with a census of 54 on the day of the survey. The findings include: 1). Observation, during the building inspection tour on 12/10/2025 at 1:08 PM, revealed an unrated power strip being used for personal electronics inside the patient care vicinity of Resident Room 215 by bed B. Interview, on 12/10/2025 at 1:09 PM with the Director of Plant Operations, revealed the facility was not aware of the unrated power strip inside the patient care vicinity. 2). Observation, during the building inspection tour on 12/10/2025 at 1:22 PM, revealed an ungrounded extension cord being used as a substitute for the fixed wiring of the structure in Resident Room 309. Further observation revealed an unrated multiplug adapter in use behind a bench in Resident Room 309. Interview, on 12/10/2025 at 1:23 PM with the Director of Plant Operations, revealed the facility was not aware of the extension cord or the multiplug adapter in the resident room. 3). Observation, during the building inspection tour on 12/10/2025 at 1:39 PM, revealed a coffee maker plugged into an extension cord being used as a substitute for the fixed wiring of the structure, the extension cord was also plugged into a power strip overloading the rating located in the Employee Lounge. Interview, on 12/10/2025 at 1:40 PM with the Director of Plant Operations, revealed the facility was not aware of the coffee maker being plugged into the extension cord, and was also not aware of the extension cord being plugged into a power strip. 4). Observation, during the building inspection tour on 12/10/2025 at 1:45 PM, revealed an ungrounded extension cord in use being used as a substitute for the fixed	K0920	Continued from page 1 K920 1. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 12-10-2025 , the Director of Plant Operations (DPO) immediately addressed the following issues Room 215 one non UL listed power strip was removed from the facility. Cords were rearranged to accommodate resident electrical needs without any need for further power strips devices. Room 309 one ungrounded extension cord and one multi plug adapter were removed from the facility. DPO rearranged plugs to accommodate patient needs. In the Employee lounge one extension cord was removed from the building and 1 coffee maker was relocated to plug directly to a wall receptacle. Room 205 One extension cord was removed from the facility. DPO rearranged cords to appropriate plugs to meet resident needs without further need of power strips or extension devices. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 12-11-2025, the Director of Plant Operations (DPO) inspected all office spaces, common areas, and resident rooms for improper use of power strips, extension cords, or multiplug adapters. No further issues identified. 3. Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning on 1-2-2026, the Facility management support educated the DPO on the appropriate use of power strips and that extension cords are strictly prohibited in all areas, including resident rooms. 4. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. Beginning on 1-5-2026, the Director of Plant Operations or will conduct an audit of all resident rooms and all office spaces to ensure proper use of power strips, and	

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		A. BUILDING 01 - FOREST SPRINGS .. B. WING	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0920 SS = E Bldg. 01	Continued from page 2 wiring of the structure located in Resident Room 205. Interview, on 12/10/2025 at 1:46 PM with the Director of Plant Operations, revealed the facility was not aware of the extension cord in the resident room. The findings were verified by the Director of Plant Operations at the time of observations and the Executive Director at the exit conference on 12/10/2025. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 10.2.4 Adapters and Extension Cords. 10.2.4.1 Three-prong to two-prong adapters shall not be permitted. 10.2.4.2 Adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. 10.2.4.2.1 All adapters shall be listed for the purpose. 10.2.4.2.2 Attachment plugs and fittings shall be listed for the purpose. 10.2.4.2.3 The cabling shall comply with 10.2.3 10.2.3.2 Grounding Conductor. 10.2.3.2.1 Each electric appliance shall be provided with a grounding conductor in its power cord. Actual NFPA Standard: NFPA 70 National Electrical Code, (2011) 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings 4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B)	K0920	Continued from page 2 no extension cords are in use, weekly for 4 weeks, every other week for 4 weeks and monthly for 3 months. The Executive Director will present the findings from the audits to the monthly QAPI Committee consisting of the Executive Director, Director of Health Services, Assistant Director of Health Services, Medical Director, Social Services Director, MDS Coordinator and Infection Preventionist. The QA Committee will determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned, ongoing audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance 12-11-2025	

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K0920 SS = E Bldg. 01	Continued from page 3 (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K0920		

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E0000	Initial Comments 42 CFR 483.73 Type of Structure: One (1) story (2015), Type V (111), protected combustible construction with six (6) smoke compartments and a complete automatic wet sprinkler system. An Emergency Preparedness Recertification Survey was conducted on 12/10/2025, in accordance with 42 Code of Federal Regulations, Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. During this Recertification Survey, Forest Springs Health Campus was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	E0000		01/19/2026

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101222	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

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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N0000	Initial Comments A Relicensure Survey, in conjunction with a Complaint Survey for 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 State regulatory requirements. Survey Dates: 12/09/2025 - 12/11/2025 Survey Census: 54 Sample Size: 26 Supplemental Residents: 7 No deficiencies were issued related to KY715489, KY715492, KY715481, KY715493, KY715494, KY715498, KY715499, KY715501, KY2638859, KY2866116.	N0000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185478	A. BUILDING B. WING	02/06/2026

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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F0000	INITIAL COMMENTS A Desk Review Revisit Survey was initiated on 02/04/2026 and concluded on 02/06/2026. It was determined the facility had achieved substantial compliance on 01/02/2026 as alleged.	F0000		

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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

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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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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.	