STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185487	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanders Ridge Health Campus	**119 East Sanders Lane , Mount Washington, Kentucky, 40047**

(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	INITIAL COMMENTS A Recertification and Abbreviated Survey, investigating KY2604780, was concluded on 06/09/2026. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. A deficiency was related to KY2604780 at F602. No deficiencies were issued related to KY2740698, KY2794419, KY2713497, KY2682252, KY2682701, KY2691030, KY2581247, KY715841, and KY715840. Survey Census: 56 Sample Size: 37	F0000		06/30/2026
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to ensure residents were free from misappropriation of property for 2 of 6 residents sampled for abuse, out of the total sample of 37, (Resident (R)33 and R67). The findings include: Review of the facility policy titled, Abuse and Neglect Procedural Guidelines, revised 06/27/2017, revealed misappropriation of property was defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Further review revealed the Executive Director was responsible for notification to Adult Protective Services (APS).	F0602	(Corrective actions for identified resident(s) affected by the deficient practice.) Resident #33 was not adversely affected by the deficient practice and remain at the campus with no concerns, negative outcomes, or psychosocial changes. Resident #67 no longer resides in the campus as of 8/28/25. LPN #5 is no longer employed by Sanders Ridge Health Campus effective 8/28/25. (Identification of other residents who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not reoccur.) Any resident has the potential to be affected by the deficient practice. A one-time questionnaire regarding pain was completed on current residents or a PAINAD if BIMs are less than 8 by Social Services (SS), Director of Health Services (DHS), Assistant Director of Health Services (ADHS), MDS Coordinator, and Infection Preventionist (IP). This began on 6/30/26 and	07/07/2026

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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F0602 SS = D	Continued from page 1 Review of the facility policy titled, Guidelines for Narcotic Count, reviewed 12/17/2024, revealed the narcotic book was to contain a sheet providing space for the off going and oncoming nursing staff to record their signatures to indicate the narcotics had been reviewed. Per review, the narcotic count sheet was to indicate how many items were in the narcotic drawer and the medications counted to ensure they were all present and accounted for. Continued review revealed the narcotic count was to be updated by two nurses to validate the changes with initials and date, as items were added or removed. Policy review revealed at the time one nurse, or other staff qualified to give medications, passed on the keys to the medication (med) cart to the oncoming staff member, the narcotics were to be reconciled by comparing the medications in the cart to the count sheets. Further review revealed both staff members were to sign the narcotic count as accurately reconciled. In addition, review revealed if the available medications did not match the count sheets, the Director of Health Services (DHS) was to be notified. Review further revealed if the DHS was unable to determine the reason for the (narcotic) count discrepancy, a thorough investigation was to be conducted. 1). Review of the clinical record for R33 revealed the facility re-admitted him on 01/20/2021, with diagnoses of hemiplegia and hemiparesis following cerebral infarction, unspecified abdominal pain, and dorsalgia (general back pain). Review of the physician orders revealed an order dated 04/17/2025, received for Hydrocodone four times a day, and a dose for once daily as needed (PRN) dated 04/17/2025.Review of the Annual Minimum Data Set (MDS) Assessment dated 06/25/2025, revealed the facility assessed the resident to have modified independence in his decision making. Continued review revealed the facility assessed R33 to have had pain in the last five days, to receive scheduled pain medication, and as rating his pain as moderate (a five out of 10 on the pain scale). Further MDS review revealed the facility also assessed R33 as receiving an opioid medication. Review of the facility's investigation documentation, regarding missing narcotic medication for R33, dated 08/24/2025, revealed the facility noted the resident only had one dose of Hydrocodone (a narcotic medication) left and his nurse called the pharmacy to obtain a refill of the medication. Per review, the pharmacy informed the nurse it was too soon to refill the narcotic medication as the pharmacy delivered 60 tablets to the facility on 08/16/2026 (eight days previously). Continued review revealed	F0602	Continued from page 1 completed on 7/2/26. On 6/30/26, the VP of Clinical confirmed there were no self-reports requiring notification to APS. (Measures put in place and systemic changes you will make to ensure that the deficient practice does not reoccur.) The VP of Clinical re-educated the Executive Director (ED), DHS, and ADHS regarding Trilogy Health Services guidelines for Abuse, Neglect and Exploitation with emphasis on misappropriation and any self-report that requires APS (DCBS) notification. This education was completed on 6/30/26. A post-test was completed with education to ensure staff knowledge was retained on the training material provided with a passing score of 100%. Once the ED, DHS, and ADHS were educated regarding Trilogy Health Services guidelines for Abuse, Neglect and Exploitation with emphasis on misappropriation and any self-report that requires APS (DCBS) notification. This education was then provided to the Licensed Staff, QMAs, CRCAs, housekeeping staff, Dietary staff, maintenance staff, and rehab staff, which started on 6/30/26 and will be completed on 7/3/26. A post-test was completed to ensure staff knowledge was retained on the above training material with a passing score of 100%. After 7/3/26, anyone that did not receive education or newly hired staff will be educated either prior to the start of their shift or through orientation by the ADHS or DHS with a post-test completed to ensure staff knowledge was retained on the above training material with a passing score of 100%. The campus does not use agency staff. Describe the Quality Assurance & Process Improvement Program that will be put into place (track and trend data over time to ensure action plan met the initially identified goal). An Ad Hoc Quality Assurance meeting was held on 6/30/26 with the Medical Director and the facility QAPI Committee Consisting of ED, DHS, ADHS, and IP to review the above plan of correction and ensure the implementation of the plan.	07/07/2026

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F0602 SS = D	Continued from page 2 the facility determined 30 of R33's Hydrocodone tablets were missing, and during the facility investigation, the facility identified another resident had missing Hydrocodone tablets with 15 tablets noted as remaining. Review of the investigation documentation revealed however, the facility was unable to locate the narcotic medication for R33 or the Narcotic Drug Use Record for the missing medication. Further review revealed Licensed Practical Nurse (LPN) 5 reported to the (former) DHS she had taken the other resident's (R67's) narcotic medication, and the facility verified misappropriation of R67's property had occurred. Review revealed LPN 5 denied taking R33's Hydrocodone medication. Additional review revealed however, the facility, "reasonably concluded" LPN 5 had been involved in both instances of diversion as she confessed to taking R67's Hydrocodone, and related to the LPN's dishonesty throughout the facility's investigation, with her being the common tie to both instances. Review further revealed the pharmacy delivered 60 Hydrocodone tablets for R33 to the facility on 08/16/2025. Continued review of the facility investigation documentation dated 08/24/2025, revealed the facility interviewed LPN 5 on 08/24/2025, regarding where she placed the previous shift to shift count sheets, as those sheets were missing. Review revealed the facility also interviewed LPN 5 about whether she knew what happened to R33's Hydrocodone medication as pharmacy could not refill the medication yet. Per review, LPN 5 reported she did not know what happened to the narcotic count sheets. Review revealed on 08/25/2025, LPN 5 counted the medication cart and signed the shift to shift narcotic logs for her shifts worked on 08/18/2025, 08/21/2025, 08/23/2025, and 08/24/2025. According to the facility's investigation documentation, LPN 5 stated she left the shift to shift logs in the (narcotic) "book" when they were full. Review of the facility's documentation revealed LPN 5 was interviewed on 08/28/2025 (when the missing Hydrocodone was discovered missing for another resident), and she denied knowing what happened to the other resident's (R67's) missing medication. Continued review revealed the facility asked LPN 5 to take another drug test in a lab, based on the new incident of missing narcotic, and the LPN agreed to complete the drug screen by 10:00 AM on 08/29/2025. Further review revealed on 08/29/2025, LPN 5 stated she had taken the Hydrocodone from the other resident (R67) and stated she had a problem; however, she denied taking R33's Hydrocodone medication. In addition, LPN 5 reported taking Hydrocodone from a different resident "about six months" prior, but could not remember the date	F0602	Continued from page 2 (Audit #1) Beginning on 7/6/26, The DHS, ADHS, SSD, or Licensed Nurse will interview 3 residents regarding pain or complete PAINAD if BIMs are less than 8. This will occur daily for 2 weeks, then decrease to 2 residents daily Monday through Friday for 2 weeks, then 2 residents 3 times a week for 2 weeks, then 1 resident monthly x 2 months or until compliance has been obtained. (Audit #2) Beginning on 7/6/26, The DHS, ADHS, SSD, or Licensed Nurse will interview 3 employees regarding abuse and/or misappropriation. This will occur daily for 2 weeks, then decrease to 2 employees daily Monday through Friday for 2 weeks, then 2 employees 3 times a week for 2 weeks, then 1 employee monthly x 2 months or until compliance has been obtained. (Audit #3) Beginning on 7/1/26 Clinical Support or Divisional Vice President will validate the ED or DHS have notified APS for any self-reports. This will be an ongoing measure. The Director of Health Services and/or Assistant Director of Health Services will present the findings from the audits to the monthly QAPI Committee. 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 (7/7/26)	07/07/2026

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F0602 SS = D	Continued from page 3 or who the resident had been. Review further revealed the facility's investigation documentation also included an interview with LPN 6 who stated she co-signed as witness for five residents with LPN 5 in the narcotic log, although she had not actually seen that the medication was empty.Review of the facility's Narcotic Count Sheet dated 08/16/2025, revealed 2 packs of Hydrocodone tablets had been delivered to the facility for R33. Review of the Controlled Drug Use Record (CDUR) revealed 60 tabs of Hydrocodone dispensed 08/16/2025, with 30 in each pack. Review of the facility's staffing schedules revealed LPN 5 worked on R33's unit on 08/18/2025, 08/21/2025, and 08/23/2025. The State Survey Agency (SSA) Surveyor requested the facility's documentation of the narcotic count log and received and removed medication log; however, the facility did not provide such documentation for the dates of 08/17/2025 through 08/21/202, for the unit R33 resided on. In addition, the facility failed to provide documentation of reporting the narcotic diversion (by LPN 5) to Adult Protective Services. Review of the Controlled Drug Use Record (CDUR) for R33 dated 08/16/2025, revealed 30 of the 60 tabs of Hydrocodone were pack one of the two packs dispensed on 08/16/2025. Continued review revealed LPN 5 signed as administering the narcotic medication on 08/21/2025, 08/22/2025, 08/23/2025, and 08/24/2025. However, the facility failed to provide documentation of the CDUR for R33 for the 08/16/2025 delivered second pack of 30 Hydrocodone tablets. Review of R33's medication administration record (MAR) for August 2025, revealed LPN 5 documented administering Hydrocodone to R33 throughout the month and through the morning of 08/24/2025. In interview with the (former) Director of Health Services (DHS) on 06/04/2026 at 4:01 PM, she stated the nurse on duty for R33 (LPN 4) notified her the morning of 08/24/2025 of R33's missing Hydrocodone and that it was too soon to refill the medication. She reported the pharmacy delivered 60 tabs of Hydrocodone to the facility on 08/16/2025. The former DHS stated during the facility's investigation, another resident's Hydrocodone was also unaccounted for, and LPN 5 later admitted to taking that medication. In interview with the Campus Clinical Support (CCS) person on 06/05/2025 at 10:04 AM, she stated on 08/24/2025, R33's nurse called the pharmacy to	F0602		07/07/2026

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F0602 SS = D	Continued from page 4 refill his Hydrocodone as the resident was out of the medication. She stated the pharmacy informed the nurse there should have been another card of the medication. The CCS person reported in the first week of the facility's investigation regarding the missing medication and audits, another resident had been identified as missing a narcotic medicine also. She said LPN 5 and LPN 6 signed that R67 had zero of the medication left; however, when she (the CCS) conducted an audit on 08/25/2025, there were 15 tabs of the medication still available. In interview with the facility's Executive Director (ED) on 06/05/2026 at 3:00 PM, he stated the CCS had been the primary investigator for R33's missing medication. He stated the facility determined R33's medication had been misappropriated, and during the investigation LPN 5 admitted to taking a different resident's (R67's) medication. The ED reported due to LPN 5's being a common tie to both instances of missing medications, and her denial of wrongdoing in multiple conversations over two days, the facility concluded LPN 5 had been involved in both instances (R33's and R67's) of missing medication. In interview with LPN 4 on 06/08/2026 at 9:36 AM, she stated she had been the nurse for R33 when she discovered he did not have any Hydrocodone left (on 08/24/2025). She said she called the pharmacy to obtain a refill of R33's Hydrocodone medication; however, was informed they just delivered 60 tabs to the facility for R33. LPN 4 reported checking the 60 tabs signed into the facility, however could not locate the rest of the tabs that had not already been administered. She further stated before R33's Hydrocodone was missing, the facility's system (of accounting for narcotic medications) had been flawed, as they had not been as diligent then as they were now. In additional interview with the CCS on 06/09/2025 at 10:25 AM, she stated when she conducted the audit of narcotic medications on 08/25/2025, she had not found any other missing medications. She said LPN 5 signed another resident as having no more narcotic medication on 08/25/2025, and LPN 6 co-signed that information. The CCS reported the facility discovered the missing narcotic medication for another resident on 08/28/2025, and when LPN 5 admitted taking that resident's medication the facility determined medication diversion occurred instead of missing medication. She further stated no one at the facility monitored the narcotic counts or the shift to shift narcotic counts were being completed prior to the incident.	F0602		07/07/2026

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F0602 SS = D	Continued from page 5 2). Review of the clinical record for R67 revealed the facility admitted the resident on 08/08/2025, with a diagnosis of diverticulitis of the large intestine with perforation and abscess. Review of the physician orders for R67 revealed an order for Hydrocodone dated 08/07/2025 - 08/17/2025, which was reordered on 08/17/2025 - 08/28/2025, every six hours as needed.Review of the Admission MDS Assessment dated 08/11/2025, revealed the facility assessed R67 as having a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating the resident was cognitively intact. Further MDS review revealed the facility also assessed R67 to receive PRN pain medication and noted the resident rated her pain as three out of ten on the pain scale. Continued review of the facility's investigation documentation for the incident on 08/24/2025, for the affected resident (R67) revealed the facility investigated the resident's missing narcotic medication. Per review, during the investigation, the facility identified R67's missing Hydrocodone, and noted LPN 5 documented the resident as having 15 doses of the Hydrocodone left on 08/25/2025. Additional review revealed however, she documented zero as remaining on the Narcotic Count Sheet. According to review of the investigation documentation, the facility’s audit revealed the medication was discovered as missing on 08/28/2025.Additional review of the facility's investigation documentation revealed the facility interviewed LPN 5 on 08/28/2025, and the LPN reported there had been zero Hydrocodone medication left for R67, but, she had not done anything with the medicine. Per review, the facility noted LPN 5 agreed to taking a drug screen in a lab by 10:00 AM on 08/29/2025, based on the new incident involving R67's missing narcotic medication. Continued review the facility's interview with LPN 5 on 08/29/2025, revealed she said she had taken R67’s Hydrocodone and admitted to having a drug problem. Review of the CDUR for R67 dated 08/13/2025, revealed the pharmacy dispensed 30 of 30 tabs of the resident's Hydrocodone on 08/12/2025. Per review, on 08/25/2025, LPN 5 documented administering one tab to R67, and noted 15 tablets remaining. Review of the Narcotic Count Sheet for the time period of 08/22/2025 through 08/27/2025, revealed on 08/25/2025 LPN 5 noted one medication removed. Review of the facility's removed and added log dated 08/23/2025 through 08/27/2025, revealed LPN 5 noted one Hydrocodone pack for R67, with zero listed as the quantity. Additional review of the removed and added log for the same	F0602		07/07/2026

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F0602 SS = D	Continued from page 6 time period revealed LPN 6 also signed with LPN 5. In interview with the former DHS on 06/04/2026 at 4:01 PM, she stated during a facility investigation initiated 08/24/2025 for missing Hydrocodone for a resident, the facility discovered R67 had missing Hydrocodone discovered on 08/28/2025. The former DHS also stated LPN 5 later admitted to taking R67's Hydrocodone medication. In interview with the CCS person on 06/05/2025 at 10:04 AM, she stated during the facility's investigation dated 08/24/2025 regarding another resident's (R33's) missing narcotic, it was discovered R67 was also missing narcotic medication. She reported she completed an initial audit of all residents who had narcotic medication ordered on 08/25/2025, and R67 was noted as having 15 doses remaining. The CCS said during another audit conducted on 08/28/2025 (three days after the other audit), R67 was discovered to have zero tablets remaining, which "was not possible." She further stated LPN 5 and LPN 6 both signed the medication count as being zero. In interview with the ED on 06/05/2026 at 3:00 PM, he stated during the facility's investigation of missing narcotic medication for another resident (R33) on 08/24/2025, which was ongoing on 08/25/2026, the facility discovered in its narcotic pain medication audits, R67 had missing narcotic medication. He said the facility had multiple conversations with LPN 5 over a two day period and LPN 5 denied any wrongdoing involving the missing narcotic medication. The ED explained the facility asked LPN 5 to take a drug screen in a lab on 08/29/2025, and she agreed to doing so. He reported however, LPN 5 did not go and take the drug screen as requested. The ED further stated LPN 5 admitted to taking R67's narcotic medication and the facility found LPN 6, who had signed with LPN 5 as R67 having no medications, had not actually witnessed the counted medications herself. In addition, the ED said R67 had none of the medication available at the time LPN 6 signed with LPN 5. In interview with LPN 4 on 06/08/2026 at 9:36 AM, she reported when trying to administer R33's Hydrocodone she noted the resident had none. She said she reported that information to the former DHS. The LPN stated she paid "close attention" after her discovery (of the missing narcotic medication for R33), and on 08/28/2025 she discovered R67 also was missing Hydrocodone tablets. She said she knew R67 had "multiple packs" of the narcotic pain	F0602		07/07/2026

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F0602 SS = D	Continued from page 7 medication. LPN 4 explained she was off work for two days, and upon her return, there was no way R67 had used all of the Hydrocodone tablets that were missing. She further stated the narcotic medication had been signed out at zero on one of the (narcotic) documentation records, but was noted as there being 15 available on another narcotic (accounting) document. In additional interview with the CCS on 06/09/2025 at 10:25 AM, she stated when she conducted an audit of narcotic medication on 08/25/2025, she had not found any other missing narcotic medications at that time (which would have included R67's). She said LPN 5 signed R67 as having no more narcotic medication on 08/28/2025, and LPN 6 co-signed with LPN 5 verifying the count. The CCS reported the facility discovered R67's medication missing on 08/28/2025, and when LPN 5 admitted to taking R67's medication, the facility determined medication diversion occurred instead of it being just a case of missing medications. She further stated prior to the missing narcotic medications incident, no one at the facility monitored the narcotic counts, nor the shift to shift narcotic counts being accurately completed.	F0602		07/07/2026