STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANKS	851 KIMSEY LANE , HENDERSON, Kentucky, 42420

(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 Based upon implementation of the acceptable Plan of Correction (PoC), the facility compliance for health on 07/25/2025.	F0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency wh ch 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185124	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANKS	851 KIMSEY LANE HENDERSON, KY 42420

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F 000	INITIAL COMMENTS	F 000		

A Recertification and Abbreviated Survey was concluded on 06/12/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.

No deficiencies were issued related to KY00045358.

Survey Dates: 06/10/2025 - 06/12/2025
Survey Census: 131
Sample Size: 27
Supplemental Residents: 0

F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761	7/25/25

§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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 1 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: AMENDED Based on observation, interview, record review, and facility policy review, the facility failed to ensure drugs and/or biologicals used in the facility were current for use and/or stored and labeled in accordance with currently accepted professional principles, including the expiration date when applicable. Medications and nutritional supplements were opened but not labeled with a date as to calculate the discard date. Medications were found loose, without identification as to whom they belonged and/or what they were. This failure affected three of three medication rooms observed (out of a total of five rooms) and two of five medication carts observed (out of a total of nine carts.) The findings include: Review of the facility's policy, titled "Storage of Medications," revised 04/2007, revealed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner and the nursing staff shall be responsible for maintaining medication storage. Additionally, drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Review of the facility's policy, titled "Administering Medications," revised 12/2012, revealed the expiration/beyond use date on the medication label must be checked prior to administering and	F 761	Plan of Correction Redbanks Survey date: June 12, 2025 Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. F761 Label/Store Drugs & Biologicals Criteria 1: - the bottle of Polyethylene Glycol and the bottle of PEG clear lax were both reordered and the new bottles were dated when opened by the licensed nurse. The old bottles were then discarded by the licensed nurse on 6/13/25 - the 3 bottles of Med Plus and the bottle of thickened orange juice were discarded by the licensed nurse and new bottles obtained from the kitchen were dated when opened on 6/13/25 -the bag of potassium chloride was discarded on 6/13/25 -The expired COVID tests were discarded on 6/13/25 -The 3 loose pills in the med cart were properly destroyed on 6/13/25	

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F 761	Continued From page 2 that when opening a multi-dose container, the date opened shall be recorded on the container. 1. Items not dated upon opening: a. An observation of the Marina Unit Medication Cart 1 on 06/12/2025 at 8:55 AM revealed one 8.3-ounce bottle of PEG 335 Polyethylene Glycol for R141, as well as one 4.1-ounce bottle of PEG Clear Lax for R140, which were opened but not dated. b. Observation of the Marina Unit medication room on 06/12/2025 at 8:45 AM revealed one 32-fluid ounce container of Med Plus NSA 1.7, High Calorie, High Protein Nutritional Drink, Vanilla Flavor, one 32-fluid ounce container of Med Plus 2.0, High Calorie, High Protein Nutritional Drink, Butter Pecan Flavor, and one 46- fluid ounce container of ReadyCare Thickened Orange Juice in the refrigerator that were opened. None of these containers had a date indicating when the containers were opened, resulting in no way of determining the "use by" date. In an interview with Licensed Practical Nurse (LPN) 4 during observation of the Marina Unit medication room on 06/12/2012 at 8:50 AM, she stated that she writes the date on anything she opens and that is what should be done by everyone. c. An observation of the South medication room on 06/11/2025 at 3:39 PM revealed a 32- ounce container of Med Pass that was opened but not dated. Interview with Certified Medication Aide (CMA) 8 revealed that containers should be dated by whoever opened them. CMA 8 stated the container should be thrown away since staff would not be sure of how long it had been opened	F 761	-the pill in the souffle cup in the drawer in the south med room was properly destroyed on 6/11/25 Criteria 2: -All med rooms and med carts were inspected by the DON/ADON/Unit Managers to determine there were no other expired items. This was completed on 6/13/25. -All med carts were inspected on 6/13/25 by the DON/ADON/Unit Managers to determine there were no other loose pills. Criteria 3: All medication administration staff have received in-service education on correct storage of drugs/biologicals including but not limited to: -dated multi dose meds when opened -use of the expiration guide for meds -The need to discard/replace all expired items. -The need to destroy any loose pills identified in the med cart. Training was provided by the DON/ADON/Unit Managers beginning on 7/1/25 through 7/24/25. Criteria 4: The Quality Assurance Performance Improvement (QAPI) audit tool for the monitoring of labeling/storage of drugs biologicals will be utilized by the DON/ADON monthly X 2 months and then quarterly to identify any issues that need to be addressed. The completed audit tools will be reviewed in the QAPI Committee meetings to monitor ongoing compliance.	

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F 761	Continued From page 3	F 761	Criteria 5: July 25, 2025	

and opened containers should be discarded 30 days after opening them.

During an interview with Registered Nurse (RN) 1 on 06/11/2025 at 3:55 PM, she stated all medicine should be dated when opened and should not be given to the residents as it could be expired.

During an interview with the South Hall Unit Manager (UM) on 06/12/2025 at 4:10 PM, she stated the CMAs and Nursing staff were responsible to check the medication rooms weekly as part of their assigned duties. She stated the facility uses a lot of Med Pass, but she expected staff to date the container as they open it.

During an interview with the Director of Nursing (DON) on 06/12/2025 at 3:40 PM, she stated she expected staff to date and initial any item when they open it. Additionally, she stated that central supply staff are to check supply expiration dates on their daily rounds, and if an item was not dated, it should be disposed of. The DON stated the unit manager was responsible for checking the medication rooms for expired medications as part of their weekly rounds.

Interview with the Executive Director on 06/12/25 at 4:15 PM, revealed that containers of nutritional drinks/supplements should be dated when opened and that dietary staff and nurses putting new items in a refrigerator should check dates.

2. Expired Supplies:

a. An observation of the Marina Unit Medication room on 06/12/2025 at 08:45 AM revealed one

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F 761	Continued From page 4	F 761		

bag of 0.45% potassium chloride in normal saline 1000 milliliters, dated 05/25. In an interview with LPN4 during this observation, she stated that expiration dates should be checked prior to using any IV fluids and, "The IV bag should have been thrown out."

b. Observation of the Marina Unit medication room on 06/12/2025 at 8:45 AM revealed an Intel Swab Covid 19 Rapid Test on the supply shelf with an expiration date of 11/30/2024. Observation of the Harbor Unit medication room on 06/12/2025 at 9:25 AM also revealed an OHC Covid-19 Antigen Self-Test on the supply shelf with an expiration date of 01/27/2024. Interview with LPN5 during the observation of the Harbor Unit medication room on 06/12/2025 revealed that covid tests should be thrown away when expired.

In an interview with the DON on 06/12/2025 at 3:40 PM, she stated that central supply staff are to check supply expiration dates on their daily rounds. She stated if containers are expired, there is a chance to have a negative outcome for the resident.

In an interview on 06/12/25 at 4:15 PM, the Executive Director stated that expired medications should be thrown out. She added that the responsibility to check expiration dates falls on the nurse using the product, and they should check the expiration date before using a product.

4. Unlabeled/Unidentified Medications:

a. Observation of Marina Medication Cart 1 at 8:56 AM on 06/12/2025 revealed loose

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F 761	Continued From page 5	F 761		

medications in the drawers without identifying information such as the name of the resident for whom it was prescribed, and the name/dose of the medication. In the left side Drawer 2, there was a capsule which was gray on one end and brown on the other end and Lifestar 404 printed on the capsule. (Per a pill identifier, this capsule was nitrofurantoin 100 milligrams (mg) (an antibiotic).) In the left side Drawer 3, there was a green, oval tablet with E imprinted on one side and 47 imprinted on the other. (Per a pill identifier, this tablet was losartan potassium 100mg (used to treat high blood pressure).) In the left side Drawer 4, there was a white, round tablet with ZC41 imprinted on one side. (Per a pill identifier, this tablet was carvedilol 12.5mg (used to treat conditions related to the heart and blood vessels).) In an interview with LPN 4 during observation of the Marina Unit medication room on 06/12/2012 at 8:50 AM, she stated that it is easy for pills to "pop out" of their cards when being replaced in the cart but they should have been removed from the draw and "wasted."

b. An observation of the South Medication Room on 06/11/2025 at 3:39 PM revealed a paper medicine cup in a drawer that contained a half tablet inside of the cup. The bottom of the medication cup had a handwritten note identifying the tablet as Keppra 250mg. During an interview with CMA8, she stated she did not know who the Keppra tablet belonged to or how long it had been in the drawer, adding that it should be discarded

During an interview with RN1 on 06/11/2025 at 3:55 PM, she stated she was not aware of the Keppra being in the drawer and did not know how long it had been there, adding that it should be discarded. She stated the nurses were

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F 761	Continued From page 6 responsible for checking the medication rooms but did not know how often it should be done. During an interview with the South Hall Unit UM on 06/12/2025 at 4:10 PM, she stated she did not have an explanation as to why the Keppra was found in a drawer. She stated it was in a drawer on the side of the medication room that was not often even used and had no idea why it was in there. Further interview revealed her statement that the CMAs and Nursing staff were responsible to check the medication rooms weekly as part of their assigned duties. In an interview with the DON on 06/12/2025 at 3:40 PM, she stated that she would not expect to find loose pills in medication carts, but it can happen, and her expectation was that staff would check for things like that. Additionally, she stated her expectation was that that the unit managers would check the medication rooms weekly and that medication carts would be cleaned weekly.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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.	F 812		7/25/25

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F 812	Continued From page 7 (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 policy, it was determined that the facility failed to store food in accordance with professional standards for food service safety and quality. Opened foods were not dated. Expired foods and/or foods which were past their "use by" date were available for use and service to residents. This failure had the potential to affect 129 of 131 residents who consume food from the facility's kitchen and/or unit refrigerators. The findings include: Review of the facility policy titled "Food: Preparation," with a revision date of 02/2023, revealed Item 17 stated that all refrigerated, ready-to-eat Time/Temperature Control for Safety (TCS) prepared foods that are to be held for more than 24 hours at a temperature of 41 degrees F or less, will be labeled and dated with a "prepared date" (Day 1) and a "use by date" (Day 7). Observation of the walk-in refrigerator, on 06/10/2025 at 6:25 AM, revealed one partial box of cabbage containing two bags of cabbage with showed a "use by" date of 06/08/2025. One opened bag of lettuce had a "use by" date of 06/08/2025 and showed browning of the lettuce. Observation of the reach-in refrigerator, on	F 812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary Criteria 1: The 2 bags of cabbage, bag of lettuce, the ham salad, the potato salad, and the chicken salad sandwiches found in the kitchen, were discarded on 6/10/25. The containers of grape juice in the med room refrigerators were discarded on 6/12/25. Criteria 2: - The Dietary Manager (DM) inspected all food for proper labeling, dating, and use by dates in the kitchen refrigerators, freezers, and dry storage on 6/13/25 All med room refrigerators were inspected by the Unit Managers/ADON/DON to determine that all opened items were dated and there were no expired items in the refrigerator as completed on 6/13/25.Criteria 3: The dietary staff have received inservice education as provided by the Registered Dietician (RD) /Dietary Manager on proper labeling, dating, and use by dates of all food as completed on7/11/25, 7/12/25, 7/13/25 7/14/25, 7/15/25, 7/16/25.	

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F 812	Continued From page 8 06/10/2025 at 6:35 AM, revealed one partial container of ham salad with a "use by" date of 05/03/2025, one partial container of potato salad with a "use by" date of 05/25/25, and one open container of parmesan cheese with an "open date" of 04/08/2025. Ongoing observation of the "Reach-in Refrigerator for Cooks" revealed two chicken salad sandwiches dated with a "use by" date of 06/09/2025. In addition, this refrigerator contained an open gallon jug of mayonnaise that was undated (no "open date"), and an open jug of teriyaki sauce with a received date of 05/28/2025 which did not list an "open date." Observation on 06/12/2025 at 1:15 PM of the "Central" nursing station resident food refrigerator revealed 15 single-serve grape juice containers with "best by" dates of 01/17/2025 and 06/08/2025. Observation on 06/12/2025 at 1:30 PM of the "South Port" nursing station resident food storage revealed seven single-serve grape juice containers with a "best by" date of 01/17/2025. Interview with the Dietary Manager (DM) on 06/10/2025 at 6:30 AM, revealed that dietary staff should have removed the items which were beyond their "use by" date from the refrigerator. Additional interview with the DM, on 06/12/2025 at 2:03 PM, revealed that once food leaves the kitchen, it is a team effort of the floor staff and kitchen staff to ensure items are not stored beyond the "best by" date for food safety to prevent food related illness. In an interview with the Dietary Supervisor (DS) on 06/12/2025 at 2:10 PM, the DS stated that it was his expectation that staff provide nutritious	F 812	All certified medication administration nursing staff (CMA) have received in-service education as provided by the DON/ADON/Unit Managers on the need to label all food/drink products upon opening and to discard all expired items as completed by 7/24/25 Criteria 4: The QAPI tool for the monitoring of Dietary Sanitation will be utilized by the RD/Dietary Manager monthly and the QAPI tool for monitoring compliance with food/drink in the med rooms, will be utilized by the DON/ADON monthly. The Unit Managers/DON/ADON will inspect the med room refrigerators weekly to determine that all items are correctly dated and items are discarded when expired -The Dietary Manager will inspect the kitchen food storage areas weekly to determine that all items are correctly dated and items are discarded when expired -The RD will inspect all sanitation practices in the kitchen monthly to determine compliance with all requirements Any issues identified will be reviewed in the facility QAPI committee meeting to ensure an effective plan of action has been implemented and to monitor ongoing compliance Criteria 5: July 25, 2025	

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F 812	Continued From page 9 and filling meals without bacterial growth. He stated once food was past the "beyond use" date, there was the potential to allow bacteria to grow and potentially cause foodborne illness. He added that in the cooler, longer storage times would allow increased moisture to form that alters the environment and may allow for contamination or cross contamination. In an interview with the Director of Nursing (DON) on 06/12/25 at 3:42 PM, the DON stated that it was the responsibility of the kitchen to remove the "beyond use" juices from the unit refrigerators. She stated the dietary department has a "stock list and pantry list" that is brought to each unit every day that includes juices, as well as other items, and the juices should be switched out every day by the dietary staff when they bring out the new tray of juices. Interview with the Executive Director on 06/12/25 at 4:15 PM revealed she expected food items to be labeled and dated to prevent potential food-borne illnesses.	F 812		
F 880 SS=E	Infection Prevention & Control 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	F 880		7/25/25

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F 880	Continued From page 10	F 880		

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 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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANKS	851 KIMSEY LANE HENDERSON, KY 42420

(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
F 880	Continued From page 11 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, and review of the facility's policy and procedure, it was determined the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases for four (Resident (R)109, R93, R37, and R41) of five sampled residents reviewed for infection control. Facility staff failed to indicate, via signage, the need for precautions, as well as provide and/or ensure the use of Personal Protective Equipment (PPE) and hand hygiene by staff and visitors for R109, who was on contact isolation precautions. Action to protect others from the risk of infection was not taken when R109 was out of her room for non-essential purposes. In addition, staff failed to follow manufacturer's instructions after cleaning/disinfecting a used glucometer used on R41. During medication pass for R93 and R37, staff handled medications with bare hands, did not perform hand hygiene as required and/or administered medication that had fallen on top of the medication cart.	F 880	F880 Infection Prevention & Control F880 CFR(s): 483.80(a)(1)(2)(4)(e)(f) Criteria 1: -Signage and Personal Protective Equipment (PPE) supplies for Contact Precautions were put in place for the room of Resident #109 on 6/11/25 by the Infection Preventionist (IP) LPN. -The certified nursing assistant (C.N.A) observed in this room was provided inservice education on correct adherence to Contact Precautions as provided on 7/15/25 by the Infection Preventionist LPN. -The family members of Resident #109 were provided inservice education on Contact Precautions and the correct use of the needed PPE and handwashing procedures on 6/11/25 by the Advanced Registered Nurse Practitioner (ARNP). -The Certified Medication Aid (CMA)	

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Findings include:
1. Review of R109's "Face Sheet" revealed that the facility admitted the resident on 01/11/2025 with diagnoses including non-traumatic brain dysfunction and unspecified dementia. R109 was placed on the facility's secured memory care unit.

Review of R109's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 04/19/2025, revealed a Brief Interview for Mental Status (BIMS) score of 12/15, which indicated the resident had moderate cognitive impairment. Per this MDS, the resident required substantial/maximal assistance from staff with transfers and was occasionally incontinent of both bowel and bladder.

Review of R109's current physician's orders revealed a new order, dated 06/07/2025 at 6:56 PM, for Macrobid (antibiotic) 100 milligrams (mg) oral capsule twice daily for a diagnosis of extended-spectrum beta-lactamase (ESBL - a type of Multidrug Resistant Organism (MDRO). Further review of physician's orders revealed an order dated 06/08/25 at 11:06 AM for "Contact Isolation Precautions." Review of this order revealed it did not note whether the resident's infection was contained or not and did not indicate that the resident could leave their room.

a. Review of the facility policy titled, "Infection Control: Standard Precautions and Isolation," revised 10/2018, revealed its purpose is to guide care for "residents known or suspected to have serious illnesses that are easily transmitted through direct contact or contact with contaminated items in the resident's environment." Further review of the policy

observed during survey was provided in-service education on correct adherence to infection control standards during the med pass, including but not limited to discarding any dropped oral pill form of medication, as completed by the DON on 7/4/25.
-The medication administration staff observed during the survey has received in-service education and been observed for correct glucometer cleaning/disinfecting, and storage as completed by the DON on 7/4/25
-The staff members observed during the survey that did not adhere to the required Transmission Based Precautions (TBP) have received in-service education and been observed for correct adherence to TBP as completed by the DON/ADON/IP as completed on 7/9/25.

Criteria 2:
-Observations were completed on medication passes on 7/4/25, 7/5/25, and 7/7/25 (3 days) on each shift by the Unit Managers/DON/ADON to determine staff were adhering to infection control standards with medication administration and glucometer cleaning/disinfecting and storage.
-Observations were completed by Unit Managers/DON/ADON/Infection Preventionist on 7/4/25, 7/7/25, and 7/11/25 (3 days) on each shift to determine staff and visitors are adhering to infection control standards when provided care for/visiting residents with Transmission Based Precautions.

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F 880	Continued From page 13 revealed staff are to wear gloves (clean, nonsterile gloves are adequate) when entering the room if any contact is to be made with the resident or items in the room; change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material and wound drainage); and remove gloves before leaving the resident's environment and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent. The policy also stated to wear a gown (a clean, nonsterile gown is adequate) when entering the room if substantial contact is anticipated with the resident, environmental surfaces, or items in the room, or if the resident is incontinent or has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing; and to remove the gown before leaving the resident's environment. The policy failed to address whether signage was required to be posted to indicate when precautions are in place. Observation of R109's room on 06/10/2025 at 6:30 AM revealed R109 was asleep in her bed. The resident's room contained two large red bins with lids marked with biohazard signage. Continued observation revealed no signage was posted either outside or inside the room to indicate that R109 was on any type of precautions. There was no Personal Protective Equipment (PPE) such as gloves and gown required for Contact Precautions present at the door prior to entering the room or visible inside the room. Observation of R109's room on 06/10/2025 at 6:42 AM revealed State Registered Nurse Aide (SRNA) 3 entered the room without donning PPE (including gloves or gown) and, using his bare	F 880	Criteria 3: -All medication administration staff have received in-service education from the DON/ADON/Unit Managers on the need to adhere to infection control standards with medication pass and glucometer cleaning/disinfection and storage as completed on 7/11/25, 7/12/25, 7/13/25,7/14/25, 7/15/25, 7/16/25. -All licensed and non-licensed nursing staff have received in-service education from the DON/ADON/Unit Managers on the need to adhere to infection control standards with Transmission Based Precautions as completed on 7/11/25 7/12/25, 7/13/25,7/14/25, 7/15/25, 7/16/25. -The facility IP/DON/ADON will review the assessment and laboratory findings for all residents identified with an multi drug resistant organism (MDRO) to determine if the infection is transmissible or contained, and will determine the type and scope of transmission based precautions to be implemented. The facility staff and resident family/visitors will be notified of the resident review findings when completed, the type/scope of precautions that must be followed, and whether or not the resident must receive all care in their room. Education on this process was provided to all nursing facility staff on 7/11/25, 7/12/25, 7/13/25,7/14/25, 7/15/25, 7/16/25 by the IP/DON/ADON/Unit Managers. Criteria 4: The QAPI tool for the monitoring of infection control standards with medication pass and Transmission	

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hands, placed a large yellow plastic bag into one of the two red biohazard bins in the rooms. He then exited the room without performing hand hygiene. In a brief interview conducted at 6:43 AM, SRNA3 stated the red bins were needed because R109 was on "precautions," and "One bin is used for soiled linens, and the other for dirty diapers."

In an interview with Licensed Practical Nurse (LPN) 4 on 06/11/2025 at 3:40 PM, she stated that Contact Precautions are required when there is a risk of exposure to infectious organisms, such as ESBL, which may be present on surfaces or linens. She reported that whenever a resident is placed on Contact Precautions, a sign should be posted "immediately" on the door of the resident's room, adding: "People must be made aware."

b. Further review of the facility policy titled, "Infection Control: Standard Precautions and Isolation," revised 10/2018, revealed that the movement of a resident on Contact Precautions should be restricted, stating: "Limit the movement and transport of the resident from the room to essential purposes only." Additionally, the policy directed that "If the patient is transported out of the room, ensure that precautions are maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment." However, the policy failed to explain how precautions were to be maintained when a resident was outside of their room, nor did it specify what actions should be taken to minimize the risk of transmission in these circumstances.

Observation of the facility's memory care unit

Based Precautions will be utilized by the DON/ADON monthly X 2 months and then quarterly thereafter to identify any issues that need to be addressed. Completed QAPI tools will be reviewed in the QAPI Committee meetings to monitor ongoing compliance.

Criteria 5: July 25, 2025

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dining room on 06/10/2025 at 12:56 PM revealed R109 was in the dining room for lunch, seated at a square, four-person table, with one resident seated to her left and another to her right. Two staff members were also seated at the table, positioned between the residents, and were providing assistance throughout the meal. This assistance included offering verbal encouragement and prompting to eat, as well as handing the residents their drinks and utensils. Neither the staff members nor R109 were wearing any PPE. SRNA11 was observed asking the resident if she was feeling uncomfortable while gently patting her back. She then requested assistance from another aide, and they helped reposition R109 in her wheelchair with their bare hands. After repositioning R109, neither of the two staff was observed to perform hand hygiene.

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c. Observation of R109's room on 06/11/2025 at 1:07 PM revealed that, after surveyor intervention, a yellow organizer was now hanging on the door with PPE stored in its pockets. A sign was now also posted, indicating that the resident was on Contact Precautions. The sign instructed visitors to speak with nursing staff before entering and outlined the required PPE, including donning gloves and a gown prior to room entry.

Observation at this time revealed R109 was in her room with two visitors, Family Member (FM) 109A and FM109B. Neither of the visitors were wearing any PPE. At 1:11 PM, LPN4, the unit charge nurse, approached the doorway and informed the visitors that they should be wearing PPE. FM109-A responded, 'We didn't think we needed to wear anything since she was in the dining room when we got here."

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Further interview with FM109-A on 06/11/2025 at 1:20 PM revealed that she had been informed by staff during a visit on 06/08/2025 that she "should wear gloves and avoid bodily fluids." However, she then expressed confusion about the need to wear PPE, stating that during her visit that day (06/11/2025) a staff member had entered R109's room without donning any PPE. An interview with FM109-B, conducted at the same time, revealed that she was also unclear regarding the PPE requirement. She stated, "No one told us (about the Contact Precautions). I saw the sign, but I thought it was okay (to not don PPE) because [R109] was in the dining room when we got here." She added that by the time LPN4 informed them they should don PPE, they had already been visiting with R109 in her room for an hour and a half.

In an interview with SRNA6 on 06/11/2025 at 2:20PM, she described the protocol for Contact Precautions for ESBL as "business as usual; they do their day-to-day things without any special stuff." SRNA6 stated that the PPE needed for Contact Precautions included a gown, gloves, and mask, but added that this PPE would just be for changing and dressing. She stated the purpose of putting residents on Contact Precautions was that infection can be passed along through clothing "or on your body." Although the policy related that movement for residents on Contact Precautions was to be restricted, SRNA6 stated that residents on Contact Precautions can attend communal dining, saying, "I think so as long as it is contained, like it is in their urine or in a catheter, or they have bandages covering it." SRNA 6 indicated that there were different signs to indicate whether a resident's infection was

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F 880	Continued From page 17 contained (making isolation unnecessary.) Review of the sign at R109's door with SRNA6 at this time revealed that SRNA6 could not tell if R109's infection was contained or whether the resident should stay in their room, except for essential purposes only. Further interview revealed SRNA 6 could not recall the last time she received any training on infection control precautions such as Contact Precautions, and that all staff members were responsible for explaining PPE requirements to visitors. In an interview with SRNA7 on 06/112025 at 2:40 PM, she stated that she was unclear about the specific requirements for Contact Precautions, stating she thought it required staff to "wear gloves." However, she then described that while providing care for a resident with an infection in the urine, she would need to wear a mask, gown, and gloves, throw everything away or put items in the hazard bins away after care was provided, and perform hand hygiene. She explained that the yellow caddies hanging on a resident's door indicate that staff need to wear PPE while providing care because the resident has "some type of infection that staff need to protect others from." SRNA7 reported being under the impression that residents on Contact Precautions were supposed to remain in their room but expressed uncertainty, exclaiming, "I am sorry; I am getting them all mixed up." When asked how she would know if a resident can leave their room, she stated, "Typically I get told by the nurse, but the door signage would also tell me." However, review of the door signage revealed it did not indicate whether the resident could leave the room. SRNA 7 further stated that she had recently returned to work at the facility and received some training on infection control	F 880		

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practices at that time; however, her last in-depth training on the topic occurred approximately one year ago.

In an interview with LPN 4 on 06/11/2025 at 3:40 PM, she stated that Contact Precautions were used because, "They [the residents] have some kind of organism you could contract if you came into contact with it." She added that for Contact Precautions, "You have to wear the gear every time you go in the room because you may come into contact with it; it may be in the room or on soiled linen." Regarding R109, she reported that R109 was on Contact Precautions due to ESBL in the urine but was unsure when the precautions were initiated. When asked about the protocol for Contact Precautions, she stated: "If it [the infection] is contained, like the urine is the issue, they [residents] can still come out [of their rooms]." LPN4 stated that R109 is "allowed to come and go as she pleases; she can go to therapy or sit in the common area." However, she acknowledged that because R109 does not don PPE, such as a gown, when exiting her room, her clothing could pose a risk for spreading ESBL and admitted that "could be an issue." LPN4 stated that on the dementia unit where R109 resided, "With these people back here, a lot of them are cognitively impaired, so it is up to staff to monitor it and make sure it isn't getting spread. [R109] does not do her own incontinent care, but if she sits on something it would have to be sanitized, but her room is infected and so her hands may not be clean." When asked whether they utilize any specific clinical criteria to determine whether a resident on Contact Precautions can participate in communal dining, she stated: "I feel that if the staff is supervising the area and the resident has been toileted, it is

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okay for them to attend the meal. No risk assessment is completed." When asked how visitors would be informed and educated about the need to follow Contact Precautions/use PPE, she replied: "We need to ensure everyone that goes in that room is wearing PPE ...Visitors could take the organism home to their family. Staff are risking every one of these residents getting it."

On 06/11/2025 at 3:55 PM, an interview was conducted with the Infection Control and Prevention Nurse (IP), along with Advanced Practice Registered Nurse (APRN) 1 and Advanced Practice Registered Nurse (APRN) 2. APRN1 stated that a resident would be placed on Contact Precautions for ESBL because "it is highly contagious; it's so I can keep them away from the other residents." APRN1 then added that the decision to place a resident with ESBL on Contact Precautions is made on a "case-by-case basis." However, no evidence was provided as to how this "case-by-case" decision was made relative to R109. APRN2 stated that R109 is permitted to leave her room, including to eat lunch in the communal dining hall at a table with other residents, because "We can't confine them to their rooms; that wouldn't be good for them." However, she later stated that staff do make efforts to keep them in their room. The IP stated, "We try to encourage them, but we can't make them stay in their room," and acknowledged that staff "should be attempting to put a gown on her." She stated that there were no additional written policies outlining these protocols.

Because staff made comments about different isolation requirements between contained and non-contained infections, a request was made on 06/12/25 at 9:06 a.m. with the IP for any policies

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differentiating Contact Precautions for contained versus non-contained infections. On 06/12/2025 at 9:35 a.m., the IP reported that there were "no additional policies" delineating the need for isolation in non-contained versus contained infections. The IP stated that it was "up to the provider" who initiates the orders to determine which should be followed. She stated that the order should contain that specification. Review of the physician's order confirmed that it did not distinguish between a contained or non-contained infection and called for "Contact Isolation Precautions."

In an interview with the Executive Director on 06/12/2025 at 4:33 PM, she stated that Contact Precautions require signage, PPE (gloves and gowns), red bins, and documentation in the resident's care plan. She reported that visitors are encouraged-but not required-to wear PPE, and staff are expected to read signage and don appropriate PPE upon entry. She explained that residents on Contact Precautions may leave their rooms based on psychosocial needs, though no formal assessment is used to determine this. She acknowledged the risk of exposure in shared spaces like the dining room and suggested that affected residents should avoid close contact with others, stating, "Hopefully they won't touch anyone else. Hopefully they are not touching the area." Further interview with the Executive Director revealed that the failure to observe Contact Precautions included the potential for "Spread of infection to residents, staff, family."

2. Review of the facility's policy and procedure titled, "Administering Medication," revised 12/2012, revealed staff shall follow established

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F 880	Continued From page 21 facility infection control procedure (e.g. hand washing, antiseptic technique, gloves, isolation, precautions, etc.) for the administrations of medication, as applicable. a. Record review revealed R93's current medications orders included an order for Linzess oral capsule 72 micrograms (mcg) by mouth once a day for constipation. Observation during a medication pass on 06/10/2025 at 7:08 AM revealed Certified Medication Aide (CMA) 1 dropped a Linzess 72 mcg capsule into her bare hand, then proceeded to put it in the medication cup and administer it to R93.Observation revealed CMA1 failed to perform hand hygiene prior to touching the resident's medication with her bare hand. Interview with CMA1, on 06/10/25 at 07:15 AM, revealed it was not best practice to give a pill that had been placed in her bare hand, and it should have been put in a medication cup to administer. b. Record review revealed R37's medication orders included a 12/02/2024 order for Aspirin 325 mg one time a day by mouth for cerebrovascular accident (CVA- stroke). Observation during a medication pass on 06/10/2025 at 7:20 AM revealed CMA1 dropped R37's Aspirin 325mg, on top of the medication cart. CMA1 then proceeded to pick up the medication with her bare hand and administer it to R37.Further observation revealed that CMA1 failed to perform hand hygiene prior to picking up the pill with her bare hand. Interview with CMA1, on 06/10/25 at 07:29 AM, revealed that a medication should not be given after it had been dropped on top of the medication cart, but discarded and staff should administer another one.	F 880		

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A joint interview was conducted with the Director of Nursing (DON) and Executive Director on 06/12/2025 at 4:33 PM. During the interview, the DON stated that nursing staff or CMAs were to discard a contaminated pill in the sharps container and get another one to administer. The DON added that the expectation of the staff is to use proper hand hygiene and standard precautions when giving medications. Further interview with the Executive Director revealed the expectation that if a medication was dropped or touched, it should be disposed of and not administered to residents.

3. Review of the facility's undated policy and procedure titled, "Obtaining A Fingerstick Glucose Level" revealed Step 18 stated staff were to "Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice."

Review of the manufacturer's instructions on the purple-topped container of Super Sani Wipes (used for disinfecting/sanitizing glucometers) revealed that staff were to "Wipe Surface thoroughly. Allow surface to remain visibly wet for two minutes. Let airdry. "

Observation during a medication pass on 06/12/2025 at 11:55 AM, revealed that, per physician's orders dated 05/25/2025, CMA4 obtained a blood glucose reading on R41. After completing the test, CMA4 placed the soiled glucometer on top of the medication cart with no barrier. CMA4 then wiped the soiled glucometer three times for less than a total of ten seconds

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with a Super Sani Wipe from a purple-topped container. After using the wipe, CMA4 then immediately placed the glucometer on top of clean medical supplies on the medication cart. The product was not allowed to dwell (remain visibly wet) for two minutes, and then airdry before it was placed on supplies which were to be used for other residents.

Interview with CMA4, on 06/10/25 at 11:30 AM, revealed that a soiled glucometer should not be placed directly on the medication cart without a barrier. Instead, it should be placed on a barrier and then cleaned. CMA4 stated education was received on how to clean the glucometer; however, she was unsure how long to allow the solution to dwell.

A joint interview was conducted with the DON and Executive Director on 06/12/2025 at 4:33 PM. The DON stated that it was an expectation that the CMAs would place the dirty glucometer on a barrier and clean it for thirty seconds and allow it to dry, according to manufacturer's recommendations, and to dispose of/not use any clean supplies that dirty equipment may have contaminated. The Executive Director confirmed it was the expectation was that nursing staff or CMAs would clean the glucometers with the designated bleach wipes and use proper contact and dry times per policy. Per the Executive Director, if a dirty glucometer was placed on clean supplies, staff should dispose of the supplies and clean the glucometer.

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F 000	INITIAL COMMENTS A Recertification and Abbreviated Survey was concluded on 06/12/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. No deficiencies were issued related to KY00045358. Survey Dates: 06/10/2025 - 06/12/2025 Survey Census: 131 Sample Size: 27 Supplemental Residents: 0	F 000		
F 761 SS=F	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	F 761		

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

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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:
Based on observation, interview, record review, and facility policy review, the facility failed to ensure drugs and/or biologicals used in the facility were current for use, stored at appropriate temperatures, and/or stored and labeled in accordance with currently accepted professional principles, including the expiration date when applicable. Medications and nutritional supplements were opened but not labeled with a date as to calculate the discard date. Medication supplies and Covid test kits were stored beyond the manufacturer's expiration date. Temperature logs for medication room refrigerators were not consistently completed as required. Medications were found loose, without identification as to whom they belonged and/or what they were. This failure affected three of three medication rooms observed (out of a total of five rooms) and two of five medication carts observed (out of a total of nine carts.)

The findings include:

Review of the facility's policy, titled "Storage of Medications," revised 04/2007, revealed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner and the nursing staff shall be responsible for maintaining medication storage. Additionally, drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received.
Review of the facility's policy, titled "Administering Medications," revised 12/2012, revealed the

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expiration/beyond use date on the medication label must be checked prior to administering and that when opening a multi-dose container, the date opened shall be recorded on the container.

1. Items not dated upon opening:

a. An observation of the Marina Unit Medication Cart 1 on 06/12/2025 at 8:55 AM revealed one 8.3-ounce bottle of PEG 335 Polyethylene Glycol for R141, as well as one 4.1-ounce bottle of PEG Clear Lax for R140, which were opened but not dated.

b. Observation of the Marina Unit medication room on 06/12/2025 at 8:45 AM revealed one 32-fluid ounce container of Med Plus NSA 1.7, High Calorie, High Protein Nutritional Drink, Vanilla Flavor, one 32-fluid ounce container of Med Plus 2.0, High Calorie, High Protein Nutritional Drink, Butter Pecan Flavor, and one 46- fluid ounce container of ReadyCare Thickened Orange Juice in the refrigerator that were opened. None of these containers had a date indicating when the containers were opened, resulting in no way of determining the "use by" date. In an interview with Licensed Practical Nurse (LPN) 4 during observation of the Marina Unit medication room on 06/12/2012 at 8:50 AM, she stated that she writes the date on anything she opens and that is what should be done by everyone.

c. An observation of the South medication room on 06/11/2025 at 3:39 PM revealed a 32- ounce container of Med Pass that was opened but not dated. Interview with Certified Medication Aide (CMA) 8 revealed that containers should be dated by whoever opened them. CMA 8 stated the

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container should be thrown away since staff would not be sure of how long it had been opened and opened containers should be discarded 30 days after opening them.

During an interview with Registered Nurse (RN) 1 on 06/11/2025 at 3:55 PM, she stated all medicine should be dated when opened and should not be given to the residents as it could be expired.

During an interview with the South Hall Unit Manager (UM) on 06/12/2025 at 4:10 PM, she stated the CMAs and Nursing staff were responsible to check the medication rooms weekly as part of their assigned duties. She stated the facility uses a lot of Med Pass, but she expected staff to date the container as they open it.

During an interview with the Director of Nursing (DON) on 06/12/2025 at 3:40 PM, she stated she expected staff to date and initial any item when they open it. Additionally, she stated that central supply staff are to check supply expiration dates on their daily rounds, and if an item was not dated, it should be disposed of. The DON stated the unit manager was responsible for checking the medication rooms for expired medications as part of their weekly rounds.

Interview with the Executive Director on 06/12/25 at 4:15 PM, revealed that containers of nutritional drinks/supplements should be dated when opened and that dietary staff and nurses putting new items in a refrigerator should check dates.

2. Expired Supplies:

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a. An observation of the Marina Unit Medication room on 06/12/2025 at 08:45 AM revealed one bag of 0.45% potassium chloride in normal saline 1000 milliliters, dated 05/25. In an interview with LPN4 during this observation, she stated that expiration dates should be checked prior to using any IV fluids and, "The IV bag should have been thrown out."

b. Observation of the Marina Unit medication room on 06/12/2025 at 8:45 AM revealed an Intel Swab Covid 19 Rapid Test on the supply shelf with an expiration date of 11/30/2024. Observation of the Harbor Unit medication room on 06/12/2025 at 9:25 AM also revealed an OHC Covid-19 Antigen Self-Test on the supply shelf with an expiration date of 01/27/2024. Interview with LPN5 during the observation of the Harbor Unit medication room on 06/12/2025 revealed that covid tests should be thrown away when expired.

c. An observation of the Harbor Unit Medication Cart 2 on 06/12/2025 at 9:25 AM revealed: one box of anti-Diarrheal- open with an expiration date of 05/27/2025. One bottle of PEG Glycol powder 8.3 ounces- with an open date written on it 01/30/2025. One 4.1-ounce bottle of Clear Lax- opened dated 03/17/2025. One 17.9-ounce bottle of Polyethylene- open, dated 05/07/2025. One bottle of Milk of Magnesia 12 fluid ounce - open, dated written 04/30/2025. One 8.3-ounce bottle of Polyethylene Glycol 3350- open, dated 04/04/2025. In an interview with LPN5 during this observation, she stated the expired medications should be thrown out.

In an interview with the DON on 06/12/2025 at 3:40 PM, she stated that central supply staff are

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to check supply expiration dates on their daily rounds. She stated if containers are expired, there is a chance to have a negative outcome for the resident.

In an interview on 06/12/25 at 4:15 PM, the Executive Director stated that expired medications should be thrown out. She added that the responsibility to check expiration dates falls on the nurse using the product, and they should check the expiration date before using a product.

3. Maintenance of Appropriate Temperatures
Observation of the Marina Unit medication room on 06/12/2025 at 8:45 AM revealed the temperature logs for the First Dose unit and the Large Refrigerator were incomplete. The First Dose log had no readings entered for 06/11/2025 or the AM reading on 06/12/2025. The Large Refrigerator log had no entry for the AM reading on 06/12/2025. A recheck at 3:25 PM on 06/12/2025 revealed the logs were still incomplete. Per the log sheet on the large refrigerator, "Nurses/CMA [Certified Medication Aides] must log temp[erature] and initial at start of each shift."

In an interview with the DON on 06/12/2025 at 3:40 PM, she stated that the temperature logs on refrigerators should be filled in day shift and night shift at any time during the shift.

In an interview on 06/12/25 at 4:15 PM, the Executive Director stated that not checking and logging the temperature of refrigerators where medications/food is kept could "lead to problems" because the facility would not know if the temperature was out of range.

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4. Unlabeled/Unidentified Medications:

a. Observation of Marina Medication Cart 1 at 8:56 AM on 06/12/2025 revealed loose medications in the drawers without identifying information such as the name of the resident for whom it was prescribed, and the name/dose of the medication. In the left side Drawer 2, there was a capsule which was gray on one end and brown on the other end and Lifestar 404 printed on the capsule. (Per a pill identifier, this capsule was nitrofurantoin 100 milligrams (mg) (an antibiotic).) In the left side Drawer 3, there was a green, oval tablet with E imprinted on one side and 47 imprinted on the other. (Per a pill identifier, this tablet was losartan potassium 100mg (used to treat high blood pressure).) In the left side Drawer 4, there was a white, round tablet with ZC41 imprinted on one side. (Per a pill identifier, this tablet was carvedilol 12.5mg (used to treat conditions related to the heart and blood vessels).) In an interview with LPN 4 during observation of the Marina Unit medication room on 06/12/2012 at 8:50 AM, she stated that it is easy for pills to "pop out" of their cards when being replaced in the cart but they should have been removed from the draw and "wasted."

b. An observation of the South Medication Room on 06/11/2025 at 3:39 PM revealed a paper medicine cup in a drawer that contained a half tablet inside of the cup. The bottom of the medication cup had a handwritten note identifying the tablet as Keppra 250mg. During an interview with CMA8, she stated she did not know who the Keppra tablet belonged to or how long it had been in the drawer, adding that it should be discarded.

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F 761	Continued From page 7 During an interview with RN1 on 06/11/2025 at 3:55 PM, she stated she was not aware of the Keppra being in the drawer and did not know how long it had been there, adding that it should be discarded. She stated the nurses were responsible for checking the medication rooms but did not know how often it should be done. During an interview with the South Hall Unit UM on 06/12/2025 at 4:10 PM, she stated she did not have an explanation as to why the Keppra was found in a drawer. She stated it was in a drawer on the side of the medication room that was not often even used and had no idea why it was in there. Further interview revealed her statement that the CMAs and Nursing staff were responsible to check the medication rooms weekly as part of their assigned duties. In an interview with the DON on 06/12/2025 at 3:40 PM, she stated that she would not expect to find loose pills in medication carts, but it can happen, and her expectation was that staff would check for things like that. Additionally, she stated her expectation was that that the unit managers would check the medication rooms weekly and that medication carts would be cleaned weekly.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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	F 812		

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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 policy, it was determined that the facility failed to store food in accordance with professional standards for food service safety and quality. Opened foods were not dated. Expired foods and/or foods which were past their "use by" date were available for use and service to residents. This failure had the potential to affect 129 of 131 residents who consume food from the facility's kitchen and/or unit refrigerators.

The findings include:

Review of the facility policy titled "Food: Preparation," with a revision date of 02/2023, revealed Item 17 stated that all refrigerated, ready-to-eat Time/Temperature Control for Safety (TCS) prepared foods that are to be held for more than 24 hours at a temperature of 41 degrees F or less, will be labeled and dated with a "prepared date" (Day 1) and a "use by date" (Day 7).

Observation of the walk-in refrigerator, on 06/10/2025 at 6:25 AM, revealed one partial box of cabbage containing two bags of cabbage with

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showed a "use by" date of 06/08/2025. One opened bag of lettuce had a "use by" date of 06/08/2025 and showed browning of the lettuce.

Observation of the reach-in refrigerator, on 06/10/2025 at 6:35 AM, revealed one partial container of ham salad with a "use by" date of 05/03/2025, one partial container of potato salad with a "use by" date of 05/25/25, and one open container of parmesan cheese with an "open date" of 04/08/2025. Ongoing observation of the "Reach-in Refrigerator for Cooks" revealed two chicken salad sandwiches dated with a "use by" date of 06/09/2025. In addition, this refrigerator contained an open gallon jug of mayonnaise that was undated (no "open date"), and an open jug of teriyaki sauce with a received date of 05/28/2025 which did not list an "open date."

Observation on 06/12/2025 at 1:15 PM of the "Central" nursing station resident food refrigerator revealed 15 single-serve grape juice containers with "best by" dates of 01/17/2025 and 06/08/2025.

Observation on 06/12/2025 at 1:30 PM of the "South Port" nursing station resident food storage revealed seven single-serve grape juice containers with a "best by" date of 01/17/2025.

Interview with the Dietary Manager (DM) on 06/10/2025 at 6:30 AM, revealed that dietary staff should have removed the items which were beyond their "use by" date from the refrigerator. Additional interview with the DM, on 06/12/2025 at 2:03 PM, revealed that once food leaves the kitchen, it is a team effort of the floor staff and kitchen staff to ensure items are not stored beyond the "best by" date for food safety to

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F 812	Continued From page 10 prevent food related illness. In an interview with the Dietary Supervisor (DS) on 06/12/2025 at 2:10 PM, the DS stated that it was his expectation that staff provide nutritious and filling meals without bacterial growth. He stated once food was past the "beyond use" date, there was the potential to allow bacteria to grow and potentially cause foodborne illness. He added that in the cooler, longer storage times would allow increased moisture to form that alters the environment and may allow for contamination or cross contamination. In an interview with the Director of Nursing (DON) on 06/12/25 at 3:42 PM, the DON stated that it was the responsibility of the kitchen to remove the "beyond use" juices from the unit refrigerators. She stated the dietary department has a "stock list and pantry list" that is brought to each unit every day that includes juices, as well as other items, and the juices should be switched out every day by the dietary staff when they bring out the new tray of juices. Interview with the Executive Director on 06/12/25 at 4:15 PM revealed she expected food items to be labeled and dated to prevent potential food-borne illnesses.	F 812		
F 880 SS=E	Infection Prevention & Control 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	F 880		

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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

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F 880	Continued From page 12 must 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, and review of the facility's policy and procedure, it was determined the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases for four (Resident (R)109, R93, R37, and R41) of five sampled residents reviewed for infection control. Facility staff failed to indicate, via signage, the need for precautions, as well as provide and/or ensure the use of Personal Protective Equipment (PPE) and hand hygiene by staff and visitors for R109, who was on contact isolation precautions. Action to protect others from the risk of infection was not taken when R109 was out of her room for non-essential purposes. In addition, staff failed to follow manufacturer's instructions after cleaning/disinfecting a used glucometer used on	F 880		

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R41. During medication pass for R93 and R37, staff handled medications with bare hands, did not perform hand hygiene as required and/or administered medication that had fallen on top of the medication cart.

Findings include:
1. Review of R109's "Face Sheet" revealed that the facility admitted the resident on 01/11/2025 with diagnoses including non-traumatic brain dysfunction and unspecified dementia. R109 was placed on the facility's secured memory care unit.

Review of R109's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 04/19/2025, revealed a Brief Interview for Mental Status (BIMS) score of 12/15, which indicated the resident had moderate cognitive impairment. Per this MDS, the resident required substantial/maximal assistance from staff with transfers and was occasionally incontinent of both bowel and bladder.

Review of R109's current physician's orders revealed a new order, dated 06/07/2025 at 6:56 PM, for Macrobid (antibiotic) 100 milligrams (mg) oral capsule twice daily for a diagnosis of extended-spectrum beta-lactamase (ESBL - a type of Multidrug Resistant Organism (MDRO). Further review of physician's orders revealed an order dated 06/08/25 at 11:06 AM for "Contact Isolation Precautions." Review of this order revealed it did not note whether the resident's infection was contained or not and did not indicate that the resident could leave their room.

a. Review of the facility policy titled, "Infection Control: Standard Precautions and Isolation," revised 10/2018, revealed its purpose is to guide

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care for "residents known or suspected to have serious illnesses that are easily transmitted through direct contact or contact with contaminated items in the resident's environment." Further review of the policy revealed staff are to wear gloves (clean, nonsterile gloves are adequate) when entering the room if any contact is to be made with the resident or items in the room; change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material and wound drainage); and remove gloves before leaving the resident's environment and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent. The policy also stated to wear a gown (a clean, nonsterile gown is adequate) when entering the room if substantial contact is anticipated with the resident, environmental surfaces, or items in the room, or if the resident is incontinent or has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing; and to remove the gown before leaving the resident's environment. The policy failed to address whether signage was required to be posted to indicate when precautions are in place.

Observation of R109's room on 06/10/2025 at 6:30 AM revealed R109 was asleep in her bed. The resident's room contained two large red bins with lids marked with biohazard signage. Continued observation revealed no signage was posted either outside or inside the room to indicate that R109 was on any type of precautions. There was no Personal Protective Equipment (PPE) such as gloves and gown required for Contact Precautions present at the door prior to entering the room or visible inside the room.

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Observation of R109's room on 06/10/2025 at 6:42 AM revealed State Registered Nurse Aide (SRNA) 3 entered the room without donning PPE (including gloves or gown) and, using his bare hands, placed a large yellow plastic bag into one of the two red biohazard bins in the rooms. He then exited the room without performing hand hygiene. In a brief interview conducted at 6:43 AM, SRNA3 stated the red bins were needed because R109 was on "precautions," and "One bin is used for soiled linens, and the other for dirty diapers."

In an interview with Licensed Practical Nurse (LPN) 4 on 06/11/2025 at 3:40 PM, she stated that Contact Precautions are required when there is a risk of exposure to infectious organisms, such as ESBL, which may be present on surfaces or linens. She reported that whenever a resident is placed on Contact Precautions, a sign should be posted "immediately" on the door of the resident's room, adding: "People must be made aware."

b. Further review of the facility policy titled, "Infection Control: Standard Precautions and Isolation," revised 10/2018, revealed that the movement of a resident on Contact Precautions should be restricted, stating: "Limit the movement and transport of the resident from the room to essential purposes only." Additionally, the policy directed that "If the patient is transported out of the room, ensure that precautions are maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment." However, the policy failed to explain how precautions were to be maintained when a

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resident was outside of their room, nor did it specify what actions should be taken to minimize the risk of transmission in these circumstances.

Observation of the facility's memory care unit dining room on 06/10/2025 at 12:56 PM revealed R109 was in the dining room for lunch, seated at a square, four-person table, with one resident seated to her left and another to her right. Two staff members were also seated at the table, positioned between the residents, and were providing assistance throughout the meal. This assistance included offering verbal encouragement and prompting to eat, as well as handing the residents their drinks and utensils. Neither the staff members nor R109 were wearing any PPE. SRNA11 was observed asking the resident if she was feeling uncomfortable while gently patting her back. She then requested assistance from another aide, and they helped reposition R109 in her wheelchair with their bare hands. After repositioning R109, neither of the two staff was observed to perform hand hygiene.

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c. Observation of R109's room on 06/11/2025 at 1:07 PM revealed that, after surveyor intervention, a yellow organizer was now hanging on the door with PPE stored in its pockets. A sign was now also posted, indicating that the resident was on Contact Precautions. The sign instructed visitors to speak with nursing staff before entering and outlined the required PPE, including donning gloves and a gown prior to room entry.

Observation at this time revealed R109 was in her room with two visitors, Family Member (FM) 109A and FM109B. Neither of the visitors were wearing any PPE. At 1:11 PM, LPN4, the unit charge nurse, approached the doorway and

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informed the visitors that they should be wearing PPE. FM109-A responded, 'We didn't think we needed to wear anything since she was in the dining room when we got here."

Further interview with FM109-A on 06/11/2025 at 1:20 PM revealed that she had been informed by staff during a visit on 06/08/2025 that she "should wear gloves and avoid bodily fluids." However, she then expressed confusion about the need to wear PPE, stating that during her visit that day (06/11/2025) a staff member had entered R109's room without donning any PPE. An interview with FM109-B, conducted at the same time, revealed that she was also unclear regarding the PPE requirement. She stated, "No one told us (about the Contact Precautions). I saw the sign, but I thought it was okay (to not don PPE) because [R109] was in the dining room when we got here." She added that by the time LPN4 informed them they should don PPE, they had already been visiting with R109 in her room for an hour and a half.

In an interview with SRNA6 on 06/11/2025 at 2:20PM, she described the protocol for Contact Precautions for ESBL as "business as usual; they do their day-to-day things without any special stuff." SRNA6 stated that the PPE needed for Contact Precautions included a gown, gloves, and mask, but added that this PPE would just be for changing and dressing. She stated the purpose of putting residents on Contact Precautions was that infection can be passed along through clothing "or on your body." Although the policy related that movement for residents on Contact Precautions was to be restricted, SRNA6 stated that residents on Contact Precautions can attend communal

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dining, saying, "I think so as long as it is contained, like it is in their urine or in a catheter, or they have bandages covering it." SRNA 6 indicated that there were different signs to indicate whether a resident's infection was contained (making isolation unnecessary.) Review of the sign at R109's door with SRNA6 at this time revealed that SRNA6 could not tell if R109's infection was contained or whether the resident should stay in their room, except for essential purposes only. Further interview revealed SRNA 6 could not recall the last time she received any training on infection control precautions such as Contact Precautions, and that all staff members were responsible for explaining PPE requirements to visitors.

In an interview with SRNA7 on 06/112025 at 2:40 PM, she stated that she was unclear about the specific requirements for Contact Precautions, stating she thought it required staff to "wear gloves." However, she then described that while providing care for a resident with an infection in the urine, she would need to wear a mask, gown, and gloves, throw everything away or put items in the hazard bins away after care was provided, and perform hand hygiene. She explained that the yellow caddies hanging on a resident's door indicate that staff need to wear PPE while providing care because the resident has "some type of infection that staff need to protect others from." SRNA7 reported being under the impression that residents on Contact Precautions were supposed to remain in their room but expressed uncertainty, exclaiming, "I am sorry; I am getting them all mixed up." When asked how she would know if a resident can leave their room, she stated, "Typically I get told by the nurse, but the door signage would also tell me."

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However, review of the door signage revealed it did not indicate whether the resident could leave the room. SRNA 7 further stated that she had recently returned to work at the facility and received some training on infection control practices at that time; however, her last in-depth training on the topic occurred approximately one year ago.

In an interview with LPN 4 on 06/11/2025 at 3:40 PM, she stated that Contact Precautions were used because, "They [the residents] have some kind of organism you could contract if you came into contact with it." She added that for Contact Precautions, "You have to wear the gear every time you go in the room because you may come into contact with it; it may be in the room or on soiled linen." Regarding R109, she reported that R109 was on Contact Precautions due to ESBL in the urine but was unsure when the precautions were initiated. When asked about the protocol for Contact Precautions, she stated: "If it [the infection] is contained, like the urine is the issue, they [residents] can still come out [of their rooms]." LPN4 stated that R109 is "allowed to come and go as she pleases; she can go to therapy or sit in the common area." However, she acknowledged that because R109 does not don PPE, such as a gown, when exiting her room, her clothing could pose a risk for spreading ESBL and admitted that "could be an issue." LPN4 stated that on the dementia unit where R109 resided, "With these people back here, a lot of them are cognitively impaired, so it is up to staff to monitor it and make sure it isn't getting spread. [R109] does not do her own incontinent care, but if she sits on something it would have to be sanitized, but her room is infected and so her hands may not be clean." When asked whether

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they utilize any specific clinical criteria to determine whether a resident on Contact Precautions can participate in communal dining, she stated: "I feel that if the staff is supervising the area and the resident has been toileted, it is okay for them to attend the meal. No risk assessment is completed." When asked how visitors would be informed and educated about the need to follow Contact Precautions/use PPE, she replied: "We need to ensure everyone that goes in that room is wearing PPE ...Visitors could take the organism home to their family. Staff are risking every one of these residents getting it."

On 06/11/2025 at 3:55 PM, an interview was conducted with the Infection Control and Prevention Nurse (IP), along with Advanced Practice Registered Nurse (APRN) 1 and Advanced Practice Registered Nurse (APRN) 2. APRN1 stated that a resident would be placed on Contact Precautions for ESBL because "it is highly contagious; it's so I can keep them away from the other residents." APRN1 then added that the decision to place a resident with ESBL on Contact Precautions is made on a "case-by-case basis." However, no evidence was provided as to how this "case-by-case" decision was made relative to R109. APRN2 stated that R109 is permitted to leave her room, including to eat lunch in the communal dining hall at a table with other residents, because "We can't confine them to their rooms; that wouldn't be good for them." However, she later stated that staff do make efforts to keep them in their room. The IP stated, "We try to encourage them, but we can't make them stay in their room," and acknowledged that staff "should be attempting to put a gown on her." She stated that there were no additional written policies outlining these protocols.

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Because staff made comments about different isolation requirements between contained and non-contained infections, a request was made on 06/12/25 at 9:06 a.m. with the IP for any policies differentiating Contact Precautions for contained versus non-contained infections. On 06/12/2025 at 9:35 a.m., the IP reported that there were "no additional policies" delineating the need for isolation in non-contained versus contained infections. The IP stated that it was "up to the provider" who initiates the orders to determine which should be followed. She stated that the order should contain that specification. Review of the physician's order confirmed that it did not distinguish between a contained or non-contained infection and called for "Contact Isolation Precautions."

In an interview with the Executive Director on 06/12/2025 at 4:33 PM, she stated that Contact Precautions require signage, PPE (gloves and gowns), red bins, and documentation in the resident's care plan. She reported that visitors are encouraged-but not required-to wear PPE, and staff are expected to read signage and don appropriate PPE upon entry. She explained that residents on Contact Precautions may leave their rooms based on psychosocial needs, though no formal assessment is used to determine this. She acknowledged the risk of exposure in shared spaces like the dining room and suggested that affected residents should avoid close contact with others, stating, "Hopefully they won't touch anyone else. Hopefully they are not touching the area." Further interview with the Executive Director revealed that the failure to observe Contact Precautions included the potential for "Spread of infection to residents, staff, family."

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2. Review of the facility's policy and procedure titled, "Administering Medication," revised 12/2012, revealed staff shall follow established facility infection control procedure (e.g. hand washing, antiseptic technique, gloves, isolation, precautions, etc.) for the administrations of medication, as applicable.

a. Record review revealed R93's current medications orders included an order for Linzess oral capsule 72 micrograms (mcg) by mouth once a day for constipation.
Observation during a medication pass on 06/10/2025 at 7:08 AM revealed Certified Medication Aide (CMA) 1 dropped a Linzess 72 mcg capsule into her bare hand, then proceeded to put it in the medication cup and administer it to R93.Observation revealed CMA1 failed to perform hand hygiene prior to touching the resident's medication with her bare hand.
Interview with CMA1, on 06/10/25 at 07:15 AM, revealed it was not best practice to give a pill that had been placed in her bare hand, and it should have been put in a medication cup to administer.

b. Record review revealed R37's medication orders included a 12/02/2024 order for Aspirin 325 mg one time a day by mouth for cerebrovascular accident (CVA- stroke).
Observation during a medication pass on 06/10/2025 at 7:20 AM revealed CMA1 dropped R37's Aspirin 325mg, on top of the medication cart. CMA1 then proceeded to pick up the medication with her bare hand and administer it to R37.Further observation revealed that CMA1 failed to perform hand hygiene prior to picking up the pill with her bare hand.

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Interview with CMA1, on 06/10/25 at 07:29 AM, revealed that a medication should not be given after it had been dropped on top of the medication cart, but discarded and staff should administer another one.

A joint interview was conducted with the Director of Nursing (DON) and Executive Director on 06/12/2025 at 4:33 PM. During the interview, the DON stated that nursing staff or CMAs were to discard a contaminated pill in the sharps container and get another one to administer. The DON added that the expectation of the staff is to use proper hand hygiene and standard precautions when giving medications. Further interview with the Executive Director revealed the expectation that if a medication was dropped or touched, it should be disposed of and not administered to residents.

3. Review of the facility's undated policy and procedure titled, "Obtaining A Fingerstick Glucose Level" revealed Step 18 stated staff were to "Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice."

Review of the manufacturer's instructions on the purple-topped container of Super Sani Wipes (used for disinfecting/sanitizing glucometers) revealed that staff were to "Wipe Surface thoroughly. Allow surface to remain visibly wet for two minutes. Let airdry. "

Observation during a medication pass on 06/12/2025 at 11:55 AM, revealed that, per physician's orders dated 05/25/2025, CMA4

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F 880	Continued From page 24 obtained a blood glucose reading on R41. After completing the test, CMA4 placed the soiled glucometer on top of the medication cart with no barrier. CMA4 then wiped the soiled glucometer three times for less than a total of ten seconds with a Super Sani Wipe from a purple-topped container. After using the wipe, CMA4 then immediately placed the glucometer on top of clean medical supplies on the medication cart. The product was not allowed to dwell (remain visibly wet) for two minutes, and then airdry before it was placed on supplies which were to be used for other residents. Interview with CMA4, on 06/10/25 at 11:30 AM, revealed that a soiled glucometer should not be placed directly on the medication cart without a barrier. Instead, it should be placed on a barrier and then cleaned. CMA4 stated education was received on how to clean the glucometer; however, she was unsure how long to allow the solution to dwell. A joint interview was conducted with the DON and Executive Director on 06/12/2025 at 4:33 PM. The DON stated that it was an expectation that the CMAs would place the dirty glucometer on a barrier and clean it for thirty seconds and allow it to dry, according to manufacturer's recommendations, and to dispose of/not use any clean supplies that dirty equipment may have contaminated. The Executive Director confirmed it was the expectation was that nursing staff or CMAs would clean the glucometers with the designated bleach wipes and use proper contact and dry times per policy. Per the Executive Director, if a dirty glucometer was placed on clean supplies, staff should dispose of the supplies and clean the glucometer.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185124	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANKS	851 KIMSEY LANE HENDERSON, KY 42420

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