

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

FORM APPROVE

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2025	
NAME OF PROVIDER OR SUPPLIER NEW CASTLE NURSING & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET , NEW CASTLE, Kentucky, 40050			
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E0000	Initial Comments Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 08/20/2025, it was determined the facility had achieved substantial compliance with Emergency Preparedness on 08/19/2025.	E0000					

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HOMESTEAD NURS B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025
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K0000 Bldg. 01	INITIAL COMMENTS Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 08/20/2025, it was determined the facility had achieved substantial compliance with Life Safety Code on 08/19/2025.	K0000		

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NAME OF PROVIDER OR SUPPLIER NEW CASTLE NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET , NEW CASTLE, Kentucky, 40050	
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K0000	<p>INITIAL COMMENTS</p> <p>42 CFR 483.90(a)</p> <p>K3 BUILDING: 0101</p> <p>K6 PLAN APPROVAL: 1971</p> <p>K7 SURVEY UNDER: 2012 Existing</p> <p>K8 SNF/NF</p> <p>Type of Structure: One (1) story (1971), Type V (111), protected combustible construction with four (4) smoke compartments and a complete automatic dry sprinkler system.</p> <p>A Life Safety Recertification Survey was initiated on 07/08/2025 and concluded on 07/08/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, New Castle Nursing and Rehabilitation was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:</p>	K0000		07/30/2025
K0324 SS = D	<p>Cooking Facilities</p> <p>CFR(s): NFPA 101</p> <p>Cooking Facilities</p> <p>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <p>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2</p>	K0324	<p>Corrective Action Taken: The alledged deficient practice had the potential to affect one (1) of one (1) kitchen, staff, and five (5) residents. On 07/08/2025, immediately upon identification of the deficient practice, the Maintenance Director restored all fire suppression nozzles to their approved design location under the Kitchen Hood Extinguishing System. Warning sign was installed adjacent to the hood system stating "DO NOT MOVE OR ADJUST FIRE SUPPRESSION NOZZLES" on 07/30/2025.</p> <p>Identification of Other Areas with Potential to be Affected: The Maintenance Director conducted a kitchen inspection on 07/09/2025 of all cooking areas and fire suppression systems to ensure no other similar issues</p>	08/01/2025

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K0324 SS = D	<p>Continued from page 1</p> <p>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to maintain an approved design location under the Kitchen Hood Extinguishing System in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) of one (1) kitchen, staff, and five (5) residents. The facility had the capacity for 60 beds with a census of 57 on the day of the survey.</p> <p>The findings include:</p> <p>Observation, during the building inspection tour on 07/08/2025 at 11:00 AM, revealed the fire suppression nozzles had been pushed back, pointing them to spray behind the gas stove and grill.</p> <p>Interview, on 07/08/2025 at 11:01 AM with the Maintenance Director, revealed the facility was not aware the staff had moved the fire suppression nozzles from the design location to clean the hood.</p> <p>The finding was verified by the Maintenance Director at the time of observation and the Administrator at the exit conference on 07/08/2025.</p> <p>Actual NFPA Standard: NFPA 101 Life Safety Code, (2012)</p> <p>19.3.2.5 Cooking Facilities.</p> <p>19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4.</p>	K0324	<p>Continued from page 1</p> <p>existed. No other issues or concerns were identified.</p> <p>Systemic Changes and Measures Implemented:</p> <p>Facility Administrator and Maintenance Director received one on one education via the Regional Director of Clinical Services on 07/30/2025 related to but not limited to Cooking Facility Requirements in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations including but not limited to moving fire suppression nozzles from the design location to clean the hood.</p> <p>On 07/30/2025, the Dietary Manager was educated one on one per the Administrator regarding the new procedure following hood suppression cleaning to verify fire suppression nozzles are not moved from the design location and to notify the Maintenance Director immediately following hood cleaning in TELS technology system so he can verify placement of the fire suppression nozzles following cleaning of the hood.</p> <p>One 07/31/2025, the Maintenance Director will begin utilizing the Preventative Maintenance Checklist and the Maintenance Director will also begin utilizing the TELS technology system to optimize building operations and assist with creating a safer environment and enhance regulatory compliance.</p> <p>Monitoring and Quality Assurance: Beginning 07/31/2025, the Maintenance Director will conduct weekly inspections of the kitchen hood fire suppression system to ensure all nozzles remain in their approved design location during weekly kitchen inspections. These inspections will be documented on a Preventative Maintenance Checklist. The Administrator, Regional Director of Clinical Services, and/or Assistant Director of Clinical Services will conduct monthly audits of the inspection logs to ensure completion and identify any patterns of non-compliance. Results will be reported to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters.</p>	

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K0324 SS = D	<p>Continued from page 2</p> <p>19.3.2.5.2* Where residential cooking equipment is used for food warming or limited cooking, the equipment shall not be required to be protected in accordance with 9.2.3, and the presence of the equipment shall not require the area to be protected as a hazardous area.</p> <p>9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service.</p> <p>Actual NFPA Standard: NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, (2011)</p> <p>12.1.2 Installation.</p> <p>12.1.2.1 All listed appliances shall be installed in accordance with the terms of their listings and the manufacturer's instructions.</p> <p>12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system.</p> <p>12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual.</p> <p>12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location.</p>	K0324		
K0511 SS = D	<p>Utilities - Gas and Electric</p> <p>CFR(s): NFPA 101</p> <p>Utilities - Gas and Electric</p> <p>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service</p>	K0511	<p>Corrective Action Taken: The alleged deficient practice had the potential to affect one (1) receptacle, staff, and two (2) residents. On 07/10/2025, the Maintenance Director installed a new cover plate on the electrical receptacle located in the attic above the Center Nurse Station. The receptacle was inspected to ensure proper function and the cover plate was verified to completely cover the opening and seat properly against the mounting surface in accordance with NFPA 70 requirements.</p>	08/05/2025

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K0511 SS = D	<p>Continued from page 3 provided no hazard to life.</p> <p>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to ensure electrical receptacles were maintained in accordance with National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect one (1) receptacle, staff, and two (2) residents. The facility had the capacity for 60 beds with a census of 57 on the day of survey.</p> <p>The findings include:</p> <p>Observation, during the building inspection tour on 07/08/2025 at 9:46 AM, revealed an electrical receptacle located in the attic above the Center Nurse Station was missing the cover plate.</p> <p>Interview, on 07/08/2025 at 9:47 AM with the Maintenance Director, revealed the facility was not aware of the missing plug cover.</p> <p>The finding was verified by the Maintenance Director at the time of record review and by the Administrator at the exit conference on 07/08/2025.</p> <p>Actual NFPA Standard: NFPA 101 Life Safety Code, (2012)</p> <p>19.5.1 Utilities.</p> <p>19.5.1.1 Utilities shall comply with the provisions of Section 9.1</p> <p>9.1.2 Electric.</p> <p>Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Actual NFPA Standard: NFPA 70 National Electric Code, (2011)</p> <p>406.6 Receptacle Faceplates (Cover Plates).</p>	K0511	<p>Continued from page 3</p> <p>Identification of Other Areas with Potential to be Affected: On 07/09/2025, the Maintenance Director conducted a facility-wide inspection of all electrical receptacles, including those in resident rooms, common areas, utility rooms, and other spaces accessible to staff and residents. This comprehensive inspection was documented using the preventative maintenance checklist to identify any other receptacles that may have missing or damaged cover plates. No other issues or concerns were identified.</p> <p>Systemic Changes and Measures Implemented:</p> <p>On 07/30/2025, the Administrator and Maintenance Director received one on one education per the Regional Director of Clinical Services related to but not limited to Utilities – Gas and Electric related to equipment using gas or related to gas piping compliance with NFPA 54 and electrical wiring and equipment compliance with NFPA 70 including missing cover plates over electrical receptacles.</p> <p>On 07/31/2025, the Maintenance Director will begin utilizing the Preventative Maintenance Checklist and the Maintenance Director will also begin utilizing the TELS (The Equipment Lifestyle System) technology system to optimize building operations and assist with creating a safer environment and enhance regulatory compliance.</p> <p>Beginning 08/04/2025, the Department Managers (Nursing, Administrative, Social Services, Dietary, Maintenance, Therapy, and Activities) will begin conducting weekly environmental rounding "Angel Rounds" that will include monitoring areas in resident areas, common areas, and facility offices for but not limited to missing cover plates. Any issues or concerns identified will be communicated to the Maintenance Director via the TELS (The Equipment Lifestyle System) Technology System.</p> <p>Monitoring and Quality Assurance: The weekly environmental rounding audits will be reviewed with the Administrator and the Maintenance Director weekly and any issues or concerns identified will be corrected immediately. The Maintenance Director will report results, findings, and orders placed in TELS to the Quality Assurance Committee quarterly and any issues or concerns identified will be addressed at this time and any changes to the plan of correction to maintain regulatory compliance will be made at this time until regulatory compliance is maintained at 100% for three</p>	

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K0511 SS = D	Continued from page 4 Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface.	K0511	Continued from page 4 consecutive months.	
K0712 SS = D	<p>Fire Drills</p> <p>CFR(s): NFPA 101</p> <p>Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly for each shift in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice affected two (2) of eight (8) fire drills, staff, and all residents. The facility had the capacity for 60 beds with a census of 57 on the day of the survey.</p> <p>The findings include:</p> <p>Record review, of the facility's fire drill records for the 12-month period prior to the survey on 07/08/2025 at 11:16 AM, revealed the facility had no documentation for fire drills completed during the first (1st) quarter of 2025 during second (2nd) shift hours and during the second (2nd) quarter of 2025 during the first (1st) shift hours.</p> <p>Interview, on 07/08/2025 at 11:17 AM with the Maintenance Director, revealed the facility was not aware the fire drills were not completed.</p> <p>The finding was verified by the Maintenance Director at the time of record review and the Administrator at the exit conference on 07/08/2025.</p>	K0712	<p>Corrective Action Taken: The alleged deficient practice had the potential to affect two (2) of eight (8) fire drills, staff, and all residents. On 07/21/2025, the Maintenance Director conducted fire drill on day shift (7a-7p) and a night shift fire drill (7p-7a) is scheduled for 08/11/2025. A fire drill tracking log was started in the TELS (The Equipment Lifestyle System) per the Maintenance Director to document all fire drills on 07/21/2025.</p> <p>Identification of Other Areas with Potential to be Affected: The Maintenance Director conducted a comprehensive review of all fire drill records for the past 24 months to identify any additional gaps in fire drill completion. No other issues or concerns were identified.</p> <p>Systemic Changes and Measures Implemented:</p> <p>On 07/30/2025, the Administrator and Maintenance Director received one on one education per the Regional Director of Clinical Services related to but not limited to quarterly fire drills including both shifts (7a-7p and 7p-7a) in accordance with National Fire Protection Association Standards.</p> <p>On 07/31/2025, the Maintenance Director will begin utilizing the Preventative Maintenance Checklist and the Maintenance Director will also begin utilizing the TELS (The Equipment Lifestyle System) technology system to optimize building operations and assist with creating a safer environment, assist with tracking fire drills, and enhance regulatory compliance.</p> <p>Monitoring and Quality Assurance: The Administrator will review the fire drill tracking log monthly to ensure compliance with the quarterly fire drills on each shift (7a-7p and 7p-7a) The Maintenance Director will report to the Quality Assurance Committee at least quarterly the documented completed fire drills, participation rates, and any identified issues. The QAPI committee will review fire drill compliance quarterly and address any identified trends or concerns. Any issues or concerns that result in the need to make a change to the plan of correction will be done at this time. Monitoring will continue until substantial compliance is maintained for three (3) consecutive quarters.</p>	08/12/2025

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K0712 SS = D	<p>Continued from page 5</p> <p>Actual NFPA Standard: NFPA 101 Life Safety Code (2012)</p> <p>19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.</p> <p>under varied conditions.</p>	K0712		
K0918 SS = F	<p>Electrical Systems - Essential Electric System</p> <p>CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing</p> <p>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on interview and record review it was determined the facility failed to perform testing for the emergency generator in accordance with National Fire</p>	K0918	<p>Corrective Action Taken: On 07/28/2025, the Maintenance Director conducted monthly transfer times. On 07/30/2025, the Maintenance Director ordered a Conductance Analyzer for generator and will begin monthly conductance testing of the generator battery on 08/11/2025 once analyzer arrives.</p> <p>Identification of Other Areas with Potential to be Affected: On 07/09/2025, the Maintenance Director conducted a comprehensive review of all emergency power system components and testing procedures. This review included examination of all documentation requirements for the emergency generator system to ensure compliance with NFPA 110 standards. No other areas were identified as having similar documentation deficiencies.</p> <p>Systemic Changes and Measures Implemented:</p> <p>On 07/30/2025, the Administrator and Maintenance Director received one on one education per the Regional Director of Clinical Services related to but not limited to Electrical System Maintenance and Testing in accordance with NFPA 110 including generator testing and maintenance including but not limited to conductance testing of the generator starting battery and monthly transfer times during monthly load test.</p> <p>On 07/31/2025, the Maintenance Director will begin utilizing the Preventative Maintenance Checklist and the Maintenance Director will also begin utilizing the TELS (The Equipment Lifestyle System) technology system to optimize building operations and assist with creating a safer environment, assist with tracking fire drills, documenting and tracking generator testing and maintenance, and enhance regulatory compliance.</p> <p>Monitoring and Quality Assurance: The Administrator will conduct weekly reviews of generator testing logs to ensure compliance with all required documentation and conduct monthly audits of generator maintenance records to verify completeness and accuracy of</p>	08/12/2025

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K0918 SS = F	<p>Continued from page 6</p> <p>Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) of one (1) generator, staff, and all residents. The facility had the capacity for 60 beds with a census of 57 on the day of survey.</p> <p>The findings include:</p> <p>1. Record Review, of the emergency generator maintenance logs for the 12 months prior to the survey on 07/08/2025 at 11:30 AM, revealed the facility was unable to provide documentation for monthly conductance testing or electrolyte specific gravity testing of the generator starting battery. Interview, on 07/08/2025 at 11:31 AM with the Maintenance Director, revealed the facility did not have a system in place to check the specific gravity or conductance of the lead acid battery installed on the generator.</p> <p>2. Record Review, of the emergency generator maintenance logs for the 12 months prior to the survey on 07/08/2025 at 11:32 AM, revealed the facility was unable to provide documentation for monthly transfer times during the monthly load test. Interview, on 07/08/2025 at 11:33 AM with the Maintenance Director, revealed the facility did not have a system in place to document the transfer times during the monthly test.</p> <p>The finding was verified by the Maintenance Director at the time of record review and by the Administrator at the exit conference on 07/08/2025.</p> <p>Actual NFPA Standard: NFPA 99 Health Care Facilities Code (2012)</p> <p>6.5.4.1 Maintenance and Testing of Essential Electrical System.</p> <p>6.4.4.1.3 Maintenance of Batteries.</p> <p>Batteries for on-site generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems.</p> <p>Actual NFPA Standard: NFPA 110 Standard for Emergency and Standby Power Systems, (2010)</p> <p>8.3 Maintenance and Operational Testing.</p>	K0918	<p>Continued from page 6</p> <p>documentation. Results and documentation of generator testing and maintenance will be reported by the Maintenance Director quarterly to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters.</p>	

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K0918 SS = F	<p>Continued from page 7</p> <p>8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available.</p> <p>8.3.4.1 The permanent record shall include the following:</p> <p>(1) The date of the maintenance report</p> <p>(2) Identification of the servicing personnel</p> <p>(3) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced</p> <p>(4) Testing of any repair for the time as recommended by the manufacturer</p> <p>8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.</p>	K0918		
K0920 SS = E	<p>Electrical Equipment - Power Cords and Extens</p> <p>CFR(s): NFPA 101</p> <p>Electrical Equipment - Power Cords and Extension Cords</p> <p>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.</p> <p>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to maintain power strips and extension cords in</p>	K0920	<p>Corrective Action Taken: The alleged deficient practice had the potential to affect nine (9) rooms, staff, and 16 residents. On 07/08/2025 and 07/09/2025, the Maintenance Director immediately removed all non-compliant power strips from Resident Rooms 118, 119, 123, 125, 106, 110, 113, and 128, and the power strip cord running through the closet wall located in the MDS Office.</p> <p>Identification of Other Areas with Potential to be Affected: On 07/09/2025, the Maintenance Director conducted a facility-wide inspection of all resident rooms and administrative areas to identify any additional non-compliant power strips or extension cords. This inspection included checking for proper UL ratings on all power strips, verifying appropriate use within patient care vicinities, and ensuring no power strips or extension cords were being used as substitutes for permanent wiring. No other issues or concerns were noted.</p> <p>Systemic Changes and Measures Implemented:</p> <p>On 07/30/2025, the Administrator and Maintenance Director received one on one education per the Regional Director of Clinical Services related to but not limited to Electrical Equipment – Power Cords and Extension Cords including the use of power strips and extension cords in resident care areas and offices in accordance with NFPA standards including but not</p>	08/05/2025

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K0920 SS = E	<p>Continued from page 8 accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect nine (9) rooms, staff, and 16 residents. The facility had the capacity for 60 beds with a census of 57 on the day of the survey.</p> <p>The findings include:</p> <p>Observation, during the building inspection tour on 07/08/2025 between 9:51 AM and 10:19 AM, revealed a UL1363A power strip that was mounted to the wall, as a substitute for permanent wiring, with personal electronics located within six (6) feet of the patient care vicinity of Resident Rooms 118, 119, 123, 125, 106, 110, 113, and 128. Interview, on 07/08/2025 at 10:20 AM with the Maintenance Director, revealed the facility was not aware of the power strip requirements in patient care areas. Observation, during the building inspection tour on 07/08/2025 at 10:29 AM, revealed a power strip cord running through a closet wall located in the Minimum Data Set Office. Interview, on 07/08/2025 at 10:30 AM with the Maintenance Director, revealed the facility was not aware of the cord running through the wall.</p> <p>The findings were verified by the Maintenance Director at the time of observations and the Administrator at the exit conference on 07/08/2025.</p> <p>Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012)</p> <p>10.2.4 Adapters and Extension Cords.</p> <p>10.2.4.1 Three-prong to two-prong adapters shall not be permitted. 10.2.4.2 Adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted.</p> <p>10.2.4.2.1 All adapters shall be listed for the purpose.</p> <p>10.2.4.2.2 Attachment plugs and fittings shall be listed for the purpose.</p> <p>10.2.4.2.3 The cabling shall comply with 10.2.3</p> <p>10.2.3.2 Grounding Conductor.</p> <p>10.2.3.2.1 Each electric appliance shall be provided with a grounding conductor in its power cord.</p>	K0920	<p>Continued from page 8 limited to use of power strips as a substitute for permanent wiring.</p> <p>Beginning 08/04/2025, the Department Managers (Nursing, Administrative, Social Services, Activities, Maintenance, Dietary) will be conducting weekly environmental rounding of all resident rooms and care areas including observation of extension cord or power strip usage in these areas. Any extension cords or power strip usage identified during these rounds will be reported to the Maintenance Director via the TELS (The Equipment Lifestyle System) technology system for review of accordance of NFPA standards. Any issues or concerns will be addressed and corrected immediately.</p> <p>On 07/31/2025, the Maintenance Director will begin utilizing the Preventative Maintenance Checklist and the Maintenance Director will also begin utilizing the TELS (The Equipment Lifestyle System) technology system to optimize building operations and assist with creating a safer environment, assist with tracking fire drills, documenting and tracking generator testing and maintenance, tracking and identification of extension cord and power strip usage, and enhance regulatory compliance.</p> <p>Monitoring and Quality Assurance: The Department Managers will conduct weekly environmental rounds of all resident rooms and common areas to ensure compliance with power strip and extension cord requirements. The Maintenance Director and Administrator will review the results of environment rounds and any issues or concerns identified will be</p> <p>The Maintenance Director will review all electrical safety inspection reports monthly and report findings to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive months.</p>	

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K0920 SS = E	Continued from page 9 Actual NFPA Standard: NFPA 70 National Electrical Code, (2011) 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K0920		
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders	K0923	Corrective Action Taken: On 07/25/2025, the Maintenance Director ordered a ventilation vent to be installed in the Oxygen Storage Room. The installation will be completed by 08/18/2025 in accordance with NFPA 99 requirements. Identification of Other Areas with Potential to be Affected: On 07/09/2025, the Maintenance Director conducted a facility-wide assessment of all medical gas storage areas to identify any similar ventilation deficiencies. The assessment confirmed that the Oxygen Storage Room was the only area storing medical gas and requiring ventilation upgrades. Systemic Changes and Measures Implemented: On 07/30/2025, the Administrator and Maintenance Director received one on one education per the Regional Director of Clinical Services related to but not limited to Gas Equipment including cylinder and container storage and oxygen storage in accordance with NFPA. On 07/31/2025, the Maintenance Director will begin	08/19/2025

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K0923 SS = D Bldg. 01	<p>Continued from page 10 available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.</p> <p>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to provide oxygen storage in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) oxygen storage room, staff, and five (5) residents. The facility had the capacity for 60 beds with a census of 57 on the day of the survey.</p> <p>The findings include:</p> <p>Observation, during the building inspection tour on 07/08/2025 at 10:07 AM, revealed the Oxygen Storage Room over 300 cubic feet of oxygen storage with no natural ventilation or mechanical exhaust ventilation installed.</p> <p>Interview, on 07/08/2025 at 10:08 AM with the Maintenance Director, revealed the facility was not aware the ventilation of oxygen was required.</p> <p>The finding was verified by the Maintenance Director at the time of observation and the Administrator at the exit conference on 07/08/2025.</p> <p>Actual NFPA Standard: NFPA 99 Health Care Facilities</p>	K0923	<p>Continued from page 10 utilizing the Preventative Maintenance Checklist and the Maintenance Director will also begin utilizing the TELS (The Equipment Lifestyle System) technology system to optimize building operations and assist with creating a safer environment, monitoring medical gas storage areas for appropriate ventilation, assist with tracking fire drills, documenting and tracking generator testing and maintenance, and enhance regulatory compliance.</p> <p>Monitoring and Quality Assurance: The Maintenance Director will conduct weekly inspections of the Oxygen Storage Room ventilation system for the first month, then monthly thereafter, using the medical gas storage compliance checklist. Results of the audit will be discussed with the Administrator monthly. Results will be documented in the preventative maintenance checklist or TELS and reported to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive quarters.</p>	

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

FORM APPROVEI

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HOMESTEAD NURS... B. WING	(X3) DATE SURVEY COMPLETED 07/08/2025
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K0923 SS = D Bldg. 01	Continued from page 11 Code, (2012) 9.3.7.5 Indoor storage or manifold areas and storage or manifold buildings for medical gases and cryogenic fluids shall be provided with natural ventilation or mechanical exhaust ventilation in accordance with 9.3.7.5.1 through 9.3.7.8.	K0923		

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E0000	Initial Comments 42 CFR 483.73 Type of Structure: One (1) story (1971), Type V (111), protected combustible construction with four (4) smoke compartments and a complete automatic dry sprinkler system. An Emergency Preparedness Recertification Survey was conducted on 07/08/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. During this Recertification Survey, New Castle Nursing and Rehabilitation was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, Subpart 483.73 et seq. (Emergency Preparedness).	E0000		07/30/2025
E0039 SS = F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or	E0039	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain. Corrective Action Taken: The alleged deficient practice had the potential to affect four (4) of four (4) smoke compartments, staff, and all residents. On 07/30/2025, the Regional Director of Clinical Services provided one-on-one education to the Administrator and Maintenance Director regarding federal requirements for emergency preparedness testing. The facility has contacted the Sheriff Department and is planning a community -based exercise that will include a table top exercise prior to the exercise and the full scale exercise a few days following. The exercise will be scheduled and conducted prior to 08/18/25 and be documented in accordance to the Emergency Preparedness Testing Requirements.	08/19/2025

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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E0039 SS = F	<p>Continued from page 1</p> <p>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or</p> <p>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next</p>	E0039	<p>Continued from page 1</p> <p>Identification of Other Areas with Potential to be Affected: The Administrator and Maintenance Director conducted a comprehensive review of all emergency preparedness documentation on 08/01/2025 to identify any additional gaps in compliance with testing requirements. This review included all four smoke compartments and emergency response protocols that had the potential to affect all four (4) smoke compartments, staff, and residents facility-wide no other areas of concern were noted during the review.</p> <p>Systemic Changes and Measures Implemented:</p> <p>The Maintenance Director will begin utilizing the Preventative Maintenance Checklist and the Maintenance Director will also begin utilizing the TELS technology system to optimize building operations and assist with creating a safer environment and enhance regulatory compliance including annual and quarterly documentation of emergency preparedness testing and drills.</p> <p>The Maintenance Director and Administrator received one on one education on 07/30/2025 per the Regional Director of Clinical Services related to Emergency Preparedness Testing Requirements and Emergency Preparedness including but not limited to participation in community based drills annually.</p> <p>Monitoring and Quality Assurance: The Administrator, Regional Director of Clinical Services, and/or the Assistant Regional Director of Clinical Services will conduct monthly audits of emergency preparedness testing documentation to ensure compliance with federal requirements. Any issues or concerns identified will be corrected immediately. The Administrator will present findings to the Quality Assurance Performance Improvement (QAPI) Committee quarterly. The QAPI Committee will review the effectiveness of the corrective actions and make additional recommendations as needed until substantial compliance is achieved and maintained three consecutive quarters.</p>	

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E0039 SS = F	<p>Continued from page 2 required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a</p>	E0039		

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E0039 SS = F	<p>Continued from page 3</p> <p>set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p>	E0039		

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NAME OF PROVIDER OR SUPPLIER NEW CASTLE NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET , NEW CASTLE, Kentucky, 40050	
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E0039 SS = F	<p>Continued from page 4</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p>	E0039		

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NAME OF PROVIDER OR SUPPLIER NEW CASTLE NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET , NEW CASTLE, Kentucky, 40050	
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E0039 SS = F	<p>Continued from page 5</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p>	E0039		

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E0039 SS = F	<p>Continued from page 6</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at</p> <p>least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p>	E0039		

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E0039 SS = F	<p>Continued from page 7</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNHCIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p>	E0039		

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E0039 SS = F	<p>Continued from page 8 This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to meet the Emergency Preparedness (EP) Testing Requirements in accordance with the Code of Federal Regulations (CFR) State Operations Manual (SOM), Appendix Z. The deficient practice had the potential to affect four (4) of four (4) smoke compartments, staff, and all residents. The facility had the capacity for 60 beds with a census of 57 on the day of survey.</p> <p>The findings include:</p> <p>Record review, of the facilities' Emergency Preparedness Plan on 07/08/2025 at 11:50 AM, revealed the facility failed to participate in a community-based exercise during the previous 12 months.</p> <p>Interview, on 07/08/2025 at 11:51 AM with the Administrator, revealed the facility had only conducted one (1) tabletop exercise within the last 12 months.</p> <p>The finding was verified with the Administrator at time of record review and at the exit interview on 07/08/2025.</p>	E0039		

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F0000	<p>INITIAL COMMENTS</p> <p>A Recertification and Abbreviated Survey were concluded on 07/09/2025. The facility was found to be in substantial compliance with 42 CFR 483 Subpart B.</p> <p>No deficiencies were issued related to KY00038838, KY00040794, KY00041223, KY00044281, and KY00044412.</p> <p>Survey Dates: 07/07/2025 - 07/09/2025</p> <p>Survey Census: 57</p> <p>Sample Size: 15</p> <p>Supplemental Resident: 22</p>	F0000		

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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