STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON NURSING AND REHABILITATION CENTER	31 DERICKSON LANE , STANTON, Kentucky, 40380

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 07/16/2025, it was determined the facility had achieved substantial compliance with Life Safety Code on 07/01/2025.	K0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON NURSING AND REHABILITATION CENTER	31 DERICKSON LANE , STANTON, Kentucky, 40380

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E0000	Initial Comments Type of Structure: One (1) story, (1974, 1990), Type III (000), unprotected ordinary construction with five (5) smoke compartments and a complete automatic dry sprinkler system. An Emergency Preparedness Recertification Survey was conducted on 06/11/2025, in accordance with 42 Code of Federal Regulations, Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. Stanton Nursing and Rrehabilitation Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	E0000		
K0000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1974, 1990 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) story, (1974, 1990), Type III (000), unprotected ordinary construction with five (5) smoke compartments and a complete automatic dry sprinkler system. A Life Safety Recertification Survey was initiated on 06/11/2025 and concluded on 06/11/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Stanton Nursing and Rehabilitation Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.	K0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2025

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K0000	Continued from page 1 The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K0000		
K0351 SS = D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to install a complete automatic sprinkler system in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) exit covered area, staff, and four (4) residents. The facility had the capacity for 81 beds with a census of 76 on the day of survey. The Findings include: Observation, during the building inspection tour on 06/11/2025 at 1:40 PM, revealed a combustible wood covered porch area connected to the building storing combustible materials and exceeding greater than four (4) feet out from the exterior wall that did not have sprinkler protection installed outside the North Hall	K0351	K351 1. Sprinkler installation service for the covered porch area was requested/scheduled with the contracted vendor on 6/30/2025. 2. On 6/11/2025, the administrator, maintenance director and regional plant operations director completed a walkthrough of the facility to verify there were no additional areas adjacent to the facility that may require sprinkler installation. No additional areas were identified. 3. On 6/26/2025, the regional plant operations director provided education to the maintenance staff on the regulatory intent of K351, specifically that sprinkler protection is required to be installed for combustible wood covered areas connected to the facility, storing combustible materials and exceeding greater than 4 feet from the exterior wall of the building. 4. Beginning 6/25/2025, the administrator and maintenance director will complete a weekly walkthrough of the facility x 12 weeks to verify there are no areas adjacent to the facility that may require sprinkler installation. The results of the audits will be provided by the Administrator at the monthly Quality Assurance Process Improvement (QAPI) meeting for 3 months for review and recommendation. The QAPI committee consists of, but is not limited to, the Administrator, Director of Nursing, Social Services, Infection Preventionist, Dietary Manager, MDS, Therapy Director, and the Medical Director. 5. Compliance date: 7/1/2025	07/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2025

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K0351 SS = D	Continued from page 2 Back of Building to the Laundry Building. Interview, on 06/11/2025 at 1:41 PM with the Director of Maintenance, revealed the facility was not aware the porch roof was not sprinkler protected. The finding was verified by the Director of Maintenance at the time of observation and the Administrator at the exit conference on 06/11/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems (2) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (3) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height Actual NFPA Standard: NFPA 13 Standard for the Installation of Sprinkler Systems, (2010) 8.15.7* Exterior Roofs, Canopies, Porte-Cocheres, Balconies, Decks, or Similar Projections.	K0351		

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K0351 SS = D	Continued from page 3 8.15.7.1 Unless the requirements of 8.15.7.2, 8.15.7.3, or 8.15.7.4 are met, sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft (1.2 m) in width. 8.15.7.2* Sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with materials that are noncombustible, limited-combustible, or fire retardant-treated wood as defined in NFPA 703, Standard for Fire Retardant- Treated Wood and Fire-Retardant Coatings for Building Materials. 8.15.7.3 Sprinklers shall be permitted to be omitted from below the canopies, roofs, porte-cocheres, balconies, decks, or similar projections of combustible construction, provided the exposed finish material on the roofs, canopies, or porte-cocheres are noncombustible, limited-combustible, or fire retardant-treated wood as defined in NFPA 703, Standard for Fire Retardant-Treated Wood and Fire-Retardant Coatings for Building Materials, and the roofs, canopies, or porte-cocheres contain only sprinklered concealed spaces or any of the following unsprinklered combustible concealed spaces: (1) Combustible concealed spaces filled entirely with noncombustible insulation (2) Light or ordinary hazard occupancies where noncombustible or limited-combustible ceilings are directly attached to the bottom of solid wood joists so as to create enclosed joist spaces 160 ft3 (4.5 m3) or less in volume, including space below insulation that is laid directly on top or within the ceiling joists in an otherwise sprinklered attic [see 11.2.3.1.4(4)(d)] (3) Concealed spaces over isolated small roofs, canopies, or porte-cocheres not exceeding 55 ft2 (5.1 m2) in area 8.15.7.4 Sprinklers shall be permitted to be omitted from exterior exit corridors when the exterior walls of the corridor are at least 50 percent open and when the corridor is entirely of noncombustible construction.	K0351		

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K0351 SS = D	Continued from page 4 8.15.7.5* Sprinklers shall be installed under roofs, canopies, porte-cocheres, balconies, decks, or similar projections greater than 2 ft (0.6 m) wide over areas where combustibles are stored.	K0351		
K0374 SS = D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier doors in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) set of corridor smoke doors, staff, and 20 residents. The facility had the capacity for 81 beds with a census of 76 on the day of survey. Findings include: Observation, during the building inspection tour on 06/11/2025 at 12:58 PM, revealed a set of Cross Corridor double smoke doors located at the Front Lobby next to the Social Services Office and the Conference Room, that were being held open by magnetic devices not tied into the fire alarm, not allowing them to close to resist the passage of smoke. Interview, on 06/11/2025 at 12:59 PM with the Director of Maintenance, revealed the facility was aware the magnetic devices were being used to hold the double doors open.	K0374	1. The identified corridor doors were tied into the facility fire alarm system by the contracted vendor on 6/16/2025. 2. On 6/11/2025, the administrator, maintenance director and regional director of plant operations completed a walkthrough of the facility to verify there were no additional corridor doors, not self-closing or automatic closing and/or not tied into the facility alarm system No additional doors were identified. 3. On 6/26/2025 the regional director of plant operations provided education to the maintenance staff on the regulatory intent of K374, specifically doors in smoke barriers must be self-closing or automatic-closing and not require latching and may not be held open by magnetic devices not tied to the fire alarm system. 4. Beginning 6/25/2025, the administrator and maintenance director will complete a weekly walkthrough of the facility x 12 weeks to verify there are no smoke barrier corridor doors held open with magnetic devices, etc., and not tied into the fire alarm system. The results of the audits will be provided by the administrator at the monthly Quality Assurance Process Improvement (QAPI) meeting for 3 months for review and recommendation. The QAPI committee consists of, but is not limited to, the Administrator, Director of Nursing, Social Services, Infection Preventionist, Dietary Manager, MDS, Therapy Director, and the Medical Director. 5. Compliance date: 7/1/2025	07/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2025

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K0374 SS = D	Continued from page 5 The finding was verified by the Director of Maintenance at the time of observation and the Administrator at the exit conference on 06/11/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel. 8.5.4 Opening Protectives. 8.5.4.1* Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grilles. The clearance under the bottom of a new door shall be a maximum of 3/4 in. (19 mm)., 8.5.4.2 Where required by Chapters 11 through 43, doors in smoke barriers that are required to be smoke leakage-rated shall comply with the requirements of 8.2.2.4. 8.5.4.3 Latching hardware shall be required on doors in smoke barriers, unless specifically exempted by Chapters 11 through 43. 8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1. 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied.	K0374		

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K0374 SS = D	Continued from page 6 7.2.1.5.2* The requirement of 7.2.1.5.1 shall not apply to door leaves of listed fire door assemblies after exposure to elevated temperature in accordance with the listing, based on laboratory fire test procedures. 7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.	K0374		
K0781 SS = D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure portable space heaters used in the facility were in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) portable space heating device, staff, and two (2) residents. The facility had the capacity for 81 beds with a census of 76 on the day of the survey. The findings include: Observation, during the building inspection tour on 06/11/2025 at 2:30 PM, revealed the facility failed to provide documentation that a heat producing portable space heater located in the Medical Services Director Office had a heating element that did not exceed 212 degrees Fahrenheit. Interview, on 06/11/2025 at 2:31 PM with the Director of Maintenance, revealed the facility was aware of the requirements for portable space heaters but was not aware that the portable space heater was in the Medical Services Director Office.	K0781	1. The identified space heater was removed from the facility on 6/11/2025 by the maintenance director. 2. On 6/11/2025, the administrator, maintenance director and regional plant operations director completed a walkthrough of the facility to verify there were no additional space heaters present in the facility. None were found/identified. 3. On 6/26/2025 the regional plant operations director provided education to the maintenance staff on the regulatory intent of K781, specifically portable space heaters shall be prohibited from resident care areas/rooms and not present in any office area where documentation is not available to support the heating element does not exceed 212 degrees. 4. Beginning 6/25/2025, the administrator and maintenance director will complete a weekly walkthrough of the facility x 12 weeks to verify there are no portable space heaters present/identified. The results of the audits will be provided by the administrator at the monthly Quality Assurance Process Improvement (QAPI) meeting for 3 months for review and recommendation. The QAPI committee consists of, but is not limited to, the Administrator, Director of Nursing, Social Services, Infection Preventionist, Dietary Manager, MDS, Therapy Director, and the Medical Director. 5. Compliance date: 7/1/2025	07/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2025

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K0781 SS = D	Continued from page 7 The finding was verified by the Director of Maintenance at the time of observation and the Administrator at the exit conference on 06/11/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.7.8 Portable Space-Heating Devices. Portable space heating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met: (1) Such devices are used only in nonsleeping staff and employee areas. (2) The heating elements of such devices do not exceed 212°F (100°C).	K0781		
K0927 SS = D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the liquid oxygen transfilling area with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) oxygen transfilling room, staff, and two (2) residents. The facility had the capacity for 81 beds with a census of 76 on the day of the survey.	K0927	1. A new, functional, mechanical fan was installed in the oxygen transfilling room on 6/25/2025 by the maintenance director. 2. There are no additional oxygen transfilling rooms in the facility. 3. On 6/26/2025, the regional plant operations director provided education to the maintenance staff on the regulatory intent of K927, specifically rooms utilized for the transfilling of liquid oxygen must be well ventilated with a functioning mechanical fan. 4. Beginning 6/25/2025, the administrator will complete a weekly inspection of oxygen transfilling room x 12 weeks to verify the mechanical fan is functioning properly. The results of the audits will be provided by the administrator at the monthly Quality Assurance Process Improvement (QAPI) meeting for 3 months for review and recommendation. The QAPI committee consists of, but is not limited to, the Administrator, Director of Nursing, Social Services, Infection Preventionist, Dietary Manager, MDS, Therapy Director, and the Medical Director. 5. Compliance date: 7/1/2025	07/01/2025

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K0927 SS = D	Continued from page 8 The findings include: Observation, during the building inspection tour on 06/11/2025 at 1:16 PM, revealed the liquid oxygen transfilling storage room did not have a functioning mechanical fan. Interview, on 06/11/2025 at 1:17 PM with the Director of Maintenance, revealed the facility was unaware the mechanical fan was not functioning. The finding was verified by the Director of Maintenance at the time of observation and the Administrator at the exit conference on 06/11/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable. 11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. 11.5.2.3.2 Transfilling to liquid oxygen portable containers at 344.74 kPa (50 psi) and under shall include the following:	K0927		

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K0927 SS = D	Continued from page 9 (1) The area is well ventilated and has noncombustible flooring. (2) The area is posted with signs indicating that smoking in the area is not permitted.	K0927		

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

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F0000	INITIAL COMMENTS A Standard Recertification Survey was initiated on 06/10/2025 and concluded on 06/12/2025. No deficient practice was identified by the Division of Health Care.	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