STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185160	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON COUNTRY PLACE	**700 MASON HEADLEY ROAD LEXINGTON, KY 40504**

(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
K 000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1979 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) story w/full basement, (1979), Type III (222), protected non-combustible construction with seven (7) smoke compartments and complete automatic wet and dry sprinkler systems. A Life Safety Recertification Survey was initiated on 04/02/2025 and concluded on 04/02/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Lexington Country Place was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation for the testing of the emergency battery lighting in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the	K 291	What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?	5/16/25

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

Electronically Signed | 04/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 291	Continued From page 1 potential to affect all battery powered emergency lights, staff, and all residents. The facility had the capacity for 111 beds with a census of 85 on the day of the survey. The findings include: 1). Record review, of the emergency lighting documentation for the 12 months prior to the survey on 04/02/2025 at 12:08 PM, revealed the facility failed to conduct the 30 second monthly testing of emergency battery lighting located throughout the facility. Interview, on 04/02/2025 at 12:09 PM with the Facilities Director, revealed the facility was not aware of the requirements for monthly 30 second testing of emergency battery lighting. 2). Record review, of the emergency lighting documentation for the 12 months prior to the survey on 04/02/2025 at 12:08 PM, revealed the facility failed to conduct the 90-minute annual testing of the emergency battery lighting located throughout the facility. Interview, on 04/02/2025 at 12:09 PM with the Maintenance Director, revealed the facility was not aware of the requirements for the 90-minute annual testing of emergency battery lighting. The findings were verified by the Facilities Director at the time of record review and by the Administrator at the exit conference on 04/02/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.2.1* Emergency illumination shall be provided for a minimum	K 291	The Facility Director was monitoring the Emergency Lighting for the 30 seconds monthly and 90 minutes annually, he was nervous about the inspection and did not pull the report from TELS. Please see the report attached from TELS. The Facility Director and/or his team will continue to to check the lighting as he is prompted monthly from TELS. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents have the potential to be affected. What Measures will be put into place, or what Systematic Changes will be made to ensure that the deficient practice does not recur? The task will continue to alert in TELS for the 30 sec check monthly and for the 90 minute test annually for the Facilities Director to ensure it has been completed. How will the Corrective Action be Monitored to ensure the deficient practice will not recur? The Facility Director was completing checks but he or his Designee (Facility Assistant) will attend the Quality Assurance Performance Improvement meetings at least Quarterly providing a TELS report to ensure the emergency	

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K 291	Continued From page 2 of 1-1/2 hours in the event of failure of normal lighting Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10.8 lux) and, at any point, not less than 0.1 ft-candle (1.1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6.5 lux) and, at any point, not less than 0.06 ft candle (0.65 lux) at the end of 11/2 hours. A maximum-to minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 291	lighting is being tested. Once 100% compliance occurs twice consectively the Quality Assurance committee including but not limited to the Administrator, Medical Director, Director of Nursing, etc. can admend as indicated.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101	K 293		5/16/25

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K 293	Continued From page 3 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to install not an exit signage in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) exterior door, staff, and 10 residents. The facility had the capacity for 111 beds with a census of 85 on the day of survey. The findings include: Observation, during a tour of the facility on 04/02/2025 at 2:25 PM, revealed signage stating not an exit was not installed on an exterior door that egressed directly into a courtyard with no exit discharge to a place of refuge. Interview, on 04/02/2025 at 2:26 PM with the Facilities Director, revealed the facility was not aware the not an exit signage was not installed as required. The finding was verified by the Facilities Director at the time of observation and the Administrator at the exit conference on 04/02/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012)	K 293	What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice? A sign stating "NOT AN EXIT" was placed on the Courtyard Door on 04/02/2025. The Facility Director and his maintainence team completed a walk through checking all exterior doors for proper signage stating "Not An Exit" or "Exit." See attached map indicating all doors were checked. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents have the potential to be affected. What Measures will be put into place, or what Systematic Changes will be made to ensure that the deficient practice does not recur?	

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K 293	Continued From page 4 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4 7.10.8.3* No Exit. 7.10.8.3.1 Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT 7.10.8.3.2 The NO EXIT sign shall have the word NO in letters 2 in. (51 mm) high, with a stroke width of 3?8 in. (9.5 mm), and the word EXIT in letters 1 in. (25 mm) high, with the word EXIT below the word NO, unless such sign is an approved existing sign.	K 293	On 4/07/2025 the Facility Director and Facility Assistant walked the proberty with map in hand. They viewed every exit door to ensure proper signage was in place. How will the Corrective Action be Monitored to ensure the deficient practice will not recur? The task for checking exit door signage was added to TELS to inspect all exit doors Quaterly for proper signage. Results will be taken to the Quality Assurance Meetings Quaterly for review and any changes will be determined by the Quality Assurance Performance Improvement team including by not limited to the Administrator, Director of Nursing, Medical Director, etc.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * 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 * 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 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324		5/16/25

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K 324	Continued From page 5 18.3.2.5.4, 19.3.2.5.4. 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. 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the kitchen hood extinguishing system in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect the kitchen hood extinguishing system, staff, and 12 residents. The facility had the capacity for 111 beds with a census of 85 on the day of the survey. The findings include: 1). Observation, during the building inspection tour on 04/02/2025 at 2:52 PM, revealed the gas-fired cooking appliances located on the cooking line in the kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Interview, on 04/02/2025 at 2:53 PM with the Facilities Director, revealed the facility was not aware of the requirement for an approved method to ensure that the appliances were returned to an approved design location after maintenance or cleaning and did not have a system in place currently.	K 324	*What Corrective Action will be accomplished fo rthose residents found to have been affected by the deficient practice? The Facility Director used Rust-Oleum High Heat Ceramic Coating 2000F (2000 degrees Fahrenheit) paint that is gas and oil resistant to paint markings on the floor in front of the electric cooking equipment. The equipment is located under the fire suppression hood to ensure proper placement so that when moved it will be returned to the correct location for safety. The facility did have the completed semi-annual inspections for the Kitchen Hood Suppression. Please see attached "Kitchen Auto Extinguishing Systems." *How will Other Residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents could be affected.	

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K 324	Continued From page 6 2). Observation, record review of the Kitchen Hood Suppression Reports for the 12 months prior to the survey on 04/02/2025 at 2:13 PM, revealed the facility had not completed the semi-annual inspections every 6 months. The documentation of the semi-annual kitchen hood suppression inspections would only indicate an inspection was completed during 12/10/2024. Interview, on 04/02/2025 at 2:14 PM with the Facilities Director revealed the facility was not aware the hood suppression system had not been inspected every six (6) months. The findings wwere verified by the Facilities Director at the time of observation and the Administrator at the exit conference on 04/02/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) Cooking Facilities. 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. 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. Actual NFPA Standard: NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, (2011) Chapter 11 Procedures for the Use, Inspection, Testing, and Maintenance of Equipment	K 324	*What Measures will be put into place, or what Systematic changes will be made to ensure that the deficient practice does not recur? The Facility Director added a task in TELS to monitor the kitchen quarterly to ensure the markings around the electrical kitchen equipment are visible so the staff can ensure the equipment is in place under the hood system. *How will Corrective Action be monitored to ensure the deficient practice will not recur? The Maintenance Director or Designee, Maintenance Assistant or Administrator will bring the TELS reports to the Quality Assurance meeting Quaterly for the Qualtiy Assurance committee including but not limited to the Adminstrator, DON, Medical Director, etc. for review. Once 100% compliance threshold is achieved for two consecutive months. This is to be amended when indicated.	

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K 324	Continued From page 7 11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems. 11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every six months.	K 324		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barriers could restrict the transfer of smoke in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect five (5) of seven (7) smoke barrier walls, staff, and 60 residents. The facility had capacity for	K 372	What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice? The smoke barrier wall located above the shower room in Anna's Hall had multiple	5/15/25

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K 372	Continued From page 8 111 beds with a census of 85 on the day of the survey. The findings include: 1). Observation, during the building inspection tour on 04/02/2025 at 10:35 AM, revealed the smoke barrier wall located above the cross-corridor doors by the shower room of Anna Hall had multiple cable and piping penetrations. Further observation revealed a two (2) foot by two (2) foot section of missing drywall in the smoke barrier. Interview, on 04/02/2025 at 10:36 AM with the Facilities Director, revealed the facility was not aware of the penetrations and missing drywall in the wall. 2). Observation, during the building inspection tour on 04/02/2025 at 10:53 AM, revealed the smoke barrier wall located above the cross-corridor doors by the shower room of Magnolia Hall had multiple cable and piping penetrations two (2) inches or greater in size. Interview, on 04/02/2025 at 10:54 AM with the Facilities Director , revealed the facility was not aware of the penetrations in the wall. 3). Observation, during the building inspection tour on 04/02/2025 at 11:05 AM, revealed the smoke barrier wall located above the cross-corridor doors of the rehab to home wing had a two (2) foot section of missing drywall around sprinkler piping in the smoke barrier. Interview, on 04/02/2025 at 11:06 AM with the Facilities Director, revealed the facility was not aware of the missing drywall in the wall. 4). Observation, during the building inspection tour on 04/02/2025 at 11:15 AM, revealed the	K 372	cable and piping penetration's as well drywall missing. Johnson Control will be out on 0512/2025 to repair wall and penetrations around the cabling. The cross-corridor doors of the rehab to home wing had a two foot section of missing drywall around the sprinkler piping in the smoke barrier. Johnson Controls installed the new sprinkler system and failed to rebuild the wall. Johnson Controls will rebuild the wall with drywall beginning 05/12/25. The smoke barrier located above the cross-corridor doors in the basement by the elevator equipment room had multiple cable and piping penetrations that were repaired by the Facility Director or Facility Assistant with the Fire Rated red caulk on 05/05/2025. The smoke barrier located above the cross-corridor doors in the basement by the central supply room had multiple cable and piping penetrations that were also repaired with fire rated red caulk on 04/29/2025. How will Other Residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All 60 residents had the potential to be affected. What Measures will be put into place, or what Systematic changes will be made to ensure that the deficient practice does not recur? The Facility Director and Facility Assistants will check the building for any	

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K 372	Continued From page 9 smoke barrier located above the cross-corridor doors in the basement by the elevator equipment room had multiple cable and piping penetrations two (2) inches or greater in size. Interview, on 04/02/2025 at 11:16 AM with the Facilities Director, revealed the facility was not aware of the penetrations in the wall. 5). Observation, during the building inspection tour on 04/02/2025 at 11:20 AM, revealed the smoke barrier located above the cross-corridor doors in the basement by the central supply room had multiple cable and piping penetrations two (2) inches or greater in size. Interview, on 04/02/2025 at 11:21 AM with the Maintenance Director, revealed the facility was not aware of the penetrations in the wall. The findings were verified by the Facilities Director at the time of observations and the Administrator at the exit conference on 04/02/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1-2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2)*Smoke dampers shall not be required in duct	K 372	attentional smoke barrier penetrations and/or repairs with the fire resistant caulk on 05/05/2025. In the future if the community has contractors or Maintenance Staff that are pulling wires or pipes the Facility Director or Facility Assistant will monitor the work when completed to ensure no penetrations of two inches or greater exist. If penetrations are present Facility Director or Facility Assistant will use the red high temperature caulk. The Maintenance Director re-educated his team on 05/02/2025 and if prn the team member will sign the next day he is scheduled to work. The Maintenance Director will add a task for himself and team in TELS to check the smoke barriers every quarter to ensure there are no penetrations in smoke barrier area. How will Corrective Action be monitored to ensure the deficient practice will not recur? The Maintenance Director /designee (Assistant) will bring the results of his findings to the Quarterly Quality Assurance Meeting for review and amendmentss will be made after review and 100% compliance at least two consecutive Quarters.	

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K 372	Continued From page 10 penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke.	K 372		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric 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 provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to install a new Packaged Terminal Air Conditioner (PTAC) unit power cord end in accordance with National Fire Protection Association (NFPA) Standards. The deficient	K 511	*What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?	5/16/25

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	185160	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 511	Continued From page 11 practice had the potential to affect one (1) PTAC, staff, and two (2) residents. The facility had the capacity for 111 beds with a census of 85 on the day of the survey. The findings include: Observation, during a building inspection tour with the Facilities Director on 04/02/2025 at 3:35 PM, revealed a newly installed PTAC unit power cord receptacle with exposed wiring plugged into the wall outlet, that would allow for contact by unqualified person(s), which could cause injury or fire. The finding was verified by the Facilities Director at the time of observation and the Administrator at the exit conference on 04/02/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 9.1.2 Electric. 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.	K 511	The Packaged Terminal Air Conditioner (PTAC) unit power cord end was replaced and a new outlet added in accordance with the National Fire Protection Association (NFPA) Standard. *How will Other Residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents had the potential to be affected by the deficient practice. *What Measures will be put into place, or what Systematic changes will be made to ensure that the deficient practice does not recur? The Facility Director re-educated his team on 04/23/2025 regarding "all Packaged Terminal Air Conditioners must be installed in accordance with NFPA guidelines and no splicing can occur and all units must have correct wiring and plugs installed." The Facility Director and team on 05/02/2025 inspected every Packaged Terminal Air Conditioner and placed it in TELS to ensure all units meet the NFPA guidelines. *How will Corrective Action be monitored to ensure the deficient practice will not recur?	

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K 511	Continued From page 12	K 511	The Maintenance Director or Designee will bring a list of newly installed Packaged Terminal Air Conditioners to the Quaterly Quality Assurance meeting with each signed off that he persoanlly inspected for proper complainace. Any amendment to will be discussed with the team after 100% has been reached at least for two consecutive Quaters.	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills 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. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: 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 one (1) of eight (8) fire drills, staff, and all residents. The facility had the capacity for 111 beds with a census of 85 on the day of survey. The findings include: Record review, of the facility's fire drill records for	K 712	What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice? Fire Drills have been completed for all 3 shifts. The second shift fire drill was completed on 03/01/2025 at 8:30 p.m. but the Facility Director was unable to locate drill at the time. The Facility Director will conduct another second shift fire drill on 05/12/2025.	5/13/25

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K 712	Continued From page 13 the 12-month period prior to the survey on 04/02/2025 at 2:20 PM, revealed the facility had no documentation for a fire drill completed during the second (2nd) quarter of 2024 on second (2nd) shift. Interview, on 04/02/2025 at 2:21 PM with the Facilities Director, revealed the facility was not aware the fire drill was missed. The finding was verified by the Facilities Director at the time of record review and the Administrator at the exit conference on 04/02/2025. Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 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. under varied conditions.	K 712	How will Other Residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents have the potential be affected. What Measures will be put into place, or what Systematic changes will be made to ensure that the deficient practice does not recur? The TELS system has the fire drills added monthly to incorporate all shifts. The Facility Director will be responsible for ensuring the task are completed in TELS immediately after they are completed. All Maintenance staff were re-educated on the importance of completing fire drills on all shifts. How will Corrective Action be monitored to ensure the deficient practice will not recur? The Facility Director or Designee will bring the TELS printout of the fire drills to the Quality Assurance Meetings Quarterly to ensure completion and to review. This schedule can be amended once 100% compliance is completed for two consecutive Quarters.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		5/16/25

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K 761	Continued From page 14 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to inspect fire doors in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect four (4) of four (4) fire doors, staff, and 85 residents. The facility had the capacity for 111 beds with a census of 85 on the day of survey. The findings include: Record review, of the facility's fire door inspection records for the 12-month period prior to the survey on 04/02/2025 at 1:56 PM, revealed the facility could not provide documentation of an annual fire door inspection for the fire doors located throughout the facility. Interview, on 04/02/2025 at 1:57 PM with the Facilities Director, revealed the facility was not aware the annual inspection had not been completed.	K 761	Corrective Action for Residents Found to Have Been Affected: All Fire Doors in the facility will be inspected by a qualified life safety professional on 05/14/2025, and any deficiencies noted will addressed and scheduled for repair. Identification of Other Residents at Risk: All Residents had the potential to be affected. Systematic Changes to Prevent Recurrence: The Facility Director has been retrained on the NFPA 5242 requirements by taking the AHCA course "Fire and Smoke Door Inspections Qualified Training" on 05/06/2025. Ramey will also be retrained by the the life safety professional conducting the Fire Door Inspections on	

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K 761	Continued From page 15 The finding was verified by the Facilities Director at the time of record review and by the Administrator at the exit conference on 04/02/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.7.6 Maintenance and Testing. See 4.6.12. 4.6.12 Maintenance, Inspection, and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. 4.6.12.2 No existing life safety feature shall be removed or reduced where such feature is a requirement for new construction. 4.6.12.3* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. 4.6.12.4 Any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. 4.6.12.5 Maintenance, inspection, and testing shall be performed under the supervision of a responsible person who shall	K 761	05/14/2025 to ensure on going inspections of fire doors are inspected and tested not less than annually by qualified personnel. A fire door inspection task enclosed will be completed no less than annually by the Facility Director. Monitoring: The Facility Director will conduct Quarterly Fire Door Inspection sheets and bring to the Quality Assurance meeting were results will be reviewed. If any adjustments or repairs are needed inspections will continue Quarterly until the Quality Assurance Team (Administrator, Director of Nursing, Facility Director, Medical Director, etc.) determines effective.	

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K 761	Continued From page 16 ensure that testing, inspection, and maintenance are made at specified intervals in accordance with applicable NFPA standards or as directed by the authority having jurisdiction.	K 761		
K 781 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 REQUIREMENT 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 eight (8) residents. The facility had the capacity for 111 beds with a census of 85 on the day of the survey. The findings include: Observation, during the building inspection tour on 04/02/2025 at 2:25 PM, revealed the facility failed to provide documentation that a heat producing electrical fireplace located in the rehab to home living room area had a heating element that did not exceed 212 degrees Fahrenheit. Interview, on 04/25/2025 at 2:26 PM with the Facilities Director, revealed the facility was aware of the requirements for portable heaters but was	K 781	What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice? The heat producing electrical fireplace located in the rehab to home living room area has not been used, therefore the breaker to the unit was kicked to ensure it cannot be turned on to produce any heat. How will Other Residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents have the potential to be affected. What Measures will be put into place, or what Systematic changes will be made to ensure that the deficient practice does not recur?	5/16/25

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K 781	Continued From page 17 not aware that the electric fireplace had a functional heat producing element. The finding was verified by the Facilities Director at the time of observation and the Administrator at the exit conference on 04/02/2025. 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).	K 781	The Facility Director was re-educated by the Administrator that the fireplace acts as portable heater and must not exceed 212 degrees Fahrenheit on 04/28/2025. The facility Director in turn re-educated his staff regarding the usage and safety of personal heaters in non-sleeping health care areas. A TELS task was added for a Quaterly walk thru of the facility to ensure NO portable heaters are being used. How will Corrective Action be monitored to ensure the deficient practice will not recur? The Facility Director or Designee will complete an audit of all areas to esure no portable heaters are being used in resident or staff sleeping areas and that any used in a non-sleeping areas have heating elements that do not exceed 212 degrees Fahrenheit. Facility Director or designee will bring to the Quality Assurance Meeting Quaterly and any amendment will occur after 2 consecutive quaters at 100 percent complaiance.	

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F 000	INITIAL COMMENTS A Recertification and Abbreviated Survey was concluded on 04/03/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 04/01/2025 to 04/03/2025 Survey Census: 85 Sample Size: 18 Supplemental Residents: 29 No deficiencies were issued related to KY00045361.	F 000		
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. (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, review of the	F 812	This Plan of Correction constitutes	5/9/25

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

Electronically Signed | 04/25/2025

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F 812	Continued From page 1 United States Department of Agriculture (USDA) web page, review of the facility's signage, and review of the facility's procedure, the facility failed to prepare and serve food under sanitary conditions as determined by observations during the initial kitchen tour and return tours. Observation on 04/01/2025 and on 04/02/2025 revealed dome lids were stacked wet. Observation on 04/01/2025 of food temperatures for the lunch service revealed an inaccurate temperature for puree food, but it was placed on the tray line for service. Additionally, observation on 04/02/2025 revealed staff changed gloves and performed tasks without proper hand hygiene. The findings include: Review of the facility's procedure titled, "Dishwashing Procedure," dated 12/15/2022, revealed to air-dry dishes and keep them in a clean area to avoid contamination. Review of the facility's sign posted in the kitchen "Use Disposable Gloves Properly," not dated, revealed to wash hands before and after use of disposable gloves and to change gloves frequently and between tasks. Review of the United States Department of Agriculture (USDA) web page https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-thermometers#:~:text=The%20food%20thermometer%20should%20be,reached%20the%20safe%20internal%20temperature revealed using a food thermometer was the only reliable way to ensure foods had been cooked to a safe minimum internal temperature to destroy any harmful	F 812	Lexington Country Place's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the intent of Lexington Country Place to procure food from sources approved or considered satisfactory by federal, state or local authorities. It is also the intent to store, prepare, distribute and serve food in accordance with professional standards for food service safety. *WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE EFFICIENT PRACTICE? Wet Dishes: Dishes were observed stacked while still wet, posing a risk of bacterial contamination. Those dishes were not used. Hand Hygiene: Improper hand hygiene practices were observed, specially related to the use of disposable gloves. Food Temperature: The temperature of pureed chicken was below safe levels. *HOW WILL OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN?	

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F 812	Continued From page 2 microorganisms that might be in the food. Per the web page, the temperature danger zone was 40 degrees Fahrenheit (F) to 140 degrees F. It also stated the safe practice was to place the thermometer into the thickest part of the food item or for thin foods through the side which reached the middle. Per the web page, always check each piece of food to ensure it had reached the safe internal temperature. In addition, size, quantity, and distribution of food when cooking caused the pieces of food to reach a safe internal temperature at different times. It did not state the food could have a cover, such as plastic, when taking the temperature. Observation on 04/01/2025 at 10:00 AM during the initial tour of the kitchen with the Food and Beverage Director (FBD), revealed dome lids for the resident plates were not aired dried. The inside of the dome had condensation with beads of water. Observation on 04/01/2025 at 11:50 PM of the lunch meal service revealed at 11:57 AM, the FBD was taking the temperature of the food on the steam table. She pushed the thermometer through the plastic wrap over the peas and carrots. In an interview with the Food and Beverage Director (FBD) on 04/01/2025 at 11:57 AM, she stated she on occasion inserted the thermometer through the plastic to take the temperature. She asked the State Survey Agency (SSA) Surveyor if she should not put the thermometer through the plastic wrap. Observation on 04/01/2025 at 12:00 PM of food temperatures on the steam table revealed the	F 812	All residents had the potential to be affected by the Wet dishes and hand Hygiene. Residents on a puree diet had the potential to be affected by the puree chicken. *WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMATIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFFICIENT PRACTICE DOES NOT RECUR? Wet Dishes: All kitchen staff were re-educated on the "Dishwashing Procedures" on 4/08/2025 re: wet dishes and the proper technique to dry to prevent contamination and bacteria growth. Wet dishes were placed on the drying rack and arranged to ensure they are air dried prior to stacking. Education was provided by the Administrator to the Food and Beverage Director, demonstrating proper technique on wire rack. The Food and Beverage Director in turn educated the rest of the Dietary Staff also demonstrating proper storage. Hand Hygiene: All kitchen staff were re-educated on 04/08/2025 regarding the compliance of hand hygiene per the "Use Disposable Gloves Properly" sign posted in the kitchen. Staff were re-educated to wash their hands before and after using disposable gloves and to change gloves frequently and between tasks. Education was provided by the Administrator to the Food and Beverage Director, demonstrating proper technique for hand washing before after glove use. The Food and Beverage Director in turn educated the rest of the Dietary Staff.	

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F 812	Continued From page 3 temperature of the puree chicken taken by the FBD was 168 degrees F. The SSA Surveyor asked for the FBD to retake the temperature. The puree chicken recheck temperature was 119 degrees F. So, the FBD asked the cook to reheat the puree chicken. Continued observation of the FBD on 04/01/2025 at 12:00 PM, revealed she asked Cook 1, "Where are the french fries?" The cook did not know the location of the french fries, and both left the tray line to find them in the walk-in freezer. Further observation of the FBD and Cook 1 revealed they removed their gloves and entered the walk-in freezer. However, they did not wash their hands after changing tasks and the glove change. Observation on 04/02/2025 at 8:19 AM and 11:51 AM revealed the dome lids and bottoms were left wet on the rail near the tray line. In an interview with the FBD on 04/02/2025 at 8:20 AM, she stated the dome lids and bottoms were air-dried on the rack in the dishroom, and then she stacked the dome lids and bottoms together. In an interview with Cook 1 on 04/03/2025 at 10:09 AM, she stated hand washing and glove use was important for controlling bacteria. She stated the french fries were not prepared for the tray line. She stated she felt rushed and had to hurry to have time to prepare all the food. She stated she dried the dishes with a towel or let them air dry for a moment before putting them away. In another interview with the FBD on 04/03/2025 at 1:54 PM, the FBD stated the process was to	F 812	Food Temperature: The temperature of the puree chicken was incorrect. The chicken was reheated properly prior to being served. All kitchen staff were re-educated on 04/08/2025 by the Administrator to the Food and Beverage Director (Food and Beverage Director in turn educated the Dietary Staff) re: the policy title "Record of Food Temperatures" including proper technique for taking temperatures (hot foods at 135F or greater, if falls into unsafe range immediately follow procedures for reheating making sure the internal temperature is 165 degrees F for at least 15 seconds. No food will be served that does not meet the safe temperature. Hot foods will be stirred during holding to redistribute the heat throughout the food product. Staff will not use plastic wrap to cover hot foods. Education was provided by the Administrator to the Food and Beverage Director, demonstrating proper technique for taking temperatures of food. The Food and Beverage Director in turn educated the rest of the Dietary Staff also demonstrating proper techniques. An Ad-Hoc Quality Assurance Performance Improvement Plan was held with the Compliance Officer, Director of Nursing, Administrator, Staff Development Coordinator, Food and Beverage Director, Minimum Data Set Nurse, Facilities Director, Human Resource Director, Activity Director, Social Service Director and Marketing Director to discuss the recent survey and current systems, policies, education and needed	

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F 812	Continued From page 4 leave dishes in the rack to drain and air dry in the dish room, and the dome lids should be placed in the rack in single file to air dry. The FBD stated there was the potential for bacteria to grow and cause cross contamination if the dome lids were left wet. The FBD stated the proper method to take food temperatures was to swab the stick of the thermometer, check the temperature, and clean between each food. The FBD stated to ensure an accurate temperature, the food should be stirred, and double checked if needed. The FBD stated to prevent the potential of food borne illness, food should be served at the correct temperature. The FBD stated staff did not use gloves on the tray line with serving utensils, and gloves should be changed when staff interrupted tasks to prevent the potential for cross contamination. In an interview with the Registered Nurse (RN) Director of Nursing (DON) on 04/03/2025 at 3:37 PM, she stated she expected staff to take care of residents through safe food handling practices. In an interview with the Administrator on 04/03/2025 at 9:18 AM and 3:49 PM, she stated the concern with the dome lids stacked together wet was bacterial growth. She stated she expected staff to take accurate food temperatures to prevent the growth of bacteria. Also, she stated she expected staff to perform proper hand hygiene and to change gloves as directed to prevent the potential for cross contamination.	F 812	modifications. The regularly (monthly) scheduled Quality Assurance Performance Improvement Plan meeting will be held 05/08/2025 and the Survey results and Plan of Correction will be discussed making any modifications as needed. All Dietary Staff have completed ServSafe Food Handlers training (60-90 minutes) starting 05/06/2025 and ending 05/07/2025 for full-time staff. Any prn staff will complete the course at the beginning of their next scheduled shift. The course consisted of Basic Food Safety, Personal Hygiene, Cross-Contamination and Allergens, Time and Temperature, Cleaning and Sanitation. All staff members have a certificate of completion upon passing the exam which requires at least a score of 75% for the 45 questions given. Staff will receive Quarterly training and re-education at a minimum starting in August on food safety protocols, including proper storage of dishes, hand washing with donning and doffing of gloves and accurately obtaining temperatures of food for safe serving. Completion of training will include a post-test or quiz to ensure understanding. Ongoing training will be provided using the Dieticians Audits as well as Exhibit B (Validation Checklist Maintaining a Sanitary Tray Line) and Exhibit C (Dietary Quality Improvement Worksheet). The training will be provided by the Food and Beverage Director and/or the Sous Chef. New Hires will be educated during orientation by the Staff Development Coordinator and/or	

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F 812	Continued From page 5	F 812	designee Director Of Nursing. *HOW WILL CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFFICENT PRACTICE WILL NOT RECUR? A spreadsheet "Validation Checklist Maintaining a Sanitary Tray Line" Exhibit B was created to audit handwashing and the proper drying of dishes. An additional spreadsheet was created, Exhibit C Dietary Quality Improvement Worksheet to audit food temperature to ensure food is served at proper/safe temperatures. Audit began on 04/18/2025. A bi-weekly audit of food safety practices, including temperature monitoring, hand hygiene (donning and doffing of gloves) and proper storage of dishes will be conducted using Exhibit B and C to ensure food is prepared and served under sanitary conditions. The audit will be completed by the Executive Director/Administrator for the first three weeks and starting on week 4 the audits will be completed weekly by the Food and Beverage Director, Sous Chef or Administrator x 4 weeks. The Dietician will also complete "Sanitation Audit Form" monthly for two months. Results of all audits will be taken to the Quality Assurance Performance Improvement Committee (Medical Director, ED/Administrator, Director of Nursing, etc.) by the Food and Beverage Director and/or the Administrator. Any non-compliance will be addressed immediately. These audits will be reviewed at the monthly Quality	

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F 812	Continued From page 6	F 812	Assurance and Performance Improvement (QAPI) meetings and any changes to the audits or frequency will be decided by the team.	
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 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	F 880		5/9/25

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F 880	Continued From page 7 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 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, review of the Centers for Disease Control and Prevention (CDC) signage for enhanced barrier	F 880	This Plan of Correction constitutes Lexington Country Place's written allegation of compliance for the	

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F 880	Continued From page 8 precautions (EBP), and review of the facility's policies, the facility failed to 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 for 5 of 19 sampled residents, Resident (R) 18, R41, R56, R68, and R73. R18, R41, R56, R68, and R73 all had active orders to be on EBP. However, observations on 04/01/2025 to 04/03/2025 revealed none of the residents had EBP signage posted on their room doors of what the infection control requirements were when entering and exiting their rooms, for the resident, staff, and visitors. The findings include: Review of the facility's policy titled, "Infection Prevention and Control, Transmission Based Precautions," dated 08/01/2024, revealed descriptions for the indications and measures for contact, droplet, and airborne precautions but no description of enhanced barrier precautions. Review of the facility's policy titled, "Enhanced Barrier Precautions (EBP)," undated, revealed EBP were enacted to prevent the transmission of multi-drug resistant organisms. Per the policy, EBP employed targeted gown and glove use during high contact resident care activities. The policy stated the same gown and gloves should not be worn for the care of more than one person. Further review of the policy revealed an order for EBP would be obtained for residents with a wound or indwelling medical device.	F 880	deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the intent of Lexington Country Place to 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 disease and infections. *WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? The Director of Nursing, Minimum Data Set Nurse and Assistant Director of Nursing ran reports for orders indicating discontinued and active Enhanced Barrier Precautions. Resident #18 had a wound that was healed. However, the physician's order for Enhanced Barrier Precautions (EBP) was not discontinued although the signage and PPE had been removed. The Physician's Order was discontinued on 05/01/2025. Resident #41 had an order for Enhanced Barrier Precautions due to a wound, however, she had a sign for contact precautions. The Contact Precaution Sign was removed and the Enhanced Barrie Sign was added. However, the Enhanced Barrier sign was	

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F 880	Continued From page 9 Review of the facility's signage utilized for EBP, undated and labeled as obtained from the CDC revealed: 1) everyone must clean their hands, including before entering and when leaving the room; and 2) providers and staff must also wear gloves and a gown for the following high-contact resident care activities, such as dressing; bathing/showering; transferring; changing linens; providing hygiene; changing briefs or assisting with toileting; device use or care with a central line, urinary catheter, feeding tube, and tracheostomy; or wound care for any skin opening that required a dressing. 1. Review of R18's "Admission Record" revealed the facility admitted R18 on 12/17/2020 with diagnoses of cerebral vascular disease, chronic obstructive pulmonary disease (COPD), and morbid obesity. Review of R18's "Clinical Orders," dated 03/24/2025 and entered by the Minimum Data Set (MDS) Nurse, revealed R18 had an active order for EBP related to a wound located on the left inner upper thigh. However, observation on 04/01/2025 at 10:00 AM and 04/02/2025 at 9:02 AM revealed no EBP signage was posted outside R18's room. 2. Review of R41's "Admission Record" revealed the facility admitted R41 on 07/25/2022 with diagnoses of unspecified dementia, anorexia, and contractures. On 03/07/2025 a diagnosis of squamous cell carcinoma of the skin of the left upper limb was added. Review of R41's "Clinical Orders," dated 02/17/2025 and entered by the MDS Nurse,	F 880	discontinued on 05/05/2025 as the wound has healed. Residents #56, #68 and #73 were given correct signage for Enhanced Barrier Precautions (EBP) per the policy and CDC guidelines. PPE placed by rooms for residents #56, #68 and #73. MDS Nurse receiving the orders for Enhanced Barrier Precautions (EBP) has been educated on 4/03/2025 by the Administrator to follow the process through when initiating precaution orders by ensuring signage is correctly placed on the exterior doors of resident's room with PPE in place outside the room. *HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED All residents with orders for Enhanced Barrier Precautions or Contact Precautions have the potential to be affected. *What systematic changes were put in to place to prevent any future deficient practice? All residents with orders for Enhanced Barrier Precautions (EBP) were reviewed on 4/03/2025 by the Director Of Nursing and the Minimum Data Set Coordinator to ensure residents meeting criteria for Enhanced Barrier Precautions had appropriate signage and PPE in place. A second audit was performed on	

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F 880	Continued From page 10 revealed R18 had an active order for EBP related to a wound. Review of R41's "Clinical Orders," dated 03/06/2025, revealed an order to apply oil emulsion gauze to the left arm biopsy site daily. Observation on 04/01/2025 at 10:06 AM revealed no EBP signage was posted outside R41's door, and on 04/02/2025 at 9:08 AM and 04/03/2025 at 8:54 AM signage for Contact Precautions was posted outside R41's room. However, during an interview on 04/03/2025 at 2:07 PM with the Infection Preventionist Nurse (IPN), she stated R41 did not have an order for Contact Precautions, she had an order for EBP because of a wound, and that was the signage that should have been posted outside her room. 3. Review of R56's "Admission Record" revealed the facility admitted R56 on 08/16/2024 with diagnoses of adult failure to thrive and dysphagia (swallowing difficulties). Review of R56's "Clinical Orders," dated 03/28/2025 and entered by the MDS Nurse, revealed R56 had an active order for EBP related to a wound located on his coccyx. However, observation on 04/01/2025 on 10:06 AM revealed no EBP signage was posted outside R56's room. 4. Review of R68's "Admission Record" revealed the facility admitted R68 on 02/28/2025 with diagnoses of fracture of the left humerus, congestive heart failure, and a pressure ulcer to the right lower back.	F 880	04/24/2025 to ensure no residents were in need of Enhanced Barrier Precautions. The process for placing and maintaining PPE outside rooms, requirements for posting CDC-based signage for Enhanced Barrier Precautions or isolation and the roles and responsibilities to monitor compliance was reviewed with Quality Assurance team at the Performance Improvement Meeting (Made it an Ad-Hoc Quality Assurance Meeting) to review the Plan of Correction. The Infection Preventionist, started training with the Nursing Staff on 04/24/2025 regarding the difference between Enhanced Barrier Precautions and Contact Precautions, Nursing Responsibilities, process and procedure along with location of signs and PPE for easy access. All full-time staff completed by 05/02/2025 and prn staff will be retrained on next scheduled day. This training will be carried out by the Staff Development Coordinator or designee (Director of Nursing) during Nursing orientation for New Hires. *How will corrective action be monitored to ensure the deficient practice will not recur? The Infection Preventionist or designee (Director of Nursing or Assistant Director of Nursing) started daily audits on 04/24/2025 and they will continue daily Monday-Friday and Saturday and Sunday will be reviewed on Monday for 4 weeks of all using Exhibit A which includes resident, reason for precautions, signage in place,	

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F 880	Continued From page 11 Review of R68's "Clinical Orders," dated 03/11/2025 and entered by the MDS Nurse, revealed R68 had an active order for EBP related to a wound and an indwelling urinary catheter. However, observation on 04/01/2025 at 10:08 AM revealed no EBP signage was posted outside R68's room. 5. Review of R73's "Admission Record" revealed the facility admitted R73 on 10/22/2024 with diagnoses of unspecified dementia, need for assistance with personal care, cognitive communication deficit, and neck fracture. Review of R73's "Clinical Orders," dated 03/10/2025 and entered by the MDS Nurse, revealed R68 had an active order for EBP related to a wound on his sacrum (lower back). However, observation on 04/01/2025 at 10:10 AM revealed no EBP signage was posted outside R73's room. During an interview on 04/03/2025 at 3:30 PM with Certified Nurse Assistant (CNA) 4, she stated this was her second week working at the facility, and she relied on the signage posted outside the residents' rooms to guide her in what personal protective equipment (PPE) to wear into the residents' rooms to provide care. She stated if there was no signage outside the resident's room, she would not know what she needed to do and to wear to care for the resident, which could place all the residents at risk for infection. CNA4 stated the residents' precautions were not indicated on the Kardex (the list of resident needs for care and assist generated by the nursing care plan), so	F 880	order in place and PPE present. The daily audits will include, reviewing physician orders, orders from Vohra (Wound Care Physician) and other orders including any criteria for Enhanced Barrier Precautions such as chronic wounds, infections, indwelling catheters, PICC lines, or any other indwelling medical devices. The Infection Preventionist and or Assistant Director of Nursing will bring Audits to the Quality Assurance meetings. After 4 weeks, audits will continue weekly for 2 month, then monthly ongoing until the Quality Assurance team determines otherwise. Plan of Correction and Audits reviewed today 05/08/2025 in the Quality Assurance Meeting.	

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she would only be aware of the need for PPE, like a gown or a mask, if it was posted outside the resident's room.

During an interview on 04/03/2025 at 3:35 PM with CNA5, she stated she had worked at the facility since 01/2025, and she looked at signage outside the resident's room to guide her as to what PPE she required to provide resident care. CNA5 further stated she would use a gown or mask as the sign posted outside the resident's room instructed. She stated if there was no sign, she would always use gloves as needed and perform hand hygiene with either soap or hand sanitizer as needed. She stated the sign was important so staff and visitors would know what to do before entering the room to keep everyone safe and infection free.

During an interview on 04/03/2025 at 3:40 PM with CNA6, she stated she had worked at the facility for two years and was also a Kentucky Medication Aide (KMA). She stated as a KMA she was able to see if a resident was on infection control precautions as she administered medications because it was visible on the resident's dashboard on the electronic medical record (EMR). She stated she would also observe the signage which should be posted outside the residents' rooms indicating what PPE was required to perform resident care. She stated this was important to prevent the spread of infection and in some cases, protect a resident from getting an infection.

During an interview on 04/03/2025 at 3:45 PM with the Staff Development Coordinator (SDC), she stated infection control precaution signage should be posted outside a resident's room

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immediately after an order was received by the nurse to ensure staff and visitor compliance with the precautions. The SDC stated if there was no signage posted outside the resident's room, staff would not know what PPE to wear to provide care. She also stated the signage would instruct staff on PPE the resident needed to wear to exit the room and would instruct visitors on what PPE they needed to wear to enter the room. She stated if staff and visitors did not have the signage information, everyone could be at risk for infection and the spread of infection.

During an interview on 04/03/2025 at 3:53 PM with the Physical Therapist (PT), she stated she had worked at the facility for 15 years. She stated if a resident was on infection control based precautions, and there was not a sign posted outside the resident's room indicating the resident was on precautions, staff and visitors would not know which PPE to wear into the room. She stated the therapy department would not be aware if a resident could leave their room for therapy or if the resident's condition required therapy be performed in the resident's room. She stated this was important to protect the resident, staff, and any visitors.

During an interview on 04/03/2025 at 2:44 PM with the Minimum Data Set (MDS) Nurse, she stated she had been at the facility for six years and had been in the role of MDS Nurse for one year. The MDS Nurse stated if she received an order for a resident for infection control precautions, she would usually let the resident's nurse or the IPN know about it. She stated she had never placed signage outside the resident's room and was not sure how soon after an order was received the signage should be placed, but it

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(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 14	F 880		

would be whatever the policy stated. She further stated the signage being placed on the door was not important as long as staff knew what the orders were, "that would be okay." She stated she felt since staff was pretty consistent at the facility, they knew the residents well and would remember what infection control precautions they were on. When asked how visitors would be made aware of the precautions, the MDS Nurse stated she was not sure but agreed staff and visitors knowing if a resident was on ordered infection control precautions was important for the safety of the resident, staff, and visitors to prevent the spread of infection.

During continued interview on 04/03/2025 at 2:07 PM with the IPN, she stated she had become certified as an IPN in July 2024. She stated it was her expectation the nurse that entered an order for a resident for any transmission-based precautions (TBP) or EBP then placed signage outside the resident's door immediately. She stated the placement of infection precaution signage outside the resident's room was important for the resident, visitors, and staff to prevent the spread of infection.

During an interview on 04/03/2025 at 2:07 PM with the Director of Nursing (DON), she stated she had worked at the facility in the role of DON for a little less than a month and had worked as a floor nurse prior to that. She stated it was also her expectation the nurse that entered an order for a resident for any TBP or EBP ensured signage was placed outside the resident's room immediately whether that nurse placed it or asked another nurse to do so. She stated signage on the door was important for the safety of the resident, visitors, and staff to prevent the spread

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185160	A. BUILDING _____ B. WING _____	C 04/03/2025

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F 880	Continued From page 15	F 880		

of infection. The DON also stated R41 should have been on EBP for a biopsy site to her left upper arm.

During an interview on 04/03/2025 at 4:30 PM with the Administrator, she stated she had been at the facility for twenty-two (22) years. The Administrator stated signage indicating what infection control precautions were ordered for a resident should be posted outside the resident's room, and that signage should posted as soon as possible after the order was received. She further stated her expectation was the nurse that received the order would be responsible for ensuring the signage was posted so all staff and visitors would comply with the infection precautions. The Administrator stated compliance with ordered infection control precautions for a resident was important to protect all residents, staff, and visitors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185160	A. BUILDING _____ B. WING _____	R 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON COUNTRY PLACE	700 MASON HEADLEY ROAD LEXINGTON, KY 40504

(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 000}	INITIAL COMMENTS An off-site/follow-up survey was initiated and concluded on 05/09/2025. It was determined the facility had corrected their deficiencies on 05/09/2025 as alleged.	{F 000}		

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

Electronically Signed | 06/12/2025

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185160	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **05/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON COUNTRY PLACE	**700 MASON HEADLEY ROAD** **LEXINGTON, KY 40504**

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{K 000}	INITIAL COMMENTS Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 05/30/2025, it was determined the facility had achieved substantial compliance with Life Safety Code on 05/16/2025.	{K 000}		

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

Electronically Signed | 06/12/2025

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 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.