STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Nursing and Rehabilitation Center	139 Pearl Street Auburn, KY 42206

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure advance directives were completed and reviewed for four (Resident (R)6, R8, R22 and R33) of four sampled residents reviewed for advanced directives. R22 had missing and conflicting information regarding code status. R6, R8, and R33 did not have advance directives or evidence that they were given the opportunity to formulate or decline one. The findings include:Review of the facility's policy titled, Advance Directives Standard of Practice, revised 04/2025, revealed that on admission, the facility will determine if the resident has executed an Advance Directive and if not, determine whether the resident would like to formulate an Advance Directive. Upon admission should the resident have an Advance Directive, copies will be made and placed in the resident's medical record/scanned into the electronic medical record (EMR). Further review of the policy revealed, the facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined to not have decision making capacities regarding Advance Directives and/or treatment provision. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to Advance Directives. Lastly the policy revealed any decision making will be documented in the resident's medical record and communicated to the Interdisciplinary Team (IDT).1. Review of a Face Sheet revealed R22 was admitted to the facility on [DATE], with diagnoses that included amyotrophic lateral sclerosis (ALS - a neurodegenerative disease that effects the ability to walk, speak, swallow, and breathe), major depressive disorder, anxiety disorder, depression and cognitive communication deficit.Review of a facility document titled, Kentucky Emergency Medical Service (EMS) Do Not Resuscitate (DNR) Order dated [DATE], signed by the resident's Power of Attorney (POA) was found in the Advance Directive section of the resident's medical record.Review of R22's Comprehensive Care Plan, start date [DATE], revealed a choice to be a Do Not Resuscitate (DNR) status with interventions in place to obtain a written DNR order from the physician, if discharged to the hospital, send copy of the written DNR order with other orders, and review code status with each quarterly care conference and as needed.Further medical record review indicated R22's code status of DNR was printed on the Face Sheet. The record also contained an Advance Directive Acknowledgement form, which did not indicate a code status.Review of R22's Physician Order capitulation, dated [DATE], indicated a code status of Cardiopulmonary Resuscitation (CPR), rather than the DNR status which was documented in other locations. There was no evidence in the record to indicate that the resident or the responsible party had requested a code status change, or that required documentation was completed to verify that this order was the resident's current advance directive. During an interview on [DATE] at 3:55 PM, Licensed Practical Nurse (LPN)1 stated she would search the side of the medical record for the red (DNR) or green (CPR) sticker to determine (continued on next page)

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.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's code status, along with looking for Advance Directive documentation in the Advance Directive tab. Further interview with LPN 1 revealed she was unclear as to what documentation she was looking for. Observation at the time of this interview revealed that R22 had a red strip, denoting DNR status, on her chart.During an interview on [DATE] at 4:07 PM, the Social Services Director (SSD) stated code status is to be reviewed every quarter during the Care Conference. The SSD retrieved an admission Packet, which contained the Kentucky (EMS) Do Not Resuscitate (DNR) Order. In addition, the SSD stated that every resident's record was to contain a Cardiopulmonary Resuscitation Consent form which must be provided at the time of admission. Review of the form revealed that it stated the following: Cardiopulmonary Resuscitation ConsentIt is my desire that I be given:______CPR (Cardiopulmonary Resuscitation)______NO CPR (No Cardiopulmonary Resuscitation)During an interview on [DATE] at 4:11 PM, the Director of Nursing (DON) searched R22's medical record under the Advance Directive tab and found the Kentucky (EMS) Do Not Resuscitate (DNR) Order and the Advance Directive Acknowledgement form. The DON was unable to locate the Cardiopulmonary Resuscitation Consent form which was referenced by the SSD.During an interview with the Administrator on [DATE] at 5:53 PM, she stated her expectation was for staff to maintain the Advanced Directives for the residents and for them to be audited as part of the medical record for accuracy. 2. Review of R6's Face Sheet revealed R6 was admitted to the facility on [DATE], with diagnoses that included dementia, altered mental status, and displaced intertrochanteric fracture of the left femur, subsequent encounter.Review of R6's medical record revealed R6 did not have an advance directive on file. Further review of R6's record revealed no evidence that the facility afforded the resident the opportunity to formulate or decline the creation of an advance directive. 3. Review of R8's Face Sheet revealed R8 was admitted to the facility on [DATE], with diagnoses that included severe bipolar disorder with psychotic features, age related physical debility, and generalized anxiety disorder.Review of R8's medical record revealed R8 did not have an advance directive on file. Further review of R8's record revealed no evidence that the facility afforded the resident the opportunity to formulate or decline the creation of an advance directive. 4. Review of R33's Face Sheet revealed R33 was admitted to the facility on [DATE], with diagnoses that included dementia, epilepsy, and chronic obstructive pulmonary disease (COPD).Review of R33's medical record revealed R33 did not have an advance directive on file. Further review of R33's record revealed no evidence that the facility afforded the resident the opportunity to formulate or decline the creation of an advance directive.In an interview with the SSD on [DATE] at 3:55 PM, she stated she does advance directives with the residents on admission. She stated if the discharging facility sends the information ahead of time, she will use that information for the advance directive status. She stated a lot of times what they get from the hospital regarding the advance directive is not what the resident wants when they get to the facility and are interviewed. The SSD stated she will ask the resident when they get here what they would want. She stated if resident has no one to come to the care conference, she will go to that resident and ask if it is something that they want or not, The SSD stated if the resident has a state guardian, she will still talk to the resident. Further interview with the SSD revealed the potential negative outcome of not formulating an advance directive is that a resident will not get CPR that wanted it or will get it but did not want it. In an interview with the DON on [DATE] at 5:02 PM, the DON stated that to determine resident code status, she would go to the resident's chart and look for the code status paper. The DON noted that if they do not have a paper in their chart, she hopes that the physician would have that information. The DON stated that if she did not have time to go look or if resident was in an active unresponsive situation, she would go ahead and call Emergency Medical Services (EMS). Further interview with the DON revealed (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that a potential negative outcome is that you could give CPR to someone who does not want CPR or vice versa and subsequently break bones and hurt them unnecessarily. The DON stated Medical Records staff performed chart audits to ensure all required documents were there. In an interview with the Administrator on [DATE] at 5:53 PM, she stated Medical Records does a chart review monthly and audits them for accuracy. She stated she expected staff to maintain the advanced directives for the residents. Interview with the Medical Records staff on [DATE] at 2:58 PM confirmed that she does perform chart audits; however, further interview revealed she did not identify the issues regarding advance directive documentation for these residents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, clean, and comfortable homelike environment for five (Resident (R) 10, R22, R35, R53, and R57) of five residents reviewed for the environment. The residents, who all resided on one of the three halls in the facility, had missing or broken floor tiles in their rooms and/or expressed concern with housekeeping and maintenance.The findings include:Review of a facility policy titled, Resident Rights, reviewed 04/01/2025, revealed, The resident has the right to a safe, clean, comfortable, and homelike environment.Review of a facility policy titled, Homelike Environment Standard of Practice, reviewed 10/01/2020, revealed The purpose of this policy is that residents are provided with a safe, clean, comfortable, and homelike environment. 1. Review of R10's Facesheet revealed R10 admitted to the facility on [DATE]. Per R10's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/10/2025, the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating R10 had intact cognition.Observation on 09/11/2025 at 09:57 AM revealed broken floor tiles near the bathroom door in R10's and R35's room. An interview was conducted with R10 on 09/11/2025 at 9:59 AM. R10 stated during the interview that housekeeping is kind of shabby on the weekends. She stated that until recently there were times when they went without their rooms being cleaned at all daily; however, that has recently changed. R10 stated the floor tiles by the bathroom have been that way since she moved in the facility. She stated concerns about the building were expressed at a recent resident council meeting. R10 added that she saw staff trying hard to do what they could; however, the facility just does not have enough staff here to control or manage some things that need tending to. 2. Observation on 09/10/2025 at 11:40 AM revealed missing and broken tiles on the floor of R 57's room between the resident's bed and the air conditioning unit.3, Observation on 09/11/2025 at 10:06 AM revealed missing and broken floor tiles in R 53's room between the resident's bed and air conditioning unit that was covered with an area rug. 4, Observation on 09/11/2025 at 10:09 AM revealed broken floor tiles in R22's room near the door. In an interview with Housekeeper (HK) 1 on 09/11/2025 at 10:09 AM, she stated she has been employed at facility for three months. HK 1 confirmed R53 had missing flooring tiles, stating that is why he had a rug over that area. HK1 noted that this end of the facility had the most problems with the flooring because it was the oldest part of the building. She stated the facility was aware of the problem, and when the new owners took over and bought the facility, they stated that they had plans to replace all the flooring in the near future. In an interview with the facility Maintenance Director on 09/12/2025 at 2:36 PM, he stated he had been employed as maintenance for the past two years. He stated it was hard to get replacement tiles for the floor, and they were in the process of getting new tiles. The Maintenance Director stated he would have started with the resident rooms first if it were up to him to make that decision; however, the owners decided they wanted to replace the tiles in the hall first, before doing the resident rooms. He added that the process was started with the previous owners and expressed the hope that once new ownership gets to take over, it will get done quickly. In an interview with the Administrator on 09/12/2025 at 5:53 PM, she stated she expects her facility to be clean. She added that she, herself, had physically replaced floor tiles in resident rooms in the past as needed. The Administrator stated the corporate office had mentioned that previous owners started replacing the tile in the hallways and were next to move to the resident rooms; however, they were then bought out. Per the Administrator, the new owners told her that they are going to continue with that plan. Further (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview with the Administrator revealed that the residents know they are trying to fix it and that the staff knows they are supposed to report any broken or missing tiles to maintenance so that they can be repaired.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review it was determined the facility failed to accurately complete the Preadmission Screening process for individuals with a mental disorder and/or individuals with intellectual disabilities for nine (Resident (R)3, R8, R9, R12, R15, R17, R25, R33, and R42) of nine sampled residents reviewed for Preadmission Screening and Resident Review (PASARR). The systemic failure to ensure the PASARR process is completed as required has the potential to affect all residents who must be screened using this process upon admission. The findings include: Review of a facility policy titled, Preadmission Screening and Resident Review (PASARR), created 09/2025, revealed the purpose was to determine if an individual seeking admission had a serious mental illness (SMI), intellectual disability (ID), or related conditions (RC) and determine eligibility for nursing facility placement and health related services. The protocol was to utilize the Kentucky Level of Care System (KLOCS) to submit and track applications using an online self-service portal, initiate level of care request and discharges (requests were automatically routed to the appropriate KLOCS personnel for review and completion of determinations), and send providers automatic task notifications and reminders to submit any requested information. 1. Review of the admission record for R3 revealed R3 was admitted on [DATE] with diagnoses including bipolar disorder with psychotic features, major depressive disorder, and anxiety. Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/27/2025, revealed the facility assessed R3 to have a Brief Interview for Mental Status (BIMS) score of 14/15, indicating the resident was cognitively intact. The MDS indicated R3 was not evaluated by the Level II PASARR (an in-depth evaluation and determination for applicants and residents with serious mental illness or intellectual and developmental disabilities to ensure appropriate placement and services are provided). Review of a Level I PASARR, dated 06/06/2025, indicated R3 had a diagnosis of bipolar and had required an intensive psychiatric treatment in order to maintain or restore functioning (ex: psychiatric hospitalization, partial hospitalization/day treatment, residential treatment). Further review of the Level 1 PASARR, which was documented through the KLOCS (a system used to enter and automatically route to the appropriate personnel for determinations before admission) revealed that although it listed the resident's diagnosis, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. There was no documented evidence R3 was referred for a Level II PASARR. 2. Review of the admission record for R17 revealed R17 was admitted on [DATE] with diagnoses including unspecified psychosis and bipolar disorder. Review of an admission MDS with an ARD of 08/03/2025, revealed the facility assessed R17 to have a BIMS score of 15/15, indicating the resident was cognitively intact. The MDS indicated R17 was not evaluated by Level II PASARR. Review of a Level I PASARR, dated 07/21/2025, indicated R17 had diagnoses of psychosis and bipolar and required intensive psychiatric treatment in order to maintain or restore functioning. Further review of the Level 1 PASARR, which was documented through the KLOCS, revealed that although it listed the resident's diagnoses, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. There was no documented evidence that R17 was referred for a Level II PASARR. 3. Review of the admission record for R9 revealed R9 was admitted on [DATE] with diagnoses including schizoaffective disorder. Review of an admission MDS with an ARD of 05/28/2024 revealed the facility assessed R9 to have a BIMS score of 3/15, indicating the resident was severely cognitively impaired. The MDS indicated R9 was not evaluated by Level II PASARR. Review of a Level I PASARR, dated 05/15/2024 indicated R9 had a diagnosis of schizoaffective disorder. Further review of the Level 1 PASARR, which was documented through (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the KLOCS, revealed that although it listed the resident's diagnosis, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. There was no documented evidence that R9 was referred for a Level II PASARR. 4. Review of the admission record for R12 revealed R12 was admitted on [DATE] with diagnoses including unspecified psychosis, altered mental status, and cognitive communication disorder. Review of an admission MDS with an ARD of 10/26/2023 revealed the facility assessed R12 to have a BIMS score of 11/15, indicating the resident had moderate cognitive impairment. The MDS indicated R12 was not evaluated by Level II PASARR. Review of a Level I PASARR, dated 10/13/2023, indicated R12 had a diagnosis of unspecified psychosis. Further review of the Level 1 PASARR, which was documented through the KLOCS, revealed that although it listed the resident's diagnosis, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. There was no documented evidence that R12 was referred for a Level II PASARR. 5. Review of the admission record for R15 revealed R15 was admitted on [DATE] with diagnoses including bipolar disorder, schizophrenia, and unspecified dementia. Review of an MDS with an ARD of 08/11/2025 revealed the facility assessed R15 to have a BIMS score of 12/15, indicating the resident had moderate cognitive impairment. The MDS indicated R15 was not evaluated by Level II PASARR. Review of a Level I PASARR, dated 06/22/2006, indicated R15 had diagnoses of bipolar disorder and schizophrenia. Further review of the Level 1 PASARR, which was documented through the KLOCS, revealed that although it listed the resident's diagnoses, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. There was no documented evidence that R15 was referred for a Level II PASARR. 6. Review of the admission record for R25 revealed R25 was admitted on [DATE] with diagnoses including bipolar disorder, anxiety, and major depressive disorder. Review of an admission MDS with an ARD of 08/14/2025 revealed the facility assessed R25 to have a BIMS score of 15/15, indicating the resident was cognitively intact. The MDS indicated R25 was not evaluated by Level II PASARR. Review of a Level I PASARR, dated 08/01/2025, indicated R25 had diagnoses of anxiety, depression, and bipolar disorder. Further review of the Level 1 PASARR, which was documented through the KLOCS, revealed that although it listed the resident's diagnoses, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. There was no documented evidence that R25 was referred for a Level II PASARR. 7. Review of the admission record for R8 revealed R8 was admitted to the facility on [DATE], with diagnoses that included severe bipolar disorder with psychotic features, age related physical debility, and generalized anxiety disorder.Review of R8's admission MDS, with an ARD of 07/27/2025, revealed the resident had a BIMS score of 3/15, indicating R8 had severe cognitive impairment. The MDS indicated R8 was not evaluated by Level II PASARR. Review of a Level I PASARR, dated 07/14/2025 indicated R8 had diagnoses of bipolar disorder, anxiety disorder, and post-traumatic stress disorder (PTSD). Further review of the Level 1 PASARR, which was documented through the KLOCS, revealed that although it listed the resident's diagnoses, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. There was no documented evidence that R8 was referred for a Level II PASARR. 8. Review of the admission record for R 33 indicated R33 was admitted to the facility on [DATE], with diagnoses that included dementia, bipolar disorder, and anxiety disorder.Review of R33's Annual MDS, with an ARD of 09/09/2025, revealed the resident had a BIMS score of 3/15, indicating R33 had severe cognitive impairment.Review of a Level I PASARR, dated 07/14/2025 indicated R33 had diagnoses of bipolar disorder, and anxiety disorder, Further review of the Level 1 PASARR, which was documented through the KLOCS revealed that although it listed the (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and review of the facility's policies, the facility failed to consistently post required staffing data. No data was posted for two of four days during the recertification survey. The failure to post required staffing data has the potential to affect any resident who wishes to know the staffing for that day.The findings include:Review of a facility policy titled Census Report, revised 01/02/2013, revealed that it addressed one required component (census) of the mandatory staffing data to be completed and posted daily. The policy stated that a daily census report was to be completed by the charge nurse on duty at midnight. The report is submitted to the Social Service Director or an Administrative designee. No further policies regarding completing and posting the required daily staffing posting were provided prior to exit.Observation during a tour of the facility on 09/09/2025 at 10:00 AM revealed that the required staffing data was not posted.Observation during a tour of the facility on 09/10/2025 at 10:05 AM revealed that the required staffing data was not posted.During an interview on 09/11/2025 at 02:22 PM, the Director of Nursing (DON) stated she had never posted a staff information sheet. The DON, who started serving as the Assistant Director of Nursing (ADON) in January and took over as DON on 09/10/2025, stated she was unaware that this was a regulation. Further interview with the DON revealed she thought the task was not done due to staffing shortages. Interview on 09/12/2025 at 11:25 AM with the Scheduler, who also served as the Staffing Coordinator, revealed that she was not aware of any regulation regarding posting the staffing sheet daily until the Administrator told her to do it on 09/11/2025 (after surveyor intervention).During an interview on 09/12/2025 at 6:13 PM with the Interim Administrator/Regional [NAME] President, she confirmed that she was aware of the regulation requiring posting of the daily staffing/census report. The Interim Administrator stated the Staffing Coordinator was supposed to have been posting the staffing sheet on a daily basis. Further interview with the Interim Administrator revealed she did not know the last time that the required staffing report was posted, nor did she know why it was not done in the past. She stated that the facility had ongoing circumstances, such as a change of owners and new administrative staff and guessed that was the reason that the forms were not completed and posted as required.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Nursing and Rehabilitation Center	139 Pearl Street Auburn, KY 42206

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of the facility's policy, the facility failed to ensure expired drugs/biologicals were not available for resident use. Two different expired influenza vaccines were stored in one of the facility's two medication refrigeratorsThe findings include: Review of a facility policy, titled Medication Administration Standard of Practice, revised 04/01/2025, revealed that medications that were expired or beyond the usage date should not be administered.Review of a facility policy titled, Label/Store Drugs and Biologicals Standard of Practice, reviewed 10/01/2020, revealed Drugs and biologicals must be labeled in accordance with currently accepted professional principles and include the expiration date when applicable. The policy further stated that expired and or discontinued medication shall be removed for the medication storage area for timely return to the pharmacy and or documented destruction.Observation of one of the facility's two medication storage refrigerators, on 09/10/2025 at 1:00 PM, revealed two separate expired influenza vaccinations stored in the refrigerator. a. Afluria 2024-2025 MDV Vaccine, lot#P100712359, with an expiration date of 06/30/2025. b. Fluzone 2024-2025 High-Dose, a box of 10 single dose prefilled syringes 0/5mL each syringe, lot #UT8425CA, with an expiration date of 06/30/2025.In an interview with Licensed Practical Nurse (LPN) 1 on 09/10/2025 at 1:10 PM, LPN1 stated she was not certain what the requirements were for medication storage, as administration (the Director of Nursing (DON)) was responsible for the task. LPN1 stated that if medications were outdated, staff were to give them to the administrative staff so they could dispose of them.In an interview with Certified Medication Aide (CMA) 1 on 09/10/2025 at 1:31 PM, she stated if she found any expired medications she was to notify the nurse or the Assistant Director of Nursing (ADON) and let them know. Additionally, she stated if she found any expired medications on the medication cart, she was to pull them and take them to the house supervisor for her to dispose of them.Interview with the DON, on 09/12/2025 at 5:02 PM, revealed that in the past (under a previous owner), the pharmacy company which serviced the facility would come in and check that medications were not expired. The DON stated that in the future she would like the DON and the nursing staff to check medications routinely but indicated that this was dependent on if they could get enough staff to do so. Further interview with the DON revealed that potential negative outcomes included a resident receiving an expired vaccination.In an interview with the Administrator on 09/12/2025 at 5:53 PM, she stated she expected the medications to be stored properly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of the facility's policy, the facility failed to store food in accordance with professional standards for food service safety. Food items were not dated or labeled at the time of storage. Opened food was not covered and/or sealed to prevent contamination. Food in the dry storage area was not free from the potential for contamination, as it was stored in bins on a top shelf approximately 8 inches from the ceiling/sprinkler heads. The failure to ensure food was stored, sealed, and/or dated after opening had the potential to affect 56 of the 56 facility's residents who consumed food from the kitchen.The findings include:Review of an undated facility policy. titled Food Storage, revealed food storage areas should be maintained in a clean, safe, and sanitary manner. Interpretation and implementation of the policy included that food services staff would store all foods or food items not requiring refrigeration, at least 18 inches from sprinkler heads. In addition, the policy noted that prepared food stored in the refrigerator until service should be dated with an expiration date and tightly sealed with plastic wrap, foil, or a lid.Review of an undated facility policy, titled Refrigerators and Freezers, revealed the facility would ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and would observe food expiration guidelines. Interpretation and implementation of the policy revealed that all food should be appropriately dated to ensure proper rotation by expiration dates. Per the policy, supervisors would be responsible for ensuring food items were not expired or past perish dates.Observation of Refrigerator 3 revealed an opened package of bacon on the top shelf that was not labeled, dated, or sealed; an opened bag of shredded cheese that was not labeled, dated or sealed; and an opened jar of grape jelly that was not dated. In addition, the refrigerator contained a package of liver loaf with an open date of 08/17/2025 and a discard date of 08/24/2025. Observation of the dry storage room on 09/09/2025 at 10:25 AM revealed a jar of apple cider vinegar that was opened but not dated. Further observation in this area revealed six totes containing dry cereal were stored on a top shelf, 8-inches from the ceiling and sprinkler heads.During an interview with the Kitchen Manager (KM) on 09/09/2025 at 10:40 AM, she stated all food items should be labeled. The KM indicated that the various food items identified during the kitchen tour should be discarded since they were not labeled. Further interview with the KM revealed that the totes should be stored 18 inches from the ceiling and sprinklers. The KM stated that she had previously asked administration for more shelving units in the dry storage area; however, she had not yet received them.During an additional interview with the KM on 09/12/2025 at 9:50 AM, she stated the expectation was that whoever opened an item, would then date and seal the item. The KM added that that meat should be stored on the bottom shelf of the refrigerator to prevent contamination to other foods. She stated she was aware that totes in the dry storage room were too close to the sprinklers and ceiling. The KM added that she had asked for more shelves; however, they had not been provided. During an interview with the Director of Nursing on 09/12/2025 at 5:01 PM, she stated she expected items in the kitchen to be sealed, labeled, and dated to prevent contamination to other items. During an interview with the Interim Administrator/Regional [NAME] President of Region 6 on 09/12/2025 at 5:50 PM, she stated she expected food in the kitchen to be labeled, dated, and sealed so the residents in the facility were not served expired or contaminated foods. Further interview with the Interim Administrator/Regional [NAME] Presidents of Region 6 revealed that she was not aware of the issue with the storage totes in the dry storage room and confirmed that they should not be stored so close to the ceiling/sprinkler heads.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy's, it was determined the facility failed to ensure medical records were complete, accurate, and maintained for 8 of 25 sampled residents (R3, R4, R9, R12, R15, R17, R25, R58).The findings include: Review of an undated Medical Records policy revealed appropriate medical/clinical records should be maintained for each resident. Review of an undated facility policy, titled, Charting and Documentation, revealed All services provided to the resident, or any changes in the resident's medical or mental condition, should be documented in the resident's medical record. Per the policy, interpretation and implementation included that All observations, medications administered, services performed, etc. must be documented in the resident's clinical records. 1. Review of the admission record for R4 revealed the facility admitted the resident on 06/24/2025 with diagnoses including nondisplaced fracture of olecranon of left ulna, unspecified dementia, and visual loss. a. Review of R4's admission orders, dated 06/24/2025, revealed the resident would be weighed per facility policy, every week for four weeks. After this, physician orders called for monthly weights. Review of facility records revealed no evidence that the four weekly weights and monthly weight thereafter were obtained as ordered. Review of the 100-hall weight binder for 2025 for the months of May-August revealed R4's last name handwritten at the bottom of one page, listing a weight of 193 pounds. There was no annotation of the month or date this weight was obtained, and no other weights for the resident were recorded. b. Review of R4's Medication Administration Records (MAR) since admission revealed they were incomplete, as they failed to include either the month or year that the record represented. During an interview with the Director of Nursing (DON) on 09/12/2025 at 5:01 PM, the DON reviewed each of the four MARs completed since admission and confirmed that the records were incomplete, as there was no month or year to indicate when the listed medications were administered. Further interview with the DON revealed she had assumed the DON position a few days ago and was the Assistant Director of Nursing (ADON) prior to that. The DON stated that she was thrown in the roles and was winging it, adding that she had not had time to perform chart audits. She stated the resident's MARs should always include a month and year. The DON related that the admission nurse was responsible for putting the dates on the form, but the ADON/DON should also review the MAR either that same evening or the next morning to ensure they were accurate. She stated she expected dates to be on the MAR's when completed. She further stated without weights having a date, there was no way to know when the weight was actually obtained. The DON stated the house supervisor was the staff previously responsible for documenting weights; however, she resigned two weeks ago. Interview with the Administrator on 09/12/2025 at 5:50 PM revealed that she expected the ADON/DON to review the MARs on a monthly basis to ensure they were accurate. The Administrator stated the MAR should be dated and weights should be done per physician orders. Interview with the Administrator revealed that the failure to accurately and completely document weights as ordered could result in the resident having a significant weight change which was not caught. Further interview revealed the failure to accurately documented the MAR with the date could result in the resident receiving medications for the wrong month or even the wrong orders. 2.a. Review of the admission record for R3 revealed R3 was admitted on [DATE] with diagnoses including bipolar disorder with psychotic features, major depressive disorder, and anxiety. Review of a Level I PASARR, dated 06/06/2025, indicated R3 had a diagnosis of bipolar and had required an intensive psychiatric treatment in order to maintain or restore functioning (ex: psychiatric hospitalization, partial hospitalization/day treatment, residential treatment). Further review of the Level 1 PASARR, which was (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	documented through the Kentucky Level of Care System (KLOCS - a system used to enter and automatically route to the appropriate personnel for determinations before admission) revealed that although it listed the resident's diagnosis, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. b. Review of the admission record for R17 revealed R17 was admitted on [DATE] with diagnoses including unspecified psychosis and bipolar disorder. Review of a Level I PASARR, dated 07/21/2025, indicated R17 had diagnoses of psychosis and bipolar and required intensive psychiatric treatment in order to maintain or restore functioning. Further review of the Level 1 PASARR, which was documented through KLOCS, revealed that although it listed the resident's diagnoses, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. c. Review of the admission record for R9 revealed R9 was admitted on [DATE] with diagnoses including schizoaffective disorder. Review of a Level I PASARR, dated 05/15/2024 indicated R9 had a diagnosis of schizoaffective disorder. Further review of the Level 1 PASARR, which was documented through KLOCS, revealed that although it listed the resident's diagnosis, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. d. Review of the admission record for R12 revealed R12 was admitted on [DATE] with diagnoses to include unspecified psychosis, altered mental status, and cognitive communication disorder. Review of a Level I PASARR, dated 10/13/2023, indicated R12 had a diagnosis of unspecified psychosis. Further review of the Level 1 PASARR, which was documented through KLOCS, revealed that although it listed the resident's diagnosis, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. e. Review of the admission record for R15 revealed R15 was admitted on [DATE] with diagnoses including bipolar disorder, schizophrenia, and unspecified dementia. Review of a Level I PASARR, dated 06/22/2006, indicated R15 had diagnoses of bipolar disorder and schizophrenia. Further review of the Level 1 PASARR, which was documented through KLOCS revealed that although it listed the resident's diagnoses, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. f. Review of the admission record for R25 revealed R25 was admitted on [DATE] with diagnoses to include bipolar disorder, anxiety, and major depressive disorder. Review of a Level I PASARR, dated 08/01/2025, indicated R25 had diagnoses of anxiety, depression, and bipolar disorder. Further review of the Level 1 PASARR, which was documented through KLOCS revealed that although it listed the resident's diagnoses, it did not include any information to indicate whether a Level II assessment was needed or not, or if the appropriate referrals were made. During an interview with the Medical Records (MR) staff and the Administrator on 09/11/2025 at 1:34 PM, MR explained that she inputs the resident's PASARR information into KLOCS. The system would then alert Life Skills (a mental health clinic) if a Level II assessment was needed, and they would send someone accordingly. She confirmed that the determination from the Level I assessment was not printing with the packet kept in the resident's record. MR stated that the determination appeared on the system and could generate error messages and instructions; however, it did not always show whether a Level II evaluation was recommended. Further interview with MR revealed she was unsure why this occurred. During this interview, the Administrator confirmed that the Level I PASARR was completed by the facility's MR person, and then Life Skills evaluated whether the resident's Level I data resulted in a Level II assessment. However, the facility could provide no further information to show that the residents' records were complete, and included the determinations made from the Level 1 screening.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview, record review, and facility policy review, it was determined the facility failed to develop, implement, and maintain an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program that focused on indicators of the outcomes of care and quality of life. The QAPI program failed to identify concerns regarding the Preadmission Screening and Resident Review (PASARR) process, affecting nine (Resident (R)3, R8, R9, R12, R15, R17, R25, R33, and R42) of nine sampled residents reviewed for this mandatory screening. In addition, the QAPI program failed to identify issues for four (R6, R8, R22, R33) of four sampled residents reviewed for advance directives, who were not given the opportunity to formulate advance directives, or for whom the process was not accurately completed, with all required documentation. The failure to ensure that the QAPI program systematically reviewed care areas, identified outliers and problems, and implemented action to correct these areas has the potential to affect all 56 residents in the facility. The findings include: Review of a facility policy titled, QAPI Process Standard of Practice, dated 08/2022, revealed the facility QAPI would serve to:1. Ensure consistent and accurate functioning of care delivery systems, incorporating current and evidenced based practice standards as applicable.2. Prevent deviation from care processes to the extent possible.3. Identify issues and concerns with facility systems, as well as identifying opportunities for improvement; and4. Develop and implement plans to correct and/or improve identified areas. 1. Record review revealed a total of 20 out of 25 sampled residents triggered in the Internet Quality Improvement and Evaluation System (IQIES) for not having a Level II Preadmission Screening and Resident Review (PASARR) completed. Further review revealed nine (R3, R8, R9, R12, R15, R17, R25, R33, and R42) of nine residents reviewed for PASARR were not assessed for a Level II PASARR to determine the need for true mental health care and services. (Refer to F645). In an interview with the Social Services Director (SSD) on 09/12/2025 at 3:55 PM, she stated that they stated they do not discuss PASARRs in QAPI meetings. During an interview with the Director of Nursing (DON) on 09/12/2025 at 5:01 PM, she stated she did not know anything about a PASARR, describing it as basically a foreign language to her. The DON, who was a member of the QAPI committee, stated she had not even heard about a PASARR until this recertification survey. She stated the QAPI committee meets monthly, and she attends QAPI meetings. Per the DON, the committee decides what they are working on by departments, with each department presenting what is in their QAPI. Further interview with the DON revealed that she was not sure if PASARRs were reviewed or even discussed in QAPI. The DON stated that the former administrator may have mentioned the subject; however, since it was not directly related to her position, she did not take it all in because she has a lot on her plate.During an interview with the Administrator on 09/12/2025 at 5:50 PM, she stated she was also a Regional [NAME] President. The Administrator, who was a member of the QAPI committee, stated she should have been reviewing Level I PASARR's to ensure they were accurately completed, and ensure that each resident did not need a Level II PASARR. Further interview revealed she thought the PASARRs were being done correctly and was not aware of an issue prior to surveyor identification. 2. Record review and interview related to advance directive forms, for four (R6, R8, R22, and R33) of four residents reviewed for advance directives, revealed the facility failed to ensure that advance directives were complete and accurate, and/or that each resident was afforded the opportunity to formulate an advance directive. (Refer to F578.) Interview with the DON on 09/12/2025 at 5:02PM revealed that Medical Records' duties include performing chart audits to ensure the presence of all required documents. In an interview with the Administrator on 09/12/2025 at 5:53 PM, she stated her expectation was for staff to maintain the advanced directives for the residents. The Administrator also stated that Medical Records does a (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	chart review monthly and audits the records for accuracy. Interview with the Medical Records staff on 09/11/2025 at 2:58 PM confirmed that she does perform chart audits; however, further interview revealed she did not identify the issues regarding advance directive documentation for these residents.