STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185076	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradford Heights Nursing & Rehabilitation	950 Highpoint Drive Hopkinsville, KY 42240

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, prepare, distribute, and serve food in accordance with professional standards for food service safety, which had the potential to affect 93 of the facility's 93 residents who consumed food from the kitchen. The findings include: Review of the facility policy titled, Food Storage, revised 10/2019, revealed the Dining Service Director/Cook(s) were to ensure all food items were stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. Observation on 09/09/2025 at 10:15 AM, with the Dietary Manager (DM) revealed her hairnet receded approximately three inches above the hairline exposing uncovered hair on both sides of her head above her ears and in the front above her forehead. Continued observation of the kitchen, of refrigerator, 1 revealed a container of strawberries covered with mold. Observation revealed two heads of lettuce stored in a plastic bag that was opened, uncovered, and undated. Observation of freezer 1 revealed a box of French toast sticks and a box of chicken patties stored in their original container which had uncovered flap, and inside a plastic container that was not covered exposing the food to air. Continued observation of freezer 1 revealed a freezer storage bag which contained 3 sausages that was not sealed, and the sausages were covered with ice crystals. Further observation of the kitchen area revealed an area beside the stove and fryer that was covered with a thick film of splattered grease and other debris on the floor, the wall, and sides of the appliances and pipes that extended from the wall into the floor and back into the wall. Additionally, observation revealed an area between the stove and fryer that was covered with a layer of splattered grease and other debris that was on the floor and the wall. During further observation of the kitchen, on 09/10/2025 at 10:30 AM, the DM was observed still wearing her hairnet as in the previous observation, exposing approximately 3 inches of hair. Additionally, observation revealed the areas previously observed to have been splattered with grease remained soiled. In interview with Dietary Aide (DA) 1, on 09/12/2025 at 9:44 AM, she stated when storing food items in the refrigerator or freezer staff should date, seal and cover the food items to prevent contamination. The DA said she did not know why that had not been done for the food observed in the refrigerator and freezer. She reported however, the person doing that had not followed food storage guidelines. DM 1 explained if staff were not following the facility's policy and procedures food could spoil, resident's might complain about the taste of the food or they could get sick. She stated all dietary staff were responsible for cleaning the kitchen and their assigned areas. The DM said cooks were responsible for cleaning the grease splatter around the fryer and stove, and most of the cleaning in that area was completed weekly. She reported grease splatter near the stove or fryer could cause a fire. DM 1 further stated she would not feel good about serving food to the residents from a soiled kitchen. Additionally, she stated she did not know why the cleaning had not been done. In interview with [NAME] (C) 1, on 09/12/2025 at 9:53 AM, she stated she had worked for the facility for about nine and a half years. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said for food items stored in the refrigerator or freezer, when finished with them, she would place it back in its original container or a new container if needed. C 1 explained she would then label and date the food items with the opened date, secure the plastic package, twist the top and put a rubber band on it to ensure it was covered. She reported there was no reason that kitchen staff should not be storing food items properly. C 1 stated every kitchen staff should be following the facility's policy and procedures. She said if food items were not being stored properly, they could become freezer burnt, and the food could possibly make the residents sick. C 1 explained she would never serve anything she would not eat herself. She stated, in regard to cleaning the kitchen, that had occurred every shift, and the cooks were responsible for cleaning the areas around the stove. C 1 reported the fryer and the grease splatters should be cleaned up every day as the buildup of grease that close to the stove and fryer could be a fire hazard. She further stated there was no reason the cleaning had not been being done and they had just not done it. In interview with the DM, on 09/12/2025 at 10:02 AM, she stated kitchen staff had cleaned the sides of the fryer, back of the stove, and floor, but the pipe would be the responsibility of maintenance. She said the floor, and surrounding area were to be done once a week and when the fryer was changed, and the task had just been overlooked and had not gotten done. The DM reported there was a potential for a fire hazard, and moving forward disciplinary action would be taken if that cleaning had not been done as required. She said the expectations for kitchen staff were for them to follow the facility's procedures to keep the kitchen area clean, free of grease, and other debris, and staff had everything necessary to ensure that was being done. The DM stated in regard to food storage and food safety kitchen staff should be using the first in first out (FIFO) method and ensure storage procedures were followed to include covering and/or resealing and labeling and dating those food items. She explained if staff were not following those procedures, the food could be past its expiration, contaminated and could potentially cause food borne illness or other sickness for the residents. Additionally, she stated her expectations for all kitchen staff was for all hair to be pulled back and secured with a hairnet at all times. She further stated that would prevent hair from falling into food that could cause potential cross contamination and sickness. In interview with the Administrator, on 09/12/2025 at 4:30 PM, she stated she had not previously believed food that was freezer burnt would make the residents sick. She said however, she expected dietary staff to follow the facility's policy for food storage to prevent contamination. The Administrator reported she expected all staff to wear their hairnets properly to ensure all hair was covered so that hair would not get into the resident's food. She stated she had not thought grease that was splattered all over the floor, walls, pipes, and appliances in the kitchen would be a hazard for the residents. The Administrator further stated however, there could be a potential for a grease fire if that area was not cleaned thoroughly and regularly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, 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 2 of 3 residents sampled for wound care out of the total sample of 20, (Resident (R)2 and R6). The findings include: Review of the facility's policy titled, Infection Prevention and Control Program, revised on 02/02/2025, revealed it was the facility's policy for hand hygiene to be performed in accordance with the facility's established hand hygiene procedures. Review of the facility's policy titled, Wound Care-Dressing Change, reviewed 03/24/2025, revealed it was the facility's policy to clean the bedside table with facility approved cleaning wipes and use a clean barrier to establish a clean field on resident's overbed table for placement of (wound care) supplies. Continued review of the policy revealed staff providing wound care were to remove their gloves and wash and dry hands thoroughly after removing the dirty (wound) dressing. Further policy review revealed staff were to apply clean gloves before cleansing the wound and remove those gloves and wash and dry hands thoroughly after cleansing the wound. Additional review of the policy revealed it was the facility's policy for staff to put on clean gloves before applying the clean dressing. 1). Review of the Face Sheet for R6 revealed the facility admitted the resident on 07/17/2025, with diagnoses that included unspecified dementia, neuromuscular dysfunction of bladder, chronic kidney disease, and essential hypertension. Review of the admission MDS Assessment, with an ARD of 07/23/2025, revealed the facility assessed R6 as having a BIMS score of 6 out of 15, indicating the resident had moderate cognitive impairment. Observation of R6's wound care on 09/09/2025 at 1:55 PM, revealed the wound care nurse failed to clean or disinfect the bedside table as per policy, before placing the clean dressing change supplies on it and removing the dirty dressing from the resident's left heel. Continued observation revealed the wound care nurse also failed to clean or disinfect her hands after removing the dirty dressing from the wound on R6's left heel and did not change her gloves or sanitize hands before applying the clean dressing. 2). Review of the Face Sheet for R2 revealed the facility admitted the resident on 03/18/2025, with diagnoses that included unspecified dementia, metabolic encephalopathy, pressure ulcer of left hip, unstageable, and other obstructive and reflux uropathy. Review of the Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 08/25/2025, revealed the facility assessed R2 as having a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating the resident had severe cognitive impairment. Observation of R2's wound care on 09/09/2025 at 2:05 PM, revealed the wound care nurse failed to clean or disinfect the bedside table prior to placing the clean dressing change supplies on it. In addition, observation revealed the wound care nurse failed to change her gloves or sanitize her hands after removing the dirty dressing from the wound on R2's right buttock and before applying the new dressing to the wound. During interview with the wound care nurse on 09/10/2025 at 11:00 AM, she stated she knew what she had done wrong during the dressing changes for R2 and R6, as soon as she did it. She said she knew she should have taken her gloves off after removing the dirty dressing, washed her hands, and put on a new pair of gloves before applying the clean dressings. The wound care nurse reported she also should have cleaned and sanitized the bedside tables prior to placing the clean drape and supplies on the bedside tables. She further stated a negative outcome of not changing one's gloves and sanitizing hands during dressing changes was the spread of infections and worsening of the residents' wounds. In interview on 09/10/2025 at 2:55 PM, the Director of Nursing (DON), who was also the facility's Infection Preventionist, stated the wound care nurse was new to her position and had only been doing the residents' wound care for two (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weeks now. She said she expected staff to follow their training and experience when performing the resident's wound care. The DON/IP her expectations also included for staff performing wound care to make sure there was a clean barrier between the bedside table and clean supplies. She reported she also expected staff providing wound care to perform hand hygiene and change their gloves after removing dirty dressing, after cleansing wounds, and before applying clean dressings. The DON/IP explained the wound care nurse received on-spot education and had been assigned lessons about wound care. She said the facility had a skills fair annually and they would be focusing more on infection prevention and were working on having the skills fairs more often. The DON/IP further stated negative outcomes of not cleaning and disinfecting the bedside table that wound care supplies were placed on and not performing hand hygiene after removing dirty dressing, was the risk of infection, spreading of infection, and deterioration of the residents' wound. During interview with the facility's Administrator on 09/12/2025 at 4:20 PM, she stated her expectations was for staff to follow wound care orders and follow the facility's infection control training as nurses and licensed professionals when providing residents' wound care.