STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185253	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carter Nursing and Rehabilitation	250 McDavid Boulevard Grayson, KY 41143

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents were free from verbal abuse and neglect which resulted in actual harm for 1 out of 10 sampled residents, Resident (R) 29. On 08/24/2025, Resident 29 had an incontinent episode and required the assistance of staff to help change her. However, instead of changing the resident, State Registered Nurse Aide (SRNA) 1 became verbally abusive to the resident and both, SRNA1 and SRNA11, neglected to provide the resident hygiene care to remove the feces from the resident. Instead, SRNA 1 and SRNA 11 covered the resident with a feces-covered blanket for a period of over three hours. The resident reported she was scared of SRNA1, and SRNA10 stated this upset the resident, which caused the resident psychosocial harm. The findings include:Review of the facility's policy titled, Abuse, Neglect, Misappropriation and Exploitation Policy, dated 07/01/2025, revealed abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Per the policy, abuse also included the deprivation by an individual, including a caretaker, of goods or services that were necessary to attain or maintain physical, mental, and psychosocial well-being. It included verbal abuse, sexual abuse, physical abuse, and mental abuse. The policy further revealed the facility would train care team members upon hire and annually on how to identify what constituted abuse, neglect, exploitation or misappropriation of resident property; how to recognize signs of abuse, neglect, exploitation or misappropriation of resident property; how Care Team Members should report their knowledge related to allegations without fear of reprisal; and how to recognize signs of burnout, frustration and stress, understanding behavioral symptoms of residents that could increase the risk of abuse and neglect, and how to respond. The policy stated if a Care Team Member was accused or suspected, the facility should immediately remove the Care Team Member from the facility and the schedule pending the outcome of the investigation. 1.Review of R29's admission Record revealed the facility admitted the resident on 05/29/2025 with diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure, human immunodeficiency virus (HIV), muscle weakness, palliative care, and anxiety. Review of R29's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 06/24/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15. That score indicated intact cognition. The MDS further revealed R29 was always incontinent of bowel and dependent on staff for toileting hygiene.2. Review of R130's admission Record revealed the facility admitted the resident on 08/21/2025 with displaced comminuted fracture of right patella, Smith's fracture of left radius, and fracture of left ulna.Review of R130's BIMS revealed the facility assessed the resident to have a score of 15 out of 15, which indicated intact cognition. Since R130 was a new admission, the facility had not completed her admission MDS yet. During an interview on 08/26/2025 at 9:40 AM, R29 stated she had fallen on 08/24/2025 after attempting to self-transfer from bed to wheelchair to allow State Registered Nurse Aide (SRNA) 1 to remove soiled bed (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 0600 Level of Harm - Actual harm Residents Affected - Few	linen from her bed after R29 had a bowel movement in her bed. R29 stated after she fell to the floor, SRNA1 made inappropriate comments such as, I knew you would do that, and, I should have called in today. R29 stated SRNA1 also told her, You do this for attention. R29 further stated that SRNA1 and SRNA11 assisted her back to bed but did not provide hygiene care to remove the feces. She stated SRNA1 and SRNA11 failed to dress her and then covered her with a feces-covered blanket. R29 stated the SRNAs stated they would return with supplies to clean her. However, she stated, after three hours, they had not returned. R29 stated she pressed her call light for assistance and was cleaned up by SRNA10. Resident 29 stated she feared SRNA1 due to being handled roughly during care. She also stated SRNA1 routinely told her she deserved to have HIV. Resident 29 stated SRNA1 and SRNA11 treated her with no respect and had mentally, verbally, and physically abused her. R29 stated she did not tell other staff, including SRNA10 about SRNA1's inappropriate remarks, because she was scared SRNA 1 would lash out at her. During an interview on 08/26/2025 at 10:00 AM, with R29's roommate R130, she stated SRNA1 and SRNA11 treated R29 awful after she fell, explaining the staff accused R29 of falling for attention, and left R29 in feces for an extended period. R130 further stated the pungent odor of bowel movement made her sick to her stomach, and her family had to leave the facility to purchase a room spray. During an interview on 08/28/2025 at 9:17 PM with R130's Family Member (FM) 6, she stated after R29 fell, SRNA1 stated, I knew this would happen. I knew I should have called off today, and You should have had a depend on. FM6 further stated she did not believe SRNA1 or SRNA11 cleaned the feces from R29 after assisting her back to bed, as the strong and prolonged smell of bowel movement remained in the room. She stated the odor made her mother sick, and she had to leave the facility to buy a room deodorizer. FM6 stated R29 remained in the uncleaned condition for approximately three to four hours before another staff member cleaned R29. FM6 further stated when SRNA10 later cleaned R29, she overheard SRNA10 repeatedly apologizing for the condition she had been left in by SRNA1 and SRNA11. During an interview on 08/28/2025 at 11:29 PM with SRNA10, she stated R29 was upset because she had been left in feces and not been cleaned. She stated R29 explained that SRNA1 and SRNA11 told R29 they would get supplies to clean her but never returned. SRNA10 further stated the feces appeared to have been on R29 for a while before she provided cleaning. SRNA10 stated it was inappropriate for SRNA1 and SRNA11 to leave the resident in that condition.During an interview on 08/28/2025 at 9:17 PM with SRNA1, she stated she did not make inappropriate remarks to R29. She also stated she did not leave R29 soiled for three hours.The State Survey Agency (SSA) Surveyor attempted to reach SRNA11 per telephone on 08/26/2025, 08/27/2025, and 08/28/2025. However, she did not answer the telephone.During an interview on 08/28/2025 at 9:54 PM, Licensed Practical Nurse (LPN) 1 stated R29 appeared angry while she conducted a skin assessment following the fall. LPN1 further stated she believed the resident was having an anxiety attack and repeatedly told her, I'm sorry I messed on myself.During an interview on 08/28/2025 at 5:04 PM with the Administrator, she stated Resident 29 had not reported anything to her, and she had been unaware of the incident until the State Survey Agency (SSA) Surveyor brought it to her attention on 08/26/2025. She stated she was going to immediately talk with Resident 29 and left the room.During additional interview with the Administrator on 08/28/2025 at 5:24 PM, she stated she suspended SRNA1 and SRNA11, reported the incident to the Office of Inspector General (OIG) and the local police, and began the investigation on 08/26/2025. She stated R29 told her about the poor care and neglect by SRNA1 and SRNA11 but did not tell her about SRNA1's abusive remarks to her. She stated R29 requested that neither staff member provide her care in the future.

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, State Registered Nurse Aide (SRNA) 10 failed to immediately report an allegation of staff abuse/neglect for 1 of 10 sampled residents, Resident (R) 29.SRNA10 did not notify the Administrator when R29 reported to her that SRNA1 and SRNA11 failed to provide timely hygiene care and left R29 soiled for hours after an episode of fecal incontinence on 08/24/2025. Resident 29 stated the SRNAs actions were neglectful of her care which made her scared of SRNA1, and SRNA10 reported the resident was visibly upset, causing the resident psychosocial harm.Refer to F600The findings include:Review of the facility's policy titled, Abuse, Neglect, Misappropriation and Exploitation Policy, dated 07/01/2025, revealed abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy also stated abuse included the deprivation by an individual, including a caretaker, of goods or services necessary to attain or maintain physical, mental, and psychosocial well-being. It included verbal abuse, sexual abuse, physical abuse, and mental abuse. It further revealed the facility would train Care Team Members, upon hire and annually, on how to identify what constituted abuse, neglect, exploitation or misappropriation of resident property; how to recognize signs of abuse, neglect, exploitation or misappropriation of resident property; and how Care Team Members should report their knowledge related to allegations without fear of reprisal. Per the policy, all allegations of abuse, neglect, or misappropriation of resident property must be reported immediately to the Administrator and to the Department of Health, but in no event later than 24 hours from the time of the incident/allegation was made known to the Care Team Member. The policy stated if a Care Team Member was accused or suspected, the facility should immediately remove the Care Team Member from the facility and the schedule pending the outcome of the investigation. Review of R29's admission Record revealed the facility admitted the resident on 05/29/2025 with diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure, human immunodeficiency virus (HIV), muscle weakness, palliative care, and anxiety. Review of R29's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 06/24/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15. That score indicated intact cognition. The MDS further revealed R29 was always incontinent of bowel and dependent on staff for toileting hygiene.During an interview on 08/26/2025 at 9:40 AM, R29 stated she fell on [DATE] after attempting to self-transfer from her bed to her wheelchair to allow SRNA1 to remove soiled bed linen from her bed after she had a bowel movement. R29 stated, after she fell to the floor and while she was still on the floor, SRNA1 made inappropriate comments such as, I knew you would do that, and, I should have called in today. R29 stated SRNA1 also told her, You do this for attention. R29 further stated SRNA1 and SRNA11 assisted her back to bed but did not provide hygiene care to remove the feces. She stated SRNA1 and SRNA11 failed to dress her and then covered her with a feces-covered blanket and told her they would return with supplies to clean her. However, she stated, after three hours, they had not returned. R29 stated she pressed her call light for assistance and was cleaned up by SRNA10. R29 stated SRNA10 repeatedly apologized for the condition R29 was left in and excused herself to get a special spray to help remove the dried feces. R29 stated she did not tell other staff, including SRNA10 about the inappropriate comments, because she was scared SRNA 1 would lash out at her. During an interview on 08/28/2025 at 9:17 PM with Family Member (FM) 6, relative of R29's roommate, she stated she was in the room when the incident happened. FM6 stated, after R29 fell, SRNA1 stated, I knew this would happen. I knew I should have called off today, and, You should have had a (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	depend on. FM6 further reported she did not believe SRNA1 or SRNA11 cleaned the feces from R29 after assisting her back to bed, as the strong and prolonged smell of bowel movement remained in the room. She stated the odor made R29's roommate sick, and she had to leave the facility to buy a spray deodorizer. FM6 stated R29 remained in this soiled condition for approximately three to four hours before another staff member cleaned her. FM6 further stated when SRNA10 cleaned R29, she overheard SRNA10 repeatedly apologizing to R29 for the condition she had been left in by SRNA1 and SRNA11. During an interview on 08/28/2025 at 11:29 PM with SRNA10, she reported R29 was upset SRNA1 and SRNA11 had left her lying in feces for hours after they told her they would return after gathering supplies to clean her. SRNA10 stated the feces appeared to have been on R29 for a while, and it was inappropriate for SRNA1 and SRNA11 to leave R29 in that condition. SRNA10 further stated she did not report the incident because R29 frequently complained, and she did not want to say anything that might get SRNA1 and SRNA11 in trouble.During an interview on 08/28/2025 at 5:04 PM with the Administrator, she stated Resident 29 had not reported anything to her, and she had been unaware of the incident until the State Survey Agency (SSA) Surveyor brought it to her attention on 08/26/2025. She stated she was going to immediately talk with Resident 29 and left the room.During additional interview with the Administrator on 08/28/2025 at 5:24 PM, she stated she suspended SRNA1 and SRNA11, reported the incident to the Office of Inspector General (OIG) and the local police, and began the investigation on 08/26/2025. She stated R29 told her about the poor care and neglect by SRNA1 and SRNA11, and the resident requested that neither staff member provide her care in the future. She stated R29 did not tell her about SRNA1's abusive remarks to her. She also stated the facility had not yet completed an investigation of the incident.During an interview on 08/26/2025 at 6:00 PM, the Administrator stated she expected staff to always report inappropriate comments or behaviors to her.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and facility policy review, the facility failed to assure that all services, as outlined by the comprehensive care plan being provided, met professional standards of quality for 1 of 6 residents reviewed for medication administration, Resident (R) 42.Review of R42's Medication Administration Record (MAR) and interviews from staff revealed the resident was administered a Zofran tablet (used to treat nausea) on 08/29/2025 at 3:54 PM by Kentucky Medication Aide (KMA) 14 without a standing order or provider's order for Zofran. The findings include:Review of the facility policy's titled, Medication Administration, dated 12/12/2023, revealed medications were administered, as ordered by the physician and in accordance with professional standards of practice.Review of R42's Face Sheet revealed the facility admitted the resident on 01/31/2018 with diagnoses of dementia, diabetes, and congestive heart failure (CHF). Review of R42's quarterly Minimum Data Set [MDS], with an Assessment Reference Date of 06/19/2025, revealed the facility assessed the resident to have a Brief Interview Mental Status [BIMS] score of three out of 15, indicating R42 was severely cognitively impaired.Review of R42's Care Plan, dated 01/18/2022, revealed an intervention to administer /medications as ordered.Observation on 08/29/2025 at 3:31 PM, while the State Survey Agency (SSA) Survey was in the South Hall medication room, a staff member came to the medication room and made Licensed Practical Nurse (LPN) 11 and KMA14 aware that R42 wanted something for nausea. KMA14 checked Point Click Care (PCC, a software program) and did not see an order. KMA14 made LPN11 aware there was no order. LPN11 then stated Zofran was a standing order (written protocols that authorize designated members of the health care team to complete certain clinical tasks without having to first obtain a physician order) and exited the medication room. Review of the facility's Standing Orders revealed Zofran was not listed as a standing order.Review of R42's Physician's Orders revealed an order for Zofran 4 milligams (mg) tablet by mouth every six hours as needed for nausea was entered on 08/29/2025 at 3:52 PM by LPN11 and under the Medical Director's name as the ordering provider. Review of R42's MAR revealed a Zofran 4 mg tablet was administered at 3:54 PM by KMA14.During an interview on 08/29/2025 at 4:22 PM with the Medical Director, she stated she thought standing orders might have been recently updated. She stated she would like to be notified if any resident was ordered and given a new medication, so she knew what the residents were receiving. She stated she did not recall Zofran being a standard order. She stated no one called her regarding Zofran for R42. She stated she would have questions about Zofran and would need to be familiar with the resident before Zofran was ordered and given.During an interview on 08/29/2025 at 5:22 PM with LPN11, she stated she was mistaken and thought Zofran was a standing order. She stated she should have obtained an order before the medication was administered. She stated she did get an order from the Nurse Practitioner (NP) on 08/29/2025 at approximately 4:50 PM and was going to correct the order that was entered to reflect the correct ordering provider. During an interview on 08/29/2025 at 5:24 PM with KMA14, she stated LPN2 pulled the Zofran from the Pyxis (an automated dispensing medication system) for her to administer to R42.However, review of a Pyxis report could not be done because the facility was unable to generate one.During an interview on 08/29/2025 at 5:27 PM with the Director of Nursing (DON), she stated it was her expectation for staff to know what was on the standing order list and an order be received before administering any medication not on that list. She stated that was important for safety reasons. During an interview on 08/29/2025 at 7:13 PM with the Administrator, she stated it was her expectation for staff to obtain a physician's order for all medications. She stated standing orders were updated annually, and staff was educated about the updates. She also stated copies of standing orders were provided to both nursing stations. She stated that was important for safety (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	precautions for residents and was a requirement for staff to stay within their scope of practice.