STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henson Park Health & Rehabilitation	203 Bruce Court Danville, KY 40422

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 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, and facility document review, the facility failed to ensure 1 (room [ROOM NUMBER]) of 45 resident rooms had a homelike environment. Specifically, room [ROOM NUMBER] was observed with ceiling tiles bulging downward and with brown stains.Findings included: An observation on 07/16/2025 at 8:38 AM revealed ceiling tiles in room [ROOM NUMBER] were bulging downward, and other ceiling tiles were noted with brown stains. An observation on 07/17/2025 at 10:55 AM revealed ceiling tiles in room [ROOM NUMBER] were bulging downward, and other ceiling tiles were noted with brown stains. An additional ceiling tile in the bathroom of room [ROOM NUMBER] was also noted with brown stains. A facility document titled, Work Order #856, dated 04/29/2025, revealed staff reported that room [ROOM NUMBER] had one tile by the bathroom door that needed to be popped back up and one tile near the window had cracks. The Work Order indicated the Maintenance Director updated the status of the Work Order to completed on 05/20/2025, with Comments that reflected, fixed. During a concurrent observation and interview with Licensed Practical Nurse (LPN) #1 on 07/17/2025 at 10:55 AM, ceiling tiles above the foot of the resident bed in room [ROOM NUMBER] were observed with brown stains and were bulging downward. Upon entrance to the resident's bathroom, one ceiling tile was observed with brown stains. LPN #1 stated she had not seen the bulging ceiling tiles or brown stains previously. LPN #1 stated that when there were issues with resident rooms, the information was input into The Equipment Lifecycle Systems (TELS), and maintenance was then responsible for fixing the concern. She stated staff were trained and expected to place any information regarding maintenance issues into the maintenance system. During an interview on 07/17/2025 at 11:17 AM, the Maintenance Director stated the facility used the TELS system to track any preventative or corrective maintenance for the building. He stated anyone was able to access the system to document concerns or issues, and once a work order was entered, he received an alert. The Maintenance Director stated he trained staff and expected them to be able to input a work order. He stated the facility did not have a written policy addressing the TELS system. During an interview on 07/17/2025 at 3:06 PM, the Assistant Director of Nursing (ADON) stated staff were trained and expected to ensure everything in a resident's room worked. The ADON stated that daily, staff should ensure there were no hazards in residents' rooms when they made rounds. She stated staff were trained to report any identified issues using the TELS system. During an interview on 07/17/2025 at 3:25 PM, the Administrator stated she expected things to be in good working order, including ceiling tiles. She said staff were trained and expected to put in work orders if there were any concerns or issues with a resident's room.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to ensure supplemental oxygen tubing was dated when changed and the physician-prescribed supplemental oxygen flow rate was followed for 1 (Resident #1) of 2 sampled residents reviewed for respiratory care.Findings included: An undated facility policy titled, Oxygen Administration, revealed, 5. Turn on the oxygen at the number of liters / [per] minute as ordered by the physician/practitioner. 6. Place appropriate oxygen device on the resident (i.e., [id est, that is] mask, nasal cannula and/or nasal catheter). 7. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is administered. An admission Record indicated the facility admitted Resident #1 on 05/28/2025. According to the admission Record, the resident had a medical history that included diagnoses of metabolic encephalopathy, chronic obstructive pulmonary disease (COPD), chronic pulmonary edema, and obstructive sleep apnea. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/04/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had shortness of breath or trouble breathing when lying flat and used supplemental oxygen during the assessment period. Resident #1's Care Plan Report included a focus area, initiated on 05/29/2025, that indicated the resident was at risk for respiratory complications secondary to COPD, pulmonary edema, obstructive sleep apnea, a history of smoking, dysphagia (difficulty swallowing), coronary artery disease, and a history of cerebrovascular accident. An intervention dated 05/29/2025 directed staff to administer supplemental oxygen as ordered. Resident #1's July 2025 Treatment Administration Record (TAR) revealed transcription of an order started on 05/28/2025 for supplemental oxygen at 2 liters per minute by way of nasal cannula, continuously. The July 2025 TAR revealed no orders for or documentation of changing or dating the resident's supplemental oxygen tubing. An observation on 07/15/2025 at 1:00 PM revealed Resident #1was receiving supplemental oxygen at a flow rate of 3 liters per minute. The resident's supplemental oxygen tubing was observed without a date to indicate when the tubing was last changed. An observation on 07/16/2025 at 11:26 AM revealed Resident #1was receiving supplemental oxygen at a flow rate of 3 liters per minute. The resident's supplemental oxygen tubing was observed without a date to indicate when the tubing was last changed. During an interview on 07/17/2025 at 10:45 AM, Licensed Practical Nurse (LPN) #1 stated the night shift nurses were responsible for changing out the supplemental oxygen tubing and for labeling the tubing. Per LPN #1, the nurses obtained the correct oxygen flow rate from the physician's orders. LPN #1 stated she checked the oxygen flow rate for residents every shift but had not checked the flow rates as of the time of the interview. LPN #1 stated staff were trained and expected to ensure the residents' oxygen flow rates were correct and to label the supplemental oxygen tubing when it was changed. During an interview on 07/17/2025 at 3:11 PM, the Assistant Director of Nursing (ADON) stated the night shift nurses were responsible for changing out the residents' supplemental oxygen tubing. The ADON stated staff were expected to date and initial the tubing when it was changed. The ADON stated staff were trained and were expected to follow physician's orders to maintain oxygen equipment. During an interview on 07/17/2025 at 3:19 PM, the Administrator stated staff were trained and were expected to follow physician's orders.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain clean and sanitary conditions in the facility's kitchen; failed to ensure proper setup of the three-compartment sink; and failed to not have personal items in the food handling area. This had the potential to affect all residents who received nutrition from the kitchen.Findings included: An initial tour of the kitchen was done on 07/15/2025 beginning at 9:20 AM with the Intern Dietary Manager (IDM) and revealed the following:-The floors of the walk-in refrigerator located inside the kitchen were sticky with a black substance on the floor. The IDM agreed the floors were dirty.-Debris and a black substance were visible on the kitchen floor between the dish station and the wall. The IDM agreed the floor was dirty.-Debris and a black substance were visible on the floor between the coffee station and the wall.-Personal sunglasses were observed on the second shelf of the cart that held the coffee, creamer, and sugar.-The tube light above the stove was observed covered with dust, and the light fixture had spots of rust.-The entire kitchen ceiling was observed with spots where paint was peeling off the tiles and some areas of the tiles had separated from the ceiling, leaving visible holes in the ceiling. The IDM agreed the kitchen ceiling did not look clean.-The IDM tested the sanitizer concentration of the three-compartment sink using a test strip. The strip showed orange, which indicated there was no sanitizing solution being dispensed from the dispenser. The IDM stated sometimes the Maintenance Director came to the kitchen to jiggle the hose and then the dispenser would work again. A concurrent interview was held on 07/15/2025 at 9:20 AM with Dietary Aide (DA) #2, DA #3, and the IDM. DA #3 stated they did not know how to check the sanitizer level for the three-compartment sink. The IDM stated there was another DA who usually worked the three-compartment sink and did the sanitizer testing, but the IDM did not know who did the testing when that DA was off work. The IDM said the kitchen was deep cleaned weekly, which included the baseboards, walls, stainless steel items, the wheels on the carts, and everything that needed to be cleaned. During an interview on 07/17/2025 at 1:47 PM with the IDM and the Administrator (ADM), the IDM stated their expectation was that the kitchen be kept clean with no personal items in the kitchen. The ADM said their expectation was that the kitchen be cleaned daily and remain clean