

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2025
NAME OF PROVIDER OR SUPPLIER Stonecreek Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4747 Alben Barkley Drive Paducah, KY 42001	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**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 a safe, clean homelike environment for 1 of 26 sampled residents, (Resident (R)21). The findings include: Review of the facility policy titled, Accidents and Supervision, last reviewed/revised 06/01/2025, revealed the resident environment was to remain as free of accident hazards as was possible. Per review, Environment referred to any environment or area in the facility that was frequented by or accessible to residents, including (but not limited to) the residents' rooms and bathrooms. Continued policy review revealed Hazards referred to elements of the resident environment that had the potential to cause injury or illness. Further review revealed Risk referred to any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influenced the likelihood of an accident. In interview on 12/03/2025 at 3:02 PM, R21 stated his commode needed repairing. Observation of R21's commode (in room [ROOM NUMBER]) on 12/03/2025 at 3:10 PM, revealed the base of the resident's commode was not secured to the floor and therefore, caused it to rotate side to side. Further observation revealed the commode also rocked front to back. Observation of R21's commode on 12/04/2025 at 4:20 PM, revealed the commode to be in the same unstable condition as the previous day. Further observation revealed there were multiple brown paper towels stuffed between the base of the commode and the floor in attempts to stabilize or level the commode. In interview on 12/05/2025 at 12:35 PM, the Maintenance Assistant stated he thought it was just a few days ago that he and his boss pulled the old commode in R21's bathroom and installed the current one. He said the commode had been installed incorrectly; however, stated, what was I supposed to do, he was my boss? The Maintenance Assistant reported in his opinion, R21's commode was unstable and unsafe, and that needed to be corrected. He explained he would get with the Administrator about the commode. The Maintenance Assistant stated it was his guess the brown paper towels had been shoved between the commode and floor by the nurse aides trying to help. Observation of the commode, with the Maintenance Assistant, during the interview, revealed the commode was in the same condition as the previous observations. In interview on 12/06/2025 at 4:20 PM, the Administrator stated she had been made aware of R21's commode condition on the previous day by the Maintenance Assistant. She further stated a plan was to be developed to make the needed repairs to the commode. The Administrator additionally stated in her opinion the commode was a potential safety hazard.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 185312	If continuation sheet Page 1 of 6

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, the facility failed to ensure a medication error rate less than 5 percent (%), which affected 1 of 8 residents sampled during medication observation, (Resident (R)50). The findings include: Review of the facility policy titled, Medication Administration, last reviewed on 06/01/2025, revealed medications were to be administered as ordered by the physician. Further review revealed the Medication Administration Record (MAR) was to be reviewed to identify the medication to be administered. Review of the facility's MAR for R50, dated 12/04/2025, for revealed one hydrocodone-acetaminophen 5 - 325 milligram (mg) tablet (a narcotic medication used to treat moderate to severe pain) ordered for administration at 4:00 PM. Continued review revealed saccharomyces boulardii 250 mg (a probiotic yeast used to support gut health), one capsule ordered for administration between 7:00 PM and 11:00 PM. Observation on 12/04/2025 at 8:30 PM, revealed Licensed Practical Nurse (LPN) 3 noting the 4:00 PM dose of R50's hydrocodone-acetaminophen had not been administered while the LPN was reviewing the resident's MAR during the bedtime medication preparation. Continued observation revealed no documented reason for why the dose of R50's hydrocodone-acetaminophen had been omitted. Additionally, observation of LPN 3, while preparing the scheduled medications, revealed the LPN discovered no saccharomyces boulardii was available for administration. During interview with LPN 3 on 12/04/2024 at 8:50 PM, she stated she added the documentation of Not Administered: Other onto R50's MAR regarding the 4:00 PM omitted dose of hydrocodone-acetaminophen. She said the missed dose of that medication would not be made-up because it had not been noticed until several hours after it was due to be administered. The LPN explained at that time (8:50 PM) it had been too close to the next scheduled dose (at 12:00 AM) for the narcotic medication to be safely administered. She reported the ordering physician/Medical Director would be notified of the 4:00 PM dose having been missed. LPN 3 further stated if R50 requested something for pain before the 12:00 AM dose of hydrocodone-acetaminophen could be administered; Tylenol would be given to the resident. Review of the MAR revealed, Not Administered: Drug/Item Unavailable was documented by LPN 3 for the missing saccharomyces boulardii dose. In continued interview on 12/04/2024 at 8:50 PM, LPN 3 stated the ordered saccharomyces boulardii bedtime dose was not available in the medication cart to administer to R50. She said she checked the facility's pyxis (medication storage cabinet) and there had been no saccharomyces boulardii available. LPN 3 reported she did not know why there was none of the medication available for administration or why it had not previously been ordered by someone else. The LPN said she ordered the replacement medication. She further stated the ordering physician/medical director would also be notified of the missed dose of R50's saccharomyces boulardii. During interview on 12/06/2025 at 3:31 PM, the Director of Nursing (DON) stated if the medication cart had none of an ordered medication, the nurse was to check the facility's omnicell (another name for a medication cabinet) to see if there was an extra supply of the missing medication. The DON said there was a button on the electronic medical record (EMR) to reorder medications when they were running low. She reported whoever was passing medication when a medication reached the designated reorder level was responsible for re-ordering the medication to ensure the supply remained available. The DON additionally stated she expected staff to follow the physician orders and expected residents receive their medications as ordered. During interview on 12/0/2025 at 4:20 PM, the Administrator stated she was not aware of the exact process for reordering medications; however, did know there was a button on the EMR to re-order medications. The Administrator further stated her expectation was for all residents to get their medications as ordered.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 4 residents sampled for infection control out of the total sample of 26 residents, (Residents (R)4, R91, R93, and R95). The findings include: Review of the facility policy titled, Transmission-Based Precautions revised 05/21/2025, revealed it was the facility's policy to take appropriate action to prevent the transmission of infectious agents, based on the agents' modes of transmission. Per policy review, healthcare personnel caring for residents on Contact Precautions were to wear a gown and gloves for all interactions that might involve contact with the resident or potentially contaminated areas in the resident's environment. Continued review revealed staff must don personal protective equipment (PPE) upon entry and discard the PPE before exiting the resident's room for residents in Contact Precautions. Further review revealed donning PPE upon room entry and discarding it before exiting the room was done to contain pathogens, especially those that had been implicated in transmission through environmental contamination. 1). Review of the Face Sheet for R95 revealed the facility admitted him on 11/28/2025, with diagnosis which included enterocolitis due to Clostridium difficile, type 2 diabetes mellitus with foot ulcer, and arteriovenous fistula, acquired-left upper arm. Further record review revealed the facility had not yet completed the admission Minimum Data Set (MDS) Assessment for R95; therefore, the Brief Interview for Mental Status (BIMS) score had been assessed for the resident. Review of the General Orders for R95 revealed an order received and started on 12/03/2025, for the resident to be in Isolation Type: Contact related to a diagnosis of Clostridium Difficile (C-Diff - a highly contagious bacterium that causes diarrhea and colitis). In interview with Certified Nurse Aide (CNA) 2 on 12/04/2025 at 11:55 AM, she stated she was familiar with R95; however, did not know why the resident was on contact precautions. She added that he may have fell or something, she was not sure. Observation on 12/05/2025 at 12:45 PM, revealed Certified Occupational Therapy Assistant (COTA) 2 pushing R95 in his wheelchair out of his room and through the hallway to the therapy room. Per observation, neither COTA 2, nor R95 were wearing any PPE. In interview with COTA 2 on 12/05/2025 at 12:47 PM, in R95's presence, he confirmed the resident was on contact precautions. He stated contact precautions meant, you have to put on a gown when you go in the room. COTA 2 said he had a gown on when he was in R95's room, but had taken it off before he exited the room with the resident. When the State Survey Agency (SSA) Surveyor asked if a resident should leave his room when contact precautions were ordered, COTA 2 did not respond and answer the question; however, R95 stated, I've been leaving my room. 2). Review of the Resident Face Sheet for R91 revealed the facility admitted the resident on 10/13/2025, with diagnoses of paroxysmal atrial fibrillation, chronic fatigue, and adult failure to thrive. Per continued review, a diagnosis of pressure ulcer of unspecified buttock, stage 3, was added on 10/23/2025. Further review revealed on 12/03/2025, a diagnosis of pressure ulcer to right buttock, unstageable, was added to the diagnosis list. Review of R91s physician orders dated 12/04/2025, revealed an order that read isolation type, contact related to Methicillin Resistant Staph Aureus (MRSA). Review of the admission MDS Assessment, with an Assessment Reference Date of 10/17/2025, revealed the facility assessed R91 to have a BIMS score of 13 out of 15, indicating intact cognition. Review of the physician orders dated 12/03/2025 for R91 revealed an order for isolation, type, contact, related to coccyx wound infection, pseudomonas/staph (Staphylococcus aureus and Pseudomonas aeruginosa most common bacteria co-isolated from chronic infected wounds). Review of R91's Comprehensive Care Plan dated 10/14/2025, the facility care planned the resident as being under EBP for an indwelling</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>urinary catheter. Per review, the interventions dated 10/14/2025, included encouraging R91 to participate in activities of choice, as tolerated to ensure psychosocial well-being, isolation per the physician's order, and promoting the resident's psychosocial well-being while in isolation. Continued review revealed all interventions on the care plan for EBP were dated 10/14/2025. The goal was that R91 would not have complications related to being in isolation. Further review revealed on 12/03/2025, the care plan had been edited and changed to read: contact precautions for Pseudomonas and Staph in the wound. Observation on 12/03/2025 at 2:11 PM, revealed Certified Nursing Assistant (CNA) 8 entering R91's room without donning PPE, even though there was signage on the door frame that read Contact Precautions. In interview with CNA 8, at the time of observation, she stated she had just been putting a blanket on R91, and thought she only had to put PPE on when she was performing direct care for the resident. CNA 8 reviewed the signage on R91's door, and stated she should have put on a gown and gloves prior to entering the resident's room. 3). Review of the Resident Face Sheet for R93 revealed the facility admitted the resident on 12/02/2025, with diagnosis of adult failure to thrive, acute kidney failure, sepsis, and Methicillin-resistant Staphylococcus Aureus (MRSA). Review of Resident 93's Entry MDS Assessment with an ARD of 12/02/2025, revealed the facility assessed the resident to have a BIMS score of 99, which indicated the interview was not completed. In interview with R93 on 12/03/2025 at 12:23 PM, he stated he just got to the facility last night. R93 further stated he was at the facility, just for rehabilitation and doesn't know anything about any precaution status. Observation on 12/03/2025 at 4:32 PM, revealed R93 was had signage outside the room indicating the resident was on isolation precautions. Continued observation revealed CNA 1 walked out of R93's room with no PPE in place. Further observation revealed CNA 1 walked to the linen cart located in the hallway, obtained a washcloth and returned to the R93's room without donning PPE. In interview with CNA 1 on 12/03/2025 at 4:51 PM, she stated she had been under the impression she did not have to don PPE if she was taking care of R93's roommate and would get clarification on that. She further stated she had been informed by her superior that as long as she was not providing care for the affected resident she did not have to don PPE. Observation on 12/03/2025 at 4:53 PM, revealed Housekeeper (HK) 1 entering R93's room without donning PPE and removing trash bags with her bare hands. Continued observation revealed after leaving R93's room, HK 1 continued to enter another resident's room to empty the trash receptacle. In interview with HK 1 on 12/03/2025 at 4:57 PM, she stated she had been employed at the facility for about eight months. She said she did not wear gloves when she was removing the trash because she did not want to change gloves so frequently. HK 1 said so she just picked up the trash with her bare hands and used hand sanitizer after each room. She reported she had not been told anything about contact isolation rooms. HK 1 further stated she had not donned PPE when she went to remove the trash from R93's room because she just doesn't do that. Observation on 12/04/2025 at 12:36 PM, revealed that CNA 6, CNA 7, and COTA 1 were in R93's room with no PPE in place, even though there was signage indicating the resident was on contact precautions. In interview with COTA 1, during the observation, she stated it was her first day working with R93. The COTA said she had not seen the contact precaution sign posted on the resident's door frame. In interview with CNA 6 on 12/04/2025 at 12:40 PM, he stated he had been following what he had been told to do by the facility's Infection Control (IC) nurse. He further stated he had not had to don PPE before prior to entering a resident room who was in contact precautions, unless he was providing direct care to the resident. In interview with CNA 7 on 12/04/2025 at 12:45 PM, she stated she had not seen the sign posted on the door frame indicating R93 was in contact precautions. The CNA reviewed the sign outside R93's door, and said she should have paid attention to it and donned PPE prior to entering the room. 4).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Resident Face Sheet for R4 revealed the facility admitted the resident on 03/27/2024, with diagnoses of congestive heart failure, chronic kidney disease and diabetes mellitus. Review of the Quarterly MDS Assessment, with an ARD of 09/18/2025, revealed the facility assessed R4 as having a BIMS score of 13 out of 15, indicating intact cognition. Observation on 12/04/2025 at 2:33 PM, revealed CNA 4 and CNA 5 were providing direct care to R4. Per observation, R4 who had signage in place outside the room for Enhanced Barrier Precaution (EBP). Further observation revealed neither of the CNAs were wearing PPE as required. In interview with CNA 4, during the observation, she stated she had forgotten to put on PPE as required. In interview with CNA 5 on 12/04/2025 at 2:33 PM, she stated she had just run into the room to help CNA 4 and had forgotten to put PPE on. CNA 4 stated she had received education provided by the Staff Development Coordinator that morning on PPE. Interview with CNA 5 on 12/04/2025 at 2:33 PM, during observation, she stated she had just run into the room to help CNA 4 and forgot to put PPE on. CNA 5 stated she was provided education by the Staff Development Coordinator this morning. (12/04/2025) on PPE. In interview with Licensed Practical Nurse (LPN) 1 on 12/03/2025 at 4:47 PM, she stated if you have a resident in contact precautions in a room you would still dress out in PPE even if you were not doing anything for the resident that was on the precautions. In interview with the Environmental Services Manager (ESM) on 12/06/2025 at 10:31 AM, she stated isolation contact rooms required staff to don full PPE. She stated she had always informed staff they should suit up for everything because you just don't know. The ESM reported if a resident had a yellow caddy hanging on their door regardless if signage was present or not. She stated staff should just don PPE to be safe. The ESM further stated the potential negative outcome of not donning PPE was possible cross contamination, disease transfer or you could become contaminated yourself with the organism. In interview on 12/06/2025 at 2:49 PM, the Assistant Director of Nursing (ADON) stated there had been no concerns before that week related to contact precautions. She stated staff had been made aware during huddle that a resident had been placed on precautions and the nurse would let the aides know more after report. The ADON said signage was placed beside the resident's door when TBP were ordered. She reported before staff went in the room of a resident on contact precautions, they need don PPE. The ADON explained there had been some confusion on whether or not staff needed to don PPE if they were going in the room to care for the affected resident or if they were going into the room in general. She further stated the correct approach was to don PPE if you were going into the room period. In interview with the Staff Development Coordinator/Infection Prevention Nurse (SDC/IP) on 12/06/2025 at 10:50 AM, she stated when a resident had contact precautions ordered staff were to put on PPE when they went into the resident's room and remove the PPE when they came out of the room. She said she thought staff were getting confused on the precautions and had since been reeducated on the facility's contact isolation precautions. The SDC/IP Nurse reported staff were to pay attention to signage which directed them on which transmission-based precaution (TBP) was applicable to the resident. She stated for a resident who had contact precautions ordered, their therapy was to be performed in the their room. The IP Nurse further stated possible outcomes from not doing proper hand hygiene and donning/doffing PPE, was the potential for staff to pass the bacteria/infection to another resident. In interview with the Assistant Director of Nursing (ADON) on 12/06/2025 at 2:49 PM, she stated staff were made aware during huddle that a resident had been placed on precautions, and when the nurse got report on a resident, she would let all other staff on the unit know about the precautions that day. The ADON said signage was placed outside the resident's room door to indicate the precautions. She further stated before staff went in the contact isolation resident's room they needed to put on PPE regardless. In interview with the Director of Nursing (DON) on 12/06/2025 at</p> <p>(continued on next page)</p>		

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