STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185341	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Acres Healthcare	402 W. Farthing Street Mayfield, KY 42066

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to inform the resident representative when there was a significant change a resident's status for 1 of 4 residents sampled for notification, out of 6 total sampled residents (Resident (R)1). The findings include:Review of the facility policy titled, Notification of Changes, reviewed [DATE], revealed when there was a change in a resident's condition requiring notification, the facility was to promptly inform the resident, consult the resident's physician, and notify the resident's representative (ex. new treatment or significant change in the resident's physical condition).Review of the closed record Facesheet for R1 revealed the facility admitted the resident on [DATE], with diagnoses to include: pressure-induced deep tissue damage of sacral region, traumatic subdural hemorrhage, and malnutrition. Review further revealed R1 was discharged to the hospital on [DATE], where he expired on [DATE].Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed R1 to have a Brief Interview for Mental Status (BIMS) score of a seven out of 15, indicating the resident was severely cognitively impaired.Review of the progress note dated [DATE] at 10:55 AM, revealed the wound care Advanced Practice Registered Nurse (APRN) gave a new order for skin prep to the tissue surrounding R1's sacrum wound, apply medical grade honey to the wound bed, cover daily and as needed. Continued review revealed additional orders which included Triad cream (cream utilized to treat wounds) to the left gluteal fold twice a day and as needed. Review revealed R1 was noted to have a new Deep Tissue Injury (DTI) to the left heel and orders given to paint the DTI with betadine and leave open to air. Additional review revealed the APRN recommended an x-ray of R1's right heel to rule out osteomyelitis. Further review revealed however, no documented evidence the resident's Power of Attorney (POA) was notified of R1's change in condition (new DTI) or the APRN's new orders.Review of the physician's orders revealed the left heel X-ray order per a verbal order which had been entered. Record review revealed however, the left heel x-ray was not obtained until [DATE], seven days after the APRN's order. During interview with the DON on [DATE] at 1:50 PM, she stated the x-ray findings were that of osteomyelitis. During interview with R1's POA on [DATE] at 11:15 AM, he stated there had been no communication from the facility regarding the resident's condition. He stated he was unaware R1's wounds were as bad as they were. The POA reported when the family visited, R1's wounds were wrapped and the staff would describe the resident's wounds as a bad bruise. He said he was never informed R1 had a bone infection or had been prescribed antibiotics for the infection. The POA further stated if family had known the wounds were that bad, they would have had something done about them sooner.During interview with Licensed Practical Nurse (LPN) 3 on [DATE] at 3:55 PM, she stated on [DATE], she performed wound rounds with the APRN. LPN 3 reported she could not recall if she notified R1's POA of the new orders the APRN had given for R1; however, she should have done that. She stated if she had done that, she would have (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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NAME OF PROVIDER OR SUPPLIER Green Acres Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. Farthing Street Mayfield, KY 42066	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the notification in a progress note. The LPN further stated she did not have access to the system to enter radiology orders and so, she notified the Director of Nursing (DON) that R1 needed an x-ray order entered. She additionally stated the POA should have been notified as soon as possible.During interview with the DON on [DATE] at 1:50 PM, she stated the wound care nurse rounding with the APRN had been responsible for notifying the resident's family and obtaining and entering any new orders. She reported the nurse should have contacted the physician to obtain the x-ray order and then should have placed the order into the radiology system. The DON said she would have expected to see documentation of notification of the POA in the progress notes. During interview with the Administrator on [DATE] at 10:55 AM, she stated staff should follow the facility's policy and procedures when making any notifications.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to develop and implement a baseline care plan with instructions to provide effective and person-centered care for 1 of 6 sampled residents, (Resident (R)1). The findings include: Review of the facility policy titled, Baseline Care Plan, reviewed [DATE], revealed the facility was to develop and implement a baseline care plan for each resident that included the instructions needed to provided effective and person-centered care of the resident to meet professional standards of quality of care. Review further revealed the baseline care plan was to be developed within 48 hours of a resident's admission. Review of the closed record revealed the Facesheet noted the facility admitted R1 on [DATE], with diagnoses to include: pressure-induced deep tissue damage of sacral region, traumatic subdural hemorrhage, and malnutrition. Review of the closed record further revealed R1 was discharged to the hospital on [DATE] and expired on [DATE]. Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed R1 as having a Brief Interview for Mental Status (BIMS) score of a seven out of 15, indicating severe cognitive impairment. Review of the baseline care plan the facility developed for risk of skin impairment revealed a start date of [DATE], seven days after R1's admission. Review of the wound care progress note dated [DATE], revealed R1 had been admitted with a Deep Tissue Injury (DTI) to the sacrum. Continued review revealed further assessment of R1 revealed since admission the resident had acquired an additional DTI to the right heel and a Stage 2 pressure injury to the right elbow. In interview on [DATE] at 1:36 PM, Licensed Practical Nurse (LPN) 2 stated she had been the admitting nurse for R1 on [DATE]. LPN 2 reported she did not know who was typically responsible for developing a resident's baseline care plan. She said she had been new at the time of R1's admission, and the Director of Nursing (DON) assisted her with the resident's admission. The LPN stated she would expect a resident assessed to have a risk for skin breakdown to have a care plan addressing that problem. She further stated the baseline care plan was to be done on a resident's admission, so other nurses would know how to care for that resident. In interview on [DATE] at 1:50 PM, the DON stated the facility process for initiating a new resident's baseline care plan was for the admitting nurse to initiate the care plan upon admission. The DON said she had assisted LPN 2 with R1's admission. The DON reported R1 should have had a baseline care plan developed for being at risk for impaired skin integrity on admission. She stated it was important to have the baseline care plan so staff would know R1 had impaired skin integrity on admission, had an area to watch for worsening. The DON further stated by not having a baseline care plan developed, R1 could have had a delay in care, harm, or staff caring for her might not have been aware of the resident's care needs. She additionally said R1 should have had a baseline care plan developed upon admission. The DON reported she was not sure what the breakdown had been or why the baseline care plan was not done; however, she or the nurse had been responsible for the baseline care plan. In interview on [DATE] at 10:55 AM, the Administrator stated she expected staff to follow the facility policies and procedures. She said if staff did not do that, residents might not get the care they needed. The Administrator reported a baseline care plan should have been implemented within 48 hours of R1's admission. She stated the purpose of the baseline care plan was to dictate the resident's care and what was going on with the resident. The Administrator further stated if the baseline care plan was completed, the resident would not receive the care they needed. She additionally stated R1's wounds might have been caught sooner if the facility had put a care plan in place.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 4 sampled residents (Resident (R)1). The findings include:Review of the facility policy titled, Pressure Injury Prevention and Management, reviewed [DATE], revealed the facility was committed to the prevention of avoidable pressure injuries unless clinically unavoidable. Per review, revealed the facility was also committed to providing treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Review of the closed record for R1 revealed the Facesheet documented the facility admitted the resident on [DATE], with diagnoses including: malnutrition, pressure-induced deep tissue damage of sacral region, and traumatic subdural hemorrhage. Per review of the closed record, R1 was discharged to the hospital on [DATE] and noted to have expired on [DATE]. Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed R1 to have a Brief Interview for Mental Status (BIMS) score of a seven out of 15, which indicated severe cognitive impairment. Review of the facility's baseline care plan for risk of skin impairment revealed a start date of [DATE], seven days after R1's admission. Review of the medical record revealed that the facility had early knowledge of skin integrity problems with the resident including notation from a document entitled, Observation Detail List Report from [DATE] at 2:17 AM which disclosed ulcer with open area to the buttocks. In interview with the DON on [DATE] at 1:50 PM, she stated she had done part of R1's admission assessment, the head-to-toe skin assessment. She stated R1 had an open area on her sacrum/coccyx, with no open areas on her heels at that time. Review of the wound care progress note dated [DATE], revealed it was noted R1 had been admitted with a Deep Tissue Injury (DTI) to the sacrum. Continued review revealed in additional assessment of R1 since admission the resident acquired a DTI to the right heel and a Stage 2 pressure injury to the right elbow. Review of the progress note dated [DATE] timed 10:55 AM, revealed the wound care Advanced Practice Registered Nurse (APRN) had given new orders, one of which was for R1's sacrum. Per review, the sacrum order was to apply skin prep to the surrounding tissue, apply medical grade honey to the wound bed, cover daily and as needed. Continued review revealed additional orders included to apply Triad cream to R1's left gluteal fold twice a day and as needed. Review of the progress note revealed documentation noting R1 had a new Deep Tissue Injury (DTI) to the left heel and the orders given were to paint that area with betadine and leave open to air. Further review revealed the APRN changed the orders for R1's right heel wound to betadine soaked gauze, apply an abdominal (ABD) pad, and wrap in Kerlix daily. In addition, review of the progress note revealed the APRN recommended an X-ray of R1's right heel to rule out osteomyelitis, a Low Air Loss (LAL) mattress and to off load bilateral heels in heel boots. Review of the left heel x-ray order revealed a verbal order entered, and the x-ray obtained on [DATE], seven days after the APRN's recommendation on [DATE]. Review of the left heel x-ray result report dated [DATE], revealed the findings were suspicious for calcaneal (heel) osteomyelitis (a serious bone infection). In interview on [DATE] at 11:15 AM, R1's POA stated the facility had not communicated with him regarding the resident's condition. The POA said he had not been aware R1's wounds were as bad as they were. He reported when the family visited R1 the wounds were wrapped, and the staff would describe the resident's wounds as a bad bruise. The POA stated he had never been informed R1 had a bone infection or had been prescribed antibiotics to treat the infection. He further stated if the family had known R1's wounds were that bad, they would (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have had something done about them sooner. In interview on [DATE] at 1:36 PM, Licensed Practical Nurse (LPN) 2 stated she had been the nurse who admitted R1 on [DATE]. LPN 2 reported she had been new at the time of R1's admission, so the Director of Nursing (DON) assisted her with the admission. She stated the DON had performed R1's admission skin assessment. LPN 2 said she would expect a resident who was at risk for skin breakdown to have a care plan to address that. She further stated a baseline care plan should be completed on a new resident's admission so other nurses would know how to care for that resident. In interview on [DATE] at 1:36PM, LPN 2 stated we do the baseline, care plan; however, I did not do one on R1 because I had not been working at the facility very long at that time. She said she had not finished R1's admission, so the DON completed it for her. In interview on [DATE] at 1:50 PM, the DON stated baseline care plans were to be developed and implemented on admission. She said R1 should have had one for skin integrity on admission, so everyone taking care of her would know she had an area to watch for worsening and that the resident was at risk for skin breakdown. The DON further stated however, she had not completed one for R1. During interview with LPN 3 on [DATE] at 3:55 PM, she stated on [DATE], she did wound rounds with the APRN. LPN 3 said she recalled R1 having several wounds that day. She reported R1 had a wound on her heels, her bottom and maybe a new one on the gluteal fold. The LPN reported she could not recall if she notified R1's POA of the new orders for the resident received that day; however, she should have done that and documented the notification in a progress note. She stated she did not have access to the facility's system to enter radiology orders and so she notified the DON that R1 needed an x-ray order entered. She further stated R1's POA should have been notified as soon as possible. In interview with the DON on [DATE] at 1:50 PM, she stated she had performed R1's admission skin assessment. The DON said R1 had an open area to her sacrum/coccyx at that time, with no open areas on the heels at that time. She explained the facility's process for initiating a new resident's baseline care plan was for the admitting nurse to initiate the care plan upon the new resident's admission. The DON stated R1 should have had a baseline care plan developed for being at risk for impaired skin integrity on admission. She said the baseline care plan was important so staff would know R1 had an area to watch for worsening and so they would know the resident was at risk for skin breakdown. The DON reported by not having a baseline care plan developed for R1's risk for skin breakdown, the resident could have experienced a delay in care, harm, or staff caring for her might not be aware of R1's care needs. She further stated she was not sure what the breakdown had been with R1 not having a baseline care plan developed for being at risk for skin breakdown and did not know why the baseline care plan had not been done. During interview with the Administrator on [DATE] at 10:55 AM, she stated her expectations were for staff to follow the facility's policy and procedures when providing resident care. She explained the facility's policies and procedures lined out with how resident's skin or wounds were to be assessed. The Administrator stated she expected staff to report any skin abnormalities to the DON or herself immediately. She reported R1 should have had a baseline care plan developed within 48 hours of admission. The Administrator said otherwise, R1 could have experienced a delay in care or not receive the care the resident would have needed. She further stated R1's new skin breakdown could potentially have been caught sooner if the resident had a baseline care plan in place. The Administrator additionally stated by staff not following the facility's policy, the resident's wound could have worsened.