STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185445	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodcrest Nursing and Rehabilitation Center	3876 Turkeyfoot Road Elsmere, KY 41018

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and review of the facility's job description, the facility failed to ensure that its medication error rate was less than five percent. Two errors out of 33 opportunities resulted in a 6.06% error rate. The findings include: Record review of the Licensed Practical Nurse (LPN) job description, updated 4/19/2024, listed essential functions of this position, including administration of medications and treatments, following approved nursing techniques. Review of the May 2025 Medication Administration Record (MAR) for Resident (R) 1 revealed Atorvastatin 20 milligrams (mg) and Loratadine 10 mg was ordered for administration between 7:00 PM and 10:59 PM. Observation on 05/20/2025 at 9:10 AM revealed LPN3 prepared two medications ordered for R1 that were scheduled for bedtime administration. Atorvastatin 20 mg was a low dose of a drug intended to lower cholesterol and triglycerides, and Loratadine 10 mg was an antihistamine medication used to treat seasonal allergies. During interview on 05/20/2025 at 9:12 AM with LPN3, she stated she understood that these medications were scheduled at night, and they were pulled in error. She stated she did not feel there would be any adverse effect. However, she stated had it been another type of medication, it could have caused the resident a problem. During interview on 05/21/2025 at 11:47 AM with the contracted Pharmacist, he stated that while he did not expect the incident would cause harm, the efficacy of the Atorvastatin given in the morning would be questionable since lipid production was typically higher in the evening and therefore more likely to have the intended result. In addition, he stated the potential of the resident drinking grapefruit juice would be higher in the morning with breakfast, and that could also decrease the desired outcome. Regarding the loratadine 10 mg, he stated because it had the potential to cause drowsiness, it could adversely affect the resident's activity level during the daytime. He also stated the maximum daily dose of this medication was 10 mg. He stated, if the medication was inadvertently given again, at bedtime, as originally scheduled, it could increase the drying effect of the medication, which in some residents could cause dizziness, dry oral mucosa, or similar anticholinergic responses. During interview on 05/21/2025 at 10:22 AM with the Director of Nursing (DON), she stated it was her expectation that medications would be administered according to the physician's orders. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 05/22/2025 at 9:46 AM with the Administrator, he stated it was his expectation that physician orders would be followed as written and that facility policies would be followed. He added that it was important to follow these orders to decrease potential harm to the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of the facility's policy, 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 affecting all facility residents, with a current census of 110 residents. 1. Observation of the Laundry Room on 05/20/2025 revealed the facility laundry area was not maintained in a clean and sanitary manner. 2. Observation of Housekeeper (HSK) 1 on 05/20/2025 revealed she walked into the dirty utility room carrying a bag of contaminated linen slung over her shoulder and up against her person. 3. Observation of HSK2 on 05/20/2025 revealed she transported clean linen against her person and through the clean area and into the dirty utility room. The findings include: Review of the facility's policy titled, Infection Prevention and Control Program [IPCP], undated, revealed the facility maintained 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 per accepted national standards and guidelines. Per the policy, all staff was responsible for adhering to IPCP policies, including the use of PPE and hand hygiene according to established procedures. Review of the facility's Housekeeping/Laundry Management and Procurement Agreement, dated 08/31/2018, revealed the facility entered into an agreement with Healthcare Service Group (HSG), to provide all housekeeping and laundry services at the facility. 1. Observation of the facility's Laundry Room on 05/20/2025 at 8:32 AM revealed the dirty utility room had two trash bins pushed against the sink, one of which was overflowing with both bagged and unbagged trash. There were two large utility bins filled with dirty laundry. The sink was blocked by the dirty laundry bins and a trash barrel, preventing staff from accessing it for hand hygiene. Furthermore, the sink was filled with clean mop heads. Further observation revealed no personal protective equipment (PPE) was available for staff to use when sorting contaminated laundry. Further observation on 05/20/2025 at 8:32 AM revealed a wall-mounted utility sink was located in the dirty utility room. It contained dirty, stagnant water. A gallon container of chemicals was sitting on the right rim of the sink, while various cleaning tools and chemicals were also nearby. Additional observation revealed a yellow mop bucket, heavily stained and containing an unwashed wet mop, was present in the room. Directly under the sink, there was a black milk crate filled with tools. Cleaning brushes and brooms leaned against the wall, and a dirty red floor scrubber pad hung from the faucet of the sink. Per observation, the floor itself was visibly stained and scattered with dirt and debris. Furthermore, there were three pillows and multiple large shipping boxes full of linen stacked on top of each other and pushed up against the dirty trash bin. The room also contained brooms and a dustpan, both full of debris and multiple bags of trash and laundry were on the floor. Continued observation on 05/20/2025 at 8:32 AM of the washroom revealed the floor area between two (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	large industrial washing machines appeared heavily worn and stained from water and detergent residue. There was evidence of rust and grime around the bases of the machines. The rest of the washroom floor was similarly stained and contained dirt and debris. There were two utility bins full of dirty laundry obstructing a handwashing sink and eyewash station. Several brooms were present, along with a dustpan that was filled with debris. In one corner of the room, debris had been swept up and pushed to the side. A clean Hoyer lift sling was hanging next to the brooms, with its straps touching the ground and resting in the dirt and debris. Additionally, a face shield was lying on the floor on top of one of the brooms, and gloves were stored on top of a bucket of washing chemicals. Additionally, observation of the laundry area on 05/20/2025 at 8:32 AM revealed the dryer room area was unkempt. The floor was visibly stained and contained dirt, debris and trash. The counter was overflowing with clothing, and the space underneath it was used for storage of clothing and linens not protected from contact with the floor. 2. Observation of the laundry area on 05/20/2025 at 8:45 AM revealed HSK1 walked into the dirty utility room carrying a bag of contaminated linen slung over her shoulder and up against her person. During an interview with HSK1 on 05/20/2025 at 8:45 AM, she stated she did not have a bin to transport the dirty linen, and it was too heavy to carry. She stated she was unaware that carrying contaminated linen against her person was an infection control issue. She stated she was employed by HSG and had been provided infection control training upon hire. She stated it was important to follow infection control policies to prevent the spread of germs. 3. Observation of HSK2 on 05/20/2025 at 8:50 AM revealed she transported clean linen against her person and through the clean area and into the dirty utility room. During an interview with HSK2 on 05/20/2025 at 8:50 AM, she stated she should not walk clean linen through the dirty areas of the laundry room. She stated doing so could contaminate the clean laundry. She stated she had received infection control training through HSG. During an interview with the Assistant Manager of Environmental Services (EVS AM1) on 05/20/2025 at 8:55 AM, she stated she worked for HSG. She stated she was concerned about the cleanliness of the room, and it was dirty and it shouldn't look this way. The EVS AM1 stated the laundry attendant was responsible for maintaining cleanliness in the area, and she worked for the contracted laundry service. She stated linen should be transported away from the body, and clean mops, Hoyer lift (mechanical lift used to transport residents from one surface to another) slings, and other supplies must not be stored in a dirty laundry area to avoid cross-contamination. Additionally, she stated keeping the laundry area clean was essential to prevent the spread of infection. During an interview with EVS AM2 on 05/20/2025 at 8:55 AM, she stated linen should be transported away from the body to avoid cross-contamination. She stated HSK1 and HSK2 had been educated to transport linen away from their person. She stated clean clothing and linen should be taken out through the clean area and not back through the dirty utility room. During an interview with HSG's Housekeeping Account Manager (AM) on 05/21/2025 at 11:35 AM, he stated HSG had a contract with the facility to provide housekeeping and laundry services. He stated he was responsible for overseeing the housekeeping and laundry departments. He stated the area was in a bad state because there was very little storage space for the washing supplies, resulting in a cluttered area. The AM further stated his team had been working on cleaning up the space. He stated it (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was important for his staff to adhere to IPCPs to prevent the spread of infection. He stated clean and dirty items should never be mixed, and staff should not carry linens against their bodies. Additionally, he stated housekeeping staff should not transport clean linens through the area designated for dirty linens. He stated his staff had received education regarding the proper handling and transportation of laundry and linens. The AM stated it was his expectation that staff maintained a clean and sanitary laundry area to help prevent the spread of germs. During an interview with the Infection Preventionist (IP) on 05/21/2025 at 11:15 AM, she stated the facility adhered to the Centers for Disease Control and Prevention (CDC) guidelines for infection control. The IP stated staff should not carry linen against their bodies, as this practice could lead to cross-contamination. She stated it was her expectation that all staff members, including contracted vendors, complied with the facility's infection prevention and control policies (IPCP). The IP stated following these policies was important for the prevention of infectious disease and to ensure a safe home for the residents. During an interview with the Director of Nursing (DON) on 05/21/2025 at 11:25 AM, she stated it was her expectation that all staff members, including contracted vendors, adhered to the facility's IPCP. She stated all staff received infection control training upon hire and periodically throughout the year. In addition, the DON stated staff was updated on current CDC guidelines when they changed. The DON stated, if nursing leadership observed any lapses in infection control practices, immediate intervention would take place, including on-the-spot education for staff and a review of their competencies. Furthermore, she stated following facility policy and CDC guidelines was important for preventing disease and ensuring the safety of both staff and residents. During an interview with the Administrator on 05/21/2025 at 11:00 AM, he stated the facility had contracted with HSG to manage the facility's housekeeping and laundry services. When asked who had oversight over the management company, he stated, I oversee them. He stated he frequently audited the laundry, but he had not been in there recently. He stated it was important to maintain a clean and sanitary laundry environment to prevent cross contamination and the spread of infections. He stated it was his expectation that HSG staff followed the facility's infection control policies and kept the laundry areas clean. He further stated that maintaining infection control measures was crucial for the safety of the residents.