STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185488	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - SKILLED NURSING B. WING	(X3) DATE SURVEY COMPLETED 02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs At Oldham Reserve	2000 East Peak Road , La Grange, Kentucky, 40031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS Based upon implementation of the acceptable Plan of Correction (POC) and the off-site revisit survey concluded on 02/16/2026, the deficiencies were determined to be corrected effective 01/20/2026 as alleged, for the survey completed on 12/17/2025.	K0000		

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185488	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/16/2026

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E0000	Initial Comments Based upon implementation of the acceptable Plan of Correction (POC) and the off-site revisit survey concluded on 02/16/2026, the deficiencies were determined to be corrected effective 01/20/2026 as alleged, for the survey completed on 12/17/2025.	E0000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs At Oldham Reserve	2000 East Peak Road , La Grange, Kentucky, 40031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 2021 K7 SURVEY UNDER: 2012 New K8 SNF/NF Type of Structure: One (1) story (2021), Type V (111), protected combustible construction with six (6) smoke compartments and a complete automatic wet and dry sprinkler system. A Life Safety Code Recertification Survey was initiated on 12/17/2025 and concluded on 12/17/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, The Springs at Oldham Reserve was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K0000		01/18/2026
K0521 SS = F Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to maintain smoke and fire dampers in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to	K0521	The submission of this plan of correction does not indicate an admission by The Springs at Oldham Reserve that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of The Springs at Oldham Reserve. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	01/20/2026

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K0521 SS = F Bldg. 01	Continued from page 1 affect all smoke and fire dampers, staff, and all residents. The facility had the capacity for 50 beds with a census of 44 on the day of the survey. The findings include: Record review, of the facility's smoke and fire damper testing records for the four (4)-year period prior to the survey on 12/17/2025 at 11:35 PM, revealed the smoke and fire dampers throughout the facility had no documentation of being tested and inspected one (1) year after they were installed in 2022. Interview, on 12/17/2025 at 11:36 PM with the Director of Plant Operations, revealed the facility was aware of the requirement for the dampers to be tested and inspected after the first year they were installed, however had failed to conduct the testing and inspection at the time of the survey. The finding was verified by the Director of Plant Operations at the time of record review and the Executive Director at the exit conference on 12/17/2025. Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 18.5.2.1 Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications, unless otherwise modified by 18.5.2.2. 9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service. Actual NFPA Standard: 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems (2012) 5.4.8 Maintenance. 5.4.8.1 Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.	K0521	Continued from page 1 The Director of Plant Operations contracted Advanced Mechanical, LLC to complete a smoke and fire damper inspection and was completed on 1/19/26. The Director of Operations was educated by facilities management Support that facility providing heating, ventilation and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications in accordance with NFPA edition 101, sections 18.5.2.1, 19.5.2.1, and 9.2. The contracted vendor will perform a one-time annual smoke and fire damper inspection in accordance with NFPA standards. Results of the inspection will be presented by the Executive Director to the Quality Assurance Team to determine whether substantial compliance has been achieved. The deficient practice had the potential to affect all smoke and fire dampers, staff, and all residents. The facility had the capacity for 50 beds with a census of 44 on the day of the survey.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185488	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - SKILLED NURSING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

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K0521 SS = F Bldg. 01	Continued from page 2 5.4.8.2 Smoke dampers shall be maintained in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. Actual NFPA Standard: NFPA 80, Standard for Fire Doors and Other Opening Protectives (2010) 19.4* Periodic Inspection and Testing. 19.4.1 Each damper shall be tested and inspected 1 year after installation. 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years. 19.4.11 Periodic inspections and testing of a combination fire/smoke damper shall also meet the inspection and testing requirements contained in Chapter 6 of NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. Actual NFPA Standard: NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives (2010) 6.5 Periodic Inspection and Testing 6.5.2* Each damper shall be tested and inspected one year after installation. The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.	K0521		

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	185488	A. BUILDING B. WING	12/17/2025

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E0000	Initial Comments 42 CFR 483.73 Type of Structure: One (1) story (2021), Type V (111), protected combustible construction with six (6) smoke compartments and a complete automatic wet and dry sprinkler system. An Emergency Preparedness Recertification Survey was conducted on 12/17/2025, in accordance with 42 Code of Federal Regulations, Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. During this Recertification Survey, The Springs at Oldham Reserve was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	E0000		01/18/2026

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	185488	A. BUILDING B. WING	03/18/2026

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F0000	INITIAL COMMENTS A Desk Review Revisit occurred and based upon the implementation of the acceptable Plan of Correction the facility was deemed to be in compliance on 12/30/2025 as alleged.	F0000		

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F0000	INITIAL COMMENTS A Recertification and Abbreviated survey concluded on 12/18/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. No deficiencies were issued related to 715853 or 715844 Survey Dates: 12/16/2025 – 12/18/2025 Survey Census: 64 Sample Size: 21 Supplemental Residents: 38	F0000		01/18/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it	F0656	F656 Development and Implementation of Careplan (Corrective actions for identified resident(s) affected by the deficient practice.) Resident 9 was not adversely affected by the deficient practice of failure to follow care plan by not implemented enhanced barrier precautions and posting Enhanced barrier precautions sign on resident door as stated in resident care plan. (Identification of other residents who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not recur.) All residents that reside at The Springs at Oldham Reserve have the potential of being affected. On 12/19/25 a 100% audit complete of all residents currently residing at The Springs at Oldham Reserve for care plans related to enhanced barrier precautions. Audit included reviewing all residents orders to ensure residents with order for enhanced barrier precautions have care plan for enhanced barrier precautions and reviewing care plans of all residents without orders for enhanced barrier precautions to ensure resident	12/30/2025

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F0656 SS = D	Continued from page 1 must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement the comprehensive person-centered care plan for each resident for one of three residents sampled for enhanced barrier precautions (Resident (R) 9). R9 was care planned for enhanced barrier precautions but observations revealed no signage posted The findings include: Review of facility policy titled "Comprehensive Cre Plan Guideline", revised 05/22/2018, revealed the comprehensive care plan was created and implemented based on the resident needs and ensured appropriateness of services and communication that met the residents' needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines. Review of the facility's medical record "Face Sheet" revealed the facility admitted R9 on 11/29/2025 with diagnoses including hypertension, congestive heart failure, diabetes, bacteremia, and paraplegia. Review of the facility's "Care plan" for R9 revealed on 12/03/2025, the facility care planned R9 for EBP during high-contact care related to the presence of an	F0656	Continued from page 1 does not have a care plan for enhanced barrier precautions. (Measures put in place and systemic changes you will make to ensure that the deficient practice does not recur.) On 12/18/25 Trilogy Health Services Campus Support-Clinical re-educated the Minimum Data Set (MDS) Coordinator, Director of Health Services, and Executive Director on comprehensive care plan implementation. (Describe the Quality Assurance & Process Improvement Program that will be put into place (track and trend data over time to ensure action plan met the initially identified goal). An "Ad Hoc" Quality Assurance meeting was convened on 12/19/25 with the Medical Director to discuss the findings from the cited deficiency related to infection prevention and control. Starting on (12/29/25), A Quality Assurance meeting will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above stated plan. (Audit #1) Starting on (12/29/25), as part of the facility's ongoing quality improvement plan, Minimum Data Set (MDS) Coordinator will complete a cumulative audit of 10 residents weekly for four weeks, 5 residents a weekly for four weeks, 5 residents biweekly for four weeks, and 5 residents monthly for one month, to ensure care plans for enhanced barrier precautions are implemented. The Director of Health Services and/or Minimum Data Set (MDS) Coordinator will present the findings from the audits to the monthly QAPI Committee. The QA Committee will determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned ongoing audits. The Executive Director has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance (12/30/25)	

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F0656 SS = D	Continued from page 2 indwelling catheter. Review of the facility's physician order for R9 revealed an order, dated 11/29/2025, indicating staff were to use EBP, including wearing gown and gloves at minimum during high contact care activities. Observation on 12/16/2025 at 10:00 AM, revealed no enhanced barrier precaution (EBP) signage for Resident (R) 9. During an interview on 12/17/2025 at 9:45 AM with Licensed Practical Nurse (LPN) 8, she stated she did not know if R9 should be on EBP for the indwelling foley catheter and was not aware that this was included on the resident's care plan. After reviewing the physician's order for EBP, LPN8 stated she was unsure why the facility did not place R9 in EBP when the order was placed. She stated it was usually the responsibility of the nurse who acknowledged the physician's order to place the EBP signage and personal protective equipment (PPE) outside the door. During an interview on 12/18/2025 at 9:48 AM with the Director of Nursing (DON), she stated it was her expectation for staff to follow care plans to ensure appropriate care was provided to the residents. During an interview on 12/18/2025 at 10:00 AM with the Administrator, he stated it was his expectation that staff followed the resident's care plans.	F0656		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F0761	(Corrective actions for identified resident(s) affected by the deficient practice.) 43 residents were not adversely affected by the deficient practice related to medication and treatment carts not being locked. (Identification of other residents who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not recur.) All residents that reside at The Springs at Oldham Reserve have the potential of being affected. (Measures put in place and systemic changes you will make to ensure that the deficient practice does not recur.)	12/30/2025

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F0761 SS = D	Continued from page 3 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls when not attended for one of four medication carts. The findings include: Review of facility policy titled "Medication Storage in the Facility" revised 11/2018, revealed "only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access." Observation on 12/16/2025 at 10:00 AM revealed a medication cart on hall 400 was unlocked and unattended. During an interview on 12/16/2025 at 10:00 AM with Registered Nurse (RN)1, she stated she had just walked away from the cart and forgot to lock it. She stated it was important to keep it locked to keep people out of the medication cart, and to keep the residents safe. During an interview on 12/18/2025 at 9:48 AM with the Director of Nursing (DON), she stated it was her expectation that all medications carts were locked when not in use to prevent residents from getting into them and taking medications that did not belong to them. During an interview on 12/18/2025 at 10:00 AM with the Administrator, he stated it was his expectation that staff followed the medication storage policy to ensure safe storage for overall monitoring of medication and resident safety.	F0761	Continued from page 3 On 12/18/25 Trilogy Health Services Campus Support-Clinical re-educated the Director of Health Services and Executive Director on medication storage Once trained, the Director of Health Services provided re-education to the Assistant Director of Health Services on medication storage Once trained, the Director of Health Services and Assistant Director of Health Services provided re-education to nurses and certified resident medication associate related medication storage On or before 12/28/25, all nurses and certified resident medication associates completed a post test administered by the Director of Health Services or Assistant Director of Health Services, which required a 100% pass rate to verify retention of the provided education After 12/28/25, any newly hired staff will be educated on medication storage through the orientation process. The Springs at Oldham Reserve does not use agency staff. (Describe the Quality Assurance & Process Improvement Program that will be put into place (track and trend data over time to ensure action plan met the initially identified goal). An "Ad Hoc" Quality Assurance meeting was convened on 12/19/25 with the Medical Director to discuss the findings from the cited deficiency related to infection prevention and control. Starting on 12/29/25, A Quality Assurance meeting will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above stated plan. (Audit #1) Starting on 12/29/25, as part of the facility's ongoing quality improvement plan, the Director of Health Services and/or Assistant Director of Health Services will complete a cumulative audit of 10 medication and treatment carts weekly for four weeks, 5 medication and treatment carts a weekly for four weeks, 5 medication and treatment carts a biweekly for four weeks, and 5 medication and treatment carts monthly for one month, to ensure that carts are locked	

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F0761 SS = D		F0761	Continued from page 4 when unattended. The Director of Health Services and/or Assistant Director of Health Services will present the findings from the audits to the monthly QAPI Committee. The QA Committee will determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned ongoing audits. The Executive Director has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance (12/30/25)	
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F0880	(Corrective actions for identified resident(s) affected by the deficient practice.) Residents 4, 9, 19, and 47 were not adversely affected by the deficient practice of failure to prevent infection by not allowing glucometer to remain wet for 2 mins after using disinfectant wipes Resident in 208 was not adversely affected by the deficient practice of failure to prevent infection by not changing gloves after cleaning one room and entering 208 to clean. 43 residents were not adversely affected by the deficient practice to prevent infections by not changing the water filter on the ice machine. Resident 9 was not adversely affected by the deficient practice of failure to prevent infection by not posting Enhanced barrier precautions sign on resident door. (Identification of other residents who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not recur.) All residents that reside at The Springs at Oldham Reserve have the potential of being affected. On 12/19/25 all residents currently residing at The Springs at Oldham Reserve, progress notes for previous 30 days were reviewed for symptoms of infection related to deficient practice On 12/19/25 a 100% audit complete of all residents	12/30/2025

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F0880 SS = F	Continued from page 5 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and review of facility policy the facility failed to provide infection control measures for one resident (Resident (R) 9) observed for enhanced barrier precautions; and one of two rooms observed for cleaning. In addition, the facility failed to monitor and assess the building's water system for Legionella and other opportunistic waterborne pathogens affecting the total census of 43.	F0880	Continued from page 5 currently residing at The Springs at Oldham Reserve for need of enhanced barrier precautions. Audit included reviewing all residents order to ensure order in place, observe room to ensure sign posted on door, and ensure ppe available near room. On 12/19/25 Director of Plant Operations ordered water filter to replace water filter in ice machine. (Measures put in place and systemic changes you will make to ensure that the deficient practice does not recur.) On 12/18/25 Trilogy Health Services Campus Support-Clinical re-educated the Director of Health Services and Executive Director providing on isolation precautions, glucometer cleaning, PDI super sani wipes contact time, and hand hygiene On 12/18/25 Trilogy Health Services Facility Maintenance Support re-educated the Director of Plant Operations and Executive Director manufacture guidelines r/t filter changes in Indigo NXT ice machine Once trained, the Director of Health Services provided re-education to the Assistant Director of Health Services on isolation precautions, glucometer cleaning, and PDI super sani wipes contact time. Once trained, the Director of Health Services provided re-education to Director of Food Services, Director of Environmental Services and Assistant Director of Health Services on hand hygiene. Once trained, the Director of Health Services and Assistant Director of Health Services provided re-education to the certified resident medication associate related to isolation precautions, glucometer cleaning, PDI super sani wipes contact time, and hand hygiene. Once trained, the Director of Health Services and Assistant Director of Health Services provided re-education to the certified resident medication associate related to glucometer cleaning and PDI super sani wipes contact time and hand hygiene. Once trained, the Director of Health Services, Director of Food Services, Director of Environmental Services, and Assistant Director of Health Services re-educate to all staff on hand hygiene.	

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F0880 SS = F	Continued from page 6 The findings include: Review of facility policy titled "Infection Prevention and Control Program (IPCP)" revised 11/15/2021, revealed the facility established and maintained an infection prevention and control program that provided a safe, and sanitary environment and also prevented the development and transmission of communicable diseases and infections. 1. Review of admission records in the facility medical record revealed the facility admitted Resident (R)9 with an indwelling urinary catheter on 11/29/2025. Admitting diagnoses included hypertension, congestive heart failure, diabetes, bacteremia, and paraplegia. Review of physician orders revealed an order for enhanced barrier precautions (EBP) dated 11/19/2025. Observation on 12/16/2025 at 10:00 AM, revealed R9 with an indwelling urinary catheter but no signage alerting staff of the EBP. Review of the facility's comprehensive care plan for R9 revealed R9 requires EBP during high-contact care related to presence of indwelling catheter, dated 12/03/2025. Review of the physician orders for R9 revealed an order dated 11/29/225 for "staff to use EBP, wearing gown and gloves at minimum during high contact care activities. During an interview on 12/17/2025 at 9:45 AM with Licensed Practical Nurse (LPN) 8, she stated she did not know if R9 should be on EBP for the indwelling foley catheter. She looked in R9 Electronic Medical Record (EMR) and looked at the order, then stated she was unsure why R9 was not placed in EBP when the order was placed. She stated it is usually the responsibility of the nurse who acknowledges the order to place the signage and Personal Protective Equipment (PPE) outside the door. During an interview on 12/18/2025 at 9:48 with the Director of Nursing (DON), she stated she did not know why EBP were not initiated for R9. She stated it was her expectation for staff to be educated on proper PPE signage and to follow the guidelines to prevent the spread of diseases. During an interview on 12/18/2025 at 10:00 AM with the Administrator, he stated it was his expectation that staff followed facility policy for maintaining proper PPE for infection control.	F0880	Continued from page 6 On or before 12/28/25, all staff completed a hand hygiene skills check and post test administered by the Director of Health Services, Executive Director, Director of Food Services, Director of Environmental Services and Assistant Director of Health Services, which required a 100% pass rate to verify retention of the provided education. On or before 12/28/25, all nurses and certified resident medication associates completed a glucometer cleaning skills check administered by the Director of Health Services or Assistant Director of Health Services, which required a 100% pass rate to verify retention of the provided education After 12/28/25, any newly hired staff will be educated on isolation precautions, glucometer cleaning, PDI super sani wipes contact time, and hand hygiene through the orientation process. The Springs at Oldham Reserve does not use agency staff. (Describe the Quality Assurance & Process Improvement Program that will be put into place (track and trend data over time to ensure action plan met the initially identified goal). An "Ad Hoc" Quality Assurance meeting was convened on 12/19/25 with the Medical Director to discuss the findings from the cited deficiency related to infection prevention and control. Starting on 12/29/25, A Quality Assurance meeting will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above stated plan. (Audit #1) Starting on 12/29/25, as part of the facility's ongoing quality improvement plan, the Director of Health Services and/or Assistant Director of Health Services will complete a cumulative audit of 10 employees weekly for four weeks, 5 employees a weekly for four weeks, 5 employees a biweekly for four weeks, and 5 employees monthly for one month, to ensure that glucometer are properly cleaned and disinfected. (Audit #2) Starting on 12/29/25, as part of the facility's ongoing quality improvement plan, the Director of Health Services and/or Assistant Director of Health Services will complete a random audit of 10 employees weekly for four weeks, 5 employees a weekly	

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F0880 SS = F	Continued from page 7 2. Observation on 12/16/2025 at 3:14 PM revealed Housekeeper #1 exited room 207 wearing gloves and carrying a spray bottle. The housekeeper carried the spray bottle to the housekeeping cart and put the bottle in the cart. Housekeeper1 then picked up a mop and entered room 208 wearing the same gloves. The housekeeper set the mop down and left the room, without removing gloves or performing hand hygiene. Housekeeper1 went to the housekeeping cart and retrieved a cleaning cloth and a spray bottle and then returned to room 208 and cleaned the shower and finished mopping. The housekeeper then put the mop and cleaning supplies back into the housekeeping cart. She did not change gloves or perform hand hygiene and then pushed the cart down the hall wearing the same gloves. During interview with Housekeeper1 just after the observation, the housekeeper stated she should have changed her gloves, but she was in a hurry. On 12/16/2025 at 3:38 PM during interview with the Housekeeping Director, she stated staff were taught to change gloves and sanitize hands after cleaning each room. On 12/18/2025 at 10:07 AM during interview with the Administrator, he stated he expected housekeepers follow their infection control training and to change gloves and clean hands after cleaning a room. 3. Review of the facility policy "Guidelines for Water Management" policy, dated 08/30/2019 revealed, "It is the policy of this facility to establish procedures to reduce risk of Legionella and other opportunistic pathogens." A risk assessment of water system components will be conducted to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. On 12/16/2025 at 10:09 AM during interview with the Director of Plant Operations, he stated the facility did not have a risk assessment of the facility's water system. He further stated the facility tested yearly for legionella, and the most recent test was performed 02/10/2025, with no legionella was detected. On 12/17/2025 at 10:44 AM during interview with the Director of Plant Operations, he stated to prevent	F0880	Continued from page 7 for four weeks, 5 employees a biweekly for four weeks, and 5 employees monthly for one month, to ensure proper hand hygiene preformed and able to verbalize when hand hygiene should be preformed. (Audit #3) Starting on 12/29/25, as part of the facility's ongoing quality improvement plan, the Director of Health Services and/or Assistant Director of Health Services will complete a random audit of 10 residents weekly for four weeks, 5 residents a weekly for four weeks, 5 residents a biweekly for four weeks, and 5 residents monthly for one month, to ensure isolation precautions implemented with signage posted and PPE available. (Audit #4) Starting on 12/29/25, as part of the facility's ongoing quality improvement plan, the Director of Plant Operations will complete an audit of the water filter in the ice machine to ensure water filter change per manufacture guideline notating date changed weekly for four weeks, biweekly for four weeks, and monthly for one month. The Director of Health Services and/or Assistant Director of Health Services will present the findings from the audits to the monthly QAPI Committee. The QA Committee will determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned ongoing audits. The Executive Director has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance (12/30/25)	

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F0880 SS = F	Continued from page 8 legionella the facility flushed the water in empty rooms, but he was not aware of how often they flushed the empty rooms in the facility as he did not keep a flow sheet. On 12/17/2025 at 4:44 PM during interview with the Facility Management Support Person (FMSP) he stated there was no risk assessment for bacteria or legionella for the facility's water system. The FMSP further stated the facility tested for Legionella once a year. The FMSP also stated the facility did not have a system to run water in rooms that were not in use.	F0880		