Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100030	A. BUILDING: _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

(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) COMPLETE DATE
P 0	Initial Comments A Complaint Survey investigating complaints KY00033013, KY00037727, KY00037877, KY00038647, KY00038663, KY00039825, KY00040484 and KY00040212, KY00040223, KY00040484 and KY00040481 was initiated on 08/28/2023, and a Re-Licensure Survey was initiated on 09/13/2023. Both were concluded on 09/22/2023. KY00033013 and KY00038647 were unsubstantiated with no deficient practice identified. KY00037727, KY00037877, KY00038663, KY00039825, KY00040212, KY00040223, KY00040484 and KY00040481 were substantiated with deficient practice identified. Based on the findings of this survey, it was determined the facility failed to have an effective system to ensure adequate supervision and monitoring, to ensure safety and prevent elopement from the facility for Resident #3 and Resident #14. In addition, it was determined the facility failed to maintain an overall environment in such a manner that the safety and well-being of residents, personnel, and visitors was assured. In addition, observations and interviews revealed an ongoing bed bug infestation at the facility. A Type A Citation was issued on 09/01/2023 related to elopement for Resident #3. An additional Type A Citation was issued on 09/22/2023 related to elopement for Resident #14. A Type B Citation was also issued on 09/22/2023 related to the environment. 1. Record review revealed the facility admitted Resident #3 on 11/27/2021. Review of the 11/27/2021 Discharge Summary, from the discharging facility, revealed diagnoses including	P 000	P00 For Both Citati… A&B has been ad…ressed And policy is …n full force. Daily h…ad Count sheet to acknow…ledge STAFF who is …n or Out the facility 24hr period. …247 Residents Sign NAME, Th… Time They Leaving w… …th Location and Time of R…turn. This will ensu… The Safety of eac… Resident EACH daily + sign out SIGN IN Sheet will be performed e… 6hrs A day 7 days A w… week to make sure each resident is Accounted for. STAFF was educated … and New STAFF as well … Reading and SIGNING an… policy gone over with… Admin.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jamie Thomas — TITLE: Admin — (X6) DATE: 4-10-24

FORM CMS-2567(02-99) LMK411 — If continuation sheet 1 of 89

PRINTED: 10/13/2023
FORM APPROVED

Office: Inspector General

	100039	B. WING	09/22/2023
NAME OF PROVIDER OR SUPPLIER: HEALTH OF ASHLAND	STREET ADDRESS, CITY, STATE, ZIP CODE: ASHLAND, KY 41101		

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	[illegible] survey was initiated on 09/01/2023. Both were concluded on 09/22/2023. KY00033013 and KY00038647 were unsubstantiated with no deficient practice identified. KY00037727, KY00037877, KY00038663, KY00039825, KY00040212, KY00040223, KY00040484 and KY00040481 were substantiated with deficient practice Based on the findings of this survey, it was determined the facility failed to have an effective system to ensure adequate supervision and monitoring, to ensure safety and prevent elopement from the facility for Resident #3 and Resident #14. In addition, it was determined the facility failed to maintain an overall environment in residents, personnel, and visitors was assured. In addition, observations and interviews revealed an ongoing bed bug infestation at the facility. A Type A Citation was issued on 09/01/2023 related to elopement for Resident #3. An additional Type A Citation was issued on [illegible] related to elopement for Resident		Sheet to acknowledge STAFF who is IN or Out the facility 24/7 24hr period. Residents Sign Name, Time They Leaving with and Time of Return. This will ensure The Safety of each Resident Sign in + out be performed 24 hrs A day 7 days A Week to make sure each resident is Accounted For. Staff	

LABORATORY DIRECTOR'S OR PROVIDER/REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATE	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY

"According to staff, resident continues to exit seek, wander guard for resident safety is pending".

Observation on 08/30/2023 at 2:23 PM revealed staff running along the sidewalk outside of the facility.

During an interview with the Administrator on 08/30/2023 at 2:23 PM, she stated Resident #3 "took off", he/she can move fast when he/she wants to". She further stated she got busy, and the resident took off.

During an interview with the facility's Owner, on 08/29/2023 at 10:45 AM, she stated she had checked on getting a Wander Guard system (a bracelet or anklet worn by the resident to trigger an alarm when the resident exited a door equipped with the Wander Guard alarm), but they were too costly. During an additional interview with the facility's Owner on 08/30/2023 at 2:45 PM, she stated Resident #3 was located at the corner of the street where the facility was located.

During an interview with Housekeeper #1 on 09/01/2023 at 4:22 PM, she stated Resident #3 was very confused and often tried to get out of the facility.

2. Record review revealed the facility admitted Resident #14 on 01/11/2023, with diagnoses that included Acute Schizophrenia, Psychosis, Asthma, and Hypertension. Resident #14 had a State Guardian.

past be Trente ... and That The ... pest. STAFF mon.thes eac ... daily to Remove ... and garbage The ... Their Beds etc. ... Clean Rooms As ... daily basis. We ... Residents not t... items IN from ... the The Streets ... facilty Bed Bug ... The electronic sy... INSTALLED with Su... WERE AT the Fa... After System was ... it WAS Tested An... well. System is ... Tested daily by ... The Alarm Butter ... WALK Thru The S...

Office of Inspector General

STATE AND P...	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		100030	A. BUILDING: _____ B. WING _____	C 09/22/2023

NAME ...	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENE ...	S HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

(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 CO... (EACH CORRECTIVE ACTION ... DEFICIENCY)	ECTION ...OULD BE	(X5) COMPLETE
F C ...	Continued From page 2 On 09/18/2023 at 4:28 PM in an interview with Resident #14, he/she stated, "I'm sick of this place. I don't want to be here anymore. They don't treat me right". The State Survey Agency On 09/19/2023 at 3:22 PM in an interview with the Administrator, she stated Resident #14 verbalized wanting to go back to the Psychiatric Hospital, on 09/18/2023 at approximately 4:40 PM. She stated she told Resident #14 that he/she would not be able to speak with State Guardianship until the next day. However, there was no evidence the facility took any actions to ensure the resident's safety after he/she voiced he/she wanted to leave. The Administrator stated at suppertime on 09/18/2023, [illegible] Resident #14 was the Administrative Assistant (AA) that Resident #14 "took (his/her) wheelchair and left". The AA stated he had heard Resident #14 talking about wanting to go back to a hospital the previous day, and the Administrator was aware. The AA stated he told the Administrator, and they decided to wait. On 09/18/2023 at 6:00 PM, a local police officer arrived at the facility. The AA informed the police officer he had received a call from a local store employee who told him Resident #14 had been	P 000	Which Begins, It ... Charted, with ... me and Initialed. Food & ... containers were ... available to ... Brought to ... Adm & A.A talks to Residents about keeping SNACKS secured with ... The Ind of The ... Containers and to throw Trash in Garbage And This will ensure ... PPT will be seen every day seven days a week holiday or Not		

Observation on 08/18/2023 at 5:06 PM, revealed Resident #14 arrived at the facility in the back of a police vehicle, with his/her wheelchair.

The facility's failure to provide adequate supervision and monitoring to ensure a safe environment and prevent elopement presents an imminent danger and creates substantial risk that death or serious mental or physical harm to the resident (s) could occur. The facility was notified of the first Type "A" Citation on 09/01/2023 and the second Type "A" Citation on 09/21/2023.

3. Review of the facility's policy titled, "Pest Control", undated, revealed it was the facility's policy that unwanted pests would be managed by all staff and a contracted agency utilizing an integrated pest management procedure.

Observation on 08/28/2023 at 8:30 AM revealed bed bugs crawling on four (4) residents' bed linens (Residents #2, #7, #9, and #10). Continued observation revealed a bed bug crawling on Resident #7.

Observation, on 09/05/2023 at 5:12 PM, revealed red lesions on Resident #13's legs and arms. During interview with Resident #13, he/she stated that the red lesions came from bedbug bites.

In an interview with the Advanced Practice Registered Nurse (APRN) on 09/14/2023 at 1:10 PM, he stated he was aware of the bed bug infestation. The APRN stated he treated the residents in the Administrator's office and never

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NAME C...	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENE...	HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

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P 0...	Initial Comments A Complaint Survey investigating complaints KY00033013, KY00037727, KY00037877, KY00038647, KY00038663, KY00039825, KY00040212, KY00040223, KY00040484 and KY00040481 was initiated on 08/28/2023, and a Re-Licensure Survey was initiated on 09/13/2023. Both were concluded on 09/22/2023. KY00033013 and KY00038647 were unsubstantiated with no deficient practice identified. KY00037727, KY00037877, KY00038663, KY00039825, KY00040212, KY00040223, KY00040484 and KY00040481 were substantiated with deficient practice identified. Based on the findings of this survey, it was determined the facility failed to have an effective system to ensure adequate supervision and monitoring, to ensure safety and prevent elopement from the facility for Resident #3 and Resident #14. In addition, it was determined the facility failed to maintain an overall environment in such a manner that the safety and well-being of residents, personnel, and visitors was assured. In addition, observations and interviews revealed an ongoing bed bug infestation at the facility. A Type A Citation was issued on 09/01/2023 related to elopement for Resident #3. An additional Type A Citation was issued on 09/22/2023 related to elopement for Resident #14. A Type B Citation was also issued on 09/22/2023 related to the environment. 1. Record review revealed the facility admitted Resident #3 on 11/27/2021. Review of the 11/27/2021 Discharge Summary, from the discharging facility, revealed diagnoses including	P 000	P00 For Both Citati... n A&B has Been ad... ressed And policy is ... n full force. Daily he... id Court Sheet to acknow... ledge STAFF who is i... or out the Facilty 24/7 24hr period, ... esidents sign NAME, Th... Time They Leaving wi... h Location and Time of Re... urn. This will ensur... The Safety of each Resident Each daily + ... sign out sign IN Sheet will be performed 24 hrs A day 7 days A We... k to make sure each ... esident is Accounted Fo... . Staff was educated A... d New STAFF as well b... Reading and Signing and ... olicy gone over with ... dmin.		

LABORATO... DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATE FO... 6899 LMK411 If continuation sheet 1 of 99

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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P 0	Continued From page 1	P 000	Type B c.tatio	with	

Dementia and Failure to Thrive. Review of the Psychiatric Nurse Practitioner's note dated 08/21/2023, revealed diagnoses of Alzheimer's Disease and Depression. The History of Present Illness (HPI) section of the same note revealed, "According to staff, resident continues to exit seek, wander guard for resident safety is pending".

Observation on 08/30/2023 at 2:23 PM revealed staff running along the sidewalk outside of the facility.

During an interview with the Administrator on 08/30/2023 at 2:23 PM, she stated Resident #3 "took off", he/she can move fast when he/she wants to". She further stated she got busy, and the resident took off.

During an interview with the facility's Owner, on 08/29/2023 at 10:45 AM, she stated she had checked on getting a Wander Guard system (a bracelet or anklet worn by the resident to trigger an alarm when the resident exited a door equipped with the Wander Guard alarm), but they were too costly. During an additional interview with the facility's Owner on 08/30/2023 at 2:45 PM, she stated Resident #3 was located at the corner of the street where the facility was located.

During an interview with Housekeeper #1 on 09/01/2023 at 4:22 PM, she stated Resident #3 was very confused and often tried to get out of the facility.

2. Record review revealed the facility admitted Resident #14 on 01/11/2023, with diagnoses that included Acute Schizophrenia, Psychosis, Asthma, and Hypertension. Resident #14 had a State Guardian.

Beegone Pest Control
every 10 days
ensure That un
Pest Re Treate
and That The f
No Issues with
Pest.
STAFF monitors eac
daily to Remove
and garbage. The
Throw in The Fl
Their Beds etc.
Clean Rooms As N
daily BASIS, We
Residents Not t
items IN From
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After System WAS
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well. System is
Tested daily by
The Alarm Button
Walk Thru The Sy

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P IC	Continued From page 2	P 000	Which Begas, Th Charted, w. th T IN. trated. Food S. containers were f for Residents to s Their SNACKS Th T. They bought for Them Admt A.A talked to Residents about keeping SNACKS Secured with The Lid of The STORAGE Container And to throw TRASH IN garbage And This will ensure NO pest will be seen Daily checks IN every day, seven days a week holiday or Not	It is me and ovided elves	

On 09/18/2023 at 4:28 PM in an interview with Resident #14, he/she stated, "I'm sick of this place. I don't want to be here anymore. They don't treat me right". The State Survey Agency (SSA) Surveyor made the Assistant Administrator (AA) aware, and he stated they would talk to Resident #14.

On 09/19/2023 at 3:22 PM in an interview with the Administrator, she stated Resident #14 verbalized wanting to go back to the Psychiatric Hospital, on 09/18/2023 at approximately 4:40 PM. She stated she told Resident #14 that he/she would not be able to speak with State Guardianship until the next day. However, there was no evidence the facility took any actions to ensure the resident's safety after he/she voiced he/she wanted to leave.

The Administrator stated at suppertime on 09/18/2023, it was discovered Resident #14 was not in the building. Resident #14's roommate told the Administrative Assistant (AA) that Resident #14 "took (his/her) wheelchair and left". The AA stated he had heard Resident #14 talking about wanting to go back to a hospital the previous day, and the Administrator was aware. The AA stated he told the Administrator, and they decided to wait until curfew at 8:30 PM to see if Resident #14 would return. The Administrator stated the resident did not return to the facility at 8:30 PM. The Administrator stated the facility was unaware of Resident #14's whereabouts until 3:00 PM on 09/19/2023.

On 09/19/2023 at 3:00 PM, a local police officer arrived at the facility. The AA informed the police officer he had received a call from a local store employee who told him Resident #14 had been

STATE AND P...	...NT OF DEFICIENCIES ...OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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P IN...	Continued From page 3	P 000			

sighted with his/her wheelchair behind the store. The AA requested the police officer pick up Resident #14 and bring him/her back to the facility.

Observation on 09/19/2023 at 3:08 PM, revealed Resident #14 arrived at the facility in the back of a police vehicle, with his/her wheelchair.

The facility's failure to provide adequate supervision and monitoring to ensure a safe environment and prevent elopement presents an imminent danger and creates substantial risk that death or serious mental or physical harm to the resident (s) could occur. The facility was notified of the first Type "A" Citation on 09/01/2023 and the second Type "A" Citation on 09/21/2023.

3. Review of the facility's policy titled, "Pest Control", undated, revealed it was the facility's policy that unwanted pests would be managed by all staff and a contracted agency utilizing an integrated pest management procedure.

Observation on 08/28/2023 at 8:30 AM revealed bed bugs crawling on four (4) residents' bed linens (Residents #2, #7, #9, and #10). Continued observation revealed a bed bug crawling on Resident #7.

Observation, on 09/05/2023 at 5:12 PM, revealed red lesions on Resident #13's legs and arms. During interview with Resident #13, he/she stated that the red lesions came from bedbug bites.

In an interview with the Advanced Practice Registered Nurse (APRN) on 09/14/2023 at 4:10 PM, he stated he was aware of the bed bug infestation. The APRN stated he treated the residents in the Administrator's office and never

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P 0 :	Continued From page 4 entered the facility past the office. Observations, from 09/13/2023 through 09/20/2023, revealed an ongoing bed bug issue. Observations revealed: the presence of cockroaches; holes in the walls; floors and carpets with dark brown matter; peeling paint and wallpaper throughout the facility; loose trim along the baseboard at the bottom of the ramp in the dining room; a black substance appearing to be mildew in bathrooms; and overflowing trash cans in residents' rooms and bathrooms. Additional observations of residents' rooms revealed; residents' belongings scattered throughout the rooms; grocery/garbage bags of clothing piled up on the floors; bags of tobacco and cigarette butts all over the floors; food containers on the floors and furniture; and mattresses that were dirty, stained, and full of holes with no mattress covers. Observations revealed the window coverings were dirty or non-existent in residents' rooms, and the lighting was poor in many residents' rooms and common areas. Observations of the ceilings and walls throughout the facility revealed brown water stains and black specks appearing to be insect feces. Also, observations revealed a dirty mop and mop water stored in the residents' dining area. During an interview with the Owner on 09/14/2023 at 1:00 PM, she stated the bed bug issue was being addressed as an exterminator was coming. She stated it was the responsibility of the Administrator and the Assistant Administrator (AA) to ensure the environment was well kept and in good repair. The facility's failure to maintain the premises to be well kept, in good repair, and free of pests presented a direct or immediate relationship to	P 000			

Office of Inspector General

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P 000	Continued From page 5 the physical health, mental wellbeing, safety, or security of any resident, but which does not create an imminent danger. The facility was notified of the Type "B" Citation on 09/22/2023.	P 000		
P 045	902 KAR 20:036 3(3)(d) Section 3. Administration and Operation (3) Admission. (d) No later than three (3) months from the most recent effective date of this administrative regulation, a PCH or SPCH shall complete the SMI Screening Form for each current resident. Upon admission, a PCH or SPCH shall complete the SMI Screening Form for each new or returning resident. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy folder, it was determined the facility failed to ensure a Serious Mental Health (SMI) screening form was completed for six (6) of twenty (20) current residents, Residents #4, #5, #9, #12, #18, and #20. The findings include: Review of the facility's policy folder revealed there was not a policy for Admission of a Resident or a policy for the completion of a Serious Mental Health (SMI) form. On 09/14/2023, a copy of the facility's policy for Admission of a Resident or a policy for the	P 045	P045 Residents upon admission will have a SMI Screening Form in Their Chart as well as Prior Resident. The ADMIN will be responsible party to ensure every Resident has one in Their Chart from here on out.	

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P045	Continued From page 6 completion of a Serious Mental Health (SMI) form was requested but was not provided by the Administrator. 1. Review of Resident #4's medical record revealed the facility admitted the resident, on 08/10/2022, with diagnoses of Chronic Schizophrenia, Cannabis Use, and Insomnia. Further review revealed Resident #4's medical record contained no documented SMI form. 2. Review of Resident #5's medical record revealed the date of admission was blank on the face sheet. Further review revealed Resident #5's admitting diagnoses were Depression and Anxiety. In addition, there was no SMI form documented in the medical record. 3. Review of Resident #9's medical record revealed the facility admitted the resident, on 05/11/2022, with diagnoses of Schizophrenia, Borderline Personality Disorder, Extrapyramidal Movements, and Hypertension. Further review revealed Resident #9's medical record contained no documented SMI form. 4. Review of Resident #12's medical record revealed the facility admitted the resident, on 01/25/2022, with diagnoses of Chronic Pain to Bilateral Knees, Type 2 Diabetes, and Allergic Rhinitis. Further review revealed Resident #12's medical record contained no documented SMI form. 5. Review of Resident #18's medical record revealed the facility admitted the resident, on 03/22/2023, with diagnoses of Depression, Diabetes Mellitus, Wheelchair Use, and Left Below the Knee Amputation. Further review revealed Resident #18's medical record				

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HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

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P 045	Continued From page 7 contained no documented SMI form. 6. Review of Resident #20's medical record revealed the facility admitted the resident, on 02/28/2023, with diagnoses of Paranoid Schizophrenia, Anxiety, and Mood Dysphoric Disorder. Further review revealed Resident #20's medical record contained no documented SMI form. In an interview with the Assistant Administrator (AA) on 09/15/2023 at 10:30 AM, he stated he had worked for the company for a long time on nights but was made AA in mid-August and came to day shift. He stated he had never heard of a SMI health screening form, and the Administrator was responsible for maintaining resident medical records. He stated any notes or evaluations done by the Advance Practice Registered Nurse (APRN) were faxed to the Administrator's home and placed in the resident chart by the Administrator. In an interview with the Administrator on 09/15/2023 at 10:55 AM, she stated she had worked for the company for twenty-three (23) years but had assumed the role of Administrator in April 2023. She stated the AA was responsible for putting the APRN visit notes into the resident charts and for maintaining resident medical records. She further stated she did not know what an SMI form was. In an interview with the Owner of the facility on 09/15/2023 at 1:00 PM, she stated she and her husband bought the facility in May 2021. She stated the Administrator did the admission paperwork on the residents and maintained their medical records. She stated she did not know what an SMI form was or what it was for.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100030	A. BUILDING: _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

(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) COMPLETE DATE
P 0	902 KAR 20:036 3(6)(b) Section 3. Administration and Operation (6) Transfer and discharge. (b) A PCH or SPCH that does not have a transfer agreement in effect, but has attempted in good faith to enter into an agreement shall be considered to be in compliance with the requirements of paragraph (a)2. of this subsection. This requirement is not met as evidenced by: Based on interview and review of the facility's policy folder, it was determined the facility failed to provide evidence of written transfer procedures and/or agreements for the transfer of residents to a higher intensity level of care if indicated. This had the potential to affect twenty (20) of twenty (20) residents who currently reside in the facility. The findings include: Review of the facility's policy folder revealed there was no policy for transferring a resident to a higher level of care or a sample of any written transfer agreements. On 09/14/2023, a copy of the facility's policy for transferring a resident to a higher level of care or a sample of any written transfer agreements the facility had was requested by the State Survey Agency (SSA) Surveyor from the Administrator but was not provided.	P 065	P065 The Transfer Pol was implemated arou 10-12-23 The Ass. t Admin to the facility The Revision. The Transfer We contacted Fo agreed, We will monitor The policy monthly and Will be Continuing The process	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100030	A. BUILDING: _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS HEALTH OF ASHLAND	[redacted] CENTRAL AVENUE ASHLAND, KY 41101

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F 0	Continued From page 9	P 065		

In an interview with the Assistant Administrator (AA) on 09/15/2023 at 10:30 AM, he stated he had worked for the company for a long time on nights but was made AA in mid-August and came to day shift. He stated he was not aware of any transfer agreements with any other facilities. He stated if the resident needed to go to the hospital, staff called 911, any family, or the State Guardian (SG) and made the family aware. He stated if the resident got transferred to the nearest state psychiatric hospital, the hospital took care of it and called the needed persons/entities to say the resident was being transferred.

In an interview with the Administrator on 09/15/2023 at 10:55 AM, she stated she assumed the role of Administrator in April 2023. She stated if a resident needed to be transferred to the hospital, 911 was called for transportation, and the resident went to the hospital for evaluation and treatment. The Administrator stated the resident either got transferred somewhere else or returned to the facility. She stated if the resident transferred somewhere else, the hospital took care of notification and the transfer. She stated she was not aware of any transfer agreements.

In an interview with the Owner on 09/15/2023 at 1:00 PM, she stated she and her husband bought this facility in May 2021. She stated she was not aware of anything called a transfer agreement, but the Administrator and the AA would take care of anything the resident needed to be transferred. The Owner requested the SSA Surveyor give her a list of whatever the residents should have and anything she needed to do, and she stated she would do it. She further stated she did not know what the State Regulations were for a Personal Care Home and requested a copy of the

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	100030	A. BUILDING: _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

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P 065	Continued From page 10 regulations from the SSA Surveyor. The Owner stated she thought the State would notify her of regulation updates and changes.	P 065		
P 085	902 KAR 20:036 3(7)(a) Section 3. Administration and Operation (7) Tuberculosis Testing. (a) All employees of a PCH or SPCH shall be screened and tested for tuberculosis in accordance with 902 KAR 20:205. This requirement is not met as evidenced by: Based on interview and review of the provided employee files, it was determined the facility failed to ensure all employees were screened and tested annually for Tuberculosis (TB) in accordance with 902 KAR 20:205 for three (3) of ten (10) sampled employees, Caregiver (CG) #2, CG #4 and the Contracted Maintenance Worker. The findings include: On 09/13/2023 a copy of the facility's Tuberculosis Infection Control Plan was requested from the Administrator but not provided. Review of CG #2's employee file on 09/13/2023 revealed CG #2's hire date was not documented, and there was no documentation any TB testing had been performed.	P 085	P085 Yes The Facility has A TB Infection Control Policy Facility has policy as long As staff can Remember All new Staff are Require To Have T.B Test before Being put on Schedule including Background check and Adult misconduct Registry TB Test will be done yearly Background ahead are done Through agency That Provider All records If Any with charges	

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STATEM... OF DEFICIENCIES AND PL...	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
...OF CORRECTION	100030	A. BUILDING: _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

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P 085	Continued From page 11 Review of CG #4's employee file on 09/13/2023 revealed CG #4's hire date was not documented, and there was no documentation any TB testing had been performed. Review of the facility's employee files on 09/13/2023 revealed no employee file for the Contracted Maintenance Worker was being maintained, and there was no documentation any TB testing had been performed. In an interview with the Assistant Administrator (AA) on 09/15/2023 at 10:30 AM, he stated he usually sent new employees to the health department for their TB skin test, and then they brought back the sheet that said they were negative. The AA stated the TB skin test result sheet was placed in their employee file by either him or the Administrator. He stated all employees should be checked for TB so the staff and residents do not get it. In an interview with the Administrator on 09/15/2023 at 10:55 AM, she stated the AA was responsible for directing staff to get their TB tests and for putting the information in the employee files. In an interview with the Owner on 09/15/2023 at 1:00 PM, she stated the Administrator and the AA took care of the residents getting their yearly TB skin tests and sending employees for TB skin tests on hire and yearly after that. She stated it was important for that testing to be kept up to date so everyone did not get TB.				
P 105	902 KAR 20:036 3(8)(c) Section 3. Administration and Operation	P 105	P105 Yes By going to a proper and good Background		

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	100030	A. BUILDING: _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGETOWN HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

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P 11	Continued From page 12 (8) Personnel. (c) A PCH or SPCH shall obtain a criminal record check on each applicant for initial employment in accordance with KRS 216.789 and 216.793.	P 105	establishment that provide full Details of an convy doing and Criminal activity. Admin will make sure new employee maintain Require a background	

This requirement is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure a criminal record check was completed on each applicant for initial employment in accordance with Kentucky Revised Statutes (KRS) 216.789 and KRS 216.793 for six (6) of ten (10) sampled employees (Caregivers (CG) #3, #4, #5, #6, #7 and the Contracted Maintenance).

The findings include:

Review of the facility's policy titled, "Policy on New Employees" revised 01/11/2013, revealed upon being hired, the facility would require a criminal record check and abuse registry check before any new hire could begin. This was to insure the safety of the residents from any harm and for the protection of the facility. Further review revealed the facility received all the information needed and then the new staff could start their duties.

Review of CG #3's employee file revealed no hire date on file, and no evidence of any criminal record checks had been documented.

Review of CG #4's employee file revealed no hire

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P 105	Continued From page 13 date on file, and no evidence of any criminal record checks had been documented. Review of CG #5's employee file revealed no hire date on file, and no evidence of any criminal record checks had been documented. Review of CG #6's employee file revealed a hire date of 04/21/2023. Further review of the file revealed no criminal record checks had been documented. Review of CG #7's employee file revealed no hire date on file, and no evidence of any criminal record checks had been documented.. Review of Contracted Maintenance's employee file revealed no hire date on file, and no evidence of any criminal record checks had been documented. In an interview with the Assistant Administrator (AA) on 09/15/2023 at 10:30 AM, he stated the Administrator was responsible for the background checks and the abuse registry checks on the new employees and the information was put in their employee file by the Administrator. He stated all employees should have a background check and an abuse registry check for the safety of the staff and the residents. In an interview with the Administrator on 09/15/2023 at 10:55 AM, she stated she was responsible for running the criminal background checks and the abuse registry checks on the staff and for putting the information in their employee files. She stated the information should have been in each employee file and that the checks were important for the safety of the residents.			

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P 105	Continued From page 14 In an interview with Owner on 09/15/2023 at 1:00 PM, she stated the Administrator and the AA took care of screening new staff and performing a background check and an abuse registry check on each person that worked at the facility, for the safety of the residents.	P 105		
P 110	902 KAR 20:036 3(8)(d)1-5 Section 3. Administration and Operation (8) Personnel. (d) Current employee records shall be maintained on each staff member and contain: 1. Name and address; 2. Verification of all training and experience, including evidence of current licensure, registration, or certification, if applicable; 3. Employee health records; 4. Annual performance evaluations; and 5. Documentation of compliance with the background check requirements of paragraphs (a) through (c) of this subsection. This requirement is not met as evidenced by: Based on interview and record review of the provided employee files, it was determined the facility failed to maintain employee records to have an annual performance evaluation for nine (9) of ten (10) sampled employees. No record of an annual performance evaluation was observed in the provided employee files for Caregiver (CG) #1, CG #2, CG#3, CG #4, CG #5, CG #6, and CG #7, the Assistant Administrator (AA), and the Administrator.	P 110	P110 By reading The Criminal Background and receiving All Information on The employee. Annual evaluation will begin 4-15-24 for every employee The Admin will be going over The eval with each employee which will be done yearly on Their job ethics, and performances	

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P 11	Continued From page 15 The findings include: The State Survey Agency (SSA) Surveyor requested a policy on maintaining employee files and performance reviews from the Administrator on 09/14/2023, but the policy was not provided. Review of CG #1's employee file on 09/13/2023 revealed a hire date of 11/27/2012. Further review of the file revealed no annual performance reviews had been performed. Review of CG #2's employee file on 09/13/2023 revealed no hire date on file, and no evidence of any performance reviews had been documented. Review of CG #3's employee file on 09/13/2023 revealed no hire date on file, and no evidence of any performance reviews had been documented. Review of CG #4's employee file on 09/13/2023 revealed no hire date on file, and no evidence of any performance reviews had been documented. Review of CG #5's employee file on 09/13/2023 revealed no hire date on file, and no evidence of any performance reviews had been documented. Review of CG #6's employee file on 09/13/2023 revealed no hire date on file, and no evidence of any performance reviews had been documented. Review of CG #7's employee file on 09/13/2023 revealed no hire date on file, and no evidence of any performance reviews had been documented. Review of the Assistant Administrator's (AA) employee file on 09/13/2023 revealed no hire date on file, and no evidence of any performance reviews had been documented.	P 110			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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P 11	Continued From page 16	P 110		
	Review of the Administrator's employee file on 09/13/2023 revealed no hire date on file, and no evidence of any performance reviews had been documented. In an interview with the AA, Administrator, and the Owner on 09/13/2023 at 4:00 PM, they all stated there had not been any employee at the facility long enough to have an annual performance evaluation.			
P 1	902 KAR 20:036 3(8)(h)2a-c Section 3. Administration and Operation (8) Personnel. (h) In-service training. 2. Documentation of orientation and in-service training shall be maintained in the employee's record and shall include: a. Name of the individual or individuals who provided the training; b. Date and number of hours the training was given; and c. A summary of the training program's content. This requirement is not met as evidenced by: Based on interview, review of the provided employee files, review of the facility provided in-service record document, and review of the facility's policy folder, it was determined the facility failed to provide evidence of in-service training content, number of training hours, or the	P 135	P135 (1) Current Employees will have new background checks performed with current criminal information if any given	4-16-24

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P 135	Continued From page 17 identity of the person that provided in-service training for nine (9) of ten (10) sampled employees. No record of in-service training was provided for Caregiver (CG) #1, CG #2, CG#3, CG #4, CG #5, CG #6, and CG #7, the Assistant Administrator (AA), and the Administrator. The findings include: The State Survey Agency (SSA) Surveyor, on 09/14/2024, requested a copy of the facility's policy for in-service training requirements from the Administrator, but the policy was not provided. Review of the facility's document Topics Inservice provided by the Administrator revealed staff was to read the following topics and sign the sheet once they had been read. The topics included: Abuse, Patient Rights, Combative Clients, Blood Borne Pathogens, Universal Precautions, Discharge Procedure, Charting, Bullying, Housekeeping Policy, Staffing, and Meal Prep. Further review revealed the document had been divided into four (4) columns with one (1) of the following years: 2020, 2021, 2022, and 2023 written at the top. Further review revealed the column labeled 2020 contained five (5) signatures; the column labeled 2021 contained four (4) signatures; the column labeled 2022 contained seven (7) signatures; and the column labeled 2023 contained thirteen (13) signatures. These thirteen (13) signatures included CG #1, CG# 2, CG #3, CG #4, CG #5, CG #6, CG #7, the AA, and the Administrator. On 09/14/2023, a copy of the in-service training content, number of training hours, and the identity of a person that provided the training to the staff was requested by the SSA Surveyor, but was not provided by the Administrator.			

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P 1	Continued From page 18	P 135			
	Review of employee files for CG #1, CG #2, CG #3, CG #4, CG #5, CG #6, CG #7, the contracted maintenance worker, the AA, and the Administrator revealed no documentation any inservice training had been provided. In an interview with the AA on 09/13/2023 at 10:50 AM, he stated staff in-services and documentation of completion were the responsibility of the Administrator. In an interview with the Administrator on 09/13/2023 at 12 :50 PM, she stated staff members were given a packet of policies to read with instructions to sign the sheet of paper she provided when completed. In an interview with the Owner on 09/13/2023 at 1:00 PM, she stated the AA and Administrator were responsible for trainings and in-services for the staff and keeping facility records of this. The Owner stated she had only been managing a Personal Care Home for two (2) years and did not know the regulations. The Owner requested the SSA Surveyor give her a list of whatever the residents should have and anything she needed to do, and she stated she would do it. She again stated she did not know what the State Regulations were for a Personal Care Home and requested a copy of the regulations from the SSA Surveyor. The Owner stated she thought the State would notify her of regulation updates and changes by mail.				
P 14	902 KAR 20:036 3(8)(h)3a-l Section 3. Administration and Operation (8) Personnel.	P 140	P 140 Each Inservice for each employee we have a handbook. 12 / Service		

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P 14	Continued From page 19 (h) In-service training. 3. In-service training shall include the following: a. Policies regarding the responsibilities of specific job duties; b. Services provided by the facility; c. Recordkeeping procedures; d. Procedures for the reporting of cases of adult abuse, neglect, or exploitation pursuant to KRS 209.030; e. Resident rights established by KRS 216.510 to 216.525; f. Adult learning principles and methods for assisting residents to achieve maximum abilities in ADLs and IADLs; g. Procedures for the proper application of emergency manual restraints; h. Procedures for maintaining a clean, healthful, and pleasant environment; i. The aging process; j. The emotional problems of illness; k. Use of medication; and l. Therapeutic diets. This requirement is not met as evidenced by: Based on interview, review of employee files, and review of the facility's policy folder, it was determined the facility failed to provide its staff with in-service training that included: policies regarding the responsibilities of specific job duties; services provided by the facility; recordkeeping procedures; procedures for reporting of cases of adult abuse, neglect, or exploitation pursuant to Kentucky Revised Statute (KRS) 209.030; resident rights established by	P 140	is included, we have called several places as Pathways to ... And Talk to ... for documentation of the Inservice provided, we have Agreed to come IN as of yet The resource each STAFF every 3 months will read And sign That they have Read and understood The INSERVICE FAcility Will Keep trying to get SOMEONE to do inservices.	4/24

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KRS 216.510 to 216.525; adult learning principles and methods for assisting residents to achieve maximum abilities in Activities of Daily Living (ADL); procedures for the application for emergency manual restraints; procedures to maintain a clean, healthful, and pleasant environment; the aging process; the emotional problems of illness; the use of medications; and therapeutic diets for ten (10) of ten (10) employees, Caregiver (CG) #1, CG #2, CG #3, CG #4, CG #5, CG #6, CG #7, the Contracted Maintenance Worker (CMW), the Assistant Administrator (AA), and the Administrator.

The findings include:

On 09/14/2024 a copy of the facility policy for in-service training requirements was requested from the Administrator, but was not provided.

Review of employee files for CG #1, CG #2, CG #3, CG #4, CG #5, CG #6, CG #7, the CMW, the AA, and the Administrator revealed no documentation any inservice training had been provided.

In an interview with Housekeeper/CG #1 on 09/18/2023 at 3:58 PM, she stated she had worked for this facility for fourteen (14) years. She stated since she had been at the facility there had never been any trainings or in-services.

In an interview with the AA on 09/13/2023 at 10:50 AM, he stated he had not done any in-services since he had been at the facility.

In an interview with the Administrator on 09/13/2023 at 12 :50 PM, she stated staff members were given a packet of policies to read at the time of hire with instructions to sign the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100030	A. BUILDING: _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

(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 CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE
P 1	Continued From page 21 sheet of paper she provided when completed. In an interview with the Owner on 09/13/2023 at 1:00 PM, she stated the AA and Administrator were responsible for trainings and in-services for the staff and keeping facility records. The Owner stated she had only been managing a Personal Care Home (PCH) for two (2) years and did not know the regulations. The Owner requested the State Survey Agency (SSA) surveyor give her a list of whatever the residents should have and anything she needed to do, and she would do it. She again stated she did not know what the State Regulations were for a PCH and requested a copy of the regulations from the SSA Surveyor. The Owner stated she thought the State would notify her of regulation updates and changes by mail.	P 140		
P	902 KAR 20:036 3(8)(h)4 Section 3. Administration and Operation (8) Personnel. (h) In-service training. 4. Each SPCH shall ensure that at least one (1) direct care staff member in addition to the administrator completes the mental illness or intellectual disability training workshop established by 921 KAR 2:015, Section 14, within six (6) months from the most recent effective date of this administrative regulation and every two (2) years thereafter. An SPCH shall employ at least one (1) direct care staff member who has received the training.	P 145	P145 Currently Not a SPCH	

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P 1...	Continued From page 22 This requirement is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure that at least one (1) direct care staff member in addition to the Administrator completed the mental illness or intellectual disability training workshop established by 921 Kentucky Administrative Regulations (KAR) 2:015, Section 14. The findings include: On 09/14/2023 a facility policy for staff requirements for completion of the mental illness or intellectual disability training workshop was requested from the Administrator but was not provided. In an interview with the Assistant Administrator (AA) on 09/15/2023 at 10:30 AM, he stated he was not aware of any special training requirement for mental illness or intellectual disabilities. In an interview with the Administrator on 09/13/2023 at 12:00 PM, she stated she was not aware of any special training requirement for mental illness or intellectual disabilities. In an interview with the Owner on 09/15/2023 at 1:00 PM, she stated she was not aware of any special training requirement for mental illness or intellectual disabilities.	P 145			
P ...	902 KAR 20:036 3(8)(i)2a-c Section 3. Administration and Operation (8) Personnel.	P 155	P155 Caregiver #1 will be continuing providing activities for residents		

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P 155	Continued From page 23 (l) Staffing requirements. 2. The administrator shall designate one (1) or more staff members to be responsible for the: a. Recordkeeping; b. Basic health and health related services; and c. Activity services. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to designate a staff person to be responsible for the activity program. This affected twenty (20) of twenty (20) current residents. The findings include: On 09/14/2023, a request was made by the State Survey Agency (SSA) Surveyor for a facility policy related to activities from the Administrator, and no policy was provided. Observations on 09/13/2023 revealed Caregiver (CG) #1 left a note for the residents posted in black marker on white paper in the dining room to participate in a coloring contest and directed the residents to the coloring pages in the dining room next to the television. A stack of coloring pages was observed next to the television, but no crayons, markers, or colored pencils were provided. Observations on 09/14/2023 revealed CG #1	P 155	Caregiver #1 was educated on charting participated Activities who participated who did not. What Activity was / is scheduled for That Day. To ensure Residents are having a Fun filled day with the activities done	3-30-24

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P 1...	Continued From page 24 arrived at the facility at approximately 1:50 PM and left the facility at approximately 4:00 PM. CG #1 had given two (2) residents each a small puzzle, but was not observed in the facility again until 09/18/2023. In an interview with Resident #7 on 09/06/2023 at 10:55 AM, the resident stated he/she had lived in the facility since 11/2022. He/she stated at a former residence, they had played bingo and he/she liked to win money and prizes but had never played bingo at this facility. He/she further stated no one had ever asked what he/she liked to do, and there had never been a shopping trip or backyard barbecue arranged for the residents. Resident #7's hair had been braided, and he/she stated it was the first time anyone at this facility had done anything like that to his/her hair. In an interview with Resident #11 on 09/15/2023 at 10:20 AM, the resident stated he/she would like to be taken out to go shopping for him/herself, but he/she never left the facility. In an interview with Resident #14 on 09/18/2023 at 4:28 PM, the resident stated there was nothing to do at the facility. In an interview with the Assistant Administrator (AA) on 09/15/2023 at 10:30 AM, he stated there was no dedicated activities person at the facility and that he had discussed this with the Owner, and she had stated she was working on it, but nothing ever changes. In an interview with the Administrator on 09/13/2023 at 12:00 PM, she stated CG #1 was the staff person responsible for resident activities and the third staff person in charge at the facility.	P 155			

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P 1...	Continued From page 25	P 155			
	In an interview with the Owner on 09/15/2023 at 1:00 PM, she stated the AA oversaw activities for the facility.				
P 1...	902 KAR 20:036 3(8)(i)3a-b Section 3. Administration and Operation (8) Personnel. (i) Staffing requirements. 3. Each PCH or SPCH shall have a full-time staff member who shall be: a. Responsible for the total food service operation of the facility; and b. On duty a minimum of thirty-five (35) hours each week. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to have a full-time staff member who was responsible for the total food service operation of the facility and was on duty a minimum of thirty-five (35) hours each week for twenty (20) of twenty (20) current residents. The findings include: Review of the facility's policy titled, "Policy Concerning Dietician Consultant", dated 01/31/1984, revealed it was the policy of the facility to have on staff a part-time dietician consultant. The consultant would provide menu suggestions; oversee the therapeutic diets;	P 160	P160 Food Service pe... ssn WAS hired IN at 35 hr A week, which ... as done Food servile Befor... at FAST Food places, ...ervice person WAS edu... tal on The duties of ... Food Service which in... ludes Seeving Nutrious ... is t meals, preparin... 2 plates at a Time ... To ensur HOT Food is serv... as soon as This pla... ove arrived to Resi... f and Report. When Food Service worker is out sick etc... An off duty or a P... N employee will ... over until Food servi... worker RETURNS. Guidl... ics on Healthy Food... with enough calorie ... intake		

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P 160	Continued From page 26 document on each of the patients' medical records during each visit; instruct on in-services for staff and residents on therapeutic diets and nutrition in general; review charts of patients checking weekly weights; periodically view a meal and make suggestions; give any needed patient diet instructions on a one to one (1:1) basis; and give staff instructions and suggestions on food preparation. Observations from 09/13/2023 through 09/15/2023 and 09/18/2023 through 09/21/2023 revealed the Administrator and the Assistant Administrator (AA) were observed as the staff who cooked lunch and supper daily. In an interview with Caregiver (CG) #1 on 09/01/2023 at 4:22 PM, she stated she did not feel the meals were substantial and the portions served to the residents were too small. In an interview with the Administrator on 09/06/2023 at 11:30 AM, she stated, "we do it all, cook and give care". She further stated both she and the AA were also responsible for administering medications. In further interview with the Administrator on 09/21/2023 at 7:45 AM, when asked if she could get all her administrative and facility work done while being responsible for cooking lunch and supper in the kitchen each day she worked, she stated, "not always but I have been doing this for twenty-three (23) years and am used to it".	P 160	With Menus showing Portions, Serving Sizes	
P 170	902 KAR 20:036 3(9)(a) Section 3. Administration and Operation (9) Medical records.	P 170	P170 Education was implemented, FAC 137	