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
GEMS 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	Continued From page 27 (a) The PCH or SPCH administrator or staff member in charge of medical records shall assure that a complete medical record is kept for each resident with all entries current, dated, and signed. This requirement is not met as evidenced by: Based on interview and record review, it was determined the facility failed to keep a complete and accurate medical record with all entries current, dated, and signed for four (4) of twenty (20) current residents (Residents #4, #5, #9, and #18). The findings include: On 09/14/2023, a request was made by the State Survey Agency (SSA) Surveyor for a facility policy related to the keeping of medical records from the Administrator, and no policy was provided. Review of Resident #4's medical record revealed the facility admitted the resident on 08/10/2022 with diagnoses of Chronic Schizophrenia, Insomnia, and Cannabis Use. Further review revealed no documented evidence of monthly weights being found in the record. Review of Resident #5's medical record revealed the facility had no date of admission form for the resident. Resident #5 was discharged from an unknown facility on 01/31/2022, with diagnoses of Depression and Anxiety Affect. Further review revealed no documentation of monthly weights and no documentation of a current annual exam being found in the record.	P 170	FACILITY STAFF WAS educated ON doing Monthly weights AND V.S. documentation	3-15-24

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P 17	Continued From page 28 Review of Resident #9's medical record revealed the facility admitted the resident in May of 2022 with diagnoses of Schizophrenia, Borderline Personality, and Extrapyramidal Effects. Further review revealed no documented evidence of an admission history and physical, no documented monthly weights, and no documented progress notes from admission to 09/01/2023 being found in the record. Review of Resident #18's medical record revealed the facility admitted the resident on 03/22/2023 with diagnoses of Depression, Diabetes Mellitus, Hypertension, Wheelchair Use and Left Below the Knee Amputation. Further review revealed no documented evidence of monthly weights and additionally, the resident's Medication Administration Record (MAR) revealed Resident #18 had received insulin daily from 09/04/2023 through 09/13/2023. However, the resident stated he/she had not received any injections and the sealed vial of insulin labeled for the resident in the facility refrigerator was intact. In an interview with the Assistant Administrator (AA) on 09/15/2023 at 10:55 AM, he stated he was responsible for putting Advance Practice Registered Nurse (APRN) notes into the charts and maintaining resident medical records. In an interview with the Owner on 09/15/2023 at 11:00 AM, she stated the Administrator was responsible for maintaining the facility and resident records.	P 170		
P 185	902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services	P 185	P185 Each STAFF ON [illegible] staff will be [illegible] responsible	

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P 185	Continued From page 29 (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to assure that the resident's health care needs are met; 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility. This requirement is not met as evidenced by: Based on observation, interview, record review, review of Google Maps, and review of the facility's policy, it was determined the facility failed to ensure basic health and health related services [illegible] #16 and Resident #18. This failure posed an imminent danger to the safety and well-being of residents. 1. On 10/11/2022 at an unknown time, Resident #16 left the facility without staff knowledge. Staff members were not aware the resident was missing until they called him/her for medication administration, and he/she was absent. Resident	P 185	for Daily Head [illegible] to ensure who is in the facility. Reminds each R to sign out if leaving facility every [illegible] STAFF checks sign in/out form 7 sec if The Resident has signed out If not STAFF stays Resident and have Resident sign back in and sign Resident #3 had prior Systems Before [illegible] Also Another System which CANNOT The NAME of is check system daily with [illegible] OF Time date [illegible]	[illegible] is in STAFF Resident leaving [illegible] has not Resident the Recall Procedure [illegible] documentation [illegible]

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KENTUCKY HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

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P 185	Continued From page 30 #16 had been missing from the facility for more than twenty-four (24) hours. 2. On 08/30/2023 at 2:23 PM, the State Survey Agency (SSA) Surveyor observed staff running outside the building and down the sidewalk to obtain Resident #3 who had exited the building without staff knowledge. Resident #3 was located at the end of the block and returned to the facility by staff. 3. On 09/18/2023 at approximately 4:40 PM, staff discovered Resident #14 was not in the facility when he/she could not be located for supper. Resident #14 was reported missing at approximately 9:00 PM on 09/18/2023. Resident #14 was not located and returned to the facility until 09/19/2023 at 3:00 PM. 4. On 09/04/2023, Resident #18 returned to the facility from the hospital with a new order for insulin to be administered every night. Review of Resident #18's Medical Administration Record (MAR) revealed the resident's insulin had been charted as administered. However, inspection of the insulin vial labeled with Resident #18's name revealed the vial was unopened, and Resident #18 confirmed he had not received any insulin since returning to the facility from the hospital. The findings include: Review of the facility's policy titled, "Medication Administration", undated, revealed the staff's careful observation of the five rights (right client, right drug(s), right dosage, right time, and right route) were extremely important to the safety of the client. On 09/14/2023 a request for a facility policy on	P 185	to monitor to make sure system is working All Residents who Returns from hospital with any new orders are documented. Process for ensuring CAMERAS are working is checked daily by Admin.	10-5-24

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STATE AND PL	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GE	HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

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P 1	Continued From page 31	P 185			

Resident Supervision was requested from the Administrator but not provided.

1. Review of Resident #16's medical record revealed the facility admitted Resident #16 on 08/16/2018 with diagnoses of Depression, Anxiety, and Diabetes.

Review of Resident #16's medical record from the local hospital revealed Resident #16 was admitted on 10/11/2022 at 4:45 PM after police were called because he/she was found sitting in a parking lot and was presumed homeless.

Review of the Emergency Physician note, from the local hospital, dated 10/11/2022 at 4:45 PM, revealed on arrival to the Emergency Department (ED), Resident #16 was alert and eating a sandwich but would not answer questions about his/her name, his/her birthday, or the year. Per the note, Resident #16 was described as appearing very thin and unkempt. The note also revealed Resident #16's blood work was unremarkable and a Computed Tomography (CT) scan without contrast of Resident #16's head was unremarkable. Resident #16 was held in the ED for geriatric psychiatric placement. However, the note stated before that was arranged, his/her identity was confirmed, and Resident #16 was sent back to the facility via ambulance on 10/12/2022 at 6:47 PM.

In an interview on 08/31/2023 at 2:29 PM with the Administrator, she stated in reference to Resident #16 being gone without the facility knowing about it that she remembered getting a call around 7:30 AM in the morning on 10/12/2022 from a local hospital asking if any of the residents at the facility were missing. She stated the person she spoke with on the phone gave a name, but it was

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F 1	Continued From page 32	P 185			

not anyone from the facility, so she told them "No". She stated she then started medication administration, and when she called Resident #16 for his/her medications, the resident did not come. She stated at that point she feared it might have been Resident #16 the hospital was calling about, so she called them back. She stated hospital staff described the man, and it sounded like Resident #16. She stated hospital staff told her the resident would be sent to the facility. The Administrator stated Resident #16 was mostly non-verbal but could say a few words like "cigarette" or "coffee" and answer yes or no questions. She further stated she was not at the facility when Resident #16 returned, so she did not know the time he/she came back to the facility. She stated the next day she asked Resident #16 what happened and he/she "just put his/her head down". The Administrator also stated she was unsure what time Resident #16 left the facility the day before.

2. Review of Resident #3's medical record 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 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 #3 continued to exit seek, and a Wander Guard (a bracelet or anklet worn by the resident to trigger an alarm when the resident exited a door equipped with the Wander Guard alarm) for resident safety was pending.

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

In an interview with the Administrator on 08/30/2023 at 2:23 PM, she stated Resident #3 "took off", and he/she could move fast when he/she wanted to. She further stated she had gotten busy, and the resident took off. The Administrator stated she supervising Resident #3 during this time.

In an interview on 08/30/2023 at 2:45 PM with the facility's Owner/Resident #3's daughter and guardian, she stated Resident #3 had been located at the corner of the street, where the facility was located.

In an interview with Caregiver #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. She further stated she felt Resident #3 needed to be on a memory care unit somewhere.

In an interview on 08/29/2023 at 10:45 AM with the facility's Owner/Resident #3's daughter and guardian, she stated she had checked on getting a Wander Guard system for Resident #3, but it was too costly.

3. Review of Resident #14's medical record revealed the facility admitted Resident #14 on 01/11/2023 with diagnoses that included Acute Schizophrenia, Psychosis, and Asthma. Per the record, Resident #14 had a State Guardian.

In an interview on 09/18/2023 at 4:28 PM 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

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P 185	Continued from page 34	P 185		
	(SSA) Surv or made the AA aware, and he stated they ould talk to Resident #14.			
	In an interv w on 09/19/2023 at 3:22 PM with the , she stated Resident #14 verbalized wanting to back to the Psychiatric Hospital, on 09/18/2023 t approximately 4:40 PM. She stated she ld Resident #14 that he/she would not be able speak with State Guardianship until the next da However, there was no evidence the facility t k any actions to ensure the resident's s fety after he/she voiced he/she wanted to l ve.			
	Observatio on 09/19/2023 at 3:00 PM, revealed a local poli officer had arrived at the facility. The AA inf ned the police officer he had received a ll from a local store employee who told him Re ident #14 had been sighted with his/her whe lchair behind the store. The AA requested e police officer pick up Resident #14 and bring h n/her back to the facility.			
	Review of e website, https://maps.google.com revealed-th distance from the local store where Resident # was located was approximately one and one-te h (1.1) miles from the facility.			
	Observatio on 09/19/2023 at 3:08 PM, revealed Resident # arrived at the facility in the back of a police ve cle, with his/her wheelchair.			
	In an interv w with the AA on 09/19/2023 at 3:12 PM, he sta d he had heard Resident #14 talking about want g to go back to a hospital the previous d , and the Administrator was aware. The AA sta d he told the Administrator that Resident # was upset and was talking about wanting to ave the facility and they decided to wait until c few at 8:30 PM to see if Resident			

Office of Inspector G eral

STATEMENT OF DEFICIEN AND PLAN OF CORRECTIO	S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE COMP	RVEY TED
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#14 would r urn. He stated when the resident did not retu by 8:30 PM, he called the Administrat , the Owner, the State Guardian on call, the Off e of the Inspector General and Adult Protective S rvices and was instructed by the State Guarc n to file a missing person's report. The AA stat the local police department was called, an o cer came to the facility, and a missing per n's report was filed. The AA stated at approxim tely 9:00 PM the Administrator called the hospital and the resident was not there either. He t n stated at approximately 11:00 PM he went to other areas to look for the resident but had no ck. The AA stated at 2:55 PM today a Salvation rmy worker called the facility and reported he he recognized the resident, and the resident wa behind the store in the alley. The AA stated th local police department had been called, and ey went and retrieved Resident #14 and brough im/her back to the facility.

In an Intervi w with the Administrator on 09/19/2023 t 3:22 PM, she stated at suppertime on 09/18/2(3, it was discovered Resident #14 was not in t e building. Resident #14's roommate l d told the Assistant Administrator that Reside #14 "took (his/her) wheelchair and left". She s ted they decided to wait until curfew at 8:30 PM see if Resident #14 would return. The Admini rator stated the resident did not return to th facility at 8:30 PM. The Administrat stated the facility was unaware of Resident #' 's whereabouts until 3:00 PM on 09/19/2023

4. Review Resident #18's medical record revealed th facility admitted Resident #18 on 03/22/2023 ith diagnoses of Diabetes Mellitus, Left Below e Knee Amputation, and Depression.

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P 185	Continued F[illegible]om page 36 Review of R[illegible]sident #18's Nurses' Note, dated 09/04/2023 [illegible]2:30 PM and written by the Administrat[illegible] revealed Resident #18 was discharged [illegible]om the hospital with the diagnosis of Sepsis (a co[illegible]dition resulting from the presence of harmful mic[illegible] organisms in the blood). Medications [illegible]ere as follows: Amoxicillin-[illegible]otassium-Clavulanate (an antibiotic) eight hundr[illegible] and seventy-five (875) milligrams/d[illegible]e hundred and twenty-five (125) milligrams e[illegible]ery twelve (12) hours for seven (7) days, Doxyc[illegible]cline (an antibiotic) one hundred (100) milligr[illegible]ns twice a day for ten (10) days, and Levemi[illegible]U-100 Insulin ten (10) units at bedtime. Review of R[illegible]sident #18's medical chart revealed no Discharg[illegible] Summary or Discharge Orders were in the [illegible]cord. Observation [illegible]n 09/14/2023 during the 8:00 AM Medication A[illegible]dministration with the AA revealed an opened box [illegible]containing a vial of Levemir U-100 Insulin label[illegible]d for Resident #18 on the bottom shelf of the [illegible]or in the resident food refrigerator. The seal on [illegible]e top of the vial was intact. In an intervi[illegible]w with Resident #18 on 09/14/2023 at 11:00 AM [illegible]he/she was found to be oriented to person, plac[illegible], time and event. Resident #18 stated he/sh[illegible] had been at the facility since March 2023 and ha[illegible] come from a hospital. Resident #18 stated h[illegible]/she checked his/her own blood sugar, and [illegible]was never above three hundred (300). Resi[illegible]nt #18 stated he/she had been on insulin since [illegible]e/she came back from the hospital but had nev[illegible] received insulin at the facility. Review of R[illegible]sident #18's Medication Administrati[illegible]n Record (MAR) dated 09/01/2023	P 185		

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P 185	Continued From page 37 to 09/13/202 revealed Resident #18's Levemir had been ch rted as given. In an intervi v with the AA on 09/14/2023 at 11:00 AM, he stat no syringes for Resident #18 had arrived, and ne Administrator was ordering them from the ph macy. When asked how Resident #18's insulir which was charted as given on the MAR had be n administered, AA stated he should have ircled his initials on the MAR indicating th medicatio was not given. In an intervi v with the Administrator on 09/14/2023 11:00 AM, she stated the pharmacy sent the ins n but not the syringes. She stated she would c ler them today. In an intervi v with the Owner on 09/15/2023 at 1:00 PM, st stated her expectation was the charting in t MAR would be done at the time the medicat n was given.	P 185		
P 220	902 KAR 20 036 4(1)(h)1-8 Section 4. Provision of Services (1) Basic he lth and health related services. (h) All resid nt medications shall be plainly labeled with he: 1. Resident name; 2. Name of e drug; 3. Strength 4. Name of e pharmacy; 5. Prescripti n number; 6. Date; 7. Prescribe s name; and 8. Caution atements and directions for use, unless a m lified unit dose drug distribution	P 220	P220	12-4-23

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P 220	Continued from page 38 system is used. This requirement is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure all medications were plainly labeled with the resident name, name of the drug, strength, name of the pharmacy, prescription number, date, prescriber's name, and caution statements/directions for use for one (1) of twenty (20) current residents, Resident #. The findings include: The medication labelling policy was requested and not found in the facility's policy folder; however it was not provided by the Administrator. Review of the facility's policy titled, "Medication Administration", undated, revealed the staff's careful observation of the five rights (right client, right drug(s), right dosage, right time, and right route) were extremely important to the safety of the client. Review of Resident #12's medical record revealed the facility admitted Resident #12 on 01/25/2022 with diagnoses of Type 2 Diabetes, Chronic Pain to Both Knees, and Allergic Rhinitis. Review of Resident #12 Physician's Orders revealed Resident #12 was prescribed Ozempic (a medication to aid with control of blood sugars in adults with Type 2 Diabetes) to be administered once weekly	P 220		

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GENESIS HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

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P 220	Continued from page 39 Observation on 09/14/2023 at 8:00 AM during a medication administration observation with the Assistant Administrator (AA), revealed an Ozempic pen was being stored on the bottom shelf of the door of the facility refrigerator with no label on it. In an interview with the AA on 09/14/2023 at 8:00 AM, he stated the medication belonged to Resident #, and the label had fallen off. He stated it was important for all medications to be labeled so they would know who it belonged to. He also stated he and the Administrator were the only people that gave medications, and they knew it belonged to Resident #12. In an interview with the AA, Administrator, and the Owner on 09/14/2023 at 8:00 AM, they all agreed medications should be labeled for the safety of the residents.	P 220		
P 225	902 KAR 20:036 4(1)(i)1-2 Section 4. Provision of Services (1) Basic health and health related services. (i)1. All medicines kept by the PCH or SPCH shall be kept in a locked place. 2. The administrator or staff person designated by the administrator shall: a. Be responsible for administering or supervising the self-administration of medication; b. Ensure that all medications requiring refrigeration are kept in a separate locked box in the refrigerator or in the medication area; and c. Ensure that drugs for external use are stored separately from those administered by mouth and injection.	P 225	P225 Mini fridge in Place 2 Lock boxes have Been implemented when use is needed All STAFF educated of Keeping INSULIN IN Mini fridge and Not in Kitchen fridge unless it IN A Lock Box	

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

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

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P 225	Continued from page 40	P 225	by it self on Separate shelf	10-4-23

This requirement is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure all medications that required refrigeration were kept in a separate locked box in the refrigerator of the medication area for two (2) of twenty (20) current residents. An Ozempic Pen for Resident #12 and a vial of Insulin for Resident #18 (both medications for Diabetes) were being kept on the bottom shelf of the door of the resident food refrigerator.

The findings include:

On 09/14/2023 a facility policy for Medication storage was requested and not provided by the Administrator.

Observation on 09/07/2023 at 11:30 AM revealed an unlabeled Ozempic Pen was being stored on the door of the kitchen refrigerator next to a jar of mayonnaise. The Assistant Administrator (AA) moved the medication to the bottom shelf on the same door and placed it next to a box which contained a vial of Insulin. Neither medication was in a separate locked box or in a refrigerator designated for medication.

Observation on 09/14/2023 at 8:00 AM during medication administration with the AA revealed an unlabeled Ozempic Pen and a vial of Insulin on the bottom shelf of the door to the resident food refrigerator.

In an interview on 09/14/2023 at 8:00 AM with the

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P 225	Continued From page 41 AA during medication administration, he stated the Ozempic Pe belonged to Resident #12. The vial of Insulin we labeled as belonging to Resident #18. He fur er stated the medications were usually stor in a separate medication refrigerator the medication room closet. However, h stated the refrigerator had broken last week, a the Owner was aware. He also stated the C ner was taking care of getting a new refriger or. In an intervi v on 09/15/2023 at 10:55 AM, the Administrat stated medications that were kept in the refrig ator should be locked up in their own box in separate refrigerator. She stated she thought he Owner was ordering another medication frigerator. In an intervi v on 09/15/2023 at 1:00 PM with the Owner, she tated she knew medications that were stored the refrigerator needed their own locked box. When told by the Administrator in front of the tate Survey Agency Surveyor that a new medica on refrigerator was needed, the Owner acte like she did not know the old one was broken	P 225		
P 235	902 KAR 20 036 4(1)(k)1-2 Section 4. Provision of Services (1) Basic h lth and health related services. (k)1. If a re dent manifests persistent behavior that might r quire psychiatric treatment, the PCH or SPCH sh ll notify the resident's physician or health care ractitioner acting within the practitioner scope of practice to evaluate and direct the r ident's care.	P 235	P 235 Evenings Wholehearth is Notified of Resident going to Hospital with Reason and updates of admittance / Discharges with follow up All STAFF have Been educate	

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P 235	Continued From page 42 2. If the resident's condition does not improve for continued stay in a PCH or SPCH, the physician or health care practitioner shall initiate transfer of the resident to an appropriate facility as soon as possible. This requirement is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to have an effective system to ensure basic health and health related services to residents related to their persistent behavior that might require psychiatric treatment for one (1) of twenty (20) current residents, Resident #4. The findings include: Review of Resident #4's medical record revealed the facility admitted Resident #4 on 08/10/2022 with diagnoses of Chronic Schizophrenia, Cannabis Use, and Insomnia. Further review, on 08/31/2023 at 2:05 PM, of Resident #4's medical record revealed a Uniform Citation was issued to Resident #4 from the local police department, on 07/14/2023 at 5:30 PM, which stated the resident grabbed a cup of soda off a table and poured it on two (2) other residents. After the citation, Resident #4 then proceeded to shove and knock a resident out of his/her chair and onto the floor. Additionally, per the record, another Uniform Citation was issued to Resident #4 from the local police department, on 07/15/23 at 1:08 AM, which stated Resident #4 was throwing rocks at staff and other residents of the facility striking a resident in the back of the head causing a small laceration.	P 235	IN Notifying Doctor Admin to get hold of the dr. for Medical and or Behavior issues. STAFF WILL CALL 911 with REASON for the CALL STAFF WILL Alert Guardian if Resident HAS one Resident will be sent TO ER for evaluation, Resident depending if not Admin Dr or NO med change Admin will file for A 302A Thru The Courts And Try to get Resident To Eastern STATE Hospital Through Pathways elvation	

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 235	Continued From page 43 However, review of Resident #4's medical record revealed no documentation he/she was evaluated after the incidents on 07/14/2023 or 07/15/2023 to assess his/her need for psychiatric evaluation/treatment. Observation on 09/05/2023 at 4:53 PM, revealed Resident #1 with swelling and bruising to the right eye. Review of Resident #12's medical record revealed, the facility admitted Resident #12 on 01/25/2022 with diagnoses of Type 2 Diabetes, Chronic Pain to Both Knees, and Allergic Rhinitis. Review of Resident #12's Accident/Incident Report, dated 09/03/2023, revealed Resident #4 punched Resident #12 on the right side of his/her face. Review of Resident #4's medical record revealed no documentation he/she was evaluated after the incident on 09/03/2023 to assess his/her need for psychiatric evaluation/treatment. In an interview with Resident #12 on 09/06/2023 at 5:39 PM, Resident #12 was asked about the bruise to his/her face, and Resident #12 stated he/she did not want to talk about it. Resident #4 was out of the facility and unavailable for interview. In an interview with the Assistant Administrator (AA) on 09/[illegible]/2023 at 5:39 PM, he stated Resident #12 got into an argument with Resident #4 on Sunday 09/03/2023. The AA stated Resident #12 asked Resident #4 to put a shirt on, and Resident #4 punched Resident #12 in the	P 235		

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 235	Continued from page 44 eye. He stated Resident #12 had to go to the hospital and received three (3) sutures. He stated Resident #4 left the facility and returned later in the evening, but he was not sure of the exact time. In an interview on 08/31/2023 at 2:18 PM with the Administrator, she stated Resident #4 left the facility, and Resident #12 was sent to the Emergency room for evaluation and treatment. The Administrator further stated when Resident #4 and Resident #12 returned to the facility, they both acted like nothing happened. In an additional interview with the Administrator on 09/06/2023 at 10:40 AM, she stated she reported the incident between Resident #12 and Resident #4 to Emergency (911), State Guardianship, and the Office of the Inspector General. In an interview with the Owner on 09/15/2023 at 1:00 PM, she stated her expectation for the residents' environment was that they feel safe, happy, and they could come to staff with anything and everything. She further stated for this resident altercation, the facility called 911 and did a report. She stated the State Guardian was notified, and they also reported the incident to the Office of the Inspector General (OIG). The Owner stated there had been no further incidents between Resident #4 and Resident #12.	P 235		
P 240	902 KAR 20:036 4(1)(l)1-4 Section 4. Provision of Services (1) Basic health and health related services. (l) Use of restraints.	P 240	P240 Resident #3 has a sec... alarm system That ale... STAFF when Client/Resid... is Near the System which T...	

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STATEMENT OF DEFICIEN AND PLAN OF CORRECTIC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE COMI	SURVEY TED
	100030	A. BUILDING: _____ B. WING _____	08/	2023

NAME OF PROVIDER OR S	PLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS HEALTH OI	ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

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P 240	Continued	om page 45	P 240	To Wert STAFF Resident is out To prevent danger or harm AND elopement The Alarm system WAS INSTALLED to prevent Any future elopements from happening again Alarm system is monitored and checked daily AND logged	1-31-23

1. Chemica and physical restraints shall not be used, exce as authorized by KRS 216.515(6).

2. Restrain that require a lock and key shall not be used.

3. Emerger y use of a manual restraint shall be applied onl by appropriately trained personnel if:
a. A resider poses an imminent risk of physical harm to sel or others; and
b. The eme gency manual restraint is the least restrictive i ervention to achieve safety.

4. Restrain shall not be used as:
a. Punisl ient;
b. Discip e;
c. Conve ence for staff; or
d. Retali ion.

This requin nent is not met as evidenced by:
Based on i erview, record review, and review of the facility's olicy, it was determined the facility failed to pr ide basic health and health related services re ted to use of restraints for one (1) of twenty (20) urrent residents, Resident #3.

The finding include:

Review of t e typed facility policy, untitled and undated, S tion 1B-Physical Abuse or Neglect, included in roper use of restraints, chemical and physical as n example of physical abuse or neglect.

Review of t esident #3's medical record revealed the facility mitted Resident #3 on 11/27/2021

STATEMENT OF DEFICIENC AND PLAN OF CORRECTIO	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY TED
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P 240	Continued F	om page 46	P 240		

with diagnos of Alzheimer's, Autoimmune Disease, Ut ine and Breast Cancer, and Depression.

Review of R sident #3's medical record revealed Resident #3 had a letter from Physician #1 that gave his/he guardian/daughter permission to use an Alzheime door lock on Resident #3's door, which was u ed to keep Resident #3 locked in his/her roon for approximately three (3) months. The letter st ted the lock was for Resident #3's safety and w ll-being and to keep him/her from leaving the cility without staff knowing.

In an intervi w on 08/31/2023 at 9:00 AM with the Administrat and the Owner/Resident #3's Guardian/D ughter in attendance, the Administrat stated they did not document how long the res ent was locked in the room and that "It just depe ded; he/she was in there at different times". The Administrator stated the staff checked on im/her "quite a bit" but did not have a set time f me for checking on him/her while he/she was the room. The Administrator stated Resident #3 would knock on the door when he/she wan d out. The Administrator stated the resident ha a private room with his/her own bathroom, a d he/she managed her pull-ups independer y. The Administrator stated the resident wa out of the room as much as he/she wanted to s cialize with other residents but sometimes referred to stay in his/her room. The Administrat stated Resident #3 took some meals in th dining area and sometimes preferred to eat in his er room. The Administrator stated the window Resident #3's room was locked, and the res ent was not able to unlock it so that was not a c ncern. The Administrator stated staff completed irty (30) minute checks during the night shift a they did on all the residents in the

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P 240	Continued From page 47 building. The Administrator stated she was responsible for completing pre-admission assessment on new residents to determine the level of care the resident needed. The Administrator stated the process for determining level of care consisted of asking the referring facility if the resident was independent in Activities of Daily Living or was able to manage their own incontinence, no other assessment was done. The Administrator stated the facility removed the lock because an Adult Protective Services worker did not like the lock and wanted it removed. The Administrator stated she was not sure the exact date the lock was removed, but the resident had the lock in place for approximately two (2) to three (3) months.	P 240		
P 260	902 KAR 20:036 4(3)(a)1a-e Section 4. Provision of Services (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (a) Room accommodations. 1. A PCH or SPCH shall provide each resident with: a. A bed that is at least thirty-six (36) inches wide; b. A clean, comfortable mattress with a support mechanism; c. A mattress cover; d. Two (2) sheets and a pillow; and e. Bed covering to keep the resident comfortable	P 260	P260 Total Number of Mattresses ordered was around 6-7. STAFF was educated on Bedding Policy, Clean linens sheet set, pillow with pillow case, Blanket or Comforter for Bed. Facility and staff have asked Residents to refrain bringing clothing, shoes etc. into the Facility and staff will check items, clothing can be	

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P 260	Continued F[illegible]om page 48 This require[illegible]ent is not met as evidenced by: Based on o[illegible]ervation and interview, it was determined [illegible]e facility failed to ensure each resident wa[illegible]rovided with a clean comfortable mattress an[illegible]mattress cover for seven (7) of seven (7) o[illegible]erved mattresses being used by residents. T[illegible]e observed mattresses were dirty, worn, and w[illegible]h no cover. The findings[illegible]nclude: On 09/14/2[illegible]3 a facility policy outlining the requirement[illegible]or mattresses and linens a resident was to be p[illegible]vided in his/her room was requested and was not[illegible]rovided by the Administrator. Observation[illegible]n 09/13/2023 at 9:10 AM revealed a mattress in[illegible]oom #1 to the left along the wall was dirty, stained and covered with clear plastic; and another mat[illegible]ess in the room, directly in front of the door, ha[illegible] dark stains all along the visible edge. Furth[illegible] observation revealed a mattress in Room #5 or[illegible]he right side of the room was stained with[illegible]d dark wet spots on both sides and the seams h[illegible]d evidence of bed bug droppings present; and[illegible]ner mattress on the left side of the room was c[illegible]ered with a white fitted mattress cover that w[illegible]s stained along the bottom edges with a dried[illegible]own liquid and had black areas in the folds, ev[illegible]ence of bed bug droppings. In addition, live[illegible]ed bugs were noted on the mattress. F[illegible]ther observation revealed a mattress in[illegible]oom #6 along the left side of the room was w[illegible]hout linen or a cover, and the yellow mattress foa[illegible]s was exposed, torn, stained with dry tan liquid and was bowed in the center. A mattress alo[illegible]g the far wall in Room #6 near the window was[illegible]ithout linen or a cover, with obvious wear in the c[illegible]nter and was bowed on the right	P 260	Will be Put IN Hot dryer For About an Hour, Ask Resident to down size Their Clothing That They WANT, TO Keep clutter down And try to maintain Keeping Rooms clean And Free OF Bed Bugs And other pest. We will Continue to STRIVE to Bed bugs ERADICATED So That We will not go Thru This Again and have the facility heated/spray whatever it Takes to get The job done	11-1-23

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P 26	Continued From page 49 side from the middle of the mattress to the foot. A mattress to the right of the door in Room #6 was without linen or a cover, and the pink mattress was stained with dry dark liquid along the edge and was bowed across the width at the top third portion. In an interview with the Administrator on 09/15/2023 at 10:55 AM she stated the Owner was ordering new mattresses. In an interview with the Owner on 09/15/2023 at 1:00 PM she asked the State Survey Agency Surveyor how many mattresses needed to be replaced and admitted she did not know how many she needed to replace upstairs because she was unable to get in there due to no heat.	P 260		
P 27	902 KAR 20:036 4(3)(a)4a-e Section 4. Provision of Services (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (a) Room accommodations. 1. A PCH or SPCH shall provide: a. Window coverings; b. Bedside tables with reading lamps, if appropriate; c. Comfortable chairs; d. A chest or dresser with a mirror for each resident; and e. A night light.	P 275	I will STAFF was educated about furnishing For Residents Rooms All Rooms either Have Dresser, Chest of - closet for clothing	

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P 275	Continued From page 50 This requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure each resident room was provided with a dresser, bedside table, a reading lamp, if appropriate, and a comfortable chair in ten (10) of (10) observed resident rooms. The findings include: On 09/14/2023 a facility policy outlining the furnishings a resident was to be provided in their room was requested and not provided by the Administrator. During a facility tour on 09/13/2023 at 9:10 AM the following was observed: Room #6 contained three (3) beds and one (1) dresser for three (3) residents. Room #5 contained three (3) beds and one (1) dresser for three (3) residents. Room #4 contained three (3) beds, two (2) dressers and one (1) bedside table for three (3) residents. None of the rooms observed contained a night light, a reading lamp, or a comfortable chair. Observation on 09/07/2023 at 10:15 AM revealed Resident #3's room did not have a mirror, a night light, or a chair. In an interview with the Assistant Administrator (AA) on 09/15/2023 at 10:30 AM, he stated he was aware residents were to be furnished with a mattress, a dresser, a nightstand, and a lamp if applicable as well as have room for a comfortable chair in their room. He admitted he had not discussed this with the Owner. In an interview with the Administrator on 09/15/2023 at 10:55 AM, she stated the facility was to	P 275		

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(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 27	Continued From page 51 provide a bed, a dresser, and toiletries. In an Interview with the Owner on 09/15/2023 at 1:00 PM, she stated each resident had a bed, and she had just ordered fourteen (14) dressers, some bedside tables, and lamps. 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 stated 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 275		
P 30	902 KAR 20:036 4(3)(b)3 Section 4. Provision of Services (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (b) Housekeeping and maintenance services. 3. Safety. The condition of the overall environment shall be maintained in such a manner that the safety and well-being of residents, personnel, and visitors is assured.	P 305	~~P035~~ P305 Resident #'s 1, 7, 9 and 13, Facility Addressed Issue with Pest Control Company to treat Facility Needed to be treated often to keep Bed Bugs down and eradicated and keep a continuous Reactive to keep from happening again. Rooms will be clean more often, changing of Beds, Mopping, Floor Removal of clutter. All	

Office : 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
GENESIS 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 305	Continued From page 52 This requirement is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, 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 for five (5) of twenty (20) current residents (Residents #2, #7, #9, #10, #13) with the potential to affect all twenty (20) of twenty (20) residents residing in the facility. The facility had a current bed bug infestation as well as many other environmental concerns. A Type B Citation was issued for the environment on 09/22/2023, stating these conditions could become an immediate risk to residents. The findings include: 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. Review of the facility's policy titled, "Maintenance", undated, revealed Maintenance pertained to all plumbing and electrical service. The maintenance duties inside the facility were	P 305	Staff educated on cleaning rooms, what to check for and clutter, Admin/or owner what they see. All staff will monitor rooms to ensure that clutter is removed even tho rooms are cluttered again the next day, staff clean again Measures to not let this happen again. Ask resident to not bring items in until inspected and put in hot dryer, down size things they don't need, pick up garbage, not throw in floors, do not leave dishes in rooms, leaving around go to dining area to eat meals/snacks	

Office: Inspector General

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 305	Continued From page 53 not addressed by the policy. Review of the facility's policy titled, "Maintenance of Property", dated 06/10/2014, revealed the expectation for the upkeep of the facility grounds outside. The maintenance duties inside the facility were not addressed by the policy. Review of the facility's document titled, "Work Order: Repairs Itemization", dated 06/02/2022, revealed a typed three (3) page list of repairs which were not observed by State Survey Agency (SSA) Surveyors as having been addressed. Observation on 08/28/2023 at 8:30 AM revealed bed bugs crawling on four (4) residents' bed linens (Resident #2, #7, #9, and #10). Observation on 08/28/2023 at 8:30 AM 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. In an interview with Resident #13 on 09/05/2023 at 5:12 PM, he/she stated that the red lesions came from bed bug bites. In an interview on 09/14/2023 at 10:30 AM with the worker from the pest control company, he stated he had been to this facility before, earlier in the year, for bed bug infestation. He stated the treatment would be more effective if all the clothing and bed linen were removed and the personal items and bed/furniture were pulled away from the walls. He stated the residents would have to be out of their rooms for four (4) hours as the chemical was a skin irritant. He said he would be returning in two (2) weeks for a second treatment.	P 305		