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 305	Continued From page 54 Observations from 09/13/2023 through 09/20/2023 revealed there was an ongoing bed bug issue; the presence of cockroaches; holes in the walls throughout the facility; floors and carpets with dark brown matter throughout the facility; peeling paint and wallpaper throughout the facility; loose trim along the baseboard at the bottom of the wheelchair ramp in the dining room; a black substance appearing to be mildew in the residents' bathrooms in the showers, sinks, and around the toilets; 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 loose tobacco and used cigarette butts all over the floors; food/food containers on the floors and furniture; and mattresses that were dirty, stained, full of holes, and with no mattress covers. Continued observations from 09/13/2023 through 09/20/2023 revealed the window coverings in residents' rooms were dirty or non-existent. The lighting in the residents' rooms was poor, and the common areas were dimly lit. Observations of the ceilings and walls throughout the facility revealed dried brown liquid matter, old brown water stains, and black specks appearing to be insect feces were present. A large yellow mop basin which contained black liquid and a dirty mop was being stored out in the open in the resident dining area. 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, it was common in this type of resident population, and it did not concern him. The APRN stated he treated the residents in the			

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P 30...	Continued From page 55 Administrator's office only and never entered the facility past the Administrator's office. In an interview with the Assistant Administrator (AA) and the Administrator on 09/15/2023 at 10:30 AM, the AA stated he had discussed his concerns about the facility with the Owner and had been told she would fix things. In an interview with the Owner on 09/14/2023 at 1:00 PM, she stated the bed bug issue was being addressed and an exterminator was coming. She stated it was the responsibility of the Administrator and the AA to ensure the environment was well kept and in good repair. She stated there was a contracted maintenance person she called when things needed to be fixed, he would fix them right away, and he had a list of all the needed repairs. She further stated her expectation for the resident environment was that they felt safe, happy, they could come to staff with anything and everything. When asked what her expectation was of the physical environment and resident surroundings, she stated she wanted the residents to feel safe.	P 305			
P 31...	902 KAR 20:036 4(3)(b)4a-d 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. 4. Maintenance. The premises shall be well kept and in good repair as established in clauses a. through d. of this subparagraph. a. The facility shall insure that the grounds are	P 310	P310 (2) Oncoming shifts will be Monitor each other to make sure Duties are Completed And properly done. We will have a Shift Audit For each shift	D	9/24

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P 3	Continued From page 56 well kept and the exterior of the building, including the sidewalk, steps, porches, ramps, and fences are in good repair. b. The interior of the building, including walls, ceilings, floors, windows, window coverings, doors, plumbing, and electrical fixtures, shall be in good repair. Windows and doors shall be screened. c. Garbage and trash shall be stored in areas separate from those used for the preparation and storage of food and shall be removed from the premises regularly. Containers shall be cleaned regularly. d. A pest control program shall be in operation in the facility. Pest control services shall be provided by maintenance personnel of the facility or by contract with a pest control company. Care shall be taken to use the least toxic and least flammable insecticides and rodenticides. The compounds shall be stored under lock if stored by the facility. This requirement is not met as evidenced by: Based on observation, interview, review of the facility's document, and review of the facility's policy, it was determined the facility failed to maintain the condition of the overall environment	P 310	Maintenance policy inside and well as the outside of the facility interior from top to bottom floor, walls ceiling painting, blind holes, patch with etc. Each shift will check each other staff after they have finished mopping will empty bucket, rinse out and store out of the way. Mops will be rinsed out on mop heads changed between shifts	6/24

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P 3	Continued From page 57 such that the safety and well-being of the residents was maintained. This affected twenty (20) of twenty (20) current residents. The findings include: Review of the facility's policy titled, "Housekeeping", dated 04/06/2015, revealed each shift would have a written work sheet listing the areas which needed to be cleaned and how to clean them would be listed. Per the policy, linen was to be changed daily and as needed. The policy stated the Assistant Administrator (AA) would come to the facility in the morning and would check the work of the second and midnight shift staff. Review of the provided eight (8) page facility documentation packet outlining the daily cleaning duties revealed each night had a specific cleaning task in addition to the regular cleaning duties. The regular cleaning duties were to clean all seven (7) bathrooms which included the toilets, sink, mirrors, tub/shower; empty trash; sweep/mop; take out all trash; run the sweeper on the wheelchair ramp and in the living room; do the laundry; and dining room/kitchen clean up. The document stated all areas would be checked before staff left at 6:30 AM. Further review of the document revealed Sunday night overall clean included sweeping and mopping all floors; running the sweeper in the living room on the rugs and on the wheelchair ramp; laundry; trash (clean the cans if needed) clean all seven (7) bathrooms plus clean doors, door frames, windows, window sills and walls; dust the furniture in the living room and the foyer; kitchen clean up-counters, stove, fridge; sweep/mop the floors and trash; and dining	P 310			11/24

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(X4) PRIF TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CTION OULD BE PROPRIATE	(X5) COMPLETE DATE
P 3	Continued From page 58 room-wipe off tables, sweep/mop. Further review of the document revealed Monday duties included wiping down the walls, doors, door frames, windows, windowsills, and dusting the desk. Further review of the document revealed Tuesday night office and regular cleaning duties included dusting off the furniture, tops of cabinets, doors, door frames, windows, windowsills, baseboards and the ceiling; removing any clutter; trash; dust the desk; sweep/mop as well as the regular cleaning which included all seven (7) bathrooms; kitchen/dining room clean up; trash; and laundry. Further review of the document revealed Wednesday regular cleaning duties and kitchen included cleaning all seven (7) bathrooms-sweep/mop, wipe down sinks, toilets, tubs and mirrors; trash; kitchen/dining room clean up after breakfast; and laundry. Kitchen clean-up included wiping down the cabinets inside, the door(s) and handles; cleaning the microwave, stove and refrigerator/freezer; cleaning under the sink cabinets (doors, handles and inside); dusting the ceiling and the pipes; wiping down the walls; and handwashing the sink and cabinet above and below. Further review of the document revealed Thursday Living Room/Foyer and regular cleaning included dusting the bookshelf, all the furniture, doors, door frames, windows, fireplace, mirror, ceiling light, pipes, baseboards, and all corners, as well as removing any trash and clutter. Further review of the document revealed Friday Night Midnight Dining Room and Bathrooms	P 310			

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P 310	Continued From page 59 included wiping down the walls, baseboards, and wall frames; dusting the TV stands and anything that needed dusting in the dining room and the nurses' station; wiping down all the chairs, tables, table tops, legs, and cleaning all the handrails. Per the document, the bathrooms should be cleaned from top to bottom which included wiping down the walls; cleaning the toilets inside and out; cleaning the sinks, tubs and mirrors; and sweeping/mopping. Further review of the document revealed Saturday duties included cleaning the basement-sweeping the floors and steps; making sure the laundry was folded; dusting the walls and pipes; wiping down the washers and dryers; emptying the lint traps; collecting all trash; and organizing and distributing clothing to whom they belonged. The runner in the hallway outside the ramp was to be taken up, and the floor underneath was to be swept and mopped, the floor dried completely, the runner replaced, and then also mopped. Observations beginning on 08/28/2023 and continuing through 09/22/2023, revealed an ongoing bed bug issue; the presence of cockroaches; holes in the walls; brown matter on the walls, floors, and carpets with dark brown matter; peeling paint and wallpaper throughput the facility; loose trim along the baseboard at the bottom of the wheelchair ramp in the dining room; mildew in bathrooms around the showers/tubs and toilets; overflowing trash cans in residents' rooms and bathrooms; resident rooms in disarray with resident belongings scattered throughout the rooms; grocery bags/garbage bags of clothing piled up on the floors; bags of tobacco, loose tobacco, and cigarette butts on the floor of Room #6; food/food containers on the floors; furniture			

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P 3	Continued From page 60 was worn and dirty; mattresses were dirty, stained, full of holes, and missing mattress covers; window coverings were dirty; lighting was poor, and most residents' rooms were dark; common areas were dimly lit; a dirty mop and black mop water was being kept in the residents' dining area; and there was evidence of an old water leak with damage to ceilings and walls. Observation on 09/19/2023 at 4:45 PM, revealed a sheet of paper taped to the wall at the top of the stairs titled, Housekeeping, dated 08/07/2023, 08/08/2023, 08/10/2023, 08/13/2023, 08/19/2023, 08/20/2023, 08/21/2023, 08/24/2023, 08/28/2023, 08/30/2023, 08/31/2023, 09/05/2023, and 09/11/2023 with the tasks labeled toilet paper, lighting, trash, clean, and sweep/mop checked off as completed. In an interview with Caregiver/Housekeeper #1 on 09/18/2023 at 3:58 PM, she stated she had worked at the facility for fourteen (14) years but was off for about five (5) months, from March 2023 through July 2023, to care for her sick husband. She stated she usually worked 12:30 PM to 10:30 PM four (4) days a week and 9:30 AM to 12:00 PM on Saturday. She stated no one cleaned at the facility but her. She stated when she returned to the facility in July 2023 after being gone, she "came back to this filth". In an interview with the Assistant Administrator (AA) on 09/15/2023 at 10:30 AM, he stated housekeeping tasks get done at night. When asked if he had been upstairs to monitor if the tasks were being completed, he stated "no". In an interview with the Administrator on 09/15/2023 at 10:55 AM, she stated housekeeping tasks were completed by second	P 310		

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P 311	Continued From page 61 and third shifts and checked off as done on the checklist which was posted at the top of the stairs. When asked if she had been upstairs to monitor if the tasks were being completed, she stated "no". In an interview with the Owner on 09/15/2023 at 1:00 PM, she stated she had not been upstairs in quite a while because she had injured her back and could not climb the stairs. She stated she relied on staff to do their assigned duties and on the AA and the Administrator to monitor the jobs were getting done. When alerted to the conditions of the resident areas upstairs and asked about the cleanliness of the home, she stated she would be talking with staff about it.	P 310		
P 320	902 KAR 20:036 4(3)(c)2 Section 4. Provision of Services (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (c) Dietary services. 2. Therapeutic diets. If the facility provides therapeutic diets and the staff member responsible for food services is not a licensed dietician or certified nutritionist, the responsible staff person shall consult with a licensed. This requirement is not met as evidenced by:	P 320	P320 FACility STill L oking fo DIETICIAN' che king on line and MAking CA Is We give Nutr. t rous Foods Water, essentia. Fatty acids Fish For examp . USing MENU With diet. IAN SIGNATURE That WAS Approved Until CAN find SOMEONE	

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F 3	Continued From page 62 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to provide a consultation with a Dietician for three (3) of twenty (20) current residents who were on a therapeutic/diabetic diet, Resident #11, #12, and #18. 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, document on each of the resident's medical records during each visit, instruct on in-services for staff and residents on therapeutic diets and nutrition in general, review charts of residents checking weekly weights, periodically view a meal and make suggestions, give any needed resident diet instructions on a one-to-one (1:1) basis, and give staff instructions and suggestions on food preparation. 1. Review of Resident #11's medical record revealed the facility admitted Resident #11 on 05/09/2022 with diagnoses of Type 2 Diabetes, Neuropathy, and Hypertension. Further review revealed no documentation a consult with a Dietician had been provided. 2. 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. Further review revealed no documentation a consult with a Dietician had been provided. 3. Review of Resident #18's medical record	P 320			

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P 32	Continued From page 63 revealed the facility admitted Resident #18 on 03/22/2023 with diagnoses of Diabetes Mellitus, Hypertension, and Left Below the Knee Amputation. Further review revealed no documentation a consult with a Dietician had been provided. In an interview with the Assistant Administrator (AA) on 09/15/ 2023 at 10:30 AM, he stated he and the Administrator cooked and served meals during the day, and whatever staff was on duty at night cooked and served breakfast. He stated he knew of no Dietician ever having been in the facility. He stated he knew there should be a Dietician on consult for the residents that were on a therapeutic diet. He further stated snacks had only been coming since the beginning of the month. He stated sometimes the 2 PM snack was refreshments/drinks only. In an interview with the Administrator on 08/30/2023 at 10:45 AM, she stated she could not remember the last time a Dietician was in the facility, but it had been years. She stated she and the AA cooked and served lunch and supper. She stated staff present on night shift cooked the breakfast meal. The Administrator stated it was important to have a Dietician develop menus to ensure the residents were getting the proper number of calories and protein needed. In an additional interview on 09/15/2023 at 10:55 AM with the Administrator, she stated she was the full time Dietary staff, did not know the regulation, and thought the Owner was looking for a Dietician. In an interview with the Owner on 09/15/2023 at 1:00 PM, she stated she was aware residents that were on a therapeutic diet required a	P 320			

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P 320	Continued From page 64 Dietician on consult. She stated she asked the Administrator to call another Personal Care Home and find out who that facility used.	P 320		
P 325	902 KAR 20:036 4(3)(c)3a-e Section 4. Provision of Services (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (c) Dietary services. 3. Menu planning. a. Menus shall be planned in writing and rotated to avoid repetition. b. A PCH or SPCH shall meet the nutrition needs of residents in accordance with physician's orders. c. Except as established in clause e. of this subparagraph, meals shall correspond with the posted menu. d. Menus shall be planned and posted one (1) week in advance. e. If changes in the menu are necessary: (i) Substitutions shall provide equal nutritive value; (ii) The changes shall be recorded on the menu; and (iii) Menus shall be kept on file for at least thirty (30) days.	P 325	P325 Ongoing Looking for dietician so this will not occur again	6-24

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P 325	Continued From page 65	P 325		

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 meet the requirements related to provision of dietary services for twenty (20) of twenty (20) current residents. Observations from 09/13/2023 through 09/15/2023 and on 09/18/2023, 09/19/2023, and 09/21/2023 revealed there was no weekly menu posted anywhere in the facility.

The findings include:

Review of the facility's policy titled, "Meal Prep Inservice", undated, revealed the facility provided snacks and three (3) hot meals daily. It stated times would be posted.

In an interview on 09/13/2023 at 8:00 AM with the Assistant Administrator (AA) and the Administrator, they stated they wrote the daily menu on the white board in the dining room.

Observation on 09/13/2023 at 8:10 AM, revealed the white board in the dining room was blank.

Observation on 09/13/2023 at 12:00 PM, revealed "Cheesy Tuna Mac, Peas and Corn and Bread with Butter" had been added to the white board in the dining room for Lunch.

Observation on 09/14/2023 at 3:00 PM, revealed no menu had been written on the white board in the dining room for Supper.

Observation on 09/15/2023 at 3:15 PM, revealed

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P 325	Continued From page 66 no menu had been written on the white board in the dining room for Supper. Observation on 09/18/2023 at 8:30 AM, revealed Lasagna and Salad had been written on the white board in the dining room for the Supper on 09/17/2023. Observation on 09/19/2023 at 12:15 PM, revealed Tuna Casserole and Bread with Butter being served for lunch. No menu had been written on the white board in the dining room. Observation on 09/21/2023 at 8:20 AM, revealed no menu for lunch or supper had been posted. In an interview with the Owner on 09/22/2023 at 8:00 AM, she stated the food and the posting of the menus was the responsibility of the AA and the Administrator, and they would have to talk about that.			
P 330	902 KAR 20:036 4(3)(c)4a-m Section 4. Provision of Services (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (c) Dietary services. 1. Food preparation and storage. a. There shall be at least a three (3) day supply of food to prepare well-balanced, palatable meals. b. Food shall be prepared with consideration for any individual dietary requirement. c. Modified diets, nutrient concentrates, and supplements shall be given only on the written order of a physician.	P 330	P330 Yes Waters Cup are Available in Residents, All Staff And Administrator 3 snacks daily every day 7 days a week Continous	11-2-23

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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 330	Continued From page 67 d. At least three (3) meals per day shall be served with not more than a fifteen (15) hour span between the evening meal and breakfast. e. Between-meal snacks, including an evening snack before bedtime, shall be offered to all residents. f. Adjustments shall be made if medically contraindicated. g. Food shall be: (i) Prepared by methods that conserve nutritive value, flavor, and appearance; and (ii) Served at the proper temperature and in a form to meet individual needs. h. A file of tested recipes, adjusted to appropriate yield, shall be maintained. i. Food shall be cut, chopped, or ground to meet individual needs. j. If a resident refuses food served, substitutes shall be offered. k. All opened containers or leftover food items shall be covered and dated when refrigerated. l. Ice water shall be readily available to the residents at all times. m. Food services shall be provided in accordance with 902 KAR 45:005. 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 consistently provide sufficient food and between meal snacks, including an evening snack before bedtime and failed to always keep ice water readily available to the residents for twenty (20) of twenty (20) current residents.	P 330		11-12-23

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

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

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P 3	Continued From page 68	P 330			11-12-23

The findings include:

Review of the facility's policy titled, "Food and Nutrition Policy", undated, revealed the staff at the personal care home would provide each resident a nourishing, palatable, well-balanced diet that met daily nutritional and special dietary needs. The policy stated three (3) meals a day would be served at regular times and snacks would be offered at 9:30 AM, 2:30 PM, and 7:30 PM. Further review revealed staff would ensure if at any time the residents came and asked for seconds at mealtime and/or anytime of the day or night there would be extra food available.

In an interview with the Administrator on 09/15/2023 at 10:55 AM, she stated resident snacks were offered three (3) times a day, 9:30 AM, 2:30 to 3:00 PM, and 7:30 PM.

Observation on 08/30/2023, from 09/13/2023 through 09/15/2023, and from 09/18/2023 through 09/22/2023 revealed no ice water was kept readily available for the residents anywhere in the facility.

Observation on 09/13/2023 at 11:00 AM, revealed a sign written on a piece of paper attached to the pass through window between the walkway and the kitchen which stated food could not be heated up after 7:30 PM because staff had other duties to do.

Observation on 09/13/2023 at 12:37 PM, revealed boxed macaroni and cheese, canned peas and corn, white bread with butter, and four ounces (4 oz) of red Kool-Aid was served to the residents for lunch.

STATE AND PLAN OF DEFICIENCIES 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
GENESIS HEALTH OF ASHLAND	3000 CENTRAL AVENUE ASHLAND, KY 41101

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P 330	Continued From page 69 Observation on 09/13/2023 at 9:30 AM and 2:30 to 3:00 PM, revealed no snack was provided to the residents between breakfast and lunch and between lunch and supper. Observation on 09/13/2023 at 12:25 PM, revealed each resident received two (2) hot dogs wrapped in a crescent roll, a scoop of canned baked beans, a scoop of potato salad, and four ounces (4 oz) of lemonade for lunch. Observation on 09/14/2023 at 9:30 AM and 2:30 to 3:00 PM, revealed no snack was provided to the residents between breakfast and lunch and between lunch and supper. Observation on 09/15/2023 at 12:30 PM, revealed two (2) fish sticks, macaroni and cheese, canned corn, and four ounces (4 oz) of water was served to the residents for lunch. Observation on 09/18/2023 at 5:45 PM, revealed an egg salad sandwich, potato chips, three (3) mini powdered donuts, and four ounces (4 oz) of red Kool-Aid was served to the residents for supper. Observation on 09/19/2023 at 9:30 AM, revealed no snack was provided to the residents between breakfast and lunch. Observation on 09/19/2023 at 12:12 PM, revealed tuna casserole, bread with butter, and four ounces (4 oz) of water was served to the residents for lunch. Observation on 09/19/2023 at 3:10 PM, revealed a peanut butter sandwich and a beverage of choice was offered for a snack.	P 330		11-12-23

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P 340	Continued From page 73 Administrator. Observation on 09/13/2023 at 10:10 AM revealed one (1) thirty-two (32) inch flat screen television situated in the corner of the resident dining room on a television stand which was elevated approximately twelve (12) to eighteen (18) inches off the floor and one (1) three (3) person sofa located diagonally across the room for the entire facility. Observation on 09/13/2023 at 10:18 AM revealed one (1) two (2) person sofa located in the front room of the facility with three (3) approximately eighteen (18) inch round side tables and a three (3) drawer chest in the room. Built in bookshelves along the wall diagonal from the sofa contained paperback books which were covered with dust. Observation on 09/13/2023 at 10:25 AM during a general facility tour revealed no posted activities calendar for the month or a posted activity event for the day anywhere in the facility. The White Board hanging in the resident dining/TV room designated for daily activities and the daily menu was blank. Observation on 09/13/2023 at 9:30 AM revealed the Owner of the facility cutting Resident #4's hair. The Owner stated she used to be a licensed hair stylist. She stated the State Guardian for some of the residents at the facility had asked her to come and assist with hair. Observation on 09/13/2023 at 12:00 PM revealed "Haircut or Style" and "Coloring Page Contest" had been added to the White Board in the resident dining/TV room.			12-15

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P 340	Continued From page 74 In an interview with Resident #7 on 09/06/2023 at 10:55 AM, the resident stated he/she had lived in this facility since 11/2022. Resident #7 stated at a former facility, residents had played bingo. Resident #7 stated he/she liked to win money and prizes but had never played bingo at this facility. Resident #7 further stated no one had ever asked what he/she liked to do, and there had never been a shopping trip or backyard bar-b-que 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, he/she 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 he had discussed this with the Owner. The AA stated the Owner had told him she was working on it, but nothing ever changed. In an interview with the Administrator on 09/13/2023 at 12:00 PM, she stated Caregiver #1/Housekeeper (CG #1) was the staff person responsible for resident activities and the third staff person in charge at the facility. In an interview with the Owner on 09/15/2023 at 1:00 PM, she stated the Assistant Administrator (AA) oversaw Activities for the facility.	P 340		12-10-23

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P 345	Continued From page 75	P 345	P345	
P 345	902 KAR 20:036 4(5)(b)1-8 Section 4. Provision of Services (5) Activity services. (b) All PCHs and SPCHs shall meet the requirements established in subparagraphs 1. through 8. of this paragraph relating to the provision of activity services. 1. Staff. The administrator: a. Shall designate a staff member to be responsible for the activity program; and b. May accept services from a volunteer group to assist with carrying out the activity program. 2. There shall be a planned activity period each day. 3. The schedule shall be current and posted. 4. The activity program shall be planned for group and individual activities, both within and outside of the facility. 5. The staff member responsible for the activity program shall maintain a current list of residents in which precautions are documented regarding if a resident's condition might restrict or modify the resident's participation in the program. 6. A living or recreation room and outdoor recreational space shall be provided for residents and their guests. 7. The facility shall provide supplies and equipment for the activity program. 8. Reading materials, radios, games, and TV sets shall be provided for the residents.	P 345	STAFF WAS educated on activity policy, caregiver #3, OWNERS will order supplies for activities as done has before	

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P 3	Continued From page 76	P 345		

This requirement is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to designate a staff member to be responsible for the Activity Program, ensure a planned activity each day, post a current activity schedule, plan group and individual activities both within and outside the facility, provide books/supplies/puzzles and equipment where all residents had access, and provide and maintain outdoor recreational space for residents and their guests for twenty (20) of twenty (20) current residents.

The findings include:

On 09/14/2023 a request for a facility Activities Policy was requested and not provided by the Administrator.

Observations from 09/05/2023 through 09/07/2023, revealed no presence of scheduled activities posted or carried out anywhere in the facility.

Observation on 09/13/2023 during a general facility tour revealed no posted activities calendar for the month or a posted activity event for the day anywhere in the facility. The White Board hanging in the resident dining/TV room designated for daily activities and the daily menu was blank.

In an interview with Resident #7 on 09/06/2023 at 10:55 AM, the resident stated he/she had lived in this facility since 11/2022. Resident #7 stated at a former facility, residents had played bingo. Resident #7 stated he/she liked to win money and prizes but had never played bingo at this facility. Resident #7 further stated no one had ever asked

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P 345	Continued From page 77 what he/she liked to do, and there had never been a shopping trip or backyard bar-b-que 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, he/she 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 he had discussed this with the Owner. The AA stated the Owner had told him she was working on it, but nothing ever changed. In an interview with the Administrator on 09/13/2023 at 12:00 PM, she stated Caregiver #1/Housekeeper (CG #1) was the staff person responsible for resident activities and the third staff person in charge at the facility. In an interview with the Owner on 09/15/2023 at 1:00 PM, she stated the Assistant Administrator (AA) oversaw Activities for the facility.			
B 025	902 KAR 20:205 2(5)(a-e) SECTION 2. TB CONTROL PROGRAM (5) At a minimum, a health care worker shall be included in the TB screening program if the worker:		B025 All staff new and old staff will have TB Test upon hiring And	

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B 112	Continued From page 78 (a) Has duties that involve face-to-face contact with patients with suspected or confirmed active TB disease, including transport staff; (b) Has the potential for exposure to M. tuberculosis through air space shared with persons with suspected or confirmed active TB disease of the respiratory system; (c) Has duties that involve the processing of laboratory specimens for TB testing or TB cultures; (d) Has duties that have the potential for exposure to the environment of care of persons with suspected or confirmed active TB disease; or (e) Performs other tasks or procedures which may generate infectious aerosol droplet nuclei in which the worker has or may have exposure to TB disease. This requirement is not met as evidenced by: Based on interview and review of the facility's employee files, it was determined the facility failed to ensure all staff were included in the Tuberculosis (Tb) screening program for two (2) of ten (10) sampled staff, Caregiver (CG) #4 and the facility Owner. The findings include: On 09/13/2023 a policy for the facility Tuberculosis screening and infection control was requested from the Administrator and not provided. Review of CG #4's employee file revealed no documentation of a date for a current Tb test. Review of the Owner's employee file revealed no	B 025	every year following New employee has To wait the TB test is read A ny With background Check and Adult Misconduct Registry check is clear Before being put on schedule. This will be A Continuous ongoing procedure	

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B 0	Continued From page 79 documentation of a date for a current Tb test. In an interview with the Administrator on 09/15/2023 at 10:55 AM, she stated she was responsible for maintaining the employee files and the Tb screening. She stated CG #4 should have had a Tb test at the time of hire, and she was not aware the Owner needed one. In an interview with the Owner on 09/15/2023 at 1:00 PM, she stated keeping employee files up to date, including the staff Tb testing documentation, was the responsibility of the Administrator.	B 025		
P 0	902 KAR 20:031-6(1)(b) Section 6. Resident Unit The following shall be included: (1) Resident rooms. Each room shall meet the following requirements: (b) Resident rooms shall be designed to permit not less than a three (3) foot space between beds, and at least a three (3) foot space between the side of the bed and the nearest wall, fixed cabinet, or heating/cooling unit. This requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure resident rooms were designed to permit not less than a three (3) foot space between beds and at least a three (3) foot space between the side of the bed and the nearest wall, fixed cabinet or heating/cooling unit in Room #5 and Room #6. This affected five (5) of twenty (20) current residents.	P 049	P049 Bedding has been Put in place. Resident Some just like sheets on Bed. STAFF makes up And STRAIGHTEN beds daily. Then Resident gets Back in the Bed 3-4 times a day and times Back IN The Room	

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F 000	Continued From page 80 The findings include: Observation on 09/21/2023 at 10:00 AM in Room #5 revealed three (3) female beds with two (2) residents assigned to the room. Two (2) of the beds were dressed with bed linen and one (1) with a mattress cover. Bed #1 was positioned with its side against a wall. The State Survey Agency (SSA) Surveyor used a tape measure for the measurements. The space between Bed #1 and the foot of Bed #2 measured approximately two (2) feet and six (6) inches. Bed #2 was positioned with its side eleven (11) inches from a dresser which was against the far wall of the room. Bed #3 was positioned with its side against the opposite wall, closest to the door. The space between the sides of Bed #2 and Bed #3 measured approximately three (3) feet. However, within the space between the side of Bed #2 and the side of Bed #3 were three side tables running down the length of both beds creating a one (1) foot space between the two (2) beds for resident access. Additionally, a dresser was positioned immediately inside the door with its back against the foot of Bed #3. No closet or wardrobe was present in the room. Observation on 09/21/2023 at 10:00 AM in Room #6 revealed three (3) male beds with three (3) residents assigned to the room. All three (3) beds were dressed with sheets only. Both Bed #1 and Bed #2 were positioned with one (1) of their sides pushed up against a wall. The SSA Surveyor used a tape measure for the measurements. The space between the side of Bed #1 and the foot of Bed #2 measured approximately two (2) feet and six (6) inches. The space between the side of Bed #2 and the foot of Bed #3 measured approximately one (1)	F 049	We as a Facility was informed THAT since We are grandfathered in THAT There would be a Leeway on our Square footage. and that they will get back to us on THAT. To This day we have yet heard back about such.	

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P 049	Continued From page 81 foot and six (6) inches. In an interview with the Assistant Administrator and the Administrator on 09/22/2023 at 11:00 AM, they both stated they were not aware of any space requirements for each resident in their rooms or in the common areas. In an interview with the Owner on 09/22/2023 at 11:00 AM, she stated the facility was licensed for twenty-two (22) beds and that was how many beds it had. She stated she was not aware of any space requirements for each resident in their rooms or in the common areas.	P 049		
P 057	902 KAR 20:031-6(1)(e) Section 6. Resident Unit The following shall be included: (1) Resident rooms. Each room shall meet the following requirements: (e) Wardrobe or closet for each resident. Minimum clear dimensions; one (1) foot and ten (10) inches deep by one (1) foot and eight (8) inches wide with full length hanging space; provide clothes rod and shelf. This requirement is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure each resident had a wardrobe or closet with minimum dimensions of one (1) foot and ten (10) inches deep by one (1) foot and eight (8) inches wide with a full-length hanging space, a clothing rod, and a shelf in Rooms #1, #2, #3, #4, #5, #6 and #102. This affected fifteen (15) of twenty (20) current residents.	P 057	P057 Meaning Rm 1 has 2 Dressers in pl[illegible] and 1 Wardrobe fo[illegible] Turning clothing fo[illegible] residents Rm #2 The Ros[illegible] has 1 fo[illegible] each one [illegible] people Rm #3 has two dressers 1 f[illegible] each person. Rm #4 h[illegible] 1 Closet And 2 d[illegible] Rm #5 Has 1 Closet and	

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P 057	Continued From page 82 The findings include: Observation on 09/21/2023 at 10:00 AM revealed no closets or wardrobes were present in Rooms #1, #2, #3, #4, and #5. In Room #6, an approximate three (3) foot by four (4) foot closet space was present within the room with a black substance on the walls and in the corners. No door, no clothing rod, and no shelf were observed. In an interview with the Assistant Administrator and the Administrator on 09/22/2023 at 11:00 AM, they both stated they were not aware of any space requirements for each resident in their rooms or in the common areas. In an interview with the Owner on 09/22/2023 at 11:00 AM, she stated the facility was licensed for twenty-two (22) beds and that was how many beds it had. She stated she was not aware of any space, furniture, or closet requirements for each resident in their rooms or in the common areas.	P 057	2 dressers with one Resident uses Hallway closet Rm # 6 has close with shelf and 2 dressers Rm # 102 Private Room Has closet, and accessories Yes was available in facility To make sure Resident have An Area/ Space for Their Clothing	
P 058	902 KAR 20:031-6(1)(f) Section 6. Resident Unit The following shall be included: (1) Resident rooms. Each room shall meet the following requirements: (f) In multibed rooms, a method of assuring visual privacy for each resident shall be provided. This requirement is not met as evidenced by: Based on observation and interview, it was determined the facility failed to assure a method	P 058	P058 Admin will Address to Owners who will Order Dividers that Will be Available at the What Resident this WAS one	10-10-23

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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 058	Continued From page 83 of visual privacy for each resident was provided. This affected fourteen (14) of twenty (20) current residents. The findings include: Observation on 09/21/2023 at 10:15 AM revealed no method of visual privacy was provided for residents in spaces with multiple beds in Rooms #1, #2, #3, #4, #5, and #103. In an interview on 09/15/2023 at 8:55 AM with Resident #7, he/she stated, "there is no privacy at this place". In an interview on 09/15/2023 at 9:10 AM with Resident #9, he/she stated there was no privacy at the facility, and she hoped to be moving somewhere else soon. In an interview with the Owner on 09/22/2023 at 11:00 AM, she stated the facility was licensed for twenty-two (22) beds and that was how many beds it had. She stated she was not aware of any space or privacy requirements for each resident in their rooms, only in the bathrooms.	P 058		
P 072	902 KAR 20:031-6(4)(a) Section 6. Resident Unit (4) Residents' dining, TV viewing, and recreation areas. (a) The total areas set aside for these purposes shall be not less than thirty (30) square feet per bed for the first fifty (50) beds, and twenty (20) square feet per bed for all beds in excess of fifty (50).	P 072	P072 facility planning on getting different tables to change the area to have more room and space will be working on square foota -	6-24