Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100314	A. BUILDING: _____ B. WING _____	R-C 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND MANOR REST HOME I LLC	1930 HIGHWAY 90 PARKERS LAKE, KY 42634

(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 000}	Initial Comments Based upon implementation of the acceptable plan of correction, an on-site revisit survey was conducted on 04/08/2024 and concluded on 04/08/2024. The facility was determined to be in substantial compliance effective 03/15/2024 as alleged in the acceptable plan of correction.	{P 000}		

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

Office of Inspector General

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P 015	902 KAR 20:036 3(1)(a-d) Section 3. Administration and Operation (1) Licensee. The licensee shall be legally responsible for: (a) The operation of the PCH or SPCH; (b) Compliance with federal, state, and local laws and administrative regulations pertaining to the operation of the facility; (c) The development and implementation of policies related to administration and operation of the facility; and (d) If the licensee is an SPCH, the development and implementation of written transition procedures to ensure cooperation with an individual or entity that assists with transitioning residents with an SMI to community living arrangements. This requirement is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure the implementation of the facility "Infection Control Policy". Observation on 01/30/2024, revealed Floor Aide #4 failed to perform hand hygiene prior to performing a blood glucose test (measures the level of glucose in the blood) using a glucometer	P 015	Duplicated citation- citation previously noted and responded to. Addressed in the AMENDED SOD.	

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

Rosetta Patrick — 3/15/24

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P 015	Continued From page 1 for Resident #6. Floor Aide #4 then failed to perform hand hygiene after performing the blood glucose test for Resident #6 and prior to performing the blood glucose test for Resident #7. Floor Aide #4 then failed to perform hand hygiene after performing the blood glucose test for Resident #7 and prior to performing the blood glucose test for Resident #8. Moreover, further observation on 01/30/2024, revealed Floor Aide #4 failed to disinfect the individual glucometers after use for blood glucose tests for Residents #6, #7, and #8. The findings include: Review of the Facility Policy titled, "Infection Control Policy" undated revealed facility staff should take precautions while interacting with residents to prevent and control the spread of infection. Precautions: Hand washing: Good hand washing using soap and water or waterless antiseptic before and after patient contact, after using the bathroom, after handling soiled material, and before and after eating. Gloves: Gloves should be worn whenever contact with any of the following was expected to occur; 1) Blood; 2) Any body fluids, secretions, and excretions; 3) Non-intact skin and/or 4) Mucous membranes. After removal of gloves, wash hands immediately or use waterless antiseptic. Patient care equipment: Handle soiled patient care equipment in a manner to prevent skin and mucous membrane exposure; contamination of clothing; and transfer of microorganisms to other patients and environments. Do not reuse patient care equipment until it has been cleaned and reprocessed appropriately and discard single use items properly.	P 015		

Rosetta Patrick 3/15/24

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P 015	Continued From page 2 1) The following observations were noted on 01/30/2024 starting at 5:45 AM, related to failure of staff to perform hand hygiene when obtaining blood glucose tests for residents: a. Floor Aide #4 failed to wash her hands prior to gloving to perform a blood glucose test using a glucometer for Resident #6. b. After performing the blood glucose test on Resident #6, Floor Aide #4 removed her soiled gloves, but failed to wash her hands prior to gloving to perform a blood glucose test on Resident #7. c. After performing the blood glucose test on Resident #7, Floor Aide #4 removed her soiled gloves, but failed to wash her hands prior to performing the blood glucose test for Resident #8. Review of the Facility Policy titled, "Regarding Accucheck Machine Cleaning", revealed the facility's Accucheck machine shall be cleaned with Super Sani-Cloth Germicidal Disposable Wipes or a reasonable substitute for that product." 2) Additional observation on 01/30/2024 starting at 5:45 AM, revealed there was no disinfecting of the glucometers after use. Each resident had his/her own glucometer. a. After Floor Aide #4 checked the blood glucose for Resident #6, she failed to disinfect the glucometer prior to placing it back into the glucometer pouch. b. After Floor Aide #4 checked the blood glucose for Resident #7, she failed to disinfect the glucometer prior to placing it back into the	P 015		

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P 015	Continued From page 3 glucometer pouch. c. After Floor Aide #4 checked the blood glucose for Resident #8, she failed to disinfect the glucometer prior to placing it back into the glucometer pouch. During an interview with Floor Aide #4 on 01/31/2024 at 3:40 PM, she stated she was aware she needed to perform hand washing and/or hand sanitizer before and after any procedure including blood glucose tests, and it was important to disinfect the glucometers prior to placing them back into the individual pouches. In continued interview, she stated failure to wash or sanitize hands and failure to disinfect the glucometers after use could cause the spread of germs. During an interview with the Administrator (ADM), on 01/31/2024 at 4:23 PM, she stated staff should be washing or sanitizing their hands when performing glucometer checks, or when providing any type of care between residents. In continued interview, she stated she expected glucometers to be cleaned/disinfected immediately following each use with the appropriate cleaning wipes stored on the medication carts.	P 015		
P 050	902 KAR 20:036 3(4) Section 3. Administration and Operation (4) Patient rights. Patient rights shall be provided for pursuant to KRS 216.510 to 216.525. This requirement is not met as evidenced by:	P 050	Duplicate citation. Citation previously noted.	

Rosetta Patrick 3/15/24

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P 050	Continued From page 4 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure Resident Rights were protected to ensure the safety of each resident for four (4) of eight (8) sampled residents; (Resident #2, Resident #3, Resident #4, and Resident #5). a.) On 11/01/2023, the facility staff heard yelling and saw Resident #4 and Resident #5 on the floor. Resident #4 was hitting Resident #5 in the face with a set of keys. Both residents were sent to the emergency room for evaluation of injuries. Resident #5 sustained a scalp abrasion, a sprained finger, and a shoulder strain. Resident #4 sustained a laceration on his/her hand, which required surgical glue for closure of the laceration. b.) On 11/28/2023, Resident #2 hit Resident #3, and while Resident #4 was attempting to protect Resident #3, Resident #2 started hitting Resident #4. Resident #2 sustained right cheek swelling in the incident and declined to go to the emergency room for evaluation of injuries sustained in the incident. Resident #2 and Resident #4 were sent to the emergency room for evaluation. Resident #4 was diagnosed in the ER with facial contusion, right rib contusion, two superficial lacerations on the face, one laceration on the forehead, and one laceration on the left cheek. The findings include: Review of the Facility Policy titled, "Rights of Residents--Duties of Facilities--Actions", effective 07/14/2022, revealed all residents shall be free from mental and physical abuse, and free from chemical and physical restraints except in emergencies or except as thoroughly justified in writing by a Physician for a specified and limited	P 050		

Rosette Patrick 3/15/24

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P 050	Continued From page 6 period of time and documented in the resident's Medical Record. Review of the Facility Policy titled, "Residents shall be free from Abuse and Neglect", revised 05/01/2022, revealed all residents shall be free from mental and physical abuse, neglect, and free from chemical and physical restraints. Continued review revealed if there were an alleged incident, all necessary parties would be notified timely. Review of the facility Policy, titled "Resident Monitoring", revised 08/22/2014, revealed a documented hourly check of each resident shall be performed and documented to observe each resident's condition and behavior and to confirm that each resident was present and accounted for on the premises. Residents shall be monitored more frequently than once per hour, as needed, such as in the event of a change of health condition, illness, physician's order, and/or behavioral changes. Review of KRS 216.515 Rights of residents, Duties of facilities, revealed all residents shall be free from mental and physical abuse. 1 a.) Review of the Facility's Investigation dated 11/01/2023, revealed Resident #4 and Resident #5 were yelling, and when staff went to investigate, staff observed Resident #4 with keys in his/her hand "beating" Resident #5 with the keys. Continued review revealed staff separated both residents, cleaned them up, and had Emergency Medical Services (EMS) transport both residents to the hospital. Review of Resident #4's "Admission Face Sheet", revealed the facility admitted the resident on	P 050		

Rosetta Patrick 3/15/24

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P 050	Continued From page 6 05/09/2022, with diagnoses to include schizoaffective disorder, bipolar disorder, sleep disturbance, and nicotine use disorder. Resident #4 had no Care Plan to review. Review of the Progress Notes, reviewed for August 2023, September 2023, and October 2023, revealed Resident #4 had no verbal or physical altercations with residents nor were aggressive behaviors noted. Review of Resident #4's Monitoring Log, revealed it was initial hourly to indicate the resident was observed on an hourly basis prior to the altercation with Resident #5. Review of Resident #4's Progress Note, entered by Floor Aide (FA) #5, dated 11/01/2023, untimed, revealed Resident #4 and another resident (Resident #5) had gotten into a fight. Continued review revealed staff separated the residents, called the Advanced Practical Registered Nurse (APRN), notified guardians of both residents, and sent Resident #4 to the hospital for further evaluation of injuries. Review of Resident #4's Hospital Emergency Room (ER) record, dated 11/01/2023, revealed Resident #4 was seen for an assault with a left-hand laceration. Continued review revealed the resident had a three (3) centimeter (cm) left hand laceration which had to be repaired with glue. Observation of Resident #4, on 01/29/2024 at 8:53 AM, revealed the resident was clean, neat, appropriately dressed, well-groomed, and without odor.	P 050		

Rosetta Patrick 3/15/24

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P 050	Continued From page 7 During an interview with Resident #4, on 01/29/2024 at 8:53 AM, he/she stated he/she remembered the incident involving Resident #5. Resident #4 stated he/she was drawing on a piece of paper using a colored pencil, when Resident #5 started "following me and was cursing at me." Resident #4 stated he/she kept trying to walk away from Resident #5, but Resident #5 started yelling at him/her. Resident #4 stated he/she "had enough", so he/she started hitting Resident #5 with his/her keys. Resident #4 continued to state, he/she hit Resident #5 "about six times." Resident #4 stated the staff separated us and sent us both to the hospital. Resident #4 further stated while at the hospital staff cleaned his/her wound and glued it together. 1 b.) Review of Resident #5's "Admission Face Sheet", revealed the facility admitted the resident on 10/26/2023, with diagnoses to include depression, schizophrenia, and behavioral disturbance. Resident #5 had no Care Plan to review. Review of the Progress Notes, reviewed for August 2023, September 2023, and October 2023, revealed Resident #5 had no verbal or physical altercations with residents nor were aggressive behaviors noted. Review of Resident #5's Monitoring Log, revealed it was initial hourly to indicate the resident was observed on an hourly basis prior to the altercation with Resident #4. Review of Resident #5's Hospital ER record dated 11/01/2023, revealed Resident #5 was treated for a shoulder strain, scalp abrasion, and finger sprain.	P 050		

Rosetta Patrick 3/15/24

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P 050	Continued From page 8 Observation of Resident #5, on 01/29/2024 at 9:10 AM, revealed the resident was clean, neat, appropriately dressed, well-groomed, and without odor. During an interview with Resident #5, on 01/29/2024 at 9:10 AM, he/she stated he/she couldn't remember the exact event, but did remember Resident #4 had a set of keys and "came out of the blue and hit me." Resident #5 stated it felt like Resident #4 had hit "my head about 30 times", causing a small scratch on top of his/her head. Continued interview revealed he/she was sent to the hospital, and the hospital did x-rays of his/her finger and shoulder and cleaned off the top of his/her head. During an interview with Floor Aide (FA) #3, on 01/29/2024 at 3:18 PM, she stated she worked the day of the incident involving Resident #4 and Resident #5. FA #3 stated she was not sure which resident started yelling, but when she arrived at the scene, "the fight was on." FA #3 stated both residents were on the floor, screaming at each other, and Resident #4 was "beating" Resident #5 with a set of keys. FA #3 stated Resident #5 had a "bloody" face and a skin tear on top of his/her head, and Resident #4 had a scratch on his/her hand. FA #3 stated both residents were sent to the hospital ER for evaluation. FA #3 stated prior to this incident, neither Resident #4 or Resident #5 appeared agitated or were showing aggressive behaviors. She was unaware of the two (2) residents having arguments in the past. 2 a.) Review of the Facility's investigation, dated 11/28/2023, revealed Resident #2, Resident #3, and Resident #4 were in the smoke building when	P 050		

Rosetta Patrick 3/15/24

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P 050	Continued From page 9 Resident #3 ran into facility and told staff Resident #2 hit him/her and Resident #4. Continued review revealed Resident #3 was observed to have a left cheek bruise, and the right cheek was puffy. Further review revealed Resident #4 was bleeding from his/her head and his/her nose. Ongoing review revealed Resident #2 stated Resident #3 was a "Russian" and Resident #4 was "Hitler", and Resident #2 got agitated with staff and attempted to hit staff while staff questioned him/her about the incident. Additional review revealed Resident #2 and Resident #4 were sent to the ER for evaluation of injuries sustained in the altercation, and Resident #3 refused to go to hospital for evaluation. Review of Resident #2's "Admission Face Sheet" revealed the facility admitted the resident on 05/09/2022, with diagnoses of schizoaffective disorder with possible synthetic induced exacerbation, asthma, diabetes mellitus, and nicotine use disorder. Resident #2 was discharged from the facility on 12/26/2023 and sent to a psychiatric hospital and per the Administrator, will not return to the facility. Resident #2 had no Care Plan to review. Review of the Progress Notes, reviewed for August 2023, September 2023, October 2023, and November 2023, revealed Resident #2 had no verbal or physical altercations with residents nor were aggressive behaviors noted prior to the altercation on 11/28/2023. Review of Resident #2's Monitoring Log, revealed it was initial hourly to indicate the resident was observed on an hourly basis prior to the altercation on 11/28/2023.	P 050		

Roberto Patrick 3/15/24

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P 050	Continued From page 10 Review of Resident #2's Progress Note, entered by Medication Technician (MT) #1, dated 11/28/2023, revealed Resident #2 got into an altercation with Resident #3 and Resident #4 and all residents were separated immediately. Continued review of the Progress Note revealed the family, and the Nurse Practitioner (NP) were notified. Review of Resident #2's ER Note, dated 11/28/2023, revealed Resident #2 was treated for an assault/suicidal ideation and behavioral problem with recommendations to follow up with the primary care provider and facility psychiatrist. Continued review of the ER Note, revealed Resident #2 told ER staff he/she reacted aggressively and attacked another person because "someone opened a lighter in his/her face". 2 b.) Review of Resident #3's "Admission Face Sheet" revealed the facility admitted the resident on 05/07/2021 with diagnoses of non-intractable headaches, impulse control, and intellectual disability. Resident #3 had no Care Plan to review. Review of the Progress Notes, reviewed for August 2023, September 2023, October 2023, and November 2023, revealed Resident #3 had no verbal or physical altercations with residents nor were aggressive behaviors noted prior to the altercation on 11/28/2023. Review of Resident #3's Monitoring Log, revealed it was initial hourly to indicate the resident was observed on an hourly basis prior to the altercation on 11/28/2023.	P 050		

Rosetta Patrick 3/15/24

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P 050	Continued From page 11 Review of Resident #3's Progress Note, entered by MT #1, dated 11/28/2023, revealed Resident #3 was hit by another resident (Resident #2), but no medical treatment was completed as Resident #3 refused to go to hospital for treatment. Continued review of the Progress Note revealed the Advanced Practical Registered Nurse (APRN), Psychiatrist, and the legal guardian were notified of the incident. Review of Resident #3's Psychiatric Note, entered by Psychiatrist dated 11/27/2023, revealed the resident had diagnoses of unspecified psychotic disorder, unspecified depressive disorder, and unspecified intellectual developmental disability. Continued review of the Psychiatric Note revealed Resident #3 was to get a Depakote level and continue with current medications. Continued review of the Psychiatric Note, revealed Resident #3 had a Depakote level within normal limits. Observation of Resident #3, on 01/29/2024 at 9:13 AM, revealed the resident was clean, neat, appropriately dressed, well-groomed, and without odor. During an interview with Resident #3, on 01/29/2024 at 9:13 AM, he/she stated he/she had gone outside to smoke with Resident #4, when Resident #2 got upset and "hit both sides of my head". Resident #3 stated Resident #2 would get upset if he/she did not get his/her own way and he/she did not know what set him/her off that day. Resident #3 stated Resident #4 stepped in to try to help him/her when Resident #2 started hitting Resident #4. Resident #3 stated he/she went inside the facility to alert staff who intervened and separated Resident #2 and Resident #4. Resident #3 stated he/she did not have any cuts.	P 050		

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P 050	Continued From page 12 but did have some swelling to the right cheek and he/she believed a bruise to his/her left cheek. Resident #3 stated he/she did not go to the hospital because he/she talked to his/her legal guardian and expressed desire to stay at the facility for monitoring. 2 c.) Review of Resident #4's "Admission Face Sheet" revealed the facility admitted the resident on 05/09/2022, with diagnoses to include schizoaffective disorder, bipolar disorder, sleep disturbance, and nicotine use disorder. Resident #4 had no Care Plan to review. Review of the Progress Notes, reviewed for August 2023, September 2023, October 2023, and November 2023, revealed Resident #4 had no verbal or physical altercations with residents nor were aggressive behaviors noted prior to the altercation on 11/28/2023. Review of Resident #4's Monitoring Log, revealed it was initial hourly to indicate the resident was observed on an hourly basis prior to the altercation on 11/28/2023. Review of Resident #4's ER Note, dated 11/28/2023, revealed Resident #4 was seen for an assault and was the victim of abuse. Continued review of the ER Note, revealed Resident #4 had been punched in the face and had a small superficial laceration, a nosebleed, and complained of chest wall pain on the right side due to Resident #4 stated he/she hit something when he/she fell during the altercation. Additional review of the ER Note, revealed Resident #4 was diagnosed with facial contusion, right rib contusion, two superficial lacerations on the face, one laceration on the forehead, and one	P 050		

R Dawette Patrick 3/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100314	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND MANOR REST HOME I LLC	1930 HIGHWAY 90 PARKERS LAKE, KY 42634

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P 050	Continued From page 13 laceration on the left cheek. Observation of Resident #4, on 01/29/2024 at 8:53 AM, revealed Resident #4 was clean, neat, appropriately dressed, well-groomed, and without odor. During an interview with Resident #4, on 01/29/2024 at 8:53 AM, he/she stated he/she remembered the incident involving Resident #2 and Resident #3. Resident #4 stated Resident #2 hit Resident #3 on the jaw and while he/she (Resident #4) was attempting to help Resident #3, Resident #2 started hitting him/her (Resident #4) in the face. Resident #4 stated Resident #3 ran inside the facility and asked staff to help. Resident #4 stated the staff removed Resident #2 from the resident area. Resident #4 further stated he/she was sent to the hospital with some bruising and some cuts on his/her face. During an interview with Medication Technician (MT) #1, on 01/29/2024 at 2:50 PM, she stated she was working during the incident involving Resident #2, Resident #3, and Resident #4. MT #1 stated she separated the residents immediately, checked all three residents for injuries, and called Emergency Medical Services (EMS) to transport Resident #2 and Resident #4 to the hospital. Further, she stated she notified the Administrator, the Advanced Practice Registered Nurse (APRN), and the families of the residents of the incident. MT #1 stated Resident #2 had some cuts to both hands, Resident #3 had a bruise to the left cheek and swelling to the right cheek, and Resident #4 had a cut on the forehead. MT #1 stated Resident #3 refused to go to hospital and Resident #3's guardian spoke with the resident and agreed not to send Resident #3 to the hospital for evaluation. MT #1 stated all the	P 050		

Rosetta Patrick 3/15/24

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 050	Continued From page 14 residents had the right to be free from abuse, but staff had no way of knowing the incident was going to occur. During an interview with the Administrator, on 01/31/2024 at 4:23 PM, she stated the process for any resident-to-resident altercation involved the residents being placed on one on one (1:1) monitoring until the residents "calmed down" and then the residents would be monitored more closely. The Administrator further stated if the facility staff had known the altercations were going to occur, the staff would not have allowed the residents to sit together. She stated she did not think more staff supervision or monitoring was the answer, as more staff "could get in the way." The Administrator further stated residents had the right to be protected from abuse, but she felt "nothing could have been done differently to prevent the incidents from occurring." Further interview revealed after the resident altercations, the residents involved were placed on every thirty (30) minute monitoring for increased supervision and staff were walking the halls more frequently to monitor residents more closely in order to be aware if residents were showing signs of agitation. Further, she stated at this time staff was attempting to keep the residents occupied by providing puzzle books, crafts, reading books, and puzzles, and doing more social activities involving games. She stated she expected staff to follow facility policies.	P 050		
P 195	902 KAR 20:036 4(1)(c) Section 4. Provision of Services (1) Basic health and health related services. (c) Medications or therapeutic services shall not	P 195		

Rosetta Pollock 3/15/24

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 195	Continued From page 15 be administered or provided to any resident, except on the order of a licensed physician or other health care practitioner as authorized under the practitioner's scope of practice. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility 'Infection Control Policy", it was determined the facility failed to ensure basic health related services regarding infection control practices during medication pass. Observation of Medication Pass on 01/30/2024 revealed the following: a) Floor Aide #4 did not her wash hands or use hand sanitizer prior to preparing medications for medication pass for Residents #1, #2, #3, #4, #5, #6, #7, and #8. b) Floor Aide #4 handled medications with her bare hands without gloves. c) After Resident #9 used his/her nasal spray, the nasal spray was placed into a basket with six (6) other resident's inhalers and nasal sprays without cleaning the nasal applicator or replacing the cap to the nasal applicator. d) Additionally, during medication pass, Floor Aide #4 put her finger into the top of the glass of liquid as she handed the glass to Resident #6 to drink when taking his/her medications. e) Floor Aide #4 did not wash her hands or use hand sanitizer between each resident and during the entire medication pass for Residents #1, #2, #3, #4, #5, #6, #7, and #8.	P 195	On 2.5.24, the Manager led an in service for all staff. The topics discussed included, but were not limited to, the importance of hand washing and using hand sanitizer in between cares, and at the start of resident cares, as well as the importance of wearing gloves. In service with staff was done in a conversational way, enabling staff to engage in conversation, ask questions, share thoughts, etc. At the completion of the in service, staff acknowledge they understood what was being discussed. Additionally, on 2.22.24, PCP Alisha Cooley, conducted an in service with the staff reviewing the importance of hand washing and using hand sanitizer between resident cares and at the start of resident cares. Upon hire, a new staff member is trained for a two day period. Of which , the first day includes a review of facility policy and procedures, to include hand washing/use of hand sanitizer as discussed in the in service.	

Rosetta Patrick 3/15/24

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P 195	Continued From page 16 The findings include: Review of the Facility Policy titled, "Infection Control Policy" undated, revealed facility staff should take precautions while interacting with residents to prevent and control the spread of infection. Precautions: Hand washing: Good hand washing using soap and water or waterless antiseptic before and after patient contact. Gloves: Gloves should be worn whenever contact with any of the following was expected to occur; 1) Blood; 2) Any body fluids, secretions, and excretions; 3) Non-intact skin and/or 4) Mucous membranes. After removal of gloves, wash hands immediately or use waterless antiseptic. During an interview with the Administrator, on 01/31/2024 at 4:23 PM, she stated the facility did not have a policy related to infection control. The following observations were noted on 01/30/2024 starting at 5:45 AM: a) Observation of Medication Preparation on 01/30/2024 starting at 6:10 AM, revealed Floor Aide #4 did not her wash hands or use hand sanitizer prior to preparing medications for medication pass for Residents #1, #2, #3, #4, #5, #6, #7, and #8. b) Continued observation during medication preparation on 01/30/2024 at 6:30 AM, revealed Floor Aide #4 prepared medications and placed them into souffle cups and then in labeled slots in a plastic container for each resident. She then poured some of the residents' medications out into her bare hand without gloves, to count them and then placed the medications back into souffle cups.	P 195	The Manager will conduct an audit once a day for 14 days (M-F) to ensure the staff are cleaning the glucometer in between each resident and hand washing/using hand sanitizer appropriately. Upon completion of the 14 days, the Manager will conduct an audit once a week for 2 weeks and then once a month for 3 months. The aforementioned audits will begin on 2.26.24. The POC completion date is 3.27.24.	

Rosetta Patrick 3/15/24

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 195	Continued From page 17 c) Additional observation on 01/30/2024 at 7:00 AM, revealed Resident #9 used his/her nasal spray, and Floor Aide #4 placed the nasal spray into a basket with six (6) other residents' inhalers and nasal sprays without cleaning the nasal applicator or replacing the cap to the nasal applicator. d) Additionally, observation during medication pass on 01/30/2024 at 7:10 AM, revealed Floor Aide #4 put her finger into the top of the glass of the liquids as she handed the glass to Resident #6 to drink when taking his/her medications. e) Furthermore, observation on 01/30/2024 starting at 6:45 AM and ending at 7:40 AM, revealed Floor Aide #4 did not wash her hands or use hand sanitizer between administering medications to each resident or during the entire medication pass for Residents #1, #2, #3, #4, #5, #6, #7, and #8. During an interview with Floor Aide #4, on 01/31/2024 at 3:40 PM, she stated she was aware she needed to perform hand washing and/or hand sanitizer before and after any procedure and she should have ensured she washed her hands prior to the start of medication pass, and in between administering medications to each resident. She stated she always carried hand sanitizer in her pocket, but failed to use it during medication pass. Floor Aide #4 stated she was not aware she had put her finger into the water glass, and further stated she should have ensured the lid/cap was on the nasal spray prior to placing into the basket. In continued interview, she stated the failure of staff to wash or sanitize their hands, and to use good infection control practices could cause the spread of germs.	P 195		

Roberta Patrick 3/15/24

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 195	Continued From page 18 During an interview with the Administrator (ADM), on 01/31/2024 at 4:23 PM, she stated staff should be washing or sanitizing their hands prior to administering medications to residents, and between residents. She further stated all staff had been given access to pocket hand sanitizers, and should always have it with them to use. She stated it was her expectation for staff to use good infection control measures during medication pass to prevent the spread of germs.	P 195		
P 215	902 KAR 20:036 4(1)(g)1-7 Section 4. Provision of Services (1) Basic health and health related services. (g)1. Controlled substances. A PCH or SPCH shall not keep any controlled substances or other habit forming drugs, hypodermic needles, or syringes except under the specific direction of a prescribing practitioner. 2. Controlled substances shall be kept under double lock, for example, stored in a locked box in a locked cabinet. 3. There shall be a controlled substances bound record book with numbered pages that includes: a. Name of the resident; b. Date, time, kind, dosage, and method of administration of each controlled substances; c. Name of the practitioner who prescribed the medications; and d. Name of the: (I) Nurse who administered the controlled substance; or (II) Staff member who supervised self-administration by a resident whose medical	P 215	On 2.5.24, the Manager led an in service for all staff. The topics discussed at the in service included, but were not limited to, the importance of ensuring the med cart is kept under double lock. The In service with staff was done in a conversational way, enabling staff to engage in conversation, ask questions, share thoughts, etc. At the completion of the in service, staff acknowledge they understood what was being discussed. The Regional Operations Manager will conduct an in service on 3.18.24 on the aforementioned as well.	

Rebecca Patrick 3/15/24

Office of Inspector General

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P 215	Continued From page 19 record includes a written determination from a health care practitioner that the resident is able to safely self-administer a controlled substance under supervision. 4. A staff member with access to controlled substances shall be responsible for maintaining a recorded and signed: a. Schedule II controlled substances count daily; and b. Schedule III, IV, and V controlled substances count at least one (1) time per week. 5. All expired or unused controlled substances shall be disposed of, or destroyed in accordance with 21 C.F.R. Part 1317 no later than thirty (30) days: a. After expiration of the medication; or b. From the date the medication was discontinued. 6. If controlled substances are destroyed on-site: a. The method of destruction shall render the drug unavailable and unusable; b. The administrator or staff person designated by the administrator shall be responsible for destroying the controlled substances with at least one (1) witness present; and c. A readily retrievable record of the destroyed controlled substances shall be maintained for a minimum of eighteen (18) months from the date of destruction and contain the: (i) Date of destruction; (ii) Resident name; (iii) Drug name; (iv) Drug strength; (v) Quantity; (vi) Method of destruction; (vii) Name of the person responsible for the	P 216	The Manager will conduct an audit once a day for 14 days (M-F) to ensure the staff are cleaning the glucometer in between each resident and hand washing/using hand sanitizer appropriately. Upon completion of the 14 days, the Manager will conduct an audit once a week for 2 weeks and then once a month for 3 months. The aforementioned audits will begin on 2.26.24 and will be done at random. The POC completion date is 3.27.24	

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P 215	Continued From page 20 destruction; and (viii) Name of the witness. 7. A PCH or SPCH that stores and administers controlled substances in an emergency medication kit (EMK) shall comply with the: a. Requirement for licensed personnel established by 201 KAR 2:370, Section 2(4)(i); b. Requirements for storage and administration established by 902 KAR 55:070, Section 2(2), (5), (7), (8), and (9); and c. Limitation on the number and quantity of medications established by 902 KAR 55:070, Section 2(6) 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 ensure controlled substances were kept under double lock. Observation on 01/29/2024 at 1:30 PM, revealed the three (3) medication carts, located in the Administrator's office, were unlocked with the narcotic keys observed lying on top of one of the carts. Continued observation revealed the medication carts and narcotics keys were not in view of the Medication Aide responsible for the medication carts and the narcotics keys during this time. The findings include: Review of the facility's policies titled, "Medication Administration", undated, and "Medication Count" undated, revealed no information related to keeping medication carts locked and narcotics	P 215		

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 215	Continued From page 21 double locked. Observation on 01/29/2024 at 1:30 PM, revealed the three (3) medication carts, located in the Administrator's office, where the Surveyors were situated during the Survey, were unlocked with the narcotic keys observed lying on top of one of the carts. Additional observation revealed the medication carts and narcotics keys were not in view of the Medication Aide responsible for the medication carts and the narcotics keys during this time. During an interview with Floor Aide #4, on 01/30/2024 at 6:10 AM, she stated all medication carts should be locked at all times with narcotic keys placed in the box behind the Administrator's door. Continued interview revealed failure to lock the medication carts could cause medications to be missing because anybody could open the unlocked medication carts and take the medications. She further stated the keys should never be left out and the carts should always been locked when not in view of the person responsible for the carts. During an interview with Floor Aide #5, on 01/30/2024 at 1:07 PM, she stated she had completed the 1:00 medication pass on 01/29/2024, and was unaware the medication carts were left unlocked after medication pass. She stated the medication carts should be locked at all times when a staff member was not present. Further, she stated the narcotic keys should be locked in the lock box on the wall behind the Administrator's office door after medication pass was completed. In continued interview, she stated if the medication carts were left unlocked anyone could take medications from the cart.	P 215		

RDsetter Patrick 3/15/24

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	180314	A. BUILDING. _____ B. WING _____	01/31/2024

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P 215	Continued From page 22 During an interview with the Administrator (ADM), on 01/31/2024 at 6:15 PM, she stated the Floor Aides were responsible for ensuring the medication carts were locked and the narcotics were double-locked, with the keys secured in the box on the wall in her office. The ADM stated the she had been in and out of her office frequently and should have noticed the unlocked carts and keys lying on top of the carts. She further stated, the door to the ADM's office should have been locked to ensure the residents did not have access to the unlocked medication carts.	P 215		
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. 4. 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. 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:	P 330	On 2.5.24 the Manager led an in service for all staff. The topics discussed at the in service included, but were not limited to, the importance of labeling and dating food. . The In service with staff was done in a conversational way, enabling staff to engage in conversation, ask questions, share thoughts, etc. At the completion of the in service, staff acknowledge they understood what was being discussed. The Regional Operations Manager will conduct an in service on 3.18.24 on the aforementioned as well. The Manager will conduct an audit once a day for 14 days (M-F) to ensure the staff are cleaning the glucometer in between each resident and hand washing/using hand sanitizer appropriately. Upon completion of the 14 days, the Manager will conduct an audit once a week for 2 weeks and then once a month for 3 months. The aforementioned audits will begin on 2.26.24 and will be done at random. The POC completion date is 3.27.24.	

 Rosetta Patrick 3/15/24

Office of Inspector General

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P 330	Continued From page 23 (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 ensure food was stored in accordance with professional standards for food service safety. Observation of the kitchen, on 01/29/2023 at 3:50 PM, revealed ice cream which had been previously opened, was stored in the refrigerator freezer and was not marked with an opened date. Continued observation of the kitchen, revealed the double door refrigerator had four (4) plastic drinking cups containing a red drink and two (2) plastic drinking cups containing milk with no opened date and no lids.	P 330		

Rosalie Patrick 3/15/24

Office of Inspector General

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CUMBERLAND MANOR REST HOME I LLC	1930 HIGHWAY 90 PARKERS LAKE, KY 42634

(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 24 Further observation revealed an opened container of mayonnaise, which was not marked with an opened date, and a one pound block of opened butter, which was not marked with the opened date. The findings include: Review of the facility Policy titled, "Food Preparation and Storage," undated, revealed all open containers or leftover food items should be covered and dated when refrigerated. During an interview with Floor Aide #3, on 01/29/2024 at 4:10 PM, she stated she was to put an opened date and label on anything that was opened in the refrigerator, and all food and drink should be covered. Continued interview revealed she had been educated on food storage. During an interview with the Administrator, on 01/31/2024 at 4:23 PM, she stated all food items stored in the refrigerators and freezers should be dated with an opened date when opened and should be covered with a lid to prevent food contamination prior to being placed back in the refrigerators/freezers.	P 330		
P 335	902 KAR 20:036 4(4)(a-e) Section 4. Provision of Services (4) Personal care services. All PCHs and SPCHs shall provide services to assist residents with activities of daily living to achieve and maintain good personal hygiene, including assistance as needed with: (a) Bathing. The facility shall provide soap, clean	P 335		

Rosetta Patrick 3/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100314	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND MANOR REST HOME I LLC	1930 HIGHWAY 90 PARKERS LAKE, KY 42634

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P 335	Continued From page 25 towels, and wash cloths for each resident and ensure that toilet articles such as towels, brushes, and combs are not used in common; (b) Shaving; (c) Cleaning and trimming of fingernails and toenails; (d) Cleaning of the mouth and teeth to maintain good oral hygiene, and care of the lips to prevent dryness and cracking. The facility shall provide all residents with tooth brushes, a dentifrice, and denture containers, if applicable; and (e) Washing and grooming. This requirement is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to provide services to assist residents to achieve and maintain good personal hygiene. Observation on 01/29/2024, revealed the resident bathroom between Room #3 and Room #5; the resident bathroom between Room #4 and Room #6; and the bathroom for Room #16 contained no paper towels, hand soap, or hand sanitizer. Additionally, observation revealed both of the communal bathrooms for women and men, did not have paper towels, hand soap, or hand sanitizer. The findings include:	P 335	On 2.5.24 the Manager led an in service for all staff. The topics discussed at the in service included, but were not limited to, ensuring there is paper towels and soap/hand sanitizer in the bathrooms. The in service with staff was done in a conversational way, enabling staff to engage in conversation, ask questions, share thoughts, etc. At the completion of the in service, staff acknowledge they understood what was being discussed. The Regional Operations Manager will conduct an in service on 3.18.24 on the aforementioned as well. The Manager will conduct an audit once a day for 14 days (M-F) to ensure the staff are cleaning the glucometer in between each resident and hand washing/using hand sanitizer appropriately. Upon completion of the 14 days, the Manager will conduct an audit once a week for 2 weeks and then once a month for 3 months. The aforementioned audits will begin on 2.26.24 and will be done at random. The POC completion date is 3.27.24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100314	A. BUILDING: _____ B. WING _____	01/31/2024

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P 335	Continued From page 26 During an interview with the Administrator, on 01/31/2024 at 4:23 PM, she stated the facility did not have a policy related to stocking the resident bathrooms with supplies. Observation during tour of the facility starting on 01/29/2024 at 2:10 PM, revealed the following: 1) The resident bathroom between Room #3 and Room #5 contained no paper towels, hand soap, or hand sanitizer in order for residents and staff to wash their hands. 2) The resident bathroom between Room #4 and Room #6, revealed no paper towels, hand soap, or hand sanitizer, and there was just one used bar of soap on the sink. 3) Room #16 had three (3) residents occupying the room; however, there were no paper towels, hand soap, or hand sanitizer, in the bathroom. 4) Both of the communal bathrooms for women and men, which had toilets, shower, and a sink, did not have paper towels, hand soap, or hand sanitizer at the sink. During an interview with the Administrator (ADM), on 01/31/2024 at 4:23 PM, she stated all residents and staff should have access to soap, and paper towels, in resident bathrooms and staff areas for hygiene purposes. She stated the maintenance man was responsible for filling up/stocking supplies such as filling soap dispensers, and putting paper towels in the paper towel dispenser. However, she stated the facility did not have a maintenance person at this time, and she was working on getting one hired.	P 335		