STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100170	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN	108 S MILLER STREET CYNTHIANA, KY 41031

(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
R 806	Continued From page 3 put those." Medication Aide #6 then pointed out another trash can with similar trash. Medication Aide #6 stated there was no shred box or special location for this type of trash. During interview on 02/28/2024 at 3:48 PM, the Administrator stated the empty, pharmacy blister packs were normally thrown in the regular trash. During interview with the Administrator on 03/01/2024 at 2:25 PM, she stated she had a shred box that she used for medical record disposal but did not use it for the empty pharmacy blister packs with resident information on them but probably should.	R 806		

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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: (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 tuberculosis (TB) screening/testing records, it was determined the facility failed to ensure all healthcare workers that had face to face contact with the residents were included in the Tuberculosis (TB) screening program for nine (9) of seventeen (17) sampled employees, Aide #4, Aide #6, Aide #12, Aide #13, Aide #14, Cook #2, Cook #3, Maintenance Staff, and the Administrator/Manager. The findings include:	B 025		

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

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B 025	Continued From page 1 The State Survey Agency (SSA) Surveyors requested, from the Administrator/Manager on 03/01/2024, a Tuberculosis (TB) policy that covered the requirements for the facility's staff members to have TB testing and/or assessment. However, review of the policy provided by the facility, via email on 03/04/2024 after survey exit, titled "Tuberculosis (TB) Prevention and Control," revised 03/01/2022, revealed it dealt with resident TB testing requirements and did not address staff requirements. No policy addressing staff was provided. The SSA Surveyors requested, from the Administrator on 03/01/2024 at 10:30 AM, the TB records for Aide #4, Aide #6, Aide #12, Aide #13, Aide #14, Cook #2, Cook #3, Maintenance Staff, and the Administrator/Manager. However, they were not provided. During an interview on 03/01/2024 at 2:25 PM with the Administrator/Manager, she stated employee files were incomplete, and it was her responsibility to keep employee files and staff and resident TB tests up to date. She further stated she was in the process of scheduling all staff to have a chest X-ray to get them all on the same schedule. She stated she preferred chest X-rays because getting the two (2) step skin tests done and read was too difficult to complete and do the follow-up.	B 025		
B 075	902 KAR 20:205 4(4)(a-d) SECTION 4. TB RISK ASSESSMENT AND TUBERCULIN (4) TB Risk Assessments and Tuberculin Skin Tests or BAMTs for Health Care Workers upon Initial Employment in a Health Facility.	B 075		

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B 075	Continued From page 2 (a) A baseline TB Risk Assessment, and a TST or BAMT if not excluded pursuant to subsection (2) of this section, shall be initiated on each new health care worker before or during the first week of employment. The results shall be documented in the health care worker's medical record or electronic medical record within the first month of employment. (b)1. A TB Risk Assessment required by paragraph (a) of this subsection and other sections shall be performed by: a. A physician; b. An advanced practice registered nurse; c. A physician assistant; d. A registered nurse, or e. A pharmacist. 2. A licensed practical nurse under the supervision of a registered nurse may perform the TB Risk Assessment. (c) An initial or first-step TST result of ten (10) millimeters or more of induration may be interpreted as positive for a new health care worker. (d) An initial or first-step TST result of five (5) millimeters to nine (9) millimeters of induration may be interpreted as positive for a new health care worker who has a medical reason as described in subsection (3) of this section for the TST result to be interpreted as positive. This requirement is not met as evidenced by: Based on interview and review of the facility's tuberculosis (TB) screening/testing records, it was determined the facility failed to ensure a baseline Tuberculosis (TB) risk assessment and	B 075		

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B 075	Continued From page 3 a tuberculin skin test (TST) or blood assay for mycobacterium tuberculosis (BAMT) was given to staff on initial employment for nine (9) of seventeen (17) sampled employees, Aide #4, Aide #6, Aide #12, Aide #13, Aide #14, Cook #2, Cook #3, Maintenance Staff, and the Administrator/Manager. The findings include: The State Survey Agency (SSA) Surveyors requested, from the Administrator/Manager on 03/01/2024, a Tuberculosis (TB) policy that covered the requirements for the facility's staff members to have TB testing and/or assessment. However, review of the policy provided by the facility, via email on 03/04/2024 after survey exit, titled "Tuberculosis (TB) Prevention and Control," revised 03/01/2022, revealed it dealt with resident TB testing requirements and did not address staff requirements. No policy addressing staff was provided. The SSA Surveyors requested, from the Administrator on 03/01/2024 at 10:30 AM, the staff members' TB screening/testing records. However, TB records for Aide #4, Aide #6, Aide #12, Aide #13, Aide #14, Cook #2, Cook #3, Maintenance Staff, and the Administrator/Manager were not provided. During an interview on 03/01/2024 at 2:25 PM with the Administrator/Manager, she stated employee files were incomplete, and it was her responsibility to keep employee files and staff and resident TB tests up to date. She further stated she was in the process of scheduling all staff to have a chest X-ray to get them all on the same schedule. She stated she preferred chest X-rays because getting the two (2) step skin tests done	B 075		

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B 075	Continued From page 4 and read was too difficult to complete and do the follow-up.	B 075		
B 090	902 KAR 20:205 5(1) SECTION 5. ANNUAL TB RISK ASSESSMENTS & TESTS Section 5. Annual TB Risk Assessments and Annual Tuberculin Skin Tests or BAMTs for Health Care Workers. (1) A health care worker shall have an annual TB risk assessment and annual education about the signs and symptoms of active TB disease. This requirement is not met as evidenced by: Based on interview and review of the facility's tuberculosis (TB) screening/testing records, it was determined the facility failed to ensure staff were provided an annual Tuberculosis (TB) risk assessment and annual education about the signs and symptoms of active TB disease for eight (8) of seventeen (17) sampled employees, Aide #1, Aide #3, Aide #5, Aide #7, Aide #9, Aide #10, Aide #11, and Aide #15. The findings include: The State Survey Agency (SSA) Surveyors requested, from the Administrator/Manager on	B 090		

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B 090	Continued From page 5 03/01/2024, a Tuberculosis (TB) policy that covered the requirements for the facility's staff members to have TB testing and/or assessment. However, review of the policy provided by the facility, via email on 03/04/2024 after survey exit, titled "Tuberculosis (TB) Prevention and Control," revised 03/01/2022, revealed it dealt with resident TB testing requirements and did not address staff requirements. No policy addressing staff was provided. The SSA Surveyors requested, from the Administrator on 03/01/2024 at 10:30 AM, documentation of staff members' annual TB risk assessment and annual education about the signs and symptoms of active TB disease. However, the facility failed to provide this information for Aide #1, Aide #3, Aide #5, Aide #7, Aide #9, Aide #10, Aide #11, and Aide #15. During an interview on 03/01/2024 at 2:25 PM with the Administrator/Manager, she stated employee files were incomplete, and it was her responsibility to keep employee files and staff and resident TB tests up to date. She further stated she was in the process of scheduling all staff to have a chest X-ray to get them all on the same schedule. She stated she preferred chest X-rays because getting the two (2) step skin tests done and read was too difficult to complete and do the follow-up.	B 090		
B 095	902 KAR 20:205 5(2) SECTION 5. ANNUAL TB RISK ASSESSMENTS & TESTS (2) A health care worker included in the TB screening program, as determined by the health facility ' s TB infection control plan, shall also have annual TB testing.	B 095		

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B 095	Continued From page 6	B 095		

This requirement is not met as evidenced by:
Based on interview and review of the facility's tuberculosis (TB) screening/testing records, it was determined the facility failed to ensure staff were provided annual TB testing for eight (8) of seventeen (17) sampled employees, Aide #1, Aide #3, Aide #5, Aide #7, Aide #9, Aide #10, Aide #11, and Aide #15.

The findings include:

The State Survey Agency (SSA) Surveyors requested, from the Administrator/Manager on 03/01/2024, a Tuberculosis (TB) policy that covered the requirements for the facility's staff members to have TB testing and/or assessment. However, review of the policy provided by the facility, via email on 03/04/2024 after survey exit, titled "Tuberculosis (TB) Prevention and Control," revised 03/01/2022, revealed it dealt with resident TB testing requirements and did not address staff requirements. No policy addressing staff was provided.

Review of TB records for Aide #1 revealed her last annual chest X-ray for TB screening was dated 02/18/2022, and there had been no

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B 095	Continued From page 7 additional TB screening/testing. Review of TB records for Aide #3 revealed her last annual chest X-ray for TB screening was dated 02/28/2023, and there had been no additional TB screening/testing. Review of TB records for Aide #5 revealed her last annual chest X-ray for TB screening was dated 01/05/2022, and there had been no additional TB screening/testing. Review of TB records for Aide #7 revealed her last annual chest X-ray for TB screening was dated 08/31/2022, and there had been no additional TB screening/testing. Review of TB records for Aide #9 revealed her last annual chest X-ray for TB screening was dated 01/26/2023, and there had been no additional TB screening/testing. Review of TB records for Aide #10 revealed her last annual chest X-ray for TB screening was dated 07/20/2022, and there had been no additional TB screening/testing. Review of TB records for Aide #11 revealed her last annual chest X-ray for TB screening was dated 01/25/2023, and there had been no additional TB screening/testing. Review of TB records for Aide #15 revealed her last annual chest X-ray for TB screening was dated 06/10/2022, and there had been no additional TB screening/testing. During an interview on 03/01/2024 at 2:25 PM with the Administrator/Manager, she stated employee files were incomplete, and it was her	B 095		

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B 095	Continued From page 8 responsibility to keep employee files and staff and resident TB tests up to date. She further stated she was in the process of scheduling all staff to have a chest X-ray to get them all on the same schedule. She stated she preferred chest X-rays because getting the two (2) step skin tests done and read was too difficult to complete and do the follow-up.	B 095		

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P 000	Initial Comments A Re-licensure and Complaint Survey investigating complaints KY00037665, KY00040808, KY00041316, KY00041795, KY00041798, KY00041947, and KY00042008 was initiated on 02/27/2024 and concluded on 03/01/2024. KY00037665, KY00040808, KY00041798, KY00041947, and KY00042008 identified no deficient practice. KY00041316 and KY00041795 identified deficient practice related to the complaints. The Re-licensure Survey also identified deficient practice. The facility's census was seventy-one (71) residents.	P 000		
P 135	902 KAR 20:036 3(8)(h)2a-c Section 3. Administration and Operation (8) Personnel. (h) In-service training. 2. Documentation of orientation and in-service training shall be maintained in the employee's record and shall include: a. Name of the individual or individuals who provided the training; b. Date and number of hours the training was given; and c. A summary of the training program's content. This requirement is not met as evidenced by: Based on interview, review of the facility's documents, and review of the facility's policy, it was determined the facility failed to provide evidence of orientation and/or annual in-service training for seventeen (17) of seventeen (17)	P 135	All staff of Shady Lawn were in-serviced on the annual in-service trainings between 3.28.24 and 3.30.24. Going forward, all in service training will be conducted upon hire and annually. As per the regulation, the in service training topics included, but were not limited to, policies regarding the responsibilities of specific job duties, services provider by Shady Lawn, record keeping procedures, reporting abuse, neglect or exploitation, resident rights, assisting residents in achieving maximum abilities in ADLs and IADLs, procedure for proper application of emergency manual restraint, maintaining a clean environment, the aging process, emotional problems of illness, use of medications and therapeutic diets. It is the Manager's responsibility to ensure that the orientation tasks place. All staff including, but not limited to, aides #1,2,3,4,5,7,8,9,10,11,12, 13 and maintenance were educated by the Asst. Manager. The Asst Manager was educated by the Manager. New Hires will be educated by the Asst Manager. Regulations will complied with in terms of the documentation required for all in service training. The Manager will audit employee files 1x/month for a period of 6 months, beginning on 8.21.24 to ensure new hire orientation was completed. The assistant manager will conduct the annual in-service trainings. The Manager will conduct an audit of the files within 6 months of when the in-service training occured to ensure it was completed. The audit will be done between the dates of 3.1.24 and 9.1.24. POC Completion Date, aside from the audits: 4.1.24	

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

Kpe admin 8-20-24 ~~8-5-24~~

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P 135	Continued From page 1 sampled employees, Aide #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, the Maintenance Staff, the Cook, and the Administrator/Manager. 1. Aide #1, #5, #7, and the Cook had evidence of prior inservices, but the last inservices were done on 02/18/2022. 2. Aide #2, #3, #4, #6, #8, #9, #10, #11, #12, #13, #14, the Maintenance Staff, and the Administrator/Manager did not have any record or documentation of any inservices. The findings include: Review of the facility's policy titled, "Staff Training-Revised," dated 03/01/2022, revealed at orientation and annually, staff at the facility would receive an in-service training that included the following topics: training and policies that corresponded to the staff members job duties; services provided by the facility; record keeping procedures; reporting of neglect, abuse and exploitation; resident rights; assisting residents in achieving his/her maximum abilities in activities of daily living; procedures for the proper application of emergency restraints; procedures for maintaining a clean and pleasant environment; the aging process; emotional problems of illness; and the use of medication and therapeutic diets. Further review of the policy revealed in addition to the aforementioned, an in-service training could be done at the Manager's discretion based on occurring events. 1. Review of the facility's document Inservice Material Summary for Aide #1 revealed the annual in-service training which covered policies of the facility, services provided by the facility,	P 135		

KR Admin 8-20-24 ~~8-5-24~~

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P 135	Continued From page 2 record keeping procedures, procedures for reporting abuse, patient rights, methods of assisting patients to achieve maximum potential, proper application of physical restraints, procedure for a clean and healthful environment, the aging process, emotional problems of illness, therapeutic diets and use of medications was last signed by Aide #1 on 02/18/2022. During an interview on 02/27/2024 at 10:20 AM with Aide #1 she stated she could not remember the last time annual education covering topics such as abuse, resident rights, and facility policies was provided to staff. Review of the facility's document Inservice Material Summary for Aide #5 revealed the annual in-service training which covered policies of the facility, services provided by the facility, record keeping procedures, procedures for reporting abuse, patient rights, methods of assisting patients to achieve maximum potential, proper application of physical restraints, procedure for a clean and healthful environment, the aging process, emotional problems of illness, therapeutic diets and use of medications was last signed by Aide #5 on 02/18/2022. Review of the facility's document Inservice Material Summary for Aide #7 revealed the annual in-service training which covered policies of the facility, services provided by the facility, record keeping procedures, procedures for reporting abuse, patient rights, methods of assisting patients to achieve maximum potential, proper application of physical restraints, procedure for a clean and healthful environment, the aging process, emotional problems of illness, therapeutic diets and use of medications was last signed by Aide #7 on 02/18/2022.	P 135		

8-20-24
KR admin ~~te-5-24~~

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P 135	Continued From page 3 During an interview on 02/29/2024 at 9:30 AM with Aide #7 she stated she could not remember the last time annual education covering topics such as abuse, resident rights, and facility policies was provided to staff. Review of the facility's document Inservice Material Summary for the Cook revealed the annual in-service training which covered policies of the facility, services provided by the facility, record keeping procedures, procedures for reporting abuse, patient rights, methods of assisting patients to achieve maximum potential, proper application of physical restraints, procedure for a clean and healthful environment, the aging process, emotional problems of illness, therapeutic diets and use of medications was last signed by the Cook on 02/18/2022. 2. On 02/28/2024 at 9:05 AM, State Surveyor Agency (SSA) Surveyors requested documentation of orientation employee trainings for staff that had been employed by the facility for less than one (1) year from the Administrator/Manager (A/M), which were not provided. The training records not provided were for Aide #2, #3, #4, #5, #6, #9, #10, #11, #12, #13, #14, the Maintenance Staff, and the Administrator/Manager. In an interview on 03/01/2024 at 2:40 PM with the Maintenance Staff, he stated he had been at the facility for three (3) months but had worked at the sister facility in the same town before that. He stated he had never received any orientation or training when he started at either facility. During an interview on 02/29/2024 at 9:30 AM with the Administrator/Manager (A/M) and	P 135		

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KR admin ~~8-5-24~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100170	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN	108 S MILLER STREET CYNTHIANA, KY 41031

(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 135	Continued From page 4 Regional Operations Manager (ROM) they provided a binder containing what they described as the proposed orientation and annual trainings content for staff going forward. The A/M stated documentation of annual (done in 2023) in-service training for employees that had been employed by the facility for over a year could not be located. During an interview on 03/01/2024 at 2:25 PM with the A/M, with the Administrator she stated as of 05/2022 when the new owners took over and going forward, there was no documentation of ongoing trainings.	P 135		
P 220	902 KAR 20:038 4(1)(h)1-8 Section 4. Provision of Services (1) Basic health and health related services. (h) All resident medications shall be plainly labeled with the: 1. Resident's name; 2. Name of the drug; 3. Strength; 4. Name of the pharmacy; 5. Prescription number; 6. Date; 7. Prescriber's name; and 8. Caution statements and directions for use, unless a modified unit dose drug distribution system is used. This requirement is not met as evidenced by:	P 220	Med cart audits will be completed by 3.29.24 by the Manager and/or an individual designated by the Manager to ensure there are no expired medications in the med carts. The pharmacy is scheduled to come on 4.5.24 to audit the med carts as well. From 3.30.24-4.29.24, the Manager wil conduct random weekly audits to ensure there are no expired medications in any of the med carts. The former manager in serviced all staff between 3.1.24 and 3.4.24 on the importance of ensuring there are no expired medications in the med cart. Staff express that they understood the in-service. POC completion date: 3.30.24	

KR admin 7-20-24 ~~7-5-24~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100170	A. BUILDING: _____ B. WING _____	03/01/2024

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P 220	Continued From page 5 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure all resident medications available for use in the medication cart were not expired. Observation of the medication cart revealed nine (9) expired medications. The findings include: Review of the facility's policy titled, "Medication Policies and Procedures," undated, under the Labeling and Storing Medication Section, item 1, revealed all medication shall be properly labeled and stored in a locked cabinet at the nurse's station. Further review of the policy under the Medication Release Section, item 3, revealed a patient's (resident's) outdated medication shall be destroyed in accordance with currently approved federal and state regulations covering the destruction of unused medication and the disposition noted in the patient's (resident's) record. Observation on 02/29/2024 at 1:20 PM during medication administration with Aide/Medication Tech #7, revealed four (4) resident medications for topical use that had expired were being stored in the medication cart. Resident #9 had one (1) Fluticasone Nasal Spray (a corticosteroid used to treat rhinitis or allergy symptoms) that had expired on 12/28/2023 and one (1) tube of Nystatin Cream (used to treat fungal or yeast skin infections) that had expired on 03/26/2021. Further observation revealed Resident #23 had five (5) bottles of Fluocinonide 0.5% Topical Lotion (a corticosteroid used to treat skin infections such as dermatitis or a rash) that had expired on 11/08/2022, 12/15/2022, 12/20/2022, 02/17/2023, and 10/02 2023. Further observation revealed Resident #24 had one (1) Albuterol 2.5	P 220		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100170	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN	108 S MILLER STREET CYNTHIANA, KY 41031

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P 220	Continued From page 6 milligrame/3 milliliter nebulizer treatment (used to open airways to help with breathing) that had expired on 01/11/2023. Further observation revealed Resident #32 had one (1) Fluticasone Nasal Spray that had expired on 12/05/2023. During an interview on 02/29/2024 at 1:20 PM with Aide/Medication Tech #7, she stated she thought a pharmacist came once a month and checked the carts. She stated extra medications and expired medications were taken to the Administrator/Manager's office. She further stated it was important for the medications to be in date to make sure they were still the proper strength for the resident. She also stated expired medications could lead to unwanted side effects. During an interview 03/01/2024 at 2:25 PM with the Administrator/Manager, she stated the pharmacist came to the facility and checked the medication carts about every six (6) months. She stated in between times she had not tasked anyone with checking the medication carts for expired medications. She stated she would be telling the medication aides to check and remove expired medications from the cart going forward, but it was ultimately her responsibility to double check and make sure it was done.	P 220		
P 225	902 KAR 20:036 4(1)(i)1-2 Section 4. Provision of Services (1) Basic health and health related services. (i)1. All medicines kept by the PCH or SPCH shall be kept in a locked place. 2. The administrator or staff person designated by the administrator shall:	P 225		

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Admin 8-5-24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	160170	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN	108 S MILLER STREET CYNTHIANA, KY 41031

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P 225	Continued From page 7 a. Be responsible for administering or supervising the self-administration of medication; b. Ensure that all medications requiring refrigeration are kept in a separate locked box in the refrigerator in the medication area; and c. Ensure that drugs for external use are stored separately from those administered by mouth and injection. 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 all medications were kept in a locked place for one (1) medication, Resident #9's insulin pen. The findings include: Review of the facility's policy titled, "Medication Policies and Procedures," undated, under the Labeling and Storing Medication Section, item 1, revealed all medication shall be properly labeled and stored in a locked cabinet at the nurse's station. Observation on 02/27/2024 at 9:30 AM revealed a clear plastic Ziploc bag with a glucometer, alcohol swabs, lancets, insulin pen needles, and an insulin pen labeled with Resident #9's name was left in the hallway on the shelf of the medication administration window unattended. During an interview on 02/28/2024 at 9:00 AM with Medication Aide (MA) #3, she stated Resident #9 took the bag with the glucometer, insulin, swabs, needles, and lancets to the	P 225	Upon being brought to the former Manager's attention, the issue was immediately addressed The former Manager in servic all med techs between 3.1.24 abd 3.4.24. All med techs acknowledged that they understood what they were being educated on. Going forward, random weekly audits will be completed by the Manager from 3.29.24-4.28.24 POC Completion Date: 3.30.24	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180170	A. BUILDING: _____ B. WING _____	03/01/2024

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P 225	Continued From page 8 adjoining nurse's station area to check his/her blood sugar. She stated Resident #9 then usually returned it to the medication aide when he/she was done. MA #3 stated she did see a problem with the bag being left out for any resident to get as it was dangerous for the residents. Additionally, MA #3 stated Resident #9 should have checked his/her blood sugar at the window and then self-administered his/her insulin in view of the medication aide. During an interview with MA #7 on 02/29/2024 at 9:30 AM, she stated the day Resident #9's bag was left out on the counter in front of the medication room she was so busy with another resident that she forgot about putting it away. MA #7 stated she knew the bag/insulin needed to be locked up in the medication room for resident safety. During an interview on 02/28/2024 at 9:05 AM with the Administrator/Manager (A/M), she stated medication aide trainees were given a packet and then were trained by an experienced medication aide for three (3) to four (4) days. During an additional interview on 03/01/2024 at 2:25 PM, the A/M stated it was her expectation all resident medications be locked up for resident safety and to prevent medications from being ingested by the wrong resident. She further stated only trained staff who knew which medications went to which residents administered medications.	P 225		
P 305	902 KAR 20:036 4(3)(b)3 Section 4. Provision of Services (3) A PCH or SPCH shall meet the following	P 305		

KP admin 8-20-24 ~~to 5-24~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100170	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN	109 S MILLER STREET CYNTHIANA, KY 41031

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P 305	Continued From page 9 requirements relating to the provisions of residential care services: (b) Housekeeping and maintenance services. 3. Safety. The condition of the overall environment shall be maintained in such a manner that the safety and well-being of residents, personnel, and visitors is assured. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's documents, it was determined the facility failed to ensure the condition of the overall environment was maintained in such a manner that the safety and well-being of residents, personnel, and visitors was assured. The second-floor fire escape was deemed unsafe by the local Fire Marshall and was blocked off making one (1) of three (3) emergency exits	P 305	By 3.20.24 all residents will have been educated on what to do in the event of an emergency, should they be on the second floor at the time of the emergency that requires one to evacuate. The Manager has a meeting scheduled with a structural engineer on 3.28.24 to determine the next steps. As of 6.4.24 the Regional Manager has reached out to the Fire Marshall a number of times with follow up questions. The Regional Manager is waiting a call back. As of 3.29.24 the cigarette butt holders will be swapped out on a weekly basis. Random audits will be conducted to ensure it is being done from 3.30.24-4.29.24. On 3.20.24 all residents and staff were educated on what to do in the event of an emergency, should they be on the second floor at the time of the emegency. The Asst. Manager conducted the education. Additionally, signs were put up on 3.20.24 the doors showing where to go in the event of an emergency. The Manager spoke with the Fire Marshall who stated that so long as the fire escape was roped off and an education was done, that is acceptable. Therefore, no reinspection was required by the fire marshall , nor did he suggest one. On 3.29.24 the ashtrays were swapped out. On 3.29.24 staff were educated by the asst manager on the importance of ensuring ashtrays are swapped out weeky. As per the regulation, we cannot ensure our residents do anything, we can only educate them. There is only one fire escape at Shady Lawn, which is roped off. Maintenance personnel will swap out the cigarette butt holders on a weekly basis. Audits were completed weekly from 3.29.24-4.29.24 by the asst manager to ensure the cigarette butt holders were replaced. No deficient practice was found POC Completion Date: 5.1.24	

8-20-24
Admin 8-5-24

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	100170	A. BUILDING: _____ B. WING _____	03/01/2024

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P 305	Continued From page 10	P 305		

inaccessible, and cigarette butts were not being disposed of properly. This affected all the current seventy-one (71) residents.

The findings include:

Review of the facility's document Smoking Disclosure and Release, undated, revealed it stated the facility had provided fire safety ashtrays in outside areas for proper disposal of cigarette butts. Further review revealed the failure to abide by this agreement might result in the termination of a resident's smoking privileges.

Review of the facility's document Location Inspection, dated 02/08/2024, from the Department of Housing, Buildings and Construction, Division of Fire Prevention, revealed the Fire Marshal had inspected the fire escape on the second floor. Further review revealed the Fire Marshal deemed it unsafe to use the fire escape until a structural engineer was consulted and repairs had been done or a new structure had been built.

Observation on 02/27/2024 at 9:30 AM, revealed the door at the second floor fire escape was locked with a hasp and keyed pad lock. Additional observation from outside, and underneath this metal fire escape, revealed the platform was very thin in some areas. As result, the next available exit was a winding stairway at the beginning of this hall, approximately twenty (20) feet away, that emptied into the front hall of the building. It was noted that resident rooms located on the same hall, past that fire escape, had no egress in the event of a fire, and the facility kitchen was located directly below.

Observation during an interview on 03/01/2024 at

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Office of Inspector General

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P 305	Continued From page 11 2:40 PM with the Maintenance Director revealed a rusted fire escape structure that led from the second floor to the ground level. The Maintenence Director stated the fire escape platform from the second floor was rusted through and the fire chief had told him to lock it off. He further stated someone from the state was supposed to come and get it back to code and that it was the only outside fire escape for that area of the upstairs but there were two more inside stairwells that would be used in an emergency. Observation on 02/27/2024 at 9:40 AM of residents smoking outside of the building on the covered porch, located off the dining room, revealed large, rusty, food storage cans that were used for diaposal of cigarettes butts. Further observation revealed a moderate amount of cigarette butts in the yard. During telephone interview with Fire Marshal #31 on 02/29/2024 at 1:30 PM, he stated, regarding the recent inspection, specifically the fire escape on the second floor, that the integrity of the structure was compromised. He stated when standing below the fire escape, he saw a big area through it. He stated the fire escape would "require an inspection by a structural engineer before it could be repaired and that it may be cheaper to just replace it." He stated it could not be used until this was done. During interview on 02/29/2024 at 3:30 PM with the Administrator, she stated she had contacted everyone she could think of and was not having success getting the contractor with the required specific licensure. The Regional Operations Manager was present and stated there were corporate level efforts as well to address the	P 305		

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P 305	Continued From page 12 second floor fire escape.	P 305		
P 310	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 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.	P 310	On 3.20.24 the sidewalks and step were fixed by the maintenance personnel. The fentioned mentioned in the citation does not belong to Shady Lawn. The ramp has since been fixed. Overnight staff were educated on 3.20.24 by the Manager on the expectations regarding cleaning overnight. From 3.20.24-4.2.24, calls will be made by the Manager or the Manager's designee in the middle of the night to ensure the tasks are being completed. From 4.3.24- 4.17.24, calls will be made on a random basis by the Manager or the Manager's designee to ensure the tasks are being completed. Curtains on the windows in the residents rooms will be up by 4.8.24. The Manager or the Manager's designee will conduct a daily random audit (M-F) from 3.30.24-4.29.24 to ensure the tasks as they relate to cleaning are being conducted. All staff will be educated on the expectations as they relate to cleaning by 3.30.24. The dining room floor is being cleaned 3x/day. The Manager or the Manager's designee will conduct a daily audit (M-F) from 3.30.24-4.29.24 to ensure this is being complied with . . [illegible] In the event that the audits are not up to par, they will continue. The following was completed on 4.3.24: Floors and baseboards in the dining room were cleaned Curved stairwell near the kitchen was cleaned Flooring in resident rooms, hall and day areas was cleaned Dining area floor, wooden staircase and hall at the top of the stairs was cleaned Dried spilles were cleaned through the building, baseboards, etc On 2.27.24 the mop bucket and mop were rmoved rom the hallway and the orange bucket and bag were removed On 4.18.24 the following was completed: - Cracked window was replaced by the2nd fl alcove and hallways walss were addressed - PVC piples and hols near 115 were repaired - Ceiling in bathroom was addressed Crakes and holes in the windows and chipped pain in rm 115 was addressed. - Window acros from teh upstairs elevtor was addressed The 2nd floor bathroom was cleaned on 3.1.24. The right hand rail was repaired on 3.25.24 The fire marshall stated teh wooden fire escape door did not need to be addressed as per regulation. Christmas decorations were removed on 4.2.24 Asst manager educated the staff on the expectations as it relates to cleanliness audit mentioned was in regards to teh dining room. In teh event that deficient practice was continues.	

K Re admin 8-20-24 ~~8-5-24~~

Office of Inspector General

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	100170	A. BUILDING: _____ B. WING _____	03/01/2024

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P 310	Continued From page 13 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 that the grounds were well kept and the exterior of the building, including the sidewalk, steps, porches, ramps, and fences were in good repair. Additionally, the facility failed to ensure the interior of the building, including walls, ceilings, floors, windows, window coverings, doors, and plumbing fixtures were in good repair and windows were screened. This affected all the current seventy-one (71) residents. The findings include: Review of the facility's policy titled, "Housekeeping Policy," revised 03/01/2022, revealed daily housekeeping would be conducted at the facility to ensure the cleanliness of the facility. Tasks were to include, but were not limited to, emptying the garbage and tidying up resident rooms. Additional review revealed while staff would encourage residents to allow staff to tidy up their rooms, a resident was allowed to refuse such a service.	P 310	Audits will not be completed in regards to the PVC pipe repair, stains on ceilings, etc. The east manager conducts daily walk throughs and at that time will make any notes she deems necessary. POC completion date: 5.1.24	

8-20-24
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	160170	A. BUILDING: _____ B. WING _____	03/01/2024

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P 310	Continued From page 14 Observation on 02/27/2024 at 9:30 AM, revealed the floors in the dining room had dried dark sticky spots in the corners and along baseboards. Dried food particles were noted under and on the dining room tables and chairs. A yellow mop bucket with a dark cloudy liquid and a mop in it was located around the corner from the kitchen in the hallway leading to the dining area. An orange bucket with a dark liquid and a used rag in it was positioned on an wooden chair with an orange back and seat cushion in the resident dining area. Per the observation, a cracked window was observed in the second floor alcove area which faced the front of the facility. The hallway walls were dirty and in need of re-painting. The curved stairwell near the kitchen that opened into the dining area had piles of dirt against the back of the tread. Per the observation, the second floor bathroom at the top of the stairs that led from the main hall upstairs had dark spots around the toilet and brown matter in the toilet. The top cement stair at the west end of the front of the facility outside was cracked and crumbling, and the metal brace was loose. Additionally, the right-hand side rail when going down the stairs was loose and would wobble an inch in either direction posing a fall risk for staff, residents, family members, and visitors. During an interview on 02/27/2024 with Aide #1 she stated she was assigned to the second floor today and would clean and get as many beds changed as she could but sometimes it was hard to get all the work done. Observation on 02/27/2024 at 9:40 AM, revealed multiple rusty food cans, used as ashtrays all over the porches. Also, cigarette butts were found on the ground.	P 310		

8-20-24
admin ~~8-5-24~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180170	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN	108 S MILLER STREET CYNTHIANA, KY 41031

(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 310	Continued From page 15 Observation on 02/27/2024 at 9:45 AM, revealed protruding PVC pipes and holes in the wall to the right side of Room 115. In an interview with Resident #11 at this time, he/she stated staff took the sink out a long time ago. In an interview with Maintenance staff on 02/27/2024 at this time the Maintenance staff stated, "Just never capped the PVC pipe or patched the holes." Observation on 02/27/2024 at 10:05 AM, revealed residents' rooms, halls, and day areas, had aged flooring with a heavy layer of dirt and grime on the edges of the floor and baseboards and what appeared to be old carpet glue on the dining area floor, wooden staircase, and hall at the top of the stairs, near the fire exit. Further observation revealed areas of dried spills observed throughout the building. These dried spills were noted on the wood flooring in the dining area, immediately off the kitchen, on the ornate wooden stairs off the dining room to the second floor, and on the baseboards along the same staircase. Dried spills were also noted on the floors in Resident Room 115, 204 and 218. Observation on 02/27/2024 at 10:18 AM, revealed walls with miscellaneous stains and spills in the Television/Activity area and in Resident Rooms 115, 212, and 218. Observation on 02/27/2024 at 10:20 AM, revealed the ceiling of the bathroom, located in the middle of the front hall, had dark stains in the right corner of the ceiling. Observation on 02/27/2024 at 1:48 PM, revealed curtains and pillows were missing out of Room 201 for three (3) of three (3) beds. In an interview with the Administrator at that time, she stated pillows were being ordered, and she would look	P 310		

8-20-24
admin

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P 310	Continued From page 16 into getting a curtains for the room. She stated Resident #12 especially needed curtains because sunlight blocked the view of his/her television screen. The Administrator stated as soon as pest control was complete, it was her goal to order new curtains. Observation on 02/28/2024 at 9:10 AM, revealed a yellow mop bucket with a dark cloudy liquid, and a mop in it was located around the corner from the kitchen in the hallway leading to the dining area. An orange bucket with a dark liquid and a used rag in it was positioned on a wooden chair with an orange back and seat cushion in the resident dining area. The dining room floor was dark and sticky and had the same dried food under the table and in the corners of it as on 02/27/2024. The curved staircase stair treads leading from the second floor to the dining area had been cleaned. Observation on 02/28/2024 at 9:50 AM, revealed cracks and holes in the windows in Room 115. The window facing the front of the building had three (3) large cracks and no screen. The window to the left had a screen, but the windowsill had large areas of chipped paint. The resident that resided in Room 115 stated he/she had told maintenance about this "a few weeks ago." Observation on 02/28/2024 at 9:55 AM, revealed the window across from the upstairs elevator had a hole in the left lower corner of the window glass. Observation on 02/28/2024 at 3:45 PM, revealed the wooden fire escape door, which had large gaps and did not seal. Day light could be seen between the door and the frame, and the wood appeared rotten. In an interview on 02/28/2024 at	P 310		

8-20-24
K [illegible] admin ~~8-5-24~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100170	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN	108 S MILLER STREET CYNTHIANA, KY 41031

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P 310	Continued From page 17 this time with Maintenance staff and the Administrator present, the Maintenance staff stated he would follow up with these issues. Observation on 02/29/2024 at 8:40 AM, revealed residents were eating in the dining room. Dried cheerios cereal and bits of biscuit were on the floor around the chairs, in the corners, and under the tables. There was a mop bucket around the corner between the dining room and the kitchen with a dirty mop and standing water. Dining room tables had a sticky liquid and crumbs/dried food on them. Further observation revealed the orange chair with an orange bucket containing a dark liquid and rag remained the same as the previous observation on 02/28/2024. The floor of the hallway between the 100 Hall and the kitchen had cigarette butts, a used tissue, and crumbs along the baseboard. In the seating area near the television room, dusty Christmas decorations were on the top shelf of the bookcase along the wall. Per observation, the alcove with the television (TV) that faced the front of the facility had five (5) windows. Only one (1) of the five (5) windows had a screen, and the window furthest to the left was cracked. The TV alcove had two (2) chairs, and there were eight (8) chairs, four (4) along each wall in the hall leading to the alcove. Total seating was 10 (ten) for the facility census of seventy-one (71) residents. During an interview on 03/10/2024 at 3:00 PM with the Administrator/Manager (A/M), she stated the physical environment of the building was not up to the standard she expected for the facility. She stated if she could hire and keep consistent staff and had more resources, that would help. She admitted the facility was a work-in-progress, and she was working on finding places to get the things the facility needed delivered faster. She	P 310		

K Re admin 8-20-24 ~~8-5-24~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100170	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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P 310	Continued From page 18 stated several months ago the Owner and the Regional Operations Manager told her and the Manager of a sister facility that they planned to hire someone to come to the facility. She stated this person was supposed to paint, work on the floors, and "do stuff to better the building," but it had not happened yet. The A/M stated she would like for the facility to be a place the residents could be proud and happy to call their home.	P 310		
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: (I) Prepared by methods that conserve nutritive value, flavor, and appearance; and (II) Served at the proper temperature and in a	P 330	On 3.4.24 the former Manager conducted an audit to ensure all foo items were date appropriately. The former Manager conducted an education with the staff on 3.4.24 on the importance of properly dat food. The Manager will conduct a random audit twice a week for two weeks starting 3.30.24. POC Completion Date : 3.5.24	

admin ~~3-5-24~~ 8-2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100170	A. BUILDING: _____ B. WING _____	03/01/2024

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P 330	Continued From page 19 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 all open containers or leftover food items were dated when refrigerated. The findings include: Review of facility Dietary Services Policy, undated, revealed the storing of food service products was to be in "properly labeled and dated food storage containers." Observation, during the kitchen tour on 02/29/2024 at 10:05 AM, revealed an undated, clear, plastic bag with three (3) slices of American cheese with no date, and there were three (3) dark spots in the middle of the top cheese slice.	P 330		

KPE admin ~~to S.D.~~ 8-20-24

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P 330	Continued From page 20 During an interview with Cook #1 on 02/29/2024 at 10:05 AM, she stated that stock was rotated with each delivery. She stated, regarding the cheese, "that should be thrown away." During interview on 03/01/2024 at 2:20 PM, the Administrator stated it was her expectation, when food items were opened that they would be dated so staff was aware of when to throw them away.	P 330		
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	P 345	The Manager or an individual designated by the Manager will conduct a daily activity with the residents as of 3.30.24. By 3.30.24 all staff were educated by the Manager on the importance of encouraging residents to participate in activities. As per the regulation, the Manager shall designate an individual to conduct the activity, volunteers may assist , the calendar should be posted and and there shall be a planned activity period each day. As per the regulation, there is a planned activity period per day, as well as items set up for residents to enjoy independent activities. The Regional Manager /Manager will conduct spot visits from to ensure the cade is being followed. [illegible] The asst manager conducts a daily activity based on the calendar posted on 3.30.24. The room for the residents was setp up on 4.5.24. Residents express the activities of interest to teh asst manager. Regulation is followed as it relates to activities, which does not require a POC tro conduct any trakcing of who participates. Spot visits were conducted by the manager/regional manager from 3.30.24-4.29.24 to ensure activity was completed daily. POC Completeion: 5.1.24	

KP Admin ~~5-30-24~~ 8-20-24

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P 345	Continued From page 21 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. 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 provide social and recreational activities to stimulate physical and mental abilities to the fullest extent; encourage and develop a sense of usefulness and self-respect; prevent, inhibit, or correct the development of symptoms of physical and mental regression; and provide sufficient variety to meet the needs of each resident. In addition, the facility failed to designate a staff member to be responsible for the activity program and provide supplies and equipment for the activity program, including items such as reading materials, radios, and games. This affected all the current seventy-one (71) residents. The findings include: Review of the facility's policy titled, "Activities-Policy," revised 03/01/2022, revealed a staff member shall be designated to provide a planned activity each day, and the facility could also accept services from a volunteer group to carry out the planned activity.	P 345		

KP Admin 8-5-24
8-20-24

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	160170	A. BUILDING: _____ B. WING _____	03/01/2024

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P 345	Continued From page 22 Observation on 02/29/2024 at 8:40 AM, revealed the supplies available to the residents on the bookshelf near the television (TV) room (alcove) on the first floor included one (1) magazine dated 4/2011, one (1) part of a newspaper dated 02/15/2024, six (6) valentine themed cookie monster coloring pages, three (3) children's books, and one (1) Sudoku pocket size large print puzzle book. Three (3) puzzles were also available but there was no table on which to work them. Further observation revealed the TV room had two (2) chairs, and there were eight (8) chairs, four (4) along each wall in the hall leading to the alcove. Total seating was 10 (ten) for the facility census of seventy-one (71) residents. During an interview on 02/29/2024 at 8:20 AM with the Administrator/Manager (A/M), she stated she had no designated activity person right now, and the medication aides did activities like corn hole, bingo, and tin can bowling. She stated staff discussed resident likes from time to time and tried to implement other activities like musical chairs (which the residents did not like), tin can bowling, corn hole, and bingo. The A/M stated there was no activities closet with supplies available on site, but she printed out word searches, crosswords, and coloring sheets and left them on the bookcase near the TV room for residents. She stated all residents had been given crayons and pencils from the community at Christmastime, and she also tried to get supplies for the residents to use. An Activity binder with records was requested by the State Survey Agency (SSA) Surveyors but was not provided, the Administrator stated there was no binder available. During a phone interview on 03/01/2024 at 11:49 AM with the Owner, she stated the facility did	P 345		

K Ra Admin ~~te-5-24~~ 8-2024

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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P 345	Continued From page 23 have a designated staff person for activities,.but she was on maternity leave. During an interview with the A/M on 03/01/2024 at 2:25 PM, she again stated she had no designated activity person at the present. She stated an aide that was on maternity leave asked to do activities with the residents and enjoyed doing it, but she was not the designated person.	P 345		

KR admin ~~10-5-24~~ 8-20-24

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R 805	KRS 216.515(6) PATIENTS' RIGHTS Every resident in a long-term-care facility shall have at least the following rights: (6) 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 period of time and documented in the resident's medical record. This requirement is not met as evidenced by: Based on interview and review of the facility's policy, it was determined the facility failed to ensure all residents were free from verbal abuse for one (1) of thirty-three (33) sampled residents, Resident #33. The findings include: Review of the facility's policy titled, "Abuse Policy," undated, revealed staff members were not allowed to be verbally abusive to any resident, other staff member, or individual related to the facility. Further review revealed all employees must report suspected abuse of any resident by any source including staff, families, and visitors.	R 805	The staff member was immediately terminated on 2.27.24. All staff present were educated on 2.27.24 by the former Regional Manger and the current REgional Manager. All staff will be educated by 3.30.24 on resident rights as it relates to abuse and neglect. POC completion date: 3.31.24.	

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

Admin 12-5-24
8-20-24