Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	R-C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 on the acceptable Plan of Correction (POC), related to P0105, P0110, and P0195, received on 09/10/2024 and the revisit survey initiated on 10/02/2024 and concluded on 10/02/2024, it was determined the facility had achieved substantial compliance on 09/30/2024 as alleged.	{P 000}		

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

PRINTED: 09/03/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100338	A. BUILDING: _____ B. WING _____	R 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2985 COLUMBIA ROAD EDMONTON, KY 42129

(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 08/22/2024 and concluded on 08/23/2024. The facility was determined to not be in substantial compliance effective 08/16/2024, as alleged in the acceptable plan of correction.	P 000		
P 105	902 KAR 20:036 3(8)(c) Section 3. Administration and Operation (8) Personnel. (c) A PCH or SPCH shall obtain a criminal record check on each applicant for initial employment in accordance with KRS 216.789 and 216.793. This requirement is not met as evidenced by: Based on review of employee files, the facility failed to maintain current employee records and contain documentation of compliance with a background check for five (5) of six (6) employees Resident Assistant (RA) 2, RA3, Housekeeper 1, Dietary 1, and Assistant Administrator (AA) for initial employment. Findings include: Review of RA2 employee file revealed, no criminal check was in the file. Review of RA3 employee file revealed, no criminal check was in the file.	P 105		

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

PRINTED: 09/03/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100338	A. BUILDING: _____ B. WING _____	R 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2505 COLUMBIA ROAD EDMONTON, KY 42129

(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 110	Continued From page 2	P 110		
P 110	902 KAR 20:038 3(8)(d)1-5 Section 3. Administration and Operation (8) Personnel. (d) Current employee records shall be maintained on each staff member and contain: 1. Name and address; 2. Verification of all training and experience, including evidence of current licensure, registration, or certification, if applicable; 3. Employee health records; 4. Annual performance evaluations; and 5. Documentation of compliance with the background check requirements of paragraphs (a) through (c) of this subsection. This requirement is not met as evidenced by: Based on review of employee files, the facility failed to maintain current employee records and contain documentation of compliance with a background check for five (5) of six (6) employees Resident Assistant (RA) 2, RA3, Housekeeper 1, Dietary 1, and Assistant Administrator (AA) for initial employment. Findings include: Review of RA2 employee file revealed, no criminal check was in the file. Review of RA3 employee file revealed, no criminal check was in the file.	P 110	9/4/24 Checked on status from KSP Criminal background checks. KSP office did say: it could Take up to 2 or more weeks To receive the results. Did speak CS about the Completion date. Completion date 9/30/24	9/7/24

PRINTED: 09/03/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100338	A. BUILDING: _____ B. WING _____	R 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2986 COLUMBIA ROAD EDMONTON, KY 42129

(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) COMPLETION DATE
P 105	Continued From page 1 Review of Housekeeping1 employee file revealed, no criminal check was in the file. Review of Dietary1 employee file revealed, no criminal check was in the file. Review of Assistant Administrator employee file revealed, no criminal check was in the file. During an interview with the Assistant Administrator (AA) on 08/22/2024 at 2:33 PM stated, the facility was aware criminal background checks were not obtained that only the misconduct registry is performed. The Administrator is responsible for background checks and, "The Administrator only runs background checks when there's a reason." She continued to state by not obtaining a background check would be the employee may have charges that prevents them from being hired. Interview with the Administrator on 08/22/2024 at 3:04 PM the administrator stated, criminal checks are not performed upon initial employment, only the misconduct registry. Upon initial employment, Assistant Administrator (AA) informs me the applicant has accepted the position. Then, the AA sends the applicants' name and social security number to the me, so I perform the misconduct registry only. I am responsible for running background checks, but was unaware criminal checks were to be performed upon initial employment. She stated, "you know who is a criminal and who is not. You have to know the residents (R) they would tell me. They would call if the person was, acting up."	P 105	9-9-24 105-110 ADMINISTRATION AND OPERATION 8/26/24 Monday-8AM talked To KSP for directions to get A criminal background check. Made 6 copies of request. 8/27/24 Sent copies to Harper's. 8/28./24 Received copies of each Staff And mailed. The Staff have in their files, a Misconduct registry and a file From a criminal background from IDTRUE.	

PRINTED: 09/03/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180338	A. BUILDING: _____ B. WING _____	R 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2805 COLUMBIA ROAD EDMONTON, KY 42129

(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 110	Continued From page 3 Review of Housekeeping1 employee file revealed, no criminal check was in the file. Review of Dietary1 employee file revealed, no criminal check was in the file. Review of Assistant Administrator employee file revealed, no criminal check was in the file. During an interview with the Assistant Administrator (AA) on 08/22/2024 at 2:33 PM she stated, the facility was aware criminal background checks were not obtained that only the misconduct registry is performed. She further stated the Administrator is responsible for background checks and, "The Administrator only runs background checks when there's a reason." She continued to state by not obtaining a background check would be the employee may have charges that prevents them from being hired. Interview with the Administrator on 08/22/2024 at 3:04 PM, she stated, criminal checks are not performed upon initial employment, only the misconduct registry. She continued to state upon initial employment the Assistant Administrator (AA) informs her that the applicant has accepted the position and sends the applicants' name and social security number and then the Administrator will perform the misconduct registry only. She further stated that she is responsible for running background checks, but was unaware criminal checks were to be performed upon initial employment. She stated, "you know who is a criminal and who is not." She further stated "you have to know the residents (R) they would tell me and they would call if the person was, acting up."	P 110	105-110 A is responsible for Obtaining background Checks from KSP. A &AA Are responsible for Completing files. A educated On 8/26/24 AA and the staff On background checks. A & AA Will monitor each month staff Files. Keep a log upon monitoring As an audit tool. A & AA will address Any variances.	9/9/24

PRINTED: 09/03/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	R 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 195)	Continued From page 4	(P 195)	195 PROVISION OF SERVICES	
(P 195)	902 KAR 20:038 4(1)(c) Section 4. Provision of Services (1) Basic health and health related services. (c) Medications or therapeutic services shall not 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's policy, it was determined the facility failed to ensure four (4) of five (5) residents; Resident (R) 1, R2, R3, and R4, received proper care and treatment related to staff performing glucometer checks as staff did not change personal protective equipment (PPE) or follow proper hand hygiene. The findings include: Review of the facility's "Resident Rights" policy not dated, revealed the facility must care for the resident in a manner that enhanced the resident's quality of life. The resident may choose their own physician and participate in their treatment and any resulting changes. The resident may self-administer drugs unless determined unsafe by the interdisciplinary team. The facility failed to provide a glucometer or infection control policy.	(P 195)	8/19/24 AND 8/24/24 Verbally A was in contact In the AM with Staff 1 and Staff 2 on the education of the Glucometer. 8/26/24 AA followed with Training and instruction (face to face) with the entire Staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100338	A. BUILDING: _____ B. WING _____	R 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 195)	Continued From page 6 Review of Resident Assistant (RA)1's employee file revealed the Third Shift Resident Assistant job duties, not dated, states staff were to ... do blood glucose checks. Further review revealed a training sheet labeled "Competency for Blood Glucose Testing" that had been signed and dated by RA1 on 07/01/2024. Step 3 of 15 in the form stated, "perform hand hygiene and don appropriate equipment (gloves, mask, etc)." Step 15 of 15 stated "Remove and discard gloves". During an observation beginning on 08/23/2024 at 5:01 AM, RA1 put gloves on, sanitized glucometer with a disinfectant wipe, sanitized R1's finger with an alcohol pad, turned the glucometer on, used lancing device on Resident 1's (R1) finger, put R1's blood on the test strip, and recorded the glucose reading in logbook at Assistant Administrator's (AA) desk. RA1 cleaned the area she was working at with a disinfectant wipe and repeated this process for R2, R3, and R4. At no time in this observation did RA1 wash their hands with soap and water or use a hand sanitizer. RA1 was also observed not changing their gloves in between resident glucose checks. During an interview with RA1 on 08/23/2024 at 5:18 AM she stated she "was not advised to change gloves between residents but she thought about it." RA1 stated transmission of diseases was a potential risk from not using hand hygiene or changing gloves. During an interview with Assistant Administrator (AA) on 08/23/2024 at 10:30 AM AA stated it was important to use proper hand hygiene and change gloves in between resident glucose checks "because of infectious diseases and to keep both myself residents safe." AA also stated that not changing gloves could transfer blood or	(P 195)	9/3/24 9/11/24 A observed Staff 1 on the Use of the Glucometer. Staff 1 followed procedures As instructed. Gloves were worn and changed On each resident plus sanitized Glucometer, shelf, and resident Before and after. 9/4/24 A did a followed-up with Staff 1's Routine using the glucometer. Completion date 9/4/24	

PRINTED: 09/03/2024
FORM APPROVED
Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	R 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2805 COLUMBIA ROAD EDMONTON, KY 42129

(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 195}	Continued From page 6 diseases between residents. AA stated her expectation was her staff will follow proper hand hygiene and change their gloves when necessary to keep themselves and residents safe. During an interview with Administrator on 08/29/2024 at 10:40 AM Administrator stated anything could happen if staff didn't change gloves. If someone had a disease it could be transferred to other residents. Administrator stated that she had the expectation for staff to change their gloves when needed and not go from one resident to another without changing gloves.	{P 195}	P195 9/9/24 A & AA once a week will Check Staff 1 & 2 to ensure The process is in place. Verbally staff will be reeducated By AA once a month to ensure the Process and document the Conversation and monitoring Completion date 9/10/24	

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 A Relicensure Survey and Complaint Survey investigating complaint KY00036051 and KY00036976 was initiated on 06/19/2024 and concluded on 06/21/2024. Complaint KY00036051 was non-compliant with regulatory violations cited. The Division of Healthcare determined complaint KY00036976 was Compliant with regulatory guidelines. Based on the findings, it was determined the facility failed to ensure resident(s) received proper care and treatment related to staff performing glucometer checks as staff provided care outside their scope of practice related to glucometer checks. In addition, staff failed to clean the glucometer and lancet device with a germicidal disinfectant before and after each resident use. During an observation on 06/21/2024 at 6:00 AM, Resident Assistant (RA) #1 picked up the glucometer and lancet device and used the lancet device to prick Resident (R) 1's finger to check the resident's morning blood sugar level. RA1 then took the same glucometer, changed the lancet inside the lancet device, wiped R6's finger with an alcohol prep, and initiated a finger prick to R6, without sanitizing the glucometer machine or lancet device with a germicidal wipe. The State Survey Agency (SSA) stopped RA1 prior to sticking R6's finger and informed RA1 the glucometer machine and lancet device had not been sanitized with a germicidal wipe prior to using it on R6. The facility was notified of the Type "A" Citation on 06/21/2024 related to staff provided care	P 000	An in-service was conducted by an outside nurse Consultanton7/1/24. Staff were in-service by the Consultant regarding the utilization of the glucometer And the proper way to sanitize the meter after each Use. The facility has purchased individual glucometer For each resident as of 6/25/2024.	7/16/24

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

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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	Continued From page 1 outside their scope of practice and staff failed to clean the glucometer and lancet device with a germicidal disinfectant before and after each resident use.	P 000		7/16/24
P 055	902 KAR 20:036 3(5) Section 3. Administration and Operation (5) Adult protection. PCHs and SPCHs shall have written policies that assure the reporting of allegations of abuse, neglect, or exploitation of adults pursuant to KRS 209.030, including evidence that all allegations of abuse, neglect, or exploitation shall be thoroughly investigated internally to prevent further potential abuse while the investigation is in progress. This requirement is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to report, investigate, and protect residents from abuse. On 03/28/2022, the facility failed to protect, report, and investigate an allegation of sexual abuse involving Resident (R)8 and a staff member. The findings include: Review of facility's "Protection from Abuse, Neglect, & Exploitation" policy adopted	P 055	All staff have been in-serviced regarding Proper interaction with residents. Staff Are routinely in-serviced regarding their Interaction with residents. Staff are In-serviced on abuse and neglect Yearly All staff records have been reviewed And all staff have a current employee file. Based on interview, record review, and facility policy review, it was determined the facility failed to report and investigation of allegations of abuse. In addition, the facility failed to notify the Administrator, the residents State Guardianship, or OIG of client involved which was one (1) of one (1). On 03/28/2022, the facility failed to report possible abuse, neglect, or exploitation between resident 9 and a staff member. The findings include: Review of facility "Protection from Abuse, Neglect, & Exploitation" adopted	

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 000	Continued From page 1	P055	The completion date for correction of the	

outside their scope of practice and staff failed to clean the glucometer and lancet device with a germicidal disinfectant before and after each resident use.

P 055 902 KAR 20:036 3(5) Section 3. Administration and Operation

(5) Adult protection. PCHs and SPCHs shall have written policies that assure the reporting of allegations of abuse, neglect, or exploitation of adults pursuant to KRS 209.030, including evidence that all allegations of abuse, neglect, or exploitation shall be thoroughly investigated internally to prevent further potential abuse while the investigation is in progress.

This requirement is not met as evidenced by:
Based on interview, record review, and facility policy review, it was determined the facility failed to report, investigate, and protect residents from abuse.

On 03/28/2022, the facility failed to protect, report, and investigate an allegation of sexual abuse involving Resident (R)8 and a staff member.

The findings include:

Review of facility's "Protection from Abuse, Neglect, & Exploitation" policy adopted

Deficiency is 7/22/24. The dietary was
Interviewed by the Assist Administrator
And Administrator at separate times. The
Resident was also interviewed. The resident was
Alert and oriented. The resident and staff both denied
That anything improper had happened. Both individuals
Made the same statement to the Administrator and Asist Adm.
When the resident stated when the resident was in the TV
Room ,that the dietary manager was also there. It should
Also be noted that in addition to being the dietary manager she
Also worked the floor.
Staff member was given a verbal warning and all staff were
In-serviced regarding abuse, neglect, and exploitation and
Relationships between residents and staff.
The in-service records and employee records were destroyed
When the basement flooded This was explained to the original
Surveyor . Staff were in-serviced routinely regarding abuse,
Neglect and exploitation. New staff are in-serviced
Immediately upon hiring and in-serviced yearly. Staff are
Supervised by the Administrator and by the head of the
Governing and outside consultation familiar with state requirements
Continual oversight and supervision will insure the alleged violation
Will not occur.
We did not feel the allegation rose to the level of reporting
Because we had no reasonable belief after investigation that any inc

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING:_____ B. WING_____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 055	Continued From page 2 09/17/2008, revealed no resident of the facility shall in any manner be abused, neglected, and exploited. Further review revealed it was the responsibility of any person that suspects abuse, neglect, or exploitation to report their concerns to the Cabinet for Health Services immediately, and it was the responsibility of an employee of a Health Care Facility to report abuse to administrative staff. Furthermore, an employee who ass determined to be guilty of abuse, neglect, or exploitation or who failed to report would be terminated. Review of the facility's "Resident Rights" policy dated 1992, revealed residents at the facility had the right to have his or her rights exercised by the person appointed under state law to act on his or her behalf. Record review revealed R8 was admitted to the facility on 04/14/2021 with diagnosis of non-insulin dependent diabetes, hypertension, hyperlipidemia, chronic obstructive pulmonary disease, and bipolar disorder. Continued review revealed R8 had a guardian at the time of the allegation. During interviews on 06/20/2024 at 2:45 PM, and again on 06/21/2024 at 9:48 AM, with the Assistant Administrator (AA), she stated Dietary Manager 2 (DM) had worked at the facility in 2022 when the allegations of sexual abuse occurred. She stated she had heard there was a relationship between DM2 and resident (R)8; however, R8 no longer resided in the facility and DM2 no longer worked at the facility. The AA stated DM #2 would sit near resident # 8 during activities and R8 would go into the kitchen with DM2 when she was in the kitchen working. The	P 055	09/17/2008 revealed no resident of this facility shall in any manner be abused, neglected, and exploited. Further review revealed it is the responsibility of any person that suspects abuse, neglect, or exploitation to report their concerns to the Cabinet for Health Services immediately. It is the responsibility of an employee of a Health Care Facility to report abuse to administrative staff. Review of the facility policy "Resident Right" revealed residents at the facility have the right if you are unable to act in your own behalf, your rights are exercised by the person appointed under state law to act in your behalf. Record review revealed resident admitted to the facility on 04/14/2021 with diagnosis of non-insulin dependent diabetes, hypertension, hyperlipidemia, chronic obstructive pulmonary disease, and bipolar disorder. Record review revealed Resident # 9 had a guardian at the time of the incident; however, he gained his guardianship back and had since left the facility. The Dietary manager #2 no longer worked at the facility and Assistant Administrator did not have employee file to provide. Interview on 06/21/2024 at 2:45 PM, with the Assistant Administrator revealed she remembered Dietary Manager #2 working at the facility. The first time was about nine years, and then for a few years the second time, which was during the allegations on 03/28/2022. She stated Dietary Manager #2 would "hang" with resident # 9 and another resident, but she never actually saw anything inappropriate	

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(X5) COMPLETE DATE
P 055	Continued From page 3 AA stated she never saw anything inappropriate between R8 and DM2. During further interview, she stated she spoke with both parties regarding her concerns related to the allegation. The AA stated both parties denied any relationship other than friendship. She stated she did not document the incident, report the incident, and she did not notify the resident's guardian, the Administrator, the Department of Community Based Services (DCBS) or the Office of Inspector General (OIG) of the possible sexual abuse allegation because the resident and DM2 denied it had occurred. The AA stated she was last trained on Abuse and Neglect around 2012 and did not remember who trained her. She stated abuse was anything that could harm a resident and abuse of any kind should be reported to the Administrator immediately. She further stated, now she probably should have reported the allegation to the appropriate reporting authorities. The State Survey Agency (SSA) requested the employee file for Dietary Manager #2 and the Assistant Administrator stated she did not have an employee file for DM2. The SSA was unable to reach the Administrator by phone. The SSA left a voicemail for the Administrator to return a call for interview. The Administrator did not return a call to the SSA prior to exiting the facility.	P 055	The allegation of abuse was investigated And it was determined this allegation was Made by a resident who has a history of Making allegation against other residents And staff with no valid evidence to backup Her claims The staff member in question Denied the allegation..The resident denied The allegation and no one witnessed any Improper behavior at any time between The two residents. The allegation was made By a resident who had no proof. The Allegation did not reach the threshold for Reporting in that the statues and the Regulation states you have to have Reasonable cause to believe the Existence of abuse, neglect and Exploitation before you report it. The evidence didn't exist, all parties Dnied the allegation and the person	7/16/24 7/16/24
P 110	902 KAR 20:036 3(8)(d)1-5 Section 3. Administration and Operation (8) Personnel. (d) Current employee records shall be maintained on each staff member and contain:	P 110	Who made the allegation countless allegations Against residents, staff including the administratc And her own family.	

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 110	Continued From page 4 1. Name and address; 2. Verification of all training and experience, including evidence of current licensure, registration, or certification, if applicable; 3. Employee health records; 4. Annual performance evaluations; and 5. Documentation of compliance with the background check requirements of paragraphs (a) through (c) of this subsection. This requirement is not met as evidenced by: Based on interview and review of employee files, it was determined the facility failed to ensure current employee records maintained annual performance evaluations for each staff member for 3 out of 3 employee files. member and contain. The findings include: Review of Resident Assistant (RA) #1's employee file, revealed she had been hired on 03/27/2012. Continued review revealed no documented evidence an annual performance evaluation had been performed. Review of Resident Assistant (RA) #2's employee file, revealed she had been hired on 09/26/2023. Continued review revealed no documented evidence an annual performance evaluation had been performed. Review of Resident Assistant (RA) #3's employee	P 110	All employees personnel records have been Updated and all employees will be given a Performance evaluation going forward. These evaluations will be conducted yearly And all employees will be evaluated within 30 days of their hire date. Employees P110 Who have worked at the facility for more Than one year have an annual evaluation. This deficiency was corrected on 6/25/24. 7/31/24 The Administrator and Asst. Administrator Updated all personnel records. Employee Files were updated and completed by 6/25/24. The Administrator and the assistant administrator Have the main responsibility plus the Utilization of outside consultant. Education was provided by administrator, Staff,and nurse consultant, and the dietary consultant After deficiencies were issued. In-service/education was provided to all staff. Supervision by administrative staff and by the facility Compliance consultant. The facility compliance officer and the nurse consultant And the administrative staff to insure compliance , and process Will be reviewed and documented monthly by administrator And assist, administrator	7/12/24

STATE FORM 6899

08:29:42 2024-08-19 Eastern

5

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 110	Continued From page 5 file, revealed she had been hired on 08/13/2022. Continued review revealed no documented evidence an annual performance evaluation had been performed. During an interview with RA1 on 06/20/2024 at 7:44 AM, she stated she had worked at the facility for twelve years and had not had an annual evaluation that she knew of. During an interview with Assistant Administrator (AA) on 06/21/2024 at 10:17 AM, she stated she did not have a process for completing annual performance evaluations or training of any kind for staff. The SSA was unable to reach the Administrator by phone. The SSA left a voicemail for the Administrator to return a call for interview. The Administrator did not return a call to the SSA prior to exiting the facility.	P 110		
P 130	902 KAR 20:036 3(8)(h)1 Section 3. Administration and Operation (8) Personnel. (h) In-service training. 1. Each PCH or SPCH employee shall receive orientation and annual in-service training that corresponds with the staff member's job duties. This requirement is not met as evidenced by:	P 130		

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 130	Continued From page 7 corresponded with RA1's job duties. Review of Resident Assistant (RA) #2's employee file, revealed she had been hired on 09/26/2023. Continued review revealed no documented evidence an annual in-service training that corresponded with RA2's job duties. Review of Resident Assistant (RA) #3's employee file, revealed she had been hired on 08/13/2022. Continued review revealed no documented evidence an annual in-service training that corresponded with RA3's job duties. During an interview with RA1 on 06/20/2024 at 7:44 AM, she stated she had worked at the facility for twelve years and had not had an annual in-service training that corresponded with her job duties that she knew of. During an interview with Assistant Administrator (AA) on 06/21/2024 at 10:17 AM, she stated she did not have a process for completing annual performance evaluations or training of any kind for staff. The SSA was unable to reach the Administrator by phone. The SSA left a voicemail for the Administrator to return a call for interview. The Administrator did not return a call to the SSA prior to exiting the facility.	P 130	7-16-24 All new employees will be in-serviced within3 Days of being hired and all current Employees will be in-serviced by 7/30/2024. All in-service training will cover abuse, neglect, And exploitation and client interaction as Well as specific training regarding Job duties. P130 7/31/24 The completion date is 7/25/24. Staff were education by administrative staff. Staff were educated on 6/30/24. Administrative staff provide oversight and Supervision to insure staff have retained the In-service and education given to them and Any variances willl be documented and further Training will be provided to staff.	
P 135	902 KAR 20:036 3(8)(h)2a-c Section 3. Administration and Operation (8) Personnel. (h) In-service training.	P 135	Facility has an established in-service program For new hires and in-serviced by the administrator And assist. Administrator. New hires will be in-serviced Within7 days of employment and will be documented And placed in employee's file. Facility administrator will routinely review job Performance of each staff person and will document Any variance . Will provide further educational Training.	

7

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 8 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 and review of employee files, it was determined the facility failed to ensure current employee records included documentation of in-service training that included (a). the name of the individual or individuals who provided the training; (b). the date and number of hours the training was given; and (c). a summary of the training program's content for 3 out of 3 employee files. The findings include: Review of Resident Assistant (RA)1's employee file, revealed she had been hired on 03/27/2012. Continued review revealed no documented evidence of in-service training that included (a). the name of the individual or individuals who provided the training; (b). the date and number of hours the training was given; and (c). a summary of the training program's content. Review of Resident Assistant (RA)2's employee file, revealed she had been hired on 09/26/2023. Continued review revealed no documented evidence of in-service training that included (a).	P 135	P135 The completion date was 6/25/24. 7/31/24 The administrator and assist. Administrator Reviewed all employee's records and updated these Records to insure compliance. The administrator And assist adm., and nurse consultant provided Direct educational to the staff on 6/25/24. Administrator staff will observe and supervise Staff of any variance in staff performance They will be Documented and staff will be re-trained Immediately. A specific in-service program Regarding job duties, reporting of variances/ Incidents/scheduling/interaction between Residents and staff. This education will be provided By administrator and assist administrator. The administrative staff will monitor for Compliance and document ;then will provide Re-training to ensure compliance,	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 9 the name of the individual or individuals who provided the training; (b). the date and number of hours the training was given; and (c). a summary of the training program's content. Review of Resident Assistant (RA)3's employee file, revealed she had been hired on 08/13/2022. Continued review revealed no documented evidence of in-service training that included (a). the name of the individual or individuals who provided the training; (b). the date and number of hours the training was given; and (c). a summary of the training program's content. During an interview with RA1 on 06/20/2024 at 7:44 AM, she stated she had worked at the facility for twelve years and had not had any in-service trainings of any kind. During an interview with Assistant Administrator (AA) on 06/21/2024 at 10:17 AM, she stated she did not have a process for completing annual performance evaluations or training of any kind for staff. The SSA was unable to reach the Administrator by phone. The SSA left a voicemail for the Administrator to return a call for interview. The Administrator did not return a call to the SSA prior to exiting the facility.	P 135		
P 140	902 KAR 20:036 3(8)(h)3a-l Section 3. Administration and Operation (8) Personnel. (h) In-service training. 3. In-service training shall include the following:	P 140		

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 140	Continued From page 10 a. Policies regarding the responsibilities of specific job duties; b. Services provided by the facility; c. Recordkeeping procedures; d. Procedures for the reporting of cases of adult abuse, neglect, or exploitation pursuant to KRS 209.030; e. Resident rights established by KRS 216.510 to 216.525; f. Adult learning principles and methods for assisting residents to achieve maximum abilities in ADLs and IADLs; g. Procedures for the proper application of emergency manual restraints; h. Procedures for maintaining a clean, healthful, and pleasant environment; i. The aging process; j. The emotional problems of illness; k. Use of medication; and l. Therapeutic diets. This requirement is not met as evidenced by: Based on interview and review of employee files, it was determined the facility failed to ensure current employee records included in-service training shall include the following: (a). Policies regarding the responsibilities of specific job duties; (b). Services provided by the facility; (c). Record keeping procedures; (d). Procedures for the reporting of cases of adult abuse, neglect, or exploitation; (e). Resident rights; (f). Adult learning principles and methods for assisting residents to achieve maximum abilities in ADLs and IADLs; (g). Procedures for the proper application of emergency manual restraints; (h).	P 140	All staff will be in-serviced regarding Specific job duties,and service offered by the Facility. They will also be in-serviced regarding Resident rights,abuse, neglect,environmental Concern, emotional and behavioral Issues and emergency restraints. Staff will also be in-serviced regarding dietary Requirements, medication issue, and will be Regarding documentation in the clients record. This will be completedmby7/30/2024. Completion date2/25/24 Staff was educated By the administrator and assist administrator On 6/25/24. Administrator staff will be Monitor and document any variance. Personnel record for all staff will be reviewed Monthly to ensure files are current information And document these reviews. New hire will in-serviced by the admin. Or assist admin. Within 7 days of initial employment by the Adm. Or assist admin. Administrator staff will supervise all new hire And retrain/reeducate as necessary.	7/31/24

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 140	Continued From page 10 a. Policies regarding the responsibilities of specific job duties; b. Services provided by the facility; c. Recordkeeping procedures; d. Procedures for the reporting of cases of adult abuse, neglect, or exploitation pursuant to KRS 209.030; e. Resident rights established by KRS 216.510 to 216.525; f. Adult learning principles and methods for assisting residents to achieve maximum abilities in ADLs and IADLs; g. Procedures for the proper application of emergency manual restraints; h. Procedures for maintaining a clean, healthful, and pleasant environment; i. The aging process; j. The emotional problems of illness; k. Use of medication; and l. Therapeutic diets. This requirement is not met as evidenced by: Based on interview and review of employee files, it was determined the facility failed to ensure current employee records included in-service training shall include the following: (a). Policies regarding the responsibilities of specific job duties; (b). Services provided by the facility; (c). Record keeping procedures; (d). Procedures for the reporting of cases of adult abuse, neglect, or exploitation; (e). Resident rights; (f). Adult learning principles and methods for assisting residents to achieve maximum abilities in ADLs and IADLs; (g). Procedures for the proper application of emergency manual restraints; (h).	P 140	All staff will be in-serviced regarding Specific job duties,and service offered by the Facility. They will also be in-serviced regarding Resident rights,abuse, neglect,environmental Concern, emotional and behavioral Issues and emergency restraints. Staff will also be in-serviced regarding dietary Requirements, medication issue, and will be Regarding documentation in the clients record. This will be completedmby7/30/2024.	7/16/24

PRINTED: 07/05/2024
FORM APPROVED

...ice of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 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 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's policy, it was determined the facility failed to ensure resident(s) received proper care and treatment related to staff performing glucometer checks as staff provided care outside their scope of practice. In addition, staff failed to clean the glucometer and lancet device with a germicidal disinfectant before and after each resident use for Residents one of two residents. This failure posed an imminent danger to the safety and well-being of residents. During an observation on 06/21/2024 at 6:00 AM, Resident Assistant (RA) #1 picked up the glucometer and lancet device and used the lancet device to prick Resident (R) 1's finger to check the resident's morning blood sugar level. RA1 then took the same glucometer, changed the lancet inside the lancet device, wiped R6's finger with an alcohol prep, and initiated a finger prick to R6, without sanitizing the glucometer machine or lancet device with a germicidal wipe.	P 195	Staff have been in-serviced in the proper Use of the glucometer and the Proper method of sanitize the Instrument before and after each use. The in-service was conducted by An outside nurse consultant 7/1/2024	7/1/24

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 195	Continued From page 13 The State Survey Agency (SSA) stopped RA1 prior to sticking R6's finger and informed RA1 the glucometer machine and lancet device had not been sanitized with a germicidal wipe prior to using it on R6. The findings include: Review of the facility's "Resident Rights" policy dated 1992, revealed the facility must care for the resident in a manner that enhanced the residents quality of life. The resident may choose their own physician and participate in their treatment and any resulting changes. The resident may self administer drugs unless determined unsafe by the interdisciplinary team. Review of the Third Shift Resident Assistant job duties, not dated, revealed staff were to sweep and mop hallways, TV area, lobby, and bathrooms, vacuum the green room, dust pictures, clean handrails, move furniture two times a week and sweep and mop behind the furniture, do blood glucose checks, serve breakfast, clean the kitchen sink and kitchen area, chart meals before leaving and check on resident every 30 minutes. Review of Resident Assistant (RA) #1's employee file, revealed she had been hired on 03/27/2012. Continued review revealed no documented evidence of in-service training that included (a). the name of the individual or individuals who provided the training; (b). the date and number of hours the training was given; and (c). a summary of the training program's content. Further review revealed no documented evidence of in-service training of any kind.	P 195	P195 Completion date 6/25/24 Cary Dabney-Administrator Virginia Estes-Assistant Administrator Daisy Ford- Housekeeping Jessica Jones-Dietary Theresa Jones-RA Brandy Goad-RA Administrator and Assist Administrator will Ensure that staff were educated. 6/25/24 Administrative staff will monitor staff to ensure knowledge Base and compliance with job duties, facility Regulations and regulatory requirement. Variances in Performance will result in retraining. This will be Documented in the employee's file. New hires will be trained by the administrator and assist. Administrator. New hire will be in-serviced withinp 7 days of Employment.	7/31/24

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 195	Continued From page 14 During an observation of medication pass on 06/21/2024 at 6:00 AM, Resident Assistant (RA) #1 picked up the glucometer and lancet device and used the lancet device to prick Resident (R) 1's finger to check the resident's morning blood sugar level. RA1 then took the same glucometer, changed the lancet inside the lancet device, wiped R6's finger with an alcohol prep, and initiated a finger prick to R6, without sanitizing the glucometer machine or lancet device with a germicidal wipe. The State Survey Agency (SSA) stopped RA1 prior to sticking R6's finger and informed RA1 the glucometer machine and lancet device had not been sanitized with a germicidal wipe prior to using it on R6. Review of Resident (R) 1's admission sheet revealed the resident had been admitted on 04/21/2009 with diagnoses of Schizophrenia, Asthma and history of Insomnia. During an interview with R1 on 06/21/2024 at 6:05 AM, she stated she felt confident she could check her glucose levels successfully but the RA's always checked it for the residents. Review of R6's admission sheet revealed the resident had been admitted 03/31/2003 with a diagnosis to include Schizophrenia. During an interview with R6 on 06/21/2024 at 6:08 AM, he stated he was too shakey to stick his own finger and after attempting to stick his finger twice, he handed the glucometer back to the RA. During an interview with RA1 on 06/21/2024 at 6:05 AM, who worked third shift, she stated she had been trained to perform glucometer checks	P 195		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 195	Continued From page 15 twelve years ago by the previous RA. She stated she was not aware that performing glucometer checks was not within her scope of practice. RA1 stated using the same glucometer machine and lancet device on more than one resident could cause an infection if the devices were not cleaned properly before and after each use. During an interview with the Assistant Administrator (AA) on 06/21/2024 at 8:15 AM, she stated the facility did not have a policy on performing glucometer checks or cleaning the glucometers before and after use. She continued to state she was not aware residents had to perform their own glucometer checks, The AA also stated she was not aware the RA's were not allowed to perform the glucometer checks, or that it was outside their scope of practice. She stated the third shift RA was responsible for checking blood glucose levels every morning on all the diabetics. The AA stated no one in the facility had a certification to pass medications or perform blood glucose checks, at the facility. During further interview with the AA she stated it was important to be cleaning the glucometer before and after use because "they bleed", and it could cause an infection to the other residents. During continued interview, the AA stated it was her expectation for staff to provide safe care to the residents to prevent illness. The State Survey Agency (SSA) was unable to reach the Administrator by phone. The SSA left a voicemail for the Administrator to return a call for interview. The Administrator did not return a call to the SSA prior to exiting the facility.	P 195		
P 310	902 KAR 20:036 4(3)(b)4a-d Section 4. Provision of Services	P 310		

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2985 COLUMBIA ROAD EDMONTON, KY 42129

(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 16 (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	Doors has been ordered-scheduled To be placed July 23,2024 by Lowes Door for entrance has been ordered 3 times. We do have the door to be placed By 8/21/24.	7/12/24 8/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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	(X5) COMPLETE DATE
P 310	Continued From page 17	P 310		

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 the interior of the building, including walls, ceilings, floors, windows, window coverings, doors, plumbing, and electrical fixtures, were in good repair.

Observation during the survey revealed the side door by the porch was missing doorknobs, handles, and a door lock.

The findings include:

Review of the facility's policy titled "Resident Rights", dated 1992, revealed the facility must provide a safe, clean, comfortable homelike environment.

Observation on 06/19/2024 at 1:00 PM, revealed the double doors located on the side porch did not have doorknobs, handles, or a lock on the interior of the door. Continued observation revealed tape had been placed over the drilled holes where the lock should be and the drilled holes over where the handle would be, were left

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 16 (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	P310 7/31/24 Completion date will be 8/15/24. Doors have been ordered and will be Delivered on 8/6/24 and installed no Later than 9/15/24. Flooring will be Finished by 8/2/ 24. Staff were in-serviced regarding the pending. Cary Dabney-Administrator Virginia Estes-Assist Administrator Jesseca Jones-Dietary Theresa Jones-RA Brandy Goad-RA Staff have been in-serviced regarding the Reporting of any problems with physical plants And administrative staff will deal with all physical plant Issues promptly. No testing was required. New hires are in-serviced by the administrator and Assist administrator on physical plant issues. A physical plant check list has been developed And will be immediately addressed. Staff have been In-serviced regarding the need to report any issues With the facility.	

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 147	Continued From page 19 Based on observations, interviews, and record review, it was determined the facility failed to ensure the hot water heating equipment was at sufficient capacity to supply the water at the temperature at a minimum temperature of 140 degrees Fahrenheit needed for sanitizing dishes in the kitchen. The findings include: During a tour of the kitchen on 06/20/2024, at 1:12 PM, the dish water temperature in the sink was 100 degrees Fahrenheit when tested with a thermometer. During a tour of the kitchen on 06/20/2024, at 1:12 PM, the rinse water temperature in the sink was 100 degrees Fahrenheit when tested with a thermometer. Observation of kitchen on 06/21/2024, at 8:10 AM, the dish water temperature in the sink was 120 degrees Fahrenheit when tested with a thermometer. Observation of kitchen on 06/21/2024, at 8:10 AM, the rinse water temperature in the sink was 116 degrees Fahrenheit when tested with a thermometer. Interview with the Dietary Manager (DM)1 on 06/19/2024 at 1:10 PM, she stated she would let the water run as hot as she could get it, she then added a cap full of the bleach, and then used a PH test strip to check the waters PH before and during washing the dishes. She continued to state she did not have a thermometer to check the dish water or rinse water temperatures, and she did not have a water temperature log to	P 1< P147	Completion date 6/30/24. A digital thermometer was purchased On 7/1/24. Staff have been In-serviced Regarding the use of the thermometer. Staff started taking water temperatures On 7/1/24 and began logging on that date. If the temperature is too cold,you add hot water If it is too hot, you add cold water to reach The mandated temperature and the proper temperature, Is logged. The consulting dietitian was Contacted for clarification and all staff were In-serviced regarding the proper process to follow On 6/27/24. The in-service was done by the assist, Administrator on 6/27/24. The assist administrator does a routine check daily to insure Compliance. No test was required.;visual compliance is utilized New staff be in-serviced regarding water temperature And the proper use of the digital thermometer and the logs. This will be included in the in-service to all new staff. This In-service to new staff will be conducted by administrative Staff within 7 days of their hire date. This in-service will be a Part of employee's record. Administrative staff will be checked daily for compliance and Have developed a check list that they sign and date.	7/31/24

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 147	Continued From page 19 Based on observations, interviews, and record review, it was determined the facility failed to ensure the hot water heating equipment was at sufficient capacity to supply the water at the temperature at a minimum temperature of 140 degrees Fahrenheit needed for sanitizing dishes in the kitchen. The findings include: During a tour of the kitchen on 06/20/2024, at 1:12 PM, the dish water temperature in the sink was 100 degrees Fahrenheit when tested with a thermometer. During a tour of the kitchen on 06/20/2024, at 1:12 PM, the rinse water temperature in the sink was 100 degrees Fahrenheit when tested with a thermometer. Observation of kitchen on 06/21/2024, at 8:10 AM, the dish water temperature in the sink was 120 degrees Fahrenheit when tested with a thermometer. Observation of kitchen on 06/21/2024, at 8:10 AM, the rinse water temperature in the sink was 116 degrees Fahrenheit when tested with a thermometer. Interview with the Dietary Manager (DM)1 on 06/19/2024 at 1:10 PM, she stated she would let the water run as hot as she could get it, she then added a cap full of the bleach, and then used a PH test strip to check the waters PH before and during washing the dishes. She continued to state she did not have a thermometer to check the dish water or rinse water temperatures, and she did not have a water temperature log to	P 147	The consulting dietitian stated That the water temperature(140) Relates only to dishwasher. She stated that water temperature For3 compartment sink range From110-120. The facility Has purchased a digital water Thermometer and have instructed The dietary staff to take Temperature daily and a log to Record. The consulting dietitian Was contacted by the administrator And clarified that the consulting Dietitian role was meal planning, And consultation on a "as need basis" The dietitian does the majority of her Tasks via telephone and text.The The issue of water temperature will be Completed 7/19/2024.	7/19/24

PRINTED: 07/05/2024
FORM APPROVED

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100336	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 147	Continued From page 20	P 147		

record water temps on a daily basis. She further stated she knew she was supposed to maintain water temperature logs, but she did not have any thermometers to check the water temps. She stated the Assistant Administrator was aware the kitchen needed thermometers but had not purchased any. The DM1 stated she used Bleach in the water to help sanitize the dishes and that's why she checked the PH levels. She further stated it was important to maintain the appropriate water temperatures and sanitizing the dishes with bleach was important to prevent infection.

During an interview with Resident Assistant (RA)1, who was cooking breakfast in the kitchen on 06/21/2024 at 5:45 AM., she stated the dish water was supposed to be kept hot when washing the dishes but stated she did not know what temperature. She stated it was important to sanitize the dishes to prevent bacteria. During further interview with RA1 she stated signs of bacterial infections would be nausea, diarrhea, and vomiting.

During an interview with Assistant Administrator (AA) on 06/21/2024 at 9:23 AM, she stated the DM1 or whoever worked in the kitchen should be checking and logging the dish water and rinse water temperatures, and water temperature logs should be maintained daily. She stated she expected all Dietary staff to keep everything clean, sanitized and temperatures within range and logged. She stated she expected all staff to help prevent disease and stop the spread of infection.

During an interview with the Nutritionist on 06/21/2024 at 4:10 PM, she stated she had

...OF DEFICIENCIES ...N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186936	A. BUILDING: _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARPER'S HOME FOR THE AGED	2905 COLUMBIA ROAD EDMONTON, KY 42129

(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 147	Continued From page 21 reviewed menus for the facility for the last five (5) or six (6) years. She stated she had not been to the facility since the Fall of 2022 and had completed a thorough walk through of the kitchen with the DM1. The Nutritionist stated she did not know she was responsible for training the DM and staff, and she was not aware she was responsible for overseeing all aspects of the kitchen on a routine basis. She stated she did not know the water temperature had to be maintained at a minimum temperature of 140 degrees Fahrenheit for sanitizing dishes in the kitchen and the staff were required to keep water temperature logs. She stated she was not aware of the regulatory guidelines, and she would expect staff to follow whatever guidelines were needed. The State Survey Agency (SSA) was unable to reach the Administrator by phone. The SSA left a voicemail for the Administrator to return a call for interview. The Administrator did not return a call to the SSA prior to exiting the facility.	P 147		