Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100155	A. BUILDING: _____ B. WING _____	R-C 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRASURE'S PERSONAL CARE HOME, INC	1308 RIVERVIEW ROAD ASHLAND, KY 41101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{P 000}	Initial Comments Based on the off-site review and implementation of the acceptable Plan of Correction (POC) received on 08/16/2024 it was determined the facility was in substantial compliance as alleged on 08/04/2024.	{P 000}		

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

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	100155	A. BUILDING: _____ B. WING _____	C 05/31/2024

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FRASURE'S PERSONAL CARE HOME, INC	1308 RIVERVIEW ROAD ASHLAND, KY 41101

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P 000	Initial Comments A Relicensure and Complaint Survey investigating KY00034648, KY00035968, KY00037813, KY00041022, KY00041100, KY00041104, KY00041122, KY00041376, KY00041500, KY00041574, KY00041575, KY00041577, KY00041578, KY00041726, KY00041764, KY00041875, KY00042004, KY00042096, KY00042206, and KY00042404 was initiated on 05/29/2024 and concluded on 05/31/2024 with no deficient practice identified related to the complaints. Deficient practice was cited related to the Relicensure. The facility census was 52.	P 000	Completion date for the whole POC is 08/04/2024	
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, the facility failed to provide evidence that all allegations of abuse were thoroughly investigated internally with the required parties notified, to prevent further potential abuse for 1 of 15 sampled residents, Resident (R) 23. Review of R23's "Progress	P 055	P055. All staff will be re-educated on the "Abuse and Neglect Policy" and the "Addendum to Abuse Policy" A QA Monitor will be put in place to ensure Compliance. Charge aid will Complete QA Monitor, Adm will check QA monitor. SEE Attachment #1 and #4	9-24-24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katrina Lynn ADM 8-14-24

TITLE (X6) DATE

RECEIVED

AUG 16 2024

CHFS Office of Inspector General
Division of Health Care - EB
MH Received by

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P 055	Continued From page 1 Note" revealed on 08/21/2022, R23 made a sexual assault allegation to staff, and the facility could not provide documentation the incident had been reported to the Office of Inspector General (OIG). The findings include: Review of the facility's policy titled, "Abuse and Neglect Policy," with the "Addendum to Abuse Policy," revision date 03/13/2017, revealed for all allegations involving resident abuse, neglect, or exploitation, the Assistant Administrator would investigate. However, if the Assistant Administrator was not available, the Charge Aide would be responsible for the investigation. Per the policy, the investigative steps included to call 911 or the local police if necessary and notify the resident's guardian or next-of-kin, OIG, Adult Protective Services, and the Administrator. Review of R23's "Face Sheet" revealed the facility admitted the resident on 02/26/2020 with diagnoses that included mild mental retardation, anger reaction, epilepsy, and anxiety. Review of R23's "Progress Note," dated 08/21/2022 at 7:30 PM, authored by a former employee Charge Aide, revealed the resident was sent to the local hospital for an alleged sexual assault, and the guardian was notified. Review of all reported incidents in the Aspen Complaint/Incident Tracking System (ACTS) from 09/16/2021 through 05/31/2024, revealed no record of a reported sexual assault received by the OIG related to R23. Review of R23's "Emergency Department (ED) Notes," dated 08/21/2022 at 10:17 PM, from a	P 055	P055 - Addendum Education Completed by Valerie Frasure RN owner Latonia Ward ADM Education time: July 2, 2024 2:00 - 2:30 pm QA monitoring begin on 7-3-2024 The Adm checks the QA monitors on her work days and the day shift charge aid checks it on the ADM days off. Orginal completion date: 7-2-24 Completed 7-3-2024	

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P 055	Continued From page 2 local hospital, revealed R23 arrived at the ED and was brought to the hospital by Emergency Medical Services (EMS). R23's chief complaint was alleged sexual assault. The note stated EMS staff told ED staff that originally EMS was called by the personal care home (PCH) because the resident reported to the PCH staff she had been sexually assaulted. However, per the note, R23 told EMS staff, when they arrived at the PCH, she had not been sexually assaulted but had consensual sex, without being forced. The note stated R23 also told the ED staff she had not been forced to have sex, but it was consensual. Also, the note stated R23 had no requests but for a blanket. Per the note, ED staff contacted R23's power-of-attorney (POA) to see if the POA wanted a rape kit to be done. The note stated the POA told the ED staff that the sex was consensual, and no charges would be pressed. Per the note, the POA also told ED staff she was fine with R23 going back to the PCH without a rape work-up. The ED note stated R23 was in no acute distress with stable vital signs (blood pressure, heart rate, and respirations) when she was discharged. In an interview with Care Aide 3 on 05/29/2024 at 1:22 PM, Care Aide 3 stated R23 was not in the facility because she has been transferred to the local hospital on 05/16/2024 for evaluation of weakness and incontinence. In an interview with R9 on 05/29/2024 at 7:55 AM; R12 on 05/29/24 at 8:13 AM; and R34 on 05/30/2024 at 3:23 PM, they all stated they had no concerns with the care and treatment at the facility and felt safe residing in the facility. In an interview with Department of Community Based Services (DCBS) 6, a case worker, on	P 056		

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P 055	Continued From page 3 05/30/2024 at 9:42 AM, he stated he did not have a record of an alleged sexual assault related to R23. In an interview with Charge Aide/Nurse Aide (CA/NA) 1 on 05/30/2024 at 1:15 PM, CA/NA1 stated the employee who authored the progress note, dated 08/21/2022 at 7:30 PM, was no longer an employee at the facility, and CA/NA1 was not able to provide a contact number for interview. In an interview with R23's Guardian (G) 7 on 05/31/2024 at 1:15 PM, G7 stated she was made aware of the allegation and transfer of R23 to the local hospital's ED on 08/21/2022 through a phone call from the facility. G7 stated R23 told G7 that R23 was making up a story and was mad at the aide for not letting her do something. G7 stated R23, when she lived with G7, had a history of pretending to have seizures for attention. In an interview with Assistant Administrator 1 on 05/31/2024 at 1:15 PM, Assistant Administrator 1 stated all documents were faxed to the appropriate agency when reporting an event and were kept in boxes to preserve the record. In an interview with the Administrator/Owner 4 on 05/31/2024 at 1:07 PM, she stated the employee who made the progress note entry no longer worked at the facility, and she did not have a contact number for said employee. She stated after searching multiple boxes of records, the facility was unable to produce documentation of a report of the alleged sexual assault. Also, she stated R23 had a history of making false allegations before the alleged incident. She stated, upon checking her calendar, the date of the alleged event was on a Sunday evening, she	P 055		

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P 055	Continued From page 4 was out of the facility the following week, and it must have fallen through the cracks. She stated while all progress note documentation was not reviewed daily, staff was expected to make the appropriate reports to the OIG according to the facility's policy.	P 055		
P 305	902 KAR 20:038 4(3)(b)3 Section 4. Provision of Services (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (b) Housekeeping and maintenance services. 3. Safety. The condition of the overall environment shall be maintained in such a manner that the safety and well-being of residents, personnel, and visitors is assured.	P 305	P 305 The concrete walking area outside rooms 109 and 110 will be repaired or replaced. The pared parking lot will be repaired or replaced. The metal railing will be repaired or replaced. Signage will be place at the doorway to the hall from the dining room 8-2-2024 Cont	

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P 305	Continued From page 5 This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy, 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. This had the potential to affect all residents (current census 52), staff, and visitors. The paved walking area outside Rooms 109 and 110 was cracked and contained areas with a 1.5 to 2.0 inch raised portion which posed a safety/fall risk to residents and staff. Additionally, the parking lot for the facility contained large portions of cracked and crumbling asphalt which created holes that also posed a safety/fall risk to residents, visitors, and staff. The lower metal railing on the smoking porch outside the Dining Room door was broken leaving a 9-inch jagged piece of rusted metal which posed an injury risk to residents using the porch. The floor in the doorway between the dining area and the medication room hall was sloped with no signage to alert residents, staff, or visitors that the change of plane existed creating an injury/fall risk to residents, staff, and visitors. The findings include: Review of the facility's policy titled, "Maintaining a Clean and Safe Environment," effective date 10/29/2013, revealed the facility would maintain a clean and safe environment by utilizing housekeeping and maintenance services. Review of the section titled, "Safety," revealed the facility	P 305	P305 Signage will be placed in Areas of uneven walking surfaces, Staff will be re-educated on general maintenance and upkeep of the facility "Maintaining a Clean and Safe Environment. 7-2-2024 A QA moniter will be put in place to ensure signage is up and maintenance is completed. 7-2-2024 QA monitor will be completed by charge aide and checked by Adm. See Attachment 2. & 4	

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P 305	Continued From page 6 shall be kept in good repair. Further review revealed the facility shall ensure the grounds were well kept and the exterior of the building, including the sidewalks and porches, and the interior of the building, including the floors, were in good repair. Observation on 05/29/2024 at 7:30 AM revealed the parking lot surface was broken in places with chunks of loose asphalt present. Observation on 05/29/2024 at 7:45 AM revealed the lower metal railing on the smoking porch outside the Dining Room door was broken leaving a 9-inch jagged piece of rusted metal exposed across the porch from where chairs for residents to sit were located. Observation on 05/29/2024 at 7:52 AM revealed a raised portion of the floor between the dining area and the medication room hallway caused two State Survey Agency (SSA) Surveyors to lose footing and stumble from the Dining Room into the hallway. Observation on 05/31/2024 at 12:45 PM revealed the paved walking area outside Rooms 109 and 110 was cracked and contained areas with a 1.5 to 2.0 inch raised portion between them which caught the toe of one SSA Surveyor's shoe, causing a loss of balance. In an interview on 05/31/2024 at 10:35 AM with Housekeeper 1, he stated he had been at the facility for seven years, and the outside concrete was filled by the Administrator/Owner's son every two to three months but not in the winter because it did not do any good. He stated the concrete would last two to three months, and there was a potential risk for residents and staff that they	P 305	P305 Addendum Education Completed by Valerie Frasure RN owner Latonia Ward Adm. Education Time: July 2, 2024 2:30 to 2:45 pm QA monitoring begin on 7-3-2024 The Adm checks the QA monitors on her workday and the dayshift charge aid checks it on ADM's day off. Work complete on parking lot on 6-16-2024. The concrete outside of room 109 and room 110 has been fixed. Signage was completed. 7-2-2024. The rusted railing with the jagged edge was temporarily made safe, and new metal was	

Next →

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P 305	Continued From page 7 could fall. He stated it was his job to ensure areas were clear, clean, and free of obstacles. He stated he informed the Administrator of areas that could possibly promote injury and was not sure why it was not addressed. In an interview on 05/31/2024 at 10:50 AM with Aide 7, she stated she had been at the facility for seven years, and it was very important for the paved areas to be fixed to prevent someone from tripping and falling and tearing their skin or hitting their head. She stated she assumed the owners would fix it, but maybe they were not aware. She stated going forward, those places definitely needed to be addressed and fixed. In an interview on 05/31/2024 with Aide 10, he stated his job was some housekeeping, to change the beds of the residents, and to monitor the health and safety of the residents. He stated he knew the pavement/concrete needed to be raised up and filled in some places for safety reasons for everyone, the residents, the visitors and the staff. He stated someone could fall and "bust their head open or break a leg or ankle." He stated he felt it was important for the facility to address it soon. In an interview on 05/31/2024 at 11:00 AM with Aide 1, he stated he had been at the facility for 10 years. He stated the physical environment needed to be free of obstacles, and the need for repair of the concrete was addressed three months ago. He stated he was not sure why it had not been fixed. He stated the Administrator/Owner's son was responsible for repairs, and the concern was someone falling and getting hurt. He stated the Administrator/Owner's son made rounds in the facility and noted any repairs that needed to be made. He stated he	P 305	P 305 Addendum continued ordered. Delivery of the metal was on 7-17-2024 The metal in the entire area will be completed 8-2-2024	

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P 305	Continued From page 8 thought the list was given to the Assistant Administrator's husband, who was the part-time maintenance person for the facility. He further stated the residents knew to be careful, but it was important to ensure resident safety that these issues be addressed. In an interview on 05/31/2024 at 12:55 PM with the Assistant Administrator, she stated she made a list of needed repairs and gave them to her husband, who worked part-time at the facility two days a week and helped with repairs. She stated she was not aware and her husband had not been made aware of the paved walkway outside Rooms 109 and 110 and the broken railing on the smoking porch. In an interview on 05/31/2024 at 1:15 PM with the Administrator/Owner, she stated her son made rounds and noted any repairs needed in the facility. She stated the contractor that had previously repaired the asphalt parking lot was no longer available, and she had contacted a new contractor who had not come to the facility for an estimate. She also stated she had not noticed or been made aware of the paved walking area outside Rooms 109 and 110 or the metal railing on the smoking porch outside the Dining Room door. She stated resident safety was a top priority at the facility, and repairs were expected to be completed as quickly as possible.	P 305	P330 Addendum Education Time: July 2, 2024 2:45 to 3:00 QA monitoring began 7-3-2024 The ADM checks the QA monitors on her work days and the day shift charge aid checks it on the ADM's days off.	
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:	P 330		

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P 330	Continued From page 9 (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 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.	P 330	P330 The Administrator will educate all Staff on P330 (c) Dietary Services to ensure knowledge of the need to date all food in the refrigerators, walk-in cooler and freezers. A QA monitor will be put in place to check daily for any undated food items. QA monitor will be completed daily by Kitchen Staff and checked by Adm, 7-2-24 See attachment #3 + 4	