Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100064	A. BUILDING: _____ B. WING _____	R 01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN COUNTY MANOR I LLC	2820 RICHARD STREET HOPKINSVILLE, KY 42240

(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 (PoC) it was determined the facility was in compliance as of 01/08/2025.	{P 000}		

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

Office of Inspector General

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	100064	A. BUILDING _____ B. WING _____	11/27/2024

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P 000	Initial Comments A Relicensure and Complaint Survey investigating KY00043314, KY00044075, and KY00044080 was initiated on 11/25/2024 and concluded on 11/27/2024. There were no regulatory violations cited related to KY00043314, KY00044075, and KY00044080. Deficiencies were cited at P0100, P0310, and P0330 for the Relicensure Survey. Survey Dates: 11/25/2024 through 11/27/2024 Survey Census: 46 Sample Size: 11	P 000	RECEIVED DEC 26 2024 CHFS Office of Inspector General Division of Health Care - WB Received by	
P 100	902 KAR 20:036 4(9)(a-b) Section 4. Administration and Operation Section 4. Administration and Operation. (9) Tuberculosis Testing. (a) All employees of a PCH or SPCH shall be screened and tested for tuberculosis in accordance with 902 KAR 20:205. (b) Residents of a PCH or SPCH shall be screened and tested in accordance with 902 KAR 20:200. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents received the required admission or annual Tuberculosis (TB) Skin Test and TB Risk Assessment per 902 KAR 20:200 for four of eight sampled residents, Resident (R)3, R4, R5, and R7.	P 100	P100: All female residents have had the TB Skin test and TB Risk Assessment completed on 12.19.24. All male residents will have their TB skin Test and TB Risk Assessment form completed on 12.30.24 Aside from 4 staff members who weren't present, the TB skin test and the TB Risk assessment form was completed on 12.10.2 The 4 remaining staff members are scheduled to have theirs done on 12.27.24. Manager will maintain a binder with the TB Skin Test and Risk assessment forms for staff and check monthly who needs an annual completed. The PCP will work with the residents to ensure annual TBs are completed. POC Completion Date: 12.28.24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Administrator — (X6) DATE 12-26-24

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P 100	Continued From page 1	P 100		

Additionally, the facility failed to ensure all employees were tested on hired and annually for Tuberculosis (TB) in accordance with 902 KAR 20:205 for five of five sampled employees, Nurse Aide (NA)1, NA2, Housekeeper2, Medication Technician1 and Cook1.

The findings include:

On 11/27/2024, a copy of the facility's Tuberculosis Policy was requested from the Administrator, but not provided.

Review of the facility document titled, "Job Description; Administrator", undated, revealed the Administrator was to direct day-to-day functions in the facility in accordance with current Federal, State, and local standards, guidelines and regulations that govern Long-Term Care facilities to assure the highest degree of quality of care would always be provided to the residents.

Review of the facility policy titled, "Resident Rights", undated, revealed the resident had the right to receive appropriate healthcare, medical treatment, and protective support services.

1. Record review revealed the facility admitted R3 on 08/29/2024, with diagnoses to include hypertension and hyperlipidemia. Further review revealed there was no documented evidence an admission TB skin test or a TB Risk Assessment had been completed.

2. Record review revealed the facility admitted R4 on 09/17/2024, with diagnoses to include history of Schizophrenia, Bipolar, and Diabetes Mellitus. Further review revealed there was no documented evidence an admission TB skin test or a TB Risk Assessment had been completed.

Vernon Davis Administrator 12-26-24

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P 100	Continued From page 2	P 100		

3. Record review revealed the facility admitted R5 on 08/10/2020, with diagnoses to include Paranoid Schizophrenia, Anxiety, Fibromyalgia, and Hypertension. Further review revealed there was no documented evidence an annual TB skin test or a TB Risk Assessment had been completed for 2023 and 2024.

4. Record review revealed the facility admitted R7 on 09/26/2023, with diagnoses to include Hypoglycemic, Bipolar, Post Traumatic Stress Disorder (PTSD), and Depression. Further review revealed there was no documented evidence a TB skin test or a TB Risk Assessment had been completed on admission. Additionally, there was no documented evidence a TB skin test or a TB Risk Assessment was completed for 2024.

In an interview with the Administrator, on 11/27/2024 at 8:30 AM, she stated the TB skin tests for residents had been completed by the former Nurse Practitioner (NP). She stated the facility had been attempting to retrieve the TB skin tests and TB risk assessments that were completed by the NP; however, the majority of the TB skin tests previously completed by the NP had no TB risk assessments included. She further stated the facility now had a new medical provider; however, many of the admission and annual TB skin tests and TB risk assessments for residents had not been completed. The Administrator further stated she was new to her position, but was working with the medical provider to ensure the required TB skin tests and TB risk assessments were up to date for all residents. She further stated she understood how important this was for the health and safety of all residents, staff, and visitors in the facility.

Vera Dunn Administrator 12-26-24

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	100084	A. BUILDING. _____ B. WING ____	11/27/2024

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P 100	Continued From page 3	P 100		

1. Review of NA1's employee file revealed a hire date of 01/20/2017. Further review revealed there was no documented evidence an annual TB skin test or TB Risk Assessment had been completed since 06/12/2022.

2. Review of NA2's employee file revealed a hire date of 10/30/2024. Further review revealed there was no documented evidence a new hire TB skin test or TB Risk Assessment had been completed.

3. Review of Housekeeper2's employee file revealed a hire date of 05/10/2022. Further review revealed there was no documented evidence a TB skin test or TB Risk Assessment had ever been completed.

4. Review of Medication Technician (MT)1's employee file revealed a hire date of 06/12/2023. Further review revealed there was no documented evidence a TB skin test or TB Risk Assessment had ever been completed.

5. Review of Cook 1's employee file revealed a hire date of 05/20/2011. Further review revealed there was no documented evidence an annual TB skin test or TB Risk Assessment was completed for 2023 and 2024.

In an interview with NA1, on 11/25/2024 at 2:45 PM, she stated she did not receive a TB skin test or TB risk assessment this year. She stated the facility should be ensuring they were completed in order to make sure no one was spreading

Administrator 12-26-24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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P 100	Continued From page 4 tuberculosis. In an interview with Lead Medication Technician 2, on 11/26/2024 at 3:00 PM, she stated she was aware her TB skin tests were not current. She stated she thought the TB skin test and TB risk assessments were to be completed at least yearly. In an interview with the Administrator, on 11/27/2024 at 12:30 PM, she stated she was aware the TB skin tests and TB risk assessments were not current for the staff. She stated she was aware the facility was not following the guidelines by performing TB testing and TB risk assessments on hire and yearly. Further, she stated she knew the importance of completing the TB skin tests and TB risk assessments, but she had only been the administrator for 3 months and still had a lot to do. The Administrator stated it was her expectation the TB skin tests and TB risk assessments for staff were up to date and she was currently in the process of ensuring the medical provider followed the regulations.	P 100		
P 310	902 KAR 20:036 5(2) Section 5. Provision of Services Section 5. Provision of Services. (2) Residential care services. A PCH or SPCH shall provide residential care services to all residents, including: (a) Room accommodations; (b) Housekeeping and maintenance services; and (c) Dietary services.	P 310	P310 Manager conducted an Inservice for the kitchen staff on 12.4.24 on how to properly store food and food safety. Administrator will conduct weekly walk throughs to ensure that all food is properly labeled. POC Completion Date: 12.5.24	

Vera Sue) Administrator 12-06-24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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This requirement is not met as evidenced by:
Based on observation, interview, and review of facility policy, the facility failed to store food in accordance with professional standards for food service safety.

Observation of the kitchen on 11/25/2024, revealed food items had been opened and removed from the original packaging, but were not labeled, dated or sealed when stored in the refrigerator, freezer, and dry storage area.

The findings include:

Review of the facility's policy titled, "Dietary Daily Tasks", dated 11/07/2020, revealed the purpose was to ensure the kitchen ran efficiently and was clean and orderly, and daily tasks were completed by all shifts. Further review revealed daily tasks included labeling and dating stock before storing.

Review of the facility's document titled, "Dietary Supervisor", dated 11/07/2020, revealed the Dietary Supervisor was responsible for the management of the kitchen, and assures all food items, including leftovers, were covered, dated, and labeled for contents prior to storing it in the refrigerator or freezer. Further review revealed cooks, dietary assistants, and other personnel in the unit would work together as a team to ensure all residents were served food from a clean and safe kitchen.

Observation of the kitchen, on 11/25/2024 starting at 3:20 PM, revealed the refrigerator had three trays consisting of desserts and fruits stacked on top of each other with one tray of individual cups of fruit stored uncovered.

Vera Dees Administrater 12-26-24

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Observation of the dry storage area on 11/25/2024 at 3:25 PM, revealed two bags of cereal had been opened and were unsealed when stored on the shelf.

Observation of the tall freezer on 11/25/2024 at 3:30 PM, revealed Salisbury steaks, pork fritters, and hamburger patties had been removed from the original packaging, and were in a clear plastic bag which was not labeled, or dated, and was unsealed.

Observation of the floor freezer on 11/25/2024 at 3:35 PM, revealed chicken wings and egg patties had been removed from the original packaging, and were in plastic bags that were not not labeled or dated, and were unsealed.

In an interview with the Kitchen Manager, on 11/27/2024 at 12:30 PM, she stated staff was to rotate food when receiving new food items, pulling old food items to the front of the refrigerators, freezers, and dry storage area. She stated staff should mark incoming items with a receive date, and when a product was opened it required a open date and a use by date. She stated all food products should be sealed correctly, and if removed from the original packaging, the item should be labeled before being stored in the refrigerator, freezer, or dry storage. She further stated if staff did not follow these procedures there could be the potential for bacteria growth to the food, and residents could get sick.

During an interview with the Administrator, on 11/27/2024 at 12:44 PM, she stated dietary staff should ensure all food was dated and rotated when received. She stated if a food item had been opened, it should have an open date and

Administrator 12-26-24

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P 310	Continued From page 7 use by date She further stated all food items should be sealed when stored, and labeled if removed from the original packaging. She Administrator stated there was the potential for negative outcomes if food items were not stored correctly including residents becoming ill from contaminated food.	P 310		
P 330	902 KAR 20:036 5(3)(b)3 Section 5. Provision of Services Section 5. 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 to ensure the safety and well-being of residents, personnel, and visitors. This requirement is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure the interior premises were well kept and in good repair. Observation of the facility, on 11/25/2024 starting at 1:45 PM, revealed multiple concerns with the facility environment being safe and in good repair related to loose handrails with some detached from the wall, non-working heating/cooling vents with exposed metal, and a resident bathroom with no working lights. Further observation revealed soiled resident room doors, missing baseboards, and missing window coverings. Additionally,	P 330	P330. Railings were replaced d on 12-5-24 Baseboards were replaced on 12-18-24. Doors will be painted by 1.6.25 The broken air units will be replaced by 12.28.24 The Kitchen vents will be cleaned by 12.28.24 Blinds will be in place by 1.7.25 POC Completion Date: 1.8.25	

Vera Dr O Administrator 12-26-24

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observation of the kitchen revealed three vents over the stove top were caked with a greasy thick covering and had not been maintained by the hood cleaning company.

The findings include:

Review of the facility's policy titled, "Maintenance Tasks", undated, revealed maintenance personnel served in the capacity to assure the facility, grounds, and operations were safe, and repairs and upkeep were done timely. Further review revealed the maintenance personnel worked with other departments to ensure a clean, safe, and therapeutic environment.

Review of the facility's policy titled, "Housekeeper Job Duties", undated, revealed housekeeping job duties included following a cleaning schedule including cleaning walls, windows, doors, and ceilings. Additionally, there should be spot cleaning between washings and disinfects when necessary. Further, housekeeping personnel were to report observations concerning structural and equipment wear, defects, and malfunctioning to the supervisor.

Observation of the facility 100 Hall on 11/25/2024 starting at 1:45 PM, revealed the following:

Several handrails were loose and detached from the wall in the community area.

There was a heating/cooling vent on the baseboard with a metal cover detached from the wall in the community area.

The 100 Hall bathroom had no working lights.

The 100 Hall resident doors were soiled with a

Administrator 12-26-24

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black substance.

The 100 Hall had baseboards missing in several sections in between resident rooms.

The 100 Hall had heating/cooling vents located in the bedrooms that were damaged or broken exposing sharp edges.

Observation on 11/25/2024 starting at 2:00 PM, of the 200, and 300 Halls revealed the following:

There were baseboards missing on the 200, and 300 Halls in several sections in between resident rooms.

There were heating/cooling vents located in the bedrooms on the 200 Hall (Rooms 209 and 212), and 300 Hall that were damaged or broken exposing sharp edges.

The 200 and 300 Hall resident doors were soiled with a black substance.

Resident rooms 209, 212, 213, and 308 had no window coverings on the windows.

Additionally, observation of the kitchen on 11/25/2024 at 3:20 PM, revealed three vents over the stove top were caked with a greasy thick covering. There was a service sticker attached to the hood that showed date serviced and date next service was due. The next service date due was 09/2024; therefore, the vents had not been maintained by the hood cleaning company.

In an interview with the Kitchen Manager, on 11/25/2024 at 3:25 PM, she stated she was not certain why the hood had not been serviced. She stated she was able to remove the center vent

Administrator 12-26-24

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and clean it, but was not able to remove the two vents on either side. She further stated there was the potential for debris and particles to fall into the resident's food if the vents were not cleaned and maintained properly.

In an interview with Resident Aide (RA)1, on 11/27/2024 at 12:00 PM, she stated she had worked at the facility for six months, and any concerns with the facility environment including repairs were to be reported to the Administrator.

In an interview with the Head Housekeeper, on 11/27/2024 at 12:14 PM, she stated ensuring the facility was cleaned regularly was important because the facility was the resident's home. She further stated she expected all housekeeping staff to do their job and complete their tasks, and work together to ensure the facility was clean. In further interview, she stated the soiled resident doors should have been cleaned. Additionally, she stated there could be negative outcomes for resident's social and mental status if the facility was not clean, especially in high traffic and community areas where germs could be spread.

In an interview with Maintenance, on 11/27/2024 at 11:30 AM, he stated his time was shared between this facility and a sister facility, but he expected the facility to call him with any concerns or repairs needed, and to notify him right away of any potentially dangerous concerns. He further stated he repaired plumbing, electrical, heating and cooling, door locks and anything that he could. The Maintenance staff member stated the hand rails had been previously repaired, but he believed the residents had leaned on them causing the rail to pull away from the wall. Further, after the hand rail concern was brought to his attention today, he repaired and welded

Administrator 12-26-24

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them to ensure they were safe.

In further interview with Maintenance on 11/27/2024 at 11:30 AM, he stated the heating/air devices that were damaged in the community areas and resident rooms did not work, were turned off, and had no live wires. He stated he had been waiting for approval to remove them from the walls. He further stated he would work to repair anything that may be dangerous as soon as possible, but otherwise some of the minor repairs were completed by the laundry and housekeeping staff. Per interview, he was aware that any environmental concerns could be a safety concern for residents and there was always a potential for harm if those issues were not repaired timely. The Maintenance staff member stated staff would let him know of repairs needed if he was in the facility, and the Administrator would contacted him when he was away from the facility. He stated he was unaware the resident bathroom light was not working. He further stated he had attempted to complete regular inspections, but this was not always possible because his time was shared between the two facilities. The Maintenance staff member stated the facility was responsible to provide an environment that was home-like and safe for the residents.

During an interview with the Administrator, on 11/27/2024 at 12:44 PM, she was questioned related to hand rails being loose or detached from the wall; non working light in the resident bathroom; non-working heating and cooling vents which were damaged with exposed metal; and missing baseboards. She stated she expected maintenance staff to ensure preventive maintenance which included completing rounds to check for repairs needed. She further stated

Vanessa LC Administrator 12 26 24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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any repairs needed were to be properly addressed in a timely manner. In continued interview, she stated she was waiting on approval from corporate to hire another maintenance staff member to oversee the facility because she did not believe repairs were completed timely. Further, she stated she was new to the Administrator position and was in the process of implementing new procedures regarding the facility environment. She stated staff was to report any environmental concerns to her. She further stated if environmental concerns such as needed repairs were not completed timely, resident safety could be jeopardized and their quality of living could be affected.

In further interview, on 11/27/2024 at 12:44 PM, the Administrator stated she was aware some resident rooms had no window coverings, and some had broken shades, and she had been working to replace them. Additionally, she stated housekeeping staff was expected to follow cleaning schedules and ensure rooms were deep cleaned daily which should include cleaning the resident room doors. She further stated the resident room doors needed to be painted. In regards to the kitchen, she stated if the vents were not being cleaned debris could fall into food on the stove and cause the potential for food borne illness for residents and she was working to get that issue resolved. In further interview, the Administrator stated the resident's safety was priority, and a clean and safe environment promoted a positive mental status for residents.

Administrator 12-26-24