Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100398	A. BUILDING: _____ B. WING _____	R 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER SENIOR LIVING I LLC	66 SHELBY STREET CADIZ, KY 42211

(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 had achieved compliance as of 01/18/2025.	{P 000}		

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

Office of Inspector General

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	100398	A. BUILDING: _____ B. WING _____	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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P 000	Initial Comments AMENDED A Relicensure and Complaint Survey was initiated on 11/25/2024 and concluded on 11/27/2024 with deficiencies cited. No regulatory deficiencies were identified for complaints KY00043110, and KY00043095. Regulatory deficiencies were identified for complaint KY00044068. Survey Dates: 11/25/2024-11/27/2024 Census: 52 Sample: 14	P 000	 In response to P 100 Tuberculosis Testing	
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, review of facility policy, and review of employee personnel records, it was determined the facility failed to ensure all employees received a Tuberculosis (TB) risk assessment and were tested annually for TB in accordance with 902 KAR 20:205 for four of six sampled employees, Medication	P 100	Better Senior Living I Administrator conducted an In-Service on 12/16/2024 concering the TB skin test for staff. Better Senior Living I is now in contract with Christian County Health Department to administor all staff TB test. Staff has been given until 1/17/2025 (health department is closed through the first of the year for holidays) to have updated TB test or they cannot return to work until done. Better Senior Living I has a binder that includes all staff and resident TB skin test and risk assessment forms that will be checked monthly. The Administrator will be working closely with the Nurse Practitioner to ensure resident TB skin test and risk assessments stay up to date. All residents will be up to date with their TB skin test by 1/10/2025. The Administrator will give a month notice to staff to renew their TB test. POC completed by 1/18/2025.	

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

Tiffany Nipper

Tiffany Nipper, Administrator 12/23/2024

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P 100	Continued From page 1 Technician (MT) 2, Housekeeper (HK) 1, Dietary Manager (DM) 1, and MT4. Additionally, the facility failed to ensure residents received the required annual Tuberculosis risk assessment and test for TB per 902 KAR 20:200 for eight of 14 sampled residents (Residents (R) 1, 7, 8, 9, 10, 11, 12, and 13). The findings include: 1. Review of the undated facility policy titled, "TB Test Policy- Staff", revealed the facility would maintain compliance with the Personal Care Home Regulations as it related to TB testing. The policy further revealed each new hire would have a TB test completed either before the start of employment or within the first week of employment. And, if a new hire had a TB test completed within three (3) months of his/her first shift at the facility, he/she would not be required to repeat the test. It was also the policy of the facility that TB test would be conducted on an annual basis. a. Review of MT2's employee file revealed a hire date of 09/19/2024. There was no documented evidence that a TB risk assessment or a TB test had been completed. b. Review of MT4's employee file revealed a hire date of 07/30/2024. There was no documented evidence that a TB risk assessment or a TB test had been completed. c. Review of HK1's employee file revealed a hire date of 07/12/2023. There was no documented evidence that a TB risk assessment to a TB test had been completed. d. Review of DM1's employee file revealed no	P 100		

Tiffany Nipper

Tiffany Nipper, Administrator 12/23/2024

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P 100	Continued From page 2 documented evidence a TB risk assessment or a TB test had been completed since 09/11/2023. During an interview on 11/27/2024 at 1:55 PM, HK1 stated she could not recall receiving a TB test unless it was when she started working at the facility in July of 2023. 2. Review of the undated facility policy titled, "TB Test Policy- Residents", revealed the facility would maintain compliance with the Personal Care Home Regulation as it related to TB testing. The policy revealed as per 902 KAR 20:200, it was the policy of the facility that either before admission or during the first week of admission, a TB test would be completed. Thereafter, it was the policy of the facility that TB tests would be conducted on an annual basis. a. Closed record review revealed the facility admitted R1 on 04/11/2023, with diagnoses to include: bipolar disorder, hypertension, and vitamin D deficiency. Further review revealed no documented evidence since 04/11/2023 that an annual TB risk assessment or TB test had been completed. b. Record review revealed the facility admitted R7 on 07/18/2019, with diagnoses to include: non-small cell carcinoma of the lungs, rheumatoid arthritis, and chronic obstructive pulmonary disease (COPD). Further review revealed no documented evidence of a TB test upon admission or since admission. c. Record review revealed the facility admitted R8 on 02/21/2024, with diagnoses to include: schizophrenia with chronic delusions. Further review revealed no documented evidence a TB risk assessment had been completed.	P 100		

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P 100	Continued From page 3 d. Record review revealed the facility admitted R9 on 08/18/2022, with diagnoses to include: schizophrenia, psychotic disorder, and diabetes type II. Further review revealed no documented evidence a TB risk assessment or an annual TB test had been completed since 11/30/2022. e. Record review revealed the facility admitted R10 on 05/11/2023, with diagnoses to include: chronic pain syndrome, nonrheumatic mitral valve prolapse, and difficulty walking. Further review revealed no documented evidence a TB risk assessment or an annual TB test had been completed since 08/07/2023. f. Record review revealed the facility admitted R11 on 02/21/2024, with diagnoses to include: depressive disorder, post traumatic stress disorder (PTSD), and hypertension. Further review revealed no documented evidence a TB risk assessment had been completed. g. Closed record review revealed the facility admitted R12 on 05/22/2024, with diagnoses to include: depressive disorder, Parkinson's disease, and chronic pain. Further review revealed no documented evidence that a TB risk assessment or a TB test had been completed. h. Record review revealed the facility admitted R13 on 12/15/2023, with diagnoses to include: anxiety, depression, and paranoid schizophrenia. Further review revealed no documented evidence a TB risk assessment or an annual TB test had been completed since admission 12/15/2023. During an interview with the Administrator on 11/27/2024 at 3:24 PM, she stated she tried to review the TB test binder every few months to	P 100		

Tiffany Nipper

Tiffany Nipper, Administrator 12/23/2024

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P 100	Continued From page 4 see when staff and residents assessment/tests need to be updated. She stated the facility recently had a new Nurse Practitioner to begin seeing residents and she had e-mailed her a list of resident's that needed updated test. The Administrator stated employees are required to go to the local health department for their TB test. The Administrator stated going forward she hoped to implement a good system flowing with the new Nurse Practitioner and did not expect there to be any reason the facility would have outdated TB test for employees or residents.	P 100		

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Tiffany Nipper, Administrator 12/23/2024

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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, review of facility policy, and review of employee personnel records, it was determined the facility failed to ensure all employees received a Tuberculosis (TB) risk assessment and were tested annually for TB in accordance with 902 KAR 20:205 for four of six sampled employees. Medication	P 100		

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P 100	Continued From page 4 see when staff and residents assessment/tests need to be updated. She stated the facility recently had a new Nurse Practitioner to begin seeing residents and she had e-mailed her a list of resident's that needed updated test. The Administrator stated employees are required to go to the local health department for their TB test. The Administrator stated going forward she hoped to implement a good system flowing with the new Nurse Practitioner and did not expect there to be any reason the facility would have outdated TB test for employees or residents.	P 100		
P 105	902 KAR 20:036 4(10)(a-e) Section 4. Administration and Operation Section 4. Administration and Operation. (10) Personnel. (a) In accordance with KRS 216.532, a PCH or SPCH shall not employ or be operated by an individual who is listed on the nurse aide and home health aide abuse registry established by 906 KAR 1:100. (b) In accordance with KRS 209.032, a PCH or SPCH shall not employ or be operated by an individual who is listed on the caregiver misconduct registry established by 922 KAR 5:120. (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. (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	P 105	In response to P 105 Administration and Operation Better Senior Living I Administrator will conduct background checks upon every potentional new hire before their first day or work. The Administrator will ensure all backgrounds are completed and located in their employee file. All employee files have been checked for background checks. POC completed by 12/27/2024.	

Tiffany Nipper

Tiffany Nipper, Administrator 12/23/2024

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P 105	Continued From page 5 6. Documentation of compliance with the background check requirements of paragraphs (a) through (c) of this subsection. (e) Each employee shall be of an age in conformity with state laws. This requirement is not met as evidenced by: Based on interview, review of personnel files, and review of facility policy, the facility failed to ensure a criminal record check was completed for one of six employees (Medication Technician (MT) 2), reviewed. The facility also failed to ensure the nurse aide and home health aide abuse registry and caregiver misconduct registry were checked upon hire of MT2. The findings include: Review of the undated policy titled, "Abuse Policy," revealed under the subtitle, "Screening," that "Kentucky State background checks will be conducted on each new employee and with any other registry board known to have employed applicant prior to or within 14 days of hire." Review of MT2's personnel file revealed the employee began employment on 09/19/2024 and her employment was terminated on 11/03/2024 without the completion of a background check. Further review of the personnel file of MT2 revealed that a consent for a background check had been signed on 09/19/2024; however, ongoing review of the personnel file failed to demonstrate compliance with the background check requirements. Additionally, there was no evidence the nurse aide abuse registry was	P 105		

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P 105	Continued From page 6 checked when MT2 was hired. During an interview on 11/27/2024 at 11:18 AM, the Administrator stated that she was responsible to obtain the background checks on employees which included the "Big background, OIG background, Board of Nursing background, and one more I do." Further the Administrator stated she was the person solely responsible to obtain the background checks and stated. "Usually I do. I probably forgot."	P 105		
P 215	902 KAR 20:036 5(1)(b) Section 5. Provision of Services Section 5. Provision of Services. (1) Basic health and health related services. (b) For a PCH or SPCH, the administrator or staff person designated by the administrator shall, relating to the provision of basic health and health-related services: 1. Be responsible for obtaining medical care promptly in response to an accident, injury, or acute illness of any resident; and 2. Document any accident, injury, illness, incident, medication error, or drug reaction in the resident's medical record. This requirement is not met as evidenced by: Based on interview, record review, review of facility documents, and review of facility policy, the facility failed to obtain medical care for one of 14 sampled residents, (Resident (R) 3). R3 was involved in a physical altercation on	P 215	In response to P 215 Provision of Services Better Senior Living I Administrator conducted an In-Service on 12/12/2024 informing staff on reporting abuse of residents. Staff has been instructed to immediately contact the administrator in any event of physical abuse, mental abuse, or injury. Staff has been instructed to document on incident reports and MTs are to chart in resident charts. MTs have been instructed to notify the Nurse Practitioner in any event of physical abuse, mental abuse, or injury. MTs have been instructed to then contact the State Guardian (if applicable) of the resident or call the after hours phone number and inform them of the situation. State Guardian after hours phone number is located in the Nurses Station. POC completed by 12/13/2024.	

Tiffany Nipper

Tiffany Nipper, Administrator 12/23/2024

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P 215	Continued From page 7 11/03/2024 and sustained a "laceration on his left eye" with bleeding as well as "swelling and bruising" of the face. Review of the medical record and facility records failed to demonstrate R3's physician was notified of the injuries or that the facility obtained medical care promptly for the resident's injuries. The findings include: Review of the facility's undated policy titled, "Abuse Policy," revealed "the Physician and responsible party will be notified of any incidents and the appropriate action that has been taken." A policy was request from the Administrator on 11/26/2024 at approximately 2:00 PM, related to obtaining medical care when a resident was sick or injured and when to notify the resident's physician/provider. The Administrator stated the facility did not have a policy specific to physician notification or obtaining medical care and provided the below in-service dated 05/24/2024. Review of an in-service dated 05/24/2024 with a subject of "Calling Guardians when Resident goes out to hospital" revealed the Administrator was listed as a co-presenter of the in-service and outlined instructions of, "when a resident becomes ill it is the responsibility of the facility to call the Medical Provider and get directive on if resident needs to be sent out to the hospital." Review of the facility document titled "Unusual Occurrence Report" dated 11/03/2024 revealed documentation regarding the physical altercation involving R3 and was authored by Medication Technician (MT) 5. Per the documentation, the report revealed R3 was struck in the face by another resident (R15) and sustained a	P 215		

Tiffany Nipper

Tiffany Nipper, Administrator 12/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100398	A. BUILDING: _____ B. WING _____	C 11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTER SENIOR LIVING I LLC	66 SHELBY STREET CADIZ, KY 42211

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P 215	Continued From page 8 "laceration on his left eye." The "Unusual Occurrence Report" indicated the physician, family or State Agency were not notified regarding the incident. Review of R3's record and face sheet revealed the facility admitted the resident on 09/05/2024 with diagnoses that included schizophrenia, gastroesophageal reflux disease (GERD), polysubstance use disorder, and constipation. Ongoing review of the face sheet revealed the resident's responsible party was a state guardian. Review of the facility census listing dated 11/25/2024 revealed R3 was not currently in the facility. Review of R3's medical record in the "Nurse's Notes" dated 10/13/2024 through 11/12/2024 revealed no documentation of the altercation between R3, and R15. An additional nurse's note, which was out of order and separate from the other nurse's notes, was authored by the Administrator, and included an account of the incident on 11/03/2024. This note revealed the police and Adult Protective Services were contacted but did not include physician notification of R3's injury. Additionally, the nurse's notes failed to include what medical care, if any, was provided for R3's injuries at the facility. In a phone interview with the State Guardian Supervisor on 11/27/2024 at 10:18 AM, the State Guardian Supervisor indicated documentation of Guardian notification of the incident on 11/03/2024 and stated the report also indicated "the injury to R3 was taken care of at the facility." In a phone interview with the Police Officer on 11/26/2024 at 9:11 PM, the Officer stated he	P 215		

Tiffany Nipper

Tiffany Nipper, Administrator 12/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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P 215	Continued From page 9 responded to the call on 11/03/2024 involving R3. He stated R3's injuries were recorded on his body camera and included bruising and swelling of the left eye with bleeding from a small cut on the eyebrow that did not look like it required sutures. He reported R3 did not suffer a loss of consciousness. In an interview with MT5 on 11/27/2024 at 8:21 AM, MT5 stated R3 did not go to the Emergency Room for evaluation and stated the "Head Med Tech" was responsible to contact the physician. However, from review of the staffing schedule, there were only two staff working when the incident occurred and those staff were MT2 and MT5. In an interview with the Administrator on 11/27/2024 at 4:23 PM, the Administrator stated the physician was not contacted and stated, "I didn't follow the in-service related to notification and documentation."	P 215		

Tiffany Nipper

Tiffany Nipper, Administrator 12/23/2024