

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14684 EAST HIGHWAY 550 PO BOX 157 LACKEY, KY 41643		
(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 KY00040503, KY00040719, KY00041472, and KY00043147 was initiated on 03/12/2025 and concluded on 03/13/2025. The Division Of Healthcare determined the facility was compliant with regulatory guidelines with no deficient practice cited.	P 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE