

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 06/03/2025
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 complaint survey investigating KY#00046333 KY#00046335 was initiated on 06/03/2025 and concluded on 06/03/2025. The Division of Health Care determined the facility was compliant for KY#00046333 KY#00046335.	P 000			

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

TITLE

(X6) DATE