Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100174	A. BUILDING: _____ B. WING _____	R 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON MANOR I LLC	201 WATSON LANE HENDERSON, KY 42420

(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	{P 000}		

Based upon the implementation of the acceptable Plan of Correction, the facility was deemed to be in compliance on 09/23/2025, as alleged.

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	100174	A. BUILDING _____ B. WING _____	07/01/2025

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P 000	Initial Comments A Relicensure and Complaint Survey investigating KY00045381, KY00045759, and KY00046709 was concluded on 07/01/2025 There were no deficiencies issued related to KY00045381. There were deficiencies issued related to KY00045756 and KY00046709. Survey date 06/30/2025 - 07/01/2025 Survey census 39 Sample size 8 Supplemental Residents: 0	P 000		
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 facility document and policy review, it was determined the facility failed to conduct the required Tuberculosis (TB) Screening and/or Testing for 7 of 8 sampled residents and 5 of 5 employees.	P 100	RECEIVED AUG 12 2025 CHFS Office of Inspector General Division of Health Care - WB Received by Facility Administrator will review all residents and employee charts to verify TB screening and/or testing has been completed For any resident that is found to be missing TB results,the administrator will coordinate with Express Mobile to perform the required testing For any employee that is found to be missing TB results, the administrator will coordinate with the Health Department to perform the required testing The administrator has been in-serviced by the Regional Manager on the importance of maintaing compliance with the 902 KAR 20:205 and 902 KAR 20:200 and will ensure all new admissions and new hires have test results, or get tested within the required timeline per the regulations. POC completion date 8/29/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kenasha Melton — TITLE: Administrator — (X6) DATE

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P 100	Continued From page 1 The facility failed to conduct the required baseline TB Risk Assessment for residents and/or TB testing upon hire for employees. In addition, the facility failed to provide annual screening for residents and employees. The findings include: 1. Review of the undated facility policy titled, "TB Test Policy - Residents", revealed the facility would maintain compliance with the Personal Care Home (PCH) Regulations as it related to TB Testing. Per review, either before admission, or during the first week after admission, a TB test was to be completed for residents. Further review revealed thereafter, it was the facility's policy that TB tests be conducted on an annual basis. 1(a). Review of Resident (R)6's medical record revealed the facility admitted the resident on 07/18/2024. Further review revealed however, the only documented TB test was on 10/19/2023 received from a previous facility. 1(b). Review of R1's medical record revealed the facility admitted the resident on 09/27/2024. Review further revealed however, no documented evidence of a TB test or TB risk assessment having ever been completed. 1(c). Review of R4's medical record revealed the facility admitted on the resident 05/29/2025. Continued review revealed however, no documented evidence of a TB test or TB risk assessment having ever been completed. 1(d). Review of R7's medical record revealed the facility admitted the resident on 12/06/2023. Further review revealed however, no documented	P 100		

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evidence of a TB test or TB risk assessment ever having been completed.

1(e) Review of R5's medical record revealed the facility admitted the resident on 12/20/2022. Continued review revealed however, no documented evidence of a TB test or TB risk assessment ever having been completed.

1(f) Review of R8's medical record revealed the facility admitted the resident on 09/09/2014. Review further revealed however, the last documented evidence of a TB test and TB risk assessment was on 10/28/2023.

1(g) Review of R3's medical record revealed the facility admitted the resident on 01/26/2024. Further review revealed however, the last documented evidence of a TB test and TB risk assessment was on 04/19/2023.

2. Review of the undated facility policy titled "TB Test Policy - Staff" revealed the facility was to maintain compliance with the PCH Regulations as it related to TB Testing. Per review, the facility would ensure each new hire had a TB test completed either before their employment start date, or within the first week of employment. Continued review revealed if a new hire had a TB test completed within the last three months of his/her first shift at the facility, it was not required to repeat the test. Review further revealed thereafter, it was the facility's policy that TB tests be conducted on an annual basis.

Review of 5 of 5 employee files revealed 0 had a TB testing at hire and/or annually.

2(a) Review of Medication Technician (MT) 1's personnel file, unknown hire date, revealed no

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evidence of a TB test or TB risk assessment having been completed.

2(b). Review of MT 2's personnel file, unknown hire date, revealed no evidence of a TB test or TB risk assessment having been completed.

2(c). Review of Kitchen Staff (KS) 2's personnel file, unknown hire date, revealed no evidence of a TB test or TB risk assessment having been completed.

2(d). Review of Housekeeping Staff (HSK) 2's personnel file, unknown hire date, revealed no evidence of a TB test or TB risk assessment having been completed.

2(e). Review of the Administrator's personnel file, unknown hire date, revealed no evidence of a TB test or TB risk assessment having been completed.

In interview on 07/01/2025 at 10:25 AM, MT 2 stated she had a TB skin test the beginning of "last year." She stated pharmacy came in to the facility to do the tests. She further states she knew she was supposed to have the TB tests yearly but had not had it done "this year."

In interview on 07/01/2025 at 10:39 AM, HSK 1 stated he did not know what a TB skin test was. When the TB testing was explained to him, HSK 1 stated he had not had one performed when hired and had not had one since he began working at the facility four to five weeks ago.

In interview on 07/01/2025 at 10:50 AM, KS 1 stated she had not been tested for TB "in a while." She said it had been over a year since she was tested. KS 1 reported she could not do

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P 100	Continued From page 4 the TB skin test and had to have a chest x-ray performed. She explained she did know how important the TB testing/screening was. KS 1 further stated her doctor was retiring and now she had to find someone else to order and do the chest x-ray. In interview on 07/01/2025 at 11:40 AM, the Administrator stated she had a TB skin test "maybe a year and a half ago." She stated she knew the importance of getting the TB testing done for staff and residents. The Administrator said she had reached out to her facility's physician to "redo" everyone's TB testing. She additionally stated she had talked to the facility's owners, and they were going to have someone come in to the facility to complete the TB testing on all residents and staff.	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:	P 105	Facility Administrator will review all employee charts to verify they have cleared the nurse aide and home health aide abuse registry, the caregiver misconduct registry and background checks in their files. For any employee that is found to be missing one, or more results, the administrator will perform the necessary on-line checks and add the results to their file. On 7/1/25 The administrator has been in-serviced by the Regional Manager on the importance of maintaing compliance with the regulations and performing these checks within the required timeline. POC completion date 8/29/25	

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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
5. 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 and record review, it was determined the facility failed to obtain a criminal background check and/or review the caregiver misconduct registry as required upon hire for 2 of 5 sampled employees, Housekeeper (HSK) 2 and the Administrator

The findings include

1. Review of the personnel file for HSK 2 revealed an unknown hire date and no documented evidence a review of the Kentucky Adult Caregiver Misconduct Registry had been conducted as required

2. Review of the personnel file for the Administrator, with an unknown hire date

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P 105	Continued From page 6 revealed no evidence that a criminal background search or review of the Kentucky Adult Caregiver Misconduct Registry had been completed In interview with the Administrator on 07/01/2025 at 11:40 AM, she stated she did not have background checks in her files. She stated she brought those when she was hired "a couple of years ago," however, did not not know why that documentation was not in her personnel file. The Administrator further stated the importance of doing the required background checks was to make sure "you have safe people working in your facility."	P 105		
P 320	902 KAR 20:036 5(3)(b)1 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 1. A PCH or SPCH shall a. Maintain a clean and safe facility free of unpleasant odors; and b. Ensure that odors are eliminated at their source by prompt and thorough cleaning of commodes, urinals, bedpans, and other sources This requirement is not met as evidenced by Based on observation, interview, and facility policy review, the facility failed to maintain a clean	P 320	Facility Administrator in-serviced all housekeeping staff on 7/22/25 regarding the performance of their duties and expectations for bathrooms specifically,with them needing to be inspected multiple times per shift to ensure they are clean and odor free. Beginning 7/22/25, Administrator is performing random checks on all bathrooms to confirm staff is maintaing cleanliness to a high standard for a period of 2 months. POC completion date 9/23/2025	

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P 320	Continued From page 7	P 320		

and safe facility free of unpleasant odors.

The findings include:

Review of the facility's policy titled, "Housekeeping & Maintenance Policy," undated, revealed the facility would maintain a clean and safe facility.

Observation on 06/30/2025 at 12:25 PM, of the men's restroom beside room revealed a strong odor of urine upon entering. Continued observation revealed a black substance around the base of the commode, as well as on the floor behind the commode.

Observation on 06/30/2025 at 3:40 PM, revealed the strong urine odor was still present in the men's restroom, and the black substance remained on the floor around the commode base and behind the commode.

Observation on 07/01/2025 at 10:20 AM, revealed the strong urine odor was still present in the men's restroom, as well as the black substance on the floor.

In interview on 07/01/2025 at 10:39 AM, Housekeeping (HSK) staff 1 stated he cleaned the men's restroom "at least" three times daily with bleach. He stated he worked "very hard" to keep a clean environment, however, said it was "extremely difficult" to do because of the residents' habits and lifestyle.

In interview on 07/01/2025 at 11:40 AM, the Administrator stated one of her goals was keeping a clean facility. She stated it would be good if the residents helped with that goal. The Administrator reported she had started

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P 320	Continued From page 8 scheduling multiple housekeepers on staggered shifts to see if that would help maintain the facility. She further stated cleanliness was important to keep residents and staff healthy and safe	P 320		
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 facility policy review, the facility failed to ensure the overall condition of the facility environment was maintained in a manner to assure the safety and well-being of residents, and personnel. The findings include:	P 330	On 7/23/2025 Room #3 has been cleaned of any furniture and cleansed of any mold. The room was painted and will be monitored for a period of 1 month to ensure no growth is detected. POC completion date 9/8/25	

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PRINTED: 07/15/2025
FORM APPROVED

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Review of the undated facility policy titled, "Housekeeping & Maintenance Policy," revealed per regulation the facility was to maintain a clean and safe facility. Per review, should there be an unscheduled maintenance or housekeeping issue that needed attention, it was to be brought to the "Manager," who would ensure the issue was addressed timely, if needed.

Observation of resident Room 3 on 06/30/2025 at 12:00 PM, revealed a black substance on all the walls and the resident's bed mattress. Per observation, a strong odor was present in the room that smelled like mold, immediately noticeable upon entering the room. Observation revealed Room 3 had not been locked and was accessible to all residents or staff entering the room.

In interview with Medication Tech (MT) 1 on 06/30/2025 at 12:50 PM, she stated when the previous Administrator discovered the condition of Room 3, she shut and locked the door and "just left it that way." She reported since the current Administrator had taken over, she had been having staff wash the walls with bleach.

In interview with the Administrator on 07/01/2025 at 11:35 AM, she stated there was a room that had "a lot of mold in it," which the previous Administrator had kept locked. She said they sprayed the room with bleach before. The Administrator reported the only reason she left that room unlocked was because she did not think she could have locked doors. She stated she was going to lock the room back up and contact an outside source to remedy the mold situation.

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P 335	Continued From page 10	P 335		
P 335	902 KAR 20:036 5(3)(b)4 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. 4. Maintenance. The premises shall be well kept and in good repair as established in clauses a. through d. of this subparagraph. a. The facility shall ensure that the grounds are well kept and the exterior of the building, including the sidewalk, steps, porches, ramps, and fences, are in good repair. b. The interior of the building, including walls, ceilings, floors, windows, window coverings, doors, plumbing, and electrical fixtures, shall be in good repair. Windows and doors shall be screened. c. Garbage and trash shall be stored in areas separate from those used for the preparation and storage of food and shall be removed from the premises regularly. Containers shall be cleaned regularly. d. A pest control program shall be in operation in the facility. Pest control services shall be provided by maintenance personnel of the facility or by contract with a pest control company. Care shall be taken to use the least toxic and least flammable insecticides and rodenticides. The compounds shall be stored under lock if stored by the facility.	P 335	On 7/9/25 a new light fixture was installed in room 24. Facility Administrator will perform on-going periodic walk-thrus of the facility and speak with staff to ask about any maintenance issues observed. POC completions 7/10	

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This requirement is not met as evidenced by
Based on observation, interview, and facility policy review, the facility failed to maintain the interior of the building in good repair

The findings include

Review of the undated facility policy titled "Housekeeping & Maintenance Policy", revealed that as per State regulation the facility was to maintain a clean and safe facility

Observation of resident Room 24 on 06/30/2025 at 12:35 PM, revealed a missing light fixture in the ceiling which resulted in exposed wires Continued observation revealed a section of the back wall, approximately 15 inches high and greater than two feet in length just above the floor, was missing and exposed a pipe and another unknown mechanical feature

Observation on 07/01/2025 at 9:30 AM, revealed resident Room 24 continued to have the missing ceiling light fixture and missing part of the back wall

Telephonic (Phone) interview on 06/30/2025 through 07/01/2025, in attempts to reach facility maintenance staff was unsuccessful and the maintenance staff were not present in the building during that timeframe

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P 335	Continued From page 12 In interview with Administrator on 07/01/2025 at 11:40 AM, she stated her expectation of her maintenance staff was for them to watch closely and keep things repaired. She stated she was unaware of the condition of Room 24. The Administrator reported currently the maintenance worker was only scheduled on an "as needed basis," which might only be a few hours a day. She further stated she expected "him" (maintenance staff) to be thorough and notify her of supplies he needed to make any necessary repairs. The Administrator additionally said the maintenance staff would be the one who would repair and replace walls and light fixtures.	P 335		
P 355	902 KAR 20:036 5(3)(c)4 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: (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	P 355	On 7/22/25 Facility Administrator performed an inservice training for kitchen staff on food storage and labeling requirements. POC completion date 7/23/25	

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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
P 355	Continued From page 13 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. This requirement is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to store food in accordance with professional standards for food service safety, which had the potential to affect all	P 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100174	A. BUILDING _____ B. WING	07/01/2025

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P 355	Continued From page 14 39 of the facility's 39 residents who consumed food from the kitchen. The findings include: Review of the undated facility policy, "Dry Food Storage and Labeling Policy," revealed all items were to be kept six inches off the floor. Continued review revealed all items were to be dated and if an item was removed from its original container, the new container should be labeled and dated. Observation of the tall freezer on 06/30/2025 at 11:45 AM, revealed two opened bags of tater tots and an opened bag of chicken patties. Continued observation revealed an opened package of frozen waffles and an opened package of egg and cheese omelets. Per observation, none of the opened food items were labeled or dated. Further observation revealed a partial case each of corn dogs, beef patty fritters, and shoepeg corn which were not closed and were not dated with an opened date. Observation on 06/30/2025 at 11:55 AM, of the double door refrigerator revealed a gallon size baggie, which according to kitchen staff present at the time of observation, contained "leftover ham" which was not labeled or dated. Additionally, observation revealed there was an unsealed gallon baggie of sliced cheese which was not labeled or dated. Observation of the dry storage area on 06/30/2025 at 12:00 PM, revealed an 18 quart container containing a white substance that appeared to be sugar, that was not labeled and the lid was not secured. Per observation, there was a partial package of hot dog buns which was	P 355		

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P 355	Continued From page 15	P 355		

undated, a partial loaf of whole wheat bread which was undated, an unsealed bag of cereal not dated, and an unsealed container of pretzels which had a date of 02/17/2025. Continued observation revealed four cases of fresh produce (three containing cucumbers and the other containing green bell peppers) which were printed with "perishable, keep refrigerated" noted on them. Further observation revealed the fresh produce was stored on the floor with no dates on the produce. In addition, the green bell peppers were very soft to the touch.

In interview with Kitchen Staff (KS) 1 on 06/30/2025 at 12:10 PM, she stated food items should be "closed good" before they were placed in the refrigerator or freezer. She reported if there was any unused food product after she prepared a meal, she threw it out because there would not be enough of it left to use. KS 1 further stated she was unsure who placed all the unlabeled/undated items in the dry storage or the freezer and refrigerator.

In additional interview with KS 1 on 07/01/2025 at 10:50 AM, she stated she had never been shown or been trained on the facility's policy titled, "Dry Food Storage and Labeling Policy." Observation revealed KS 1 made a copy of the policy and stated she was going to hang it in the kitchen to reference. She further stated that if food was not stored under proper conditions "it could be bad because it could spoil" and make "people" sick.

In interview with Administrator on 07/01/2025 at 11:35 AM, she stated she knew the requirement for storing foods in the refrigerator and freezer was that they were to be labeled and dated. She reported she planned to have a staff meeting to make sure all her staff knew what to do. The

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P 355	Continued From page 16 Administrator said she had gone into "her" kitchen and educated the staff on storing items appropriately She additionally stated if "you serve someone bad food they could get sick "	P 355	Type text here	