

Office of Inspector General

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                                                      |
|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>100398          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>10/08/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETTER SENIOR LIVING I LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>66 SHELBY STREET<br>CADIZ, KY 42211 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X5)<br>COMPLETE<br>DATE |                                                      |
| P 000                                                          | Initial Comments<br><br>A Complaint Survey was concluded on 10/08/2025 investigating KY00047100, KY00047141, KY00047185, and KY00047225. The facility was found not to be in compliance.<br><br>There were no deficiencies related to KY00047225.<br><br>There were deficiencies cited related to KY00047100, KY00047141, and KY00047185<br><br>Survey Dates: 10/07/2025-10/08/2025<br><br>Survey Census: 55<br><br>Survey Sample: 19<br><br>Supplemental Residents: 0                                         | P 000                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          |                                                      |
| P 320                                                          | 902 KAR 20:036 5(3)(b)1 Section 5. Provision of Services<br><br>Section 5. Provision of Services.<br>(3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services:<br>(b) Housekeeping and maintenance services.<br>1. A PCH or SPCH shall:<br>a. Maintain a clean and safe facility free of unpleasant odors; and<br>b. Ensure that odors are eliminated at their source by prompt and thorough cleaning of commodes, urinals, bedpans, and other sources. | P 320                                                                        | In response to P 320<br>Provisions of Services / Housekeeping and Maintenance Services<br><br>The administrator conducted an In-Service with all staff on 10/17/2025 explaining job descriptions, how to properly clean the building, grounds, resident rooms, common areas, bathrooms, dining spaces, offices, and utility areas. The administrator will monitor the cleanliness of all areas and ensure all job duties are being done for 1 month starting 10/18/2025 and ending on 11/19/2025.<br><br>Rooms #121, 125, 107, 116, 104, were properly cleaned by resident aides. All rooms received clean linens on 10/08/2025.<br>100 Hall women's bathroom was properly cleaned by resident aides on 10/08/2025. |                          |                                                      |

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

TITLE

DATE

STATE FORM

0000

JDCF11

If continuation sheet 1 of 11

*Tiffany Nipper*

Tiffany Nipper, Administrator

Office of Inspector General

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                   |
|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>100398             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X3) DATE SURVEY COMPLETED<br><br>C<br>10/08/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETTER SENIOR LIVING I LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>66 SHELBY STREET<br>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 320                                                          | <p>Continued From page 1</p> <p>This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policies, the facility failed to maintain a clean and safe facility and ensure that odors were eliminated at their source by prompt and thorough cleaning of commodes and other sources.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Physical Environment Policy", undated, revealed that it was the facility's policy for all facility areas to be cleaned and sanitized on a regular schedule to maintain cleanliness and prevent odors. Continued review of the policy revealed that the policy applies to all facility buildings, grounds, resident rooms, common areas, bathrooms, dining spaces, offices, and utility areas.</p> <p>Review of the facility's policy titled "Housekeeping and Maintenance", dated 08/14/2024, revealed that it was the facility's policy to maintain a clean and safe facility.</p> <p>Observations on 10/07/2025 at 8:50 AM, revealed dried red stains that appear to be blood on the floor outside of room 121. Further observation in room 121, revealed black, dried and caked dirt, trash and dead bugs all over the floor.</p> <p>Observations on 10/07/2025 at 9:00 AM in room 125 revealed R2 sitting on the side of the bed and the floor around his bed is extremely dirty with dried black stains, dirt, grime, and trash stuck to the floor. Further observation revealed dirty, urine-stained linens on bed-A.</p> | P 320                                                                        | <p>The administrator will walk the facility to ensure all staff are properly cleaning all areas in the facility. The administrator will monitor job duties to ensure the duties are being done for 1 month starting 10/08/2025 and ending 11/09/2025.</p> <p>All staff will clean the facility as described in the job description to make sure all odors are eliminated.</p> <p>The facility has a current Pest Control policy. Maintenance personnel take care of spraying areas for Bed Bugs with a solution that is provided by an approved company. All staff will monitor residents for bed bug bites. The lead med tech will follow the orders of the physician to ensure the residents are being met. The administrator in-serviced all staff on reporting any pest control issues, and recording it on the pest control log for maintenance to treat appropriately. The administrator will monitor the pest log for 1 month to ensure the facility is being properly treated. Monitoring will start 10/18/2025 and will end 11/19/2025.</p> <p>It is the job duties of housekeepers and resident aides to ensure resident rooms are being properly cleaned. The administrator will make sure all staff have a copy of their job duties. Staff will sign stating they are aware of all job duties while on shift. The administrator in-serviced all staff on job duties on 10/18/2025.</p> |                                                   |

*Tiffany Nipper*

Tiffany Nipper, Administrator

Office of Inspector General

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                              |                                                                                                                          |                          |                                                   |
|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>100398             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY COMPLETED<br><br>C<br>10/08/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETTER SENIOR LIVING I LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br>66 SHELBY STREET<br>CADIZ, KY 42211 |                                                                                                                          |                          |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                   |
| P 320                                                          | <p>Continued From page 2</p> <p>Observations on 10/07/2025 at 9:15 AM in room 107, revealed R4 sitting on the side of her bed. Further observation revealed the floor in the room was caked with trash, food particles, and dirt.</p> <p>Observations on 10/07/2025 at 11:01 AM of the 100-hall bathroom/shower, revealed feces in the toilet, wet and dirty towels on the floor surrounding the toilet, trash can with feces on it and soiled briefs, dirty toilet tissue on the floor, and a pungent odor of urine and feces noted.</p> <p>Observations on 10/07/2025 at 3:05 PM in room 116, revealed a strong odor of urine coming from the bathroom. Further observation revealed the floor extremely dirty and contained caked dirt, trash, grime, crumbs, cigarette butts, and 2 dead roaches. Continued observation revealed no linens on either bed.</p> <p>Observations on 10/08/2025 at 9:46 AM in room 104, revealed the floor to be soiled with grime and food particles and were overly cluttered with clothing and other miscellaneous items, empty containers, food wrappers and trash were sitting around the rooms in excess.</p> <p>During an interview with R3 in room 130 on 10/07/2025 at 9:05 AM, he stated that his only complaint about this facility are the floors need to be cleaned, and they don't have a cleaning lady. He stated that one of the residents cleans a lot, but they don't pay him.</p> <p>During an interview with R4 in room 107 on 10/07/2025 at 9:10 AM, she stated that she has bed bugs. She stated that she thinks they are on her floor. She stated that they spray with alcohol and the last time they sprayed was about 2 weeks ago. She stated that they do not clean her room</p> | P 320                                                                        |                                                                                                                          |                          |                                                   |

*Tiffany Nipper*

Tiffany Nipper, Administrator

Office of Inspector General

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                     |                                                                                                                          |                          |                                                      |
|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>100398 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>10/08/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETTER SENIOR LIVING I LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>66 SHELBY STREET<br>CADIZ, KY 42211                                             |                          |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                      |
| P 320                                                          | <p>Continued From page 3</p> <p>hardly ever.</p> <p>During an interview with the Department of Protection and Advocacy (DPA) Disability Rights Advocate on 10/07/2025 at 1:02 PM, she stated that she and a coworker were at this facility in August of this year and the facility was very dirty, especially the bathroom on the women's hall. She stated that some of the residents reported bed bug bites and having bed bugs in their rooms and no hot water. She stated that she was here on a routine visit.</p> <p>During an interview with R9 on 10/07/2025 at 3:02 PM, he stated that he does not have sheets on his bed and the facility does not have housekeeping. He stated that no one ever cleans the floors in the rooms. He stated that staff does none of that. He stated that the administrator has told the residents that it is their responsibility to clean, or they will get evicted. He stated that if he asks for cleaner and a mop, they won't give it to him and they don't ever make their beds.</p> <p>During an interview with Nurse Aide 2 on 10/08/2025 at 9:40 AM, she stated that she has worked at this facility off and on for over 30 years. She stated that the facility does not have a dedicated housekeeper. She stated that she is a nurse aid and works on the weekends from 7pm-7am at night and was just called in today to help clean resident rooms. She stated that sometimes they call employees to come help clean, but "as you can see, not very often". She stated that if she does come help clean, she will sweep and mop the bedroom floors, make beds, and clean bathrooms.</p> <p>During an interview with the facility's administrator on 10/08/2025 at 2:00 PM, she stated that the</p> | P 320                                                               |                                                                                                                          |                          |                                                      |

*Tiffany Nipper*

Tiffany Nipper, Administrator

Office of Inspector General

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                    |                                                   |
|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>100398             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                    | (X3) DATE SURVEY COMPLETED<br><br>C<br>10/08/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETTER SENIOR LIVING I LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>66 SHELBY STREET<br>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 320                                                          | Continued From page 4<br><br>facility has not had a housekeeper for several months. She stated that she has a housekeeper starting on Monday. She stated that she thinks it is important to keep the facility clean and the residents deserve a safe, clean, and comfortable environment. She stated that they have a lot of residents that will use the bathroom "down the hallway" and they do rounds every two hours, but they do not check the shower rooms every two hours.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | P 320                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                    |                                                   |
| P 335                                                          | 902 KAR 20:036 5(3)(b)4 Section 5. Provision of Services<br><br>Section 5. Provision of Services.<br>(3) APCH or SPCH shall meet the following requirements relating to the provisions of residential care services:<br>(b) Housekeeping and maintenance services.<br>4. Maintenance. The premises shall be well kept and in good repair as established in clauses a. through d. of this subparagraph.<br>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.<br>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.<br>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.<br>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 | P 335                                                                        | In response to P 335<br>Housekeeping and Maintenance Services<br><br>All toilets were repaired on 10/9/2025 by maintenance staff. The hot water issue was fixed by a licensed plumber on 10/17/2025.<br><br>Estimates are being obtained for repairs to the fence outside the building. Once a contractor is chosen, we anticipate repairs to be completed by 12/31/2025. The facility has a current pest control contract in place. The facility manages treating the bed bugs in house with an approved spray solution. The administrator in-serviced all staff on the importance of logging any repairs needed to be done on the maintenance repair log located in the nurses station. The bed bug log is also located in the nurses station for staff to log when bed bugs are noticed. The administrator will walk the interior and exterior of the building to ensure the facility is well kept. The administrator will get with maintenance staff weekly to go over repairs needed to be done. The administrator will monitor the maintenance and bed bugs for 1 month to ensure repairs are being done and bed bugs are being treated. The monitoring will start 10/18/2025 and end 11/19/2025. |                    |                                                   |

*Tiffany Nipper*

Tiffany Nipper, Administrator

Office of Inspector General

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                      |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>100398</b>           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/08/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETTER SENIOR LIVING I LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>88 SHELBY STREET<br/>CADIZ, KY 42211</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| P 335                                                                 | <p>Continued From page 5</p> <p>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> <p>This requirement is not met as evidenced by: Based on observation, interview, and record review, and facility policy review, the facility failed to provide housekeeping and maintenance services by not keeping or maintaining the premises in good repair and not having an effective pest control program for bedbugs for all residents.</p> <p>Observations on 10/07/2025 and 10/08/2025, revealed the following: Twelve broken metal fence posts containing jagged, sharp edges, on the grounds around the sidewalk and front porch of the facility; Toilet not working and still in use, in restroom on the women's hall, ineffective in-house pest control for bedbugs; No hot water in resident rooms on women's hall. This failure had the potential to effect 55 out of 55 residents</p> | P 335                                                                                |                                                                                                                          |  |                                                                    |

*Tiffany Nipper*

Tiffany Nipper, Administrator

Office of Inspector General

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                  |                                                                                                                 |                    |                                                   |
|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>100398 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                          |                    | (X3) DATE SURVEY COMPLETED<br><br>C<br>10/08/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BETTER SENIOR LIVING I LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>66 SHELBY STREET<br>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 335                                                          | <p>Continued From page 6 in the facility.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Physical Environment Policy", undated, revealed that it was the facility's policy to maintain all structural, mechanical, plumbing, and electrical systems in safe operating condition. Further review of the policy revealed that walkways, steps, porches, ramps, and fences shall be kept in good repair and free from hazards.</p> <p>Review of the facility's policy titled "Pest Control Policy", dated 08/14/2024, revealed that it was the facility's policy for the pest control company to spot check for bed bugs on a monthly basis and if a concern is noted it will be brought to the administrator's attention.</p> <p>Review of the facility's documents titled "Bed Bug Control Log", revealed that bed bugs were reported and confirmed to be present on 09/02/2025, 09/08/2025, 09/09/2025, 09/15/2025, 09/16/2025, 09/23/2025, 09/29/2025, 09/30/2025, and 10/08/2025 with in-house treatment done on each date in multiple resident rooms.</p> <p>Further review of the documents revealed that room 131 was treated on 09/02/2025, 09/09/2025, 09/16/2025, and 09/23/2025, and room 104 was treated on 09/08/2025, 09/15/2025, with both rooms having confirmed bed bugs on each date.</p> <p>Review of the facility's pest control contract with Pass Pest Control, dated 11/11/2024, revealed that the pest control company checks and treats for multiple specific pests on a monthly basis and bedbugs are excluded.</p> | P 335                                                            |                                                                                                                 |                    |                                                   |

STATE FORM

0089

JDCR-11

If continuation sheet 7 of 11

*Tiffany Nipper*

Tiffany Nipper, Administrator

