STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185310	A. BUILDING 01 - MAIN BUILDING 0... B. WING	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Episcopal Church Home	7504 Westport Road , Louisville, Kentucky, 40222

(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) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 09/25/2025, it was determined the facility had achieved substantial compliance with Life Safety Code on 09/16/2025.	K0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185310	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

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K0000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 2003 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) story, (2003) Type V (111), protected combustible construction with three (3) smoke compartments and a complete automatic dry sprinkler system. A Life Safety Recertification Survey was initiated on 08/13/2025 and concluded on 08/13/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, The Episcopal Church Home was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K0000		09/12/2025
K0293 SS = F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	K0293	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. K293 The Maintenance Lead and/or Maintenance Technician visually inspected exit signage to validate proper working order by 9/11/25. On 9/9/25, the Administrator developed and implemented an exit-signage inspection form to document monthly inspections of exit signage	09/12/2025

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K0293 SS = F	Continued from page 1 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to visually inspect exit signage in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect three (3) of three (3) smoke compartments, staff, and all residents. The facility had the capacity for 26 beds with a census of 23 on the day of the survey. The findings include: Record review, of the exit sign inspection log on 08/13/2025 at 11:10 AM, revealed the facility failed to visually inspect exit signage for operation of the illumination sources monthly. Interview, on 08/13/2025 at 11:11 AM with the Maintenance Technician, revealed the facility was not aware of the requirement to visually inspect exit signs monthly. The finding was verified by the Maintenance Technician at the time of record review and by the Administrator at the exit interview on 08/13/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. 7.10.9 Testing and Maintenance. 7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3. 7.10.9.2 Testing. Exit signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3.	K0293	Continued from page 1 and to validate that exit signage is in proper working order. The Administrator also created a monthly inspection schedule to aid in the timely inspections of exit signage. On 9/9/25, the Administrator educated Maintenance staff on the inspection process, proper completion of the exit-signage inspection form and maintaining records of the inspections. A Safety Team was created as a subcommittee of the QAPI committee, which consists of the Administrator, Director of Nursing, Household Coordinators, Dietary Director, Social Services Director, Maintenance Director and Dudley Resident Life Enrichment Director. The Safety Committee met on 9/10/25, and will meet monthly to review exit sign inspections for compliance. The Safety Committee will report results of the monthly exit signage inspections to the QAPI Committee for further review and recommendations. Thirty-three percent of exit sign inspection records will be audited by facility Administrator monthly times three months. Audit results will be reported to the QAPI committee on a monthly basis for further review and recommendations. Additionally, the Safety Committee will report exit signage findings to the QAPI committee monthly for further review and recommendations.	
K0712 SS = E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is	K0712	K 712 The Maintenance Director and/or Maintenance Technician conducts monthly fire drills, ensuring one has been completed on each shift per quarter. The missing fire drill forms for 2024 and 2025 cannot be found. The facility will continue with the Fire Drill schedule for 2025 and secure proper documentation.	09/11/2025

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K0712 SS = E	Continued from page 2 aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly for each shift in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice affected five (5) of 12 fire drills, staff, and all residents. The facility had the capacity for 26 beds with a census of 23 on the day of the survey. The findings include: Record review, of the facility's fire drill records for the 12-month period prior to the survey on 08/13/2025 at 1:46 PM, revealed the facility did not have a documented fire drill for the third (3rd) quarter of 2024 or 2025 on second (2nd) shift and third (3rd) shift. Further review revealed no fire drill was documented for the fourth (4th) quarter of 2024 on the first (1st), second (2nd) or third (3rd) shift. Interview, on 08/13/2025 at 1:47 PM with the Maintenance Technician, revealed the facility was unaware the fire drills were missing documentation. The finding was verified by the Maintenance Technician at the time of record review and the Administrator at the exit conference on 08/13/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. under varied conditions.	K0712	Continued from page 2 The Maintenance Staff was re-educated by the Administrator on 9/9/25 on the requirement of maintaining records of fire drills. A copy of the fire drill sheets will be maintained in the Administrator's office in addition to the document maintained in the maintenance office/binder. A Safety Team was also created as a subcommittee of the QAPI committee consisting of the Administrator, Director of Nursing, Household Coordinators, Dietary Director, Social Services Director, Maintenance Director and Dudley Resident Life Enrichment Director. The Safety Committee met on 9/10/25, and will meet monthly to review fire drill documentation for compliance. The Safety Committee will report results of the monthly fire drills to the QAPI Committee for further review and recommendations. The Fire Drill records will be audited monthly by the Administrator to validate fire drills occurred and records are in place. Additionally, the Safety Committee will report fire drill documentation to the QAPI committee monthly, for review and recommendations.	
K0918 SS = F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and	K0918	K 918 Varitech Inc., contract vendor completes monthly load tests of the generator. Monthly load tests were completed for September 2024, December 2024, January 2025, and February 2025. The Administrator called Varitech on 9/4/25, and obtained records for those	09/11/2025

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K0918 SS = F	Continued from page 3 associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to perform testing for the emergency generator in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) of one (1) generator, staff, and all residents. The facility had the capacity for 26 beds with a census of 23 on the day of survey. Findings include: 1. Record review, of the emergency generator testing for the 12 months prior to the survey on 08/13/2025 at 11:00 AM, revealed the facility was unable to provide documentation for weekly generator inspections for the 12 months prior to the survey. Interview, on 08/13/2025 at 11:01 AM with the Maintenance Technician, revealed the facility was not aware the weekly tests were not documented. 2. Record Review, of the Emergency generator maintenance log for the 12 months prior to the survey on 08/13/2025 at 11:02 AM, revealed the emergency	K0918	Continued from page 3 months. On 9/10/25, the Maintenance Technician inspected the generator to validate proper working order and documented inspection results in the Maintenance Binder. On 9/9/25, the Administrator developed and implemented a new inspection form to validate a thorough weekly inspection of the generator is completed. On 9/9/25, the Administrator also created a schedule for the weekly generator inspections. The Maintenance staff was educated on the new inspection process, form completion and importance of maintaining records by the Administrator on 9/9/25. A Safety Team has been created as a subcommittee of the QAPI committee consisting of the Administrator, Director of Nursing, Household Coordinators, Dietary Director, Social Services Director, Maintenance Director and Dudley Resident Life Enrichment Director. The Safety Committee met on 9/10/25, and will meet monthly to review weekly generator inspections and monthly generator load tests documentation for compliance. The Safety Committee will report results of the monthly fire drills to the QAPI Committee for further review and recommendations. The weekly generator inspection records will be audited by the Administrator twice a month for two months then monthly for 3 months. The audit results will be reported to the QAPI committee on a monthly basis for review and recommendations. The Administrator will also review the monthly load test to validate completion and report findings to the QAPI committee monthly for review and recommendations. Additionally, the Safety Committee will report weekly generator inspections and monthly generator load tests to the QAPI committee monthly, for review and recommendations.	

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K0918 SS = F	Continued from page 4 generator for the facility did not have documentation indicating the generator had been exercised under load during December or September 2024 and January or February of 2025. Interview, on 08/13/2025 at 11:03 AM with the Maintenance Technician, revealed the facility was unaware the monthly load tests were not documented. The findings were verified by the Maintenance Technician at the time of record review and the Administrator, at the exit conference on 08/13/2025. Actual NFPA Standard: NFPA 99 Health Care Facilities Code (2012) 6.5.4 Administration (Type 2 EES). 6.5.4.1 Maintenance and Testing of Essential Electrical System. 6.5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. 6.5.4.1.1.2 Inspection and Testing. Generator sets shall be inspected and tested in accordance with 6.4.4.1.1.3. 6.4.4.1.1.3 Maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, Chapter 8. Actual NFPA Standard: NFPA 110 Standard for Emergency and Standby Power Systems, (2010) 8.3 Maintenance and Operational Testing. 8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 The permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of	K0918		

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K0918 SS = F	Continued from page 5 electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.1.1 If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, providing the same record as required by 8.3.4. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating 8.4.2.1 The date and time of day for required testing shall be decided by the owner, based on facility operations. 8.4.2.2 Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source. 8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.	K0918		
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is	K0921	K 921 On 9/12/25, the Administrator developed a policy for Patient Care Related Electrical Equipment (PCREE). On 9/7/25, the VP, Residential Healthcare signed a contract with ISS Solutions to complete the PCREE inspection. The PCREE inspection is scheduled to be completed on 9/15/25.	09/16/2025

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K0921 SS = F Bldg. 01	Continued from page 6 performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to establish policies for the Patient Care Related Electrical Equipment (PCREE) in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect all PCREE, staff, and all residents. The facility had the capacity for 26 beds with a census of 23 on the day of the survey. The findings include: Record review, of the PCREE testing documentation on 08/13/2025 at 11:30 AM, revealed PCREE was in use throughout the facility and there were no policies or protocols for the type of test and intervals of testing for PCREE. Interview, on 08/13/2025 at 11:31 AM with the Maintenance Technician, revealed the facility was not aware of the PCREE requirements. The finding was verified by the Maintenance Technician at the time of record review and by the Administrator at the exit conference on 08/13/2025. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012)	K0921	Continued from page 6 On 9/12/25, the Administrator educated Maintenance Staff and the Safety Committee on the PCREE policy. A schedule has been created by Facility Administrator for the annual inspection of Patient Care Related Electrical Equipment to ensure it is completed as required going forward. Also, a Safety Team has been created as a subcommittee of the QAPI committee consisting of the Administrator, Director of Nursing, Household Coordinators, Dietary Director, Social Services Director, Maintenance Director and Dudley Resident Life Enrichment Director. The Safety Committee met on 9/10/25, and will meet monthly to review results of the PCREE policy and PCREE inspection as applicable. The Safety Committee will report results of the PCREE inspection to the QAPI Committee for further review and recommendations. The Administrator will oversee the schedule to validate the PCREE inspection is completed annually. Additionally, the Safety Committee will report PCREE inspection results as applicable to the QAPI committee, for review and recommendations.	

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K0921 SS = F Bldg. 01	Continued from page 7 3.3.137 Patient-Care-Related Electrical Equipment. Electrical equipment appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. 10.5.2.1 Testing Intervals. 10.5.2.1.1 The facility shall establish policies and protocols for the type of test and intervals of testing for patient care-related electrical equipment.	K0921		

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E0000	Initial Comments 42 CFR 483.73 Type of Structure: One (1) story, (2003) Type V (111), protected combustible construction with three (3) smoke compartments and a complete automatic dry sprinkler system. An Emergency Preparedness Recertification Survey was conducted on 06/03/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. During this Recertification Survey, The Episcopal Church Home was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E0000		09/12/2025
E0004 SS = F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E0004	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. On 9/2/25, the Administrator lead the QAPI Team in the review of the Emergency/Disaster Plan to validate accuracy and determine any updates that needed to be made. The Leadership team, consisting of Director of Nursing, Household Coordinators, Director of Social Services, Dietary Director, HR Director, Chaplain, Administrative Manager, Dudley Life Enrichment Director, Community Outreach Director and Director of Fund Development, has been educated to the importance of updating the Emergency/Disaster Plan when changes, such as policies and key leaders change. The Administrator placed a documentation of changes page in the Emergency/Disaster Preparedness binder on 8/13/25 to record all revisions	09/11/2025

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E0004 SS = F	Continued from page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to maintain an Emergency Preparedness Program (EPP) in accordance with the Code of Federal Regulations (CFR) State Operations Manual (SOM), Appendix Z. The deficient practice had the potential to affect three (3) of three (3) smoke compartments, staff, and all residents. The facility had the capacity for 26 beds with a census of 23 on the day of the survey. The findings include: Record review, of the facilities' EPP on 08/13/2025 at 12:58 PM, revealed the facility failed to review and update the Emergency Preparedness Program on an annual basis. Interview, with the Administrator on 08/13/2025 at 12:59 PM, revealed the facility was unaware the EPP was not reviewed within a year from the date of the survey. The finding was verified by the Administrator at time of record review and at the exit interview on 08/13/2025.	E0004	Continued from page 1 as they occur. The Administrator added an annual review of the Emergency/Disaster plan to the QAPI calendar to ensure it is reviewed and updated at minimum once a year. Also, a Safety Team has been created as a subcommittee of the QAPI committee consisting of Facility Administrator, Director of Nursing, Household Coordinators, Dietary Director, Social Services Director, Maintenance Director and Dudley Resident Life Enrichment Director. The Safety Committee met on 9/10/25, and will meet monthly and review the monthly calendar, recommend changes as applicable and when appropriate update the documentation of changes page in the Emergency/Disaster Plan for compliance. The Safety Committee will report changes and updates to the documentation of changes page in the Emergency/Disaster Plan to the QAPI Committee for further review and recommendations.	
E0029 SS = F	Development of Communication Plan CFR(s): 483.73(c)	E0029	E0029 The Administrator reviewed the communication plan and	09/11/2025

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E0029 SS = F	Continued from page 2 §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to maintain a communication plan in accordance with the Code of Federal Regulations (CFR) State Operations Manual (SOM), Appendix Z. The deficient practice had the potential to affect three (3) of three (3) smoke compartments, staff, and all residents. The facility had the capacity for 26 beds with a census of 23 on the day of the survey. The findings include: Record review, of the facilities' EPP on 08/13/2025 at 1:02 PM, revealed the facility failed to review and update the communication plan on an annual basis. Interview, with the Administrator on 08/13/2025 at 1:03 PM, revealed the facility was unaware the Communication Plan was not reviewed within a year from the date of the survey. The finding was verified by the Administrator at time of record review and at the exit interview on 08/13/2025.	E0029	Continued from page 2 made necessary revisions on 8/13/25. The plan was reviewed by the QAPI committee on 9/2/25 to validate the annual review and revisions. The Leadership team, consisting of Director of Nursing, Household Coordinators, Director of Social Services, Dietary Director, HR Director, Chaplain, Administrative Manager, Dudley Life Enrichment Director, Community Outreach Director and Director of Fund Development, has been educated on the importance of updating the Communication plan when changes such as key leaders change. The Administrator placed a documentation of changes page in the Emergency/Disaster Preparedness binder on 8/13/25 to record all revisions as they occur. The Administrator added an annual review of the Communication plan to the QAPI calendar to ensure it is reviewed and updated at minimum once a year. Also, a Safety Team has been created as a subcommittee of the QAPI committee consisting of facility administrator, Director of Nursing, Household Coordinators, Dietary Director, Social Services Director, Maintenance Director and Dudley Resident Life Enrichment Director. The Safety Committee met on 9/10/25, and will meet monthly and review the monthly calendar, recommend changes as applicable and when appropriate update the documentation of changes page in the Emergency/Disaster Plan for compliance. The Safety Committee will report changes and updates to the documentation of changes page in the Emergency/Disaster Plan to the QAPI Committee for further review and recommendations.	

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F0000	INITIAL COMMENTS An abbreviated survey was initiated on 08/07/2025 to investigate complaint, 2582828. On 08/12/2025 the survey transitioned into a Recertification survey and concluded on 08/15/2025. Immediate Jeopardy (IJ) was identified on 08/15/2025 at 10:12 AM, in the areas of 42 CFR 483.25, Quality of Care F689, and was determined to exist on 07/30/2025. On 08/15/2025 at 10:12 AM, the Administrator and the Vice President of Residential HealthCare were provided a copy of the CMS IJ Template and were notified that the elopement of Resident (R) 19 constituted Immediate Jeopardy. The facility provided an acceptable plan for removal of the Immediate Jeopardy on 08/15/2025 and the survey team validated the immediate jeopardy (IJ) was removed on 08/06/2025, prior to the State Survey Agency's (SSA) entrance into the facility. The immediate jeopardy was determined to be past non-compliance. Survey Dates: 08/07/2025 - 08/15/2025 Survey Census: 24 Sample Size: 18 Supplemental Residents: 10	F0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0000	INITIAL COMMENTS An abbreviated survey was initiated on 08/07/2025 and concluded on 08/15/2025. The complaint, 2582828, had deficiencies cited. Immediate Jeopardy (IJ) was identified on 08/15/2025 at 10:12 AM, in the areas of 42 CFR 483.25, Quality of Care F689, and was determined to exist on 07/30/2025. On 08/15/2025 at 10:12 AM, the Administrator and the Vice President of Residential HealthCare were provided a copy of the CMS IJ Template and were notified that the elopement of Resident (R) 19 constituted Immediate Jeopardy. The facility provided an acceptable plan for removal of the Immediate Jeopardy on 08/15/2025. The survey team validated the immediate jeopardy was removed on 08/06/2025, prior to the State Survey Agency's (SSA) entrance into the facility. The immediate jeopardy was determined to be past non-compliance. Survey Dates: 08/07/2025 - 08/15/2025 Survey Census: 24 Sample Size: 18 Supplemental Residents: 10	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F0689	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0689 SS = SQC-J	Continued from page 1 accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide adequate supervision and effective assistance devices to prevent accidents for one (Resident (R) 19) of three sampled residents reviewed for elopement risk. R19, who had severe cognitive impairment, eloped from the facility on 07/30/2025. The facility's equipment (alarm system) used for supervision of location failed to sound in a manner to immediately alert staff when the resident left the facility without staff knowledge/supervision. The failure to prevent R19's elopement, at a time when the outdoor heat index was 107 degrees, created an Immediate Jeopardy situation with the likelihood for serious harm or death. Immediate Jeopardy was identified on 08/15/2025 and was determined to exist as of 07/30/2025 (the day of the elopement), in the area of 42 CFR 483.25, Quality of Care. This deficiency also constituted Substandard Quality of Care (SQC). The Administrator and the Vice President of Residential Health Care were notified of the Immediate Jeopardy on 08/15/2025 at 10:12 AM. On 08/15/2025 at 10:12 AM, the Administrator and the Vice President of Residential Health Care were provided a copy of the CMS IJ Template and were notified that R19's elopement from the facility on 07/30/2025 constituted an Immediate Jeopardy. The facility provided an acceptable plan for removal of the Immediate Jeopardy on 08/15/2025 at 2:00 PM. The survey team validated the Immediate Jeopardy was removed on 08/06/2025 at 2:00 PM following the facility's implementation of the plan of removal of the Immediate Jeopardy and the deficient practice was determined to be past non-compliance The findings include: Review of the facility's policy, "Elopement/Missing Resident Policy ('Code Yellow')," dated 02/06/2024 and in effect at the time of R19's elopement, revealed the facility defined elopement as, "When a patient or resident who is cognitively, physically, mentally,	F0689		

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F0689 SS = SQC-J	Continued from page 2 emotionally, and/or chemically impaired; wanders away, walks away, runs away, escapes, or otherwise leaves a caregiving facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge." Review of the policy revealed that although it addressed the steps to take after a resident eloped, it did not describe steps to prevent elopements from occurring. Review of R19's "Resident Face Sheet" revealed R19 was admitted on 01/14/2025 with diagnoses including unspecified dementia, anxiety disorder, and insomnia due to mental disorder. Review of R19's Admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 02/05/2025 revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 5/15, indicating severe cognitive impairment. Per this MDS, R19 displayed wandering behaviors 1-3 days during the assessment period, and these behaviors placed the resident at a significant risk of getting to a potentially dangerous place, such as outside the facility. The MDS documented the resident was independent with indoor mobility (ambulation) and used a walker. Review of R19's baseline care plan, initiated on 01/15/2025 and comprehensive care plan, initiated 02/11/2025, revealed the resident was at risk for elopement. The care plans included multiple interventions, including placement on a unit for residents with advanced dementia (secured unit), and the use of a Code Alert bracelet (device which sounds an alarm if the resident comes near a door), with its placement and functionality checked every shift. Additional interventions included elopement assessments, redirection of the resident by talking about her past work as a Missionary, and allowing R19 to speak to her family, which calms her. Review of the "Observations," tab in the Electronic Medical Record (EMR) revealed that, per the care plan, the facility assessed R19 as being at risk for elopement on the following dates: 01/14/2025, 01/29/2025, 04/18/2025, and 07/13/2025. Review of the 07/13/2025 "ECH Elopement Risk Assessment" form (most recent prior to R19 eloping on 07/30/2025) revealed that R19's risk factors included a diagnosis of dementia, attempts to leave the facility, independence with mobility in the presence of dementia, a change in medications, verbalizations of intent to leave, wandering to find family, wandering aimlessly, and actively having exit-seeking behaviors.	F0689		

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F0689 SS = SQC-J	Continued from page 3 Review of R19's EMR, under "Progress Notes," revealed she attempted to exit the facility on each of the following dates: 05/04/2025, 05/07/2025, twice on 06/30/2025, 07/06/2025, and 07/11/2025. Each of these times, R19 was re-directed by staff once the door alarm was engaged. Review of the facility's "Initial Report," dated 07/30/2025 and signed by the Administrator, revealed R19 exited the facility without staff's knowledge or supervision on 07/30/2025. At 1:08 PM, the Director of Life Enrichment (DLE), who was driving through the property, found R19 walking on a sidewalk. At that time, the DLE stopped, got R19 into her car, and returned R19 to the facility. Per the report, R19 was immediately assessed and found to be free of injury, and she displayed no signs or symptoms of heat-related concerns. The document estimated R19 was outside the facility no longer than five minutes, and all necessary parties were informed of the elopement at the appropriate times. Further review of the facility's "Initial Report," revealed all the exterior doors and alarms in the facility were inspected, with no concerns identified, and were found to be in proper working order. The document stated education was provided to all staff regarding response to alarms, and the elopement and abuse policies. The incident report stated R19 provided no verbalizations or behaviors to indicate she had suffered any physical or psychosocial harm. Review of the form, "Kentucky Cabinet for Health and Family Services, Office of Inspector General – Division of Health Care, Long-term Care Facility – Self-Reported Incident Form, Final Reports/5 Day Follow-Up," ("5-Day FU report"), dated 08/05/2025 and signed by the Administrator, revealed that all staff members working on R19's secure unit were interviewed following the incident. The form indicated no one saw R19 exit the building. Further review of the "5-Day FU Report" revealed the door alarm sounded when R19 pushed the door bar. However, the two Versatile Workers ((VWs), 1 and VW4) on the unit were providing care in another resident's room with the door closed, and did not hear the alarm. During the time that staff could not hear the alarm, R19 had an opportunity to wait for the 15-second egress to engage and then walked out the door undetected and unsupervised. Further review of this report revealed that VW3 had escorted R19 to her neighborhood (secure unit) prior to the elopement, and stated R19 made the comment that she	F0689		

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F0689 SS = SQC-J	Continued from page 4 needed to go home. VW3 said she explained to R19 that her daughter knew where R19 was and would come to visit her soon. Per the report, R19 admitted she opened the door, then stated that she, "...wasn't looking for anything, but I know I shouldn't have done that. I don't think I have meandered like that before, I won't do that again." Further review of the "5-Day FU Report," revealed the DLE stated R19 was talkative and smiling when she put R19 into her car, and the DLE stated R19 was not sweating and did not feel hot to the touch. The document indicated the DLE brought R19 back into the facility through the front doors at 1:12 PM. Review of facility video records revealed there was no video footage to verify when the resident left the facility. Video footage of the facility's front door verified R19 and the DLE walked back into the facility on 07/30/2025 at 1:11:46 PM. Review of R19's "Progress Notes," dated 07/30/2025 at 2:02 PM, entered by Registered Nurse (RN) 1, revealed R19 was assessed immediately after her return to the unit. R19 was alert to self, was in no pain, and denied feeling hot. Further review of RN1's entry in R19's "Progress Notes," revealed R19 was tearful and apologized and hoped she had not gotten any staff in trouble. Review of Weather Channel website revealed the temperature on 07/30/2025 (the day of R19's elopement) was 93 degrees, with a heat index of 107 degrees. Observation of R19 on 08/08/2025 at 4:22 PM, revealed the resident was wearing a Code Alert bracelet on her left wrist. The resident was sitting on a couch, watching TV in a common area on the secured unit. The resident was noninterviewable, based on cognitive status. Further observation at this time, revealed that the door through which R19 eloped, on 07/30/2025, was down the hall, approximately 20-25 feet from the kitchenette on the secure unit, where R19 resided. The door was observed to be alarmed, with a sign on the door noting that if you hold the (panic) bar for 15 seconds, it would unlock. Further observation of the door revealed that to open it, a person had to turn the lock above the handle, as well as hold the bar in for 15 seconds, for the door to unlock and be opened. The exit door opened into a sidewalk which led to the parking lot and onto a busy road. In an interview with VW1 on 08/08/2025 at 11:35 AM, she stated she was working on 07/30/2025 when R19 eloped. VW1 stated she and VW 4 were in another resident's room, providing care with the door closed for privacy.	F0689		

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F0689 SS = SQC-J	Continued from page 5 VW1 related that all staff were to respond when a door alarm was sounding. However, because they were in the room with the door closed, they did not hear the door alarm going off. VW1 stated they were not aware the alarm went off until they came out of the resident's room, and it was still sounding. She stated she and VW4 opened the door where the alarm was sounding, and when they did not see anyone, they did not go outside to look and see if a resident had gone out the door. VW1 stated she was not aware R19 exited the building until after the resident was found. VW1 stated there were three aides working the floor on 07/30/2025 - herself, VW4 who was her orientee, and VW3, who was R19's aide. VW1 was not aware that VW3 was on a break at the time of the elopement. VW1 stated she did not believe staffing was an issue in contributing to the elopement, adding, "The problem is when everyone is busy." VW1 was aware R19 was at risk for elopement and wore a Code Alert bracelet. She stated the last place she saw R19, before the elopement, was in the dining room, and she did not see R19 display exit-seeking behaviors on 07/30/2025, prior to the elopement. VW1 stated, "The door she [R19] went out, it should have locked when she [R19] was close to it because she [R19] had a Code Alert bracelet on." In an interview with VW4 on 08/08/2025 at 3:00 PM, she stated VW1 was orienting her on 07/30/2025, as she had only been working in the facility for two weeks. VW4 stated she and VW1 were in a resident's room, cleaning the resident up and putting them back in bed when the incident occurred. She stated the alarm was sounding; however, neither she nor VW1 heard it until they came out of the room. She stated she and VW1 checked the door, but did not see anyone. VW4 stated VW1 thought a staff member had just taken out the trash, causing the alarm to sound. VW4 stated she learned of the elopement shortly after, when other staff members informed her. VW4 was aware R19 was at risk for elopement, stating that was why the resident wore a Code Alert bracelet. VW4 denied observing R19 with any exit-seeking behaviors earlier in the day. VW4 also stated she was not aware of VW3 being on break at the time of the elopement. In an interview with VW3 on 08/08/2025 at 2:32 PM, she stated R19 was sitting in the common area of the secured unit, watching television when she (VW3) left the unit to go to the bathroom. She confirmed that she was not on the secure unit at the time of the elopement, as she left the unit to use the restroom. She then went to the break room for her 15-minute break. VW3 stated that she did not inform VW1 or VW4, who were the other staff on the unit, that she was	F0689		

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F0689 SS = SQC-J	Continued from page 6 leaving the unit at that time and would not be available for supervision of other residents while they were providing care in individual resident rooms. She stated she did not hear the door alarm when R19 exited the facility, and did not know that R19 eloped from the facility until she heard other staff members talking about it in the breakroom. VW3 was aware of R19 being at risk for elopement and knew she had a Code Alert bracelet in place. VW3 stated all staff were to respond to a door alarm. VW3 stated R19 did have behaviors related to exit-seeking on 07/30/2025 when R19 stated, "I'm going to look for my daughter." VW3 told R19 her daughter knew where she (R19) was, and the daughter was coming to visit later in the day. VW3 stated the day prior to the elopement, R19 woke up and stated, "I've got to go," and VW3 reassured R19 her daughters were coming to visit later. An interview with Registered Nurse (RN) 1, on 08/08/2025 at 12:05 PM, revealed she was R19's nurse on 07/30/2025. She stated she last observed R19 walking back to the secure unit after eating lunch in the main dining room. RN1 stated she was on the other side of the unit at the time R19 eloped. RN1 stated her assumption was there were three aides on the unit with R19. She was unaware one of the three was not on the unit, and the other two were in a closed room, providing care, at the time of the elopement. RN1 stated she did not hear the door alarm and did not know about the elopement until another staff told her. RN1 was aware R19 was at risk for elopement and had a Code Alert bracelet on. RN1 stated some of the doors inside the facility locked when a resident with a Code Alert bracelet got near the door. However, she continued, the Code Alert device for the door, through which the resident exited, does not lock due to a Fire Safety Code requirement. RN1 stated she assessed R19 after she was brought back to the secure unit, inside the facility and R19 had no skin issues or injuries. In an interview with the Director of Life Enrichment (DLE) on 08/08/2025 at 2:08 PM, she stated that on 07/30/2025 at approximately 1:07 PM, she was driving around the campus to get to a meeting she was running late for, as the meeting was supposed to start at 1:00 PM. The DLE stated once she drove past the dumpsters, on the left side of the building, she saw a resident walking with her walker, alone, which raised some concern. The DLE stated she put her car into reverse, confirmed the resident was alone, then asked if the resident needed any help. The DLE stated R19 told her while she smiled, "I just need to get home." The DLE stated the temperature was in the 90s on this day and she helped R19 get into her car. She noted R19 was not	F0689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = SQC-J	Continued from page 7 sweating, her skin was cool to the touch, she did not have any shortness of breath and was in no distress. The DLE proceeded to drive R19 back around to the front of the building, where she escorted R19 back into the facility, safely, at 1:12 PM. The DLE recalled the alarm sounding as they walked into the building because of R19's Code Alert bracelet. The DLE stated another VW was in the front lobby and offered to escort R19 back to her secured unit at that time, and the DLE stated she went to inform the Administrator of the elopement at that time. The DLE stated she felt "blessed" to have found R19 when she did. In an interview with the Director of Nursing (DON), on 08/08/2025 at 3:49 PM, she stated, "It's everyone's responsibility to answer the door alarms." Per the DON, the elopement on 07/30/2025 occurred when staff could not hear the alarm, since they were working in a resident's room with the door closed. The DON added that, due to this, the facility had since replaced the alarms with ones that were louder. Further interview with the DON revealed that when a door alarm was sounding, staff should not only look outside the door, but they must also go outside to look around and possibly identify a resident who had eloped. The DON stated R19 did not have exit seeking behaviors or any behaviors out of the ordinary on the day of the elopement and was unaware that VW3 had observed behaviors related to exit seeking prior to the elopement. The DON stated R19 was assessed as being at risk for elopement. She stated once it was known the resident had exited the facility, all units or neighborhoods in the facility must conduct a head count to ensure all residents were accounted for. The DON stated there must be a search of the neighborhood completed by staff, the nurse should call the receptionist desk and notify of the missing resident, notify the DON and the Administrator, begin to search for the resident and expand the search if needed, and lastly the police would be called if the resident was still missing. After the elopement, the DON stated all the staff were interviewed and new elopement assessments were completed on each resident. In an interview with the Administrator, on 08/08/2025 at 4:27 PM, she stated the DLE notified her of R19's elopement on 07/30/2025. She stated immediately after being notified, she initiated a head count on all units of all the residents, then she had maintenance check the door alarms and locks to ensure they were all functioning, which they were. She stated RN1 assessed R19 once she was returned to the unit. The Administrator stated, "I decided, ultimately, this was just a perfect storm." She stated that all staff on	F0689		

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F0689 SS = SQC-J	Continued from page 8 R19's unit were responsible for R19, but VW4 and VW1 were the only staff on the unit when R19 eloped. She continued that they were in another resident's room, providing care, with the door closed for privacy, and were unable to hear the door alarm. The Administrator stated she went into a resident's room and had another staff person engage the alarms, and she verified the alarm was not able to be heard. To address this, the Administrator stated they purchased new "screamer" alarms that were much louder. The facility provided an acceptable plan for removal of the Immediate Jeopardy on 08/15/2025 at 2:00 PM. The survey team validated the Immediate Jeopardy was removed on 08/06/2025 at 2:00 PM following the facility's implementation of the plan of removal of the Immediate Jeopardy and the deficient practice was determined to be past non-compliance The Removal of Immediate Jeopardy/Past Non-compliance was validated with implementation of the following measures: 1. R19 was evaluated/assessed immediately for signs and symptoms of any heat-related issues, none were noted. A head-to-toe assessment was completed by a nurse for R19 upon arrival back to the secure unit. R19 was placed on enhanced supervision/observation upon her return to the secure unit, and every 15-minute checks were performed for the 24 hours following the elopement. Notification of the elopement was made to R19's physician and her Power of Attorney (POA). R19 was interviewed for her thoughts/feelings of the elopement. R19's medication regime reviewed for any changes that could have contributed to the elopement, and none were identified. R19's orders and progress notes were reviewed to identify increasing behaviors leading up to the elopement, and none were identified. A new elopement risk assessment was completed for R19. R19's POA was contacted for more detailed information of R19's past, and memorabilia was requested, to develop an individualized activity box. The Comprehensive care plan was updated to reflect the elopement, and more elopement interventions were added. 2. A head count of all residents in the facility was done, all residents were accounted for. A facility-wide audit of residents for elopement risk was completed within 24 hours. All residents' care plans were reviewed for elopement risks and any revisions needed were made. Activity programming for all residents was reviewed to validate the appropriateness for the	F0689		

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F0689 SS = SQC-J	Continued from page 9 population of residents. 3. Statements were obtained from all staff working on 07/30/2025, the date of the elopement, on R19's secure unit. Inspection of all exterior doors for proper functioning and alarms completed, no issues identified, all doors and alarms functioned properly. A Root, Cause, and Analysis of the elopement event completed. In response, new, louder alarms were purchased and installed on all doors that lead outside of the facility. The door alarms were inspected by a technician, the volume was increased to the maximum level, and alarms are functioning properly. In addition, Elopement books on each unit were audited to ensure they were accurate, with updated pictures of the residents who are at risk for elopement. "Treatment Administration Record" (TARs) audited for proper placement and function of Code Alert device. The procedure for escorting residents back and forth to and from the primary dining room and the secure unit was revised. There will now be an extra staff member available to remain in the dining room to either escort resident(s) or coordinate a staff member to remain in the dining room and/or assist the resident(s) back to their unit. New process implemented for the Versatile Workers, they now must sign in and out for lunch and breaks, to ensure all staff are aware of who is actually available on the units. Staff were educated on elopement risk, door alarm response, supervision requirements, and new escorting residents to and from the primary dining room procedure implemented. All new education was also added to the newly hired staff education and checklists. 4. An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held to discuss elopement policies and procedures. An audit of the door alarms to validate staff's response began 07/31/2025, daily for two weeks, then three days a week for two weeks, then once a week for a total of four weeks.	F0689		