Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100155	A. BUILDING. _____ B. WING _____	R 12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRASURE'S PERSONAL CARE HOME, INC	1308 RIVERVIEW ROAD ASHLAND, KY 41101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{P 000}	Initial Comments Based on the acceptable Plan of Correction (POC) received on 12/01/2025, it was determined the facility had achieved substantial compliance on 12/31/2025, as alleged.	{P 000}		

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

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100155	A. BUILDING. _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY STATE, ZIP CODE
FRASURE'S PERSONAL CARE HOME, INC	1308 RIVERVIEW ROAD ASHLAND, KY 41101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Initial Comments A Relicensure and Complaint Survey was initiated on 11/04/2025 and concluded on 11/06/2025 with regulatory violations identified. A deficiency was issued related to KY00044488 at P210. A deficiency was issued related to KY00046866 at P330. No deficiencies were issued related to KY00048290, KY00043338, KY00047199, KY00047470, KY00042938, KY00044598, KY00046068, KY00045907, KY00043845, KY00046928, KY00044583, KY00046429, KY00045307, KY00047287, KY00046929, KY00046361, KY00042722, KY00043702, KY00045775, KY00042703, and KY00047525. Facility Census: 58	P 000		
P 210	902 KAR 20:036 5(1)(a) Section 5. Provision of Services Section 5. Provision of Services. (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to ensure that the resident's health care needs are met; 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility.	P 210	P210 The Charge/Medication Aide that administered the wrong medication on 12/12/2024 was immediately counciled by phone for med error and instructed to seek medical evaluation from KDMC ER. Written counciling and education on correct medication administration was completed on 12/13/2024.The facility corrected the practice prior to inspection date of 11/5/2025.All medication aides will be re-educated on the practice of one resident at a time and from the medication cart before 12/05/2025. A QA(quality assurance) monitor will be put in place and medication aides will be a(cont)	

RECEIVED

DEC - 1 2025

CHFS Office of Inspector General
Division of Health Care - EB
BT Received by

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Latonia Ward — TITLE: ADM — (X6) DATE: 12-1-25

STATE FORM 6899 MW6L11 If continuation sheet 1 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100155	A. BUILDING _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERASURE'S PERSONAL CARE HOME, INC	1308 RIVERVIEW ROAD ASHLAND, KY 41101

(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 210	Continued From page 1	P 210	P210 educated on the QA mnitor by 12/18/2025.The QA monitor will have the ADM or Another Medication Aide witness a medication administration pass of every medication aide once a month for six months to ensure compliance. The ADM will monitor the QA form. Monitoring will start by 12/31/2025, completion date12-31-2025	

This requirement is not met as evidenced by:
Based on interview, record review, review of the facility's investigation, and review of the facility's policies, the facility failed to control medication administration for 1 of 48 residents. Resident (R) 4.

The findings include

Review of the facility's policy titled, "Medication Administration-General Guidelines," dated 12/18/2012, revealed medications were administered as prescribed in accordance with good nursing principles.

Review of the facility's policy titled, "Maintaining a Clean and Safe Environment," effective date 10/29/2013, revealed the facility shall take appropriate precautions to insure the safety of all residents.

Review of the facility's "Investigation," dated 12/12/2024, revealed Charge Aide/Nurse Aide/Dietary Aide/Housekeeping Aide (CH/NA/DA/HA) 8 placed Resident (R) 7's donazepam (an anti-anxiety medication) on the shelf of the medication room door. Per the investigation, CH/NA/DA/HA8 turned around, and R4 took the medication. Further review revealed R4 was sent to the hospital but returned the same day, with no treatment needed.

Latonia Ward ADM 12-1-25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100155	A. BUILDING: _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRASURE'S PERSONAL CARE HOME, INC	1308 RIVERVIEW ROAD ASHLAND, KY 41101

(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 210	Continued From page 2 Review of the R4's "Admission Record" revealed the facility admitted R4 on 07/01/2016 with diagnoses to include alcohol use, stroke, and history of left hip replacement. During interview with R4 on 11/04/2025 at 10:56 AM, he stated he did not remember taking another resident's medications. He further stated he received good care in the facility. During telephone interview with CH/NA/DA/HA8 on 11/06/2025 at 10:12 AM, she stated she was giving medications, and she placed R7's medication on the shelf of the medication door. She stated she turned around, and R4 took R7's medication. She stated she was educated the next day on medication administration During interview with CH/NA/DA/HA1 on 11/04/2025 at 11:44 AM, he stated he gave medications one at a time. He stated he took the medication cart to the resident's room. During interview with CH/NA/DA/HA6 on 11/04/2025 at 2:52 PM, she stated she gave medication at the resident's room. She stated she had not had a resident take another resident's medication. During interview with the Administrator on 11/06/2025 at 3:33 PM, she stated CH/NA/DA/HA8 was educated after the incident when R4 took R7's medication. She stated all staff had been educated on medication administration. She stated she now had staff give medications in the resident's room.	P 210	Katonia Ledford from 12125	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100155	A. BUILDING _____ B. WING _____	C 11/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRASURE'S PERSONAL CARE HOME, INC	1308 RIVERVIEW ROAD ASHLAND, KY 41101

(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 330	Continued From page 3	P 330	P330 Walk-in-refrigerator The walk-in refrigerator was cleaned and ice removed on 12-15-2026. the walk-in-refrigerator will be cleaned per incident and monthy. a QA monitor will begin by 12-18-2025. the dietary supervisor will monitor the QA monitor to ensure compliance. Staff will be educated by 12-18-2025. Ice Machine A new ice machine was purchased on 11-7-2025. Due to the cost of a filter being almost equal to a new machine. Until the facility received the statement of deficiencies on 11-21-2025 the facility was unaware that the filter was located above the ice machine. the filter above the ice machine will be replaced by 12-15-2025.A QA monitor will be utilized to insure the filter above the ice machine is replaced yearly. Ice scoop and container the ice scoop and container was cleand on 11-25-2025,as it wasnt mentioned in the exit interview. The ice scoop and container will be cleaned weekly A QA monitor will be in place to ensure compliance. The dietary supervisor will monitor the QA form to ensure compliance. Staff education will be completed by 12-18-2025 All ice used in the facility has been purchased bagged ice and will be until filter is replaced.	
P 330	902 KAR 20:036 5(3)(b)3 Section 5. Provision of Services Section 5. Provision of Services. (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (b) Housekeeping and maintenance services. 3. Safety. The condition of the overall environment shall be maintained to ensure the safety and well-being of residents, personnel, and visitors. This requirement is not met as evidenced by: Based on observation, interview, review of the manufacturer's recommendations for use, and review of the facility's policy, the facility failed to ensure the condition of the overall environment was maintained to ensure the safety and well-being of 48 of the 48 residents residing in the facility. The findings include: Review of the facility's policy titled, "Maintaining a Clean and Safe Environment," effective date 10/29/2013, revealed the facility would maintain a	P 330	Antonia Ward 12-1-25 AOM	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100165	A. BUILDING _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRASURE'S PERSONAL CARE HOME, INC	1308 RIVERVIEW ROAD ASHLAND, KY 41101

(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 330	Continued From page 4 clean and safe environment. 1. Observation of the walk-in refrigerator on 11/04/2025 at 2:16 PM revealed a red substance on the top middle shelf. There was a build-up of ice on the cooling device over the middle shelf with food on the shelf. During interview with the Dietary Supervisor on 11/05/2025 at 10:15 AM, she stated the shelf in the walk-in refrigerator should have been cleaned. She stated he was not sure what the red substance was on the shelf. She stated they called a local refrigeration contractor to clean the ice when it built up on the condenser above the middle shelf. She further stated that contractor would be called today. During interview with the Administrator on 11/06/2025 at 4:11 PM, she stated the shelves in the walk-in refrigerator should be cleaned monthly and as needed. She stated they would be cleaned today. She stated the contractor would be contacted to remove the ice on the concentrator above the middle shelf. 2. Observation of the ice machine on 11/05/2025 at 10:01 AM revealed the filter was located above the machine, and it had a patch of brown paint at the bottom near the wall. The wall was painted gray. Also, there was a brown substance covering the filter. Observation of the container holding the scoop for the ice revealed a brown substance on the cover of the container. During interview with the Dietary Supervisor at the time of the observation, she stated the ice machine was cleaned once a month. She stated the machine was emptied and cleaned with an unscented disinfectant. She further stated she did	P 330	P330 Dishwasher Sprayer Brown substance on bottom of dishwasher sprayer cleaned by date of Statement of deficiencies. Dish washer to be cleaned and sanitized monthly and as needed. A QA monitor will be put in place to ensure comliance. The QA monitor will be monitored by the dietary supervisor. All staff will be re-educated on 12-18-2025. Laundry Room Cleaning of Laundry room, along with repairs to the dryer venting system, cleaning of sprinkler heads, lint on floors, walls and ceiling, repairs to the ceiling , water leak at sink will be completed by 12-18-2025.A QA monitor will be put in place by 12-31-2025 to ensure compliance. The QA monitor will be monitored by the ADM.All issues related to P330 will completed by 12-31-2025. Katonia Lillard ADM 12-1-25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100155	A. BUILDING: _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRASURE'S PERSONAL CARE HOME, INC	1308 RIVERVIEW ROAD ASHLAND, KY 41101

(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 330	Continued From page 5 not know when the filter was changed. Review of the manufacturer's recommendations for the ice machine model CU0715MA-1A, serial number 2304132001 4904, stated the filter should be changed yearly. Further review revealed the machine was purchased on 01/23/2023. During interview with the Administrator on 11/06/2025 at 4:11 PM, she stated the filter cost $318.00, and the ice machine cost $400 27. She stated the facility was going to purchase a new machine every year, and they would purchase ice for now. 3. Observation of the dishwasher on 11/06/2025 at 10:10 AM revealed there was a brown substance on the bottom of the dishwasher below the sprayer. During interview with the Dietary Supervisor at the time of the observation, she stated the dishwasher was to be cleaned once a month and as needed. She stated she was not sure what the brown substance was on the bottom of the dishwasher. During interview with the Administrator on 11/06/2025 at 4:11 PM, she stated the dishwasher should be cleaned by the Housekeeping Aide monthly. She stated she was not sure why the machine had not been cleaned. 4. Observation on 11/06/2025 at 7:27 AM of the laundry room revealed water on the floor going from the sink to the drain in the middle of the room. The three dryer vents exited into the room. The wall had lint from the floor to the ceiling with a heavier amount near the vents that exited into the room. The two ceiling vents above the dryers	P 330	Katrina Lebard RDM 12-1-25	

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100155	A. BUILDING _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRASURE'S PERSONAL CARE HOME, INC	1308 RIVERVIEW ROAD ASHLAND, KY 41101

(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 330	Continued From page 6 were covered in plastic. An opening approximately 2 feet by 2 feet in the middle of the ceiling in the laundry room was partially covered in plastic. The five sprinkler heads in the laundry room were covered with dust and spider webs. The local Fire Marshall was contacted on 11/06/2025 at 9:06 AM, and he stated he would come to the facility. During interview with the Fire Marshall on 11/06/2025 at 2:55 PM, he stated he was not aware of the dryer vents exiting into the laundry room. He stated it could cause a mold problem. He further stated the plastic over the vent in the middle of the room could cause a fire hazard. He stated he was going to issue an order, and the facility would have 30 days to fix the issues in the laundry room. During interview with the Administrator on 11/06/2025 at 4:11 PM, she stated she was aware of the water on the laundry room floor. She stated the facility was having difficulty with finding workers to repair the water leak. The Administrator stated she was not sure why the vents on the ceiling above the dryers were covered. She stated the previous owners put the plastic on the vents. She stated she was not sure why the dryer vents exited into the room.	P 330		

Deborah Leland AOM 12-1-25