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HENDERSON MANOR I LLC	201 WATSON LANE HENDERSON, KY 42420

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P 000	Initial Comments A Complaint Survey investigating KY00047548, KY00047555 and KY00047836 was initiated on 02/03/2026 and concluded on 02/04/2026 with deficiencies cited. A deficiency was issued related to KY00047548 No deficiencies were issued related to KY00047555, KY00047836 Survey Dates: 02/03-02/04/2026 Facility Census: 46	P 000		
P 060	902 KAR 20:036 4(5) Section 4. Administration and Operation Section 4. Administration and Operation. (5) Adult protection. PCHs and SPCHs shall have written policies that ensure the reporting of allegations of abuse, neglect, or exploitation of adults pursuant to KRS 209.030, including evidence that all allegations of abuse, neglect, or exploitation shall be thoroughly investigated internally to prevent further potential abuse while the investigation is in progress. This requirement is not met as evidenced by: Based on observation, interview, record review and review of the facility policy, it was determined	P 060		

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

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the facility failed to ensure that one (1) of three (3) sampled residents(R) R1, were protected from abuse by ensuring all allegations of abuse were reported to facility administration immediately and that allegations of abuse were investigated thoroughly.

The findings include:

Review of the facility policy titled "Abuse Policy", revised 01/01/2025, revealed that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, were to be reported immediately to the administrator. A full investigation would occur, including documentation of all steps taken and the outcomes, including dates and signatures of those staff members involved in the investigation. If the allegation involved an employee, the employee would be suspended pending the investigation or reassigned to job duties without patient contact, if available. The physician and the responsible party would be notified of any incidents and the appropriate action that had been taken. The facility must provide in-services dealing with subject of abuse in an effort to help employees identify possible incidents of abuse or situations that may contribute to abuse.

Review of the facility document titled "Record of Admission" revealed that the facility admitted Resident (R)1 to the facility on 12/29/2021 with diagnoses which included traumatic brain injury, seizure disorder, and hypertension. Further review of the document revealed R1 had a State appointed Guardian.

Review of the facility incident report titled "Alleged Incident/Accident Report" dated 11/10/2025 and

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completed by Resident Aide (RA) 5 between 10:00 and 10:30 PM, revealed, RA 5 and RA6 were at the desk when R1came up to the front and started talking about spiders and bugs, saying, that the staff needed to spray his room and that some needed to do a better job cleaning, talking about RA 2 and Housekeeper (HK) 1, not cleaning like they should. About that time, RA2 came in and got defensive. She was yelling at R1, cussing him out, in his face. Then she goes out back and gets Housekeeper (HK)1. HK 1 comes in yelling at R1 and shoved his fingers in his cheek and his left side and then shoved him back telling him he was going to kick his ass. Both HK1 and R1 fell through the big doors and RA 6 was saying call the police. If I hadn't, R1 would have gotten hurt, probably bad. RA2 was yelling at R1 and RA6 and was trying to stop them. When the police arrived R5 and RA6 told them everything that happened and RA2 lied and told them that R1 had started it and punched HK1. HK1 left to avoid police and then came back. RA2 left for the rest of her shift.

Review of the time sheet for HK1 revealed that there was no clock-in or clock-out recorded on 11/10/2025. Continued review revealed that HK1 returned to work on 11/12/2025 at 10:12 PM and worked until 6:53 AM on 11/13/2025. Indicating he was not suspended for 3 days following the incident, per facility policy.

Review of the timesheet for RA2 revealed that on 11/10/2025, RA2 clocked in at 10:08 PM and clocked out at midnight. RA2 clocked in again on 11/12/2025 at 10:15 PM and worked until 6:59 AM on 11/13/2026.

Review of the employee file for HK 1 revealed a hire date of 09/10/2025. A criminal background

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check and abuse registries were checked on 09/04/2025.

Review of a document titled "Corrective Action Report" dated 11/11/2025 and signed by the Administrator, revealed, "Put employee off to investigate accusations. Spoke to all staff and the resident and the resident said he was not touched by an employee but given three days off to reflect on how to properly address situations in fractions of job duties". The report indicates that HK 1 would be suspended without pay for three (3) days. However, HK 1 did not sign the document.

Review of employee file Resident Aide (RA) 2 revealed a hire date of 02/19/2025. A criminal background check and abuse registries were completed on 02/20/2025.

In an interview with Guardianship Services on 02/04/2026 at 8:57 AM, she stated that Guardianship was not made aware of the incident between R1 and a staff member (HK1). Guardianship stated with the incident occuring late in the evening, that the facility would have called the on-call services and that that would have been documented.

Interview with R1s Guardian on 02/04/2026 at 10:59 AM, he stated that he became R1s Guardian in February 2022. He stated R1 was very polite, well-mannered, and well spoken. He stated there were some issues with him having an increase in his seizures, and that he was aware that R1s medications were being adjusted. R1's Guardian stated he was not aware of any type of behavior that R1 had. He further stated that he was made aware on 02/03/2026 about the Adult Protective Services (APS) report. He stated he was not made aware when the incident

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P 060	Continued From page 4 occurred. In an interview with R1 02/04/2026 at 12:00 PM, he stated he had been at the facility since December of 2021. R1 stated that he had a "brain injury" from a four-wheeler accident. R1 stated he had wanted to be a therapist because he loved helping people. He said he tries to help the other residents by going to the store for them to get sodas and snacks. R1 stated that RA2 and HK1 worked the night shift. He stated that when they were there, he stayed in his room to avoid any contact with them. He stated that the Administrator had changed their schedules because at one time they were working together and now they mostly don't work together. He stated that when they worked together, they were causing problems. R1 stated that he did remember R2 raising her voice at him but doesn't really remember her cursing. He stated he sometimes has memory problems because of his brain injury. R1 stated there was an altercation but would not elaborate. He stated that he was not hurt during the altercation. In an interview with Resident Aide (RA) 2 on 02/04/2026 at 12:22 PM, she stated she had been at the facility for one year. RA2 stated that on the night of 11/10/2025. She and HK1 had just gotten to work, and R1 was upset. She stated that R1 often became agitated. She stated that he was upset about his laundry, and she told him that she had already done his laundry. She stated R1 was also upset about them cleaning the floors. She stated R1 and HK1 had an argument and that R1 had refused to go to his room. She stated that R1 and another resident grabbed HK1 and shoved him. She stated after that, HK1 clocked out and went home. RA 2 stated she attempted to call the Administrator multiple times	P 060		

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and left several messages with no response. She stated the police came and took statements from everybody, and that she told them they had cameras so that R1 could be arrested for assaulting HK1, but the cameras didn't work. She further stated that she had provided the facility with it by writing it on the shift report sheet. She stated neither she nor HK1 were suspended.

In an interview with Dietary Aide (DA) 1 on 02/04/2026 at 3:50 PM, she stated that R1 was a very sweet, calm and he did not have outbursts or behaviors. DA1 stated that on 11/10/2025 RA2 and HK1 arrived at work and that R1 was complaining about the floors not being clean and that he wanted his room sprayed for bugs. RA2 became defensive and started yelling and cursing at R1. She stated she witnessed RA2 went outside to get HK1, her boyfriend and HK 1 came in and jumped on R1 and they went through the doorway and landed in the floor. DA 1 stated she told RA 5 to call the police. She stated if she remembered correctly, R1 had a seizure following that incident. She stated HK 1 or RA 2 were suspended. DA 1 further stated she was not asked to provide a statement about the incident.

In an interview with the Administrator on 02/04/2026 at 4:02 PM, she stated that she was made aware of the incident involving R1 and HK1 on 11/11/2025 at 6:19 AM. She stated she woke up to a text message from RA5. The Administrator stated that following an incident, the residents were checked on, and the guardian and APS were made aware of the incident. The Administrator stated she spoke with R1 and he denied the incident and told her HK 1 did not touch him. She stated incidents should be documented in the chart, and an incident report completed. She stated that RA 5 did not complete

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P 060	Continued From page 6 all the tasks, so she had her return to the facility at 8:00 AM to complete the task. She stated that for the investigation, she spoke to the staff but did not obtain witness statement. The Administrator brought in the shift-to-shift report book and confirmed that there was no documentation from RA2 in the report book regarding the incident. She stated if HK1 had no time recorded then he was not scheduled to work.	P 060		
P 120	902 KAR 20:036 4(10)(h) Section 4. Administration and Operation (h) In-service training. 1. Each PCH or SPCH employee shall receive orientation and annual in-service training that corresponds with the staff member's job duties. 2. Documentation of orientation and in-service training shall be maintained in the employee's record and shall include: a. Name of the individual or individuals who provided the training; b. Date and number of hours the training was given; and c. A summary of the training program's content. 3. In-service training shall include: a. Policies regarding the responsibilities of specific job duties; b. Services provided by the facility; c. Recordkeeping procedures; d. Procedures for the reporting of cases of adult abuse, neglect, or exploitation pursuant to KRS 209.030; e. Resident rights established by KRS 216.510 through 216.525; f. Adult learning principles and methods for assisting residents to achieve maximum abilities in ADLs and IADLs; g. Procedures for the proper application of	P 120		

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P 120	Continued From page 7 emergency manual restraints; h. Procedures for maintaining a clean, healthful, and pleasant environment; i. The aging process; j. The emotional problems of illness; k. Use of medication; and l. Therapeutic diets. 4. Each SPCH shall ensure that at least one (1) direct care staff member in addition to the administrator completes the mental illness or intellectual disability training workshop established by 921 KAR 2:015, Section 14, within six (6) months of hire and every two (2) years thereafter. An SPCH shall employ at least one (1) direct care staff member who has received the training. This LEVEL A is not met as evidenced by: Based on interview, record review and review of the facility policy it was determined the facility failed to ensure that each employee received orientation and annual in-service training on abuse for five (5) of 13 employees reviewed for education on abuse. Housekeeper (HK) 1 and Resident Aide (RAs) 2, 7 8 and 9. The findings include: Review of an in-service sign-in sheet revealed the Administrator provided education on abuse	P 120		

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neglect to staff on 07/22/2025. However, there were no documented signatures for 5 of 13 employees.

All employees are cross-trained for Resident Aides, Housekeeping, and Dietary positions.

1. Review of Housekeeper (HK) 1's personnel file revealed a hire date on 09/10/2025. Continued review revealed no documented evidence of in-service records/trainings provided for the employee, which included abuse and the procedures for reporting cases of adult abuse and neglect.

2. Review of Resident Aide (RA) 2's personnel file revealed a hire date of 02/19/2025. Continued review revealed no documented evidence of in-service records/trainings provided for the employee, which included abuse and the procedures for reporting cases of adult abuse and neglect.

3. Review of RA 7s personnel file revealed a hire date of 04/232025. Continued review revealed no documented evidence of in-service records/trainings provided for the employee, which included abuse and the procedures for reporting cases of adult abuse and neglect.

4. Review of RA 8's personnel file revealed a hire date of 11/13/2025. Continued review revealed no documented evidence of in-service records/trainings provided for the employee, which included abuse and the procedures for reporting cases of adult abuse and neglect.

5. Review of RA 9's personnel file revealed a hire date of 11/13/2025. Continued review revealed no documented evidence of in-service

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P 120	Continued From page 9 records/trainings provided for the employee, which included abuse and the procedures for reporting cases of adult abuse and neglect. In an interview with the Administrator on 02/04/2026 at 3:46 PM, she stated she provided abuse education upon hire. She stated she went over abuse, but no signatures were obtained. She stated there were postings throughout the facility on abuse. She stated she did education on abuse in July 2025 after the annual survey. She further stated she had not provided any other education on abuse since 07/2025. The Administrator stated that an in-service was done today on abuse for the staff who were working.	P 120		
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.	P 330		

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This requirement is not met as evidenced by:
Based on observation, interview, record review and review of the facility policy, it was determined the facility faciled to ensure the condition of the overall environment was maintained to ensure the safety and well-being of residents, personnel, and visitors related to Resident 3 observed t0 be smoking in her room.

The findings include:

Review of facility policy titled "Smoking Policy", dated 01/01/2025, revealed, "residents who choose to smoke tobacco must smoke outside, smoking was not permitted anywhere inside the facility, residents could hold their cigarettes and lighters, in the event that there was an incident, depending on the severity, the resident/guardian, if applicable, would be given a warning. If an incident occurred again, there would be a conversation about next steps to ensure the safety of the resident and all others".

Review of document titled "Smoking Disclosure, Consent and Release, dated 01/01/2025, revealed, it was the policy of the facility to promote the rights, health and safety of all residents. Smoking poses serious risk to residents' health and safety and is against medical advice. However, we acknowledge and respect an individuals right to smoke. Residents would not be supervised while smoking. The residents desire to smoke may prevent hazardous conditions to the resident staff and visitors. Continued review revealed the facility

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was outside smoking only. The facility had provided fire safety ashtrays in the outside area for proper disposal of cigarette butts. Failure to abide by this agreement may result in the termination of a resident's smoking privilege.

Review of record revealed the facility admitted R3 to the facility on 11/19/2024 with diagnoses of paranoid schizophrenia, epileptic seizures and type 2 diabetes.

Observation on 02/03/2026 at 1:30 PM, during facility tour, revealed Resident 3 was in her room sitting on the side of her bed with her back to the door. Room appears smokey and smell of cigarettes. There are cigarette ashes and nine (9) cigarette butts in the floor at the bedside. Spoke to R3 and asked if she was ok and she stated yes. No observation of cigarette but R3 appeared to be hiding something between her legs.

Observation in R3's room on 02/04/2026 at 3:30 PM, revealed cigarette butts in the floor at the bedside and cigarette ashes were noted in her lap.

Interview with R3 at time of observation, she stated she had been at the facility for about one (1) year. R3 denied smoking in her room and stated she went outside to smoke. She further stated that staff never talked to her about smoking.

Review of "Nurses Note" dated 02/07/2025 at 6:50 PM revealed resident was smoking in her room, when asked to put it out, she did.

Review of "Nurses Note" dated 07/24/2025 at 5:00 PM, revealed resident was caught smoking in her room. When asked to put it out she said

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P 330	Continued From page 12 "no". Interview with Resident Aide (RA) 1 on 02/04/2026 at 10:39 AM, she stated R3 smoked in her room everyday. She stated there was always cigarette ashes and butts in her floor. She stated R3 did not listen when she was told she could not smoke in her room. Interview with Dietary Aide (DA) 1 on 02/04/2026 at 3:50 PM, she stated she was scared of R3 and did not bother her. She stated R3 was a handful and when she did not get her way she would scream and curse and slam doors. Interview with the Administrator with the Regional Nurse present, on 02/04/2026 at 3:58 PM, she stated she was aware that R3 smoked in her room "off and on". She stated R3 would stop for a while when she was told she could not smoke in her room, but that she always does it again. She stated their policy says to take smoking privileges away. She further stated that R3 was a paranoid schizophrenic and almost seven (7) feet tall and she was not going to tell her she could not smoke. She stated she would have to call the police or 911. Interview with Regional Nurse on 02/04/2026 at 3:58 PM, she stated discharging R3 was not really an option for them and they were to provide a safe place for residents. She stated with R3's behaviors, diagnosis and history that was near impossible.	P 330		