STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100168	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR I LLC	317 ODDVILLE AVENUE CYNTHIANA, KY 41031

(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 Complaint Survey investigating complaints KY00042550, KY00043308, and KY00043341 was initiated on 09/04/2024 and concluded on 09/06/2024. KY00042550 and KY00043308 identified no deficient practice. KY00043341 identified deficient practice related to the complaint. Additional deficient practice was identified unrelated to the complaints.	P 000		
P 150	902 KAR 20:036 4(11)(b)4 Section 4. Administration and Operation Section 4. Administration and Operation. (11) Medical records. (b) Each record shall include: 4. Report by the physician or health care practitioner acting within the practitioner's scope of practice, documenting completion of an annual medical evaluation of each resident; This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policies, the facility failed to maintain medical records that included the annual medical evaluation for 2 of 11 sampled residents, Resident (R) 3 and R11. Review of the facility's policy titled, "General Duties and Responsibilities for All Three Shifts," not dated, revealed that charts were to be kept properly and filled out in detail.	P 150		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/03/24

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P 150	Continued From page 1 Review of the facility's policy titled, "Health Care Policy," not dated, revealed that each resident's health care was under the continuing supervision of an attending physician who saw the resident as needed and in no case less than annually. It was the responsibility of the facility to see that the physician's orders were carried out and to maintain a complete medical record for each resident. Review of R3's medical record revealed there was no documentation of an annual medical assessment. Review of R11's medical record revealed there was no documentation of an annual medical assessment. In an interview with the Administrator on 09/05/2024 at 2:53 PM, she stated she would have to request the annual medical examination for R3 and R11. She stated they were put in the online electronic record for any resident. In an interview with the Regional Manager (RM) on 09/05/2024 at 4:54 PM, she stated the residents' annual medical evaluations were completed once a year and were filed in the paper charts by the Administrator. An attempt was made to interview the owner of the facility by phone. A voicemail message was left on 09/05/2024 at 5:12 PM and the call was never returned.	P 150		
P 210	902 KAR 20:036 5(1)(a) Section 5. Provision of Services Section 5. Provision of Services.	P 210		

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P 210	Continued From page 2 (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. This requirement is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to provide basic health and health related services related to supervision monitoring for 1 of 11 sampled residents, Resident (R)10. On 08/17/2024 R10 left the facility without staff knowledge and without supervision. She was later found lying in a ditch area beside a two (2) lane highway and transferred to the Emergency Room of the local hospital. The findings include: Review of the facility's policy entitled, "Incident	P 210		

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and Accident Reporting," not dated, revealed that a written report would be completed on all residents involved in an accident, injury, illness, and medication error. These reports would then be given to the Physician and to the Administrator to review and sign.

Review of the facility's policy entitled, "Resident Monitoring Policy," dated 12/03/2013 revealed visual surveillance would be performed, by Parkside Manor LLC Personnel daily. Residents' wellbeing would be checked on daily, for visual safety at mealtimes and at medication times. However, if a resident should leave the premises of Parkside Manor, it was understood that Parkside Manor would not be responsible for any resident's actions or physical wellbeing while away from the premises of the facility.

Review of the facility's policy entitled, "Resident Assessment Notification of Physician," not dated stated that the attending physician should be notified when there was a significant change in a condition of a resident.

Review of the facility's policy that was not titled nor dated, revealed that each resident of Parkside Manor had the right to come and go as he/she wished. There would be a book at the nurses' desk for them to sign out when they left and sign in when they returned.

Review of R10's medical chart revealed the facility admitted R10 on 03/03/2020 with diagnoses to include depressive disorder, borderline intellectual functioning, hypothyroidism, and hypokalemia.

Review of R10's Progress Notes from her chart revealed that on 08/17/2024 at 11:36 AM resident

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was found lying in the middle of a ditch by a jogger. An ambulance and the police were called. The jogger stated that she said something about her family. Her sister who was her guardian was called and management was notified.

A review of R10's hospital report revealed that she denied any complaints of pain or discomfort. She stated that she did not remember falling and had no memory of how she came to be in the ditch. Her family reported that she had problems for years and they were only recently made aware that her memory had become foggy, and this led to her wandering. There was no evidence of trauma other than some abrasions. She was found to have low blood pressure and altered mental status. R10 was discharge and returned to the facility.

Observation of where R10 was said to be lying, on 09/06/2024 at 10:18 AM and 12:22 PM respectively, revealed in one account it was 900 feet from the front porch of the facility and in a second account it was 0.2 miles from the facility. Both were near a busy two-lane road and in a ditch. R10 did not cross the road in either instance. The day the event occurred, it was 65 degrees Fahrenheit for the low and 88 degrees Fahrenheit for the high.

Observation of the sign in/out binder on 09/05/2024 at 11:33AM revealed that there were no sign in sheets in the binder. The binder was an empty black binder sitting on the table by the main door to the facility. Further review revealed no documented evidence R10 had signed out to leave the facility on 08/17/2024.

In an interview on 09/04/2024 at 1:17 PM, R10

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stated that she had been at the facility for 3 years. She stated she did not remember being found lying in a ditch. She stated that she only remembered going to the hospital. R10 stated that she went out for fresh air and a walk and she did not tell anyone before leaving the facility. R10 was not aware she needed to sign out or to let the staff know before leaving. She stated that she had not been out of the facility since that day and that she did not go out often.

In an interview on 09/04/2024 at 1:55 PM with the Ombudsman, it was revealed that R10 did not leave her room much. It was odd that she was out of the facility, she stated. The Ombudsman spoke with her after the incident and asked her why she went out. R10 stated that she did not remember going out. The Ombudsman stated that the aides said that she was in line to get money and then she left. They thought that she went back to her room. They went to check on her and that was about the time the police officer arrived at the facility.

In an interview on 09/04/2024 at 6:03 PM with the Police Officer called to the scene, he stated he received a call about a lady lying in the ditch off the road in front of the facility at 11:05 AM. Due to him being at another call he was unable to arrive at the scene until 11:20 AM and EMS was already there. He stated that he tried to speak with R10, and she was unable to answer questions at that time. R10 was transferred to a nearby hospital. He went to the facility at 11:26 AM and found a staff member on the porch talking to R10's sister. He stated that the staff member told him that she had only been gone five (5) minutes, but it had been 20 minutes since
the call occurred.

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P 210	Continued From page 6 In an interview on 09/05/2024 at 9:57 AM with Medicine Aide (MA)1, she stated there were sign in/out sheets for the residents in a binder by the door. Residents could sign out or tell a staff member when leaving. MA1 stated that some of the residents liked to go across the street to the park and play basketball. She stated that these sign out sheets were kept on file in the Administrator's office. MA1 also stated that if a resident who went out did not return in 2 hours staff started getting worried. Most of the residents were never gone that long, she stated. MA1 said that how often a resident was checked on depended on what their guardian wanted. During the day this was typically every 30 minutes to one (1) hour. MA1 stated that she was the MA on duty the day that R10 left the facility. She stated it was the day that residents got their monthly pay out and that R10 was in line to get her money. She stated that she told her that she was next to get her money and that she would get it soon. When MA1 turned to count out the money for the resident in front of R10 in line and then turned back, R10 was gone. MA1 thought that R10 had returned to her room. When MA1 was finished counting out money for the other residents that were in line behind R10, MA1 went to R10's room. She was not there. At this time another resident (she did not remember who) said that R10 was down by the road in the ditch laying down and Emergency Medical Services (EMS) and the police had arrived. MA1 stated that she called R10's sister to let her know what occurred and that EMS took her to the hospital to be checked out. She was released later that day, no injuries. The police came to the facility to talk with MA1 and to get R10's information for his report. In an interview with Family Member (F)2 on	P 210		

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09/04/2024 at 6:39 PM , she stated that she was notified about this incident. F2 felt like R10 was overly medicated and got disoriented and wandered off. F2 stated R10 was in the process of getting moved to a facility with locked doors for her safety. F2 stated that R10's cognition was worsening.

In an interview 09/06/2024 at 9:33AM with Aide (A) 1, she stated she was working the day R10 wandered off and was found in the ditch. She stated that it occurred after breakfast, around 10:00 AM. R10 was not gone more than 10 minutes she stated before another resident said that she was lying in a ditch on the side of the road and at that same time she stated that she heard sirens. She revealed that R10 had been in line for her monthly payout and when A1 and MA1 looked back from counting money, she was gone. A1 thought that R10 had just gone back to her room. A1 stated that to her knowledge R10 did not leave the facility and had only wandered away, unsupervised, once before.

In an interview with the Advance Practical Registered Nurse (APRN) on 09/05/2024 at 9:09 AM she stated that before and after visits revealed there were no changes in R10's mental, psychosocial, or physical well-being. The APRN stated that she had not seen any change in her mentality or her behaviors.

In an interview on 09/05/2024 at 4:54 PM with the Regional Manager (RM), she stated the amount of time a resident could be out before someone started to worry or call the police to look for them went on a person-by-person basis. If a resident normally went out, then they would not worry so much as opposed to someone that never or rarely went out. For residents like R10 that never left

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P 210	Continued From page 8 the building and was found gone, the facility would report it immediately to the police. If a resident was gone after dark they would report it to the police. The RM stated that R10 had memory issues that had not yet been diagnosed. The RM used to be the Administrator at this facility and was familiar with R10. She stated that R10 would tell them she did not know where she was, and this was a sign that she was going to try to wander away from the facility. An attempt was made to interview the owner of the facility by phone. A voicemail message was left on 09/05/2024 at 5:12 PM and the call was never returned. In an interview with the PNP on 09/05/2024 at 5:14 PM, he stated that he saw R10 monthly. R10 had wandering behaviors but those behaviors had decreased due to behavioral modifications. He stated that he did not remember the incident with her lying in the ditch only that within the last month that R10 had wandered away from the facility. The PNP stated that he had not seen any worsening in the cognition of R10 recently. In an interview on 09/06/2024 at 10:56 AM with the Administrator, she stated R10 was found by the road at the bottom of the steps that led into the yard. She stated resident checks were done throughout the day at the facility. All residents that leave the facility needed to sign in/out or tell the staff. The Administrator further stated those residents that commonly left the facility were on a routine.	P 210		
P 320	902 KAR 20:036 5(3)(b)1 Section 5. Provision of Services	P 320		

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P 320	Continued From page 9 Section 5. Provision of Services. (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (b) Housekeeping and maintenance services. 1. A PCH or SPCH shall: a. Maintain a clean and safe facility free of unpleasant odors; and b. Ensure that odors are eliminated at their source by prompt and thorough cleaning of commodes, urinals, bedpans, and other sources. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility failed to maintain a clean and safe facility, free of unpleasant odors, and failed to ensure odors were eliminated at their source through prompt cleaning. The findings include: Review of the facility's policy entitled, "Duties of First Shift-Both First and Second Floors," not dated, revealed that Aides would be responsible for cleaning which included sweeping and mopping all floors, straightening, and dusting rooms, and changing bed linens as needed. All shifts were responsible taking out garbage to the	P 320		

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dumpster. The policy did not mention cleaning the bathrooms.

Review of the facility's police entitled, "Second Shift 3-11," revealed they were responsible for doing laundry left from first shift and for taking the garbage to the dumpsters.

Review of the facility's Nursing Aide Job Duties revealed that the nursing aide cleaned and tidied the patients' rooms, cared for flowers, changed bed linens, ran errands, directed visitors, collected and bagged soiled linens and stored clean linens, and discharged household duties such as cleaning commodes, sewing, and cleaning equipment for general use.

Review of the facility's policy, "Provision of Residential Care Services," not dated, revealed that facility would maintain a clean and safe facility, free from unpleasant odors. Soiled clothing and linens should receive immediate attention and should not accumulate. Odors should be eliminated at their source by prompt and thorough cleaning.

Observation, upon entry to the facility at 7:53 AM on 09/04/2024 revealed a large stain of dried vomit on the steps leading into the facility.

Observation of the nurses' station at 8:03 AM on 09/04/2024 revealed the walls and the floors appeared dirty. The walls had dried black and brown flecks. The floor had a black dirty substance on it.

Observation at 8:29 AM on 09/04/2024 of the first-floor women's bathroom closest to the front entrance, revealed it smelled strongly of urine. There was brown matter that Surveyor thought

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was feces splattered on the wall beside the toilet. Where the toilet was attached to the floor there was a black substance coating the caulk. A large black bug was observed crawling across the floor.

Observation on 09/04/2024 at 8:38 AM of the upstairs hallway, revealed there was a trash bag containing trash sitting on the floor. It contained trash and a brown substance that looked like feces.

Observation on 09/04/2024 at 8:40 AM of the upstairs bathroom revealed the floor in front of the toilet was saturated with urine. There was a large puddle. The bathroom smelled strongly of urine.

Observation on 09/04/2024 at 8:53 AM of the men's bathroom closest to the front entrance revealed it was dirty. The caulk around the base of the toilet was black. It smelled strongly of urine.

Observation on 09/04/2024 at 11:21 AM of rooms 35, 37, 38, 39, and 40 revealed they all had dirty floors. They were blackened with dirt. Room 36 contained two beds that had soiled linens on them. Room 37 had a dried, sticky substance spilled in the floor beside the bed.

Observation on 09/04/2024 at 11:15 AM of the men's shower room on the first floor, revealed there was a black ring around the base of the toilet where the caulk was located. The floors, walls, and shower stall was dirty and had brown and black matter flecked upon it. It smelled like urine.

Observation on 09/04/2024 at 2:57 PM revealed the bathroom on the second floor still had a

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P 320	Continued From page 12 strong odor of urine. The urine on the floor had dried. Observation on 09/05/2024 at 8:43 AM revealed that the women's bathroom on the first floor by the front entrance smelled strongly of urine. The brown matter was still on the walls from the day prior. The floors were dirty and had black spots on it. The men's bathroom on the first floor by the front entrance smelled like urine. Observation on 09/05/2024 at 8:44 AM revealed the women's shower room on the first floor had dirty floors, smeared with a black substance. The toilet was dirty and needed flushing. There was urine on the toilet seat. Observation on 09/05/2024 at 8:46 AM revealed the men's shower room had a dirty floor, with blackened caulk around the toilet base. Observation on 09/05/2024 at 8:48 AM revealed the upstairs bathroom had a black soiled area around the base of the toilet and the floor in front of the toilet was soaked with urine. The bathroom smelled strongly of urine. In an interview with Resident (R)1 on 09/04/2024 at 8:12 AM he stated he tried to help by cleaning the facility. He stated that he cleaned up the puke on the front steps and had tried to keep the bathroom on the second floor clean, but someone kept urinating in the floor and not in the toilet. R1 stated he wished they would give him gloves to wear when cleaning up vomit and urine. In an interview with R6 on 09/04/2024 at 8:44 AM, he stated the upstairs bathroom, the one which R6 used, was dirty sometimes and there would be urine in the floor.	P 320		

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P 320	Continued From page 13 In an interview with R9 on 09/05/2024 at 8:55 AM, he stated the facility finally got the sinks working in the men's and women's shower rooms again. They had not worked for a while due to them being clogged up. He stated that they get low on hand soap frequently and sometimes run out of toilet paper. In an interview with the Maintenance Director (MD) on 09/04/2024 at 1:23 PM, he stated the black substance around the bases of the toilets was where the caulk has turned black from urine causing dirt to stick to the caulk. He stated to get rid of it they would have to remove the blackened caulk and replace it with new caulk. The MD stated the Aides were the ones who cleaned the bathrooms. They also cleaned the residents' rooms and swept and mopped the floors in the common areas. He stated certain rooms got cleaned each day and it rotated until all were cleaned. In an interview with Medication Aide (MA)1 on 09/05/2024 at 9:57 AM, she stated Aides were responsible for cleaning the bathrooms. She stated the facility did not employ houskeeping staff. She stated that there was no documentation of when the bathrooms were cleaned. MA1 stated she and the other Aides did residents' laundry, swept and mopped the floors, change the residents' bed linens, and took out the trash. In an interview with A1 on 09/06/2024 at 9:33 AM it was revealed that the Aides cleaned the resident rooms, and the Medicine Aides washed the residents' laundry. She stated that the bathrooms were to be checked three times per shift. Checking the bathrooms, she stated,	P 320		

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	100168	A. BUILDING: _____ B. WING _____	C 09/06/2024

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entailed that they got cleaned, mopped, stocked and the trash taken out. She stated that there were no cleaning logs for the bathrooms.

In an interview with the Administrator on 09/05/2024 at 10:50 AM it was revealed that her expectation was that the bathrooms got rounded on every two hours. During the rounds the bathrooms should be cleaned, restocked, and the trash taken out. She stated that the shower rooms should be cleaned as often as the other bathrooms, every two hours. Bathrooms should get cleaned immediately if a resident reports to staff they were dirty. The floors in the facility got mopped once a shift. The staff were the ones that clean the residents' rooms, she stated. Rooms got cleaned once or twice a week. Each day, 5 or 6 rooms were thoroughly cleaned. She stated they could clean the entire first floor in a week. The Administrator stated she did spot checks to make sure bathrooms and resident rooms were getting cleaned. She did not keep a paper log of the audits of the cleaning or checkoff lists for the Aides to complete when they clean.

In an interview with the Regional Manager on 09/05/2024 at 4:54 PM, she stated A1 was the housekeeper as well as an Aide. She stated A1 should be cleaning the common areas of the facility. She stated her expectation was that the bathrooms get cleaned every two hours. She stated the wax rings on the toilets were replaced several months ago and that they had fixed the issue with the black substance around the base of the toilets.

An attempt was made to interview the owner of the facility by phone. A voicemail message was left on 09/05/2024 at 5:12 PM and the call was never returned.

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P 370	902 KAR 20:036 5(5)b Section 5. Provision of Services Section 5. Provision of Services. (5) Activity services. (b) All PCHs and SPCHs shall meet the requirements established in subparagraphs 1. through 8. of this paragraph relating to the provision of activity services. 1. Staff. The administrator: a. Shall designate a staff member to be responsible for the activity program; and b. May accept services from a volunteer group to assist with carrying out the activity program. 2. There shall be a planned activity period each day. 3. The schedule shall be current and posted. 4. The activity program shall be planned for group and individual activities, both within and outside of the facility. 5. The staff member responsible for the activity program shall maintain a current list of residents in which precautions are documented regarding if a resident's condition might restrict or modify the resident's participation in the program. 6. A living or recreation room and outdoor recreational space shall be provided for residents and their guests. 7. The facility shall provide supplies and equipment for the activity program. 8. Reading materials, radios, games, and TV sets shall be provided for the residents.	P 370		

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This requirement is not met as evidenced by:
Based on observation and interview, the facility failed to provide social and recreational activities to the residents on a consistent basis.

Observation on 09/04/2024 at 1:15 PM revealed that there were 13 residents sitting in the dining room watching television (TV) and 10 residents sitting on the front porch smoking.

Observation on 09/04/2024 at 1:17 PM revealed Resident (R) 10 was sitting at a dining room table staring at the blank wall.

Observation on 09/05/2024 at 10:37 AM revealed there was a bulletin board in the hallway with the facility's menu posted and some pictures of the residents posted; however, there was no observation of an activities calendar posted.

In an interview with the Ombudsman on 09/04/2024 at 1:55 PM, she stated when the new owners took over the facility they eliminated the position of activity's director.

In an interview with R9 on 09/05/2024 at 8:55 AM, he stated the facility had movie night occasionally but he wanted them to have more for the residents to do. He stated there were not activities done daily.

In an interview with Aide (A) 1 on 09/06/2024 at 9:33 AM, she stated sometimes they play Bingo with the residents, which was done when she had extra money to buy prizes for the residents. She stated residents can go to church if they want to

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but the facility does not schedule outings. A1 confirmed the facility did not provide an hour of activities for the residents each day, and she had asked the owner and the Regional Manager (RM) for money to provide activities, however it was not in the budget. She further stated there was nothing for the residents to do, the facility did have some puzzles and coloring sheets, but there were not many supplies for activities. A1 stated residents would "hang out" on the steps or porch, walk to the park across the street, or watch TV.

In an interview with the Administrator on 09/05/2024 at 10:50 AM, she stated the facility did not have an activity's director. She further stated Aide (A) 1 would do activities with the residents sometimes, a couple of times a week, with examples being Bingo, movie night, and cornhole. She stated most of the residents would not participate, and she had tried to get them to go outside to do things.

In further interview with the Administrator on 09/05/2024 at 2:53 PM, she stated the facility had an activities schedule, though confirmed it was not posted anywhere.

In an interview with the Regional Manager (RM) on 09/05/2024 at 4:54 PM, she stated the facility did not have an activities director but the administrator would assign an aide daily to do an activity with the residents. She further stated they only had to provide one hour of activities per day to the residents. The RM stated the activities calendar was posted by the dining menus on the bulletin board, but that residents often like to remove it.

An attempt was made to interview the owner of the facility by phone. A voicemail message was

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P 370	Continued From page 18 left on 09/05/2024 at 5:12 PM and the call was never returned.	P 370		