Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100033	A. BUILDING _____ B. WING _____	10/09/2025

RECEIVED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS II HEALTH	250 WEST CENTRAL AVENUE ASHLAND, KY 41101

JAN 13 2025
CHFS Office of Inspector General
Division of Health Care - EB
BT Received by

(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	(X5) COMPLETE DATE
P 000	Initial Comments A Relicensure and Complaint Survey was initiated on 10/07/2025 and concluded on 10/09/2025 with deficient practice related to the Relicensure Survey. Deficiencies were issued related to KY00040795 at P0057, P0059, and P0315. Deficiencies were issued related to KY00042868 at R0805. Deficiencies were issued related to KY00045945 at P0058. Deficiencies were issued related to KY00046303 at P0370 and R0805. Deficiencies were issued related to KY00046676 at P0105 and R0805. Deficiencies were issued related to KY00047288 at P0105 and P0355. No deficiencies were issued related to KY00036913, KY00040874, KY00041473, KY00041513, KY00045076, KY00046300, KY00046449/KY00046454, and KY00046671. Based on the findings of this survey, the facility failed to have an effective system in place to ensure thorough pre-employment background checks were performed, failed to ensure each resident's rights were protected related to being free from mental and physical abuse, and failed to thoroughly investigate allegations of abuse to prevent further abuse. Review of Caregiver (CG) 1's criminal record, dated 09/10/2024, revealed two separate cases that involved criminal charges. The criminal record check was done by a third-party vendor and not directly through the Administrative Office of the Courts or the Kentucky State Police. The facility did not investigate to determine what the	P 000	P000 Based on findings of this of this facility failed effective system in place to ensure pre employment background check to ensure resident being free from mental and physical abuse. CG1 criminal record dated 9-10-24 revealed two separate criminal charges. The background check from a third party vendor didnt't specify what the charges was.Facility has to go thru KSP and or AOC to get information for pre employment and to have all information is needed to ensure all residents will be safe around the individual being around residents. CG1 was determined by video that R6 had recorded Cg1 calling R6 mental and a fucking retard when asked for a washcloth and CG1 was rude to him as well.	10/20/25

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

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P 000	Continued From page 1 criminal charges were or when they occurred. Review of a video, dated 06/21/2025, and report from Resident (R) 6, revealed R6 was called "mental" and a "fucking retard" by CG1 when R6 asked for a washcloth. During an interview with the Administrator on 10/08/2025, he stated the Owners were fully aware of the behaviors and incidents related to CG1. The Administrator stated he had expressed concerns regarding the behaviors of CG1 to the previous Administrator and Owners on multiple occasions; however, nothing was done to address CG1's behaviors toward the residents. Review of CG1's employee file revealed no disciplinary actions were taken for the incident with R6 on 06/21/2025. Review of CG1's documented "disciplinary action," dated 08/01/2025, revealed CG1 received his first notice related to his behavior/actions to be unsatisfactory for threatening a client. Review of a video, dated 09/01/2025, revealed CG1 was seen charging after R7 in the dining room, after R7 asked for more milk for his cereal, and then CG1 followed the resident to the front porch. In the video, CG1 was observed backing R7 against the wall, and CG1 pointed his finger in R7's face while he was leaning in toward R7 in an aggressive manner. Further review revealed R7 defensively dropped his head and shoulders during the incident. Review of the text messages between the Administrator and Owners of the facility, dated 09/23/2025 at 1:03 PM, indicated the owners were notified of the occurrence that took place on 09/01/2025 between R7 and CG1.	P 000	continue During interview Admin said Owners were fully aware of CG1 behaviors incidents. Admin talked to CG1 before about watching his tone on how the way he talks and interreacts with residents. CG1 1 was found to gulity of verbal abuse towards residents. CG1 was seen from video charging after R7 in dining room due to R7 asked for milk on his cereal due to he had no teeth . Video showed CG1 backed R7 against the wall and point ing his finger in his face. R7 went to front porch he can feel CG! behind him coming at him in aggressive manor. SA did not know about any of this. SA told Admin that she is to about all that goes or happens in the facility. Owner didn't know about this situation as well.	

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P 000	Continued From page 2 Further record review revealed no documentation of disciplinary actions taken against CG1 after the incident with R7 on 09/01/2025. Review of the facility's staffing schedule revealed CG1 was still employed by the facility and was working directly with the residents, on night shift, on 10/08/2025 and 10/09/2025. During an interview with the Senior Administrator (SA) on 10/09/2025 at 10:45 AM, she stated she observed the criminal charges listed on CG1's third-party vendor background check, the facility's electronic background check system used to review criminal history results. The SA stated she did not further investigate the nature of the charges or determine whether the employee was appropriate to work with residents. The Senior Administrator stated she had no knowledge of CG1's behaviors toward the residents, there was no internal investigation of either incident of abuse, and there was no documented evidence either incident was reported to the Cabinet as required by Kentucky Revised Statute (KRS) 209.030. Imminent danger was identified on 10/09/2025 related to the facility's failure to ensure criminal background checks, including Caregiver (CG) 1's background check, were performed through the Kentucky Administrative Office of the Courts and/or through the Kentucky State Police prior to the employee's interaction with residents. The facility's failure to enforce its zero-tolerance abuse policy when the same employee verbally abused Resident (R) 6 and R7 and was permitted to continue working without disciplinary action created substantial risk that serious mental or physical harm to the resident(s) could occur. The	P 000	P000 SA and Owner walked around ar talked to each resident and told that they can call us at anytime and they can tell us anything and don't be afraid to tell is if someone being mean to them. We are here to keep you safe from harm and protect all of you. SA did state she saw CG1 background check and from here on out pre employment checks will be done by KSP or AOC. SA did not about CG1 behavior toward residents. CG1 was fired on 10-8-25 termination letter was included and CG1 was informed of his termination and was reported on the abuse registry on 10-8-25.	10/12/25

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P 000	Continued From page 3 facility was notified of the Imminent Danger and Type "A" Citation on 10/09/2025. A Type "A" Citation was issued to the facility on 10/17/2025.	P 000		
P 100	902 KAR 20:036 4(9)(a-b) Section 4. Administration and Operation Section 4. Administration and Operation. (9) Tuberculosis Testing. (a) All employees of a PCH or SPCH shall be screened and tested for tuberculosis in accordance with 902 KAR 20:205. (b) Residents of a PCH or SPCH shall be screened and tested in accordance with 902 KAR 20:200. This requirement is not met as evidenced by: Based on interview, review of the facility's employee files, and review of the facility's policy, the facility failed to ensure staff received annual tuberculosis (TB) screening as required by the facility's policy and the agency's TB prevention and control procedures. This failure resulted in 2 of 7 sampled staff, Caregiver (CG) 1 and CG6 not receiving required annual TB testing, which placed residents and staff at potential risk of exposure to communicable disease. The findings include: Review of the facility's policy titled, "Tuberculosis [TB] Prevention and Control," (undated), revealed	P 100	P 100 Requirement not met For Tb screening before working at the f facility and done yearly after that. Having a Tb screening ensure resident are safe from diseases and prevent widespread of Tb. Upon hiring it is and will be required for TB screening with the background criminal check before the first day of employment.	

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P 100	Continued From page 4 TB screening and testing would be required for every employee upon hire and annually thereafter to identify any employee showing signs of possible TB infection or disease. 1. Review of CG1's employee file revealed the last TB test was completed in September 2024. The file lacked both a documented hire date and evidence that the required annual TB screening was completed for 2025. 2. Review of CG6's employee file revealed a hire date of 05/10/2024. The file lacked documentation of any TB testing or screening completed at the time of hire or annually thereafter. In an interview with the Administrator on 10/08/2023 at 1:55 PM, he stated he was responsible for maintaining the employee files and the TB screening. The Administrator stated CG3 should have had a TB test at the time of hire. In an interview with the facility's Owner on 10/08/2025 at 1:45 PM, she stated keeping employee files up-to-date, including the staff TB testing documentation, was the responsibility of the Administrator.	P 100	continue P 100 CG1 tb screening was overlooked as also for CG6. CG1 is no longer employed at the facility. Admin will make sure all employees are updated with tb screening by making at list when the employees are due to get their yearly.	10/15/25
P 105	902 KAR 20:036 4(10)(a-e) Section 4. Administration and Operation Section 4. Administration and Operation. (10) Personnel. (a) In accordance with KRS 216.532, a PCH or SPCH shall not employ or be operated by an individual who is listed on the nurse aide and home health aide abuse registry established by	P 105	P 105 section 4	

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P 105	Continued From page 5 906 KAR 1:100. (b) In accordance with KRS 209.032, a PCH or SPCH shall not employ or be operated by an individual who is listed on the caregiver misconduct registry established by 922 KAR 5:120. (c) A PCH or SPCH shall obtain a criminal record check on each applicant for initial employment in accordance with KRS 216.789 and 216.793. (d) Current employee records shall be maintained on each staff member and contain: 1. Name and address; 2. Verification of all training and experience, including evidence of current licensure, registration, or certification, if applicable; 3. Employee health records; 4. Annual performance evaluations; and 5. Documentation of compliance with the background check requirements of paragraphs (a) through (c) of this subsection. (e) Each employee shall be of an age in conformity with state laws. This requirement is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a criminal record check was completed on each applicant before initial employment in accordance with Kentucky Revised Statutes (KRS) 216.789 and	P 105	P 105 continue Findings included that AA along with CG1, CG2, CG5, CG7 ,CG10 and CG11 didn't have background checks Back grounds checks are now being done by the KSP and or AOC to get proper details on activities' SA on all potential new employees will go thru KSP and r AOC to get accurate charges of dates and out come of each charge.	

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P 105	Continued From page 6 216.793 for 7 of 8 sampled employees, the Assistant Administrator, Caregiver (CG) 1, CG2, CG5, CG7, CG10, and CG11. The findings include: Review of KRS 216.789 revealed a long-term care facility and a health-care services agency providing staff to a nursing facility, or assisted-living community shall not knowingly employ a person in a "direct care services" position if that person had been convicted of a felony related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or a sexual crime. The statute further required the facility or agency to request all conviction information from the Kentucky Justice and Public Safety Cabinet for each applicant for employment. It permited only temporary employment pending receipt of that information. 1. Review of CG1's personnel file revealed no documented hire date. The facility obtained a background check, on 09/10/2024, from a third-party vendor on 09/10/2024, which identified three criminal records. However, the facility failed to obtain the required criminal record information from the Kentucky Court System to verify and determine the nature of the offenses. Further review revealed CG1 was terminated on 10/08/2025 for verbally abusing two residents. 2. Review of CG5's personnel file revealed a hire date of 02/21/2025. The facility obtained a background check, on 03/16/2025, from a third-party vendor, which identified three criminal records; however, the facility failed to obtain the required criminal record information from the Kentucky Court System to verify and determine the nature of the offenses.	P 105	P 105 continue The review of CG1 file background from third party vendor which identified three criminal records that did not list what charges where CG1 was terminated on10/8/25 for verbal abuse on two residents. Review CG5 file revealed that back check was done after hiring which not happen again and will go thru KSP or AOC from here on out.	11/12/25

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P 105	Continued From page 7 3. Review of CG2's personnel file revealed a hire date of 05/10/2024. The facility obtained a background check, on 10/09/2025, from a third-party vendor, which identified three criminal records; however, the facility failed to obtain the required criminal record information from the Kentucky Court System to verify and determine the nature of the offenses. 4. Review of CG7's personnel file revealed a hire date of 09/26/2025. The facility obtained a background check, on 10/05/2025, from a third-party vendor, which identified four criminal records; however, the facility failed to obtain the required criminal record information from the Kentucky Court System to verify and determine the nature of the offenses. 5. Review of CG10's personnel file revealed no documented hire date. The facility obtained a background check, on 07/21/2025, from a third-party vendor, which identified two criminal records; however, the facility failed to obtain the required criminal record information from the Kentucky Court System to verify and determine the nature of the offenses. 6. Review of CG11's personnel file revealed a hire date of 03/08/2024. The facility obtained a background check, on 03/17/2024, from a third-party vendor, which identified 12 criminal records; however, the facility failed to obtain the required criminal record information from the Kentucky Court System to verify and determine the nature of the offenses. 7. Review of the Assistant Administrator's (AA) personnel file revealed a hire date of 08/16/2024. The facility obtained a background check, on	P 105	P 105 CG2 background check will be done KSP and or AOC to get accurate background CG7 background check will be done KSP and or AOC to get accurate background 11/12/25 CG10 background check will be done by KSP and or AOC to get accurate background CG11 background check will be done by KSP and or AOC for accurate Background AA background check will be done by KSP and or AOC for accurate background	

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P 105	Continued From page 8 09/25/2024, from a third-party vendor, which identified one criminal record. However, the facility failed to get the required criminal record information from the Kentucky Court System to verify and determine the nature of the offenses. In an interview with the Administrator on 10/15/2025 at 10:00 AM, he stated the Senior Administrator was responsible for the new employees' background and abuse registry checks. He stated all employees should have a background check and an abuse registry check for the safety of the staff and the residents. In an interview with the Senior Administrator on 10/09/2025 at 10:15 AM, she stated she was responsible for running the criminal background checks and the abuse registry checks on the staff. She further stated the facility used a third-party company that showed if the person had any criminal charges. However, she stated she failed to verify what the charges were and if the employee was safe around the facility's residents.	P 105	SA will stop using the third party vendor for background checks and will be using the KSP and or AOC for accurate background for every potential new employee that will be an ongoing continuous process. Background checks will be comp and sent showing results	11/12/25 12-30-25
P 315	902 KAR 20:036 5(3)(a) 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: (a) Room accommodations. 1. A PCH or SPCH shall provide each resident with: a. A bed that is at least thirty-six (36) inches wide; b. A clean, comfortable mattress with a support mechanism; c. A mattress cover;	P 315	P 315 Section5	12/15/25

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P 315	Continued From page 9 d. Two (2) sheets and a pillow; and e. Bed covering to keep the resident comfortable. 2. Each bed shall be placed so that a resident does not experience discomfort because of proximity to a radiator, heat outlet, or exposure to a draft. 3. Except for married couples or domestic partners, there shall be separate sleeping quarters for males and females. 4. A PCH or SPCH shall provide: a. Window coverings; b. Bedside tables with reading lamps, if appropriate; c. Comfortable chairs; d. A chest or dresser with a mirror for each resident; and e. A night light. 5. A resident shall not be housed in a room, detached building, or other enclosure that has not previously been inspected and approved for residential use by the Office of Inspector General and the Department of Housing, Buildings and Construction. 6. Basement rooms shall not be used for sleeping rooms for residents. 7. Residents may have personal items and furniture, if feasible. This requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide each resident with a bedside table, a reading lamp, and a comfortable chair in their bedroom in 3 of 3 observed multi-bed	P 315	P 315 Requirement not met based on observation facility failed to provide each resident with a bedside table lamp and a comfortable chair 3 of 3 observed multi beds. Resident rooms revealed no seating for resident in any of the bedrooms. On 10-8-25 SSA requested a policy on provisions of resident room and furniture but none was provided. In women's ward of 7 women and 13 men multi bed had no chair reading lamp or beside table. Owner stated if she knows what is needed she will get it and to let her know how many of each items is needed.	12/20/25

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P 315	Continued From page 10 resident rooms. Observation revealed no seating for residents in any of the bedrooms. The findings include: On 10/08/2025 at 9:25 AM, the State Survey Agency (SSA) Surveyor requested a policy for the provision of resident furniture from the Administrator. However, it was not provided. Observation, during a facility tour on 10/07/2025 at 10:15 AM, revealed the the women's multi-bed room housed seven women, none of which had a bedside table, comfortable chair, or a lamp. Continued observation revealed both men's multi-bed rooms housed a total of 13 men, none of which had a bedside table, comfortable chair, or a lamp. During interviews with Resident (R) 2 and R3 on 10/07/2025 at 11:58 AM, both stated they did not have a chair, bedside table, or a reading lamp in their rooms but would like one. During an interview on 10/07/2025 at 12:11 PM with R5, she stated it would be nice to have a room divider for privacy as well as a place to hang her clothes. R5 further stated a chair and a table with a lamp on it so she did not have to write in her notebook on her bed would also be good, but she did not know how all the furniture would fit into the room. During an interview with the Administrator on 10/08/2025 at 2:49 PM, he stated he had worked for the facility for two and a half years and began his role of Administrator in August 2025. He stated he was not aware of the furniture requirements for each resident in their bedrooms. He stated no one had really trained him on the	P 315	Admin will make known of what is needed for each resident for the rooms. this will consist of lamps chairs and bedside tables and mirrors for each resident. Privacy blind or shade will be available if resident request one. R5 requested privacy and she has one in her room Admin will get a copy of the Regs to ensure he is up to date on every-thing from top to bottom.	12/17/25 11/8/25

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P 315	Continued From page 11 state regulations for personal care homes, and he would speak to the facility's owners about it.	P 315		
P 355	902 KAR 20:036 5(3)(c)4 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: (c) Dietary services. 4. Food preparation and storage. a. There shall be at least a three (3) day supply of food to prepare well-balanced, palatable meals. b. Food shall be prepared with consideration for any individual dietary requirement. c. Modified diets, nutrient concentrates, and supplements shall be given only on the written order of a physician. d. At least three (3) meals per day shall be served with not more than a fifteen (15) hour span between the evening meal and breakfast. e. Between-meal snacks, including an evening snack before bedtime, shall be offered to all residents. f. Adjustments shall be made if medically contraindicated. g. Food shall be: (i) Prepared by methods that conserve nutritive value, flavor, and appearance; and (ii) Served at the proper temperature and in a form to meet individual needs. h. A file of tested recipes, adjusted to appropriate yield, shall be maintained. i. Food shall be cut, chopped, or ground to meet individual needs. j. If a resident refuses food served, substitutes shall be offered. k. All opened containers or leftover food items	P 355	P 355 Section 5 Provision of Services	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS II HEALTH	250 WEST CENTRAL AVENUE 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 355	Continued From page 12 shall be covered and dated when refrigerated. l. Ice water shall be readily available to the residents at all times. m. Food services shall be provided in accordance with 902 KAR 45:005. This requirement is not met as evidenced by: Based on observation, interview, review of the facility policy and review of information from the Department of Agriculture Food and Nutrition website, the facility failed to ensure sufficient food and a three-day supply of food was available for the residents, failed to ensure daily between meals snack and a snack at bedtime was offered to the residents, failed to ensure all opened containers or leftover food items were covered and dated, and failed to ensure a 35 hour a week Cook responsible for the food service program at the facility was employed. This affected 20 of 20 current residents. The findings include:	P 355	Requirement not met by observation that facility failed to ensure sufficient food and a 3 day suppy of food was available for resident failed to ensure daily snacks between meal and snack at bedtime offered and to ensure left over food is covered with label and dated and have a cook on had with 35 hrs a week. Findings include	

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P 355	Continued From page 13 Review of the facility's policy titled, "Services Provided by the Facility," effective date 09/2023, revealed the facility would provide three hot meals a day and snacks. Review of the facility's policy titled, "Artrip PCH Food and Nutrition Policy," undated, revealed the facility would offer snacks at 9:30 AM, 2:30 PM, and 7:00 PM. Review of the facility's policy titled, "Food Storage Policy," undated, revealed all opened products must be properly sealed in a container and labeled with a date. Review of the document "Thrifty Food Plan" located on the United States Department of Agriculture Food and Nutrition Service website at www.fns.usda.gov, dated 09/2025, outlined the costs for four monthly food plans, listed lowest to highest in dollar amount. These were classified as thrifty, low, moderate, and liberal. Review of the "Thrifty Food Plan" revealed the average cost of food for an adult female aged 20-50 was $248.40 per month and for an adult female aged 51-70 was $231.20 per month. The "Thrifty Food Plan" further revealed the average cost for an adult male aged 20-50 was $311.20 per month and for an adult male aged 51-70 was $275.10 per month. Based on calculations with the above food costs, the average cost to feed any individual, male or female between the ages of 20-70 would be approximately $266.48 per month. Given the number of 21 residents that currently resided in the facility, the facility's minimum amount of money spent on food to qualify for the "Thrifty Food Plan" would be $5,596.08. Observation on 10/07/2025 at 10:15 AM revealed	P 355	P 355 Facility does provide 3 hot meals and snacks between meal n bedtime daily Food has to be covered and dated and used at a certain length of time per Health Department all staff was informed about dating and labeling food and use leftovers within 2-4 days. Leftovers can be used as a snack as well. Which snacks can consist of fruits , cookies , popcorn any item that can or would be a well balance snack in between meals Observation on 10/7/25 revealed	10/12/25

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P 355	Continued From page 14 the inside refrigerator 2 contained one bowl of chocolate pudding with a film formed on top, uncovered and undated, and an opened package of deli ham with no opened date. Further observation on the top of the microwave revealed an overripe banana with live bugs crawling on it. Observation of the two refrigerators/freezers on 10/07/2025 at 10:15 AM in the kitchen revealed no ready to heat/prepared food in storage. Observation on 10/07/2025 at 10:27 AM of the locked metal pantry in the dining room revealed seven cans of vegetables, two boxes of oatmeal cookies, and one box of hamburger helper. During an interview with the Administrator on 10/07/2025 at 10:27 AM, he stated he was allowed about $500 per week or $2000 per month on food for the residents. He stated he was never trained on how to calculate how much food to buy or prepare for each resident, so he bought and prepared enough for 24 residents. He stated once the food was gone, it was gone. He stated sometimes the residents did ask for seconds, and there were none. The Administrator further stated the $500 per week was supposed to provide three meals and one snack per day for the residents, and the snack was provided at bedtime. He stated he had not been made aware of the regulation which required residents also be provided a snack between each meal and the facility have a three-day supply of food at the facility at all times. However, he stated he could see how that would be important in case of an emergency. The Admininistrator stated he had ordered groceries which were to be delivered that day at 12:00 PM. However, he stated lunch was scheduled to be served at 11:30 AM.	P 355	P 355 Revealed pudding not covered or dated and lunchmeat open no date a banana that should have been thrown away and cleaned up Pudding was thrown away and the lunch meat was used the banana thrown away and the microwave was sanitized and cleaned There is not a limit on groceries Admin is learning to shop or order right there is plenty of food for a week and days after. SA told Admin if you serve 2nds and run out and the resident still want more the give the leftovers or make them sandwiches.	10/10/25

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P 355	Continued From page 15 Observation on 10/07/2025 at 11:45 AM revealed a driver arriving to the facility with three bags of groceries which were used to prepare lunch. During an interview on 10/07/2025 at 11:58 PM with Resident (R) 3, he stated if he could not have a second helping of a meal or if something he did not like was served, he kept instant noodles in his room and could use the hot water from the dispenser in the dining room to heat them. During an interview on 10/07/2025 at 12:11 PM with R5, she stated she did not always want what was prepared for a meal, so she just did not eat. R5 also stated the facility offered one snack a day at about 7:30 PM, and sometimes she did get hungry in-between meals. However, she stated she knew there were no snacks at the facility. Observation on 10/08/2025 at 10:00 AM revealed Owner 1 (O1) arrived at the facility with multiple grocery bags and announced, "I've brought snacks." During an interview on 10/08/2025 at 10:35 AM with State Guardian (SG) 1, she stated she had been made aware by the residents of complaints of not enough food and had requested the staff take a daily photo of the breakfast meal and send it to her. SG1 stated she would get a photo a couple of times a week from staff and of course the portions always appeared adequate. During an interview on 10/08/2025 at 11:57 AM with the Administrator, he stated there was not a 35 hour per week Cook at the facility but "that would be great." He further stated right now, whatever staff was at the facility cooked for the residents. He stated he tried to hire a staff person	P 355	P 355 For any resident who doesn't like the the meal. the staff prepares a substitution for that resident or residents Some of the resident order out or just not hungry at the time and their plate is put back for them when they are ready to eat. When owner brought the extra snacks SA was in kitchen serving cookies and coffee to the residents SA is in a process of hiring someone to be the cook but having trouble finding someone who want the job but will continue on. Ongoing.	10/31/25

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P 355	Continued From page 16 as the Cook to be at the facility all day and provide all three meals for the residents, but he was told he could not do that. He stated he was told the reason two staff members were here during the day was so one could cook. He stated he could not remember if the Senior Administrator (SA) or O1 told him that. He stated stated the Assstant Administrator did it all: cooked, administered medications, housekeeping duties, activities with residents, and whatever else needed to be done. During an interview on 10/08/2025 at 1:30 PM with O1, she stated she relied on the staff at the facility to make her aware of what was needed at the facility in terms of food. O1 further stated she could not address what was needed at the facility if she was not informed.	P 355	Admin was not told by SA he coulnd't hire a cook. Facility previously had a cook but quit. Ongoing trying to fins someone Admin has posted facility is h for a cook and apply within and so Owner has told the staff to let her what is needed and she will get it	
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.	P 370	p370 Section 5 Provision of Services Requirement not met for facility policy on daily activities and a responsible staff to be activity director	

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P 370	Continued From page 17 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. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy, the facility failed to designate a staff member to be responsible for the activity program; plan an activity period each day; post a current activity schedule to include group and individual activities, both within and outside of the facility; and provide reading materials, radios, games and supplies/equipment as needed for the residents. This affected 20 of 20 current residents. The findings include: Review of the facility's policy titled, "Activities Policy," revised 10/01/2023, revealed the program was to meet the mental, physical, social,	P 370	p 370 Based on observation the facility failed to designate a staff member to be responsible for activity program which includes planning daily activity and provide book puzzles games art and craft supplies and document who participates and what the activity was. This program was to meet the mental	

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P 370	Continued From page 18 educational, and physical needs of the residents in a group setting. A group was defined as any number of residents together in a setting doing the same activity. Further review of the policy revealed activities would be overseen by the Assistant Administrator (AA), the activities calendar would be posted monthly in the dining room, and activity participation would be kept and monitored. The policy stated the facility would provide the needed supplies for activities with a monthly celebration at the end of the month to celebrate all birthdays for that month. Observation on 10/07/2025 at 10:45 AM revealed no monthly activity calendar posted in the dining room and no visible activity items such as puzzles, puzzle books, art supplies, or games available for the residents. Observation on 10/07/2025 at 2:20 PM revealed a black zippered binder sitting on one of the dining room tables with a log dated 09/01 to 09/21 which was blank. Multiple observations from 10/07/2025 to 10/09/2025 at different times revealed no organized activities occurred for the residents. During an interview on 10/07/2025 at 11:58 AM with Resident (R) 2 and R3, they both stated no planned activities were provided for the residents. R2 stated she enjoyed crafts and coloring. R3 stated the last activity he could remember was a coloring page activity around Valentine's Day. R3 further stated he would like to play bingo where prizes would be a can of pop or a small bottle of shampoo. R3 stated he also wished church services would come to the facility once in a while. R2 and R3 both stated things were "kind of boring at the facility on the whole."	P 370	P370 and physical needs of the residents AA is in charge of calendar of posting daily activities each month and also documenting who attended and who didn't. And to set planned activity out so resident can see what is planned for the day Owner had bible study with residents a few showed up and was asking questions about the lesson which enjoyed. this was on 10/7/25 and 10/8/25 which took place in the dining room. Activities will we planned so residents can enjoy and have fun.	10/22/25

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P 370	Continued From page 19 Observation on 10/07/2025 at 2:21 PM revealed the AA mopping the floors of the facility. Additional observation on 10/08/2025 at 11:27 AM revealed the AA cooking lunch for the residents. During an interview with the AA on 10/08/2025 at 11:27 AM, she stated the staff working for the day were in charge of activities, she had many responsibilities at the facility, and she could do just about everything. The State Survey Agency (SSA) Surveyor requested activity logs from the AA at this time, but they were not provided. During an interview with the Administrator on 10/07/2025 at 2:49 PM, he stated it was the responsibility of the staff on duty to be in charge of activities for the residents. The Administrator stated the AA did it all: cooked, administered medications, did housekeeping, did activities with residents, and whatever else needed to be done. The SSA Surveyor requested activity logs from the Administrator at this time, but they were not provided.	P 370		

Office of Inspector General

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P 057	902 KAR 20:031-6(1)(e) Section 6. Resident Unit The following shall be included: (1) Resident rooms. Each room shall meet the following requirements: (e) Wardrobe or closet for each resident. Minimum clear dimensions; one (1) foot and ten (10) inches deep by one (1) foot and eight (8) inches wide with full length hanging space; provide clothes rod and shelf. This requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide a wardrobe or closet for each resident with minimum dimensions of one foot and ten inches deep by one foot and eight inches wide, with full length hanging space, a clothes rod, and a shelf for three of three observed resident rooms, one ward room with seven female beds and two ward rooms with seven male beds each. This affected all 20 current residents of the facility. The findings include: The State Survey Agency (SSA) Surveyor, on 10/09/2025 at 9:20 AM, requested the facility's policy on furniture requirements from the Administrator. However, it was not provided. Observation on 10/07/2025 at 10:15 AM of the seven bed female ward room and both the seven bed male ward rooms revealed each resident had either a dresser or a portion of a repurposed kitchen cabinet provided for the storage of their clothes. However, there was no place to hang any clothing.	P 057	P 057 based on interview facility failed to provide wardrobe or closet for each resident with hanging space for clothing. Findings includes policy on furniture requirements was not provided. Residents provided with dressers for folded clothing. SA talked to owner owner said they can install hanging rods for resident in the ward to hang clothing. Staff will have resident to go thru their clothing to thin out what resident don't want and store summer clothes and switch out per seasons' Admin was previously told what the regulations where to have in each resident room such as lamp chair bedside table and each resident a mirror.	12/6/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jamie Thomas TITLE ADMIN (X6) DATE 11/3/25

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P 057	Continued From page 1 During an interview on 10/07/2025 at 11:58 AM with Resident (R) 2, she stated she had no place to hang any of her clothes but had a couple of drawers in a cabinet that were hers. During an interview on 10/07/2025 at 11:58 AM with R3, he stated he had no place to hang any clothes, so he kept his in a cabinet. During an interview on 10/07/2025 at 12:11 PM with R5, she stated she would like to have a place to hang her clothes but did not know where there would be room to put that. During an interview with the Administrator on 10/08/2025 at 2:49 PM, he stated he had worked for the facility for two and a half years and began his role of Administrator in August 2025. He stated he was not aware of the furniture requirements for each resident in their bedroom. He stated no one had trained him on the state regulations for personal care homes, and he would speak to the facility's owners about it.	P 057	P057 Owner will look into it to ensure resident will be provided with hanging ability for clothing.	
P 058	902 KAR 20:031-6(1)(f) Section 6. Resident Unit The following shall be included: (1) Resident rooms. Each room shall meet the following requirements: (f) In multibed rooms, a method of assuring visual privacy for each resident shall be provided. This requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure, in multibed rooms, a method of assuring visual privacy for each resident was	P 058	P 058 Requirement for privacy in rooms to ensure visual privacy for each resident provided wards /rooms revealed no visual means of privacy was provided in female ward room and two	10-15-25

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P 058	Continued From page 2 provided. This affected 20 of 20 current residents. The findings include: The State Survey Agency (SSA) Surveyor, on 10/09/2025 at 9:20 AM, requested the facility's policy on visual privacy from the Administrator, but it was not provided. Observation on 10/07/2025 at 10:15 AM in the one seven bed female ward room and the two seven bed male ward rooms revealed no visual means of privacy was provided for each resident. During an interview on 10/07/2025 at 11:58 AM with Resident (R) 2, she stated she would like to have a divider between her bed and the bed of her roommates to help her sleep better. During an interview on 10/07/2025 at 11:58 AM with R3, he stated he would like a divider between him and his roommates for privacy. During an interview on 10/07/2025 at 12:11 PM with R5, she stated she would like to have a screen or a curtain between her and her roommates and the door for privacy so she did not feel like everyone was looking in her room. During an interview with the Administrator on 10/08/2025 at 2:49 PM, he stated he had worked for the facility for two and a half years and began his role of Administrator in August 2025. He stated he was not aware of the privacy requirements for each resident in their room. He stated no one had trained him on the state regulations for personal care homes, and he would speak to the owners about it.	P 058	seven bed male ward' Interview with R2 stated she would like to have privacy between her bed and roommates. Privacy blind/shade has been provided for R5 R3 would also like to have a privacy divider between him and roommates for privacy. Privacy screen will be provided for residents who request shade. Privacy shade will be on hand for anyone who needs one.	10/15/25

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P 059	Continued From page 3	P 059	P 059	
P 059	902 KAR 20:031-6(2)(a) Section 6. Resident Unit (2) Resident toilet and bathing areas for existing facilities. (a) Where a centralized bathing area is used, the facility shall provide for each sex on every floor the following: One (1) shower stall or one (1) bathtub for each twelve (12) residents or major fraction thereof is required. This requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure where centralized bathing was used, each sex was provided one shower stall or one bathtub for each 12 residents. This affected 20 of 20 current residents. The findings include: The State Survey Agency (SSA) Surveyor, on 10/09/2025 at 9:20 AM, requested the facility's policy on centralized bathing from the Administrator, but it was not provided. Observation on 10/08/2025 at 9:15 AM revealed the facility had two bathtubs/showers for resident use. Bathroom 1 (BR1) near the residents' bedrooms had a nonfunctioning sink and one bathtub that would not drain. Bathroom 2 (BR2) near the residents' dining room had one shower. During an interview on 10/08/2025 at 9:25 AM with Resident (R) 2, R3, and R5, they all stated	P 059	SSA surveyor founded on 10/9/25 9:20am requested facility on centralized bathing policy which t facility has now and will be available when asked. Policy was made and will be enforced. Observation on 10-8-25 revealed facility had two baths shower for residents use. Bathrm1 had non functional sink and tub wouldn't drain and smelled like sewer. And Bathrm 2 had one shower. Interview R2 R3 and R5 stated they were unable to shower due to drain issues. Owner stated she wasn't aware of the	10/29/25

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P 059	Continued From page 4 they were unable to use the shower in BR1 because the tub "would not drain, and the water had a sewer like smell to it." R2 and R3 stated all 20 residents had to use the shower in BR2. During an interview on 10/07/2025 at 10:15 AM with the Administrator, he stated the bathtub and sink in BR1 had been worked on, but they were still not fully repaired. He further stated the facility did not have a regular maintenance staff, but when something in the facility needed repair, he notified Owner (O) 1. He stated O1 made arrangements for the repairs in the facility to be done. The Administrator stated O1 was aware the bathtub/shower and sink in BR1 were not working. During an interview on 10/08/2025 at 1:30 PM with O1, she stated she relied on the staff to tell her what was needed at the facility, or she did not know what needed to be done. She stated she was not aware the bathtub in BR1 was not draining or the sink was not working.	P 059	continue Owner can't fix things in they don't SA also has to told what goes on in' the facility as well and to know if resident need anything. Bathrm 1 tub is now draining sink will be repaired.	11/16/25

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	100033	A. BUILDING: _____ B. WING _____	C 10/09/2025

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R 805	KRS 216.515(6) PATIENTS' RIGHTS Every resident in a long-term-care facility shall have at least the following rights: (6) All residents shall be free from mental and physical abuse, and free from chemical and physical restraints except in emergencies or except as thoroughly justified in writing by a physician for a specified and limited period of time and documented in the resident's medical record. This requirement is not met as evidenced by: Based on interview, record review, review of two videos, and review of the facility's policy, the facility failed to have an effective system in place to ensure thorough pre-employment background checks were performed, failed to ensure each resident's rights were protected related to being free from mental and physical abuse, and failed to thoroughly investigate allegations of abuse internally to prevent potential future abuse for 2 of 24 residents reviewed for abuse, Resident (R) 6 and R7. This failure posed an imminent danger to the safety and well-being of residents. The findings include:	R 805	R 805 Requirement not met based on two videos and facility failed to have effective system in place for pre employment. Review of CG1 employee file revealed criminal backgrour dated on 9-10-24 contained 2 cases that involved criminal charges. CG1 had a verbal warning about his tone and how he said and presented himself towards resident. On 6-21-25 a video R6 took and recorded on his	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jamie Thomas TITLE Senior Admn (X6) DATE 11/3/25

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R 805	Continued From page 1 Review of the facility's policy titled, "Policy on Abuse," revised 10/12/2023, revealed the facility was committed to providing safe and respectful environments that supported the health and well-being of all people receiving services. The policy established a zero-tolerance approach toward any actions that jeopardized the health, safety, or welfare of residents. It further required staff to exercise safe, responsible, and respectful behavior toward residents, to protect individuals from abuse and neglect, and for the facility to take disciplinary action against any staff whose conduct was determined to be inappropriate. Review of Caregiver (CG) 1's employee file revealed his criminal record, dated 09/10/2024, contained two separate cases that involved criminal charges. The criminal record check was done by a third-party vendor and not directly through the Kentucky Administrative Office of the Courts and/or the Kentucky State Police. Further review revealed no documentation the facility investigated the background check further to determine what the criminal charges were or when they occurred. Additionally, review of CG1's disciplinary action by the facility, dated 08/01/2025, revealed he received a first notice that his behavior/actions were found to be unsatisfactory for threatening a resident. 1. Review of a video taken on R6's personal cell phone, dated 06/21/2025, and report from R6, revealed R6 was being called "mental" and a "fucking retard" by CG1 when R6 asked for a washcloth. During an interview with R6 on 10/09/2025 at 2:13 PM, he stated on 06/21/2025 he asked CG1 for a washcloth so he could shower. He stated he	R 805	continue personal cell phone showed CG1 calling R6 him mental and a fucking retard for asking for a washcloth. During interview withR6 on 10/9/25 R6 asked CG1 for washcloth so he cold take a shower. R6 said CG1 was rude and inappropriate with his behavior when residents asked CG1 for anything they needed. CG1 was verbally warned by Admin. Due to background check was done by a third party vendor the background didn't specify what the criminal charges were and the outcome of one of them. SSA stated that third party vendor is not what to use to accurate information on background checks for pre employment for potential new hires. We as a facility has to get reports thru KSP or AOC to get a detailed informative check.	10/20/25

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R 805	Continued From page 2 decided to record CG1 from his own personal cell phone because CG1 had inappropriate rude behaviors toward residents when they asked him for something they needed. He stated he asked CG1 for a washcloth, and CG1 proceeded to call him a "fucking retard" and then proceeded to call him "mental." R6 stated he had intellectual disabilities and was only at the facility due to losing his waiver. He stated the State Guardian only found the facility at the time to place him until the waiver became available to him again. Further review of CG1's employee file revealed no documentation of disciplinary actions were taken for the incident with R6 on 06/21/2025. 2. Review of a video, dated 09/01/2025, revealed CG1 was seen charging after R7 in the dining room and then following the resident to the front porch. In the video, CG1 was observed backing R7 against the wall, and CG1 pointed his finger in R7's face while he was leaning in toward R7 in an aggressive manner. During an interview with R7 on 10/08/2025 at 1:03 PM, he stated, on 09/01/2025, he did not receive enough milk in his cereal for it to become soggy for him to eat due to not having any teeth. He stated he had told CG1 on many occasions he needed more milk in his cereal. R7 stated he called CG1 a "Nigger" and then left the dining area to go to the front porch. He stated he could feel CG1 following him to the porch. R7 stated once he got to the front porch CG1 pointed his finger in R7's face and stepped up to him in an aggressive manner. R7 stated CG1 told him if he called CG1 a "Nigger" again, CG1 was going to kill him. R7 stated he feared CG1, but the facility was the only home he had.	R 805	R 805 R6 stated he has intellectual disabilities and was only placed at the facility due to losing his waiver and now is waiting for waiver to become available again. Review of video revealed R7 was charged at by CG1 in dining room. R7 stated he ask for more milk for his cereal due to he had no teeth CG1 was shown as R7 was going to front porch and backing R7 against the wall and pointing his finger in R7 face and leaning towards R7 in an aggressive manner. R7 stated he did call CG1 a nigger and CG1 stepped up to him in an aggressive manner and CG1 said he would kill him. R7 stated he feared CG1 but the facility was the only home he had. CG1 has been terminated from the facility as of 10-8-25. Owner and SA walked around and told residents that CG1 is no longer working here	10/8/25

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R 805	Continued From page 3 Review of a text message, dated 09/23/2025, from the Administrator to the facility's Owner, revealed the Administrator sent the 09/01/2025 video to the Owner. Further review of the text messages/video between the Administrator and Owner, dated 09/23/2025 at 1:03 PM, indicated the Owner was notified of the occurrence. Further review of CG1's employee file revealed no documentation of disciplinary actions were taken for the incident with R7 on 09/01/2025. Review of the facility's staffing schedule revealed CG1 was still employed by the facility and was working directly with residents, on night shift, on 10/08/2025 and 10/09/2025. During an interview with the Administrator on 10/09/2025 at 8:29 AM, he stated he had informed the previous Administrator and the facility's Owner of CG1's behaviors and incidents with residents on multiple occasions. He stated the Owner had access to the camera and frequently watched the activities at the facility. He stated he spoke up about situations that were occurring at the facility involving CG1, but they never were resolved. He stated he could only do so much and did not have the authority to fire anyone, but he felt CG1 was not safe to leave with the residents. During an interview with the Senior Administrator (SA) on 10/09/2025 at 10:45 AM, she stated she reviewed the criminal charges listed on the third-party vendor's electronic background check system used to review criminal history results. The SA stated she did not further investigate the nature of the charges or determine whether the employee was appropriate to work with residents. She stated she should have conducted a more	R 805	there is to be afraid of and they can come to staff and SA and Owner. CG1 was notified that he was taken off schedule 10-8-25 and fired for verbal abuse and put on abuse registry. Termination letter was typed and signed ny Admin and SA on 10/8/25 Admin does have the authority to hire and fire anyone who is breaking the rules not following rules and regulations. Admin was told by Owner that why he has the title to run the facility and make decisions for the best of the facility. Interview with SA she stated that she will conduct Background checks thru the proper agencies to get a -proper report and go thru KSP and or AOC ongoing program.	10/8/25 10/25/25 10/20/25

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R 805	Continued From page 4 thorough review to ensure resident safety. She stated she had no knowledge of CG1's behaviors toward residents. She stated the Administrator was not required to report to her. She stated perhaps the Administrator felt uncomfortable and in fear of retaliation because CG1 was related to her. Therefore, she stated the Administrator reported to the Owner.	R 805		10/20/25
R 826	KRS 216.520(1) PATIENTS' RIGHTS - FACILITY ACTIONS For the purpose of supplementing the rights of residents in long-term-care facilities, such facilities shall take the following actions: (1) Every long-term-care facility shall conspicuously post throughout the facility a listing of the resident's rights and responsibilities as defined in KRS 216.515 to 216.525. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy, the facility failed to ensure a copy of the Resident Rights was conspicuously posted throughout facility. An observation revealed one copy of "Resident Rights" was posted in the foyer of the facility behind a tall bookcase and out of view. This affected 20 of 20 current residents. The findings include: Review of the facility's policy titled, "Resident Rights for Residents in Kentucky Long Term Care Facilities," undated, revealed no section	R 826	R 826 Requirement not met based on observation of facility policy facility failed to ensure Patient's Rights in a conspicuous place to be for residents to view. Poster was moved so all residents can see and read about patient rights and everything listed for them	10/12/25

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R 826	Continued From page 5 documenting the posting of "Resident Rights" in the facility. Observation on 10/07/2025 at approximately 10:00 AM, revealed a poster "Resident Rights" partially visible in the foyer of the facility behind a tall book case. During interview on 10/07/2025 at 11:58 PM with Resident (R) 2 and R3, they both stated they did not know where the resident rights were posted and did not know what all their rights were. During an interview on 10/07/2025 at 12:11 PM with R5, she stated she did not know where the resident rights were posted or what they were. During an interview on 10/09/2025 at 1:15 PM with the Assistant Administrator and the Administrator, they stated they were not aware the "Resident Rights" were to be posted in the facility within view of the residents, but they would put it on their list of things to do.	R 826	Poster has been removed behind the bookcase and moved forward in site for residents. Admin and AA was told by SA that the poster has to be to where it can be seen SA told Admin and AA if they are unsure of anything to call and ask questions	10/12/15

Office of Inspector General

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{P 000}	Initial Comments Based on the off-site revisit survey and implementation of the acceptable Plan of Correction (PoC) received via email on 01/15/2026, the facility was deemed to be in compliance on 12/30/2025, as alleged.	{P 000}		

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