STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100382	A. BUILDING: _____ B. WING _____	C 06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR	920 HENRY CLAY STREET SHELBYVILLE, KY 40065

(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 AMENDED A Complaint Survey investigating KY00045948, KY00046038, KY00046055, and KY00046078 was initiated on 05/12/2025 and concluded on 05/16/2025. The complaint survey was re-opened, after supervisory review, on 06/06/2025 and concluded on 06/20/2025. Deficiencies were issued related to KY00045948; KY00046038; KY00046055; and KY00046078. A Type A Citation was issued to the facility on 06/13/2025 related to KY00046038 and KY00046055. Based on the findings of the Complaint Survey, the facility failed to provide basic health and health related services related to supervision and monitoring. This affected 2 of 6 sampled residents, Resident (R)1 and R2. R1 left the facility without staff's knowledge and unsupervised, and was deemed missing on 04/30/2025. However, the Police Department's "Missing Person File" was not completed until 05/05/2025, 5 days later. Additionally, R1's State Guardian was not notified until 05/06/2025, 6 days later. Moreover, a "Golden D Alert" was never issued for the resident. There was no documented evidence R1 was signing himself in and out of the facility as per the facility "Admission Agreement", during April and May of 2025. Additionally, per the "Kentucky Missing Person's Report", R2 was deemed missing by the facility	P 000		

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

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P 000	Continued From page 1 and was reported to be last seen on 01/17/2025 at 5:30 PM. Also, per the "Kentucky Incident Based Reporting System" Report, dated 04/11/2025 at 2:15 PM, it was reported R2 assaulted another resident and a staff member, which caused minor injury; and the police were unable to locate R2 at that time. There was no documented evidence R2 was signing himself in and out of the facility in January, February, March, and April of 2025. IJ was removed on 06/09/2025. Survey Dates: 05/12/2025 - 05/16/2025; 06/06/2025 - 06/20/2025 Survey Census: 55 Sample Size: 6 Supplemental Residents: 49	P 000		
P 040	902 KAR 20:036 4(1)(a-e) Section 4. Administration and Operation Section 4. Administration and Operation. (1) Licensee. The licensee shall be legally responsible for: (a) The operation of the PCH or SPCH; (b) Compliance with federal, state, and local laws and administrative regulations pertaining to the operation of the facility; (c) The development and implementation of policies related to administration and operation of the facility; (d) If the licensee is a SPCH, the development and implementation of written transition procedures to ensure cooperation with an individual or entity that assists with transitioning residents with an SMI to community living arrangements; and (e) If the licensee is an SPCH, access to	P 040		

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P 040	Continued From page 2 confidential and secure telehealth services unless access is impossible to provide due to a lack of: 1. Broadband service; or 2. An appropriate physical space for residents. This requirement is not met as evidenced by: Based on interview, record review, and review of facility policy, the Administration failed to develop and implement policies related to the administration and operation of the facility. This affected 1 of 6 sampled residents, Resident (R)1. The facility's policies failed to include information related to the timeframe in which a missing resident should be reported to the authorities or to the resident's responsible party. R1 was deemed to be missing on 04/30/2025. However, the Police Department's "Missing Person File" was not completed until 05/05/2025, 5 days later. Additionally, R1's State Guardian was not notified until 05/06/2025, 6 days later. Refer to P-0210 The findings include: Review of the facility's policy titled, "Missing, Lost, or Runaway Patient," undated, revealed staff should notify the charge person in the facility, then the charge person should notify other	P 040		

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P 040	Continued From page 3	P 040		

personnel in the facility and check the chart and check sign-out sheets to see if the patient has left the facility or had planned to leave the facility. Next, staff should perform a thorough search outside of the building beginning with the front entrance. Next, staff should search inside the premise, including the laundry room, dining area, activity area, rest rooms, and all patient rooms. Further review of the policy, revealed after the search inside the building, if the patient is still not located, the charge person should notify the Administrator, then the Administrator should notify the family or the resident's responsible party to make them aware of the situation and ask for possible information on where the patient may be and to inform them of the steps that have been taken to locate the patient. Next, the police should be informed for additional help locating the patient. However, the policy did not specify any time frames as to when these notifications should be made regarding a missing patient.

Review of all the facility's policies and procedures, revealed there was no documented evidence of a policy which stated when a missing resident should be reported to law enforcement or to the responsible parties.

Review of R1's "Admissions/Summary Sheet," revealed the facility admitted the resident on 05/24/2024. Further review revealed R1 was diagnosed with aggression, schizophrenia, and a history of wandering.

Review of the facility "Incident Report", dated 04/30/2025, revealed R1 had been missing from the facility since 04/30/2025. The report was not signed.

Review of R1's "Resident's Notes," revealed an

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P 040	Continued From page 4	P 040		

entry on 04/30/2025, which stated the resident was last seen on this day and had not been seen from day or night shift.

The next entry of R1's "Resident's Notes," dated 05/05/2025, stated the facility reported R1 was missing to the local police.

Review of the Police Department's "Missing Person File," dated and timed 05/05/2025 at 4:25 PM, revealed the facility Administrator documented on the form as "Caretaker," reported R1's last contact was on 04/30/2025 at 10:30 PM.

During an interview with the police detective, on 05/14/2025 at 9:49 AM, he stated police were not notified of R1 missing from the facility until 05/05/2025 at 3:04 PM.

During an interview with State Guardian (SG)2, on 05/14/2025 at 10:00 AM, she stated she was the current State Guardian for R1, and she was only made aware of R1 missing from the facility on 05/06/2025. She further stated the Regional Director sent an email on 05/06/2025 at 1:39 PM, which stated R1 was missing, and the facility had initiated a missing person's report with the police department.

In an interview with the Administrator, on 05/13/2025 at 10:00 AM, she stated R1 would leave, come back, would be gone all day, and then would always return to the facility by 9:00 PM. The Administrator further stated the employees were supposed to be completing "Bed Checks," to verify the residents were in the facility, but they were not completing them accurately or correctly. She stated if the bed checks were being done correctly, staff would have readily identified R1 was missing. The State

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P 040	Continued From page 5	P 040		

Survey Agency Representative asked the Administrator if the facility policy should have included timeframes to designate when the responsible party and police were to be notified of a missing resident. The Administrator stated staff had all been trained that the State Guardians/responsible parties were to be notified immediately if a resident was missing. In further interview, she stated staff was also trained the police were to be notified after a resident was missing for 24 hours. She further stated she was not concerned about the five to six days it took the facility to notify the State Guardian and police of R1 missing because the resident was not "really missing." She stated this was because he would come and go all the time.

In an interview with the Regional Director, on 05/14/2025 at 9:20 AM, and at 1:32 PM, she stated as far as she could remember, even with the prior ownership, staff was supposed to wait twenty-four (24) hours before reporting a resident missing. The Regional Director stated, "Once it's been twenty-four (24) hours, the staff would then call the police and file a Missing Person's Report." When questioned why the facility waited five (5) days to call the police and report R1 missing, the Regional Director stated because R1 left the facility all the time, so she didn't consider him missing until he never returned to the facility. The Regional Director stated the last time anyone from the facility saw R1 was on 04/30/2025 around 10:30 PM.

In further interview with the Regional Director, on 05/14/2025 at 3:20 PM, she stated if a resident had a State Guardian, the guardian should be notified immediately about any changes or issues or concerns about that resident. The Regional Director further stated there was even a phone

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P 040	Continued From page 6 number to call to report these things throughout the night. She stated staff had been educated on multiple occasions regarding when to notify a State Guardian about anything that was going on with the resident.	P 040		
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 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.	P 105		

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P 105	Continued From page 7	P 105		

This requirement is not met as evidenced by:
Based on interview, and review of personnel files, the facility failed to ensure all pre-employment background checks to include nurse aide registry checks, criminal background checks, and caregiver misconduct registry checks were completed prior to hire for 5 of 6 sampled employees (Medication Technician (Med Tech)1, Med Tech 2, Personal Care Assistant (PCA)1, PCA2, and Kitchen Supervisor).

Additionally, PCA 2's criminal background check revealed a currently active bench warrant issued on 10/24/2024, related to a charge of assault in the fourth degree, originally filed on 11/04/2022.

The findings include:

1. Review of Medication Technician (Med Tech)1's personnel file revealed a hire date of 08/20/2019; however, there was no documented evidence a nurse aide abuse registry check was completed.

2. Review of Med Tech 2's personnel file revealed a hire date of 03/15/2025. Med Tech2's nurse aide abuse registry check was completed; however, the date of completion was not provided.

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P 105	Continued From page 8 Additionally, Med Techs 2's criminal background check was not completed until 06/12/2025, which was the same date the personnel files were requested from the facility to review, by the State Surveyor Agency (SSA) Representative. 3. Review of Personal Care Assistant (PCA)1's personnel file revealed a hire date of 08/05/2024. PCA1's nurse aide abuse registry check and caregiver misconduct registry check were both completed after the hire date, on 08/06/2024. Additionally, PCA1's criminal background check was completed on 08/07/2025, after the hire date. 4. Review of PCA 2's personnel file revealed a hire date of 04/28/2025. PCA 2's nurse aide abuse registry check was completed, but there was no date of completion provided. Additionally, PCA 2's caregiver misconduct registry and criminal background checks were not completed until 06/12/2025, which was the same date the personnel files were requested from the facility for review by the SSA Representative. Furthermore, PCA 2's criminal background check revealed a currently active bench warrant issued on 10/24/2024, related to a charge of assault in the fourth degree, originally filed on 11/04/2022. 5. Review of the Kitchen Supervisor's personnel file revealed a hire date of 10/03/2008. However, the Kitchen Supervisor's caregiver misconduct registry check was not completed until 11/04/2014. Also, the Kitchen Supervisor's criminal background check was completed, but there was no date of completion provided.	P 105		

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P 105	Continued From page 9 In an interview with the Administrator, on 06/19/2025 at 11:57 AM, she stated she was solely responsible for completing all the pre-employment checks prior to hiring staff to work in the facility. The Administrator stated the caregiver misconduct registry check was the first thing she ran once she received an application from a potential employee. She stated next, she completed the criminal background check, which included asking the potential employee for an explanation for anything that may come back on the background check. Further, the Administrator stated the results of the criminal background check were received by herself and also the Regional Director. The Administrator stated she then reviewed the nurse aide abuse registry checks for new employees. She further stated she was unaware all pre-employment background checks were not completed prior to hire. In continued interview with the Administrator, on 06/19/2025 at 11:57 AM, she explained once she received results for the caregiver misconduct registry check, the criminal background check, and nurse aide abuse registry checks, she sent an email to the owners of the facility, who would in turn send an email to the potential employee with their W2 (wage and tax statement), wage offer with the shift they would be working, and other paperwork that needed to be filled out. The Administrator stated those three (3) checks must be completed with no negative results, otherwise the employee would not be hired to work at the facility. She stated these pre-employment checks were extremely important regarding the residents' safety, and the safety of staff as well. In further interview, the Administrator stated the residents' safety was the absolute most important thing and the required pre-employment checks were to be	P 105		

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P 105	Continued From page 10 completed to prevent "bad people" from being around the residents, who were vulnerable due to their mental health issues.	P 105		
P 210	902 KAR 20:036 5(1)(a) Section 5. Provision of Services Section 5. Provision of Services. (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to ensure that the resident's health care needs are met; 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility. This requirement is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies and "Admission Agreement", the facility failed to provide basic health and health related services in regards to supervision and monitoring and supervision of medications. This affected 2 of 6	P 210		

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P 210	Continued From page 11 sampled residents, Resident (R)1 and R2. R1 had a history of leaving the facility without staff's knowledge and unsupervised, and was deemed missing on 04/30/2025. However, the Police Department's "Missing Person File" was not completed until 05/05/2025, 5 days later. Additionally, R1's State Guardian was not notified until 05/06/2025, 6 days later. Moreover, a "Golden D Alert" was never issued for the resident. R1 was not found until 05/10/2025, 10 days later. Interviews with staff revealed R1 was able to come and go as he pleased. However, there was no documented evidence R1 was signing himself in and out of the facility as per the facility "Admission Agreement", during April and May of 2025. Additionally, per the "Kentucky Missing Person's Report", R2 was deemed missing by the facility and was reported to be last seen on 01/17/2025 at 5:30 PM. Also, per the "Kentucky Incident Based Reporting System" Report, dated 04/11/2025 at 2:15 PM, it was reported R2 assaulted another resident and a staff member, which caused minor injury; and the police were unable to locate R2 at that time. Staff interviews revealed R2 would come and go as she pleased and at times would walk several miles. There was no documented evidence R2 was signing herself in and out of the facility as per the facility "Admission Agreement" in January, February, March, and April of 2025. Moreover, staff interviews and record review revealed R2 consistently displayed aggressive behaviors toward staff and other residents. However, there was no documented evidence the resident's behaviors were addressed by the facility in an attempt to ensure supervision and monitoring of R2 in order to keep R2 and other resident's as	P 210		

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P 210	Continued From page 12 well as staff safe from harm. Furthermore, the facility failed to ensure R2 received supervision related to administration of medications. On 04/12/2025, the facility gave R2's medications to her Grandmother for a home visit, but mistakenly also supplied R2's Grandmother with five (5) of R6's medications. R2's Grandmother administered R6's medications to R2 for 26 days until the medication errors were discovered by R2's new physician's Office Manager on 05/08/2025. It was reported R2 suffered multiple side effects of R6's medications, including dizziness, weakness, near passing out on several occasions, and drowsiness. R2 was being given her own medications plus two (2) antihypertensive medications, one of which was a very high dose, an antidepressant medication, an antipsychotic medication, and a medication to treat high cholesterol. There was no incident report filed for a medication error, and the staff interviews revealed they were not aware of the incident. Based on the findings, the facility's failure to provide basic health and health related services regarding supervision and monitoring presents an imminent danger and creates substantial risk that death or serious mental or physical harm to the resident could occur. The facility was notified of the Type "A" Citation on 06/13/2025. The findings include: Review of the facility's policy titled, "Missing, Lost, or Runaway Patient," undated, revealed staff should notify the charge person in the facility, then the charge person should notify other personnel in the facility and check the chart and check sign-out sheets to see if the patient has left	P 210		

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the facility or had planned to leave the facility. Next, staff should perform a thorough search outside of the building beginning with the front entrance. Next, staff should search inside the premise, including the laundry room, dining area, activity area, rest rooms, and all patient rooms. Further review of the policy, revealed after the search inside the building, if the patient is still not located, the charge person should notify the Administrator, then the Administrator should notify the family or the resident's responsible party to make them aware of the situation and ask for possible information on where the patient may be and to inform them of the steps that have been taken to locate the patient. Next, the police should be informed for additional help locating the patient. However, the policy did not specify any time frames as to when these notifications should be made regarding a missing patient. Refer to P0040

Review of the facility's policy titled, " Incident and Accident Reporting," undated, revealed staff at the facility are to notify the resident's responsible party immediately of any incident or accident.

Review of the facility's, "Admission Agreement", undated, under the header, "Additional Policies and Procedures & Facility Rules," revealed residents are expected to use the "sign out" form when leaving the facility property. Further review revealed the document stated, "I must be signed out when I leave and must sign immediately upon my return. I understand that if I do not sign in and out and do not return to the facility in a 24-hour period, I may be considered a voluntary discharge, AMA [Against Medical Advice]. I understand that if I cannot follow this policy, I may be asked to leave this facility."

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P 210	Continued From page 14 Observations made during the survey, 05/12/2025 through 05/14/2025, and 06/12/2025 through 06/16/2025, revealed multiple residents walking outside. Some residents left the property, then returned. There were no observations of the residents signing themselves in and out of the facility. 1. Review of R1's "Admissions/Summary Sheet," revealed the facility admitted the resident on 05/24/2024 with diagnoses including aggression, schizophrenia, and a history of wandering. Review of R1's "Psychiatry Progress Note," dated 08/02/2024, (time not specified), revealed it was ordered by the psychiatric physician for the facility administration to file a Mental Inquest Warrant (MIW) for R1 due to repeatedly refusing medically necessary medications and due to being, " ...delusional, disorganized, agitated, and aggressive, raising his fist at staff and others." Review of the psychiatry "Assessment and Plan ", portion of the note, revealed R1 was assessed as having unstable schizophrenia; a history of multiple inpatient psych hospital stays; continuous refusal of medication; flat affect; disorganized thinking and delusions; paranoia, and agitation. Continued review revealed R1 used nonsensically speaking during the assessment, and had a disheveled appearance. (A MIW is a court order requested by a citizen to summon an individual for a psychiatric evaluation because of concerns regarding that individual's mental stability). Review of an email sent from the Regional Director to State Guardian (SG)2, on 09/09/2024, revealed the Regional Director was made aware SG2 was the State Guardian for R1.	P 210		

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P 210	Continued From page 15 Review of R1's "Resident's Notes," revealed an entry on 09/10/2024 at 8:00 AM, which stated the resident was located at a nearby hospital and was admitted. There were no further Resident's Notes and there were no Incident Reports related to the resident missing on 09/10/2024. Review of the hospital "Discharge Summary", dated 09/16/2024, revealed the patient (R1) was admitted to the hospital on 09/16/2024 and discharged on 10/18/2024. Per the Discharge Summary the patient was transferred from a University Hospital on a Mental Inquest Warrant (MIW) and was brought in by a Crisis Interventions Team after being found wandering in a stranger's yard. Further review revealed the patient was diagnosed with schizophrenia, and was noncompliant with medications and having labs drawn during the first part of the hospital stay. The patient improved towards the end of the stay and became compliant with taking medications and showed some improvement. Per the Summary, the patient received several PRN (as needed) Intramuscular injections to try and calm him down. Review of R1's "Resident's Notes," revealed an entry on 12/29/2024 at 12:00 PM, which stated a local hospital contacted the facility to verify R1 was their resident because the police had picked up the resident from "the street" and took him to a local hospital. An entry on 01/02/2025, stated the facility had contacted the most recent hospital in which R1 had been admitted and found out he had been transferred to a different psychiatric hospital, which the facility contacted as well. A second entry on 01/02/2025, stated the facility spoke with the psychiatric physician and received verbal orders to discharge R1 to a higher level of care. The third entry, dated 01/02/2025, stated	P 210		

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the facility notified the State Guardian of the new discharge order from the psychiatric physician. An entry on 01/03/2025, stated the hospital was unable to contact the State Guardian and therefore R1 was brought back to the facility. This entry also indicated the State Guardian was actively searching for a locked all male unit for R1.

Review of the hospital "Discharge Summary", dated 12/29/2024, revealed the patient (R1) was diagnosed with schizophrenia, and received group therapy, individual therapy, and structured milieu. Further, the patient was responsive and showed some improvement.

Review of the facility's "Kentucky Missing Person's Report (KMPR)", completed by the Assistant Administrator (AA), revealed the last time R1 was seen was 04/16/2025 at 10:30 PM on the front porch of the facility. This KMPR was signed by the AA on 04/29/2025.

Review of R1's "Resident's Notes," revealed an entry on 04/30/2025, (time not specified), which stated the resident was last seen on this day and had not been seen from day or night shift. This note was signed by the AA.

Review of the facility "Incident Report," dated 04/30/2025, (time not specified), revealed R1 had been missing from the facility since 04/30/2025. In the "responsible party notified" field, it was marked "yes, later date." In the, "When was Administration notified and any action taken" field, it was marked, "yes, at a later date." This report was not signed.

The next entry in R1's "Resident's Notes," dated 05/05/2025, (time not specified), stated the facility

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reported R1 was missing to the local police. This form was signed by the AA.

Review of the Police Department's "Missing Person File, " dated 05/05/2025 at 4:25 PM, and marked, "Missing Disabled," revealed the facility Administrator documented on the form as "Caretaker," reported R1's last contact was on 04/30/2025 at 10:30 PM.

Review of R1's "Resident's Notes," dated 05/10 (no year specified) (no time specified), revealed police brought R1 back to the facility around 12:30 PM, then the police completed paperwork and took R1 to the hospital. This entry was signed by Medication Technician (Med Tech)5.

In an interview with Med Tech5, on 06/12/2025 at 3:05 PM, she stated she was unable to explain her entry in R1's "Resident's Notes," dated 05/10 as it was illegible. Med Tech5 stated she recalled the police attempted to bring R1 back to the facility, but she notified the police that R1 needed to be taken to a hospital. Med Tech5 stated she and the police filled out the necessary paperwork, and the police took R1 to the hospital.

Review of the University Hospital "Emergency Department (ED) Note", dated 05/10/2025, revealed the patient (R1) was found and released to Shelbyville police, and it was believed he had been on the streets. The patient was brought to the Emergency Room at 18:23 (6:23 PM) by the Crisis Intervention Team. Per the ED Note, the patient's feet were dirty, and he was sun-burned.

Review of the University Hospital "History and Physical", dated 05/10/2025, revealed patient (R1) went missing from the facility on 04/30/2025, and was recovered on 05/10/2025. Further review

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revealed per report, patient had been without basic needs and medications during this time. Officers report patient was unable to communicate clearly, and refused food and water. In Emergency Psychiatric Services, patient noted to be disorganized and bizarre. Unable to participate in evaluation, nonsensical responses to all questions. On evaluation, patient seen in his room, laying in bed, with bright, red sunburn on all exposed parts of his body. Further review revealed the resident was diagnosed with schizophrenia, and he received several PRN medications to try to calm him down.

During an interview with the Police Detective, on 05/14/2025 at 9:49 AM, he stated police were not notified of R1 missing from the facility until 05/05/2025 at 3:04 PM. He stated he spoke with SG2 and she told him R1 had been missing since 04/16/2025. The police detective stated R1 had returned to the facility since 04/16/2025, and left again. He further stated the facility made 207 calls requesting help from the police since June 2023, and only 130 of the calls were actually "police matters." The police detective stated the facility, " ...always has something going on. These residents are always walking around in other people's yards, or getting into screaming matches with other residents, but most of their [the facility's] problems are between the residents and the staff. "

Review of an email sent 05/06/2025 at 1:53 PM, revealed SG2 asked the Regional Director if R1 had been missing since 04/16/2025. There was no reply from the Regional Director. In another email sent 05/06/2025 at 2:31 PM from SG2 to the Regional Director, SG2 asked if staff spoke with SG1, because there was no documentation to support SG1 was ever notified of R1 missing

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from the facility. The Regional Director replied she would have to get back with SG2 once she spoke with staff regarding the details.

During an interview with SG2, on 05/14/2025 at 10:00 AM, she stated she was the current State Guardian for R1, and she was only made aware of R1 missing from the facility on 05/06/2025. She further stated the Regional Director sent an email on 05/06/2025 at 1:39 PM, which stated R1 was missing, and the facility had initiated a missing person's report with the police department. SG2 stated she replied to the email asking when R1 went missing, and she requested an incident report from the Regional Director. SG2 stated the Regional Director sent her another email on 05/06/2025 at 1:49 PM, stating staff from the facility had notified SG1 with the first report of R1 missing on 04/16/2025, and the next report related to R1 missing was made with the police on 05/05/2025.

During an interview with SG1, on 05/08/2025, she stated nobody from the facility contacted her regarding R1 missing from the facility, and she was not currently the State Guardian for R1. SG1 stated guardianship for R1 changed from herself to SG2 on 07/25/2025.

Review of the Weather Channel website revealed the following weather conditions for Louisville, KY for 04/30/2025 through 05/10/2025, the days R1 was missing from the facility.

All temperatures are in degrees Fahrenheit:
04/30/2025 - High temperature 84 , low temperature 65 , and cloudy.
05/01/2025 - High temperature 78 , low temperature 70, and cloudy.
05/02/2025 - High temperature 79, low

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temperature 63, and cloudy.
05/03/2025 - High temperature 65, low temperature 56, and scattered showers.
05/04/2025 - High temperature 55, low temperature 50, and scattered showers.
05/05/2025 - High temperature 58, low temperature 48, and cloudy.
05/06/2025 - High temperature 70, low temperature 52, and mostly cloudy.
05/07/2025 - High temperature 76, low temperature 56, and cloudy.
05/08/2025 - High temperature 75, low temperature 62, and cloudy.
05/09/2025 - High temperature 71, low temperature 53, and mostly sunny.
05/10/2025 - High temperature 73, low temperature 51, and mostly cloudy.

Review of the facility's form titled, "Resident Sign Out Roster" for April and May of 2025, revealed R1's name was not on any of the forms, meaning he failed to sign in or out, during the times he left and returned to the facility.

During an interview with Personal Care Assistant (PCA)1, on 05/13/2025 at 2:35 PM, he stated R1 came and went as he pleased, and he did not sign in or sign out when leaving the property or when returning. Further, he recalled on 04/25/2025, on Friday, when he left work, R1 was not at the facility. PCA1 stated when he returned the next day, Saturday, R1 was still not at the facility. He further stated that was when staff realized R1 had been out of the facility for at least twenty-four (24) hours and he reported this to the Assistant Administrator. PCA1 stated he was not instructed to search for R1 after he reported the resident missing. He stated he searched for R1 on his own, looking inside and outside on the grounds, but the resident was not located. He

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further stated he also talked to R1's roommate to see if he knew where he went, but the roommate had no idea.

During an interview with Med Tech1, on 05/13/2025 at 10:15 AM, she stated R1 came and went, and he did not sign in or sign out when leaving the property or when returning. In continued interview, she stated R1 went missing, " ...about four (4) weeks ago." She then stated it was the last week of April. Med Tech1 was unable to provide the exact date R1 left the facility. She stated the residents were free to come and go as they pleased, and the staff at the facility were not permitted to restrain or detain the residents in any way. She stated if she detected a decline in a resident's mental capacity, she would try to deter them from leaving the building. Med Tech1 further stated she did not like for the residents with severe cognitive impairments to be allowed to go in and out of the facility as they pleased because there was a "big risk they will get hurt." When questioned of R1 acted as though he had cognitive impairment, she stated R1 was not able to have a conversation with anyone, and he never talked to staff or other residents. Med Tech1 further stated R1 made nonsensical comments all the time and did not make eye contact with anyone.

During an interview with the AA, on 05/13/2025 at 3:15 PM, she stated the KMPR she signed on 04/29/2025 was completed after staff informed her the resident had been missing over 24 hours. She stated she also wrote the "Resident's Notes," entry on 04/30/2025. However, she stated she could not recall details related to the resident missing or the date the resident returned to the facility. In continued interview, the AA stated R1 was actually deemed missing from the facility on

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04/30/2025. The AA stated R1 did wander off all the time, sometimes just around the property outside the facility, and other times, he may go farther. In continued interview, she stated the residents had rights and staff was not allowed to try and make the residents stay at the facility. When questioned how the facility supervised and monitored residents, she stated all residents were to sign in and out, but most of them didn't. The AA stated the Administrator made the decision of when to call the police for a missing resident.

During an interview with the Administrator, on 05/13/2025 at 10:00 AM, and on 05/14/2025 at 9:20 AM, she stated R1 was in and out of the facility all the time, but he usually returned before 9:00 - 10:00 PM, when the night-time medications were being administered. She stated R1 had, " ...significant cognitive impairment, and he refused his medications on a regular basis. She stated R1, " ...always refused his medications." She further stated his doctor was aware, as was his State Guardian. In continued interview the Administrator stated the resident was noted to be missing on 04/16/2025, but returned, and she could not recall any details as to where he had gone or how long he had been away. In additional interview, the Administrator stated staff noticed R1 was missing from the facility on 04/30/2025. She stated no notification was made to the police or to the State Guardian for at least five or six days.

During continued interview with the Administrator, on 05/13/2025 at 10:00 AM, and on 05/14/2025 at 9:20 AM, she was questioned how the facility supervised and monitored the residents. She stated the employees were supposed to be completing "Bed Checks," to verify the residents were in the facility; however, they were not

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completing them accurately or correctly. She stated if the bed checks were being performed correctly, the facility would have recognized the resident was missing sooner. According to the Administrator, the bed checks were still a work in progress and she planned to have all staff re-trained or educated on the correct way to do the bed checks. Further, the Administrator stated the residents were to sign themselves in and out of the facility as per the facility agreement; however, the residents were not doing this.

During interview with the Regional Director, on 05/14/2025 at 1:32 PM, she was questioned whether R1 had been missing from the facility since 04/16/2025 or 04/30/2025. She stated R1 left the facility on 04/16/2025, as he did all the time, but he returned to the facility another day. She stated the facility realized the resident was missing again from the facility on 04/30/2025. The Regional Director stated R1 would leave and be gone all day on a regular basis, and sometimes he would stay gone all night. She stated R1 was sometimes outside the facility walking around, and he had walked all the way to Louisville before. The Regional Director stated staff knew R1 was always on the go, and that was why she didn't think anything of him being absent.

During continued interview with the Regional Director, on 05/14/2025 at 1:32 PM, she stated she was unaware of a "Golden D Alert" or what it was. (A Golden D Alert is a type of missing person alert used in Kentucky specifically for individuals with cognitive or developmental disabilities who are missing and believed to be at risk). She stated she had always waited 24 hours, and then notified the police for a missing resident. When questioned why it took five days for the facility to notify the police that R1 was missing,

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she stated staff didn't know he was "missing" because he was in and out of the facility all the time. In further interview, she stated R1 was found after he was reported missing and was admitted to a local hospital.

During interview with the Regional Director, on 05/14/2025 at 3:20 PM, she stated the facility staff had been educated numerous times regarding State Guardian notifications. The Regional Director stated the Stated Guardian, or anyone who was a Responsible Party for a resident, should always be notified immediately with any kind of change, incident, or issue with the resident although the facility did not have a policy with this information. She stated there was also an after-hours number available for staff to call if something happened throughout the night. The Regional Director was unable to give a reason as to why SG2 was not notified until six days after the facility identified R1 was missing.

2. Review of the document titled, "Order of Appointment of Guardian," dated 09/28/2023, revealed the state was awarded guardianship over R2.

Review of the facility's "Admission/Summary Sheet," revealed the facility initially admitted R2 on 12/01/2023 with admitting diagnoses which included history of a head injury, hypertension, cerebral trauma, personality disorder, and drug and alcohol use. Further review revealed R2 was under the care of a State Guardian.

Review of the "Kentucky Missing Person's Report," dated 01/18/2025, by the local police department, revealed R2 was deemed missing by the facility and was reported to be last seen on 01/17/2025, at 5:30 PM. R2 was reported missing

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to the police on 01/18/2025 at 4:29 PM by the Regional Director. (There were no facility incident reports or resident notes related to the resident missing during this time).

Review of the facility's "Incident Report," dated 02/25/2025 (no time indicated), revealed R2 was walking the halls and outside screaming and cursing. Further review revealed the Med Tech notified the State Guardian on third shift. This report was signed by the Assistant Administrator on 02/26/2025.

Review of the facility's "Incident Report," dated 03/05/2025 at 12:00 PM, revealed R2 was hitting the walls, getting up in multiple residents' faces, and hit Personal PCA1. Further review revealed the Med Tech notified the State Guardian. The form was not signed.

Review of the facility's "Incident Report," dated 04/11/2025 at 1:30 PM, revealed R2 hit another resident in the face because of the way he was looking at R2. Further review revealed the State Guardian was notified at 2:00 PM. The form was signed by the Assistant Administrator on 04/11/2025.

Review of the "Kentucky Incident Based Reporting System" Report, dated 04/11/2025 at 2:15 PM, revealed it was reported R2 assaulted another resident and Med Tech4, which caused minor injury. When the police officers arrived at the facility, R2 was no longer at the facility. Further review of the report, revealed the police were unable to locate R2 at this time.

Review of the facility's "Incident Report," dated 04/11/2025 at 2:25 PM, revealed R2 came down the stairs and threw a pizza box at Med Tech 4,

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COLONIAL MANOR	920 HENRY CLAY STREET SHELBYVILLE, KY 40065

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and hit her on the right side of her head. Further review revealed the State Guardian was notified at 2:27 PM and the AA and Administrator were notified at 2:45 PM. The document also revealed an assault charge was filed through the police department. This form was signed by the AA and Med Tech 4 on 04/11/2025.

Review of the facility's "Incident Report," dated 04/13/2025 (no time indicated), revealed R2 pushed another resident on the floor causing the other resident to hit her face on the floor. Further review revealed the Med Tech working that shift notified the State Guardian on first shift. This form was signed by the AA on 04/14/2025.

In an interview with PCA1, on 05/13/2025 at 2:35 PM, he stated R2 was very aggressive. PCA1 stated he was at the facility on 04/11/2025, when R2 hit one of the other residents, then she hit Med Tech 4 on the side of the head. PCA1 stated R2 was not upset or angry prior to this incident. PCA1 further stated R2 left the facility before the police arrived, and he did not know when she came back to the facility.

In an interview with Med Tech1, on 05/13/2025 at 10:15 AM, she stated R2 had multiple incidents of hitting others, screaming and cursing, and leaving the facility. Med Tech1 stated she was working at the facility on 4/11/2025, when R2 hit another resident and hit Med Tech 4. She stated there was another incident on a different day, when R2 threw a bowling ball at another resident for no reason. Med Tech1 stated the bowling ball did not actually hit that resident, but it was close. Med Tech1 stated after R2 acted out, she would always run away from the facility, but she always came right back.

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P 210	Continued From page 27 Review of the facility's forms titled, "Sign IN/OUT Sheet," for the months of January, February, March, and April of 2025, revealed R2 did not sign herself out of the facility when she left the property, and she did not sign herself back into the facility when she returned. In an interview with R2's Grandmother, on 06/13/2025 at 3:02 PM, she stated in January 2025, (she was unsure of the exact date), R2 was missing from the facility for two to three days, then the facility reported R2 missing. The Grandmother was unable to recall details of where R2 was located, when she was located, or any other details of the incident related to the resident missing in January 2025. In continued interview, R2's Grandmother stated on 04/12/2025, someone who worked at the "smoke shop," located approximately one mile from the facility, called her (Grandmother) to inform her R2 was outside the "smoke shop," upset. The Grandmother stated she was several hours away from R2, so she called R2's Step-Father, and asked him to go pick R2 up from the "smoke shop." In an interview with R2's Step-Father, on 06/17/2025 at 1:42 PM, he stated he did not recall exactly what date, but he received a call from R2's Grandmother, then went to pick up R2 from the "smoke shop," located approximately one mile from the facility. R2's Step-Father stated R2 had been crying and was upset when he picked her up. He stated he drove R2 back to the facility, but she made it very clear she was not going to stay at the facility. R2's Step-Father stated he let the facility know he was taking R2 to visit her Grandmother so R2 went inside to pack enough clothes for a few days.	P 210		

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P 210	Continued From page 28 During an interview with PCA1, on 05/13/2025 at 2:35 PM, he stated R2 was very aggressive and he was scared of her. The PCA stated R2 was always starting fights with other residents and lashing out at staff for no apparent reason. PCA1 stated R2 recently hit two residents and a staff member. PCA1 further stated R2 just walked up to the staff person and punched her in the side of the head, and was not provoked in any way. In continued interview, PCA1 stated he was not aware of R2 missing in January 2025, and he was not aware of R2 missing in April 2025. PCA1 stated R2 always left and returned to the facility, and he did not know if she signed herself in and out of the facility. During an interview with Med Tech1, on 05/13/2025 at 10:15 AM, she stated R2 just had her days, and had slapped or hit other residents and staff. Med Tech1 stated R2 had picked up a bowling ball and threw it across the room at another resident at one time. Med Tech1 further stated R2 had been discharged home to her Grandmother, and she as well as the rest of the staff believed that was safest for R2 at this time. Med Tech1 stated R2 was able to come and go as she wished while at the facility, and she was unaware if R2 ever signed herself in/out of the facility. Med Tech1 was unaware of R2 missing in January 2025 or April 2025. During an interview with the AA, on 05/13/2025 at 3:15 PM, she stated she was unaware of R2 missing in January 2025, and was also unaware of R2 missing in April 2025. She then stated she did not recall the date, but sometime in April, R2 left the facility because she got mad and took off walking away from the facility. The AA stated she saw R2 crossing the railroad tracks, just down the road from the facility, and she stopped and asked	P 210		

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R2 where she was going. The AA stated R2 told her she didn't know. The AA stated an hour later, she saw R2 again at a local restaurant. The AA further stated staff called and notified her that R2's Grandmother had requested her cell phone number, and then she (AA) began texting with the Grandmother regarding the home visit the Grandmother wanted to set up for R2. The AA stated staff was told by R2's Grandmother, R2 was going to be on a home visit for some time.

During continued interview with the AA, on 05/13/2025 at 3:15 PM, she stated she told her staff on numerous occasions to be sure and document when they knew a resident had left the property, whether they left the facility frequently or not. The AA stated staff should let the next shift know if a resident was not on the property when they changed shifts, and once a resident had been gone for 24 hours, they were to report that resident as missing. She stated sometimes police would conduct an interview over the phone with staff, and other times they would come to the facility to get a statement from staff if a resident was missing. The AA further stated the residents were supposed to sign in and out, but sometimes they didn't remember to do that, and she would remind them or at least try and find out where the resident was going and when they planned to return to the facility. She stated it was hard to keep up with all of the residents coming and going at all times.

During an interview with the Administrator, on 05/13/2025 at 10:00 AM, she stated R2 left the facility almost every single day, but she would return before 9:00 PM every night. The Administrator stated R2 was at the "vape shop", down the road from the facility in April, either the 10th or the 11th, and decided to call her

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Grandmother to come and get her. The Administrator stated she was unaware of R2 missing in January 2025 and R2 was never missing during April 2025. She stated R2 did leave on numerous days in April, but she was never missing.

In an interview with the Administrator, on 06/06/2025 at 1:45 PM, and 2:25 PM, she stated R2's family told the facility R2 was going with her Grandmother for a "home visit," but never mentioned R2 was to be discharged until later. The Administrator stated SG2 notified the facility, on 04/18/2025, to discharge R2 effective 04/13/2025.

In a follow up interview with the Administrator, on 06/20/2025 at 11:13 AM, she stated she had previously been confused on the dates R2 was at the facility last. The Administrator stated she recalled R2 assaulting a staff member and another resident on 04/11/2025. She stated 04/12/2025 was the day R2 went to the smoke shop, and was picked up by family. She further stated 04/12/2025 was the last day R2 was in the facility.

During an interview with the Regional Director, on 05/14/2025 at 4:15 PM, she stated R2 left the facility every day, but was always back by 9:00 PM every night. Further, she stated she could not recall the exact date, but R2's Grandmother texted her (Regional Director) to let her know she had picked up R2 and the resident would be staying with her from now on. She could not recall where R2's family had picked up the resident. The Regional Director stated R2 went everywhere, and once R2 walked all the way to Louisville.

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In an interview with the Regional Director, on 06/20/2025 at 1:30 PM, she was unable to recall any details about R2 missing in January of 2025; however, she did recall trying to file a Mental Inquest Warrant (MIW) for R2 some time in January 2025. She stated there were multiple times the MIW was attempted on R2 during January 2025, but it kept getting denied or canceled by the police department or by the Judge. The RD did not recall filing a missing person's report for R2 in January, 2025. A copy of the Missing Person's Report was provided to the Regional Director, but she was unable to recall any details of the report. The Regional Director was also unable to recall R2 missing in April 2025.

3. Review of the facility's "Medication Delivery Policy for Home Visits or Leave of Absence", undated, revealed the facility requires a 24 hour notice for residents to leave the facility for overnight home visits or other leave of absences. Further review of the policy revealed the reason for the notice is to allow pharmacy enough time to fill the medications for the home visits. The policy did not include the process for sending medications on leave with the residents.

Review of the facility's Discharge form, dated 04/18/2025, revealed R2 was officially discharged from the facility on 04/13/2025.

Review of the facility's "Medication Administration Record", dated May 2025, revealed facility staff signed as R2 receiving medication through 04/12/2025.

In an interview with R2's Step-Father, on 06/17/2025 at 1:42 PM, he stated he could not recall the exact date in April 2025, but he went to

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the nurse's station at the facility, and picked up R2's medications. R2's Step-Father stated he did not have to sign any paperwork, staff did not ask him for any identification, and they seemed to be very busy at that time. He stated he had been at the facility to visit R2 on multiple occasions.

In an interview with R2's Grandmother, on 06/09/2025 at 10:31 AM, she stated upon R2's discharge on 04/13/2025, she administered R2's medications from the medication cards received from the facility. She stated she took R2 to the new physician's office on 05/08/2025 after the resident was discharged from the facility, in order to get R2's medications restarted. R2's Grandmother stated she gave all R2's medications to the Office Manager at the new physician's office on 05/08/2025, the day she took R2 to the physician for the first time. R2's Grandmother stated the Office Manager realized the facility had given her (R2's Grandmother) another resident's (R6's) medications as well. R2's Grandmother stated the Office Manager took pictures of R6's medications before destroying them.

In further interview, on 06/09/2025 at 10:31 AM, R2's Grandmother stated she gave R6's medications to R2 starting on 04/13/2025, until the medication errors were discovered by R2's new physician's Office Manager on 05/08/2025 (26 days later). R2's Grandmother stated she popped the pills out of the medication cards, and handed them to R2, and R2 then took the medications. R2's Grandmother stated she just gave the medications like the cards said, once a day or twice a day or whatever, and she did not look at the name on the cards. In continued interview with R2's Grandmother, she stated R2 suffered multiple side effects from taking R6's

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medications including dizziness, weakness, near passing out on several occasions, and drowsiness.

In an interview with the Office Manager of R2's new physician, on 06/09/2025 at 10:53 AM, she stated she had pictures of all R6's medications that were brought into the office by R2's Grandmother, and R2 had been administered these medications by mistake.

Review of the email sent by the Office Manager of R2's new physician's office, dated 06/09/2025 at 10:53 AM, to the State Survey Agency Representative, revealed pictures of the cards/sheets of medications prescribed by the facility's physician, with R6's name. The medications were as follows:
*Atorvastatin 40 milligram (mg) - Take one tablet by mouth at bedtime (medication to treat high cholesterol).
*Amlodipine 5 mg - Take one tablet by mouth every day (medication to treat high blood pressure, and this medication can lower heart rate).
*Olanzapine 15 mg - Take one tablet by mouth at bedtime (atypical antipsychotic medication).
*Metoprolol 100 mg - Take one tablet by mouth twice daily (medication to lower blood pressure and lower heart rate). (This is the highest dosage available to prescribe.)
*Paroxetine HCL 20 mg - Take one tablet by mouth every evening (anti-depressant medication).

In an interview with R2's new physician's Office Manager, on 06/09/2025 at 8:28 PM, she stated, " ...the resident [R2] wasn't necessarily given more or less of any medications, she was given medications she should not be taking at all. For

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example, she [R2] was given two (2) blood pressure medications that she should not be taking, and she was given an additional antipsychotic, with the one she was already taking." The Office Manager further stated she noticed R6's name on five (5) of the medication cards and notified R2's Grandmother and also notified R2's new physician. The Office Manager stated she contacted the facility and notified them of the medication error on 05/08/2025, but she could not recall which staff member she spoke with.

In an interview with R2's new Physician, on 06/10/2025 at 11:47 AM, she stated the medications R2 had been given that were prescribed to R6, could have potentially caused R2's blood pressure to drop too low, which could have, in turn, caused her to pass out, and potentially lead to permanent, physical harm.

In an interview with the Pharmacist, on 06/13/2025 at 2:42 PM, he stated R6's medications that were given to R2's Grandmother to administer to R2 could have potentially caused R2 harm. He stated the physician's order for one (1) of the blood pressure medications, metoprolol, was 200 mg every day, and that was the maximum dose for that medication, which could have caused severe effects on someone who did not have high blood pressure. The pharmacist further stated the physician's order for the other blood pressure medication, amlodipine, was for 5 mg daily, and that was a "regular" or "average" dose. The pharmacist stated the two medications blood pressure medications together, could have potentially lowered R2's blood pressure, and heart rate. He further stated if R2's blood pressure and heart rate were already at a normal rate prior to the administration of these

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P 210	Continued From page 35 medications, this could potentially, " ...not sustain human life." In an interview with Med Tech 5 on 06/12/2025 at 3:05 PM, she stated the day R2's Step-Father came to pick up R2's medications was very busy, and there was a lot going on. She stated she, and another Med Tech, who was training with her at the time, worked on getting R2's medications together for what the facility thought was a home visit. Med Tech 5 stated she was not aware R2's family was given the wrong medications. She stated there was so much chaos going on at that time and between her and the other Med Tech, they must have grabbed R6's medications by mistake. She stated when residents left for a home visit, the facility was notified in advance, so they usually had the medications together when the family arrived. However, she stated they did not have R2's medications together before the family arrived on 04/12/2025. In an interview with the Administrator, on 06/06/2025 at 1:45 PM, she stated she was unaware of R2's family receiving another resident's medications. The Administrator stated staff should always check the Medication Administration Record (MAR) to see what medications a resident was currently prescribed prior to sending medication home with the responsible party for a home visit. The Administrator stated R2's family told the facility R2 was going with her Grandmother for a "home visit," but never mentioned R2 was to be discharged until later. The Administrator stated SG2 notified the facility, on 04/18/2025, to discharge R2 effective 04/13/2025.	P 210		

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P 320	902 KAR 20:036 5(3)(b)1 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. 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, and interview, the facility failed to maintain a clean and safe environment free of unpleasant odors. The findings include: Observation on 05/12/2025 at 2:15 PM, revealed the front entrance hallway had an unpleasant odor consistent with the smell of urine. Observation on 05/13/2025 at 8:45 AM, revealed a strong unpleasant odor consistent with the smell of urine noted when walking in the front doors of the facility. Staff was cleaning the front	P 320		

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P 320	Continued From page 37 entrance as the State Survey Agency (SSA) Representatives entered the building, but the area continued to have a lingering unpleasant odor. In an interview with the Regional Director, during the exit conference over the phone, on 05/16/2025 at 5:00 PM, she laughed when she was told of the urine smell when walking into the facility. The Regional Director stated, "It's a personal care home, it's always going to smell like urine. The residents pee on themselves and make it smell like urine. I'm not sure what exactly you want me to do about that."	P 320		
P 335	902 KAR 20:036 5(3)(b)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: (b) Housekeeping and maintenance services. 4. Maintenance. The premises shall be well kept and in good repair as established in clauses a. through d. of this subparagraph. a. The facility shall ensure that the grounds are well kept and the exterior of the building, including the sidewalk, steps, porches, ramps, and fences, are in good repair. b. The interior of the building, including walls, ceilings, floors, windows, window coverings, doors, plumbing, and electrical fixtures, shall be in good repair. Windows and doors shall be screened. c. Garbage and trash shall be stored in areas separate from those used for the preparation and storage of food and shall be removed from the premises regularly. Containers shall be cleaned	P 335		

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P 335	Continued From page 38 regularly. d. A pest control program shall be in operation in the facility. Pest control services shall be provided by maintenance personnel of the facility or by contract with a pest control company. Care shall be taken to use the least toxic and least flammable insecticides and rodenticides. The compounds shall be stored under lock if stored by the facility. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility Maintenance Log/Repair Form, the facility failed to ensure the facility was kept in good repair. The findings include. Observation on 05/12/2025 at 2:15 PM, revealed a hole in the ceiling of the front porch which was approximately two feet long and one foot wide.	P 335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100382	A. BUILDING: _____ B. WING _____	C 06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR	920 HENRY CLAY STREET SHELBYVILLE, KY 40065

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P 335	Continued From page 39 Observation on 05/12/2025 at 2:30 PM, revealed the Dining room had three stains which were brown in color on the ceiling tiles; a sticky floor; chipped paint on the walls; cracks in several windows, and rotting windowpanes around the window air conditioner. Observation on 05/12/2025 at 3:36 PM, of Bathroom #4 on the first floor, revealed missing tile over the shower and sink exposing pipe. Observation on 05/12/2025 at 3:41 PM, of Bathroom #1, revealed missing ceiling tiles from the lowered ceiling exposing damage to the original ceiling. The damage to the original ceiling included missing drywall exposing old broken wood and exposed pipes and wire, and black and dark areas that appeared to be consistent with mildew. There was also an air vent tube hanging out of the wall and a crack in the shower floor. Observation on 05/12/2025 at 3:44 PM, of Bathroom #2, revealed missing tile exposing pipes. There were three brown stained ceiling tiles, and one of the ceiling tiles had a hole. Additionally, the front of the sink was cracked. Observation of Bathroom #6, on 05/12/2025 at 3:46 PM, revealed a broken ceiling tile. The door to the bathroom had holes and cracks on the front side. Observation of the Employee Breakroom, on 05/13/2025 at 9:52 AM, revealed it was very cluttered with two large pieces of plywood, cleaning supplies, and large bags containing unknown items. The room had chairs on the counter and there was very little room to move around. One of the chairs was cloth with several dark colored stains. Additionally, there were	P 335		

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P 335	Continued From page 40 brown stains on the walls and ceiling. Record review confirmed there was an estimate for the entire roof repair, but it was not dated. Further, there was an estimate for repairs for Rooms #1, #11, and #19 which was prepared on 03/05/2025. However, there were no estimates for repair of the bathrooms, dining room or breakroom included in the information submitted for review. Review of the facility "Maintenance Log/Repair" Form, revealed eight items needed repair. The items included: 1) Window pane in dining room needed painted, which was reported on 01/05/2024, and not initialed as completed. 2) Door in Room #6 needed tightened, which was reported on 01/05/2024, and not initialed as completed. 3) Door in Room #3 needed tightened, reported on 01/05/2024, not initialed as completed. 4) Light socket in dining room, no description, reported on 01/05/2024, "getting electrician". Not initialed as completed. 5) Toilet seat in bathroom reported on 03/11/2025, "getting new toilet seat". Not initialed as completed. 6) Door knob in Room #30 coming off, reported on 04/27/2025, not initialed as completed. 7) Closet door in Room #5, no description, reported on 04/29/2025, not initialed as completed. 8) Toilet leaking in Bathroom #1, reported on 05/08/2025, not initialed as completed. Record review revealed monthly in-service training since January 2025, with staff regarding maintenance services and policy related to reporting repairs needed.	P 335		

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P 335	Continued From page 41 During an interview with the Regional Director, on 05/14/2025 at 9:23 AM, she stated the facility did not have a full-time maintenance person. She stated the former full-time maintenance person retired when the current owners purchased the facility a little over a year ago. She further stated the current part-time maintenance person could only do minor repairs. The Regional Director stated the facility was looking for a full-time maintenance person and contractors to make the major repairs needed. She further stated the facility had received an estimate for roof repair. During an interview with the Administrator, on 06/06/2025 at 1:45 PM, she stated she had been in the position since around the end of February this year (2025). She stated the prior Administrator was the current Regional Director. The Administrator further stated there was now a full-time maintenance person on-site, who lived next door to the facility and he was on-call 24/7. The Administrator stated residents were to report any maintenance issues at the nurse's station. She stated the maintenance log was checked daily and was kept in the nursing station. The Administrator further stated she met with the maintenance person weekly to review issues and repairs. During continued interview with the Administrator, on 06/06/2025 at 1:45 PM, she stated response time for repairs depended on the repairs needed. She stated major repairs required a contractor, and the contract had to be sent to the Regional Director for approval. She further stated the facility did have a contract with a company for major repairs pending approval. Review of the contract proposal, dated	P 335		

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P 335	Continued From page 42 05/08/2025, submitted for review revealed the following areas were included as needing repair: bathrooms, bedrooms (40 units), hallways, flooring, front porch, and roof.	P 335		