STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100190	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISONVILLE REST HOME I LLC	140 GIVENS STREET MADISONVILLE, KY 42431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Initial Comments A Relicensure and Complaint Survey were concluded on 05/21/2025. The facility was found not to be in substantial compliance. No deficiencies were issued related to KY00046127. Survey Dates: 05/20/2025 - 05/21/2025 Survey Census: 52 Sample Size: 12	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 and record review, it was determined the facility failed to conduct required tuberculin (TB) screening and/or testing for two of nine sampled residents and six of six employees. The facility failed to conduct a required baseline Tuberculosis (TB) Risk assessment, and/or TB testing upon hire. In addition, the facility failed to provide annual screening.	P 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jessica Darnell TITLE Administrator (X6) DATE 6-20-25

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P 100	Continued From page 1 The findings include: Review of a facility policy titled "TB infection control plan", dated 08/2016, revealed staff members, new hires, residents, and new admissions would receive annual PPD skin test, BAMT, or chest X-ray in accordance with state regulations. Additionally, risk assessments would be completed on an annual basis. 1. Review of Medication Technician (MT) 1's employee file revealed a hire date of 09/22/2022. Further review revealed there was no documented evidence that an annual TB risk assessment had been completed. 2. Review of Resident Aide (RA) 1's employee file revealed a hire date of 09/20/2024. Further review revealed there was no documented evidence that a TB risk assessment had been completed. 3. Review of RA 2's employee file revealed a hire date of 11/15/2015. Further review revealed there was no documented evidence that an annual TB risk assessment had been completed. 4. Review of RA 3's employee file revealed a hire date of 10/06/2023. Further review revealed there was no documented evidence that an annual TB risk assessment had been completed. 5. Review of Dietary Manager (DM)'s employee file revealed a hire date of 05/09/2022. Further review revealed there was no documented evidence that an annual TB risk assessment had been completed. 6. Review of Maintenance Director (MD)'s employee file revealed a hire date of 10/02/2024.	P 100	"Facility Administrator will ensure adherence to state regulations regarding TB screening and/or testing for all residents as well as baseline TB risk assessments, and /or TB testing for all staff upon hire and again annually for staff/residents. Testing may be conducted via PPD skin test, BAMT., or chest x-ray in accordance with state regulations. POC completion date 6-11-25"	

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P 100	Continued From page 2 Further review revealed there was no documented evidence that a TB risk assessment had been completed. Review of Resident (R)4's medical record revealed the facility admitted the resident on 01/21/2025. Further review revealed no documented evidence that he received TB testing or a risk assessment upon admission. Review of R6's medical record revealed the facility admitted the resident on 11/13/2024. Further review revealed no documented evidence that she received TB testing or a risk assessment upon admission. During an interview with the Administrator on 05/21/2025 at 2:00 PM, she stated she did not know the facility was required to complete a risk assessment along with the TB test. She stated she would be doing that going forward. She further stated she thought since the facility did Chest X-rays, they were not required to do a risk assessment. The Administrator stated R4 and R6 did not have admission TB test and she was not sure why. She stated she was unable to locate a TB test for either resident. She stated her expectations were to ensure TB test and Risk assessments were done and up to date per regulations.	P 100		
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	P 105		

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P 105	Continued From page 3 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. This requirement is not met as evidenced by: Based on interview and record review, the facility failed to obtain Nurse Aide Abuse Registry (NAAR) checks and Adult Caregiver Misconduct Register (ACMR) checks as required upon hire for six (6) of six (6) sampled employees.	P 105	"Facility Administrator will ensure that prior to an offer of employment, applicants have been run against the nurse aide and home health aide abuse registry, the caregiver misconduct registry, that a criminal record check is run as well as maintaining employee records with requisite documentation. POC completion date 6-3-25."	

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P 105	Continued From page 4 The findings include: 1) Review of the Maintenance Director's personnel record revealed a hire date of 10/02/2024. Further review of the personnel record revealed no evidence that a NAAR or ACMR was completed at the time of hire. 2) Review of the Resident Aide (RA) 1's personnel record revealed a hire date of 09/20/2024. Further review of the personnel record revealed no evidence that a NAAR or ACMR was completed at the time of hire. 3) Review of the RA 2's personnel record revealed a hire date of 11/15/2015. Further review of the personnel record revealed no evidence that a NAAR or ACMR was completed at the time of hire. 4) Review of the Dietary Manager's personnel record revealed a hire date of 05/09/2022. Further review of the personnel record revealed no evidence that a NAAR or ACMR was completed at the time of hire. 5) Review of the RA3's personnel record revealed a hire date of 10/06/2023. Further review of the personnel record revealed no evidence that a NAAR or ACMR was completed at the time of hire. 6) Review of the Medication Technician (MT)'s personnel record revealed a hire date of 09/22/2022. Further review of the personnel record revealed no evidence that a NAAR or ACMR was completed at the time of hire. During an interview with the Administrator on 05/21/2025 at 2:00 PM, she stated she was	P 105		

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P 105	Continued From page 5 responsible for personnel records and obtaining the required background checks. She stated she was unable to provide facility policies regarding conducting NAAR or ACMR checks for employees upon hire. Further interview with the Administrator revealed that she was not aware those checks were required and the only thing she had been doing was the criminal background check. She stated she could see the importance of doing the checks to ensure the facility wasn't hiring someone that had a history of abuse and could possibly hurt one of the residents. She stated someone could have told her she needed to do that and it may have slipped her mind but she should have asked more questions to clarify what she needed to be doing.	P 105		
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; 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	P 315		

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P 315	Continued From page 6 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 ensure each resident was provided with a clean, comfortable mattress with a support mechanism for two (2) of 12 residents (R) (R11 and R12). The findings include: Review of a facility "Resident Admission Packet" revealed the facility would provide a furnished room for the resident(s).	P 315		

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P 315	Continued From page 7 The State Survey Agency requested a policy related to what furniture the facility supplied to each resident, however, the Administrator was unable to provide a policy. Review of a Face Sheet revealed the facility admitted R11 on 10/11/2006 with diagnoses to include: Bipolar disorder, obsessive compulsive disorder, and depression. Review of a Face Sheet revealed the facility admitted R12 on 10/11/2006 with diagnoses to include: depression and personality disorder. Further review of R11 and R12's medical record revealed they are a married couple sharing a room at the facility. An observation on 05/21/2025 at 8:15 AM revealed R11 and R12's full size mattress was broken with no support. During an interview with the Maintenance Director (MD) on 05/21/2025 at 1:20 PM, he stated R11 and R12's mattress had been in bad shape for a while but was getting worse. He stated he was responsible for replacing resident's mattresses when needed. The MD stated he did not know if the facility owners would purchase a new mattress for the couple or not since they had a full size bed. He stated they usually provided twin size beds and mattresses but he did not know what the policy was. During an interview with the Regional Consultant (RC) on 05/21/2025 at 2:15 PM, she stated the facility's policy was to provide a twin size bed and mattress for each resident. She stated if a married couple wanted to sleep together they would be responsible for purchasing a larger bed	P 315	"Facility Administrator will ensure each resident has a clean, comfortable and supportive mattress, which is at least "36 wide. Starting on 6/19/25 the Administrator will perform periodic checks of the beds to confirm all mattresses and frames are in compliance. POC completion date 8/19/25."	

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P 315	Continued From page 8 and mattress. During an interview with the administrator on 05/21/2025 at 2:00 PM, she stated she was not made aware of the condition of R11 and R12's mattress until today. She stated she had contacted the RC to notify her of the condition of the mattress and see if the facility would purchase another one. She stated if the R's wanted to share a bed, they would have to supply their own bed and mattress.	P 315		
P 330	902 KAR 20:036 5(3)(b)3 Section 5. Provision of Services Section 5. Provision of Services. (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (b) Housekeeping and maintenance services. 3. Safety. The condition of the overall environment shall be maintained to ensure the safety and well-being of residents, personnel, and visitors. This requirement is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure the condition of the overall environment was to be maintained in such a	P 330		

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P 330	Continued From page 9 manner that the safety and well-being of residents, personnel, and visitors were assured. The findings include: Review of a facility policy titled, "Maintenance", dated 06/2009, revealed the facility would monitor for maintenance problems within the facility and report accurately. An observation of the 200 hall bathroom on 05/20/2025 at 8:30 AM revealed a broken/missing door from the vanity leaving the plumbing exposed. During an interview with the Maintenance Director (MD) on 05/21/2025 at 1:20 PM, he stated he was responsible for facility repairs. He stated the bathroom vanity drawer had been fixed in the past but a resident had kicked it in again and broke it a few days ago. During an interview with the Administrator on 05/21/2025 at 2:00 PM, she stated she did not know how long the vanity door had been broken. She stated it had been fixed in the past. She further stated the vanity was old and needed to be replaced.	P 330	"Starting on 6/19/25 Facility Administrator will perform periodic checks on a weekly basis, for a period of 2 months, with random checks ongoing, to identify, report and resolve any necessary repairs which were observed. POC completion date 8/19/25."	
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	P 355		

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P 355	Continued From page 10 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 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.	P 355		

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P 355	Continued From page 11 This requirement is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to label, date, and cover food items when stored for 52 residents. The findings include: Review of a facility policy titled, "Food Storage and Labeling", not dated, revealed all items should be dated and if an item was removed from it's original container, the new container should be labeled and dated. Observation of the walk in cooler on 05/20/2025 at 10:25 AM, revealed a gallon of whole milk that had been opened but was not labeled or dated, a block of sliced cheese that was opened but not labeled or dated, a bag of sausage patties and pepperoni that had been opened, were not sealed, labeled or dated, 10 bottles of ketchup with no date, and a pitcher of unsweet tea with a prepared date of 05/13/2025 but no discard date. Observation of the dry storage area on 05/20/2025 at 10:25 AM, revealed 4 containers with filled with a dry powdered substance that were not labeled or dated, and two bags of dry noodles that were opened but not sealed, labeled, or dated. During an interview with the Kitchen Manager	P 355	"Facility Administrator has conducted an in-service training with all kitchen staff on 6-1-25 and will randomly monitor the kitchen to inspect food items, starting on 6-1-25 for a period of 3 months, to verify compliance with food storage and labeling requirements. POC completion date 9/1/25."	

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P 355	Continued From page 12 (KM) on 05/20/2025 at 10:45 AM, she stated her kitchen staff were lazy and she had a hard time getting them to do what they were supposed to. She stated the facility had purchased ketchup in a bulk bag and they reused old ketchup bottles to pour the ketchup into to make it easier to use but the staff did not put a date on the bottle. She stated she expected whoever opened a container to label and date it at that time. She stated staff would not know when an item expired or should be discarded without the dates on there. She stated if that was not done, residents could be served expired foods. She stated she expected staff to label and date any food when they open it or when it was prepared to prevent from using food or drinks that were potentially no longer any good. During an interview with the Cook on 05/21/2025 at 1:30 PM, she stated if she opened an item, she would put the date it was opened and the date it expired. She stated an item could go bad or mold if you didn't do that. She also stated the next person would not know when the item had been opened or when it would expire without it being labeled and dated. During an interview with the Administrator on 05/21/2025 at 2:00 PM, she stated she had recently inserviced the kitchen about labeling and dating items because it had been an issue of it not being done by the staff. She stated it was important to ensure the food was being stored properly to prevent bacteria from growing, germs from spreading or rodents from getting into the items. The Administrator stated she expected staff to follow the regulations and it was just something that has to be done.	P 355		