PRINTED: 08/11/2020 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		SURVEY PLETED =	
		18G007	B. WNG		07	C 07/31/2020	
	ROVIDER OR SUPPLIER  GARDENS		440	REET ADDRESS, CITY, STATE, ZIP CODE 1 LOUISE UNDERWOOD WAY UISVILLE, KY 40216			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 000	KY32028) and a CC control survey was i concluded on 07/31 to be in compliance Physical Environme Centers for Medicar and Centers for Disc (CDC) recommende COVID-19. Compla unsubstantiated. Immidentified at 42 CFR (W0122). Standard	gation (KY32014 and DVID-19 focused infection nitiated on 07/21/2020 and 1/2020. The facility was found with 42 CFR 483.470 nt and has implemented the e & Medicaid Services (CMS) ease Control and Prevention ed practices to prepare for	W 000				
	identified on 07/31/2 on 06/17/2020, and Review of Client #1 revealed the client I (the persistent eatin nutritional value) art to supervise the clie required to be within client, and one staff within unobstructed revealed staff were surroundings and rebatteries and other ingest, to ensure th 06/17/2020, staff far required supervision battery. Client #1 v where it was confirmately and laxative assist with passage	2020, was determined to exist					

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

-	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		18G007	B. WING_		C 07/31/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4401 LOUISE UNDERWOOD WAY LOUISVILLE, KY 40216		01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 000	reported that he/she Client #1 was transfe	supervision and Client #1 had swallowed a "toilet bolt." erred to the hospital where an client had a metallic hex nut	wo	00		
W 122	CLIENT PROTECTI CFR(s): 483.420	ONS sure that specific client	W 1	22		
	Based on interview, the facility's policies footage, it was deternensure clients were one (1) of three (3) see Review of Client #1' revealed the client houtritional value) and to supervise the clie and 07/10/2020, sta	a not met as evidenced by: record review, and review of and video surveillance mined the facility failed to protected from neglect for sampled clients (Client #1). Is Individual Life Plan (ILP) and a history of pica behavior of substances that have no d required two staff members int. However, on 06/17/2020 If failed to supervise the client client ingested foreign objects ex nut).				
	Protocol-Bingham G revealed all resident Review of the facility	titled, "Abuse and Neglect fardens," dated 04/01/2019, ts would be free from neglect. y's policy titled, "Facility Risk col," revised October 2019,			T	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		18G007	B. WING		0.	C 7/31/2020
	ROVIDER OR SUPPLIER GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE  4401 LOUISE UNDERWOOD WAY  LOUISVILLE, KY 40216			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 122	Appendix A, revealed	e 2 I neglect was defined as or individual with known	W 122			
	revealed the facility a 07/12/2018 with diag Moderate Intellectual Generalized Anxiety Personality Disorder, Impulse-Control, and of Client #1's Individu the client had a histo persistent eating of supervise the client required to be within client, and one staff within unobstructed I revealed staff were resurroundings and rer	noses that included Disability Disorder, Pica, Disorder, Antisocial and Unspecified Disruptive, Conduct Disorder. Review ual Life Plan (ILP) revealed ry of pica behavior (the ubstances that have no I required two staff members at. One staff member was two (2) arms' length of the member was required to be ine of sight. Further review equired to sweep Client #1's move items, including ems the client could possibly				
	O6/17/2020 at 2:15 F Professional (DSP) # supervision for Clien within two (2) arms' r report revealed the of remote and swallower intervene. Per the intransferred to the ho treatment. The hosp recommendation wallaxatives to assist with	lent Report (IR) dated IM revealed Direct Support If was providing line of sight It #1 and DSP #2 was to be reach of the client. The Idient obtained the television Icident report, the client was Ispital for evaluation and Initial treatment Is the administration of Ith passage of the battery. Ideo surveillance of the Idia trevealed after making a				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		18G007	B. WING_		- a   o	7/31/2020
	ROVIDER OR SUPPLIER GARDENS		196	STREET ADDRESS, CITY, STATE, ZIP CODE 4401 LOUISE UNDERWOOD WAY LOUISVILLE, KY 40216		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
W 122	phone call, Client #1 and removed the bal ingested a battery, premote control, and table. The event of the battery occurred (8) second period. It observed turning his interacting with anot the video revealed Ecouch with a blockin turned away from Client #1 reported to bolt from the toilet. The hospital for evalunt hexagonal metallic for the client's sto Resident Care Note transferred back to 12:55 AM.  Observation of facili 07/10/2020 at appro DSP #4 and DSP#5 Client#1's bedroom	picked up the remote control tery cover. The client then laced the cover back on the placed the remote back on a the client removing/ingesting over an approximately eight During this time, DSP #1 was back on the client and her client. Further review of DSP #2 was observed hitting a g pad while her head was	W			
	07/30/2020 at 2:48 member providing to was required to obs and the staff membereach supervision, v. (2) arms' reach of the staff members are supervision, v. (2) arms' reach of the staff members are supervision.	ommunity Director on PM, revealed the staff he line of sight supervision erve the client at all times, er providing the within arms' was required to stay within two he client. The Community were required to do pica				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			LETED			
		18G007	B. WNG	dr		31/2020
	OVIDER OR SUPPLIER		440	REET ADDRESS, CITY, STATE, ZIP COD 01 LOUISE UNDERWOOD WAY OUISVILLE, KY 40216	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
W 122 W 149	client moved from on and should have che environment for item According to the Con not following levels of considered neglect.  Refer to F149.  STAFF TREATMENT	s environment when the e environment to another cked the client's s that could be ingested. nmunity Director, if staff were f supervision it was	W 122			
	policies and procedumistreatment, neglect mistreatment, neglect This STANDARD is Based on interview, the facility's policy at determined the facili policy to protect one clients from neglect The findings include	elop and implement written res that prohibit ct or abuse of the client.  not met as evidenced by: record review, and review of nd video surveillance it was ty failed to implement facility (1) of three (3) sampled (Client #1).				
	Management Protoc Appendix A, reveale "lack of supervision special needs."	r's policy titled, "Facility Risk ol," revised October 2019, d neglect was defined as for individual with known titled, "Abuse and Neglect 01/2019, revealed all free from neglect.				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		C	(X3) DATE SURVEY COMPLETED	
	1	18G007	B. WING _		1	C 07/31/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4401 LOUISE UNDERWOOD WAY LOUISVILLE, KY 40216			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		
W 149	revealed the facility a 07/12/2018 with diag Moderate Intellectual Generalized Anxiety Personality Disorder, Impulse-Control, and of the Individual Life date of 06/09/2020 rextensive history of a the client had a beha intervention plan dev which directed staff to supervision and to be environment to look a potentially ingest when environment to another evealed the client legion (2) staff members; or required to be within client, and one staff within unobstructed lattempted pica behablock and intervene in the control of client.	al record for Client #1 admitted the client on noses that included Disability Disorder, Pica,	W 1				
	three (3) staff memb client's bed wearing Equipment (PPE). Interview with Client 07/22/2020, revealed swallowed a bolt from	#1 at 2:50 PM on d the toilet and that his/her othering him/her. Client #1					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/11/2020 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_ B. WNG 18G007 07/31/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4401 LOUISE UNDERWOOD WAY **BINGHAM GARDENS** LOUISVILLE, KY 40216 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID. (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 149 Continued From page 6 W 149 a. Review of an Incident Report (IR), dated 06/17/2020 at 2:15 PM, revealed Direct Support Professional (DSP) #1 completed the incident report and marked the type of incident as Pica. According to the report, two (2) staff members were providing supervision for Client #1. DSP #1 was providing line of sight supervision and DSP #2 was to be within two (2) arms' reach of the client. The report revealed the client obtained the remote and swallowed a battery before staff could intervene. Per the incident report, the client was sent to the hospital for evaluation and treatment. Further review revealed the incident was followed up with an internal/special investigation. A review of the Hospital x-ray report dated 06/17/2020 at 5:27 PM revealed Client #1 had a 3.6-centimeter linear radiopaque foreign body in the region of the stomach. A review of resident care notes revealed when the client returned from the hospital the client was ordered to receive Magnesium Citrate (a laxative), five (5) ounces now and five (5) ounces in 12 hours. Review of the facility's "Internal/Special Investigation Report," dated 06/28/2020, revealed the facility initiated an investigation of the pica incident on 06/17/2020. Client #1 was confirmed to have swallowed an AA battery from the remote control and according to hospital records, the battery was in the client's stomach. The facility concluded that based on the preponderance of evidence and review of video, the staff followed Client #1's level of supervision and no abuse or neglect was suspected. However, the facility failed to identify staff's failure to provide Client #1's assessed level of supervision to prevent

Client #1 from ingesting a battery.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		18G007	B. WING_				l '	31/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4401 LOUISE UNDERWOOD WAY LOUISVILLE, KY 40216				3172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B	SHOULD BE COMPLET	
W 149	Continued From page	e 7	W 1	49				(4)
	from 06/17/2020, rev PM, Client #1 came of the phone. The client remote control and colying on the desk. The remote control and pure directly behind him/hiphone from the desk to another staff mem the client. Client #1 house phone, turned remote control, and right The client then ingest cover back on the removing/ingesting the approximately eight (this time, DSP #1 was on the client and interest DSP #2 was not obscribed to staff were observed.	s video surveillance footage ealed at approximately 2:15 but of the bedroom to use t sat down at a desk where a ell phone were observed he client picked up the laced the remote on a table er. Client #1 picked up a cell and handed the cell phone ber that was not assigned to completed his/her call on the around, picked up the emoved the battery cover. Ited a battery, placed the mote control, and placed the mote control, and placed the able. The event of the client he battery occurred over an (8) second period. During is observed turning his back tracting with another client. Erving Client #1 while the phone, and was not within arms' reach of the client sted the battery. In addition, ed to block or attempt to Client #1 from the pica						
	revealed he was ass supervision" for Clier watching the client u DSP #1, he was requall times and to main in case the client dis required intervention	et on 07/30/2020 at 1:03 PM, igned to provide "line of sight at #1 on 06/17/2020, and was se the phone. According to uired to observe the client at tain line of sight supervision played a behavior that DSP #1 stated the client did not see the client ingest			± ± ± ± ± ± ± ± ± ± ± ± ± ± ± ± ± ± ±			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION		SURVEY PLETED
		18G007	B. WING		- 1	C
NAME OF P	ROVIDER OR SUPPLIER	100001		STREET ADDRESS, CITY, STATE, ZIP COD		/31/2020
BINGHAM	GARDENS			4401 LOUISE UNDERWOOD WAY		
DINGHAN	GARDENS			LOUISVILLE, KY 40216		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
W 149	Interview with DSF PM, revealed she of 06/17/2020, and w reach of the client. she did not work w to DSP #2, she was of Client #1 because the client did not lill she did not observ 06/17/2020, or interview with the on 07/30/2020 at 2 conducted an inverse According to the R did not consider st thought Client #1 supervision. The I stated DSP #3 (ne client when the client with the client when the client with the client when the client with the cl	was assigned to Client #1 on as assigned to be within arms' Further interview revealed with Client #1 often. According is not within two (2) arms' reach se she wears glasses, which ke. Further interview revealed we Client#1 ingest a battery on ervene because she was killing about to bite another client.  The Risk Management Director 2:11 PM, revealed she estigation of the incident. Lisk Management Director, she was within his/her level of Risk Management Director with Management Director with hired staff) was near the ent swallowed the battery and a DSP #3 was not assigned to		149		
	o7/30/2020 at 2:48 responsible for the facility and reviews Community Direct the community day client's level of sur Community Direct #1 was out of his/lithe Risk Manager was in his/her level Per the Community providing the line required to observe	Community Director on B PM, revealed he was a day-to-day operation of the ed all incident reports. The or stated he made rounds in ity to ensure staff followed each pervision. According to the or, he was not aware that Client her level of supervision because informed him that the client el of supervision on 06/17/2020. Ity Director, the staff member of sight supervision was we the client at all times, and the viding the within arms' reach				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED			
		18G007	B. WNG			1	31/2020
	GARDENS			4	STREET ADDRESS, CITY, STATE, ZIP CODE 4401 LOUISE UNDERWOOD WAY LOUISVILLE, KY 40216	, 017	-
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 149	supervision was requireach of the client. The stated staff were required the client's environment on the client's environment of the could be ingested the bedroom to the limitary of the could be ingested the bedroom to the limitary of the could be ingested to be intervene and block in the could be intervene and block in the facility protocol, if the facility protocol, if the could be a revealed DSP #4 con according to the report of the could be compared to use the could be considered to use the could be considered to the considered to the could be considered to the considered to th	ired to stay within two arms' he Community Director aired to do pica sweeps of ent when the client moved at to another and should ent's environment for items d when the client went from ving room. The Community etaff were to attempt to f the client had a pica to the Community Director, if and levels of supervision, per et was considered neglect.  dated 07/10/2020 at 6:52 PM, anpleted the report. ort, at 6:48 PM, Client #1 bathroom and staff (DSP #4	W	149			
	and DSP #5) took the client informed DSP had swallowed a bold hospital and according the client had a hexathe stomach.  A review of the Emer 07/10/2020 at 8:31 Pdiagnosed with foreign of the hospital x-ray 9:39 PM, revealed a hexagonal metallic for stomach.  Interview with DSP # revealed she was as reach of Client #1 on she and DSP #5 tool after the client asked.	e client to the bathroom. The #4 and DSP #5 that he/she is. Client #1 was sent to the ing to the hospital x-ray report gonal metal foreign body in gency Room Record dated M, revealed Client #1 was in body ingestion. A review report, dated 07/10/2020 at 2.2-centimeter diameter preign body within the distal 44 on 07/22/2020 at 3:19 PM, signed to be within arms' 107/10/2020. DSP #4 stated is to use the bathroom. DSP the bathroom with Client #1.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		18G007	B. WING_				C 07/31/2020	
	GARDENS		3		SS, CITY, STATE, ZIP CODI INDERWOOD WAY KY 40216			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		(EA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 149	DSP #5 was behind she did not see Clie looked at the toilet had swallowed a not loose. The DSP strangervisor.  Interview with DSP AM, revealed she vanother staff memb 07/10/2020, and the bathroom. DSP #5 with Client #1 to the #5, she did not mai of Client #1 because and the client. Furnot see Client #1 in the bathroom. The aware the client ing told staff he/she has stated she saw the supervisor.  Observation of faci 07/10/2020 at appr DSP #4 and DSP# Client#1's bedroom providing the client as DSP #4 was no #5 was not within lied. An interview with the Disabilities Profess 2:56 PM, revealed facility for two year history of pica behaladmission. The Qilents of pica behaladmission.	ge 10 Il arms' reach supervision and if her. According to DSP #4, ent #1 swallow a nut but after the client reported he/she at and observed a bolt was ated she then informed the  #5 on 07/23/2020 at 10:39 was covering a break for per assigned to Client #1 on eclient asked to use the estated she and DSP #4 went estated she and DSP main line of sight supervision at DSP at was between her of the interview revealed she did agest a nut while he/she was in a DSP stated she was not pested anything until the client and ingested a "bolt." The DSP loose bolt and informed the  Ility video surveillance on oximately 6:41 PM, revealed to were observed looking out of a door. The staff were not suffer in arms' reach and DSP and of sight of Client #1.  The Qualified Intellectual client (QIDP) on 07/28/2020 at Client #1 had lived at the service of the client had an extensive avior that was present on IDP stated an Individual Life reloped for Client #1, which	W 1	49				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		18G007	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	100001			REET ADDRESS, CITY, STATE, ZIP CODE	07/31/2020	
- 1					1 LOUISE UNDERWOOD WAY		
BINGHAN	GARDENS			LО	UISVILLE, KY 40216		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
W 149	included a positive be crisis intervention plate pica behavior. According to the control of the	ehavior support plan and a an to help manage the client's rding to the QIDP, Client #1 of members assigned to one staff member with in two es, and one staff member in sight at all times. The QIDP hibited behaviors the staff d block to prevent the pica.  Community Director on PM, revealed the staff ent on 07/10/2020, were off the tome of the investigation. To this incident was in to the Community Director, of stay within line of sight and at #1, per the facility protocol. In the Community Director	W	149			

**FORM APPROVED** Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 07/31/2020 100198 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4401 LOUISE UNDERWOOD WAY **BINGHAM GARDENS** LOUISVILLE, KY 40216 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1000 1 000 Initial Comments A complaint investigation (KY32014 and KY32028) and a COVID-19 focused infection control survey was initiated on 07/21/2020 and concluded on 07/31/2020. Complaint #KY32028 was unsubstantiated. Complaint #KY32014 was substantiated and deficient practice was identified. No deficient practice was identified related to the infection control survey. A Type "A" Citation was issued to the facility on 08/04/2020. 1012 902 KAR 20:086-3(6) Section 3. Administration 1012 and Operation (6) Patient rights. Patient rights shall be provided for pursuant to KRS 216.510 to 216.525. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy and video surveillance it was determined the facility failed to implement facility policy to protect one (1) of three (3) sampled clients from neglect (Client #1). The findings include:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Review of the facility's policy titled, "Facility Risk Management Protocol," revised October 2019,

TITLE

(X8) DATE

Office of Inspector General

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. Boicbind.		С	
		100198	B. WING		07/31/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
BINGHAM	GARDENS		UISE UNDERWOO ILLE, KY 40216	D WAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE {EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY}	IOULD BE COMPLETE	
l 012	Continued From page	e 1	1012			
	Appendix A, revealed	d neglect was defined as or individual with known				
	Review of the policy Protocol," dated 04/0 residents would be fr					
	revealed the facility a 07/12/2018 with diag Moderate Intellectual Generalized Anxiety Personality Disorder Impulse-Control, and of the Individual Life date of 06/09/2020 rextensive history of the client had a behaintervention plan dewisch directed staff to supervision and to denvironment to look potentially ingest whenvironment to another vealed the client less than the control of the client less than the control of the client less than the clie	Disability Disorder, Pica,				
	required to be within client, and one staff within unobstructed attempted pica beha block and intervene behavior.  Observation of Clien PM, revealed the client three (3) staff memb	two (2) arms' length of the member was required to be line of sight. If client #1 viors staff were required to in an attempt to prevent the t #1 on 07/22/2020 at 2:50 ent lying in bed, awake, with ers in the room near the full Personal Protective				

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 100198 07/31/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4401 LOUISE UNDERWOOD WAY BINGHAM GARDENS** LOUISVILLE, KY 40216 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1012 1012 Continued From page 2 Interview with Client #1 at 2:50 PM on 07/22/2020, revealed the client stated he/she swallowed a bolt from the toilet and that his/her stomach had been bothering him/her. Client #1 denied swallowing other objects. a. Review of an Incident Report (IR), dated 06/17/2020 at 2:15 PM, revealed Direct Support Professional (DSP) #1 completed the incident report and marked the type of incident as Pica. According to the report, two (2) staff members were providing supervision for Client #1. DSP #1 was providing line of sight supervision and DSP #2 was to be within two (2) arms' reach of the client. The report revealed the client obtained the remote and swallowed a battery before staff could intervene. Per the incident report, the client was sent to the hospital for evaluation and treatment. Further review revealed the incident was followed up with an internal/special investigation. A review of the Hospital x-ray report dated 06/17/2020 at 5:27 PM revealed Client #1 had a 3.6-centimeter linear radiopaque foreign body in the region of the stomach. A review of resident care notes revealed when the client returned from the hospital the client was ordered to receive Magnesium Citrate (a laxative), five (5) ounces now and five (5) ounces in 12 hours. Review of the facility's "Internal/Special Investigation Report," dated 06/28/2020, revealed the facility initiated an investigation of the pica incident on 06/17/2020. Client #1 was confirmed to have swallowed an AA battery from the remote control and according to hospital records, the battery was in the client's stomach. The facility concluded that based on the preponderance of evidence and review of video, the staff followed Client #1's level of supervision and no abuse or

PRINTED: 08/11/2020 FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WNG 100198 07/31/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4401 LOUISE UNDERWOOD WAY **BINGHAM GARDENS** LOUISVILLE, KY 40216 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY 1012 Continued From page 3 1012 neglect was suspected. However, the facility failed to identify staff's failure to provide Client #1's assessed level of supervision to prevent Client #1 from ingesting a battery. Review of the facility's video surveillance footage from 06/17/2020, revealed at approximately 2:15 PM, Client #1 came out of the bedroom to use the phone. The client sat down at a desk where a remote control and cell phone were observed lying on the desk. The client picked up the remote control and placed the remote on a table directly behind him/her. Client #1 picked up a cell phone from the desk and handed the cell phone to another staff member that was not assigned to the client. Client #1 completed his/her call on the house phone, turned around, picked up the remote control, and removed the battery cover. The client then ingested a battery, placed the cover back on the remote control, and placed the

STATE FORM

behavior.

remote back on the table. The event of the client removing/ingesting the battery occurred over an approximately eight (8) second period. During this time, DSP #1 was observed turning his back on the client and interacting with another client. DSP #2 was not observing Client #1 while the client was using the phone, and was not within the required two (2) arms' reach of the client when the client ingested the battery. In addition, no staff were observed to block or attempt to intervene to prevent Client #1 from the pica

Interview with DSP #1 on 07/30/2020 at 1:03 PM, revealed he was assigned to provide "line of sight supervision" for Client #1 on 06/17/2020, and was watching the client use the phone. According to DSP #1, he was required to observe the client at all times and to maintain line of sight supervision in case the client displayed a behavior that

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
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		4401 LOU	ISE UNDERWOO	D WAY		
BINGHAM	GARDENS		LE, KY 40216			
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I 012	Continued From page	e 4	1012			
	, -		1 1			1 1
		DSP #1 stated the client did not see the client ingest				5
	Interview with DSP #2 on 07/30/2020 at 12:37 PM, revealed she was assigned to Client #1 on 06/17/2020, and was assigned to be within arms'					
#0	she did not work with to DSP #2, she was	urther interview revealed Client #1 often. According not within two (2) arms' reach she wears glasses, which				
	the client did not like she did not observe 06/17/2020, or interv	Further interview revealed Client#1 ingest a battery on ene because she was killing				
	an insect that was at	oout to bite another client.				
	on 07/30/2020 at 2:1 conducted an investi According to the Risl did not consider staff thought Client #1 wa supervision. The Ris	Risk Management Director  1 PM, revealed she gation of the incident.  K Management Director, she fineglect because she s within his/her level of K Management Director y hired staff) was near the				22
	client when the client she was not aware D	t swallowed the battery and OSP #3 was not assigned to				
24	1	emmunity Director on				
20	facility and reviewed Community Director the community daily client's level of super Community Director,	ay-to-day operation of the all incident reports. The stated he made rounds in to ensure staff followed each roision. According to the he was not aware that Client				70
	the Risk Manager in was in his/her level of	r level of supervision because formed him that the client of supervision on 06/17/2020. Director, the staff member				

PRINTED: 08/11/2020 FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ 100198 07/31/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4401 LOUISE UNDERWOOD WAY **BINGHAM GARDENS** LOUISVILLE, KY 40216 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 1012 1012 Continued From page 5 providing the line of sight supervision was required to observe the client at all times, and the staff member providing the within arms' reach supervision was required to stay within two arms' reach of the client. The Community Director stated staff were required to do pica sweeps of the client's environment when the client moved from one environment to another and should have checked the client's environment for items that could be ingested when the client went from the bedroom to the living room. The Community Director stated both staff were to attempt to intervene and block if the client had a pica behavior. According to the Community Director, if staff were not following levels of supervision, per the facility protocol, it was considered neglect. b. A review of an IR dated 07/10/2020 at 6:52 PM. revealed DSP #4 completed the report. According to the report, at 6:48 PM, Client #1 requested to use the bathroom and staff (DSP #4 and DSP #5) took the client to the bathroom. The client informed DSP #4 and DSP #5 that he/she had swallowed a bolt. Client #1 was sent to the hospital and according to the hospital x-ray report the client had a hexagonal metal foreign body in the stomach. A review of the Emergency Room Record dated 07/10/2020 at 8:31 PM, revealed Client #1 was diagnosed with foreign body ingestion. A review of the hospital x-ray report, dated 07/10/2020 at

stomach.

9:39 PM, revealed a 2.2-centimeter diameter hexagonal metallic foreign body within the distal

Interview with DSP #4 on 07/22/2020 at 3:19 PM, revealed she was assigned to be within arms' reach of Client #1 on 07/10/2020. DSP #4 stated she and DSP #5 took the client to the bathroom

Office of Inspector General (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_\_ C B. WING 07/31/2020 100198 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4401 LOUISE UNDERWOOD WAY BINGHAM GARDENS** LOUISVILLE, KY 40216 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1012 1012 Continued From page 6 after the client asked to use the bathroom. DSP #4 stated she was in the bathroom with Client #1. and she maintained arms' reach supervision and DSP #5 was behind her. According to DSP #4, she did not see Client #1 swallow a nut but looked at the toilet after the client reported he/she had swallowed a nut and observed a bolt was loose. The DSP stated she then informed the supervisor. Interview with DSP #5 on 07/23/2020 at 10:39 AM, revealed she was covering a break for another staff member assigned to Client #1 on 07/10/2020, and the client asked to use the bathroom. DSP #5 stated she and DSP #4 went with Client #1 to the bathroom. According to DSP #5, she did not maintain line of sight supervision of Client #1 because DSP #4 was between her and the client. Further interview revealed she did not see Client #1 ingest a nut while he/she was in the bathroom. The DSP stated she was not aware the client indested anything until the client told staff he/she had ingested a "bolt." The DSP stated she saw the loose bolt and informed the supervisor. Observation of facility video surveillance on 07/10/2020 at approximately 6:41 PM, revealed DSP #4 and DSP#5 were observed looking out of Client#1's bedroom door. The staff were not providing the client's required level of supervision as DSP #4 was not within arms' reach and DSP #5 was not within line of sight of Client #1. An interview with the Qualified Intellectual Disabilities Professional (QIDP) on 07/28/2020 at 2:56 PM, revealed Client #1 had lived at the facility for two years. The client had an extensive history of pica behavior that was present on admission. The QIDP stated an Individual Life

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		LOUISVI	LLE, KY 40216			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5) COMPLETE
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1.040	Continued From 1999	- 7	1012			
I 012	Continued From pag	je /	1012			
	Plan had been deve	loped for Client #1, which				
	included a positive b	ehavior support plan and a	1 1			
	crisis intervention pl	an to help manage the client's				
	pica behavior. Acco	ording to the QIDP, Client #1				
		ff members assigned to			2.	
		one staff member with in two				
		nes, and one staff member in				
		sight at all times. The QIDP				
	stated if the client exhibited behaviors the staff				A.	
		nd block to prevent the pica				
	behavior.			_		i
	On intensional state the	- Carrey-ity Director on				
		e Community Director on PM, revealed the staff			1	
		ent on 07/10/2020, were off				
	1	utcome of the investigation.				
		to this incident was in	ì			·
		g to the Community Director,		E <sub>2</sub>		
		to stay within line of sight and				- 1
	1	nt #1, per the facility protocol.				
	1	th the Community Director				
		P, pica sweeps were				
35	completed by staff t	out were not required to be	1			S.
	documented, until a	fter the incident occurred on				
	07/10/2020. The C	ommunity Director stated				
		ed for both staff members to				
		lient's bedroom door. The				
		r stated staff had a two-way		18		
	1	ontact the supervisor or	1			
		ded. Per the Community				
		vas more at risk for pica				
		nt was not being provided				
	1 '	rdance with the Individual Life				
	Plan.					
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE  4401 LOUISE UNDERWOOD WAY  LOUISVILLE, KY 40216				
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E 000	Initial Comments		E 000				
	survey was initiated concluded on 07/31 to be in compliance	/2020. The facility was found with 42 CFR 483.475 dness related to E0024. No					
					in (5)		
		ė.					
:			8				
					E		
LABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>	TITLE	(X6) DATE		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



#### CABINET FOR HEALTH AND FAMILY SERVICES OFFICE OF INSPECTOR GENERAL

Andy Beshear Governor Donetta Ball, Human Services Program Branch Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744
(606) 330-2030
Fax: (606) 330-2054
http://chfs.ky.gov/agencies/os/oig

Eric C. Friedlander Secretary

> Adam Mather Inspector General

August 11, 2020

ELECTRONIC MAIL (chad.newby@newvista.org)

Mr. Chad Newby Bingham Gardens 4401 Louise Underwood Way Louisville, Kentucky 40216

Dear Mr. Newby:

On July 31, 2020, an abbreviated survey and COVID-19 focused infection control survey was completed at your facility by the Division of Health Care to determine if your facility was in compliance with federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. During this survey, Immediate Jeopardy was identified at 42 CFR 483.420 Client Protections. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations. No deficient practice was identified related to the focused infection control survey.

Based on our determination of Immediate Jeopardy in your facility, this office is recommending termination of your provider agreement effective August 23, 2020, to the State Medicaid Agency and the Centers for Medicare and Medicaid Services Regional Office. The Division of Health Care will conduct a revisit prior to the expiration of the recommended 23-day termination if we receive a written allegation of removal of the Immediate Jeopardy.



Mr. Chad Newby August 11, 2020 Page Two

You will receive a formal notice from the State Medicaid Agency describing your rights to due process under 907 KAR1:671. If you should have questions regarding this information, please contact our office.

Sincerely,

Donetta Ball

Donetta Ball

Human Services Program Branch Manager

DB:et:lk

**Enclosures** 

c: CMS Regional Office



#### CABINET FOR HEALTH AND FAMILY SERVICES OFFICE OF INSPECTOR GENERAL

Andy Beshear Governor Donetta Ball, Human Services Program Branch Manager
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116 Commerce Avenue
London, Kentucky 40744
(606) 330-2030

(606) 330-2030 Fax: (606) 330-2054 http://chfs.ky.gov/agencies/os/oig Eric C. Friedlander Secretary

Adam Mather Inspector General

August 11, 2020

ELECTRONIC MAIL (chad.newby@newvista.org)

Mr. Chad Newby Bingham Gardens 4401 Louise Underwood Way Louisville, Kentucky 40216

Dear Mr. Newby:

The Division of Health Care completed a complaint investigation and infection control survey at your facility on July 31, 2020. This survey was conducted to determine compliance with state licensure requirements. The survey found that your facility failed to meet minimum state licensure requirements for operation of an intermediate care facility for individuals with intellectual disabilities. The deficiencies cited are listed on the enclosed Statement of Deficiencies/Plan of Correction document. No deficient practice was identified related to the infection control survey.

As part of the investigation process, each facility is required to submit a written plan for the correction of all deficiencies noted during the survey. The plan shall specify:

- The date by which the violation shall be corrected;
- The specific measures utilized to correct the violation; and
- The specific measures utilized to ensure the violation will not recur.



Mr. Chad Newby August 11, 2020 Page Two

902 KAR 20:008 Section 2.(5)(b) requires that a plan for correction of licensure deficiencies be submitted to this agency within ten (10) days from receipt of this letter. The plan, outlining methods of correction and proposed completion dates for each deficiency, should be incorporated in the column provided on the enclosed form. The form should be signed by you or an authorized representative and received in this office within ten (10) days of receipt of this letter. You should make a copy of the form for your records.

Please mail your plan of correction to the following address:

Donetta Ball
Human Services Program Branch Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744

Should you prefer faxing or emailing the plan of correction please fax it to 606-330-2054 or email it to <a href="lisa.koger@ky.gov">lisa.koger@ky.gov</a>.

Continued failure to meet minimum state licensure requirements will result in a recommendation for revocation of a license to operate an intermediate care facility for individuals with intellectual disabilities.

If you have any questions, please contact our office.

Sincerely,

Donetta Ball

motta Ball

**Human Services Program Branch Manager** 

DB:et:lk

Enclosure