STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185481	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Trace	3802 Turkeyfoot Road Elsmere, KY 41018

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview, review of the facility's documents, and review of the facility's handbook, the facility failed to support and encourage residents to organize and participate consistently in the Resident Council meeting for 2 out of 5 sampled residents, Resident (R) 6 and R38. The findings include: Review of the facility's Resident Handbook - Grievances and Complaints, undated, revealed, Residents may also voice grievances during the Resident Council meetings. Review of the facility's monthly activity calendars, dated from 02/2025 to 07/2025, revealed there were no scheduled Resident Council meetings noted on the calendar. Review of the Resident Council minutes, dated 02/2025 to 06/2025 and provided by the facility, revealed there were no other minutes or meetings during that time frame. Observation of the Resident Council meeting on 08/20/2025 at 1:00 PM revealed the Ombudsman was present, along with five resident participants. During the Resident Council meeting on 08/20/2025 at 1:00 PM R6 expressed a concern for not having consistent Resident Council meetings. Review of R6's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 05/07/2025 revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 11 out of 15, which indicated moderate cognitive impairment.In addition, during the Resident Council meeting on 08/20/2025 at 1:00 PM, R38 also expressed a concern for not having consistent Resident Council meetings. Review of R38's quarterly MDS, with an ARD of 04/11/2025, revealed the facility assessed the resident to have a BIMS score of 11 out of 15, which indicated moderate cognitive impairment.During an interview with the Ombudsman on 08/20/2025 after the Resident Council meeting at 2:14 PM, she stated she had not been notified of ongoing council meetings and asked for the Social Services Director to convene one for July 2025, and the facility complied. During an interview with the Administrator on 08/20/2025 at 2:30 PM after the council meeting, she stated she knew there had been a lapse in the regularity of the meetings since the Resident Council president transferred to another facility. She stated there were no meetings from 02/2025 through 06/2025. She stated it was her expectation that staff scheduled the Resident Council meetings and to encourage residents to participate.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185481	A. Building B. Wing	08/22/2025

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Emerald Trace	3802 Turkeyfoot Road Elsmere, KY 41018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of the facility's policy, the facility failed to store frozen green beans appropriately. Observation on 08/19/2025 of the main kitchen freezer in building B revealed the frozen green beans were taken out of the cases by staff, placed onto the shelf, and not dated according to facility policy.The findings include:Review of the facility's policy titled, Food and Supply Storage, revised 01/2025, revealed all food would be stored in a manner to prevent contamination and to maintain the safety and wholesomeness of the food for human consumption. Per the policy, staff was to use the Daymark labeling system or permanent marker to mark the received date on all items removed from the original shipping box and complete all sections of a food label sticker.Observation in the main kitchen, ground floor in building B, on 08/19/2025 at 2:45 PM revealed in the walk-in freezer, on the top shelf, staff had taken the frozen green beans out of the boxes, discarded the box, and did not date the green beans according to the date found on the box. In an interview with the Senior of Dining Services on 08/21/2025 at 2:48 PM, he stated all food should be dated according to their process, which was to put a date on all food items taken out of the case. In an interview with the Director of Health Services (DHS) on 08/22/2025 at 11:39 AM, she stated her expectation was for all food to be dated according to their process.In an interview with the Administrator on 08/22/2025 at 12:26 PM, she stated all food must be dated.