

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100413	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 12/10/2024
NAME OF PROVIDER OR SUPPLIER DISHMAN PERSONAL CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WORSHAM LANE MONTICELLO, KY 42633		
(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 Based upon implementation of the acceptable plan of correction, an off-site revisit survey was conducted on 12/10/2024. It was determined the facility was in substantial compliance as of 12/03/2024 as alleged in the acceptable plan of correction.	{P 000}			

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

TITLE

(X6) DATE

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

TITLE

(X6) DATE

STATE FORM

639

CS1U11

If continuation sheet 1 of 3

Brittany Davis

Office of Inspector General

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NAME OF PROVIDER OR SUPPLIER DISHMAN PERSONAL CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WORSHAM LANE MONTICELLO, KY 42633		
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P 190	Continued From page 1 services for one resident of one-sampled resident. The facility failed to ensure prompt medical care was obtained in a timely manner for acute lice infestation. The findings include: Observations of R44 on 11/13/2024 at 2:30PM, revealed a tall thin lady with disheveled hair dressed in long sleeve peach top, medium blue pants, and tennis shoes. No bruises or scabs were noted on R44's face or hands. R44 was observed to walk up and down the hallway scratching at her head. On 11/13/2024 at 5:23PM R44 was observed in the dining room. R44 was observed to frequently scratch at her head during dinner. Record review revealed resident(R)44 was admitted to the facility with an appointed state guardian on 11/15/2010, with Diagnoses of Schizophrenic disorder, manic bipolar, and personality disorder cluster b, hypertension, and hypothyroidism. Record review revealed the administrator emailed the nurse at the doctor's office on 11/13/2024, with concerns regarding R44 with lice and orders were received for Permethrin for R44. There was no documentation in the resident's medical record that the resident's physician was notified when the resident refused the Permethrin. Record review revealed on 10/28/2024, R44 was ordered Permethrin topical 5%, for head lice which was filled by the pharmacy on 10/28/2024. During interview on 11/13/2024 at 2:30PM, the Administrator stated R44 refused her Permethrin medication for treatment of lice infestation. The Administrator stated the resident refused to take showers, and refused medications except the orange pill the resident R44 thought was a Vitamin C tablet. During an interview with the facility nurse	P 190	Admin also asked Nurse if the medication could be crushed and administrated through applesauce. Then confirming it could be. R44 ate all applesauce with medication mixed on 11-22-24. It was charted in R44 Medical chart and Dr's nurse was notified 12-3-24 that R44 had took the medicine. R44 room was then deep cleaned. since visit on 11-12-24 Admin has done the following to approve the situation and to make sure it doesn't happen again Admin had a in-service on 11-22-24 with nursing staff on charting in residents medical charts (Inservice attached). also to ensure charting is done the admin will be doing random checks to make sure charting is being done we also plan to have refresh courses about charting and notifying Dr about refused medication and treatment in up coming monthly in-service.		

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P 190	Continued From page 2 practitioner (NP) on 11/15/2024, the facility NP stated she had written R44 a prescription for lice treatment again on 11/14/2024. The NP stated she would expect to be notified if residents were refusing treatment or not responding well to prescribed treatment regimen. The facility failed to reach out to the NP regarding follow up care for R44 when the resident refused and/or the treatment was not effective.	P 190	we will be doing weekly or as needed first one started 12-2-24 Head Lice checks (also attached) all findings sent to nurse at Dr Office for treatment and charted in Residents medical charts. Will continue to chart any updates. (progress notes included for examples) we also deep clean rooms weekly unless needed sooner and headchecks to ensure the infestation does not happen again.	12-3-24	