Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100413	A. BUILDING: _____ B. WING _____	R 06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISHMAN PERSONAL CARE HOME	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 on-site revisit survey was conducted on 06/16/2025 - 06/17/2025. It was determined the deficiencies were deemed corrected as of 05/29/2025 as alleged in the acceptable plan of correction.	{P 000}		

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

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P 000	Initial Comments A relicensure and abbreviated survey investigating complaints KY00045383 and KY00045471 was initiated on 03/31/2025 and concluded on 04/03/2025 with deficiencies cited. The Complaints KY 00045383 and KY00045471 were not in compliance with the regulatory requirements and deficient practice was cited. The Census was 47	P 000	TO Correct The Cited deficiences that was initiated on 03/31/2025 through 04/03/2025. The CEO done new background checks on all employees on 04/15/2025. As well as a caregivers misconduct registry and nurse aide abuse registry. A copy was placed in employee folders. Each Employee folder was Checked to asure correct paperwork was in each one. Administrator and Asst. Administrator now send all of the above. in when we do their new hire assessment with the CEO.	
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	P 105		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sethra Brown — TITLE: Admin — (X6) DATE: 5-29-25

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P 105	Continued From page 1 (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 record review and interview, it was determined the facility failed to maintain current employee records containing evidence of background checks, including the nurse aide abuse registry and caregiver misconduct registry, for 3 of 4 employee records reviewed. The findings include: In an interview with the Administrator on 04/03/2025 at 11:15 AM, she stated that there was no policy regarding employee records. Review of the Assistant Administrator employee file revealed a hire date of 09/12/2024. There was no evidence of a criminal background check, a caregiver misconduct registry, or a nurse aide abuse registry on file. Review of the Medication Aide (MA) 1's employee file revealed a hire date of 03/26/2025. There was no evidence of a caregiver misconduct registry or proof of a nurse aide abuse registry check on file. A review of Medication Aide (MA) 2's employee file revealed a hire date of 03/27/2025. There	P 105	Background Checks was completed for all employees currently hired, by the CEO. Administrator, Asst. Admin. and CEO assure to do all checks needed before hiring all/any new employee...	4/15/25 When they are hired

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P 105	Continued From page 2 was no evidence of a completed caregiver misconduct registry or a nurse aide abuse registry check on file. In an interview with the Administrator on 04/03/2025 at 11:15 AM, the Administrator stated she had only been in the administrator role for one week. The Administrator indicated that it was the Chief Executive Officer's job to obtain all new employee's criminal background checks, caregiver misconduct registry, and a nurse aide abuse registry when the employee was hired. The Administrator stated that she expected every new hire to have a background check, a caregiver misconduct registry, and a nurse aide abuse registry to be completed before employment to ensure they were eligible for employment at the facility.	P 105	Administrater conducted an inservice/refresher for all Staff on 04/16/2025. on employee JOB duties and correct Paperwork to be filled out daily by all Staff.	04/16/25
P 120	902 KAR 20:036 4(10)(h) Section 4. Administration and Operation (h) In-service training. 1. Each PCH or SPCH employee shall receive orientation and annual in-service training that corresponds with the staff member's job duties. 2. Documentation of orientation and in-service training shall be maintained in the employee's record and shall include: a. Name of the individual or individuals who provided the training; b. Date and number of hours the training was given; and c. A summary of the training program's content. 3. In-service training shall include: a. Policies regarding the responsibilities of specific job duties; b. Services provided by the facility; c. Recordkeeping procedures;	P 120	Admin and asst. Admin agreed to write ups for any employee that fails to do the job duty and paperwork daily.	04/17/25

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P 120	Continued From page 3 d. Procedures for the reporting of cases of adult abuse, neglect, or exploitation pursuant to KRS 209.030; e. Resident rights established by KRS 216.510 through 216.525; f. Adult learning principles and methods for assisting residents to achieve maximum abilities in ADLs and IADLs; g. Procedures for the proper application of emergency manual restraints; h. Procedures for maintaining a clean, healthful, and pleasant environment; i. The aging process; j. The emotional problems of illness; k. Use of medication; and l. Therapeutic diets. 4. Each SPCH shall ensure that at least one (1) direct care staff member in addition to the administrator completes the mental illness or intellectual disability training workshop established by 921 KAR 2:015, Section 14, within six (6) months of hire and every two (2) years thereafter. An SPCH shall employ at least one (1) direct care staff member who has received the training. This LEVEL A is not met as evidenced by: Based on Observation, Interview, and review of the facility policy, it was determined the facility failed to ensure that all dietary staff maintained a food handler card and one staff member was a certified food protection manager, per county	P 120	The CEO Contracted Eastern State Hospital and Several other places for mental illness or intellectual disability training disability training workshop. Could not find any where that offers these trainings. DIG confirmed no where was giving the trainings. CEO will follow up monthly to find training. On tuesday 04/29/2025 Eventus the doctor will be doing glucose monitoring and weight loss training and when to notify doctor. Gap Drug will be doing med pass training with Staff on 04/30/25. 04/30/2025 EMS will be doing CPR training, First aid training 04/30/2025 cnt →	

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P 120	Continued From page 4 guidelines. Review of the policy titled "Dishman PCH Policies & Procedures Manual," undated, revealed the facility will follow all relevant local, state, and federal laws, regulations and standards. Review of the county's health department website revealed, as per Health Department and the FDA Food Code 2013 requirements, each establishment shall have a certified food protection manager who is able to direct and control food preparation and service. The local health department requires all food handlers to become certified food employees. In an interview, on 04/01/2024 at 9:28 AM, Health Environmentalist stated that one staff member from the facility had to take the "Food Managers Class" and any staff member who prepared or cooked food needed to have a food handler card. In an interview, on 04/01/2025 at 9:45 AM, Cook 1 stated that both she and Cook 2 were managers of the kitchen but that she had not taken any course for management certification and did not currently hold a food handler card. In an interview, on 04/01/2025 at 9:45 AM, Cook 2 stated that he was a manager of the kitchen but did not hold any certifications or a food handler card. Additionally, Cook 2 stated that it had been "a long time" since he or Cook 1 had any of their certifications updated. In an interview, on 04/03/2025 at 3:31 PM, the Administrator stated no current staff member had	P 120	With Staff on 04/30/25. An account was Set up on 04/23/2025 with Statecert.com. Administrator and Kitchen Manager Completed food manager Course Starting 04/23/2025. All other Staff members Completed the regular food handlers course Starting on 04/23/2025. Administrator and Asst. Administrator plan to Sign all new employees up and get their food handlers Completed within a month of being hired.	04/23/2025

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P 120	Continued From page 5 their food handler card. Additionally, the Administrator stated that she was unaware staff had to have food handler cards that were issued through the local Health Department the facility was in.	P 120	Medical records was not always available by the nurse practioner. So facility owners switched to Eventus Whole Health PA Mike Helm. He started seeing the residents on 03/25/2025 and continues to do so every tuesday of each week. Psych is through the same company. Keisha Todd comes to the facility twice monthly. Both can be reached through the company app when residents need something or them. CNB	03/25/25
P 155	902 KAR 20:036 4(11)(b)5 Section 4. Administration and Operation Section 4. Administration and Operation. (11) Medical records. (b) Each record shall include: 5. Physician, health care practitioner, or QMHP progress notes indicating any changes in the resident's condition, documented at the time of each visit by the physician, health care practitioner, QMHP, or consultant; This requirement is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain current resident medical records containing physician or health care practitioner notes indicating any changes in the resident's condition, documented at the time of each visit for one Resident (R) (Resident 1) of 26 sampled residents records reviewed. The findings include: During an interview on 04/01/2025 at 11:57 AM, the Administrator stated, "The facility does not have a policy that describes what documents must be the resident's medical record." A review of R1's "Admission Face Sheet"	P 155		

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P 155	Continued From page 6 revealed that the facility admitted the resident on 01/30/2025 with a diagnosis of schizophrenia and depression. A review of R1's medical record revealed that he was admitted under Nurse Practitioner 1's services. The review further revealed that R1's medical record contained no notes from a healthcare practitioner since his admission on 01/30/25. During an interview on 03/31/2025 at 3:30 PM, R1 stated, "I have seen the nurse practitioner a couple of times since I have been at the facility." During a further interview on 04/03/2025 at 11 AM, the Administrator stated, "Nurse Practitioner 1 had seen R1 a couple of times but uses her company's laptop with their system, and we do not have access to the records. We have requested the records of the residents in the facility that Nurse Practitioner 1 cares for but have never received the visit notes or lab results ordered on residents." The Administrator stated, "This has been an ongoing issue with Nurse Practitioner 1, and the facility is in the process of discontinuing services."	P 155	Summarys of each visit from the Health care provider and psych provider is sent to facility via Fax. The arrive by the next day prior to having their visit with the provider..	
P 175	902 KAR 20:036 4(11)(b)9 Section 4. Administration And Operation Section 4. Administration and Operation. (11) Medical records. (b) Each record shall include: 9. Documentation of social services, dental, laboratory, x-ray, or reports from consultants or therapists if the resident receives any of these services;	P 175		

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P 175	Continued From page 7 This requirement is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain current resident medical records containing documentation of laboratory results for one Resident (R) (Resident 1) of 26 sampled residents records reviewed. The findings include: During an interview on 04/01/2025 at 11:57 AM, the Administrator stated, "The facility does not have a policy that describes what documents must be the resident's medical record." A review of R1's "Admission Face Sheet" revealed that the facility admitted the resident on 01/30/2025 with a diagnosis of schizophrenia and depression. R1's medical record review revealed that Nurse Practitioner 1 admitted R1 under her care. The review further revealed that R1 had the following labs: CMP, Lipids, A1C, UA, Hep C, and Lithium levels on admission and monthly lithium levels. However, R1's medical record contained no laboratory results since admission on 01/30/25. During an interview on 03/31/2025 at 3:30 PM, R1 stated, "No one has ever discussed any of my lab results since my admission to the facility." During an interview on 04/03/2025 at 3:05 PM, Nurse Practitioner 1 stated, " I don't have R1's lab results."	P 175	Eventos PA Mike Helm is having Lab come on Site to check appropriate blood levels needed on each resident. The results will be sent U/A fax to put into the residents charts for their medical records. They will be discussed on the next follow up visit with the doctor. -Mako Medical come to do labs on all residents that the doctor needed done. They come to facility on 04/30/2025 and then again on 05/07/2025.	-04/30/2025 and 05/07/2025

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P 175	Continued From page 8 During a further interview on 04/03/2025 at 11 AM, the Administrator stated, "Nurse Practitioner 1 had seen R1 a couple of times but uses her company's laptop with their system, and we do not have access to the records. We have requested the records of the residents in the facility that Nurse Practitioner 1 cares for but have never received the visit notes or lab results ordered on residents." The Administrator stated, "This has been an ongoing issue with Nurse Practitioner 1, and the facility is in the process of discontinuing services."	P 175	Lab work will be done on site as ordered by PA.	
P 195	902 KAR 20:036 4(11)(b)13 Section 4. Administration and Operation Section 4. Administration and Operation. (11) Medical records. (b) Each record shall include: 13. Copy of a completed SMI Screening Form for each PCH or SPCH resident; and This requirement is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to ensure the completion of the Serious Mental Illness (SMI) Screening Form for 10 of 26 sampled residents: Residents (R) R1, R2, R4, R5, R6, R7, R8, R10, R17, and R22. The findings include: On 4/03/2025 at 11 AM, the State Survey Agent (SSA) requested the facility's policy for ensuring	P 195	Administrator made sure all charts had an updated and completed SMI in all residents Charts. This was done on 04/09/2025 Administrator put a copy in all new intake packets to reassure that the SMI is completed when come to the facility.	04/09/2025 04/09/2025

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P 195	Continued From page 9 the SMI Screening Form was completed; however, the facility had no policy for completing that form. 1. Record review revealed the facility admitted R1 on 01/30/2025, with diagnoses that included schizophrenia and depression. Further record review revealed no documented evidence of an SMI Screening form in R1's record as required. 2. Record review revealed the facility admitted R2 on 05/17/2017 with the following diagnoses: acute renal failure. A continued record review revealed no documented evidence of the required SMI screening form in R2's medical record. 3. Record review revealed the facility admitted R4 on 01/16/2024, with diagnoses that included schizophrenic affective disorder, hypertension, and diabetes. Continued review revealed no documented evidence of the required SMI Screening form. 4. Record review revealed the facility admitted R5 on 06/27/2022, with diagnoses which included dementia and pacemaker. Further record review revealed no documented evidence of the required SMI Screening form in the medical record. 5. Record review revealed the facility admitted R6 on 11/01/2024, with diagnoses to include epilepsy, schizophrenia, and major depressive disorder. Further record review revealed no documented evidence of the required SMI Screening form. 6. Record review revealed the facility admitted	P 195	Administrator went through the following Sampled residents plus all the others to make sure all the correct SMI forms was in all residents charts.	04-09-25

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P 195	Continued From page 10 R7 on 12/22/2023, with no admitting diagnoses listed. Further record review revealed no documented evidence of the required SMI Screening form. 7. Record review revealed the facility admitted R8 on 12/05/2024, with diagnoses to include obsessive-compulsive disorder and schizophrenia. Further record review revealed no documented evidence of the required SMI Screening form. 8. Record review revealed the facility admitted R10 on 11/12/2024, with diagnoses which included Anemia, morbid obesity, schizophrenia affective disorder, and anxiety. Further record review revealed no documented evidence of the required SMI Screening form in the medical record for this resident. 9. Record review revealed the facility admitted R17 on 11/01/2024, with no admitting diagnoses listed. Further record review revealed no documented evidence of the required SMI Screening form in the medical record. 10. Record review revealed the facility admitted R22 on 10/30/2015, with diagnoses that included paranoid schizophrenia, hyperlipidemia, hypertension, and non-insulin-dependent diabetes. However, further review revealed no documented evidence of the required SMI Screening form in the resident's medical record. During an interview with Administrator 1 on April 2, 2025, at 11:13 AM, she stated that the previous Administrator had neglected to complete the SMI Screening form before the admission of new residents to the facility. The Administrator	P 195		

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P 195	Continued From page 11 emphasized the importance of completing the SMI form for prospective residents before their admission, stating "that it is essential to ensure they meet the eligibility requirements for a Personal Care Home."	P 195	During in service held on 04/16/2025 Administrator went over the safety and importance of our hourly head count and situations when residents needs to be put on 15. minute checks. Administrator also went over suicidal prevention and if they are told by resident they are going to harm themselves or others they are to keep Resident With staff at all times until cnt→	04/16/25
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 record review, facility policy review, and interview, it was determined that the facility failed to provide supervision of a resident to ensure that the residents health care needs were met for one Resident (R) (Resident 1) of 26 sampled residents. The findings include:	P 210		

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P 210	Continued From page 12 A review of facility policy, "Policy 4.11 Suicidality and Risk Assessment Policy" (undated), revealed that a resident with suicidal ideation must be continuously engaged and not left alone. A review of R1's "Admission Face Sheet" revealed that the facility admitted the resident on 01/30/2025 with a diagnosis of schizophrenia and depression. A review of R1's medical record revealed a progress note entry on 02/07/2025 at 10:15 AM when R1 heard voices telling him to walk out into traffic. The staff talked to the resident and advised R1 to stay in the facility for the time being and talk to the staff about the voices. The Administrator notified Nurse Practitioner 1 and the resident was placed on 15-minute checks. However, a review of R1's medical record revealed that the resident never received 15-minute checks and was just instructed to stay inside the facility." During an interview on 03/31/2025 at 3:30 PM, R1 stated, "I don't remember any situations when the staff stayed with me one-on-one." During an interview on 04/03/2025 at 3:05 PM, Nurse Practitioner 1 stated she ordered R1 to be on 15-minute checks due to suicide ideations. Nurse Practitioner 1 further said, "We always do 15-minute checks for any resident experiencing suicidal ideation. I expect Dishman staff to follow supervision orders due to the seriousness of threats that can lead to suicide in vulnerable unsupervised residents." During an interview on 04/03/2025 at 11 AM,	P 210	Ems Arrives to insure their safety. Admistrator also goes over sucidal prevention during monthly in-service. to insure the violation does not recur. For new hires Admin or Asistant Admin will go over all rules and regulations as well as suicide prevention and the steps to take if it does happen. All Staff is to contact Admin or Ast. Admin to let them be aware of any situation with residents so they can insure the correct steps are being done.	

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P 210	Continued From page 13 Administrator 1 stated, "One-on-one supervision would be ideal for suicidal ideation to prevent residents from committing suicide, but we don't have enough staff to do this, especially during the evening and nighttime hours due to only having one staff member in the building." Administrator 1 further stated that she had reviewed the supervision logs, and R1 never had 15-minute checks on 02/07/2025."	P 210	Administrator and [redacted] Assistant Admin. done a walk through of each room to ensure each room and residents had what was needed and made a paper stating What all 20 rooms needed and what the Ceo needed to purchase. on 04/23/2025. Dressers and lights and Curtains was ordered on 04/28/2025. Recieved curtains on 05/02/2025. Recieved mirrors on 05/02/2025 and mirrors was ordered on 04/24/2025 CHN →	04/23/25 04/28/25 05/02/25 05/02/25 04/24/25
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 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;	P 315		

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P 315	Continued From page 14 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, interview, and facility policy review, the facility failed to provide each resident with two sheets, and/or a dresser/chest with a mirror. In addition, residents were being housed in a new enclosure that had not been inspected and approved by OIG or the Department of Housing, Buildings and Construction for 12 of 26 sampled residents The findings include: Observation on 03/31/2025 at 3:53 PM of Room 2, revealed no sheets on the residents bed. Resident (R) 21 stated he liked sheets on his bed and had asked for sheets but none were given to him. Observation on 03/31/2025 at 3:15 PM of Room	P 315	Recieved the dressers/ nightstand on 05/01/2025. Recieved Lights for Bedsides on 04/30/2025 A resident Room Sign Off Sheet has also Been created for whatever staff is on 1st Shift to Complete to ensure the cleanliness and to make sure each Resident has what they need in their Rooms this was gone over during our 5 hour training CtN→	05/01/25 04/30/25

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P 315	Continued From page 15 11 revealed one bed with no sheets. R13 stated he liked having sheets, and sometimes they had sheets and sometimes they did not. Observation on 03/31/2025 at 4:45 PM revealed two resident rooms had been added in an area that was a prior break room. Two beds were noted in one room and one bed in the other room. One resident was observed in each room during observation. Further observation revealed each room had conduit running from the light fixture, down the wall to a light switch and an electrical outlet in each room. During an interview on 04/03/2025 at 3:00 PM with R10, R10 stated she could not put her lipstick on due to no mirror in her room. During an interview on 04/03/2025 at 3:23 PM R17 stated she kept all her personal belongings on the floor in boxes due to no closet or chest available in her room. During an interview on 04/03/2025 at 3:37 PM with R6 she stated I do not have a dresser or closet and I keep my clothes in bags on the floor. R6 further stated "This is my home and I only have this bed". During an interview on 04/02/2025 at 11:15 AM Maintenance 2 stated the building owner instructed him to close in the two rooms. He further stated he used the existing light fixtures and electrical outlets in the two new resident rooms. Continued interview revealed he was not aware of an inspection completed after the work or that the work needed to be inspected. During an interview on 04/03/2025 at 4:15 PM	P 315	after CPR and med safety. Administrater went over with all staff about the room Signoff binder on 4/30/25 on 6/3/2025 Admin Contacted OIG to get information on how to get new rooms inspected. on 6-4-2025 Admin removed residents from the additional rooms adons and Placed them in rooms that have beeninspected in the passed. Admin then emailed Ann Clark with OIG to get rooms inspected. To ensure this violation, dont recur admin wont Place residents in rooms without being inspected first	4-30-25 6-4-25

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P 315	Continued From page 16 with the Administrator, she stated the rooms were created in December 2024 or January 2025 by maintenance and she did not know if any inspection of the new resident rooms was conducted prior to putting residents in the rooms. Continued interview revealed the facility had plenty of sheets and bed covers. She stated the residents only had to ask for them when they needed them. The Administrator further stated she was expecting a delivery today with some furniture, possibly dressers.	P 315	walk through was completed to ensure residents had everything they needed since the Furniture got here and put up. Admin and Asst. Admin walked through on 05-08-2025	5-8-25
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, interview, record review, review of the facility's job descriptions, and review of the facility's policy, the facility failed to maintain a clean and safe facility and ensure that odors were eliminated at their source by prompt and thorough cleaning of commodes and other sources.	P 320	All items for rooms was purchased by the CEO. on 04/15/2025 maintenance fixed clogged commodes that had a leak.	4-15-25

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P 320	Continued From page 17 The findings include: Observation on 03/31/2025 at 3:20 PM revealed a strong odor of feces outside the door of the men's common shower room. Observation of one of two commodes in the room revealed one commode full of brown liquid, and toilet paper. Review of the "Nurse Aide and Orderly" job description, undated, revealed the aide/orderly was required to make beds and general housekeeping duties in all parts of the building, and to thoroughly clean resident rooms when necessary. Review of the "Medical Assistant" job description, undated, revealed they were responsible for maintaining a safe, clean and healthy environment through light housekeeping including changing bed linens, dusting, sweeping, mopping and laundry.The Medical Assistant was also responsible to keep restrooms clean and mopped hourly. Review of the facility document titled "Training Packet" revealed 2nd shift duties included, checking bathrooms to keep them cleaned up, helping with supper and cleaning up the kitchen and doing laundry. Further review of the training packet revealed 3rd shift duties included checking bathrooms and laundry baskets, doing laundry if needed, dust, sweep, mop and emptying the trash in the office. And 2nd shift staff were responsible to ensure the bathrooms were clean before 1st shift arrrived. . Continued review of the training packet revealed	P 320	During Monthly inservice/refresher that was completed on 03/27/2025 and on 04/16/2025 administrator went over job duties for each shift and what is expected of each employee on their Shifts.	03/27/25 04/16/25

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P 320	Continued From page 18 staff were required to clean floors, check the bathrooms, sweep the hallways from end to end and all of the resident rooms, sweep and mop the breezeways, wipe the walls down, and the bathroom doors, re-mop if the floor had marks, clean windows and doors, do laundry and passing it out to the residents, help with cleaning the kitchen, sweeping the floors, mopping, wiping the tables, and rechecking the bathrooms before going home. However the training packet failed to identify the staff responsible to complete those tasks. In an interview on 04/01/2025 at 9:00 AM with the Administrator, she stated there was no set cleaning schedule. She stated each shift should be cleaning, sweeping and mopping the bathrooms. She stated she was responsible for oversight but had not had any issues. . During an interview on 04/01/2025 at 3:17 PM with the Administrator she stated each shift was required to sweep the hall and bathrooms. She further stated maintenance had unstopped the commode in the men's bathroom but the residents put items in the commode that stopped it back up again. During an interview on 04/02/2025 at 10:20 AM with the housekeeper she stated the commode had been stopped up for a long time and maintenance had attempted to unstop the commode. During an interview on 04/02/2025 at 11:15 AM with Maintenance 2 he stated he was not aware until today the commode was stopped up. He further stated if anyone had worked on the commode it would have been him but he had not	P 320	A sign off sheet was made and has to be completed and filled out daily. And during in-service 04/16/2025 we discussed the importance of Cleaning and keeping A clean facility and making sure each room was cleaned and each bed has appropriate Bedding. The commode was pulled up on 04/15/2025 and fixed by the Maintenance.	04/16/25 04/15/25

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P 320	Continued From page 19 attempted to unstop it. He further stated he planned to pull the commode tomorrow morning. During an interview on 04/03/2025 at 4:15 PM with the Administrator, she stated education had been provided for cleaning and that staff would be getting more training on cleaning.	P 320		
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, and review of the facility policy, it was determined the facility failed to maintain a clean and safe environment to ensure the safety and well-being of residents, personnel, and visitors . Observations, on 04/03/2025 revealed multiple residents smoking inside the facility. The findings include:	P 330	For smoking Policy and fire Hazard reasons Administrator collected all lighters from the residents.	04-03-2025

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P 330	Continued From page 20 Review of the facility's policy titled "Resident Smoking Policy," undated, revealed smoking is restricted to the outside of the facility. Residents may not have lighters or matches in their possession. No smoking is allowed in patient's rooms or anywhere inside the facility. Interview, on 04/02/2025 at 10:03 AM, Resident Family (RF)2 stated that when she would visit her family in the facility, she would see residents smoking in their rooms and her family member had "burn holes" in their cover and bed when they would drop lit cigarettes on their bedding. Interview, on 04/02/2025 at 11:37 AM, RF3 stated that when they would come to visit their family member in the facility, they would walk up the halls and see several residents smoking in their rooms with no staff intervention. Observation, on 04/02/2025 at 2:53 PM, revealed the Administrator walking down the main hall and turning around and asking staff to open a resident's door because she could "smell smoke". The Administrator stated, "I know they smoke in their rooms." Observation, on 04/03/2025 at 10:00 AM, revealed a resident smoking in the hallway the lead to the smoking area. The smoking area was closed and had sandbags preventing the door from being open and a blanket laid in front of it. There was a handwritten sign taped to the door stating "Don't go out here. Smoke out back or front because of flooding." Observation, on 04/03/2025 at 10:12 AM, revealed Resident (R)6 lighting a cigarette in the	P 330	Administrator went over Smoking Policy with all residents and explained to them how lighters and matches was a fire hazard. When a new resident arrives while doing admit paper work with Admin we go over the smoking policy and resident signs it then if they have a lighter Admin will confiscate it during Admit process.	04-03-2025

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P 330	Continued From page 21 common area and then proceeding outside. Observation, on 04/03/2025 at 10:14 AM, revealed a resident sitting in the vestibule of the building on a milk crate smoking a cigarette. Interview, on 04/03/2025 at 10:15 AM, Housekeeper 1 stated that some staff would let residents smoke in the vestibule area but she did not because it wasn't safe. Housekeeper 1 was observed telling the resident that she needed to go outside and finish her cigarette. Observation, on 04/03/2025 at 10:32 AM, revealed two residents sitting in vestibule sitting on milk crates smoking cigarettes. Observation, on 04/03/2025 at 10:40 AM, revealed three residents smoking in the hall leading to the outside smoking area. Interview, on 04/03/2025 at 10:40 AM, R6 stated that she thought it was okay to smoke there because she saw several of the male residents smoking there "all the time". Interview, on 04/03/2025 at 10:46 AM, the Administrator stated that she was not sure if residents were able to smoke in the vestibule area, she knew residents would smoke there but she was not sure if they were allowed to. In continued interview, the Administrator stated that she didn't know how she was supposed to keep residents from having lighters or matches because they could "just go buy more" if she took the ones that they already had. Additionally, the Administrator stated that smoking inside could be a safety hazard to residents as it could lead to a fire in the building	P 330	In monthly in-Service with Staff admistrator went over smoking Policy and we have to enforce it If any staff sees a resident with lighters or matches they are to confiscate them. when new employees are hired resident Smoking Policy is gone over while being trained.	04-16-2025

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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 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.	P 335	A refresher was Completed during in-service on 04/16/25 on Cleaning facility and making sure all paperwork is done daily. Administrator and Assistant Administrator is in charge of training all new hires for Cleaning. Administrator and Assistant Admin... are Both in charge of making sure the required cleaning is done on a daily basis. The charts on the walls get checked Daily to make sure all Staff is doing the cleaning.	4/16/25

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P 335	Continued From page 23 This requirement is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to maintain a clean environment and provide maintenance services for 26 of 26 sampled residents. Review of the job description titled " Housekeeping Assistant/Health Assistant Floor" not dated revealed the duties included performing housekeeping and cleaning within the facility. Review of the document titled "Job functions/Duties, for the medical assistant included maintaining a safe, clean and healthy environment through light housekeeping including changing bed linens, dusting, sweeping, mopping and laundry of clients. Further review of the policy revealed a job duty was to keep restrooms clean and mopped hourly. Observations on 03/31/2025 at 3:35 PM included one of two commodes in the men's common shower/bath room was backed up and full of a dark brown liquid substance. One of two sinks were stopped up and holding water. Additionally tiles were missing from the bottom of the inside wall next to the door of the men's common bathroom. Further observation of the men's common shower area revealed no liner or bag in the trash can. Continued observation revealed a small closet	P 335	Since observation on 03/31/2025 Maintenance has fixed the commodes in the bathrooms and also fixed the sinks that was holding water. 04/17/25 Maintenance is fixing missing and loose tiles throughout the facility. Started on 05/04/25 Inservice was completed on 04/16/2025 on keeping a clean facility and checking on Cleaning the Bathrooms on each shift. 04/16/25 Maintenance cleaned out Closet water heater is in. Faucets in kitchen was replaced by maintenance to Stop the leaks. 04/22/25	

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P 335	Continued From page 24 near the shower where the hot water heater was located with papers and trash observed around the water tank. Observation on 03/31/2025 at 4:35 PM in the kitchen area revealed the kitchen sink leaking into the floor and a blanket placed in the floor to catch the water. Observation on 03/31/2025 at 4:00 PM revealed the single women's shower room with dirty clothes noted lying in the floor. Interview on 04/02/2025 at 10:20 AM with Housekeeper 1, she stated the commode in the men's common shower room had been stopped up for a long time. She estimated longer than two weeks. The housekeeper stated she cleaned the bathrooms daily. During an interview with the Administrator on 03/31/2025 at 4:20 PM, she stated the resident rooms were cleaned daily, and deep cleaned weekly which included sheets to be changed. She further stated the hallways and bathrooms were to be cleaned each shift.	P 335	Facility owner has a contract with dietician Rebecca Lyons and she come on May 1st 2025. During in-service Admin went over physician ordered diets and serving sizes. When dietician came and spoke with Kitchen Staff on 05/01/2025 she went over resident diets and portion sizes.	05/1/25 05/01/25
P 345	902 KAR 20:036 5(3)(c)2 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. 2. Therapeutic diets. If the facility provides therapeutic diets and the staff member responsible for food services is not a licensed dietitian or certified nutritionist, the responsible	P 345	Admin has monthly in-service refreshers with Kitchen staff.	05/27/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISHMAN PERSONAL CARE HOME	220 WORSHAM LANE MONTICELLO, KY 42633

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P 345	Continued From page 25 staff person shall consult with a licensed dietician or certified nutritionist. This requirement is not met as evidenced by: Based on observation, interview, record review and review of the facility policy it was determined the facility failed to provide therapeutic diets to residents and failed to have staff members responsible for food services, who were a licensed dieticians or a certified nutritionist. In addition, the facility failed to consult with a licensed dietician or certified nutritionist for three of six sampled residents, Resident (R) 24, 25, and 26. The findings include: Review of the facility policy titled, "Dishman PCH Policies & Procedures Manual" revealed the facility did not have a policy regarding a licensed dietician or certified nutritionist. Observation and interview with R24, on 04/01/2025 at 12:10 PM, revealed R24 was eating goulash, garlic bread, and mandarin oranges. The resident acknowledged that they were enjoying their meal. Additionally, the resident stated that they did not receive meals that were different than what the other residents were eating. Continued observation revealed the	P 345	Dietician observed the menu and made Changes to the menu for the Summer menu. Dietician Sent a Sheet for the "Low Carbohydrate Diet" Sheet. Sent this to help us with our residents diets. Dietician Also Sent us a new copy of Scoop sizes so we Can give them the Correct proportion.	05/01/25 05/01/25 05/01/25

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P 345	Continued From page 26 resident was on a "low carb" diet. Observation interview, on 04/01/2025 at 2:46 PM, R25 and R26 stated that they were not given meals that were different from the other residents, they ate what they were given. Observation of R25's chart revealed the resident should be on a "reduced carb" diet. Observation of R25's chart revealed the resident should be on a "cardiac diet". Interview with Registered Dietician (RD)1, on 04/02/2025 at 9:56 AM, stated she had not had a contract with the personal care home since 12/31/2024, when her contract expired. RD1 stated that the personal care home had contacted her on 04/01/2025 to negotiate a new contract. In an interview, on 04/03/2025 at 3:31 PM, the Administrator stated that she was unaware that the Registered Dietician was no longer contracted with the facility. Continued interview revealed, not having a dietician or nutritionist could cause harm to residents because the facility did not have anyone on staff to oversee the special diets for residents. The administrator stated that if the residents were not following the diets they needed it could cause them health issues and potentially cause them to have to be hospitalized.	P 345	Kitchen staff has posted current menus on the door for residents to be able to view. To ensure violation does not recur Kitchen manager will train new staff as needed. Admin will have monthly inservice refreshers with all Kitchenstaff to insure all guidelines are being followed attached last inservice training report	05/01/25 05-27-25
P 350	902 KAR 20:036 5(3)(c)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:	P 350		

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P 350	Continued From page 27 (c) Dietary services. 3. Menu planning. a. Menus shall be planned in writing and rotated to avoid repetition. b. A PCH or SPCH shall meet the nutrition needs of residents in accordance with physician's orders. c. Except as established in clause e. of this subparagraph, meals shall correspond with the posted menu. d. Menus shall be planned and posted one (1) week in advance. e. If changes in the menu are necessary: (i) Substitutions shall provide equal nutritive value; (ii) The changes shall be recorded on the menu; and (iii) Menus shall be kept on file for at least thirty (30) days. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to post planned menus one week in advance. The facility had not replaced the "Fall" menu with the most current "Winter" menu that was posted in the dining area for residents, guests, and staff to view. The facility census was 47. The findings include: Review of the facility's policy, titled "Kitchen	P 350	The kitchen manager is responsible for keeping a updated menu on the door. Administrator will be Checking over the doors to make sure that the Menus are posted. 05/01/25 The Assistant Administrator made a binder for all kitchen paperwork. That is done daily. 05/01/25 We will continue our visit again with the Dietician after our Six week menu is up. every Six weeks TO Keep this from occuring we will continue to keep her on a Scheduled [redacted] every Six weeks.	

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P 350	Continued From page 28 Policies," not dated, revealed the facility did not have a policy for updating the menu and placing it in a public space. Observation, on 04/01/2025 at 10:50 AM, in the dining room revealed a Fall menu posted on the entrance door with no updated or current menu available. Interview with the Administrator, on 04/01/2025 at 2:45 PM, stated it was the responsibility of the kitchen staff to hang the menus in the dining room. Additionally, the Administrator stated that she didn't think having the menu posted was necessary because residents didn't look at it. Interview with Resident (6), on 04/01/2025 at 3:37 PM, stated it would be nice to be able to look at the menu and not have to ask staff what meals would be served. During an interview with Registered Dietician (RD)1, on 04/02/2025 at 9:56 AM, RD 1 stated she had not had a contract with the personal care home since 12/31/2024, when her contract expired. RD 1 stated that there should be a spring menu released around March or April of the year. Interview with Cook 1, on 04/02/2025 at 10:20 AM, stated it was important to post updated and correct menus so residents would be aware what was being served. Observation, on 04/02/2025 at 10:35 AM, revealed Cook 1 changed the fall menu posted on the entrance door to the dining room with the winter menu.	P 350	Facility has a contract with dietician which was signed on 04/04/2025 and she come to the facility on 05/01/2025.	04/04/25 05/01/25

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P 355	Continued From page 29	P 355		
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 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	P 355	Each log created for kitchen has to be done daily by the kitchen staff.	daily

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P 355	Continued From page 30 residents at all times. m. Food services shall be provided in accordance with 902 KAR 45:005. This requirement is not met as evidenced by: Based on observation, interview, record review and review of the facility policy it was determined the facility failed to maintain temperature logs, provide ice water to residents, cover and date open drink items in the refrigerator, and cook food properly before placing on the steam table for 47 of 47 residents. The Findings Include: 1. Review of the policy titled, "Kitchen Policies," undated, revealed no requirements to maintain temperature logs for refrigerators, freezers, or foods being served to residents. Observation on, 03/31/2025 at 4:35 PM, revealed that the facility had not recorded temperature logs for the refrigerators that stored food and drinks for residents since 02/04/2025. Continued observation revealed the facility had not recorded temperatures for breakfast, lunch, or dinner for 03/02/2025 thru 03/14/2025 and from 03/18/2025	P 355	During in-service on 04/16/2025 we went over any open containers are to have correct dates on them and food has to be cooked Properly before placed onto the steam table. Kitchen Manager made Sure to teach the new kitchen staff that you have to cook everything before putting it on the Steam table. and made Sure to Show the new kitchen staff that things need to be Labeled.	04/16/25 05/05/25 and 05/06/25

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P 355	Continued From page 31 thru 03/31/2025. In an interview, on 03/31/2025 at 4:38 PM, Cook 2 stated that the dietary staff had not been keeping up with temperature logs for a while, but he had recorded the food temperatures for dinner, on this day. Continued interview revealed that it was important to record refrigerator and freezer temperatures to ensure the equipment was working properly and was holding the foods at correct temperatures. Additionally, Cook 2 stated that it was important to record the temperatures of the foods being served to residents to ensure they were safe to eat. In an interview, on 03/31/2025 at 4:45 PM, the Administrator stated that all logs regarding temperature were kept in the kitchen, and it was the responsibility of the kitchen staff to complete the logs. Continued interview with the Administrator revealed that it was important to check the temperature of food before serving to residents to ensure that they don't get sick or get a foodborne illness. In an interview, on 04/01/2025 at 8:45 AM, Cook 1 stated that the previous administrator had thrown away the first half of Marches temperature log and and had just not completed the second half of the temperature logs. Continued interview with Cook 1 revealed that she was going to create a new log sheet for the month of March and fill the information back in. Cook 1 stated that she did not know the correct temperatures, but she was going to guess and do her best. 2. Review of the policy titled, "Kitchen Policies," undated, revealed no requirements to provide ice	P 355	Since the last Visit The CEO Brought water containers for the kitchen Staff On 1st Shift to refill the ice water in the Containers. All kitchen Staff is to keep an eye on the containers At all times they have to keep ice water in it. One Container was Placed in the dinning Room area and one Container is placed in the living room area.	04/10/25

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P 355	Continued From page 32 water to residents, at all times. Observation and Interview on 03/31/2025 at 4:25 revealed a wet floor around the ice machine. Interview with Cook 2 revealed the ice machine had developed a leak "at some point." Continued observation revealed the ice machine was turned on and producing ice. Interview, on 04/02/2025 at 10:46 AM, with contracted maintenance worker 1 stated he had instructed the dietary staff to turn the ice machine off "at some point" yesterday, 04/01/2025. In continued interview contracted maintenance worker 1 stated that he had been made aware of the leaking ice machine yesterday and had it turned off to prevent more leaking and causing a possible injury to staff. Additionally, contracted maintenance worker 1 stated that he would have to make the repair at night because he would have to be able to turn the water off to the kitchen and he was unable to do that during day hours. Contracted maintenance worker 1 stated he did not have an estimate on when the repairs to the ice machine would be completed, electrical and plumbing issues were the priority. Interview, on 04/02/2024 at 10:55 AM, with contracted maintenance worker 2 stated he had been the primary maintenance worker for the building since the Summer of 2024 but was just made aware of the leaking ice machine the morning of 04/02/2025. In continued interview contracted maintenance worker 2 stated that the repairs would have to be made at night when the water could be turned off to the kitchen. Additionally, contracted maintenance worker 2 stated that he did not have a timeframe for when the repairs to the ice machine would be	P 355	Maintenance fixed the leaking valve on ice machine. In addition there is ice water in the big drinking containers at all times. this was fixed on April 15th 2025	04/15/25

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P 355	Continued From page 33 completed. Observation, on 04/02/2025 at 2:58 PM, revealed Resident (R) 4 asking Cook 2 for ice water. Cook 2 advised R 4 that the machine wasn't working and she couldn't have ice water but could have just water instead. During an interview, on 04/02/2025 at 3:02 PM, R4 stated that she enjoyed being able to drink ice water, and that the colder it was the better it tasted. Interview, on 04/03/2025 at 3:09 PM, with Cook 2 stated that the ice machine was still not working. Continued interview with cook 2 revealed that residents were receiving "regular tap water". Additionally, Cook 2 stated that residents love ice in their water and they love to eat it too. Interview, on 04/03/2025 at 3:31, with Administrator, stated that that the residents do like to have ice available to them. Continued interview with Administrator, stated that she was unsure on when the ice machine would be working. Additionally, Administrator stated that she was unaware that she had to have ice available to provide to residents. 3. Review of the policy titled, "Kitchen Policies," undated, revealed no requirements to cover and date all open containers when refrigerated. Observation, on 03/31/2025 at 4:23 PM revealed two one-gallon jugs of orange juice and one container of lemon juice opened and undated in the refrigerator. Interview, on 04/03/2025 at 3:09 PM, Cook 2	P 355	Administrator went over labeling and putting correct dates on all items in the kitchen during our in-Service on April 16th 2025. Administrator and Assistant Administrator went over with all Staff in the kitchen that food is to be cooked at correct food temps. Before being placed on the hot bar at all times. Administrator and Asst. Administrator also went over with all kitchen Staff that they have to be doing all temp Logs and making Sure they are signed daily and the Administrator and Assistant Administrator will be monitoring if these are done.	04/16/25 04/16/25

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P 355	Continued From page 34 stated that it was important to label items when you open them, so you know when they expire. Additionally, Cook 2 stated that it was important to not serve anything past its expiration date because you could make the residents sick, give them an upset stomach, or hospitalize them. Interview, on 04/03/2025 at 3:31 PM, the Administrator stated that she depended on the dietary staff to follow all appropriate rules and guidelines, as she was not very familiar with the kitchen. 4. Review of the policy titled, "Kitchen Policies," undated, revealed no requirements to serve foods at a proper temperature and in a form to meet individual needs. Observation, on 03/31/2025 at 3:47 PM, revealed Cook 2 opened a can of baked beans and put them directly on the hot bar to warm. Interview, on 04/03/2025 at 3:09 PM, Cook 2 stated that he would open canned corn, green beans, baked beans, and other canned items and put them directly on the hot bar without cooking the food items to an appropriate internal temperature necessary to eliminate potential bacterial contamination. In continued interview Cook 2 stated he was trained by previous dietary staff to warm items this way and Cook 2 stated he felt it was safe to prepare foods in this manner. Additionally, Cook 2 stated that if food wasn't cooked and held at a safe internal temperature it could cause residents to get food poisoning. Interview, on 04/03/2025 at 3:31 PM, the Administrator stated that there were health	P 355	Administrator and Assistant Administrater will be doing refreshers Monthly with kitchen Staff during the in-services.	Monthly

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P 355	Continued From page 35 concerns regarding not cooking food to a correct temperature and it could cause residents to get a foodborne illness.	P 355		
P 370	902 KAR 20:036 5(5)b Section 5. Provision of Services Section 5. Provision of Services. (5) Activity services. (b) All PCHs and SPCHs shall meet the requirements established in subparagraphs 1. through 8. of this paragraph relating to the provision of activity services. 1. Staff. The administrator: a. Shall designate a staff member to be responsible for the activity program; and b. May accept services from a volunteer group to assist with carrying out the activity program. 2. There shall be a planned activity period each day. 3. The schedule shall be current and posted. 4. The activity program shall be planned for group and individual activities, both within and outside of the facility. 5. The staff member responsible for the activity program shall maintain a current list of residents in which precautions are documented regarding if a resident's condition might restrict or modify the resident's participation in the program. 6. A living or recreation room and outdoor recreational space shall be provided for residents and their guests. 7. The facility shall provide supplies and equipment for the activity program. 8. Reading materials, radios, games, and TV sets shall be provided for the residents.	P 370	Since the last Visit the administrator has the assistant Administrator (and hired addiitional staff to cover weekends and days the assistant cant do it.) doing actuities one hour daily every day.	04/7/25

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P 370	Continued From page 36 This requirement is not met as evidenced by: Based on observations, facility policy and interviews, it was determined the facility failed to ensure the resident(s) were provided with an activity program or a planned activity period each day to assist with their social needs. The findings include: A review of the "Policy 5.5 Recreation Policy" (undated) revealed the facility should have a designated staff member to plan, coordinate, and offer a daily recreational activity. Observations from 03/31/2025 through 04/03/2025 revealed that the facility did not provide an activity program or a planned activity period each day to assist with the social needs of the residents. An interview with R6 on 04/03/2025 at 10:15 AM revealed there were no activities or scheduled events offered in the facility. Further, R6 stated that she and other residents were bored because they had nothing to do but smoke. During an interview with R10 on 03/31/2025 at 4:01 PM, R10 stated the facility provided no activities for the residents. R10 further stated having something to do during the day would help with her depression. An interview with the Administrator on 04/03/2025 at 11:00 AM revealed the facility did	P 370	The Facility has provided out door activities for residents and will also have some indoor activities provided as well.	04/07/25

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DISHMAN PERSONAL CARE HOME	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 370	Continued From page 37 not have an assigned activity staff or scheduled activities but felt the residents would benefit from and even enjoy an activity program. The Administrator stated that all the residents have mental health diagnoses with multiple behaviors and outbursts; therefore, she felt it would be important and beneficial for the residents to have activities and help keep them occupied.	P 370	A monthly calendar is being made of different activities for each day with what the residents will be doing on their activities. So they will know ahead of time what activities they decide that they want to do they can. The assistant Admin will make a monthly activity Calender and it is posted on the break room door for residents to view. To ensure violation does not recur Admin with review each calender monthly.	04-29-2025