PRINTED: 09/06/2024
FORM APPROVED

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-C 07/19/2024

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 A Revisit Survey was initiated on 07/17/2024 and concluded on 07/19/2024. Based on implementation of the plan of correction, it was determined the facility had implemented corrective actions to remove the imminent danger related to the Type "A" Citation which was cited related to resident medications. However, deficient practice continued for tag P0175.	{P 000}	* All correction to be implented with 2 days to ensure all Shift envolved are aware of changes to follow by inservice / meeting with all staff members	
{P 175}	902 KAR 20:036 3(9)(b)1-13 Section 3. Administration and Operation (9) Medical records. (b) Each record shall include: 1 Identification information, including: a. Resident's name; b. Social Security, Medicare, and Medical Assistance identification number (if appropriate), c. Marital status; d. Birthdate, e. Age; f. Sex; g. Home address; h. Religion and personal clergyman, if any (with consent of the resident); i. Attending physician, health care practitioner acting within the practitioner's scope of practice, QMHP, dentist, and podiatrist, if any, and address and phone number for each; j. Next of kin or responsible person, address, and telephone number; k. Date of admission and discharge; l. If the resident is discharged, transferred, or transitioned to a community living arrangement, a copy of the summary of resident's records; and	{P 175}	To ensure complaint with requirment and audit of resident chart regulation 902 Kar 20.032 3(A) (B) 1-3 Section 3 Administration and operation and 1-13 Section 3 Administration and operation of medical records was related and will be completed within 24-48 hours of admission to information being placed into chart based on: Observation, interview and review of facility policy also ensure medical	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Jerman — TITLE: Admin — (X6) DATE: 9-10-24

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{P 175}	Continued From page 1 m. Monthly recording of the resident's weight; 2. If admitted from another facility, a discharge summary or transfer summary. 3. Admitting medical evaluation 4. Report by the physician or health care practitioner acting within the practitioner's scope of practice, documenting completion of an annual medical evaluation of each resident; 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; 6. Orders for medication or therapeutic services; 7. Nurses' or staff notes indicating any changes in the resident's condition as changes occur; 8. Documentation of any accident, injury, illness, medication error, or drug reaction impacting the resident; 9. Documentation of social services, dental, laboratory, x-ray, or reports from consultants or therapists if the resident receives any of these services; 10. Medication and treatment sheets, including all medications, treatments, and special procedures performed for that resident, with the date and time of each service documented and initialed by the individual rendering treatment or administering medication;	{P 175}	record include medication errors missed medication and bloodwork to fill Curtain_blood work could impact residents condition	

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{P 175}	Continued From page 2 11. Documentation of the use of an emergency manual restraint for that resident, including justification for why the procedure was used; 12. Documentation of the resident's discharge, transfer, or transition destination, if applicable; and 13. Monthly documentation of ADL and IADL skills instruction provided to, or made available and refused by the resident if the resident is an SPCH resident who is transitioning to living independently in the community pursuant to 908 KAR 2:065. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy, the facility failed to ensure the medical record included documentation of two (2) staffs' signatures for narcotic medication refusals for 1 of 3 sampled residents (R14). The findings include: Review of the facility's policy, titled "Medication Use Policy," not dated, revealed the facility would provide supervision of self-administered medications, storage and control of medications as prescribed by a resident's health care provider. Continued review revealed all expired or unused controlled substances would be disposed of or destroyed in accordance with 21 C.F.R. Part	{P 175}	Chemical and physical restraint shall not be used as Authorized by KRS 216.515.(4) Restraints that require a lock and key shall not be used, They are not utilized in the facility as no staff are trained or certified to use the restraints Restrant are not to be used as. A) Punishment B) Discipline C) Staff convinence D) Retalation Documention in chart will be on treatment plan of planned transition to independ. living. Pursuant to 908 Kar 2:065 Policy update Policy procedure	

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{P 175}	Continued From page 3 1317. However, the policy did not define 21 C.F.R 1317. Further review revealed the Administrator was respons'b e for dispos'ng of medication in a way that made it unavailable and unusable. The review revealed the destroyed controlled medications should be maintained for a minimum of eighteen months from the date of destruction. The documentation would 'nclude: date, resident's name, drug name, strength, quantity, destruction method and mane of person responsible for destruction; and, the name of the witness Add'tional review revealed the Administrator and Assistant Administrator would complete a random controlled medication count audit at least three (3) times each month. Review of R14's admission record revealed R14 was admitted on 04/10/2017 w'th diagnoses oof Bipolar Disorder, Personality Disorder, and Schizoaffective Disorder. Review of R14's July 2024 Medication Administration Record (MAR) revealed Clonazepam 0.3 milligrams(mg) 1 tablet twice daily. (a controlled sedative used for panic disorders and anxiety) was refused by R14, for 6:00 AM dose on 07/02/2024, 07/05/2024, 07/09/2024, 07/12/2024, 07/13,2024, 07/14/2024, 07/16/2024, 07/17/2024 and 8:00 PM dose on 07/16/2024. However review of document titled "Narcotic Sign Out," log revealed there was only one staff signature noted for the Clonazepam 0.3 milligrams (mg) signed out for R14, and no documentaion of the R14's refusal or disposal of the medications. During an interview on 07/17/2024 at 11:50 AM, with Medication Aide (MA) 1, she stated she had recent training regarding medication refusals and wasting medications. She stated that two (2) staff	{P 175}	#13 cont Contains information Regarding narcotic refusal Information of refusal of medication esp narcotic will be passed on report documented according to policy. Reported to Physican, providers guardian if assigned family, OIG, APS, Social Ser System All medication employees who fill and pass Medications will be aware of all information to include. When meds are destroyed narcotic, ~~witness~~ med name, date Residents name Strength, quanity and name of witness Random audit will be conducted at least 3 times a month by Administration	

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{P 175}	Continued From page 4 members were to witness and sign the narcotic sign out log if a medication had to be wasted. During an interview with the Administrator (ADM) on 07/17/2024 at 4:17 PM, she stated she had been doing audits on the Narcotic Sign Out Logs to ensure all the narcotic counts were correct but she had not been comparing the Narcotic Sign Out Logs to the MAR's. She stated she had provided education to the staff on 06/17/2024 regarding 2 staff members being present when destroying scheduled drugs, but she failed to include signing off narcotics by 2 staff members. During an interview on 07/18/2024 at 7:00 AM with Medication Aide (MA) 5, she stated that when disposing of a controlled medication, she had been instructed to wait until another staff was present to witness a controlled medication destruction. She further stated the process included dropping the medication into the drug buster container and shaking it to dispose of the medication. During an interview on 07/19/2024 at 4:09 PM with the ADM she stated that she would re-educate staff that the "Narcotic Sign Out" log required 2 staff members to witness and sign when controlled medications had to be destroyed. She further stated that she expected staff to follow the policy regarding 2 staff members witnessing and signing with medication destruction.	{P 175}	And assisant admin this covers all medications narcotics to be Checked 3 x ~~week~~ month and Once a week by assigned Staff. to ensure no missed or refused medications are signed off or disposed correctly Audit to began 7-2224 Regarding narcotic admenstration med will be signed out and if required State on Mar med refused and wasted Per policy document refusal on Mars and in chart, Report to on coming Shift and both going off Shift and coming will observe wasting of meds by signing as they do everytime a Shift Change. Staff in service Re: Call pharmacy of med will soon run out and needs to be reordered by provider Call them, document, leave message, then follow up until resolved 7/22/24	