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 11/15/2024

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 11/12/2024 and concluded on 11/15/2024. It was determined the deficiencies were deamed corrected on 11/15/2024.	{P 000}		

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

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P 000	Initial Comments A Complaint Survey investigating Complaint KY00043039 was initiated on 07/18/2024 and concluded on 07/19/2024. Regulatory violations were identified related to Complaint KY00043039. A Type A Citation was issued to the facility on 07/25/2024 related to KY00043039. Survey dates: 07/18/2024 - 07/19/2024 Survey Census: 42 Sample Size: 14	P 000	Re: To KY00043039 Action will be initiated immediately to insure residents safety. Observervation of residents increased agitation will be addressed re need for PRN, physician or health care provider will be notified and resident will be redirected. Resident will be observed for increase of abuse verbal or action to ~~under~~ intervene as necessary.	
P 055	902 KAR 20:036 3(5) Section 3. Administration and Operation (5) Adult protection. PCHs and SPCHs shall have written policies that assure the reporting of allegations of abuse, neglect, or exploitation of adults pursuant to KRS 209.030, including evidence that all allegations of abuse, neglect, or exploitation shall be thoroughly investigated internally to prevent further potential abuse while the investigation is in progress.	P 055	Re: protection of residents continued redirection and need for PRN. Health care provider will be notified as well immediately and 911 will be notified as well and will obtain MIW or appropriate paperwork needed to resolve conflict.	
	This requirement is not met as evidenced by: Based on interview, record review and review of facility policy, the facility failed to ensure residents were protected from abuse and failed to report allegations of abuse to the appropriate state agencies for two of 14 sampled residents (Resident (R) 8, and R9). On 08/10/2024, R10 was cursing staff and residents and tried to pick fights with other residents. The facility failed to			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Foreman — TITLE: Admin — (X6) DATE: 8-14-24

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P 055	Continued From page 1 notify R10's health care practitioner of the resident's behavior and on 06/11/2024, R10 physically abused R8 resulting in a fracture to the resident's left humerus (bone in the upper arm). Although, the police were notified, there were no other documented actions taken by the facility to protect other residents from further abuse. On 06/12/2024, R10 physically abused R9 by hitting the resident multiple times on the head. Additionally, the facility failed to report each of the incidents of abuse to R8 and R9 to the Cabinet for Community Based Services (DCBS) or the State Survey Agency. The findings include: Review of the facility's policy titled "Resident Abuse Policy", undated, revealed the facility upheld resident rights to be free from and strictly prohibits verbal, sexual, physical, and mental abuse of residents; involuntary seclusion; corporal punishment; mistreatment and neglect of residents; and misappropriation of resident's property. Further review revealed it was the policy of the facility to report and thoroughly investigate all allegations of mistreatment, neglect, abuse, misappropriation of resident property, or an injury of unknown origin. Continued review of the policy revealed that all incidents involving abuse would be reported to the Department of Social Services (DCBS) and Licensing and Regulation (State Survey Agency) would be notified immediately. During a Revisit at the facility, an interview was conducted on 07/18/2024 at 7:00 AM, with Medication Aide (MA) 4. The State Survey Agency (SSA) surveyor was made aware of an incident that involved R8 sustaining a fractured humerus after the resident was attacked by R10.	P 055	Conversation Re future action and plans will be discussed ↑ in aggression and physical acts towards other peers will resume initating MIW, Reports of Mistreatment unknown, Resident injury neglect, Abuse reports of Missing property will be reported to on coming shift and closer observation of resident with increase Aggression will be Closer Observation and resident that is being targeted will be closer observed. ~~Both~~ two individuals involved or will be kept apart or moved to different areas, If and when incident escalates to physical injury All has been called, MIW Obtained and Resident who is being sent for MIW, An incident report will be immediately begun,	

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P 055	Continued From page 2 1. Review of R10's admission record revealed the facility admitted the resident on 10/18/2019 with diagnoses which included bipolar disorder and schizoaffective disorder. Review of R10's physician's order revealed the resident was to receive Invega (an antipsychotic medication used to treat schizoaffective disorder) 234 milligrams (mg)/1.5 milliliters (ml) give 1.5 ml by injection every 28 days. Further review of R10's Medication Administration Record (MAR) revealed the resident did not receive the Invega every 28 days as ordered. Per the MAR, the resident did not receive the medication in March, April, June, or July 2024. Per the MAR, R10 refused the medication. Interview with the Administrator on 07/10/2024 at 12:22 PM revealed R10's May 2024 MAR could not be located. Additionally, there was no documentation the resident's physician had been notified of the medication refusal. Review of R10's progress notes dated 06/10/2024 at 8:00 PM, written by Administrator, revealed R10 was cursing staff and other residents and trying to pick fights with elder residents. Per the note, the guardian of R10 was notified of the incident. Continued review of the documentation revealed no evidence the facility notified R10's physician or health care practitioner of the resident's behavior. Review of the incident report dated 06/11/2024 at 6:00 PM, completed by Medication Aide (MA)5 revealed R10 had picked up an 80-year-old resident and threw her onto the hallway floor and punched her in the head then proceeded to make threatening comments to other residents. Per the documentation check list, the physician, police, guardian and administrator were notified.	P 055	This includes documental of situation leading up to removed for Evaluation VIA MCU and transported by police. Individual injuried will be sent to ER if warranted Documentation and incident report filled out when all is Returned to safe enviromant for Residents and Staff are safe	

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P 055	Continued From page 3 However, there was no documentation that DCBS or the State Survey Agency were notified. Review of a second incident report dated 06/11/2024 at 7:50 PM documented by MA5 revealed R10 continued to make threats to other female residents and was still trying to attack the older residents. Review of third incident report dated 06/11/2024 at 8:00 PM completed by MA6 revealed R8 was sent to the hospital by Emergency Management Systems (EMS). Per an updated note on the incident report, R8 had sustained a fractured humerus. Review of R10's progress notes dated 06/11/2024 at 7:50 PM, documented by the Administrator, revealed R10 became aggressive. Per the progress note, R10 hit another female resident, picked her up and threw her. Continue review of the note revealed R10 punched the same elderly female resident in the face, stating "I kicked that old lady's ass", and then laughed. Per the note, the police were called and an officer spoke with R10. Further review of R10's record revealed no evidence of actions taken by the facility to protect other resident from R10's behavior. Review of admission record of R8 revealed the facility admitted the resident on 06/27/2022 with diagnosis of dementia, weakness and a pacemaker. Review of R8's hospital record physician note sheet dated 06/11/2024 revealed R8 was treated for a left humerus fracture and an immobilizer was placed. Review of the hospital discharge summary revealed R8 was discharged and returned to the facility on 06/11/2024 at 9:37 PM.	P 055	Aggression/Agitation threat to other continues Requires futher conversation ☐ health care providers A Resident when sent to hospital will have v/s obtained prior to leaving for ER	

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P 055	Continued From page 4 On 07/17/2024 at 11:45 AM, R8 was observed sitting in her room in her wheelchair with no sling on her left arm. An attempt to interview the resident was unsuccessful due to the resident's mental status. On 07/18/2024 at 1:45 PM, the resident was asked how her left arm was injured and she stated she did not know but her arm hurt. On 07/19/2024 at 9:34 AM, R8 was observed to have a sling on the left arm. The resident was noted to partially remove the sling and then move the sling back into place. Interview on 07/17/2024 at 1:36 PM with Medication Aide (MA)5 he stated he working as a medication aide on the evening of 06/11/2024 but did witness the incident between R8 and R10. He stated after the incident happened, he did not have to separate the residents because R10 had stepped away from R8 and walked to the front of the building. He further stated the ambulance was contacted for R8 and she was transported to hospital. During an interview on 07/17/2024 at 12:22 PM with the Administrator, she stated on 06/11/2024 after the initial incident when R10 threw R8 on the floor, she contacted the police. She stated the police refused to take R10 to jail or for an evaluation without an Mental Inquest Warrant (MIW) or unless R8 would press charges. The Administrator stated she asked R8 if she wanted to press charges but R8 stated she did not. The Administrator stated that she felt R8 was not confused that day and comprehended what was being asked. Further the Administrator stated after R8 returned to the facility on 06/11/2024, she ensured R8's safety by having staff to be near or go by R8's room every fifteen to thirty minutes. However, the Administrator stated she	P 055	An individual with a diggnosis of Dementia or Senile Dementia of Alzhemiers type will be reminded often of what to mindful of with Slings or other medical issues often and observed closer more often to insure compliance & treatment	

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P 055	Continued From page 5 did not have a log or documentation of monitoring. She further stated staff were to monitor R10 more closely after the incident and redirected as needed. However, the Administrator stated there was no documentation of the monitoring for R10. The administrator stated that the incident was reported to the resident guardian, DCBS (adult protection agency), and the State Survey Agency. However, upon review of the incident report and the fax confirmation receipt, only the state guardian of R8 was notified via fax. 2. Review of R10's progress notes dated 06/12/2024 at 8:00 AM, documented by the Administrator, revealed R10 was in her room, but still displaying behaviors and "believes it is funny to hurt people." Staff explained to resident that cannot happen again (referring to the abuse of R8). Review of R10's progress note dated 06/12/2024 at 6:00 PM, documented by the Administrator, revealed "Resident in front hall and was pacing, yelling, cursing, and trying to start a fight with 3 females sitting in the chairs." R10 walked up to R9 and began punching R9 in the face and head. Per the note, R9 had not provoked R10. Continued review of the progress note revealed R10 was also yelling that she was going to kill the older residents. The police, guardian, and administrator were notified. Review of R10's progress note dated 06/12/2025 at 9:00 PM revealed R10 was sent out for a Mental Inquest Warrant (MIW) to a psychiatric hospital and remains there. Additionally, the progress note revealed that R10 had been refusing medications by mouth and injection.	P 055	An assigned staff could be assigned to keep resident in line of site to insure complant & futher and futher injury	

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P 055	Continued From page 6 Review of R9's admission record revealed R9 was admitted on 09/08/2023 with diagnosis of schizophrenia, anxiety disorder and dependent personality disorder. Review of the facility incident report dated 06/12/2024, no time documented, revealed R9 was assaulted by another resident (R10). Per the incident report, the resident "Took a beating to the head from hands." Further review of the incident report revealed R10 beat R9 in the head with her fist, numerous times before walking away from R9. Resident 9 declined medical treatment. Per the incident report, R10 was sent out for a MIW at 10:30 PM. Interview with R9 on 07/18/2024 at 11:26 AM she stated another resident beat her up about a month ago. She stated R10 beat her in the head and hurt her head but she was okay. She stated the police came and R10 was no longer at the facility. During an interview on 07/17/2024 at 12:22 PM, with the Administrator, she stated when notifying the State Survey Agency and DCBS she sent a fax. Per the Administrator, the incident with R9 and R10 was reported to the State Survey Agency and DCBS. However, upon review of the incident report and the fax confirmation receipt, neither agency was notified via fax. After looking at the faxed paperwork, she stated she thought the incident reports had been faxed to the state agencies but was not. She further stated she felt that increased checks on R10 was okay, but she probably should have notified the physician. On 07/19/2024 at 2:38 PM, further interview with Administrator revealed she had been recently hired as the	P 055	An incident ~~form~~ was filled out with proper information placed in document holder and placed in medication room on wall for reference for all individuals.	7/15/24

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P 055	Continued From page 7 Administrator in March 2024. The Administrator stated that all allegations or incidents of abuse should have an incident report completed at the time each incident occurred. She further stated per policy she was required to report to the Cabinet. However, she stated she was not aware she was required to report to the State Survey Agency.	P 055		7/15/24
P 305	902 KAR 20:036 4(3)(b)3 Section 4. 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 in such a manner that the safety and well-being of residents, personnel, and visitors is assured.	P 305	Policy and Procedures Curtain housekeeping and maintance of facility.	7/30/24

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P 305	Continued From page 8 This requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure the overall environment was maintained in a manner that was safe and in good repair and failed to ensure soiled linen were immediately replaced with clean linens when soiled. The findings include: Interview on 07/18/2024 at 4:17 PM with the Administrator revealed the facility did not have policy related to linens or the environment. 1. Observation on 07/17/2024 at 10:45 AM, on 07/18/2024 at 12:05 PM, and on 07/19/2025 at 9:34 AM in Resident 8's room revealed the resident's bed sheet had two brown smeared stains approximately four inches in length and two inches wide on the sheet at the edge of the bed. The stains were dried and looked the same during each observation on 07/17/2024, 07/18/2024 and 07/19/2024. An interview on 07/17/2024 at 11:50 AM with Floor Aide 1 revealed she assisted with bathing residents, cleaning, and changing bed sheets. She stated there no specific times to change the residents' sheets but staff just changed them as needed or when the residents asked for clean sheets. Per Floor Aide 1, she did not know when or who changed R8's sheets last.	P 305 305 305	facility to be overhauled beginning 8/12/24 and will be done in approximately 2 weeks 8/26/24 Resident have recived new bedding and new mattress, Bedding, Clean bedding Changed every tuesday 7/30/24 7/30/24	7/30/24

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P 305	Continued From page 9 2. Observation on 07/17/2024 at 10:30 AM revealed the double doors at the entrance of facility had a large hole in the glass on the right side of the door and cracked glass around the large hole. The glass section of the door was covered with cardboard. Observation on 07/17/2024 at 10:30 AM revealed the hallway between resident rooms leading toward the back of the building had debris and dirt and dried brown spilled stains on the floor. Further observation revealed the floors in rooms 2, 3, 8, 15 and 17 had paper trash, loose rolling tobacco particles, and clothes on the floors and/or under the beds. Observation on 07/17/2024 at 10:35 AM revealed a puddle of water on the floor in front of a water fountain located in the hallway where resident rooms are located. Observation on 07/19/2024 at 9:14 AM of the bathroom utilized by residents located on the back hall across from the kitchen revealed the rubber chalking between the tub and shower wall was hanging loose. During an interview on 07/18/2024 at 10:55 AM with the Maintenance Supervisor, he stated he was at this facility weekly and as needed. He further stated when something was needed, the staff filled out a work order and submitted it to him. Per the Maintenance Supervisor, he was working on a water lead today near the water fountain and men's shower which had been reported to him this week. He stated he did not know how long the water had been leaking. He further stated the glass company would be at the facility the next day or Monday to repair the	P 305	Replaced by Monticello Glass mirror Extra Cleaning Reminder to close doors to prevent leaves Blowing in doors. -Rooms/done 1x day Hallways/Bathrooms Cleaned each shift and as needed. Repaired	7/30/24 7/30/24 7/30/24

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P 305	Continued From page 10 broken glass in the front door. An interview on 07/18/2024 at 11:12 AM with the Administrator revealed she had provided education to the staff on deep cleaning of resident rooms, keeping laundry clean and off the floors. She further stated she did the training/education verbally with staff and did not get signatures or have documentation of the education. Further interview with the Administrator on 07/19/2024 at 10:57 AM revealed the glass company was to be at the facility today to repair the glass in the front door. She stated a resident had thrown a rock, hit the door, and broke the glass on 07/13/2024.	P 305	Deep Cleaning done once a week Room/ By Room	7/30/24 7/30/24
P 325	902 KAR 20:036 4(3)(c)3a-e Section 4. Provision of Services (3) A PCH or SPCH shall meet the following requirements relating to the provisions of residential care services: (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:	P 325	Re KAR 20:036 Dietian to arrive and begin was present Inspected Kitchen menu Reviewed.	8/14/24 8/14/24

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P 325	Continued From page 11 (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 menus, the facility failed to follow the planned menus for four of four meals observed which included the lunch meals on 07/17/2024, 07/18/2024, and 07/19/2024, and the evening meal on 07/19/2024. The findings include: Dietary and menu policies were requested from the Administrator on 07/18/2024 at 4:17 PM The Administrator stated all policies were being revamped by administration and she did not have those in the facility at this time. During an interview on 07/19/2024 at 9:10 AM with Cook 1, she stated the facility was currently on week two of the four week menu.	P 325	Relayed information to administor/Cook to call her if needed * No dietian since Dec 23 past dietian was Kathy Tucker Dietian was here and spoke to cooks and Administrator and Asst Administrator No Dietian Since 12/23/23	8/14/24 8/14/24 8/4/24

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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 _____	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

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P 325	Continued From page 12 Observation on 07/17/2024 at 12:15 PM of the lunch meal served to residents revealed each resident received four chicken nuggets, approximately a 1/4 cup of peas, and mandarin orange slices and a ten ounce orange drink, milk, or coffee. Review of the menu for Week 2 of the weekly menus revealed the lunch meal for 07/17/2024 should have been Lasagna, green beans, garlic bread, tropical fruit, and drink of choice. Observation on 07/18/2024 at 12:10 PM the lunch meal served to residents revealed each resident was served 1/2 cup of chicken noodle soup, and approximately 1/4 cup of cooked apples and a 10 ounce glass of orange drink or coffee, or milk. Review of the weekly menu revealed the lunch meal for 07/18/2024 should have been chicken pot pie, mashed potatoes, green beans, butterscotch pudding and drink of choice. Observation on 07/19/2024 at 12:05 PM of the lunch meal served to the residents revealed the resident's received pork loin, a baked potato, mixed fruit, greens and a slice of bread, a 10 ounce orange drink, coffee, or milk. Review of the weekly menu revealed the lunch meal for 07/19/2024 should have been pork loin, scalloped potatoes, carrots, chocolate cake and drink of choice. Observation on 07/19/2024 at 5:10 PM of the dinner meal served to the residents revealed the residents received a slice of fried bologna, cooked apples, scrambled eggs, and a slice of bread and a 10 ounce orange drink, coffee, or milk.	P 325	Per Dietian facility menus are posted on board New Dietian on Board	8-14-24 8-14-24

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P 325	Continued From page 13 Review of the weekly menu revealed for dinner on 07/19/2024 should have been vegetable beef soup, grilled cheese, tropical fruit cup and drink. Review of the past monthly menus labeled weeks 1-4, not dated revealed no documented changes noted on the menu's to indicate changes made or advance notice of changes to the menu. Additionally, the menus did not include the changes to the menu for the lunch meals on 07/17/2024, 07/18/2024, 07/19/2024 or the dinner meal on 07/19/2024. During an interview on 07/19/2024 at 9:10 AM with Cook 1, she stated the oven in the kitchen had not been working since March 2024. She further stated it had been worked on but still did not work. She stated anytime the menu needed to be changed she made the Administrator aware verbally. Per Cook 1, she does not document the change on anything, only made the Administrator aware. She further stated the menu changes occurred if they run out of certain foods designated on the menu and replaced the foods with something else. She stated she had prepared the meals and used what she had if the menu items were not available. She further stated she had never spoke with the current Dietician. During an interview on 07/19/2024 at 5:00 PM with the Administrator she stated the facility had a newly hired dietitian. The Administrator stated she had not met her and had no contact with the dietician. The Administrator stated that when the menu changed the dietary staff made her aware. Per the Administrator, some of reasons for change in the menu was due to the food delivery running late. The Administrator stated the facility did not have a Dietary Manager, only a Cook 1,	P 325		8-14-24 8/14/24

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P 325	Continued From page 14 who works part- time.	P 325	New dietian on Board All infromation was went over with all Staff Verbally and all Stated they understood Will cont to monter all Cleaning, menu and Saftey of residents	8-14-24 8-14-24