Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100168	A. BUILDING: _____ B. WING _____	R-C 06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR I LLC	317 ODDVILLE AVENUE CYNTHIANA, KY 41031

(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 on the On-Site Revisit Survey initiated and concluded on 06/30/2026, it was determined the facility had corrected the deficiencies as of 06/30/2026.	{P 000}		

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

Office of Inspector General

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	100168	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR LLC	317 ODDVILLE AVENUE CYNTHIANA, KY 41031

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P 000	Initial Comments A Complaint Survey investigating KY00045388 and KY00045435 was initiated on 03/25/2025 and concluded on 03/28/2025. Regulatory deficiencies were identified and cited related to KY00045388 and KY00045435. A Type "A" citation was issued to the facility on 03/31/2025. Based on the findings of the Complaint Survey, the facility failed to ensure Resident (R) 5 received medications as prescribed by the physician. R5 was admitted on 03/07/2025 with a physician's order to receive two antiseizure medications daily, an antipsychotic medication daily, and a narcotic pain medication, two times daily and as needed. The facility failed to obtain the physician ordered medications from the pharmacy, and R5 was not administered the prescribed medications on 03/07/2025 through 03/09/2025. On 03/10/2025, R5 was found unresponsive, requiring emergency treatment. Interview with a Nurse Practitioner (NP) who provided medical services to residents in the facility revealed the facility's failure to administer the prescribed antiseizure medications had resulted in R5 having seizure activity that required emergency medical intervention in a hospital emergency department. Based on the findings, the facility's failure to ensure R5 received physician prescribed medications to treat medical conditions presented an imminent danger and creates substantial risk that death or serious mental or physical harm to the resident could occur. The facility was notified of the Type "A" citation on 03/28/2025.	P 000	Effectively 4/23/25 no new admissions will be done on Friday's to ensure we can have all medication's in the facility prior to the weekend. Completion 4/24/25	

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

Regional Manager
Kim Perez 4/26/25

Office of Inspector General

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P 040	Continued From page 1	P 040		
P 040	902 KAR 20:036 4(1)(a-e) Section 4. Administration and Operation Section 4. Administration and Operation. (1) Licensee. The licensee shall be legally responsible for: (a) The operation of the PCH or SPCH; (b) Compliance with federal, state, and local laws and administrative regulations pertaining to the operation of the facility; (c) The development and implementation of policies related to administration and operation of the facility; (d) If the licensee is a SPCH, the development and implementation of written transition procedures to ensure cooperation with an individual or entity that assists with transitioning residents with an SMI to community living arrangements; and (e) If the licensee is an SPCH, access to confidential and secure telehealth services unless access is impossible to provide due to a lack of: 1. Broadband service; or 2. An appropriate physical space for residents. This requirement is not met as evidenced by: Based on interview, record review, review of the facility's policies and review of the facility's job description, the facility failed to develop and implement policies related to administration and operation of the facility including medication administration and pharmacy services for 1 of 9	P 040		

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P 040	Continued From page 2 sampled residents, Resident (R) 5. The findings include: Review of the facility's policy titled, "Medication Policies and Procedures," not dated, revealed all prescribed drugs should be supplied by the drug store of the president's choice. Further review revealed the policy contained no process instructions for ordering or obtaining medications from the pharmacy. Review of the facility's policy titled, "Medication Ordering and Receiving from Pharmacy Provider," dated 08/03/2024, revealed steps to follow when medication had been administered or removed from the "Emergency Box," but there was no information on ordering or receiving of daily scheduled medications. Review of the facility's document "Nursing Aide Job Duties," not dated, revealed nursing aide duties included administering medications. Further review revealed qualifications included to be in good health, have a pleasant disposition, be able to work with others, have an interest in the elderly, and be free from home responsibilities that interfered with work. The State Survey Agency (SSA) Surveyor requested the facility's job description and responsibilities for the medication aide on 03/26/2025 at 2:20 PM. The second request was on 03/28/2025 at 10:04 AM. However, the facility did not produce this document. In an interview on 03/25/2025 at 2:15 PM with Medication Aide 1, she stated she stated she had never seen a job description, policy, or information manual on how to administer	P 040		

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P 040	Continued From page 3 medications and based her performance on what another staff member told her to do. In an interview on 03/25/2025 at 2:40 PM with Medication Aide 2, she stated she stated the facility did not provide any written instructions, training materials, job description, or policies related to administering medications. She stated another medication aide verbally gave her all the information she needed to know about the medication cart and administering medications. In an interview on 03/27/2025 at 10:31 AM with the Pharmacist, he stated the pharmacy had a contract with the facility to provide pharmacy services. He stated the pharmacy assigned an account manager for the facility that visited quarterly and was the contact for any questions from the facility. He stated the pharmacy did not provide any policies or procedures to the facility for staff training and had no part in developing specific facility policies or protocols concerning medications. In an interview on 03/26/2025 at 2:20 PM with the Administrator, she stated the facility did not have a job description for medication aides. She stated medication aides were educated on job role and duties by other medication aides because they were not required to be licensed. In an interview on 03/27/2025 at 1:10 PM with the Regional Manager, she stated the facility did not have any policies on medications, and staff followed the physician's orders and instructions for medication administration.	P 040		
P 120	902 KAR 20:036 4(10)(h) Section 4 Administration and Operation	P 120		

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(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;
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

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P 120	Continued From page 5 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 interview, record review, review of the facility's job description, and review of the facility's policy, the facility failed to maintain records of orientation and/or annual in-service training for medication aides that included the name of the individual who provided training, date and number of hours training was given, summary of training program content, recording keeping procedures, policies regarding the responsibilities of specific job duties, and use of medications. The deficient practice was identified for 4 out of 4 medication aides reviewed, Medication Aide 1, 2, 3, and 4, and affected all residents of the facility. The findings include: Review of the facility's policy titled, "Medication Policies and Procedures," not dated, revealed all medications would be administered by nurse's aides, and each dose administered would be recorded in the medical record. Review of the facility's document "Nursing Aide Job Duties," not dated, revealed nursing aide duties included administering medications. Further review revealed qualifications included to be in good health, have a pleasant disposition, be	P 120	All orientation will be done by 5/15/25 and will be maintained and kept in each individual's file. Completion by 5/16/25	

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P 120	Continued From page 6 able to work with others, have an interest in the elderly, and be free from home responsibilities that interfered with work. The State Survey Agency (SSA) Surveyor requested the facility's job description and responsibilities for medication aides on 03/26/2025 at 2:20 PM, with a second request made on 03/28/2025 at 10:04 AM. However, the SSA Surveyor did not receive the document. Review of employee files for Medication Aides 1, 2, 3, and 4 revealed the following documents were included: job application, tuberculosis verification of testing, background check including sex abuse registry report and abuse registry report. Further review revealed no documents or records of orientation or annual in-service completion for medication aide training, no summary or description of training program content, the person that provided training, hours of training, and had no job requirements or responsibilities. In an interview on 03/25/2025 at 2:15 PM with Medication Aide 1, she stated she had been at the facility for approximately six months. She stated she was trained for one week on how to give medication by another staff member, and training did not include any web-based information, videos, written information, or testing. She stated she had never seen a job description, policy, or information manual on how to administer medications. She stated she based her performance on what another staff member told her to do. In an interview on 03/25/2025 at 2:40 PM with Medication Aide 2, she stated she had been at the facility giving medications for approximately	P 120		

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P 120	Continued From page 7	P 120		

12 years. She stated she received three days of training by another staff member on how to administer medications. She stated she was not provided with any written instructions, training materials, job description, or policies. She stated all the information she needed to know about the medication cart and administering medication was received verbally from another medication aide.

In an interview on 03/26/2025 at 1:30 PM with Medication Aide 3, she stated she had been at the facility for approximately five years. She stated she was trained on how to administer medication by another medication aide for three days, then they shadowed her for a shift to make sure she made no mistakes. She stated there was no formal training, videos, or written information, and all information was received verbally.

The State Survey Agency (SSA) Surveyor attempted a telephone interview with Medication Aide 4 on 03/26/2025 at 6:33 PM; 03/27/2025 at 9:27 AM; and 03/28/2025 at 8:58 AM. However, all three instances were unsuccessful because there was no answer, and voice mail was unavailable.

In an interview on 03/26/2025 at 2:20 PM with the Administrator, she stated medication aide training was typically four days in length and provided by another medication aide. She stated the medication aide trainee's progress and readiness was assessed by watching the trainee administration medications with zero errors and a verbal discussion between the trainee and the medication aide trainer. She stated there was no documentation of the orientation, no written program content, no documentation of the

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P 120	Continued From page 8 employee's orientation or training being completed, and no performance evaluations. In an interview on 03/27/2025 at 1:10 PM with the Regional Manager, she stated medication aide training could last one week to one month, dependent upon the trainee's skill level. She stated all training was provided by other medication aides verbally. She stated orientation was the part before employment and was not included in employee files. She stated in-service trainings were done every three months, and that training was kept in employee files.	P 120		
P 170	902 KAR 20:036 4(11)(b)8 Section 4. Administration And Operation Section 4. Administration and Operation. (11) Medical records. (b) Each record shall include: 8. Documentation of any accident, injury, illness, medication error, or drug reaction impacting the resident; This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy, the facility failed to maintain medical records that included documentation of medication errors for 1 of 3 sampled residents, Resident (R) 5. Refer to P0220 and P0235 The findings include:	P 170		

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P 170	Continued From page 9 Review of the facility's policy titled, "Medication Policies and Procedures," not dated, revealed medication errors would be reported immediately to the resident's physician and recorded in an incident report transmitted to the Administrator or Manager. Review of R5's "Admission Record" revealed the facility readmitted her on 03/07/2025 with diagnoses including seizure disorder and chronic obstructive pulmonary disease (COPD). Review of R5's "Physician's Orders," signed as reviewed by the Administrator on 03/07/2025, revealed the following medications were ordered: Keppra, a medication for preventing seizures, 1000 milligrams (mg) twice a day by mouth (PO); Dilantin, a medication for preventing seizures, 100 mg capsules, take 3 capsules PO at bedtime; hydrocodone 5 mg-acetaminophen 325 mg tablet, a narcotic medication for pain, take 1 tablet PO every 6 hours as needed for moderate to severe pain; fluticasone 250 micrograms (mcg)-salmeterol 50 mcg, an inhaled medication used for chronic obstructive pulmonary disease (COPD), take 1 inhalation twice a day; vitamin D3 capsule 400 units, take 1 capsule daily; Remeron 15 mg tablet, a medication for depression, take 1/2 tablet PO at bedtime; Paliperidone ER 6 mg tablet, an antipsychotic medication used to treat schizophrenia, take 1 tablet PO daily; alendronate 70 mg tablet, a medication used to strengthen bones, take 1 tablet weekly; and Certavite, a vitamin, take one PO daily. Review of R5's "Medication Administration Record [MAR]," for March 2025, revealed the physician ordered medications had been transcribed on the MAR, with directions to staff for administration. However, further review	P 170	RM will have a staff meeting with all med-techs on 5/14/25 to refresh them and ensure that they are following policies on any med errors . Also to remind them to document, any med errors ,contact doctor, and notify management as well as any guardians if applicable. Completion 5-15-25	

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P 170	Continued From page 10	P 170		

revealed no medications were administered to R5 on 03/07/2025, 03/08/2025, 03/09/2025, and 03/10/2025 (R5 at the local ED) by the facility's staff.

Review of R5's "Progress Notes," dated 03/07/2025, revealed documentation of R5's return to the facility from a skilled nursing facility (SNF). The note revealed the Administrator signed that the medication orders had been sent to the pharmacy. Further review revealed notes dated 03/08/2025 and 03/09/2025 both documented that "medication is not in facility" and were signed by the Administrator.

Review of R5's "Accident or Incident Report," dated 03/10/2025 at 12:45 AM and written by Medication Aide 4, revealed at 12:30 AM, R5 was found by the facility's staff during bed check, slumped over and without speech or movement. The report stated Emergency Medical Services (EMS) was called, and R5 was taken to the local ED. Further review of the report revealed it did not mention any medication error.

In an interview on 03/26/2025 at 1:30 PM with Medication Aide 3, she stated she worked on 03/09/2025 and assessed there was no medication for R5. She stated she sent a text message to the Administrator informing her of the missing medication. Medication Aide 3 stated she did not complete an incident report because she had not been instructed to. She stated the facility did not have any policies or manuals concerning medication administration, medication errors, or incident reporting.

In an interview on 03/26/2025 at 2:20 PM with the Administrator, she stated she worked on 03/08/2025 as the medication aide. She stated

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P 170	Continued From page 11 she realized R5 did not have any medications, contacted the pharmacy, and was told medication could not be refilled until 03/15/2025. The Administrator stated she did not take any further action to secure medications due to not knowing what else to do. She stated she did not complete an incident report or notify the provider that medications were not given. In an interview on 03/27/2025 at 1:10 PM with the Regional Manager, she stated the facility did not have any policies on medications, and they followed the physician's orders and instructions for medication administration. She stated a medication error was anytime the wrong medication was given to the wrong resident.	P 170		
P 220	902 KAR 20:036 5(1)(c) Section 5 Provision of Services Section 5. Provision of Services. (1) Basic health and health related services. (c) Medications or therapeutic services shall not be administered or provided to any resident, except on the order of a licensed physician or other health care practitioner as authorized under the practitioner's scope of practice. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents received medications as prescribed by the physician. The deficiency was identified for 1 of 9 sampled residents, Resident (R) 5.	P 220	No New admissions will be done on Friday's to ensure that all medications are reviewed by physicians and sent from pharmacy. Completion 4/25/25	

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P 220	Continued From page 12 R5 was admitted on 03/07/2025 with a physician's order to receive two antiseizure medications daily, an antipsychotic medication daily, and a narcotic pain medication, two times daily and as needed. The facility failed to obtain the physician ordered medications from the pharmacy, and R5 was not administered the prescribed medications on 03/07/2025 through 03/09/2025. On 03/09/2025, R5 was found unresponsive, requiring emergency treatment and transfer to the local Emergency Department (ED) via Emergency Medical Services (EMS) on 03/10/2025. At the ED, R5 exhibited seizure like activity, and the ED Physician suspected this was due to the anti-seizure medications being omitted from 03/07/2025 through 03/09/2025. Based on the findings, the facility's failure to ensure R5 received physician prescribed medications to treat medical conditions presented an imminent danger and creates substantial risk that death or serious mental or physical harm to the resident could occur. The facility was notified of the Type "A" citation on 03/28/2025. The findings include: Review of the facility's policy titled, "Medication Policies and Procedures," not dated, revealed all prescribed drugs should be supplied by the drug store of the resident's choice. Further review revealed there was no process instructions for ordering or obtaining medications from the pharmacy. Review of R5's "Admission Record" revealed the resident was readmitted to the facility on 03/07/2025, with diagnoses to include seizure disorder and chronic obstructive pulmonary disease (COPD), and the resident was had a	P 220		

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P 220	Continued From page 13 State Guardian appointed. Review of R5's "Admission Agreement," not dated, revealed the facility would administer or assist residents with medications under the order of the physician. Further review revealed the facility had an available pharmacy for delivery of residents' medications Review of R5's "Resident's Rights," signed on 11/29/2018 by R5's responsible party, revealed every resident at the facility had the right to receive adequate and appropriate health care, medical treatment, and protective support services. Review of R5's "SMI Screening Form," signed on 10/05/2020 by R5's responsible party, revealed R5 had a diagnosis of a "serious mental illness" (SMI). Further review revealed SMI was a mental illness or disorder that was diagnosed by a physician or behavioral health practitioner of impaired functioning in one or more major areas of living that was unlikely to improve without treatment, services, or support. Review of R5's "Physician's Orders," signed as reviewed by the Administrator on 03/07/2025, revealed the following medications were ordered. Keppra, a medication for preventing seizures, 1000 milligrams (mg) twice a day by mouth (PO), Dilantin, a medication for preventing seizures, 100 mg capsules, take 3 capsules PO at bedtime, hydrocodone 5 mg-acetaminophen 325 mg tablet, a narcotic medication for pain, take 1 tablet PO every 6 hours as needed for moderate to severe pain; fluticasone 250 micrograms (mcg)-salmeterol 50 mcg, an inhaled medication used for chronic obstructive pulmonary disease (COPD), take 1 inhalation twice a day; vitamin D3	P 220		

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P 220	Continued From page 14 capsule 400 units, take 1 capsule daily; Remeron 15 mg tablet, a medication for depression, take 1/2 tablet PO at bedtime; Paliperidone ER 6 mg tablet, an antipsychotic medication used to treat schizophrenia, take 1 tablet PO daily; alendronate 70 mg tablet, a medication used to strengthen bones, take 1 tablet weekly; and Certavite, a vitamin, take one PO daily. Review of R5's "Medication Administration Record [MAR]," for March 2025, revealed the physician ordered medications had been transcribed on the MAR, with directions to staff for administration. However, further review revealed no medications were administered to R5 on 03/07/2025, 03/08/2025, 03/09/2025, and 03/10/2025 (R5 at the local ED) by the facility's staff. Review of R5's "Progress Note," dated 03/07/2025, revealed documentation of R5's return to the facility from a skilled nursing facility (SNF), and the note, signed by the Administrator, stated the medication orders were sent to the pharmacy. Further review revealed notes signed by the Administrator and dated 03/08/2025 and 03/09/2025 both documented "medication is not in facility." Review of R5's "Accident or Incident Report," dated 03/10/2025 at 12:45 AM and written by Medication Aide 4, revealed at 12:30 AM, R5 was found by the facility's staff during bed check, slumped over and without speech or movement. The report stated Emergency Medical Services (EMS) was called, and R5 was taken to the local ED. Review of the EMS "Run Form," dated 03/10/2025, revealed at 12:27 AM, EMS received	P 220		

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a call from the facility about R5, and at 12:28 AM, EMS arrived at the facility and transported R5 to the local ED, transferring care to ED staff on 03/10/2025 at 12:55 AM. Per the EMS personnel assessment, R5 had a medical history of epilepsy or seizure disorder. EMS personnel documented that R5, upon their arrival to the facility, was sitting slouched over in bed and was oriented to name only. In addition, according to the form, R5 had an uneventful transport to the local ED except for blood oxygen saturation levels that dropped into the 80's (normal 95 to 100 percent on room air). EMS personnel applied oxygen initially at 2 liters per minute (lpm) per nasal cannula and increased the flow rate to 4 lpm per nasal cannula to increase R5's blood oxygen saturation level to 94 percent.

Review of R5's hospital ED medical records revealed the resident arrived at the local ED on 03/10/2025 at 12:55 AM with altered mental status. Diagnostic tests included computed tomography (CT) scans of the abdomen, head, neck, and chest (small area of possible infiltrate). Per the record, laboratory tests included a complete blood count (CBC), a comprehensive metabolic profile (CMP), and two venous blood gases. The record stated, upon arrival, R5's blood oxygen saturation level was 95 percent on oxygen at 2 lpm per nasal cannula. Per the record, the ED Nurse documented at 3:43 AM, R5 had a myoclonic seizure-like movement and did not make eye contact. R5's blood oxygen saturation level dropped to 74 percent, and R5's oxygen flow rate was increased to 6 lpm per nasal cannula, which raised the resident's oxygen level to 98 percent. The record also stated the ED Physician witnessed R5 having the seizure-like activity and suspected R5 had not been receiving prescribed antiseizure

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medications. Per the record, R5 received levetiracetam (Keppra) 2000 mg IV at 3:44 AM. Other medications R5 received during her ED stay were phenytoin (Dilantin) 300 mg PO at 8:15 AM; doxycycline 100 mg PO at 6:33 AM (an antibiotic started for acute exacerbation of COPD); and prednisone 50 mg PO at 6:32 AM (a steroid given for acute exacerbation of COPD). Further review revealed on 03/10/2025 at 7:30 AM, the Physician spoke with unnamed facility staff who confirmed R5 had not been administered any of her prescribed medications since admission to the facility on 03/07/2025.

Review of R5's hospital medical record document "SW [Social Worker]/Discharge Planner Note," dated 03/10/2025 at 9:47 AM, revealed the facility's Administrator informed the hospital that R5 arrived at the facility on 03/07/2025 from a SNF after 5:00 PM, and medications were unable to be filled. Per the note, the Administrator verified that R5 did not receive any medications throughout the weekend. The note also stated the Administrator informed the hospital staff she would fax a current medication list and was waiting on the consent to be signed by R5's State Guardian. Further review revealed the Administrator informed the hospital staff that a telehealth visit would occur upon R5's return to the facility. Per the note, the Administrator requested the hospital send R5's evening dose of medication with the resident at discharge.

In an interview with R5 on 03/25/2025 at 11:18 AM, she stated she did not clearly remember the incident, but "just woke up in the hospital." She stated when she was readmitted to the facility from the SNF, the facility did not have her medication for two to three days. She stated when she returned to the facility from the hospital,

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she started getting her medicine again. She stated she now knew her "seizure pill" was her only pill that was a long white capsule that she received twice a day. She stated she now looked at her medicine to make sure she got her "seizure pill." She stated now she was more cautious with staff. She stated she knew she was going to get her medicine now, but she always checked.

In an interview on 03/26/2025 at 8:30 AM with State Guardian 1, she stated she received a call from Adult Protective Services (APS) about a complaint received from a local hospital concerning R5 not being administered prescribed medications, which resulted in R5 having a seizure. State Guardian 1 stated the assigned guardian for R5 was not available, and as her backup, she was sent to the facility to investigate. She stated that on arrival to the facility on 03/10/2025, she observed the medications available at the facility for R5 did not match the ordered medications, with the antiseizure medication Keppra still not available. State Guardian 1 stated she spoke with Medication Aide 3 while at the facility and was told she would call the pharmacy and straighten out the situation.

In an interview on 03/26/2025 at 8 46 AM with State Guardian 2, she stated she gave consent for R5 to return to the facility from a SNF following rehabilitation after surgery. State Guardian 2 stated she had been out of office when R5 returned to the facility, and upon return to office, she received an update from State Guardian 1. She stated residents currently at the facility under guardianship were designated as "high" priority meaning they were checked on frequently, including looking at their MARs and their medications due to the concerns they had for residents receiving medications.

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P 220	Continued From page 18 In an interview on 03/26/2025 at 9:27 AM with the SNF Social Worker, she stated she had a video call with R5 and the Administrator on 03/05/2025 so they could assess R5's appropriateness to return to the facility. The SNF Social Worker stated at the end of the video call the Administrator stated R5 was accepted and agreed on a return date of 03/07/2025. She stated the Administrator and was given R5's pharmacy contact information to send R5's current medication list. She stated R5 left the SNF on 03/07/2025 as arranged, and her remaining medications were returned to their pharmacy for credit back to the insurer, as directed by their facility policy. In an interview on 03/25/2025 at 2:40 PM with Medication Aide 2, she stated medications were typically delivered on the same day they were ordered. In an interview on 03/26/2025 at 1:30 PM with Medication Aide 3, she stated she worked on 03/09/2025 and assessed there was no medication for R5. She stated she sent a text message to the Administrator informing her, and then called the pharmacy to inquire about getting the medications. She stated the pharmacy told her the medication had to be paid for out-of-pocket because the refill date range had not been met. Medication Aide 3 stated the Administrator documented on R5's MAR for 03/09/2025 and 03/10/2025 that R5 was out of the facility and did not receive medication as indicated by her initials with a circle surrounding it. She stated on 03/10/2025, when R5 returned from the hospital, she informed the Administrator that medication sent from the hospital included four medications. Medication Aide 3 stated she	P 220		

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P 220	Continued From page 19 called the pharmacy and asked for the cost of a five-day medication supply and paid for R5's medication out of her own pocket. In an interview on 03/27/2025 at 10:31 AM with the Pharmacist who serviced the facility, he stated the pharmacy kept documentation of communication with providers regarding new medication orders, clarifications, and questions that arose concerning specific medications. He stated the pharmacy provided the facility with seven day a week delivery service, including a late-night delivery. He stated if the medications were not due to refill or if there were any other problems with filling the medications, they routinely worked with the facility to ensure the resident received their ordered medications. He stated, in some instances, the insurer would allow an override, and paying out of pocket was also an option. In an interview on 03/26/2025 at 11:27 AM with the Nurse Practitioner (NP), she stated she was the primary care provider for R5 and had not been notified by the facility of the missed doses of medications. The NP stated an on-call provider was available 24/7 for any concerns. She stated abruptly stopping antiseizure medications and missing several doses was a direct cause of R5 experiencing seizures, and the facility not having medication to administer to R5 was unacceptable. In an interview on 03/25/2025 at 3:09 PM with the Administrator, she stated she had a video call with the SNF to assess if R5 was appropriate to return to the facility. She stated once that was confirmed, the SNF Social Worker was given the phone and fax number to the pharmacy and told her (the Administrator) they would send a list of medications and a three-day order for	P 220		

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P 220	Continued From page 20 medications. The Administrator stated she worked on 03/08/2025 as the medication aide and realized R5 did not have any medications, so she contacted the pharmacy. She stated the pharmacy told her R5's medication could not be refilled until 03/15/2025, and the option was to pay out-of-pocket. However, she stated R5 could not afford to pay for the medications out-of-pocket. The Administrator stated she did not take any further action to secure medications because she did not know what else to do. In a follow-up interview with the Administrator on 03/26/2025 at 2:20 PM, the Administrator stated she did not notify the provider that R5 had missed several days of medications. In an interview on 03/27/2025 at 1:10 PM with the Regional Manager, she stated the facility followed the physician's orders and instructions for medication administration. In further interview she stated the Administrator called the pharmacy and was told they could not fill the order. The Regional Manager stated she did not see any further wrongdoing in the Administrator's actions.	P 220		
P 235	902 KAR 20:036 5(1)(f) Section 5. Provision of Services Section 5. Provision of Services. (1) Basic health and health related services. (f) 1. The administrator or staff person designated by the administrator shall make a written report of any incident or accident involving a: a. Resident, including a medication error or drug reaction; b. Visitor; or c. Staff member. 2. The report shall:	P 235		

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P 235	Continued From page 21 a. Identify any staff member who might have been witness to the incident; and b. Be filed in an incident file. This requirement is not met as evidenced by: Based on interview and record review it was determined the facility failed to make a written report of an incident involving a medication error. The facility failed to obtain and administer prescribed medications for 1 of 3 sampled residents, Resident (R) 5, on 03/07/2025, 03/08/2025, and 03/09/2025. However, no incident report was completed about the medication error. Refer to P0220 The findings include: Review of facility's policy titled, "Medication Policies and Procedures," not dated, revealed medication errors would be reported immediately to the resident's physician and recorded in an incident report transmitted to the Administrator or Manager. Review of R5's "Admission Record" revealed the facility readmitted her on 03/07/2025 with diagnoses which included seizure disorder and chronic obstructive pulmonary disease (COPD). Review of R5's "Physician's Orders," signed as reviewed by the Administrator on 03/07/2025, revealed the following medications were ordered: Keppra, a medication for preventing seizures, 1000 milligrams (mg) twice a day by mouth (PO); Dilantin, a medication for preventing seizures,	P 235	RM will have a meeting with staff 5/14/25 to ensure they are aware of the importance of following policy and following the steps of reporting any and all medications errors or issue that may happen. Also to refresh the med-techs that it is vital to contact all the following management,physician and guardian if applicable. Completion 5-15-25	

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P 235	Continued From page 22 100 mg capsules, take 3 capsules at bedtime PO; hydrocodone 5 mg-acetaminophen 325 mg tablet, a narcotic medication for pain, take 1 tablet PO every 6 hours as needed for moderate to severe pain; fluticasone 250 micrograms (mcg)-salmeterol 50 mcg, an inhaled medication used for chronic obstructive pulmonary disease (COPD), take 1 inhalation twice a day; vitamin D3 capsule 400 units, take 1 capsule daily; Remeron 15 mg tablet, a medication for depression, take 1/2 tablet PO at bedtime; Paliperidone ER 6 mg tablet, an antipsychotic medication used to treat schizophrenia, take 1 tablet PO daily ; alendronate 70 mg tablet, a medication used to strengthen bones, take 1 tablet weekly; and Certavite, a vitamin, take one PO daily. Review of R5's "Medication Administration Record (MAR)," for March 2025, revealed the physician ordered medications had been transcribed on the MAR, with directions to staff for administration. However, further review revealed the facility's staff administered no medications to R5 on 03/07/2025, 03/08/2025, and 03/09/2025. Review of R5's "Progress Notes," dated 03/07/2025 and signed by the Administrator, revealed R5 returned to the facility from a skilled nursing facility (SNF), and the medication list was sent to the pharmacy. Further review revealed notes, dated 03/08/2025 and 03/09/2025 and signed by the Administrator, both documented "medication is not in facility." Review of R5's "Accident or Incident Report," dated 03/10/2025 at 12:45 AM and written by Medication Aide 4, revealed at 12:30 AM, R5 was found by the facility's staff during bed check, slumped over and without speech or movement	P 235		

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The report stated Emergency Medical Services (EMS) was called, and R5 was taken to the local ED. Further review of the report revealed it did not mention any medication error.

Review of R5's hospital Emergency Department (ED) medical records revealed the resident arrived at the local ED on 03/10/2025 at 12:55 AM with altered mental status. Additional review revealed on 03/10/2025 at 3:43 AM, the ED Physician witnessed R5 having seizure-like activity and suspected R5 had not been receiving prescribed antiseizure medications. Further review revealed on 03/10/2025 at 7:30 AM, the ED Physician spoke with unnamed facility staff who confirmed R5 had not been administered any of her prescribed medications since admission to the facility on 03/07/2025.

Review of R5's hospital ED medical record document "SW [Social Worker]/Discharge Planner Note," dated 03/10/2025 at 9:47 AM, revealed the facility's Administrator informed hospital staff that R5 arrived to the facility on 03/07/2025 (a Friday) from a SNF after 5:00 PM, and medications were unable to be filled. Per the note, the Administrator verified that R5 did not receive any medications throughout the weekend (03/08/2025 and 03/09/2025).

In an interview on 03/26/2025 at 1:30 PM with Medication Aide 3, she stated she worked on 03/09/2025 and assessed there was no medication for R5. She stated she sent a text message to the Administrator informing her. Medication Aide 3 stated she did not complete an incident report because she had not been instructed to do so. In further interview, she stated the facility did not have any policies or manuals concerning medication administration,

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P 235	Continued From page 24 medication errors, or incident reporting. In an interview on 03/26/2025 at 2:20 PM with the Administrator, she stated she worked on 03/08/2025 as the medication aide, realized R5 did not have any medications, and contacted the pharmacy. She stated the pharmacy told her R5's medication could not be refilled until 03/15/2025. The Administrator stated she did not take any further action to secure R5's medications because she did not know what else to do. She stated she did not complete an incident report or notify the provider that medications were not given. In an interview on 03/27/2025 at 1:10 PM with the Regional Manager, she stated the facility did not have any policies on medications, and staff followed the physician's orders and instructions for medication administration. She stated a medication error was anytime the wrong medication was given to the wrong resident.	P 235		

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