Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100854	A. BUILDING: _____ B. WING _____	R-C 05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISPORT REST HOME I LLC	1580 FOURTH STREET LEWISPORT, KY 42351

(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 (PoC) the facility complaince for health on 05/02/2025.	{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 KY00045045, KY00045504, and KY00045187 was concluded on 04/02/2025. The facility was found not to be in compliance with State regulatory requirements with deficient practice identified for KY00045045. There was no deficient practice identified with KY00045504, and KY00045187 Survey dates: 04/01/2025-04/02/2025 Survey Census: 54 Sample Size: 8 Supplemental Residents: 0	P 000	RECEIVED APR 27 2025 CHFS Office of Inspector General Division of Health Care - WB _____ Received by	
P 180	902 KAR 20:036 4(11)(b)10 Section 4. Administration and Operation Section 4. Administration and Operation. (11) Medical records. (b) Each record shall include: 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; This requirement is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure medications administered to residents were initialed by the individual administering the	P 180	All Policies pertaining to aministering Medications and recording medications have been reviewed by all medication staff. An inservice will be held by the administrator May 2nd, 2025 to ensure that all medications are given and recorded as ordered. Violation will be corrected May 2nd. The administrator will make sure that all Med-techs sign a in service attendance sheet as a verification of understanding on the importance of recording routine and PRN medications in the MAR by the med-tech that gave them and initialed. Administrator and assistant administrator will monitor indefinatly	

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

Brenda Conner Administrator 4-26-2025

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P 180	Continued From page 1 medications for 1 of 8 sampled residents, (Resident (R)7). Review of R7's medication administration record (MAR) revealed that the facility's Administrator documented R7's promethazine 25 mg and acetaminophen 1000 mg were administered by Medication (Med) Technician (Tech) 3 on 02/01/2025 at 2:00 PM. Further review of R7's MAR revealed the Administrator also documented Med Tech 2 administered the resident's diphenhydramine hydrochloride (HCL) 25 mg at 5:45 AM on 02/01/2025. The findings include: Review of the facility policy titled, "Medical Records," effective 06/2009, revealed to correct an entry in the residents' medical record a line must be drawn through the error. Per review, staff were to write "error" and place their initials where they were correcting an error. Review of the facility document titled, "Job Description, 7-3 Med Tech", undated, revealed the Med Tech's responsibilities included administering medications and treatments as ordered by the physician. Further review revealed the Med Tech's responsibilities also included charting on the residents assigned to them. Review of the facesheet for R7 revealed the facility admitted the resident on 06/30/2021, with diagnoses that included mild mental retardation, hypertension, schizophrenia, and type 2 diabetes. Review of R7's MAR revealed the facility's Administrator noted the resident's promethazine 25 mg and acetaminophen 1000 mg medications	P 180	to ensure that medications are re-corded correctly. This will be corrected May 2nd, 2025.	

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P 180	Continued From page 2 had been administered by Med Tech 3 on 02/01/2025 at 2:00 PM. Further review of R7's MAR revealed the Administrator additionally documented Med Tech 2 administered the resident's diphenhydramine HCL 25 mg medication at 5:45 AM on 02/01/2025. In interview with the Department for Community Based Services (DCBS) Worker 04/01/2025 at 1:41 PM, she stated during her investigation she interviewed Med Tech 3 said R7 had taken her medications. The DCBS Worker said Med Tech 3 told her she administered R7's PRN Tylenol and promethazine to the resident. She reported "another" Med Tech, who worked day shift, told her it was not noted on R7's MAR where Med Tech 3 had given the resident's medication. The DCBS Worker further stated when she came to the facility to initiate her investigation, R7's medications were documented as given. She additionally stated the Administrator admitted to her that she documented the medications as administered for Med Tech 3 "later." In interview with Med Tech 3 on 04/01/2025 at 2:44 PM, she stated the Administrator documented the medications (PRN Tylenol and promethazine) that she had given to R7 on Saturday morning because she had forgotten to document it on the resident's MAR. She stated however, it was not appropriate for the facility's Administrator to document medications administered by someone else, especially since she (the Administrator) had not been present at the time the medications were administered. In interview with the Administrator's Assistant (AA) on 04/02/2025 at 9:30 AM, she stated she expected her staff to sign the residents' medicines out after they gave it. She stated if	P 180		

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P 180	Continued From page 3 someone forgot to sign a medication out, she expected staff to let the Administrator know or come back and sign the book themselves. The AA further stated she would not expect anyone else to sign that they gave a medication if they were not the person who had given it. In interview with the facility's Administrator on 04/02/2025 at 10:15 AM, she stated she documented that Med Tech 3 had given R7's promethazine and Tylenol medications on 02/01/2025 at 2:00 PM. She reported she knew that she was not supposed to document medications given by someone else. She said, "I know now that I was not supposed to do that." The Administrator stated she had been "on the phone" with Med Tech 3 while she was documenting R7's medication as given. She reported she also documented Med Tech 4 gave R7 Benadryl at 5:45 AM on 02/01/2025. The Administrator further stated Med Tech 3 and Med Tech 4 had forgotten to document those medications when they gave them to R7. She additionally said she documented the medications as given on R7's MAR on 02/03/2025 at "around" 12:00 PM.	P 180		