Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100314	A. BUILDING: _____ B. WING _____	R-C 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND MANOR REST HOME I LLC	1930 HIGHWAY 90 PARKERS LAKE, KY 42634

(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 An Onsite Revisit Survey was initiated on 1/29/2024 and concluded on 01/31/2024.The Survey found the facility had corrected the deficiencies as alleged in the acceptable (POC) Plans of Corrections for this survey cycle. However, the facility continued to be in non-compliance at this time due to another complaint survey conducted in conjunction with revisit, but un-related to this survey cycle.	P 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/10/24

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	100314	A. BUILDING: _____ B. WING _____	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND MANOR REST HOME	1930 HIGHWAY 90 PARKERS LAKE, KY 42634

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P 000	Initial Comments A Complaint Survey was initiated on 05/01/2023 and concluded on 05/05/2023. After supervisory review, the survey was reopened on 08/29/2023 and concluded on 08/30/2023. KY#37161 was found Compliant with no deficient practice noted. KY#37683, KY#37837, KY#38385, KY #39319, and KY #39398 were found Non-Compliant with deficient practice cited.	P 000	Cumberland Manor has initiated an appeal of the deficiencies cited below, and is awaiting the adjudication of that appeal as of the date of this Plan of Correction.	
P 050	902 KAR 20:036 3(4) Section 3. Administration and Operation (4) Patient rights. Patient rights shall be provided for pursuant to KRS 216.510 to 216.525. This requirement is not met as evidenced by: Based on interview, record review, review of the facility's policies, it was determined the facility failed to protect resident rights for two (2) of fourteen (14) sampled residents (Resident #1 and Resident #2). In addition, the facility failed to provide accommodations to residents who needed to make long distance phone calls, including calls to guardians and families. a). On 03/27/2023, Resident #1 left the facility without staff knowledge and was confirmed deceased on 08/14/2023. b). In April 2023, the facility failed to report Resident #2's had multiple refusals of antipsychotic medication to the Medical Director and Legal Guardian. c). During interviews with Resident # 2, #5, #6,	P 050	On 5.11.23, an in service training Was provided by the COO to the staff Of Cumberland Manor. Topics Discussed included, but are not Limited to, the importance Of educating residents to sign out When leaving the facility and Medication refusal notifications To the appropriate individuals. Staff members were asked if there Were any questions/if they Understood what was discussed, to Which all acknowledged they Understood and had no Questions. Medication refusals will be reported to the The provider and Guardian, if Applicable and will properly Document such. New hires are trained over a 2 day Period by the Administrator, with the First day of training beginning on the New staff member's first shift, Regarding the regulations and Facility policies.	

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

TITLE

12:43:21 2024-01-25 Eastern

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Rosetta Patrick 1/25/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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P 050	Continued From page 1 and #9 on 08/29/2023 at 10:30 AM, they stated the facility staff required residents to call collect or buy calling cards if they needed to make long distance phone calls to family members or legal guardians. The findings include: Review of the facility's policy titled "Residents should be Free from Abuse and Neglect", not dated, revealed all residents of the facility should be free from mental and physical abuse, neglect, and free from chemical and physical restraints except in emergencies or except as thoroughly justified in writing by a physician for a specified and limited period of time and documented in the resident's medical record. Further review revealed the policy included a copy of KRS 216.515 Rights of Residents-Duties of facilities-Actions which included every resident in a long-term care facility should have at least the following rights: Before admission to a long-term care facility, the resident and the responsible party or his responsible family member or his guardian should be fully informed in writing as evidenced by the resident's written acknowledgement and that of the responsible party or his responsible family member or his guardian, of all services available at the long term care facility and every long term care facility should keep the original document of each written acknowledgement in the resident's personal file; Before admission to a long term care facility, the resident and the responsible party or his responsible family member or his guardian should be fully informed in writing as evidenced by the resident's written acknowledgement and that of the responsible party or his responsible family member or his guardian, of all resident's responsibilities and rights as defined in this	P 050	Topics discussed upon hire include, But are not limited to, abuse and Neglect, reporting abuse and Neglect, resident monitoring, etc. Each time the PCP sees the resident, The PCP is evaluating the resident To ensure he/she is an appropriate Fit for a PCH. The facility will monitor its performance Relative to resident rights by performing Spot interviews of five residents and/ Or Guardians, twice a year. The spot Interviews began on 11.6.23. A yearly Audit between 11.6.23 and 11.5.24 of 10 randomly selected Resident charts will be conducted. On 5.11.23, the topics discussed in the in-service included, but are not limited to, resident rights, Admission policy/agreements, abuse a And neglect, reporting abuse And neglect and resident monitoring.	

Rosetta Patrick 1/25/24

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P 050	Continued From page 2 section and KRS 216.520 to 216.530 and every long term care facility should keep the original document of each written acknowledgement in the resident's personal file; The resident and the responsible party or his responsible family member or his guardian should be fully informed in writing, as evidenced by the resident's written acknowledgement and that of the responsible party or his responsible family member, or his guardian, prior to or at the time of admission and quarterly during the resident's stay at the facility, of all service charges for which the resident or his responsible family member or his guardian is responsible for paying; the resident and the responsible party or his responsible family member or his guardian should have the right to file complaints concerning charges which they deem unjustified to appropriate local and state consumer protection agencies and every long term care facility should keep the original document of each written acknowledgement in the resident's personal file; Residents should be permitted and encouraged to go outdoors and leave the premises as they wish unless a legitimate reason could be shown and documented for refusing such activity; If the resident is adjudicated mentally disabled in accordance with state law, the resident's guardian should act on the resident's behalf in order that his rights be implemented. Review of the facility's policy "Resident Monitoring", not dated, revealed a documented hourly check of each resident should be performed and documented to observe each resident's condition and behavior and to confirm each resident was present and accounted for on the premises, and a resident monitoring form should be marked with the time, staff initials, and date of the hourly checks, as the hourly check of	P 050	The facility changed telephone providers On 10.18.23 and now provides its residents With long distance telephone Calls at no charge. POC completion date: 11.19.23	

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P 050	Continued From page 3 each resident was performed. Further review revealed residents should be monitored more frequently than once per hour, as needed, such as in the event of a change of health condition, illness, physician's order and/or behavioral changes. Continued review revealed any resident who provided facility staff with verbal notice the resident was an elopement risk should be monitored every thirty (30) minutes and until further notice from the Administrator. Review of the facility policy "Policy of Reporting Abuse", not dated, revealed if a newly admitted resident appeared to have been abused or neglected, the facility agreed to report their findings to the Department of Human Resources immediately. Review of the facility's policy "Medication Administration", not dated, revealed that facility staff should administer medications in accordance with medical treatment provider/physician orders and maintain records of the medication administration in a medication record for each resident. Review of the facility's policy "Steps to Take if a Resident Refuses Care", not dated, revealed if a resident refused medications, the facility staff should contact the office of the Prescribing Physician/medical treatment provider to notify him/her of the refusal, and contact the legal guardian, if applicable, of the refusal. 1. Review of Resident #1's Admission Summary/Face Sheet revealed the facility admitted the resident on 01/10/2022 from Western State Hospital with diagnoses which included Schizophrenia Spectrum and Psychotic Not Otherwise Specified. Further review revealed	P 050		

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P 050	Continued From page 4 the resident had two (2) people listed as the Responsible Party for the resident. Review of Resident #1's chart revealed an unsigned copy of the Admission Policy and the Resident Admission Agreement. Review of the facilities Admission form titled "Assessment Regarding Abilities and Restrictions for Unrestricted Access to Leave/Return to the Facility" revealed a Questionnaire to be completed by the Primary Care, Medical Treatment Provider. Questions included "Do you believe the Resident should be restricted from leaving the facility premises, unaccompanied and without assistance or supervision from facility staff or others, such as a legal guardian or family?", "Is the Resident physically capable of leaving the facility building and premises with or without an assistive device?", "Do you believe the Resident has the mental and physical abilities necessary to safely have unrestricted, unaccompanied access to leave and return to the facility without placing the Resident into potential harm?", "Do you believe it is in the Resident's best interest to have unrestricted access to leave and return to the facility at all times?", "Is the Resident disoriented to place, which increases the Resident's risk of leaving the facility unattended and placing the Resident into potential harm?", "Does the Resident have cognitive impairment with poor decision making skills?", and "Is it likely the Resident would be a danger to himself/herself if he/she traveled unescorted outside of the facility?". Further review revealed the Conclusion of the Assessment was an area for the Medical Provider to circle if the Resident should or should not have unrestricted access to leave and return to the facility. However, the facility failed to complete	P 050		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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P 050	Continued From page 5 the Assessment for Resident #1 on Admission . Review of a Commonwealth of Kentucky Petition to Determine If Disabled document, filed by the Knott County Circuit Clerk's Office on 12/13/2018, revealed Resident #1 was diagnosed with Schizophrenia and Bipolar Disorder and could not make decisions for himself. Review of the Commonwealth of Kentucky Order for Emergency Appointment of Fiduciary, filed by the Knott County District Court on 12/18/2018, revealed a physician stated if immediate action was not taken, there was an imminent danger of a serious impairment to the health or safety of Resident #1 related to the resident's diagnosis of Schizophrenia. Further review revealed Resident #1 had two (2) Guardians/Conservators appointed. Review of Resident #1's Psychiatric Evaluation, dated 11/25/2022, revealed the resident had a diagnosis of Schizophrenia with an order for Risperdal (an antipsychotic medication used to treat Schizophrenia), Cogentin (an Antiparkinson medication sometimes used to treat involuntary movements due to the side effects of antipsychotic medications), Benadryl (an antihistamine medication sometimes used as a sedative/hypnotic, and Saphris (an antipsychotic medication). Review of the facility Incident Report, dated 02/26/2023 at 4:46 PM, revealed Resident #1 went out the fire exit, staff attempted to get the resident to return to the facility, and the resident refused to return to the facility until the staff took him/her to the Dollar General Store to get coffee. Further review revealed the staff took the resident to the Dollar General Store and returned him/her	P 050		

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CUMBERLAND MANOR REST HOME	1930 HIGHWAY 90 PARKERS LAKE, KY 42634

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P 050	Continued From page 6 back to the facility at 5:43 PM. Continued review revealed the resident was agitated at the time of the incident. Additional review revealed the Guardian was not notified at the time of the incident. Review of Resident #1's Psychiatric Note, dated 03/27/2023, revealed the resident had complained of not sleeping at night with an order to discontinue Saphris and Benadryl and start the resident on Seroquel (an antipsychotic medication). Further review of the note revealed the resident assessment section of the note was not completed. Review of the Commonwealth of Kentucky Missing Persons Report, dated 03/27/2023, revealed Resident #1 was missing at 6:30 PM, the McCreary County Sheriff's Office was notified at 8:03 PM, and Deputy Sheriff #1 arrived at the facility at 9:02 PM and cleared the call at 11:00 PM. Further review revealed the facility called McCreary County nine-one-one (911) to report Resident #1 missing and was last seen on 03/27/2023 at 6:30 PM, then was noticed missing at approximately 7:00 PM. At that time, the facility staff checked the premises and noticed footprints sliding down the wall under a window, then facility staff canvassed the area and drove roads surrounding the facility looking for the resident, then, after the staff were unable to locate the resident, they notified the nine-one-one (911) center approximately ninety (90) minutes after the resident was discovered missing. Continued review revealed Deputy Sheriff #1 drove the roads surrounding the facility and checked side roads and stores without being able to locate the resident and attempted to notify the next of kin without contact, but the facility staff stated they had contacted the next of kin.	P 050		

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CUMBERLAND MANOR REST HOME	1030 HIGHWAY 90 PARKERS LAKE, KY 42634

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P 050	Continued From page 7 Review of the facility's Incident Report, dated 03/27/2023 at 7:00 PM, revealed staff were passing 7:00 PM medications when they could not locate Resident #1, and he/she was last seen at 6:30 PM. Further review revealed staff searched for the resident and called the Owner #1 at 7:27 PM, who called the Administrator at 7:30 PM. Staff searched the building and roadway and called McCreary County Nine-One-One (911) at 8:03 PM and notified the Guardian at 8:09 PM, then notified Pulaski County Nine-One-One (911) at 8:24 PM. Continued review revealed Owner #1 emailed the "Abuse Hotline" on 03/28/2023. Review of email from Owner #1, dated 03/28/2023 at 9:55 AM, revealed he notified the Cabinet for Health and Family Services Department of Community Based Services Central Intake of "a report of self-abuse/neglect" regarding Resident #1. Review of Resident #1's Nurse's Notes, dated 04/28/2023, revealed Owner #1 had talked to a facility where the resident previously resided who stated Resident #1 eloped a few times from the previous facility. Further review of the facility's Nurse's Notes revealed the Administrator notified the Ombudsman on 04/06/2023. Continued review of Nurse's Notes revealed Owner #1 called a psychiatric facility in another town who had been familiar with Resident #1 and was told Resident #1 had eloped from another facility and was gone several months before he/she was located. Additional review of the Nurse's Notes revealed a deceased body was found on 05/01/2023 under a cliff in a location near the facility and a Sheriff's Deputy had shown the staff pictures of the shoes and belongings found with	P 050		

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P 050	Continued From page 8 the body, but the staff did not recognize it. Review of the Nurse's Notes revealed the Coroner notified the facility, on 08/10/2023 at 3:55 PM, the DNA matched Resident #1 and was awaiting an official report. Further review revealed the Coroner called the facility, on 08/14/2023 at 3:00 PM, and stated he had received a report which showed the body was a match for Resident #1. Continued review revealed Owner #2 notified the Office of Inspector General on 08/15/2023 at 9:00 PM that the deceased body found matched Resident #1. 2. Resident #2 was admitted to the facility with a diagnosis of Schizophrenia. Review of Resident #2's April 2023 Medication Administration Record revealed the resident had multiple refusals of antipsychotic medications. Review of Resident #2's Progress Notes revealed no documented evidence the facility had notified the residents State Guardian.. In an interview with Advanced Practice Registered Nurse (APRN) #1, on 05/04/2023 at 2:15 PM, she stated she did not receive notification of all medications at the time of resident refusal. She further stated she reviewed the medication records when she was in the facility weekly and, if there were a pattern of resident missing medication, alternatives for the refused medications could be discussed. She continued to state that the refusal of medications such as antipsychotic's and mood stabilizing medications could cause residents to have aggressive behaviors. In an interview with State Guardian #1, on	P 050		

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P 050	Continued From page 9 05/04/2023 at 3:20 PM, she stated she was not notified of Resident #2's medication refusal. She further stated she felt that the resident had behaviors that could have been avoided had she and the physician been notified of the medication refusal and alternate medications given. During an interview with the Administrator, on 08/29/2023, at 9:15 AM, she stated when she received a new referral, she looked at the patient's level of care, diagnoses, history, medications, and ability to self-transfer. She further stated the facility did not provide nursing services such as insulin injections, and if a resident could not self-transfer from a wheelchair or ambulate unassisted, they were unable to provide care for the resident and denied the referral. She continued to state if a current resident had signs or symptoms of deterioration, the staff would discuss the resident's condition with a medical provider and determine if the resident needed to be transferred to a higher level of care, and the facility does have a transfer agreement with a Long-Term Care Facility. Beechtree Manor in Jellico, Tennessee. She stated residents could sign themselves in and out of the facility unless they had a legal guardian, and, if a resident had a legal guardian, they were required to call and ask the guardian if a resident could leave the facility and/or if the resident could have visitors, and they usually obtained a standard order from the Guardian that the residents could have visitors or go out to eat or leave the facility. She further stated most residents were mentally able to leave the facility, and they had good community support to notify the facility if they saw anyone walking down the roads close to the facility to check to see if it was a resident from the facility. She continued to state she was certain Owner #1 discussed the	P 050		

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P 050	Continued From page 10 Admission Policy and Resident Admission Agreement with Resident #1's Guardian; however, she was unable to provide any written documentation the Guardian reviewed and signed the Admission documents to include the Admission form titled "Assessment Regarding Abilities and Restrictions for Unrestricted Access to Leave/Return to the Facility".The Administrator further stated Psychiatrist #1 was in the facility to visit residents on 03/27/2023, but Resident #1 had already been discovered missing from the facility prior to Psychiatrist #1 being able to visit him/her. During a Follow Up Interview with the Administrator, on 08/29/2023 at 10:35 AM, she stated if a resident did not have a cell phone, he/she could ask to use the telephone or staff would bring staff to the telephone if they had a phone call. She further stated residents were free to call locally, but if they needed to call long distance, they needed a calling card or call collect. She continued to state if a resident wished to talk with family or a Guardian that had a long-distance number, the staff would sometimes call the person and have them call the Resident. She continued to state that approximately half of the Residents had cell phones.	P 050		
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	P 055		

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CUMBERLAND MANOR REST HOME	1930 HIGHWAY 90 PARKERS LAKE, KY 42634

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P 055	Continued From page 11 Internally to prevent further potential abuse while the investigation is in progress. This requirement is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to report and investigation allegations of abuse. In addition, the facility failed to notify the residents State Guardianship of client involved incidents, nor was the attending Advanced Practice Registered Nurse (APRN) notified of all incidents for one (1) of fourteen (14) sampled residents (Resident # 1). On 03/27/2023, the facility failed to report Resident #1's elopement from the facility to the Medical Doctor and the State Agency. The findings include: Review of the facility's policy titled "Residents should be Free from Abuse and Neglect", not dated, revealed all residents of the facility should be free from mental and physical abuse, neglect, and free from chemical and physical restraints except in emergencies or except as thoroughly justified in writing by a physician for a specified and limited period of time and documented in the resident's medical record. Further review revealed the policy included a copy of KRS 216.515 Rights of Residents-Duties of facilities-Actions which included every resident in a long-term care facility should have at least the following rights: Before admission to a long-term care facility, the resident and the responsible party or his responsible family member or his guardian should be fully informed in writing as	P 055	On 5.11.23,6.28.23 and 10.27.23 an in service training Was provided by the COO to the staff Of Cumberland Manor. Topics Discussed included, but were not Limited to, the policies for Reporting abuse and/or neglect to the Manager and the appropriate parties. Additionally, the in service Training including notifying a resident's Guardian and/or responsible Party if applicable and ensuring Proper documentation. Staff members were asked if there Were any questions/if they Understood what was discussed, to Which all acknowledge they understood And have no questions. New hires are trained over a 2 day Period by the Manager, with the First day of training beginning on the New staff member's first shift, Regarding the regulations and Facility policies. Topics discussed upon hire include, But are not limited to, abuse and Neglect, reporting abuse and Neglect and resident monitoring.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND MANOR REST HOME	1030 HIGHWAY 90 PARKERS LAKE, KY 42634

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P 055	Continued From page 12 evidenced by the resident's written acknowledgement and that of the responsible party or his responsible family member or his guardian, of all services available at the long term care facility and every long term care facility should keep the original document of each written acknowledgement in the resident's personal file; Before admission to a long term care facility, the resident and the responsible party or his responsible family member or his guardian should be fully informed in writing as evidenced by the resident's written acknowledgement and that of the responsible party or his responsible family member or his guardian, of all resident's responsibilities and rights as defined in this section and KRS 216.520 to 216.530 and every long term care facility should keep the original document of each written acknowledgement in the resident's personal file; The resident and the responsible party or his responsible family member or his guardian should be fully informed in writing, as evidenced by the resident's written acknowledgement and that of the responsible party or his responsible family member, or his guardian, prior to or at the time of admission and quarterly during the resident's stay at the facility, of all service charges for which the resident or his responsible family member or his guardian is responsible for paying; the resident and the responsible party or his responsible family member or his guardian should have the right to file complaints concerning charges which they deem unjustified to appropriate local and state consumer protection agencies and every long term care facility should keep the original document of each written acknowledgement in the resident's personal file; Residents should be permitted and encouraged to go outdoors and leave the premises as they wish unless a legitimate reason could be shown and	P 055	The facility will monitor its performance Relative to resident rights by performing Spot interviews of five residents and/ Or Guardians, twice a year. The spot Interviews began on 11.6.23. A yearly Audit between 11.6.23 and 11.5.24 of 10 randomly selected Resident charts will be conducted. On 5.11.23,6.8.23,10.27.23, the Following topics were discussed in An in service with the staff: Resident rights, admission policy/ Resident agreement and resident Monitoring. Staff were asked if There were any questions/if They understood, to which staff Acknowledged they understood. POC completion date: 11.19.23	

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P 055	Continued From page 13	P 055		

documented for refusing such activity; if the resident is adjudicated mentally disabled in accordance with state law, the resident's guardian should act on the resident's behalf in order that his rights be implemented.

Review of the facility policy "Policy of Reporting Abuse", not dated, revealed if a newly admitted resident appeared to have been abused or neglected, the facility agreed to report their findings to the Department of Human Resources immediately.

1. Review of Resident #1's Admission Summary/Face Sheet revealed the facility admitted the resident on 01/10/2022 from Western State Hospital with diagnoses which included Schizophrenia Spectrum and Psychotic Not Otherwise Specified. Further review revealed the resident had two (2) people listed as the Responsible Party for the resident.

Review of Resident #1's chart revealed an unsigned copy of the Admission Policy and the Resident Admission Agreement.

Review of the facilities Admission form titled "Assessment Regarding Abilities and Restrictions for Unrestricted Access to Leave/Return to the Facility" revealed a Questionnaire to be completed by the Primary Care, Medical Treatment Provider. Questions included "Do you believe the Resident should be restricted from leaving the facility premises, unaccompanied and without assistance or supervision from facility staff or others, such as a legal guardian or family?", "Is the Resident physically capable of leaving the facility building and premises with or without an assistive device?", "Do you believe the

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P 055	Continued From page 14 Resident has the mental and physical abilities necessary to safely have unrestricted, unaccompanied access to leave and return to the facility without placing the Resident into potential harm?", "Do you believe it is in the Resident's best interest to have unrestricted access to leave and return to the facility at all times?", "Is the Resident disoriented to place, which increases the Resident's risk of leaving the facility unattended and placing the Resident into potential harm?", "Does the Resident have cognitive impairment with poor decision making skills?", and "Is it likely the Resident would be a danger to himself/herself if he/she traveled unescorted outside of the facility?". Further review revealed the Conclusion of the Assessment was an area for the Medical Provider to circle if the Resident should or should not have unrestricted access to leave and return to the facility. However, the facility failed to complete the Assessment for Resident #1 on Admission . Review of a Commonwealth of Kentucky Petition to Determine if Disabled document, filed by the Knott County Circuit Clerk's Office on 12/13/2018, revealed Resident #1 was diagnosed with Schizophrenia and Bipolar Disorder and could not make decisions for himself. Review of the Commonwealth of Kentucky Order for Emergency Appointment of Fiduciary, filed by the Knott County District Court on 12/18/2018, revealed a physician stated if immediate action was not taken, there was an imminent danger of a serious impairment to the health or safety of Resident #1 related to the resident's diagnosis of Schizophrenia. Further review revealed Resident #1 had two (2) Guardians/Conservators appointed.	P 055		

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P 055	Continued From page 15 Review of a Commonwealth of Kentucky Disability Judgement, signed by a Judge on 05/02/2019, revealed the Court determined Resident #1 was wholly disabled in managing his/her personal affairs and financial resources as defined in KRS Chapter 387 and a guardian and a conservator should be appointed. Review of a Commonwealth of Kentucky Order of Appointment of Guardian, signed by a Judge on 05/02/2019, revealed the resident was determined to have two (2) Guardians appointed indefinitely. Review of Resident #1's Psychiatric Evaluation, dated 11/25/2022, revealed the resident had a diagnosis of Schizophrenia with an order for Risperdal (an antipsychotic medication used to treat Schizophrenia), Cogentin (an Antiparkinson medication sometimes used to treat involuntary movements due to the side effects of antipsychotic medications), Benadryl (an antihistamine medication sometimes used as a sedative/hypnotic, and Saphris (an antipsychotic medication). Review of the facility Incident Report, dated 02/26/2023 at 4:46 PM, revealed Resident #1 went out the fire exit, staff attempted to get the resident to return to the facility, and the resident refused to return to the facility until the staff took him/her to the Dollar General Store to get coffee. Further review revealed the staff took the resident to the Dollar General Store and returned him/her back to the facility at 5:43 PM. Continued review revealed the resident was agitated at the time of the incident. Additional review revealed the Guardian was not notified at the time of the incident.	P 055		

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P 055	Continued From page 16 Review of Resident #1's Psychiatric Note, dated 03/27/2023, revealed the resident had complained of not sleeping at night with an order to discontinue Saphris and Benadryl and start the resident on Seroquel (an antipsychotic medication). Further review of the note revealed the resident assessment section of the note was not completed. Review of the Commonwealth of Kentucky Missing Persons Report, dated 03/27/2023, revealed Resident #1 was missing at 6:30 PM, the McCreary County Sheriff's Office was notified at 8:03 PM, and Deputy Sheriff #1 arrived at the facility at 9:02 PM and cleared the call at 11:00 PM. Further review revealed the facility called McCreary County nine-one-one (911) to report Resident #1 missing and was last seen on 03/27/2023 at 6:30 PM, then was noticed missing at approximately 7:00 PM. At that time, the facility staff checked the premises and noticed footprints sliding down the wall under a window, then facility staff canvassed the area and drove roads surrounding the facility looking for the resident, then, after the staff were unable to locate the resident, they notified the nine-one-one (911) center approximately ninety (90) minutes after the resident was discovered missing. Continued review revealed Deputy Sheriff #1 drove the roads surrounding the facility and checked side roads and stores without being able to locate the resident and attempted to notify the next of kin without contact, but the facility staff stated they had contacted the next of kin. Review of the facility's Incident Report, dated 03/27/2023 at 7:00 PM, revealed staff were passing 7:00 PM medications when they could not locate Resident #1, and he/she was last seen at 6:30 PM. Further review revealed staff	P 055		

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P 055	Continued From page 17 searched for the resident and called the Owner #1 at 7:27 PM, who called the Administrator at 7:30 PM. Staff searched the building and roadway and called McCreary County Nine-One-One (911) at 8:03 PM and notified the Guardian at 8:09 PM, then notified Pulaski County Nine-One-One (911) at 8:24 PM. Continued review revealed Owner #1 emailed the "Abuse Hotline" on 03/28/2023. Review of email from Owner #1, dated 03/28/2023 at 9:55 AM, revealed he notified the Cabinet for Health and Family Services Department of Community Based Services Central Intake of "a report of self-abuse/neglect" regarding Resident #1. Review of Resident #1's Nurse's Notes, dated 04/28/2023, revealed Owner #1 had talked to a facility where the resident previously resided who stated Resident #1 eloped a few times from the previous facility. Further review of the facility's Nurse's Notes revealed the Administrator notified the Ombudsman on 04/06/2023. Continued review of Nurse's Notes revealed Owner #1 called a psychiatric facility in another town who had been familiar with Resident #1 and was told Resident #1 had eloped from another facility and was gone several months before he/she was located. Additional review of the Nurse's Notes revealed a deceased body was found on 05/01/2023 under a cliff in a location near the facility and a Sheriff's Deputy had shown the staff pictures of the shoes and belongings found with the body, but the staff did not recognize it. Review of the Nurse's Notes revealed the Coroner notified the facility, on 08/10/2023 at 3:55 PM, the DNA matched Resident #1 and was awaiting an official report. Further review revealed the Coroner called the facility, on	P 055		

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P 055	Continued From page 18 08/14/2023 at 3:00 PM, and stated he had received a report which showed the body was a match for Resident #1. Continued review revealed Owner #2 notified the Office of Inspector General on 08/15/2023 at 9:00 PM that the deceased body found matched Resident #1. During an interview with the Administrator, on 08/29/2023, at 9:15 AM, she stated when she received a new referral, she looked at the patient's level of care, diagnoses, history, medications, and ability to self-transfer. She further stated the facility did not provide nursing services such as insulin injections, and if a resident could not self-transfer from a wheelchair or ambulate unassisted, they were unable to provide care for the resident and denied the referral. She continued to state if a current resident had signs or symptoms of deterioration, the staff would discuss the resident's condition with a medical provider and determine if the resident needed to be transferred to a higher level of care, and the facility does have a transfer agreement with a Long-Term Care Facility, Beechtree Manor in Jellico, Tennessee. She stated residents could sign themselves in and out of the facility unless they had a legal guardian, and, if a resident had a legal guardian, they were required to call and ask the guardian if a resident could leave the facility and/or if the resident could have visitors, and they usually obtained a standard order from the Guardian that the residents could have visitors or go out to eat or leave the facility. She further stated most residents were mentally able to leave the facility, and they had good community support to notify the facility if they saw anyone walking down the roads close to the facility to check to see if it was a resident from the facility. She continued to state she was certain Owner #1 discussed the	P 055		

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P 055	Continued From page 19 Admission Policy and Resident Admission Agreement with Resident #1's Guardian; however, she was unable to provide any written documentation the Guardian reviewed and signed the Admission documents to include the Admission form titled "Assessment Regarding Abilities and Restrictions for Unrestricted Access to Leave/Return to the Facility".The Administrator further stated Psychiatrist #1 was in the facility to visit residents on 03/27/2023, but Resident #1 had already been discovered missing from the facility prior to Psychiatrist #1 being able to visit him/her. She further stated she thought when she emailed the Abuse Hotline, all required agencies were notified and she was unaware she needed to contact the State Agency separately.	P 055		
P 110	902 KAR 20:036 3(8)(d)1-5 Section 3. Administration and Operation (8) Personnel. (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 (a) through (c) of this subsection. This requirement is not met as evidenced by: Based on interview record review, and review of	P 110	~~The manager was educated by the~~ COO on 9.20.23 on the Maintenance of employee files, as Well as the documentation contained Therein as it complies with the Regulation. The manager was asked If there were any questions, to which She responded that she understood. The manager conducted an audit Of all current employee files by 11.6.23 to Ensure each file contained the Regulatory required documentation And information. Going forward, In -services will be Evidenced by the sign in sheet that Will be maintained.	

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P 110	Continued From page 20 the facility's policy, it was determined the facility failed to ensure each employee file contained proof of each employees criminal background checks, Abuse Registry checks, proof of employee training and experience, and evidence of current licensure, registration or certification required by law for six (6) out of (6) employee files. The findings included: Review of the facility's policy titled "Employee Records", dated March 1993, revealed all employee record should include a record of employee's training and experience and evidence of current licensure, registration or certification where required by law. Review of Employee Records on 05/05/202, revealed no documentation to support employee criminal background checks,Abuse Registry checks, proof of employee training and experience, and evidence of current licensure, registration or certification required by law for Dietician #1, Advanced Practice Registered Nurse (APRN) #1, Physician #1, Owner #1, Owner #2, or Owner #3. During an interview with Administrator, on 05/05/2023 at 10:00 AM, she stated the facility did not keep records for Dietician #1, Advanced Registered Nurse Practitioner #1, Physician #1, Owner #1, Owner #2, or Owner #3. She further stated the facility had not conducted licensure verification on Advanced Registered Nurse Practitioner #1 or Physician #1 because they were not employees of the facility and she was unaware of the need to obtain licensure verification.	P 110	The manager will conduct An annual audit from 11.6.23-11.5.24 of employee files to ensure compliance with regulation on an on-going basis. POC Completion Date: 11.19.23	

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P 130	Continued From page 21	P 130		
P 130	902 KAR 20:036 3(8)(h)1 Section 3. Administration and Operation (8) Personnel. (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. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it as determined the facility failed to ensure each employee received annual in-service training that corresponded with their respective job duties for three(3) out of twelve (12) employee files. The findings included: Review of the facility's policy,titled " In-Service Training", not dated, revealed all employees should receive in-service training to correspond with their respective jobs and documentation of in-service training should be maintained in the employee record and should include the date and summary of the training and who gave the training. Review of Administrator #1, Dietician #1, and Staff Member #2's employee files revealed they had not had the required annual in-service	P 130	~~On 5.11.23 and 6.8.23 an in~~ Service was conducted by the COO discussing the job descriptions Of each position. Staff members Were asked if they understood/had Any questions, to which they Responded they understood what Was discussed. Going forward, Trainings will be evidenced by Employee sign in sheets. The manager will conduct an annual Audit from 11.6.23-11.5.24 of the employee files to ensure compliance with the Regulation relative to the in service Training as it relates to their Respective job duties. ~~POC Completion Date: 11.10.23~~	

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P 130	Continued From page 22 training for their job duties, to include abuse training. During an interview with Staff member #1 on 05/05/2023 at 12:45 PM she stated she had not received annual in-service training in 2022 because she was on medical leave, and had not have in-service training in 2023. During an interview with the Dietician on 05/05/2023 at 1:15 PM she stated she was not a full time employee of the facility and she had not had annual in-service training, and did not realize she needed to have any of the annual training. During an interview with the Administrator, on 05/05/2023 at 10:00 AM, she stated she had provided annual in-serviced training to other staff and was unsure why she did not have an annual in-service training record. She further stated Staff Member #2 had been off work at the time of the in-service training and had not received the training upon return to work. She continued to state the Dietician was contracted and did not come to the facility routinely and the Administrator was unaware the Dietician needed annual in-service training.	P 130		
P 185	902 KAR 20:036 4(1)(a)1-4 Section 4. 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 assure that the resident's health care needs are met;	P 185		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND MANOR REST HOME	1930 HIGHWAY 90 PARKERS LAKE, KY 42634

(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 185	Continued From page 23 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 interview, record review, and review of the facility's policy, it was determined the facility failed to provide supervision and monitoring for two (2) of fourteen (14) sampled residents (Resident #1 and Resident #2). In addition, on 01/10/2022, the facility failed to assess Resident #1's ability to leave the facility safely without supervision, and failed to assess the residents' appropriate level of care prior to admission and obtain guardian's permission regarding the residents' ability to leave the facility unsupervised at the time of the residents' admission to the facility for one (1) out of fourteen (14) sampled residents (Resident #1) On 03/27/2023, Resident #1 left the facility without staff knowledge and was confirmed deceased on 08/14/2023. The findings include: Review of the facility's policy "Resident Monitoring", not dated, revealed a documented	P 185	On 5.11.23,6.8.23 and 10.27.23 staff Were educated by the COO on The importance of educating Residents on signing out before They go out. Staff were asked If they have any questions/understood What was discussed, to which staff Acknowledged that they do Understand. New hires are trained over a 2 day Period by the Administrator, with the First day of training beginning on the New staff member's first shift, Regarding the regulations and Facility policies. Topics discussed upon hire include, But are not limited to, abuse and Neglect, reporting abuse and Neglect, resident monitoring, etc. Each time the PCP sees the resident, The PCP is evaluating the resident To ensure he/she is an appropriate Fit for a PCH.	

Rosetta Patrick 1/25/24

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12:43:21 2024-01-25 Eastern

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P 185	Continued From page 24 hourly check of each resident should be performed and documented to observe each resident's condition and behavior and to confirm each resident was present and accounted for on the premises, and a resident monitoring form should be marked with the time, staff initials, and date of the hourly checks, as the hourly check of each resident was performed. Further review revealed residents should be monitored more frequently than once per hour, as needed, such as in the event of a change of health condition, illness, physician's order and/or behavioral changes. Continued review revealed any resident who provided facility staff with verbal notice the resident was an elopement risk should be monitored every thirty (30) minutes and until further notice from the Administrator. Review of Resident #1's chart revealed an unsigned copy of the Admission Policy and the Resident Admission Agreement. Review of the facilities Admission form titled "Assessment Regarding Abilities and Restrictions for Unrestricted Access to Leave/Return to the Facility" revealed a Questionnaire to be completed by the Primary Care, Medical Treatment Provider. Questions included "Do you believe the Resident should be restricted from leaving the facility premises, unaccompanied and without assistance or supervision from facility staff or others, such as a legal guardian or family?", "Is the Resident physically capable of leaving the facility building and premises with or without an assistive device?", "Do you believe the Resident has the mental and physical abilities necessary to safely have unrestricted, unaccompanied access to leave and return to the facility without placing the Resident into potential harm?", "Do you believe it is in the Resident's	P 185	The facility will monitor its performance Relative to resident rights by performing Spot interviews of five residents and/ Or Guardians, twice a year. The spot interviews began on 11.6.23. A yearly Audit between 11.6.23 and 11.5.24 of 10 randomly selected Resident charts will be conducted. Monitoring will be on-going. POC Completion Date: 11.19.23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100314	A. BUILDING: _____ B. WING _____	C 08/30/2023

STATE FORM 6899 0ECD11 If continuation sheet 1000 of 1000

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P 185	Continued From page 25 best interest to have unrestricted access to leave and return to the facility at all times?", "Is the Resident disoriented to place, which increases the Resident's risk of leaving the facility unattended and placing the Resident into potential harm?", "Does the Resident have cognitive impairment with poor decision making skills?", and "Is it likely the Resident would be a danger to himself/herself if he/she traveled unescorted outside of the facility?". Further review revealed the Conclusion of the Assessment was an area for the Medical Provider to circle if the Resident should or should not have unrestricted access to leave and return to the facility. However, the facility failed to complete the Assessment for Resident #1 on Admission . Review of a Commonwealth of Kentucky Petition to Determine if Disabled document, filed by the Knott County Circuit Clerk's Office on 12/13/2018, revealed Resident #1 was diagnosed with Schizophrenia and Bipolar Disorder and could not make decisions for himself. Review of the Commonwealth of Kentucky Order for Emergency Appointment of Fiduciary, filed by the Knott County District Court on 12/18/2018, revealed a physician stated if immediate action was not taken, there was an imminent danger of a serious impairment to the health or safety of Resident #1 related to the resident's diagnosis of Schizophrenia. Further review revealed Resident #1 had two (2) Guardians/Conservators appointed. Review of Resident #1's Psychiatric Evaluation, dated 11/25/2022, revealed the resident had a diagnosis of Schizophrenia with an order for Risperdal (an antipsychotic medication used to treat Schizophrenia), Cogentin (an Antiparkinson	P 185		

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P 185	Continued From page 26 medication sometimes used to treat involuntary movements due to the side effects of antipsychotic medications), Benadryl (an antihistamine medication sometimes used as a sedative/hypnotic, and Saphris (an antipsychotic medication). Review of the facility Incident Report, dated 02/26/2023 at 4:46 PM, revealed Resident #1 went out the fire exit, staff attempted to get the resident to return to the facility, and the resident refused to return to the facility until the staff took him/her to the Dollar General Store to get coffee. Further review revealed the staff took the resident to the Dollar General Store and returned him/her back to the facility at 5:43 PM. Continued review revealed the resident was agitated at the time of the incident. Additional review revealed the Guardian was not notified at the time of the incident. Review of the Commonwealth of Kentucky Missing Persons Report, dated 03/27/2023, revealed Resident #1 was missing at 6:30 PM, the McCreary County Sheriff's Office was notified at 8:03 PM, and Deputy Sheriff #1 arrived at the facility at 9:02 PM and cleared the call at 11:00 PM. Further review revealed the facility called McCreary County nine-one-one (911) to report Resident #1 missing and was last seen on 03/27/2023 at 6:30 PM, then was noticed missing at approximately 7:00 PM. At that time, the facility staff checked the premises and noticed footprints sliding down the wall under a window, then facility staff canvassed the area and drove roads surrounding the facility looking for the resident, then, after the staff were unable to locate the resident, they notified the nine-one-one (911) center approximately ninety (90) minutes after the resident was discovered missing.	P 185		

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P 185	Continued From page 27 Continued review revealed Deputy Sheriff #1 drove the roads surrounding the facility and checked side roads and stores without being able to locate the resident and attempted to notify the next of kin without contact, but the facility staff stated they had contacted the next of kin. Review of the facility's Incident Report, dated 03/27/2023 at 7:00 PM, revealed staff were passing 7:00 PM medications when they could not locate Resident #1, and he/she was last seen at 6:30 PM. Further review revealed staff searched for the resident and called the Owner #1 at 7:27 PM, who called the Administrator at 7:30 PM. Staff searched the building and roadway and called McCreary County Nine-One-One (911) at 8:03 PM and notified the Guardian at 8:09 PM, then notified Pulaski County Nine-One-One (911) at 8:24 PM. Review of Resident #1's Nurse's Notes, dated 04/28/2023, revealed Owner #1 had talked to a facility where the resident previously resided who stated Resident #1 eloped a few times from the previous facility. Further review of the facility's Nurse's Notes revealed the Administrator notified the Ombudsman on 04/06/2023. Continued review of Nurse's Notes revealed Owner #1 called a psychiatric facility in another town who had been familiar with Resident #1 and was told Resident #1 had eloped from another facility and was gone several months before he/she was located. Additional review of the Nurse's Notes revealed a deceased body was found on 05/01/2023 under a cliff in a location near the facility and a Sheriff's Deputy had shown the staff pictures of the shoes and belongings found with the body, but the staff did not recognize it. Review of the Nurse's Notes revealed the Coroner notified the facility, on 08/10/2023 at 3:55	P 185		

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P 185	Continued From page 28 PM, the DNA matched Resident #1 and was awaiting an official report. Further review revealed the Coroner called the facility, on 08/14/2023 at 3:00 PM, and stated he had received a report which showed the body was a match for Resident #1. Continued review revealed Owner #2 notified the Office of Inspector General on 08/15/2023 at 9:00 PM that the deceased body found matched Resident #1. During an interview with the Administrator, on 08/29/2023, at 9:15 AM, she stated when she received a new referral, she looked at the patient's level of care, diagnoses, history, medications, and ability to self-transfer. She further stated the facility did not provide nursing services such as insulin injections, and if a resident could not self-transfer from a wheelchair or ambulate unassisted, they were unable to provide care for the resident and denied the referral. She continued to state if a current resident had signs or symptoms of deterioration, the staff would discuss the resident's condition with a medical provider and determine if the resident needed to be transferred to a higher level of care, and the facility does have a transfer agreement with a Long-Term Care Facility, Beechtree Manor in Jellico, Tennessee. She stated residents could sign themselves in and out of the facility unless they had a legal guardian, and, if a resident had a legal guardian, they were required to call and ask the guardian if a resident could leave the facility and/or if the resident could have visitors, and they usually obtained a standard order from the Guardian that the residents could have visitors or go out to eat or leave the facility. She further stated most residents were mentally able to leave the facility, and they had good community support to notify the facility if they saw anyone walking down the	P 185		

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P 185	Continued From page 29 roads close to the facility to check to see if it was a resident from the facility. She continued to state she was certain Owner #1 discussed the Admission Policy and Resident Admission Agreement with Resident #1's Guardian; however, she was unable to provide any written documentation the Guardian reviewed and signed the admission documents to include the Admission form titled "Assessment Regarding Abilities and Restrictions for Unrestricted Access to Leave/Return to the Facility". The Administrator further stated Psychiatrist #1 was in the facility to visit residents on 03/27/2023, but Resident #1 had already been discovered missing from the facility prior to Psychiatrist #1 being able to visit him/her. The Administrator stated staff should have followed the facility's policy and should have provided supervision and monitoring to Resident #1.	P 185		

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