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 _____	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 AMENDED: An Onsite Revisit Survey for the Complaint Surveys dated 08/30/2023 and 11/02/2023; a Re-Licensure Survey; and Complaint Survey investigating complaints KY #41113, KY #41334, and KY #41717 was initiated on 01/29/2024 and concluded on 01/31/2024. Complaints KY #41113, and KY #41334, were non-compliant with regulatory deficiencies cited. Additionally, Complaint KY #41717 was non-compliant with a deficiency cited at F0165. On 01/14/2024, Resident #1 exited the facility without staff's knowledge. Resident #1 was last seen by Medication Technician (MT #1) #1 at 4:45 PM, when she was assisting residents to the dining room for supper. Afterwards she noted the resident was not in his/her usual place in the dining room and she searched the inside of the building as well as the outside area surrounding the building, she then alerted Floor Aide (FA) #1 around 5:05 PM, that she could not find the resident. During this time, FA #3/kitchen cook was notified by another resident (she could not recall which resident) at approximately 5:05 PM, that Resident #1 left the building. Staff searched inside and outside the perimeters of the facility for Resident #1; however, were unable to locate the resident. Subsequently the police were notified at approximately 5:15 PM, and a Golden Alert was issued. Resident #1 was located on 01/14/2024 at 9:33 PM, by local authorities in the backyard of a private residence, approximately two (2) miles away from the facility. The resident was observed to be wearing a long sleeve sweatshirt, sweatpants, socks, and tennis shoes, but no coat. The weather on 01/14/2024 around the time of the elopement was between 19 degrees and	P 000		

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

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P 000	Continued From page 1 25 degrees Fahrenheit, and it was snowing. The area from the facility to the residence where the resident was located had a road which was curvy with hills and valleys, and there were wooded areas with deep valleys and steep hills. The resident was outside the facility approximately four (4) hours and 45 minutes before being located. Interview with Resident #1 revealed he/she left the building by climbing out a window; however, observation and interview with the Administrator, revealed the facility had not adjusted the windows to prevent them from fully opening. Additionally, interview with Resident #1's legal Guardian, revealed the resident "had gotten out of the house when he/she lived at home", prior to admit to the facility. However, interview with the Administrator revealed she was unaware of the resident's history of leaving the house unaccompanied prior to being admitted to the facility. Based on these findings, it was determined the facility failed to ensure each resident received adequate supervision and monitoring to prevent elopement. This failure presents an imminent danger and creates substantial risk that death or serious physical harm to residents could occur. The facility was issued a Type "A" Citation on 01/30/2024. The Survey found the facility had corrected the deficiencies at P0055, P0110, and P0130 as alleged in the acceptable Plans of Corrections (POC) dated 11/19/2023 and 11/22/2023. However, the Revisit Survey determined the facility continued to be in non-compliance at P0050, and P0185. Additional deficiencies were cited at P0015, P0195, P0215, P0330, P0335, and P0147.	P 000		

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P 015	902 KAR 20:036 3(1)(a-d) Section 3. 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; and (d) If the licensee is an 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. This requirement is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure the implementation of the facility "Infection Control Policy". Observation on 01/30/2024, revealed Floor Aide #4 failed to perform hand hygiene prior to performing a blood glucose test (measures the	P 015	On 2.5.24, the Manager led an in service for all staff. The topics discussed included, but were not limited to, the importance of cleaning the glucometer between each resident as well as the importance of hand washing and using hand sanitizer in between cares, and at the start of resident cares. In service with staff was done in a conversational way, enabling staff to engage in conversation, ask questions, share thoughts, etc. At the completion of the in service, staff acknowledge they understood what was being discussed. Additionally, on 2 22.24, PCP Alisha Cooley, conducted an in service with the staff reviewing the importance of cleaning the glucometer in between residents, as well as the importance of hand washing and using hand sanitizer between resident cares and at the start of resident cares. Upon hire, a new staff member is trained for a two day period. Of which , the first day includes a review of facility policy and procedures, to include hand washing/use of hand sanitizer and cleaning the glucometer, as discussed in the in service.	

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P 015	Continued From page 3 level of glucose in the blood) using a glucometer for Resident #6. Floor Aide #4 then failed to perform hand hygiene after performing the blood glucose test for Resident #6 and prior to performing the blood glucose test for Resident #7. Floor Aide #4 then failed to perform hand hygiene after performing the blood glucose test for Resident #7 and prior to performing the blood glucose test for Resident #8. Moreover, further observation on 01/30/2024, revealed Floor Aide #4 failed to disinfect the individual glucometers after use for blood glucose tests for Residents #6, #7, and #8. The findings include: Review of the Facility Policy titled, "Infection Control Policy" undated, revealed facility staff should take precautions while interacting with residents to prevent and control the spread of infection. Precautions: Hand washing: Good hand washing using soap and water or waterless antiseptic before and after patient contact, after using the bathroom, after handling soiled material, and before and after eating. Gloves: Gloves should be worn whenever contact with any of the following was expected to occur; 1) Blood; 2) Any body fluids, secretions, and excretions; 3) Non-intact skin and/or 4) Mucous membranes. After removal of gloves, wash hands immediately or use waterless antiseptic. Patient care equipment: Handle soiled patient care equipment in a manner to prevent skin and mucous membrane exposure; contamination of clothing; and transfer of microorganisms to other patients and environments. Do not reuse patient care equipment until it has been cleaned and reprocessed appropriately and discard single use items properly.	P 015	The Regional Operations Manager will conduct an in service for the staff on the aforementioned on 3.18.24. The Manager will conduct an audit once a day for 14 days (M-F) to ensure the staff are cleaning the glucometer in between each resident and hand washing/using hand sanitizer appropriately. Upon completion of the 14 days, the Manager will conduct an audit once a week for 2 weeks and then once a month for 3 months. The aforementioned audits will begin on 2.26.24. The POC completion date is 3.27.24.	

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P 015	Continued From page 4 1) The following observations were noted on 01/30/2024 starting at 5:45 AM, related to failure of staff to perform hand hygiene when obtaining blood glucose tests for residents: a. Floor Aide #4 failed to wash her hands prior to gloving to perform a blood glucose test using a glucometer for Resident #8. b. After performing the blood glucose test on Resident #6, Floor Aide #4 removed her soiled gloves, but failed to wash her hands prior to gloving to perform a blood glucose test on Resident #7. c. After performing the blood glucose test on Resident #7, Floor Aide #4 removed her soiled gloves, but failed to wash her hands prior to performing the blood glucose test for Resident #8. Review of the Facility Policy titled, "Regarding Accucheck Machine Cleaning", revealed the facility's Accucheck machine shall be cleaned with Super Sani-Cloth Germicidal Disposable Wipes or a reasonable substitute for that product." 2) Additional observation on 01/30/2024 starting at 5:45 AM, revealed there was no disinfecting of the glucometers after use. Each resident had his/her own glucometer. a. After Floor Aide #4 checked the blood glucose for Resident #6, she failed to disinfect the glucometer prior to placing it back into the glucometer pouch. b. After Floor Aide #4 checked the blood glucose for Resident #7, she failed to disinfect the	P 015		

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P 015	Continued From page 5 glucometer prior to placing it back into the glucometer pouch. c. After Floor Aide #4 checked the blood glucose for Resident #8, she failed to disinfect the glucometer prior to placing it back into the glucometer pouch. During an interview with Floor Aide #4 on 01/31/2024 at 3:40 PM, she stated she was aware she needed to perform hand washing and/or hand sanitizer before and after any procedure including blood glucose tests, and it was important to disinfect the glucometers prior to placing them back into the individual pouches. In continued interview, she stated failure to wash or sanitize hands and failure to disinfect the glucometers after use could cause the spread of germs. During an interview with the Administrator (ADM), on 01/31/2024 at 4:23 PM, she stated staff should be washing or sanitizing their hands when performing glucometer checks, or when providing any type of care between residents. In continued interview she stated she expected glucometers to be cleaned/disinfected immediately following each use with the appropriate cleaning wipes stored on the medication carts.	P 015		
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.	P 050		

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P 050	Continued From page 6 This requirement is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure Resident Rights were protected to ensure the safety of each resident for four (4) of eight (8) sampled residents; (Resident #2, Resident #3, Resident #4, and Resident #5). a.) On 11/01/2023, the facility staff heard yelling and saw Resident #4 and Resident #5 on the floor. Resident #4 was hitting Resident #5 in the face with a set of keys. Both residents were sent to the emergency room for evaluation of injuries. Resident #5 sustained a scalp abrasion, a sprained finger, and a shoulder strain. Resident #4 sustained a laceration on his/her hand, which required surgical glue for closure of the laceration. b.) On 11/28/2023, Resident #2 hit Resident #3, and while Resident #4 was attempting to protect Resident #3, Resident #2 started hitting Resident #4. Resident #3 sustained right cheek swelling in the incident and declined to go to the emergency room for evaluation of injuries sustained in the incident. Resident #2 and Resident #4 were sent to the emergency room for evaluation. Resident #4 was diagnosed in the ER with facial contusion, right rib contusion, two superficial lacerations on the face, one laceration on the forehead, and one laceration on the left cheek. The findings include: Review of the Facility Policy titled, "Rights of Residents–Duties of Facilities–Actions", effective 07/14/2022, revealed all residents shall be free from mental and physical abuse, and free from chemical and physical restraints except in emergencies or except as thoroughly justified in	P 050	On 2.5.24, the Manager led an in service with the staff on abuse and neglect. In the event that there is a resident to resident altercation, the resident's PCP and Guardian, if applicable, will be notified. The staff will await further guidance from the PCP and Guardian, if applicable, on if anything more should be done , other than what has already been implemented. Staff will continue to notify the appropriate clinician and Guardian, if applicable, of a medication refusal, in addition to the date and time of the medication refused so that relevant patterns can be noted. On 3.18.24, the Regional Operations Manager will lead an in service with the residents on the importance of taking medications as scheduled, as well as maintaining boundaries with other residents. The Regional Operations Manager will also lead an in service with the staff on the importance of continuing to notify all applicable parties in the event of a refused medication and/or behavior, and following the instructions provided. POC Completion Date: 3.19.24	

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P 050	Continued From page 7 writing by a Physician for a specified and limited period of time and documented in the resident's Medical Record. Review of the Facility Policy titled, "Residents shall be free from Abuse and Neglect", revised 05/01/2022, revealed all residents shall be free from mental and physical abuse, neglect, and free from chemical and physical restraints. Continued review revealed if there were an alleged incident, all necessary parties would be notified timely. Review of the facility Policy, titled "Resident Monitoring", revised 08/22/2014, revealed a documented hourly check of each resident shall be performed and documented to observe each resident's condition and behavior and to confirm that each resident was present and accounted for on the premises. Residents shall 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. Review of KRS 216.515 Rights of residents, Duties of facilities, revealed all residents shall be free from mental and physical abuse. 1 a.) Review of the Facility's Investigation dated 11/01/2023, revealed Resident #4 and Resident #5 were yelling, and when staff went to investigate, staff observed Resident #4 with keys in his/her hand "beating" Resident #5 with the keys. Continued review revealed staff separated both residents, cleaned them up, and had Emergency Medical Services (EMS) transport both residents to the hospital. Review of Resident #4's "Admission Face Sheet",	P 050		

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P 050	Continued From page 8 revealed the facility admitted the resident on 05/09/2022, with diagnoses to include schizoaffective disorder, bipolar disorder, sleep disturbance, and nicotine use disorder. Resident #4 had no Care Plan to review. Review of the Progress Notes, reviewed for August 2023, September 2023, and October 2023, revealed Resident #4 had no verbal or physical altercations with residents nor were aggressive behaviors noted. Review of Resident #4's Monitoring Log, revealed it was initial hourly to indicate the resident was observed on an hourly basis prior to the altercation with Resident #5. Review of Resident #4's Progress Note, entered by Floor Aide (FA) #5, dated 11/01/2023, untimed, revealed Resident #4 and another resident (Resident #5) had gotten into a fight. Continued review revealed staff separated the residents, called the Advanced Practical Registered Nurse (APRN), notified guardians of both residents, and sent Resident #4 to the hospital for further evaluation of injuries. Review of Resident #4's Hospital Emergency Room (ER) record, dated 11/01/2023, revealed Resident #4 was seen for an assault with a left-hand laceration. Continued review revealed the resident had a three (3) centimeter (cm) left hand laceration which had to be repaired with glue. Observation of Resident #4, on 01/29/2024 at 8:53 AM, revealed the resident was clean, neat, appropriately dressed, well-groomed, and without odor.	P 050		

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P 050	Continued From page 9 During an interview with Resident #4, on 01/29/2024 at 8:53 AM, he/she stated he/she remembered the incident involving Resident #5. Resident #4 stated he/she was drawing on a piece of paper using a colored pencil, when Resident #5 started "following me and was cursing at me." Resident #4 stated he/she kept trying to walk away from Resident #5, but Resident #5 started yelling at him/her. Resident #4 stated he/she "had enough", so he/she started hitting Resident #5 with his/her keys. Resident #4 continued to state, he/she hit Resident #5 "about six times." Resident #4 stated the staff separated us and sent us both to the hospital. Resident #4 further stated while at the hospital staff cleaned his/her wound and glued it together. 1 b.) Review of Resident #5's "Admission Face Sheet", revealed the facility admitted the resident on 10/26/2023, with diagnoses to include depression, schizophrenia, and behavioral disturbance. Resident #5 had no Care Plan to review. Review of the Progress Notes, reviewed for August 2023, September 2023, and October 2023, revealed Resident #5 had no verbal or physical altercations with residents nor were aggressive behaviors noted. Review of Resident #5's Monitoring Log, revealed it was initial hourly to indicate the resident was observed on an hourly basis prior to the altercation with Resident #4. Review of Resident #5's Hospital ER record dated 11/01/2023, revealed Resident #5 was treated for a shoulder strain, scalp abrasion, and	P 050		

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P 050	Continued From page 10 finger sprain. Observation of Resident #5, on 01/29/2024 at 9:10 AM, revealed the resident was clean, neat, appropriately dressed, well-groomed, and without odor. During an interview with Resident #5, on 01/29/2024 at 9:10 AM, he/she stated he/she couldn't remember the exact events, but did remember Resident #4 had a set of keys and "came out of the blue and hit me." Resident #5 stated it felt like Resident #4 had hit "my head about 30 times", causing a small scratch on top of his/her head. Continued interview revealed he/she was sent to the hospital, and the hospital did x-rays of his/her finger and shoulder and cleaned off the top of his/her head. During an interview with Floor Aide (FA) #3, on 01/29/2024 at 3:18 PM, she stated she worked the day of the incident involving Resident #4 and Resident #5. FA #3 stated she was not sure which resident started yelling, but when she arrived at the scene, "the fight was on." FA #3 stated both residents were on the floor, screaming at each other, and Resident #4 was "beating" Resident #5 with a set of keys. FA #3 stated Resident #5 had a "bloody" face and a skin tear on top of his/her head, and Resident #4 had a scratch on his/her hand. FA #3 stated both residents were sent to the hospital ER for evaluation. FA #3 stated prior to this incident, neither Resident #4 or Resident #5 appeared agitated or were showing aggressive behaviors. She was unaware of the two (2) residents having arguments in the past. 2 a.) Review of the Facility's investigation, dated 11/28/2023, revealed Resident #2, Resident #3,	P 050		

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P 050	Continued From page 11 and Resident #4 were in the smoke building when Resident #3 ran into facility and told staff Resident #2 hit him/her and Resident #4. Continued review revealed Resident #3 was observed to have a left cheek bruise, and the right cheek was puffy. Further review revealed Resident #4 was bleeding from his/her head and his/her nose. Ongoing review revealed Resident #2 stated Resident #3 was a "Russian" and Resident #4 was "Hitler", and Resident #2 got agitated with staff and attempted to hit staff while staff questioned him/her about the incident. Additional review revealed Resident #2 and Resident #4 were sent to the ER for evaluation of injuries sustained in the altercation, and Resident #3 refused to go to hospital for evaluation. Review of Resident #2's "Admission Face Sheet" revealed the facility admitted the resident on 05/09/2022, with diagnoses of schizoaffective disorder with possible synthetic induced exacerbation, asthma, diabetes mellitus, and nicotine use disorder. Resident #2 was discharged from the facility on 12/28/2023 and sent to a psychiatric hospital and per the Administrator, will not return to the facility. Resident #2 had no Care Plan to review. Review of the Progress Notes, reviewed for August 2023, September 2023, October 2023, and November 2023, revealed Resident #2 had no verbal or physical altercations with residents nor were aggressive behaviors noted prior to the altercation on 11/28/2023. Review of Resident #2's Monitoring Log, revealed it was initial hourly to indicate the resident was observed on an hourly basis prior to the altercation on 11/28/2023.	P 050		

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(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 050	Continued From page 12 Review of Resident #2's Progress Note, entered by Medication Technician (MT) #1, dated 11/28/2023, revealed Resident #2 got into an altercation with Resident #3 and Resident #4 and all residents were separated immediately. Continued review of the Progress Note revealed the family, and the Nurse Practitioner (NP) were notified. Review of Resident #2's ER Note, dated 11/28/2023, revealed Resident #2 was treated for an assault/suicidal ideation and behavioral problem with recommendations to follow up with the primary care provider and facility psychiatrist. Continued review of the ER Note, revealed Resident #2 told ER staff he/she reacted aggressively and attacked another person because "someone opened a lighter in his/her face". 2 b.) Review of Resident #3's "Admission Face Sheet" revealed the facility admitted the resident on 05/07/2021 with diagnoses of non-intractable headaches, impulse control, and intellectual disability. Resident #3 had no Care Plan to review. Review of the Progress Notes, reviewed for August 2023, September 2023, October 2023, and November 2023, revealed Resident #3 had no verbal or physical altercations with residents nor were aggressive behaviors noted prior to the altercation on 11/28/2023. Review of Resident #3's Monitoring Log, revealed it was initial hourly to indicate the resident was observed on an hourly basis prior to the altercation on 11/28/2023.	P 050		

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 _____	C 01/31/2024

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P 050	Continued From page 13 Review of Resident #3's Progress Note, entered by MT #1, dated 11/28/2023, revealed Resident #3 was hit by another resident (Resident #2), but no medical treatment was completed as Resident #3 refused to go to hospital for treatment. Continued review of the Progress Note revealed the Advanced Practical Registered Nurse (APRN), Psychiatrist, and the legal guardian were notified of the incident. Review of Resident #3's Psychiatric Note, entered by Psychiatrist dated 11/27/2023, revealed the resident had diagnoses of unspecified psychotic disorder, unspecified depressive disorder, and unspecified intellectual developmental disability. Continued review of the Psychiatric Note revealed Resident #3 was to get a Depakote level and continue with current medications. Continued review of the Psychiatric Note, revealed Resident #3 had a Depakote level within normal limits. Observation of Resident #3, on 01/29/2024 at 9:13 AM, revealed the resident was clean, neat, appropriately dressed, well-groomed, and without odor. During an interview with Resident #3, on 01/29/2024 at 9:13 AM, he/she stated he/she had gone outside to smoke with Resident #4, when Resident #2 got upset and "hit both sides of my head". Resident #3 stated Resident #2 would get upset if he/she did not get his/her own way and he/she did not know what set him/her off that day. Resident #3 stated Resident #4 stepped in to try to help him/her when Resident #2 started hitting Resident #4. Resident #3 stated he/she went inside the facility to alert staff who intervened and separated Resident #2 and Resident #4.	P 050		

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P 050	Continued From page 14 Resident #3 stated he/she did not have any cuts, but did have some swelling to the right cheek and he/she believed a bruise to his/her left cheek. Resident #3 stated he/she did not go to the hospital because he/she talked to his/her legal guardian and expressed desire to stay at the facility for monitoring. 2 c.) Review of Resident #4's "Admission Face Sheet" revealed the facility admitted the resident on 05/09/2022, with diagnoses to include schizoaffective disorder, bipolar disorder, sleep disturbance, and nicotine use disorder. Resident #4 had no Care Plan to review. Review of the Progress Notes, reviewed for August 2023, September 2023, October 2023, and November 2023, revealed Resident #4 had no verbal or physical altercations with residents nor were aggressive behaviors noted prior to the altercation on 11/28/2023. Review of Resident #4's Monitoring Log, revealed it was initial hourly to indicate the resident was observed on an hourly basis prior to the altercation on 11/28/2023. Review of Resident #4's ER Note, dated 11/28/2023, revealed Resident #4 was seen for an assault and was the victim of abuse. Continued review of the ER Note, revealed Resident #4 had been punched in the face and had a small superficial laceration, a nosebleed, and complained of chest wall pain on the right side due to Resident #4 stated he/she hit something when he/she fell during the altercation. Additional review of the ER Note, revealed Resident #4 was diagnosed with facial contusion, right rib contusion, two superficial lacerations on	P 050		

Rosella Patrick 3/15/24

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P 050	Continued From page 15 the face, one laceration on the forehead, and one laceration on the left cheek. Observation of Resident #4, on 01/29/2024 at 8:53 AM, revealed Resident #4 was clean, neat, appropriately dressed, well-groomed, and without odor. During an interview with Resident #4, on 01/29/2024 at 8:53 AM, he/she stated he/she remembered the incident involving Resident #2 and Resident #3. Resident #4 stated Resident #2 hit Resident #3 on the jaw and while he/she (Resident #4) was attempting to help Resident #3, Resident #2 started hitting him/her (Resident #4) in the face. Resident #4 stated Resident #3 ran inside the facility and asked staff to help. Resident #4 stated the staff removed Resident #2 from the resident area. Resident #4 further stated he/she was sent to the hospital with some bruising and some cuts on his/her face. During an interview with Medication Technician (MT) #1, on 01/29/2024 at 2:50 PM, she stated she was working during the incident involving Resident #2, Resident #3, and Resident #4. MT #1 stated she separated the residents immediately, checked all three residents for injuries, and called Emergency Medical Services (EMS) to transport Resident #2 and Resident #4 to the hospital. Further, she stated she notified the Administrator, the Advanced Practice Registered Nurse (APRN), and the families of the residents of the incident. MT #1 stated Resident #2 had some cuts to both hands, Resident #3 had a bruise to the left cheek and swelling to the right cheek, and Resident #4 had a cut on the forehead. MT #1 stated Resident #3 refused to go to hospital and Resident #3's guardian spoke with the resident and agreed not to send Resident #3	P 050		

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P 050	Continued From page 16 to the hospital for evaluation. MT #1 stated all the residents had the right to be free from abuse, but staff had no way of knowing the incident was going to occur. During an interview with the Administrator, on 01/31/2024 at 4:23 PM, she stated the process for any resident-to-resident altercation involved the residents being placed on one on one (1:1) monitoring until the residents "calmed down" and then the residents would be monitored more closely. The Administrator further stated if the facility staff had known the altercations were going to occur, the staff would not have allowed the residents to sit together. She stated she did not think more staff supervision or monitoring was the answer, as more staff "could get in the way." The Administrator further stated residents had the right to be protected from abuse, but she felt "nothing could have been done differently to prevent the incidents from occurring." Further interview revealed after the resident altercations, the residents involved were placed on every thirty (30) minute monitoring for increased supervision and staff were walking the halls more frequently to monitor residents more closely in order to be aware if residents were showing signs of agitation. Further, she stated at this time staff was attempting to keep the residents occupied by providing puzzle books, crafts, reading books, and puzzles, and doing more social activities involving games. She stated she expected staff to follow facility policies.	P 050		
P 185	902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services (1) Basic health and health related services.	P 185		

Rosetta Patrick 3/15/24

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P 185	Continued From page 17 (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; 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 observation, interview, record review, review of the facility's investigation, and review of facility Policy, it was determined, the facility failed to have an effective system to ensure safety of residents by providing supervision and monitoring to prevent elopement for one (1) of eight (8) sampled residents (Resident #1). On 01/14/2024, Resident #1 exited the facility without staff's knowledge. Resident #1 was last seen by Medication Technician (MT #1) #1 at 4:45 PM, when she was assisting residents to the dining room for supper. Afterwards she noted the resident was not in his/her usual place in the dining room and she searched the inside of the	P 185	As per 902 KAR 20:036 4(1)(a) 1-4, a PCH or SPCH shall provide basic health and health related services including: supervision and monitoring of the resident to assure that the resident's health care needs are met, supervision of self-administration of medications, storage and control of medications, and arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility. Furthermore, as per KY State Resident Rights "Residents shall be permitted and encouraged to go outdoors and leave the premises as they wish unless a legitimate reason can be shown and documented for refusing such activity." The residents stated in this citation received supervision and monitoring to ensure their health care needs are met as ordered by the provider. In the event that there is a refused medication, the provider and Guardian, if applicable, would be notified. Furthermore, without adequate documentation from either a provider and Guardian, as stated in	

Roselle Pollock 3/15/24

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P 185	Continued From page 18 building as well as the outside area surrounding the building. She then alerted Floor Aide (FA) #1 around 5:05 PM, that she could not find the resident. During this time, FA #3/kitchen cook was notified by another resident (she could not recall which resident) at approximately 5:05 PM, that Resident #1 left the building. Staff searched inside and outside the perimeters of the facility for Resident #1; however, were unable to locate the resident. Subsequently the police were notified at approximately 5:15 PM, and a Golden Alert was issued. Resident #1 was located on 01/14/2024 at 9:33 PM, by local authorities in the backyard of a private residence, approximately two (2) miles away from the facility. The resident was observed to be wearing a long sleeve sweatshirt, sweatpants, socks, and tennis shoes, but no coat. The weather on 01/14/2024 around the time of the elopement was between 19 degrees and 25 degrees Fahrenheit, and it was snowing. The area from the facility to the residence where the resident was located had a road which was curvy with hills and valleys, and there were wooded areas with deep valleys and steep hills. The resident was outside the facility approximately four (4) hours and 45 minutes before being located. Interview with Resident #1 revealed he/she left the building by climbing out a window; however, observation and interview with the Administrator, revealed the facility had not adjusted the windows to prevent them from fully opening. Additionally, interview with Resident #1's legal Guardian, revealed the resident "had gotten out of the house when he/she lived at home", prior to admit to the facility. However, interview with the Administrator revealed she was unaware of the resident's history of leaving the house unaccompanied prior to being admitted to the facility.	P 185	In the KY State Resident Rights, residents are encouraged to go outside and leave the premises. Cumberland Manor will continue to respect resident rights, as well as the orders from the prescribing clinician and Guardian, if applicable. On 3.18.24, the Regional Operations Manager will conduct an in service with the staff on the importance of reminding residents to sign in/out if they are to leave the premises, although we can't force any resident to do so. Additionally, the Regional Operations Manager will conduct a resident meeting to discuss the importance of signing in/out if they would like to leave the premises. POC Completion date: 3.19.24	

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P 185	Continued From page 19 Based on these findings, it was determined the facility failed to ensure each resident received adequate supervision and monitoring to prevent elopement. This failure presents an imminent danger and creates substantial risk that death or serious physical harm to residents could occur. The findings include: Review of the facility Policy, titled "Resident Monitoring", revised 08/22/2014, revealed a documented hourly check of each resident shall be performed and documented to observe each resident's condition and behavior and to confirm that each resident was present and accounted for on the premises. Residents shall 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 of the Policy, revealed if the resident was an elopement risk, the resident shall be monitored every thirty minutes until further notice from the Administrator. Review of the facility policy, titled "Steps to Take if Resident Becomes Sick/Acutely Ill/Injured and/or In the Event of Medication Error or Elopement", revised on 11/23/2021, revealed if a resident became sick, acutely ill, injured, or in the event of a medication error or an elopement, the facility staff shall contact the resident's primary care provider. Review of the facility's investigation, dated 01/14/2024, revealed staff saw Resident #1 walking up and down the hallway at 4:00 PM. When getting residents up for supper at 5:00 PM, the facility staff noticed Resident #1 had ran off. The facility staff started searching the facility and	P 185		

Rosetta Patrick 3/15/24

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P 185	Continued From page 20 drove around outside looking for the resident. Additional review revealed Law Enforcement, the Office of Inspector General, and the Abuse Hotline were notified with report ID #394904. Continued review of the facility's investigation, revealed Resident #1 was found at approximately 9:33 PM in the backyard of a house approximately two (2) miles away from the facility and was brought back to the facility by Sheriff Deputy (SD) #1 at 9:36 PM. This was all the information submitted for review related to the facility investigation. Review of Resident #1's "Admission Face Sheet", revealed the facility admitted the resident on 02/13/2023 from a Psychiatric Hospital with diagnoses including Psychotic Disorder with probable Schizophrenia Spectrum, and Methamphetamine/Hallucinogen/Ecstasy use disorder. Review of Resident #1's medical record revealed no care plans to review. Review of Resident #1's Progress Notes from November and December 2023, and January 2024, revealed no exit seeking behaviors until 01/14/2024. There were no psychiatry notes to review after the date of admission. Review of Resident #1's Observation Log, dated 01/14/2024, revealed hourly checks were initialed by staff, with the last check prior to the elopement being initialed by FA #1 at 4:30 PM. Review of Resident #1's Progress Notes, entered by Medication Technician (MT) #1, on 01/14/2024, untimed, revealed the resident was missing from the facility and staff had reported the incident to the proper authorities. Continued	P 185		

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P 185	Continued From page 21 review revealed the resident was located behind "someone's" house and the resident returned to the facility at 9:33 PM. Review of the County Sheriff's Department Missing Person File, dated 01/14/2024, revealed the facility called 911 at 5:15 PM on 01/14/2024, and Sheriff Deputy (SD) #1 arrived at the facility at 5:40 PM to start the investigation. Continued review revealed Resident #1 was found in the backyard of a residential home at 9:33 PM and returned to the facility at 9:38 PM. Review of the Emergency Medical Services (EMS) Run Report, dated 01/14/2024, revealed EMS arrived on scene at 9:42 PM and transported Resident #1 to the hospital for evaluation at 9:45 PM. Review of Resident #1's Emergency Room (ER) Note, dated 01/14/2024, revealed the resident was treated for mood disorder with psychiatric evaluation to be done while in the ER as the resident told the ER staff he/she jumped out of the window approximately twelve (12) feet high to go to "the beach." Additional review of the ER Note, revealed Resident #1 was just monitored and Psychiatry did not evaluate as the resident did not meet the criteria. Continued review of the ER Note, revealed the resident had increased white blood cell count, but was in "good" condition and was sent back to the facility with no new orders at time of discharge from the hospital. Review of Resident #1's Progress Note, entered by Medication Technician (MT) #1, dated 01/14/2024, untimed, revealed Dispatch found Resident #1 on 01/14/2024 at 9:33 PM behind a house approximately two (2) miles away from the facility, and police brought Resident #1 back to	P 185		

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P 185	Continued From page 22 the facility at 9:38 PM. Per the Note, Resident #1 was promptly sent to the hospital emergency room (ER) for evaluation at 9:45 PM and returned to the facility on 01/15/2024 at 2:02 AM with no new orders. Observation on 01/30/2024 at 10:15 AM, during a drive on the road where Resident #1 was found, revealed the road was curvy with hills and valleys and there were wooded areas with deep valleys and steep hills. Continued observation revealed per google maps the distance from the facility to the road where the resident was located was 2.1 miles. Review of the local weather history, according to weather channel by google, revealed the temperature was between 19 degrees and 25 degrees Fahrenheit (F), on 01/14/2024 between 5:00 PM and 10:00 PM during the time the resident was out of the building. Observation on 01/29/2024 at 9:30 AM, revealed there were two doors in the facility with a door alarm in place. The Surveyor tested the door alarms by pushing on the doors, and both alarming doors were functioning. Review of Resident #1's Observation Log, dated 01/15/2024, revealed the resident was initially started on thirty minute checks after arriving at the facility from the ER. Per the Log, the thirty minute checks lasted until 01/16/2024. Review of Resident #1's Progress Notes, dated 01/16/2024, entered by MT #1, revealed the resident started voicing homicidal ideation on 01/16/2024 and was admitted to a Psychiatric Unit. Review of the Progress Notes, dated 01/24/2024, revealed the resident returned to the	P 185		

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P 185	Continued From page 24 During an interview with Medication Technician (MT) #1, on 01/29/2024 at 2:50 PM, she stated she started her shift at 3:00 PM on 1/14/2024, and remembered Resident #1 walking up and down the hallway as usual. MT #1 stated she last saw the resident at 4:45 PM when she was getting residents out to the dining room for supper. She further stated she noticed Resident #1 was not in his/her usual "spot" at the supper table, so she checked inside and outside the facility to see if she could locate him/her. MT #1 stated she did not alert the other floor aides until she had searched for the resident, and she alerted FA #1 around 5:05 PM, that the resident was missing. During further interview, with Medication Technician (MT) #1, on 01/29/2024 at 2:50 PM, she stated she could not locate Resident #1, and called the Administrator at 5:10 PM to alert her the resident was missing from the facility. MT #1 stated she then got in her car and called 911, and started driving down the road to see if she could locate the resident. MT #1 further stated she notified Resident #1's family and the Nurse Practitioner (NP), and arrived back at the facility about fifteen minutes after the Police showed up to search for the resident. In further interview, MT #1 stated she did another head count to make sure the other residents were still in the building after she returned from her search for Resident #1 and no other issues were found. During continued interview, with Medication Technician (MT) #1, on 01/29/2024 at 2:50 PM, MT #1, she stated she was in the facility when SD #1 brought Resident #1 back and noted the resident had scratches on his/her hands and he/she was sent to the hospital. MT #1 stated Resident #1 had been on hourly checks prior to	P 185		

Rosetta Patrick 3/15/24

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P 185	Continued From page 25 the incident. She further stated Resident #1 had no exit seeking behaviors prior to the elopement and all residents had hourly checks unless an incident occurred and then the resident would be monitored more often. During further interview, MT #1 stated she did not hear any doors alarming prior to realizing the resident was missing. She further stated she did not think the resident went out a window because there were no windows left open during their search for the resident. She stated there was three (3) staff on duty at the time of the resident's elopement. She further stated she and FA #1 were working the floor, and FA #3 was in the kitchen cooking. During an interview with FA #1, on 01/29/2024 at 2:30 PM, she stated there was no specific staff members assigned to the residents at the facility for supervision and monitoring, but the staff worked together. She stated Resident #1 was his/her usual, quiet self prior to leaving the facility on 01/14/2024 and she last saw the resident at 2:30 PM that day. FA #1 stated Medication Technician (MT) #1 alerted her that Resident #1 was missing around 5 :00 PM or a little after. She further stated she helped search inside and outside the facility and was present when Resident #1 returned to the facility later. FA #1 stated Resident #1 had a few scratches on his/her hands from briars, but otherwise looked okay. In continued interview, on 01/29/2024 at 2:30 PM, FA #1 stated prior to the elopement, all residents were monitored hourly unless there had been an incident, which would increase the checks from hourly to at least fifteen (15) or thirty (30) minutes checks. FA #1 further stated Resident #1 had never had any exit seeking behaviors, nor had the resident left the building unaccompanied by staff	P 185		

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	100314	A. BUILDING: _____ B. WING _____	C 01/31/2024

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P 185	Continued From page 26 to her knowledge prior to this incident. Further, she stated Resident #1 had been checked hourly prior to the incident. FA #1 stated she did not hear any door alarms go off prior to the resident leaving, and she did not think Resident #1 got out by the window as there were no open windows noted when staff searched the building for the resident. During an interview with FA #3, who was also the kitchen cook, on 01/29/2024 at 3:18 PM, she stated she was working in the kitchen the evening of 01/14/2024, when another resident told her Resident #1 had left the facility. FA #3 could not remember which resident informed her of this, but stated it was at approximately 5:05 PM. FA #3 stated about that time, MT #1 alerted her Resident #1 was missing and she assisted with searching for the resident inside and outside the building. FA #3 stated MT #1 notified the Administrator that Resident #1 was missing and called 911. FA #3 further stated she was present when SD #1 brought Resident #1 back to the facility, and she recalled the resident's hands were "real red" and he/she complained of being cold. Further, she stated Resident #1 stated he/she got lost and wanted to go "to the beach." FA #3 further stated all residents were on hourly checks, but if "something happened", then the Administrator would increase increase frequency of the checks. FA #3 stated she was unaware of Resident #1 leaving the building unaccompanied prior to this incident. She further stated she did not recall the resident having any exit seeking behaviors or talking about leaving prior to the elopement. In continued interview, FA#3 stated she did not hear any door alarms sounding when the resident left the building. Further, she did not think the resident exited the building through a window as there were no windows open during	P 185		

Rosetta Patrick 3/15/24

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P 185	Continued From page 27 the inside search of the building. During an interview with Sheriff Deputy (SD) #1, on 01/30/2024 at 7:00 AM, he stated he was notified by Dispatch of a missing resident at the facility on 01/14/2024 at 5:15 PM, and a Golden Alert was issued through the county dispatch. SD #1 stated Resident #1 was found approximately 2.1 miles away (per google maps), from the facility. SD #1 further stated Resident #1 was knocking on the door of a residence and when SD #1 went up to the resident, he/she told SD #1 that he/she was cold. SD #1 stated he assisted the resident into his warm vehicle and noted he/she was wearing a dark long sleeve thick sweatshirt with sweat pants, tennis shoes, and socks, but no jacket. Further, SD #1 stated Resident #1 complained of his/her hands and feet being cold, but was able to move his/her fingers and toes. In continued interview, the SD #1 was not sure of the exact temperature outside at the time he located Resident #1, but stated it "was getting colder and it had started snowing". SD #1 stated he radioed dispatch to have EMS meet him at the facility and once he got the resident back to the facility, the staff and EMS personnel checked Resident #1 for injuries. SD #1 further stated Resident #1 had a few scratches on his/her bilateral hands from going through a briar patch and his/her hands were red. SD #1 stated EMS transferred Resident #1 to the hospital for evaluation. During an interview with Volunteer Fire Firefighter (VFF) #1, on 01/30/2024 at 7:32 AM, he stated the Volunteer Fire Department received a called out to assist in the search of a missing resident from the facility on 01/14/2024 around 5:45 PM. VFF #1 stated SD #1 was in charge of the scene and he was directing the searchers on where to	P 185		

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P 185	Continued From page 28 search for the missing resident. VFF #1 further stated he was still searching for the resident when SD #1 radioed that Resident #1 had been located and was being returned to the facility. In continued interview, VFF #1 stated he did not lay eyes on Resident #1 because the golden alert was canceled, so he didn't know what condition Resident #1 was in when found and brought back to the facility. However, VFF #1 stated the weather outside that night was "cold and snowy". During a phone interview on 01/30/2024 at 3:28 PM, with Resident #1's legal Guardian, who was the resident's Mother, she stated the resident "had gotten out of the house when he/she lived at home". She further stated if Resident #1 got it in his/her head to leave, it didn't matter if the windows were locked with a 10 foot fence around the facility, the resident would find a way out. The Surveyor phoned Nurse Practitioner (NP) #1, on 01/29/2024 at 2:00 PM; 01/30/2024 at 8:45 AM; and 01/31/2024 at 1:16 PM, in an attempt to conduct an interview and voice messages were left. However, there was no return phone call. During an interview with the Administrator, on 01/31/2024 at 4:23 PM, she stated residents in the facility usually did not leave the facility unsupervised and none of the current legal guardians had given permission for residents to leave the facility unsupervised. Further, she stated Resident #1 had showed no signs of wanting to leave the facility and had no exit seeking behaviors prior to the elopement. She stated the facility did not complete elopement assessments and she was unaware the resident had a history of leaving his/her home unaccompanied while living at home, prior to admit to the facility.	P 185		

Rosetta Patrick RPP 3/15/24

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P 185	Continued From page 29 Continued interview with the Administrator, on 01/31/2024 at 4:23 PM, revealed staff was to monitor the residents every hour, and document the monitoring. Further, if there was a problem such as behavior issues, or if an incident occurred, the resident would be monitored more frequently. The Administrator stated, since the incident, the facility had increased supervision of the residents by providing more activities and she felt more staff would just get in the way and cause more trouble. She further stated staff monitored the residents by walking the hallways more frequently, keeping the residents occupied by providing puzzle books, crafts, reading books, and puzzles, and doing more social activities involving games to keep the residents happy. During additional interview with the Administrator on 01/31/2024 at 4:23 PM, she stated it was her expectation for her staff to continue closer monitoring of residents by walking the hallways more frequently during the shift so staff would be aware of the location of all residents. She stated the facility did not utilize a wander guard system, did not utilize licensed nurses, or have an overhead paging system for missing residents. She further stated staff was to listen for the alarming doors and respond to ensure a resident had not left the building unaccompanied. Additional interview with the Administrator, revealed she felt the resident went out the door to the fenced in smoking area and jumped the fence; however, the facility was unable to determine how the resident got out of the building. Per interview, she stated the windows had not been adjusted in order for them to not open fully at this time. The Administrator then stated, "nothing different could have been done to prevent the resident from leaving the facility	P 185		

Rosette Patrick 3/15/24

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P 185	Continued From page 30 unsupervised".	P 185		

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P 147	902 KAR 20:031-14(5)(a) Section 14. Mechanical Requirements (5) Hot water heaters and tanks. (a) The hot water heating equipment shall have sufficient capacity to supply the water at the temperature and amounts indicated below: Use Resident Dishwasher Laundry Gal/hr/bed 6 1/2 4 4 1/2 Temp. F. 100-110 180* 140-180** * Temperature may be reduced to 140 if chlorilizer is used. ** If the temperature used is below 180 the home shall utilize detergents and other additives to insure that the linens be adequately cleaned. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to maintain water temperatures between 100-110 degrees Fahrenheit in resident care areas. In addition, it was determined the facility failed to maintain water temperature and sanitation logs. Observation on 01/29/2024 at 5:00 PM, revealed the water temperatures tested in the women's shower and sink were ninety (90) degrees Fahrenheit. Observation on 01/29/2024 at 5:05 PM, revealed the water temperatures tested in the men's shower was eighty-two (82) degrees Fahrenheit. Observation on 01/30/2024 at 12:25 PM, revealed water temperature logs had not been completed	P 147	On 2.5.24, the Manager led an in service for all staff. The topics discussed at the in service included, but were not limited to, the importance of maintaining proper water temperature logs and sanitation loges, when the 3-compartment sink is in use, as well as for when/if the dishwasher is used. Maintaining temperature logs for the washing machine was discussed as well. The in service with staff was done in a conversational way, enabling staff to engage in conversation, ask questions, share thoughts, etc. At the completion of the in service, staff acknowledge they understood what was being discussed. The Regional Operations Manager will conduct an in service on 3.18.24 on the aforementioned as well. The Manager will conduct an audit once a day for 14 days (M-F) to ensure the staff are cleaning the glucometer in between each resident and hand washing/using hand sanitizer appropriately. Upon completion of the 14 days, the Manager will conduct an audit once a week for 2 weeks and then once a month for 3 months. The aforementioned audits will begin on 2.26.24 and will be done at random. The POC completion date is 3.27.24.	

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

Danielle Patrick 3/15/24

(X6) DATE

Office of Inspector General

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P 147	Continued From page 1 for the Dishwasher in the kitchen or the washing machines located in the laundry room since October 2023. Continued observation of the kitchen, revealed staff had not maintained water sanitation logs since October 2023. The findings include: During an interview with Administrator, on 01/31/2024 at 4:23 PM, she stated the facility did not have a policy related to maintaining water temperatures between 100-110 degrees Fahrenheit for the resident sinks and showers. Continued interview revealed the facility did not have a policy related to testing and documenting water temperatures in the kitchen for the dishwasher, nor was there a policy related to documenting water sanitation logs in the kitchen. Further, she stated there was no policy related to testing and documenting the water temperatures for the washing machine in the laundry room. During an interview with Floor Aide #2, on 01/30/2024 at 2:25 PM, she stated she knew the hot water would be cool later in the day with increased water usage, but it usually heated back up within approximately thirty (30) minutes. She further stated she was not aware that the laundry water temperatures for the washing machines in the laundry room should be checked. In continued interview, with Floor Aide #2, she stated the facility had a small new dishwasher located in the kitchen, but the dishwasher did not hold many dishes, so she did not use the dishwasher and typically washed all the dishes in the sink by hand. She stated, if the water was not hot enough to wash the dishes, she sometimes would wait approximately thirty (30) minutes for the water to heat back up, and then she would wash the dishes.	P 147		

Rosetta Patrick 3/15/24