| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 100007 | A. BUILDING: _____ B. WING _____ | 05/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CORNERSTONE MANOR I LLC | 515 WATER STREET SCOTTSVILLE, KY 42164 |

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| P 000 | Initial Comments<br><br>A Complaint Survey investigating KY00048428, KY00048451, KY00048452, KY00048455, and KY00048459 was concluded on 05/19/2026.<br><br>Defiiciences were cited related to KY00048451 and KY00048452 at P090, P0210, and P0290.<br><br>No deficiences were issued related to KY00048428, KY00048455, and KY00048459.<br><br>Survey Dates: 05/18/2026 to 05/19/2026.<br>Survey Census: 34.<br>Sample Size: 7. | P 000 | | |
| P 090 | 902 KAR 20:036 4(8)(d) Section 4. Administration and Operation<br><br>Section 4. Administration and Operation.<br>(8) Transfer and discharge.<br>(d) The administrator shall initiate a transfer through the resident's physician or appropriate agencies if the resident's condition is not within the scope of services of the PCH or SPCH.<br><br>This requirement is not met as evidenced by:<br>Based on interview, record review, document review, and review of the facility's policies, the facility failed to ensure a transfer / discharge was initiated through the resident's physician, or appropriate agencies when the resident's condition was not within the scope of services of the facility for 1 of 34 residents (Resident (R)1). | P 090 | | |

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

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| P 090 | Continued From page 1<br>The findings include:<br><br>Review of the facility's policy titled, "Plan of Care", not dated, revealed changes in the resident's condition will be reported to the provider. Per the policy, the purpose was to ensure residents received care consistent with provider recommendations.<br><br>Review of the admission packet, titled "Rights of Residents", dated July 14, 2022, revealed residents shall be transferred or discharged for medical reasons or own welfare.<br><br>Review of R1's "Resident Identification Sheet" revealed the facility admitted R1 on 07/03/2025 with diagnoses of schizophrenia, type 2 diabetes mellitus without complications, and essential hypertension.<br><br>Review of the facility incident report revealed R1 was absent of leave on 05/11/2026 and was reported to R1 state guardian and police on 05/12/2026. Continued review revealed R1 was found on 05/13/2026 in a ditch over fifteen miles away from the facility by police and taken to a hospital and returned to the facility on 05/14/2026.<br><br>Review of R1's medical record revealed there was no documentation of notification made to the primary care or psychiatric provider that R1 had been absent without leave on 05/11/2026 since 3:00 PM and arrived back at the facility on 05/14/2026.<br><br>During an interview with Resident Aide (RA)1 on 05/18/2026 at 4:30 PM, it was stated if residents did not return to facility by 10:00PM the staff were required to call state guardianship and the facility | P 090 | | |

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| P 090 | Continued From page 2<br>administrator.<br><br>During an interview with RA2 on 05/19/2026 at 9:45 AM, it was stated residents were required to sign out and return by 10:00 PM and staff were required to notify after hours guardianship, call police, and notify the administrator if residents did not return. It was further stated that R1 did not sign out at any time R1 left the facility.<br><br>During an interview with RA3 on 05/19/2026 at 10:25 AM, it was stated that staff were required to call guardianship, police, and the facility administrator if residents did not return by 10:00 PM.<br><br>During an interview with the FNP on 05/19/2026 at 12:53 PM, it was stated it was difficult to keep up with R1's absence without leaves from the facility, she stated she was not aware of R1's May absence without leave, and that R1 needed to be in a locked psychiatric unit.<br><br>During an interview with FNP-BC on 05/19/2026 at 1:00PM, it was stated the provider was not notified of R1's May absence without leave and that the resident R1 needed a secured facility.<br><br>During an interview with the facility Administrator on 05/19/2026 at 4:02 PM, it was stated the facility did not inform the medical and / or psychiatric provider until today and the providers did not initiate a transfer and / or discharge. | P 090 | | |
| P 210 | 902 KAR 20:036 5(1)(a) Section 5. Provision of Services<br><br>Section 5. Provision of Services.<br>(1) Basic health and health related services. | P 210 | | |

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| P 210 | Continued From page 3<br>(a) A PCH or SPCH shall provide basic health and health related services, including:<br>1. Supervision and monitoring of the resident to ensure that the resident's health care needs are met;<br>2. Supervision of self-administration of medications;<br>3. Storage and control of medications; and<br>4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility.<br><br>This requirement is not met as evidenced by:<br>Based on interview, record review, and review of facility documentation, the facility failed to ensure the healthcare needs of its residents were met for 1 of 34 residents (Resident (R)1).<br><br>The findings include:<br><br>Review of R1's "Resident Identification Sheet" revealed the facility admitted R1 on 07/03/2025 with diagnoses of schizophrenia, type 2 diabetes mellitus without complications, and essential hypertension.<br><br>Review of the facility document titled, "Nurse's Notes"; revealed R1 was monitored by a medical and psychiatric provider. Continued review | P 210 | | |

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| P 210 | Continued From page 4 | P 210 | | |

revealed the medical and psychiatric provider were contacted on 05/19/2026 because R1 was absent without leave on 05/11/2026.

Review of the facility incident report revealed R1 absent of leave on 05/11/2026 was reported to R1 state guardian and police on 05/12/2026. Continued review revealed R1 was found on 05/13/2026 in a ditch over fifteen miles away from the facility by police and taken to a hospital and returned to the facility on 05/14/2026.

During an interview with R1 on 05/18/2026 at 1:13 PM, he stated that he walked toward the country not the city and to become a vampire. He further stated he cannot recall a recent absent without leave and going to the hospital.

During a telephone interview with FNP on 05/19/2026 at 12:53 PM, it was stated R1 had frequent absent without leaves and cannot account of dates. It was stated that the residents blood pressure remained stable, was a diabetic, and that he took all diabetic medications. It was further stated her primary concern with R1 absent without leave was R1's psychiatric diagnoses and that R1 needed a locked psychiatric facility placement.

During a telephone interview with FNP-BC on 05/19/2026 at 1:00 PM, it was stated that monitoring of R1 took place monthly, as needed, and last evaluated R1 on 05/05/2026. Further it was stated R1 was stable on 05/05/2026 and that it was difficult for her to assess R1 on a daily basis without being onsite. Per the FNP-BC interview, she was not notified R1 had an absent without leave on 05/11/2026 until today before the interview. She stated R1 had significant mental illness, absence of leave can be dangerous for

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| P 210 | Continued From page 5<br>R1 due to possibly becoming lost, being harmed, inability to have food or drink, and that he needed a secure facility.<br><br>During an interview with the Administrator on 05/19/2026 at 2:52 PM, she stated she did not notify the FNP or FNP-BC at the time of absent of leave on 05/11/2026. She stated R1 was medically cleared at Sumner County Hospital after the incident. The Administrator stated that the FNP came to the facility on Tuesdays, and that she notified the FNP today at the facility. The Administrator stated that she notified the FNP-BC via phone today when the FNP-BC called the facility asking the reason the Office of Inspector General representative called her office for a phone interview. She stated she planned to notify the FNP-BC the next time the FNP-BC was at facility and thought that it would be next week and that R1 could benefit from a locked facility. | P 210 | | |
| P 290 | 902 KAR 20:036 5(1)(k) Section 5. Provision of Services<br><br>Section 5. Provision of Services.<br>(1) Basic health and health related services.<br>(k)<br>1. If a resident manifests persistent behavior that might require psychiatric treatment, the PCH or SPCH shall notify the resident's physician or health care practitioner acting within the practitioner's scope of practice to evaluate and direct the resident's care.<br>2. If the resident's condition does not improve, making continued stay in a PCH or SPCH unfeasible, the physician or health care practitioner shall initiate transfer of the resident to an appropriate facility as soon as possible. | P 290 | | |

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| P 290 | Continued From page 6 | P 290 | | |

This requirement is not met as evidenced by:
Based on interview, record review, and review of facility documentation, the facility failed to notify the Primary Care Provider of a resident's persistent behaviors in order to evaluate and direct resident care for 1 of 34 residents (Resident (R)1).

The findings include:

Review of facility document titled, "Admissions Policy Statement", not dated, stated if a resident should become persistently disturbed or unmanageable, he or she will be transferred to an appropriate facility. Further review revealed during the distressed state, the resident's physician will be notified.

Review of the facility's policy titled, "Plan of Care", not dated, revealed changes in the resident's condition will be reported to the provider. Per the policy, the purpose was to ensure residents received care consistent with provider recommendations.

Review of the admission packet, titled "Rights of Residents", dated July 14, 2022, revealed residents shall be transferred or discharged for medical reasons or own welfare.

Review of R1's "Resident Identification Sheet" revealed the facility admitted R1 on 07/03/2025 with diagnoses of schizophrenia, type 2 diabetes mellitus without complications, and essential hypertension.

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| P 290 | Continued From page 7<br><br>Review of the facility incident report revealed R1 was absent of leave on 05/11/2026 and was reported to R1 state guardian and police on 05/12/2026. Continued review revealed R1 was found on 05/13/2026 in a ditch over fifteen miles away from the facility by police and taken to a hospital and returned to the facility on 05/14/2026.<br><br>Review of a Nursing Progress Note dated 05/11/2026, revealed R1 was absent without leave since 3:00PM. Further review of nursing progress notes revealed an absent without leave on 03/15/2026 and returned to facility by police at 2:00 AM.<br><br>During an interview with R1 on 05/18/2026 at 1:13 PM, he stated he cannot recall any absent without leave and going to the hospital. R1 stated he walked toward the country not the city.<br><br>During an interview with Resident Aide (RA)1 on 05/19/2026 at 10:10 AM, it was stated R1 wandered during the night inside and outside the facility. Further it was stated that it was difficult to monitor R1 at all times as two RA's work the entire facility during third shift.<br><br>During an interview with RA3 on 05/19/2026 at 10:25 AM, it was stated R1 wandered at night after facility curfew inside and outside the facility. It was further stated that the facility attempted to monitor R1 more than hourly required checks.<br><br>During a telephone interview with FNP on 05/19/2026 at 12:53 PM, she stated R1 was frequently absent without leave and was unable to account for all dates. It was stated that the residents blood pressure remained stable, the | P 290 | | |

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| P 290 | Continued From page 8 | P 290 | | |

patient was diabetic, and that he took all diabetic medications. She stated her primary concern with R1 being absent without leave was R1's psychiatric diagnoses and that R1 needed a locked psychiatric facility placement.

During a telephone interview with FNP-BC on 05/19/2026 at 1:00 PM, she stated that she monitored R1 monthly, as needed, and last evaluated R1 on 05/05/2026. She further stated R1 was stable on 05/05/2026 and it was difficult for her to assess R1 on a daily basis without being onsite. Per the FNP-BC interview, she was not notified R1 had an absent without leave on 05/11/2026 until today before the interview. She stated R1 had significant mental illness and that absence of leave can be dangerous for R1 due to possibly becoming lost, being harmed, inability to have food or drink, and that he needed to be placed in a secure facility.

During an interview with the facility Administrator on 05/19/2026 at 2:52 PM, she stated she did not notify the FNP or FNP-BC at time of absent of leave on 05/11/2026. She stated, R1 was medically cleared at Sumner County Hospital. The Administrator stated the FNP came to the facility on Tuesdays, and she notified the FNP today at the facility. The Administrator stated she notified the FNP-BC via phone today when the FNP-BC called the facility asking the reason the Office of Inspector General representative called her office for a phone interview. She stated she planned to notify the FNP-BC the next time FNP-BC was at facility and thought that it would be next week and that R1 could benefit from a locked facility.