Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100050	A. BUILDING _____ B. WING _____	R-C 08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOMES	219 STEVENS AVENUE PRINCETON, KY 42445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(P 000)	Initial Comments Based upon implementation of the acceptable Plan of Correction (PoC), the facility was deemed to be in compliance on 07/18/2024.	(P 000)		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X8) DATE

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P 000	Initial Comments A Complaint Survey investigating KY00042580 and KY00042783 was initiated on 06/25/2024 and concluded on 06/28/2024 No deficient practice was identified with KY00042783, however, deficient practice was identifed with KY00042580 and a deficiency was cited	P 000	RECEIVED AUG - 9 2024 CHFS Office of Inspector General Division of Health Care - WB Received by	
P 005	902 KAR 20:036 2(1)(a-d) Section 2 Scope of Operations and Services (1) A resident in a PCH or SPCH shall (a) Be admitted in accordance with KRS 216.765 (b) Be ambulatory or mobile nonambulatory, (c) Be able to manage most of the activities of daily living, and (d) Have care needs that do not exceed the capability of the PCH or SPCH. 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 initiate referral and transfer to a higher level of care for two (2) of eighteen (18) sampled residents (R) who required more assistance than the facility could provide. (R16 and R18)	P 005	Highland Homes complies with orders as provided by the PCP and/or Psych providers of the facility. In the event that an order for a higher level of care is provided, the Manager will initiate the process to obtain an appropriate level of placement. For those two individuals identified in the SOD, the Manager contacted the provider. Since then, an order for a higher level of care was obtained on 7-18-24, and the Manager will begin the process to find appropriate placement The primary and psych provider at Highland Homes was switched to a new group who visits the facility more frequenetly. This will allow for better communication between the Manager and the providers. In regards to this deficiency, the order for a higher level of care was obtained by the provider on 7-18-24. Upon receipt of the orders, Guardianship was notified and the referral packet was sent to Guardianship so that placement can be found. Placement has not yet been secured, but is being followed up on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Branaman — TITLE: Administrator — (X6) DATE: 8/8/2024

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1. R16 experienced an exacerbation of congestive heart failure (CHF) and new onset of atrial fibrillation (a-fib) requiring transfer to a hospital emergency room (ER). After return to the facility from on 05/23/2024 through 06/18/2024, R16 experienced increased incontinence of bowel and bladder and required bathing and incontinence care assistance from staff.

2. R18 required assistance of staff for incontinence care and transferring.

The findings include:

A facility policy addressing admission requirements was requested from on 06/26/2024 from the Administrator and Regional Manager stated there was no such policy. The Regional Manager, on 06/26/2024 at 3:35 PM, stated there were admission requirements, but there was no paper screening form. She stated she had learned basically from experience how to screen residents for PCH level of care. The Regional Manager stated she screened residents to ensure the resident could feed himself/herself, and to ensure they could do some of their Activities of Daily Living (ADLs), including maneuvering their wheelchair, transferring self, and administer their insulin if diabetic. She stated she also ensured the prospective resident was not a sex offender and was free of communicable diseases.

Review of the information sheet, included in the facility admission packet, revealed under a heading labeled "Services Provided Under the Basic Charge," subcategory number 2, revealed the facility "would provide assistance in attaining the maximum level of ADL's" (Activities of Daily

Mary Dunaway 8/6/2024 Administrator/Manager

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Living). Continued review of the information sheet under Subcategory labeled number 3 revealed the facility "would provide assistance with grooming and hygiene."

Review of the Addendum Survey Report Form revealed eight (8) of seventy (70) residents required mechanical assistance with ambulation and zero residents were incontinent.

1. Review of R16's facesheet, located in the medical record revealed the facility admitted the resident on 05/01/2019, with diagnoses of schizo-affective schizophrenia and chronic condition with acute exacerbation. Ongoing record review revealed R16 had required transfer to the ER related to an exacerbation of CHF and a new onset of a-fib. Review of the nursing progress notes documented from 05/23/2024 through 06/18/2024, R16 had been experiencing increased incontinence of bowel and bladder and required another ER visit on 06/18/2024 due to peripheral edema. Review of the progress note dated 05/19/2024, revealed R16 "was not able to walk" and "gave him a wheelchair." Review of the progress note dated 06/18/2024 at 12:00 PM, revealed R16 was "urinating and having bowel movements on himself."

Observation of R16 on 06/25/2024 at 2:15 PM, revealed the resident had been incontinent of urine as evidenced by the lower portion of his shirt, and the hips, buttocks, and groin areas of his pants being wet. R16 stated, in interview at the time of observation, he had "wet" himself.

Observation on 06/26/2024 at 12:16 PM, revealed R16 was seated in a wheelchair in the hall with liquid dripping onto the floor from beneath the wheelchair and the resident's wet pants.

Tiffany Administrator 8/8/2024 Administrator/Manager

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Continued observation revealed staff gathering supplies to take R16 to the shower and provide him clean clothing.

In interview with Nurse Aide 4 (NA4) on 06/26/2024 at 2:30 PM, she stated she had "18 wetters" (incontinent residents) that she had to assist with changing. In an additional interview at 5:05 PM on that date, NA4 stated she "must" assist R16 with incontinence care and a shower after incontinent episodes, in addition to the daily showers that she was assigned to do.

Charge Aide (CA) 3, stated in interview on 06/26/2024 at 11:21 AM, R16 had "completely gone downhill, healthwise and all" and "was incontinent 99% of the time and now needed help."

In interview on 06/27/2024 at 2:04 PM, Guardian 2, who indicated that at her last visit with R16 on 05/01/2024, R16 had been able to ambulate with a rollator (walker). The Guardian stated however, the use of a wheelchair for R16 would be a decline in the resident's level of function.

2. Review of R18's facesheet, located in the medical record, revealed the facility admitted the resident on 06/028/2023, with diagnosis that included schizophrenia, hypertension, non-insulin dependent diabetes mellitus, chronic obstructive pulmonary disease, and history of a brain aneurysm.

Observation of R18 on 06/26/2024 at 3:02 PM, revealed R18 sitting in a wheelchair. Continued observation revealed staff had to assist R18 to move the resident to an area that was more conducive for an interview, as R18 was unable to self propel the wheelchair.

Mary Davidson Administrator/Manager 8/8/2024

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In interview with CA3 on 06/26/2024 at 11:21 AM, she stated she had been an employee at the facility for 11 years and stated residents in a PCH were to be able "to do for themselves." CA3 said there were residents who had declined with age and who would no longer meet the PCH level of care including R18 who could barely get around in the wheelchair now.

In interview with R18 on 06/26/2024 at 3:02 PM, the resident stated she can halfway walk, but staff "must" help her with everything. R18 stated she had bladder accidents at night and required assistance of staff to change her adult incontinence product and to change into dry clothing. The resident further stated she was not able to transfer herself from the wheelchair and onto another surface without the assistance of staff, and staff had to help her with "everything" now.

In interview on 06/26/2024 at 4:25 PM, the Assistant Administrator R18's decline began after returning from an acute hospitalization approximately one year ago. She stated when R18 returned to the facility after that hospitalization she required the use of a wheelchair.

In interview on 06/26/2024 at 4:28 PM, the Administrator stated R18 would not be able to leave the building without assistance if the building were on fire.

In an interview on 06/25/2024 at 12:33 PM, R7 stated there were people living in the facility that should be in a nursing home. R7 further stated there needed to be better care provided for "those people."

May Cannon Administrator 7/8/24

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In an interview with Former NA (FNA) 15 on 06/25/2024 at 2:59 PM, the NA stated there were PCH guidelines for level of care and "these people" were not PCH level of care. FNA15 stated some residents were incontinent and could not shower by themselves.

In a phone interview with R16's State Guardian 8 on 06/27/2024 at 11:13 AM, she stated she received R16 onto her caseload three weeks ago and was not able to speak to his prior level of functioning and stated she had not seen the resident since she had been assigned as the Guardian. She stated he was scheduled to be seen at the end of July. State Guardian 8 further stated R18's brother had recently located the resident, after five years of looking for him, and planned to transfer R18 to a facility closer to him soon.

In interview on 06/26/2024 at 11:21 AM, CA3 stated residents in the facility should be able to do for themselves and agreed there were residents currently in the facility who do not meet level of care, stating the R18 can "barely get around in the wheelchair."

In a phone interview with the Home Health RN (RN1) on 06/27/2024 at 12:19 PM, RN1 stated she had been assigned to see R16 since he went to the hospital for CHF and a-fib. The RN stated she saw him first on 05/24/2024 and has seen him weekly since. RN1 stated R16 had good days and bad days and if R16 was having a bad day she agreed R16 would require a higher level of care.

In interview with the Nurse Practitioner (NP), who had provided care for residents in the facility prior

Mindy Dennison (Interim Health Manager) 8/6/2024

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P 005	Continued From page 6	P 005		

to the new owners, stated on 06/27/2024 at 2:40 PM, he was no longer providing services at the facility. The NP stated he had not visited the facility for about two months, but agreed some residents in the facility, in his opinion did not meet the PCH level of care. He stated staff had asked about the level of care for some residents, who included R16 and R18; however, he did not recall what happened after that nor did he recall who he had spoken to regarding the residents' level of care.

In interview on 06/26/2024 at 11:38 AM, the facility's Physician, who had provided care to the residents prior to the change in ownership, stated he currently provided care for residents in the facility. He stated he had heard the facility had new owners, but stated he had not received any notification that he would not continue to provide care to the residents in the facility and that this was the first he had heard of that. He stated he was not aware of any resident in the facility who did not meet the level of care when asked. The Physician stated if there was a resident in the facility, who needed a higher level of care, facility staff would notify him, and he would initiate an order to begin the process of getting the resident to a more appropriate level of care. He further stated he felt it was still appropriate for staff to call him for any resident needs or issues.

In interview on 06/26/2024 at 8:25 AM, the Assistant Administrator (AA) 7 stated she had been employed at the facility for 18 years. She stated she thought the facility needed more staff to care for the residents due to the level of care required by some of the residents. AA 7 identified specific residents she felt required a level of care above the PCH level of care, which included R16 and R18. The AA stated the facility had been

Mary Richardson Administrator/Manager 6/6.2024

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bought by new owners and stated they had been instructed that the facility would no longer be utilizing the Physician or NP who had been providing care for the residents. She said she had been told the NP and Physician had been given his notice. AA 7 stated a group of Nurse Practitioners would be starting to see the facility residents next week. She stated if a resident had an acute issue right now that they would have to call the Physician, or if the issue was serious enough, they would call an ambulance to transport the resident to the ER. AA 7 further stated the Physician overseeing the facility residents had performed some follow up visits after the new owners took over, and the residents who were scheduled to see the Physician at the office kept their appointments as scheduled

In interview on 06/26/2024 at 10:00 AM and 10:17 AM, the Administrator stated she had been employed at the facility for one month, and reported her background included work at a PCH, long term care facility, and intermediate care facility for intellectually impaired residents. The Administrator stated she was aware of the level of care a PCH was supposed to provide and agreed there were residents in the facility who did not meet that level of care. She stated she had expressed her concern to her Regional Manager, who responded to begin getting Physician's orders to get the residents transferred to the level of care they required. The Administrator stated she had a list of residents and planned to get started on getting the residents transferred According to the Administrator, she had not yet initiated getting the residents transferred She stated due to the new ownership and future changing of healthcare providers, the new Primary Care Providers had not visited the facility yet She said the new owners had certain people

Mary Richardson Administrator, Municipal 8/8/24

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P 005	Continued From page 8 they wanted to use and did not want to use the facility's old healthcare providers. The Administrator stated if a resident had a problem, staff would contact the current Physician and he would see the resident, even though the new owners did not want to use him. The Administrator stated if all the residents in the facility were truly PCH level of care residents, the facility would have sufficient staffing to care for them. She stated she did not feel there was enough staff for the level of care needs of the facility's residents at that time. She further stated her plan was to get Physician's orders to send referrals to get the residents who needed a higher level of care, to the level of care they needed and stated the new Primary Care Providers were supposed to start next week.	P 005		

Mary Bernardon Administrator/manager 8/8/24