# Personal Care Home:

## An Investigative Report of Golden Years Rest Home Jenkins, Kentucky

A Report by Kentucky Protection & Advocacy

# Personal Care Home:
# An Investigative Report
# of Golden Years Rest Home
# Jenkins, Kentucky


## Kentucky
## Protection & Advocacy
100 Fair Oaks Lane
Frankfort, Kentucky 40601
Tel: (502) 564-2967
Toll Free: (800) 372-2988
Fax: (502) 564-0848
TTY/TDD (800) 372-2988
www.kypa.net
http://twitter.com/KyAdvocacy
http://www.youtube.com/user/KyAdvocacy


Kentucky Protection and Advocacy (P&A) is Kentucky's protection and advocacy system mandated by federal and state law to advocate for individuals with disabilities. Kentucky P&A receives part of its funding from the Administration on Developmental Disabilities, the Center for Mental Health Services Substance Abuse and Mental Health Services Administration, the Rehabilitation Services Administration, the Health Resources and Services Administration, and the Social Security Administration. Kentucky P&A is a member of the National Disability Rights Network NDRN, a nonprofit umbrella organization to which all 57 protection and advocacy systems belong.

Congress gave P&As the authority to access individuals with disabilities, their records and the locations where they receive services and supports to investigate abuse and neglect, monitor facilities, provide information and referral services, and pursue legal and other remedies on their behalf.

Upon the conclusion of reading this report, we encourage you to ask yourself:
Is this the best Kentucky has to offer persons with mental illness?
We can and must do better.

Marsha Hockensmith
Executive Director
Kentucky Protection & Advocacy
August 13, 2012

| | |
|---|---|
| Project Leaders | Susan Abbott and Jeff Edwards |
| Layout and Design | Amy Marlatt |

A special thank you to those who shared their personal stories.

# Personal Care Home: An Investigative Report of Golden Years Rest Home Jenkins, Kentucky

Kentucky Protection and Advocacy (P&A) is a client-directed legal rights agency that protects and promotes the rights of persons with disabilities. P&A is an independent state agency, and derives its authority from both federal and state law: specifically the Developmental Disabilities Assistance and Bill of Rights Act (DD Act) 42 U.S.C. § 6000 et seq.; the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act), 42 U.S.C. §10801 et seq.; and Kentucky Revised Statute 31.010 (2).

The DD Act and the PAIMI Act authorize P&A to conduct abuse/neglect investigations for eligible individuals if incidents are reported to P&A or if P&A has probable cause to believe the incidents occurred. 42 USC § 15043(a)(2)(B); 42 USC §10805(a)(1)(A). This is to ensure the safety and protection of all individuals with disabilities from abusive and neglectful practices in public and privately owned facilities, including institutions and community placements.

Also included in both federal statues is the mandate for P&A to monitor facilities where persons with disabilities receive services, including where they reside. Facilities are defined to include both public and private entities. P&A does not function in the same manner as the state Office of Inspector General which has the statutory and regulatory power to cite facilities for regulatory violations and to require corrective actions.

## Personal Care Homes in Kentucky

Personal Care Homes (PCHs) are one of seven types of long term care facilities in Kentucky. KRS 216.750 states a personal care home is a place "devoted primarily to the maintenance and operation of facilities for the care of aged or invalid persons who do not require intensive care normally provided in a hospital or nursing home, but who do require care in excess of room, board and laundry." Kentucky Administrative Regulations define a personal care home as "an establishment with permanent facilities including resident beds. Services provided include continuous supervision of residents, basic health and health-related services, personal care services, residential care services and social and recreational activities."[1] A resident in a personal care home must be 18 years of age or older per KRS 216.765(2), and per the regulation, must be "ambulatory or mobile non-ambulatory, and be able to manage most of the activities of daily living. Persons who are non-ambulatory are not eligible for residence in a personal care home."[2]

PCHs provide services to people with mental health diagnoses, developmental and intellectual disabilities, and other disabilities.

The services provided to residents of personal care homes are:

- room accommodations
- housekeeping, including laundry
- maintenance services
- three meals a day, and snacks between meals and before bedtime
- soap, clean towels, washcloths, and linens
- planned individual and group activities
- recreational room or space
- reading materials, radios, games, and television sets.[3]

Per Kentucky Revised Statutes, "All residents shall be encouraged and assisted throughout their periods of stay in a long-term care facility to exercise their rights as a resident and a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and to outside representatives of their choice, free from restraint, interference, coercion, discrimination, or reprisal."[4] KRS 216.515 (6) states that "all residents shall be free from mental and physical abuse."

Other rights of individuals in a personal care home include, but are not limited to:

- the right to be safe
- the right to be treated with respect and dignity
- the right to privacy
- the right to receive and send unopened mail
- the right to access the telephone for making and receiving calls
- the right to participate in social, religious, and community groups of choice
- the right to go outdoors and leave the premises as you wish unless the facility documents why this should not occur
- the right to be free from chemical or physical restraints
- the right to keep and wear own clothing.[5]

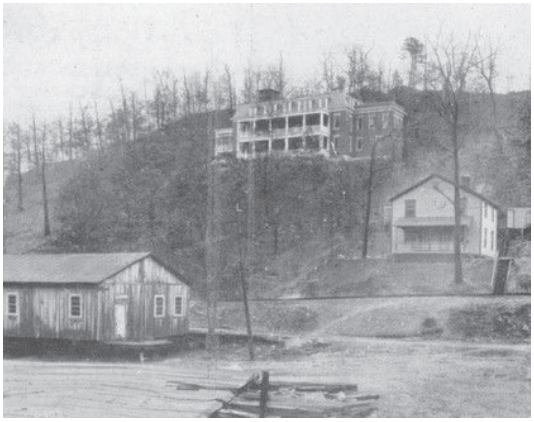
Personal care homes are licensed by the Office of Inspector General (OIG), within the Cabinet for Health and Family Services. The OIG is Kentucky's regulatory agency for licensing all health care, day care, long-term care facilities, and child adoption and child-placing agencies in the Commonwealth. Prior to licensure, long term care facilities must obtain a certificate of need. According to the OIG, there are 6,128 Personal Care Home beds in Kentucky. Of those, 4371 beds are located in 81 free-standing PCHs that are not part of a nursing facility. Residents at PCH's who are recipients of Supplemental Security Income (SSI) use their monthly benefits checks plus a state supplement to cover costs. As of January 2012, PCHs receive $1,218 for each resident ($698.00 from the resident's SSI and $520.00 from the state supplement). Each resident is allowed to retain $60.00 a month for personal spending.

Many PCHs also receive a rate certified by the OIG to provide additional supplementation for individuals who have a mental illness or intellectual disability. This supplement is in addition to the regular $1,218 per month. To qualify for this supplement, 35% of the residents must have a mental illness or intellectual disability. Other requirements to receive this certification are that the facility has verification on file that the staff receives training and a licensed nurse or certified medical technician must be on duty for at least four hours during the first or second shift. The nurse must demonstrate knowledge of psychotropic drug side effects. The facility must also provide group and individual activities to meet the needs of persons with mental illness or an intellectual disability.

## Rights Trainings provided at PCHs in 2009 and 2010

P&A staff and members of the Protection & Advocacy for Individuals with Mental Illness (PAIMI) Advisory Council conducted trainings at 44 Personal Care Homes throughout the state in 2009 and 2010. Residents at PCHs were given information about long term care rights, psychiatric advance directives, guardianship, including restoration of rights, and voting.

## Rights Training provided at Golden Years Rest Home in 2010




Golden Years Rest Home (GYRH) is a two story facility that sits on top of a hill overlooking the town of Jenkins, Kentucky in Letcher County. It was built in 1915 by a coal company to serve as a hospital for the town. In 1969, the building was leased to Golden Years Rest Home, Inc., which had been established as a 40-bed rest home for underprivileged Letcher County residents 62 years of age or older. James "Chum" Tackett was the administrator until 2009 when he pled guilty to reckless abuse of an adult, after a resident stated that Tackett smacked him in the face and hit him on the head with a rubber hammer. He was sentenced to two years' probation. As part of the probation agreement, he was no longer allowed to have contact with GYRH. His grandson, Jonah Tackett, became acting administrator of the GYRH in 2009.

On August 21, 2010, P&A staff and a member of the PAIMI Advisory Council provided training to the residents of GYRH. GYRH was provided notice of the upcoming training for residents and while the focus was residents' rights, staff was invited to attend. Staff from GYRH did not attend the training.

As a result of the training provided at GYRH, P&A received complaints, including allegations of abuse and neglect, from both residents and staff at GYRH and agencies that provide services to individuals residing at GYRH. P&A found probable cause of abuse and neglect at the facility and initiated an investigation. P&A also reviewed annual surveys for GYRH conducted by the OIG for the past three years.

## Timeline of P&A's Investigation
## August 2010 - September 2011

On **August 21, 2010**, P&A staff and a member of the PAIMI Advisory Council provided rights training at GYRH. P&A reported the below allegations of abuse and neglect and other complaints to the Department for Community Based Services (DCBS), the OIG, and the Long Term Care Ombudsman (LTCO) upon returning from the August visit to GYRH.

### Resident to resident sexual abuse

Five residents stated they witnessed at least two male residents sexually assault another male resident numerous times. The alleged victim was a man with an intellectual disability and very small in stature. The abuse involved anal sex, oral sex, and fondling. The witnesses reported this sexual abuse continued for years. As a result of the allegations of sexual abuse, the alleged victim was placed on 15 minute supervised checks.

### Verbal abuse by staff

A GYRH resident stated a staff person took another resident's animal crackers, stomped on them, and called her a "God damned whore." When staff were questioned about the process for reporting allegations of abuse and neglect they stated reports were made to the administrator (Chum Tackett or Jonah Tackett) who then decided if he would contact the OIG, DCBS or the police.

### Financial exploitation of residents

Residents at GYRH complained they did not receive the stimulus payment distributed to beneficiaries of Social Security in 2009. Many complained they did not receive financial statements or explanation regarding their benefits.

### Restrictions placed on resident's freedom of movement

Several of the residents at GYRH brought up the issue of freedom of movement to P&A staff, stating GYRH staff had told them they could not leave the facility. When asked what happened when they left without permission, residents stated GYRH staff called the local police who searched for them and brought them back to GYRH.

### Confusion among residents and staff about guardianship and/or SSI representative payee status

Four residents at GYRH reported they did have a guardian and ten residents reported they were unsure whether or not they had a guardian. Several residents at GYRH stated they would like to live elsewhere but did not have anyone to assist them with finding another place to live.

Staff at GYRH indicated they did not know the guardianship and/or SSI representative payee status for residents. In situations where an individual had been appointed a legal guardian, GYRH staff was unaware for which areas of a resident's life the guardian had been granted decision making authority. Due to the confusion regarding guardianship status, GYRH staff did not know who should be notified about a medical emergency for residents.

### Residents not receiving medications

There were complaints about the facility running out of prescribed medications, including medication for a seizure disorder, chronic pain, and other medical conditions. Another resident who had cancer stated that the facility often did not have her medication. One resident stated his pain medication was confiscated by Chum Tackett because the resident could become dependent on the medication. He did not know what happened to his medication.

On **September 20, 2010**, P&A staff interviewed fourteen residents at GYRH using a tool designed for conducting interviews with persons residing at personal care homes. The interview tool included questions about personal safety, freedom of movement, daily activities, access to the telephone, receipt of mail and visitors, availability and quality of food, privacy, handling of complaints and grievances, and allegations of abuse and neglect.

Residents at GYRH reported the following problems to P&A staff during their visit to the facility on September 20, 2010.

### Lack of food and quality of food

Some residents stated they did not get enough to eat at the facility and others complained the food was often served cold. Residents stated that if a resident did not like what was being served, sometimes an alternative, such as a bologna sandwich, was offered. Residents reported that oftentimes, the facility ran out of bread. Both GYRH residents and staff reported the facility ran out of milk on a regular basis.

### Availability of staff

Residents at GYRH complained that staff at GYRH was not available to assist residents with arranging for and taking them to medical appointments, or referring them to services such as case management and day services from the local community mental health center. Residents also stated there were times when staff was not present on the floors at the facility, an issue of particular concern given the allegations of resident to resident sexual abuse at the facility.

### Lack of clothing and supplies

Residents at GYRH reported they frequently did not have hot water. Both residents and staff at GYRH reported shortages of toiletries, including toilet tissue paper, and clothing, including underwear. Further, they indicated all clothing was dumped on the floor and they could select clothing that may fit them.

On **September 20, 2010**, P&A staff also toured the facility observing the following regarding accessibility:

- The exterior stairs, sidewalks, and pavement were broken leading up to and around the facility.
- There was no designated accessible parking at the facility.
- The ramp on the outside of the building was not built to ADA specifications, including slope and railings.
- The elevator was frequently inoperable.
- There was no required signage at entrances, bathrooms, residents' rooms, the elevator and stairs), as required by the ADA and
- The bathrooms were not accessible (i.e., mirror, lavatory, faucets, shower stalls, soap dispensers, and the incorrect position of grab bars).



**"Accessible entrance" to the facility**

Stairs residents use for access to the community


Resident's bedroom


Resident's bedroom table

The resident rooms were located on the first and second floors of the facility. Up to four residents

shared a room. None of the rooms had privacy curtains and old sheets were used for window treatments. The furniture was stained and in disrepair and many beds had exposed mattresses which were old and stained. Most of the beds did not have clean linens or pillows. Residents did not have an option or method for securely storing their personal possessions. There was peeling paint, and cracked and fallen ceilings in resident rooms. Carpet throughout the building was stained and worn. The hallways were dark with little lighting.

**Resident's bathroom**

There was a strong odor of feces and urine coming from the toilet on the first floor. The origin of the odor was found in the men's restroom where the toilet was soiled with feces. The floor of the bathroom had broken tiles at the entrance and by the urinal. The shower and curtain were stained with a black and green substance around the bottom of the shower entrance. This strong odor was also present in the main hall on the second floor. The men's restroom on the second floor was found to be in the same condition as the first floor men's restroom.

**Resident's bathroom**

## Common areas for residents

The day room/community room was located on the second floor of the facility with limited seating capacity. The television in the day room had only sound with no picture and the furnishings in this room were stained and in disrepair. The dining room and the staff office were located in the basement of the building, which according to staff, was the morgue when the building was used as a hospital. The dining room smelled of raw sewage and was dark with little lighting. When the elevator was inoperable, the only way to access the dining room was by a dimly lit stairwell. There was no menu plan posted. While there was an outside picnic area, the area was littered with garbage.


Picnic area

There was also a shed toward the back of the picnic area. Residents stated they used this shed to engage in sexual activity.


Shed in picnic area

On **September 21, 2010**, P&A reported problems, including lack of accessibility, to the OIG. These were issues brought to P&A's attention during the visit on September 20, 2010. P&A also reported an additional allegation of resident to resident sexual abuse to the OIG and the DCBS.

On **November 23, 2010**, P&A reviewed copies of the investigations completed by the OIG and the DCBS. Allegations of resident on resident sexual abuse were unsubstantiated by both the OIG and the DCBS.

On **November 29, 2010**, P&A staff conducted interviews with staff at GYRH regarding the protection of residents and the protocol for reporting abuse and neglect, how the residents spend their day, and training provided to the staff. P&A staff also toured the facility. GYRH staff reported there was usually only two staff who worked on the third shift and that one staff stayed in the office in the basement and the other staff rotated between the two residential floors.

Staff at GYRH was interviewed using a tool designed for conducting investigations and monitoring visits at personal care homes. This interview tool gathered information regarding the protocol for reporting abuse and neglect, protection of residents, daily activities of residents, and training provided to staff.

During interviews with GYRH staff, one staff reported having made an unannounced visit during third shift to determine if staff was conducting 15 minute supervised checks on the resident who had been allegedly sexually abused. This staff witnessed the alleged perpetrator leaving the room of the alleged victim.

One female resident stated the another resident raped her 10 years ago; however she did not report the rape and remained fearful of this resident.

On **December 2, 2010**, P&A, following their visit to GYRH on November, 29, 2010, reported the below concerns to the OIG:

### Lack of activities

Ten residents at GYRH stated they spent their time watching TV, sitting outdoors, going for a walk, smoking, sleeping, and eating. There was no activity calendar posted. The residents stated there had not been an activity director for months, and there were no planned or organized activities. When asked if they ever went into the community, one resident stated he went to Pizza Hut the previous year for his birthday. The lack of transportation and insufficient staff were both mentioned by residents as reasons they did not regularly go into the community. While there was a van owned by GYRH in the parking lot, residents reported the van was not in working condition. For most of the residents living at GYRH, any contact with the outside community was limited to walking to town, going to the doctor, and occassional interactions with the faith community. While all of the residents living at GYRH would have been eligible to attend a Therapeutic Rehabilitation Program (TRP), only one reported attending the TRP, a day program operated by Kentucky River Community Care. In terms of daily activities for residents, GYRH staff reported that residents smoke, walk the halls, sit on the porch, and some attend the TRP.

### Access to phone and mail

All of the residents interviewed stated they often did not receive their mail for several weeks. GYRH

staff reported that all mail was delivered to a post office box, and then brought to the facility by Jonah Tackett, adding the mail was not delivered daily. There was a pay phone for the residents, but it was located in a hall and did not allow residents to have private conversations.

### Access to and availability of Administrator

Upon arrival at the facility, on November 29, 2010, P&A requested to meet with the Administrator, Jonah Tackett. GYRH staff reported the Administrator was usually not in the facility, nor was he immediately available by phone. GYRH staff placed a call to Mr. Tackett while P&A staff was present at the facility and the call was not returned. P&A staff also made three attempts to contact him the same day, without success. One GYRH staff reported she had seen the Administrator a total of eight times during her one year employment at GYRH, while other staff reported seeing him at the facility from several times a week to monthly.

On **December 8, 2010**, the OIG visited GYRH to investigate complaints made on December 2, 2010.

On **December 28, 2010**, the OIG issued a Statement of Deficiencies to GYRH.

On **January 3, 2011**, the Statement of Deficiencies was delivered via mail to GYRH.

On **January 6, 2011**, P&A, after reviewing the Statement of Deficiencies, dated December 28, 2010, reported the following concerns to the OIG:

- Confusion among both residents and staff at GYRH regarding guardianship and representative payee status, which raised concern over who could give medical consent for treatment;
- Restrictions on freedom of movement, as several residents reported they were not allowed to leave the facility;
- Problems with bedroom arrangements for residents, as multiple residents shared a bedroom and there were no partitions or other means provided to ensure privacy of residents; and
- Presence of mold and feces in the bathrooms.

On **January 19, 2011**, P&A called the OIG to inquire about status of the submission of the Plan of Correction (POC) by GYRH.

On **January 20, 2011**, GYRH submitted an unaccecptable POC to the OIG.

On **January 25, 2011**, P&A again reported alleged resident to resident sexual abuse after receiving a call from a resident at GYRH alleging that such abuse was continuing at the facility. The DCBS did not investigate this allegation on the basis that it did not meet criteria for investigation.

On **February 22, 2011**, P&A staff returned to GYRH and interviewed both residents and staff, and toured the facility. P&A staff made the following observations;

- The menu plan was not posted;
- Choices of activities posted were watching TV and coloring;
- All of the residents interviewed indicated they wanted to live somewhere else; and
- There was a strong odor of sewage at the facility.

On **March 2, 2011**, P&A called the OIG to inquire about the status of the POC for GYRH. The OIG stated an acceptable POC had not been submitted. It was also reported by the OIG they had not received a POC for a type A citation issued in 2009.

On **March 3, 2011**, P&A called in new complaints of neglect to the OIG.

On **March 14, 2011**, the LTCO made an unannounced visit to GYRH during third shift and found problems, including inadequate supervision and lack of hot water, these problems were reported to the OIG.

On **March 31, 2011**, P&A requested a meeting with OIG.

On **April 11, 2011**, the OIG issued a Type A Citation to GYRH for failing to ensure medication was stored under lock and key.

On **April 14, 2011**, P&A staff met with the OIG to discuss on-going neglect, including lack of staff, no planned activities, and the dirtiness and disrepair of the facility. P&A staff also made the OIG aware of continued complaints from residents about the lack of food, and not having soap, clean linens, or toilet paper. P & A asserted that allowing this to continue jeopardized the safety of the residents living at GYRH.

On **May 2, 2011**, the OIG issued a Type A Citation for failing to ensure staff was present on each floor of the facility at all times.

On **May 12, 2011**, GYRH staff reported to P&A that the food supplier had threatened to stop deliveries due to non-payment of the bill. GRYH staff also reported residents did not have toothpaste, toothbrushes, or supplies for activities. Finally GYRH staff reported there was often insufficient staffing levels at the facility. P&A reported this to the DCBS, the OIG, and the LTCO.

On **May 26, 2011**, P&A assisted eight residents with intellectual disabilities living at GYRH with applications to receive the Supports for Community Living Waiver (SCL). P&A assisted with transition for all eight who were approved to receive SCL funding and now live in the community.

On **June 9, 2011**, Letcher Circuit Court Judge Sam Wright issued a restraining order at the request of Attorney General's Office to prohibit current and former administrators from access to GYRH, and appointed a receiver to take over operations of facility.

On **June 15, 2011**, the OIG issued a Type A Citation for failing to ensure staff was present and providing supervision at all times.

On **July 27, 2011**, P&A staff visited the facility, met with staff and residents and toured the facility.

On **September 30, 2011**, GYRH closed and all residents moved to other placements.

# Response of other government agencies

## The Office of Inspector General (OIG)

The Division of Health Care within The Office of Inspector General (OIG) is responsible for inspecting, monitoring, licensing, and certifying all health care facilities, and is in charge of investigating complaints against health care facilities, reviewing of plans, and developing facility regulations. There are four regional offices of the Division of Health Care. The regional offices are responsible for conducting on-site visits of all health care facilities in the state to determine compliance with applicable licensing regulations and when applicable, Medicare/Medicaid certification requirements.

### Statements of Deficiencies and Citations issued by the OIG

In **2007**, GYRH received a Type A Citation for not notifying police, family members, or the guardian of a resident who was missing from the facility. The resident had left without permission six times previously. He was found dead on the side of a road, seventeen hours after he left.

Also in **2007** the OIG issued a Statement of Deficiencies to GYRH for failing to appropriately administer or read the results of TB inoculations. The food supply that was available for residents revealed some products had expiration dates.

In **2008**, the OIG issued a Statement of Deficiencies for:

- Failure to conduct criminal background checks on four employees;
- No documentation of TB testing for some of the staff;
- Failure to appropriately administer insulin (giving residents the same amounts of insulin regardless of finger stick reading and residents' diabetic status);
- Numerous broken tiles on the kitchen floor, inoperable dishwasher, and failure of staff to wear hair coverings;
- Failure to follow the posted menu;
- Broken and stained floor tiles in the bathroom;
- Strong odor of urine and dirty faucets in the bathroom; and
- Missing wall tiles around the commode.

On **July 15, 2009**, the former facility administrator, Chum Tackett, was present at GYRH when the OIG was conducting the annual survey at the facility. He was not to have any contact with the facility due to his probation agreement. Due to his presence the OIG issued a Type A Citation on August 3, 2009, for failure to ensure residents were protected from potential abuse, which posed an imminent threat to the health and safety of the residents.

On **December 28, 2010**, OIG issued a Statement of Deficiencies to GYRH for multiple violations, as detailed below.

**Administrator**

The facility was cited for failure to provide access to the Administrator and failure to designate a responsible

party to oversee operation of the facility in the absence of the Administrator.

### Medications

The facility was cited for improper storage of medication. Medications were found stored in a box corroded with rust lying alongside food items on the top shelf of the refrigerator. Roach and ant spray and hairspray were also lying on the same shelf as medications for the residents. The medications were stained with Kool-Aid. Some medications had expiration dates of more than one year old.

### Lack of clean linens

The facility was cited for failing to provide an adequate supply of clean linens for the 35 residents living at the facility. The linen closet on the first floor did not have any towels or washcloths. The second floor linen closet had one towel and three washcloths. The staff working stated because there were not enough towels and washcloths, the residents could only wash/bathe or shower every other day.

### Lack of food

The facility was cited for failing to provide milk for drinking or for food preparation. The menu plan for 30 days revealed that 84 of 84 meals called for 2% milk to be served to the residents, yet the staff stated milk deliveries had stopped and the facility had not received milk for a month.

### Failure to provide activities

The facility was cited for failing to offer activities to residents, noting both residents and staff at GYRH stated there had not been any planned activities since October 31, 2010.

On **January 25, 2011**, a new Statement of Deficiencies was issued by the OIG. The OIG visited the facility on this date to conduct an annual survey and to investigate concerns that were reported on January 6, 2011 by P&A. The exit interview with Jonah Tackett had to be conducted over the phone on January 27, 2011, because he was not present in the facility.

On **March 3, 2011**, a complaint was reported to the OIG regarding the expiration of a resident's Medicaid card. There were concerns that other residents' Medicaid cards had also expired. As of March 16, 2011, the OIG had not received an acceptable POC.

On **April 11, 2011**, GYRH received a Type A Citation for failing to provide continuous supervision and monitoring of residents to assure their healthcare needs were met and failing to insure medications were stored under lock and key. A resident entered the medication storage room, ingested an overdose of medication and was taken to the emergency room for treatment.

On **May 2, 2011**, the OIG issued a Type A Citation to GYRH for failing to ensure staff was present to provide resident supervision on each of the floors of the facility at all times. Two residents were involved in a physical altercation in March. One resident sustained injuries and was treated at the hospital.

On **June 15, 2011**, another Type A Citation was issued for failing to ensure staff was present and providing supervision on each floor at all times.

## The Department of Community Based Services (DCBS)

The Department of Community Based Services (DCBS) with the Cabinet for Health and Family Services, investigates allegations of abuse, neglect, and exploitation of adults. DCBS also provides preventive and general adult services. The preventive services may include, but are not limited to, assisting the adult in securing appropriate community or institutional placement, in-home supports, medical treatment, crisis assistance, and guardianship.

On August 21, 2010, P&A staff contacted the DCBS via their Adult Abuse Hotline to report allegations of abuse and neglect at GYRH. However, the hotline receptionist answering the call stated she did not know how to handle a report involving multiple allegations of a facility's failure to protect residents from abuse and neglect. The receptionist agreed to take the information, but did not offer further instructions. P&A staff then asked if there was a number for contacting the local DCBS on-call person to make the report, but the hotline employee did not provide this number. P&A staff did obtain and call the local on-call pager number, but a return call was not received. On August 23, 2010, P&A staff reported all the above mentioned complaints to the county DCBS office where GYRH is located, the OIG, and the LTCO.

## The Long Term Care Ombudsman (LTCO)

The Long-Term Care Ombudsman (LTCO) program advocates for residents of nursing homes, personal care homes, and family care homes. Services of the state LTCO are coordinated through the Cabinet for Health and Family Services, Department for Aging and Independent Living, Office of the State Long Term Care Ombudsman. The LTCO program is responsible for identifying, investigating, and resolving complaints made by or on behalf of residents and providing information to residents about long-term care services.

Since 2009, staff with the LTCO program had visited GYRH numerous times. Their many requests to meet with then facility administrator, Jonah Tackett, were ignored. Staff with the LTCO program made reports of allegations of abuse and neglect to both the DCBS and the OIG over the past two years and made numerous attempts, including repeated visits to the facility, to assist residents living at GYRH.

The LTCO visited the facility on March 14, 2011, at approximately 12:20 am after receiving calls that the facility was without hot water and the elevator was not in working order.

The LTCO found:

- No floor supervision (two staff working)
- Elevator turned off at night
- No hot water
- No toilet paper
- Two of the urinals in the men's bathroom not in working order
- The water fountain not in working order
- The light cover broken with jagged pieces hanging loose in the men's bathroom

## Closure of Golden Years Rest Home

On **June 9, 2011**, Letcher Circuit Court Judge Sam Wright, at the request of the Attorney General's Office, issued a restraining order to remove the current and former administrators from having access to GYRH and appointed a receiver to take over operations of GYRH. Judge Wright stated the manner in which GYRH conducted its business was dangerous to the safety of its residents.

Due to the financial costs, including outstanding debt and needed facility repairs, GYRH closed on September 30, 2011, under the direction of state officials and a court-appointed state receiver. All 27 residents either moved to other placements, including nursing homes, personal care homes, and group homes.

## Conclusion

Problems, including abuse and neglect, and rights violations at the facility, had been reported to and documented by regulatory and investigatory agencies since 2009. Little had been done to address or correct these issues. Residents living at GYRH made multiple allegations of resident-to-resident sexual abuse, rights violations, financial exploitation, and staff-to-resident verbal abuse. Reports were also received and reported from both staff and residents regarding regulatory violations due to inadequacies in staffing, staff training, food, basic hygiene products, cleaning supplies, linens, as well as resident activities, services, and privacy. Throughout P&A's involvement with GYRH there were multiple reports made to both the OIG and the DCBS, and on-going communication with the LTCO.

Simple tasks such as supplying the facility with toilet paper were on-going problems at GYRH. Until the OIG cited the facility for not having enough linens, residents had to share the same towel to bathe. The facility regularly ran out of bread and milk. Residents stated their daily activities consisted of sleeping, watching TV, and walking around the building. They were not allowed, regardless of guardianship status, to go off "the hill". Many of these residents did not have a guardian.

As asserted in "Home or Institution? A Report by Kentucky Protection & Advocacy" released in March, 2012, "...personal care homes are congregate settings that segregate persons with disabilities from the community." The report concludes personal care homes "...are institutions [and] fail to integrate persons with disabilities into the social mainstream, fail to promote equality of opportunity, and fail to maximize individual choice." Even when operated exactly as required by regulations and under ideal oversight conditions, Kentucky personal care homes violate the Supreme Court's ruling in Olmstead v. L.C. that "[un]justified isolation...is properly regarded as discrimination based on disability."

This investigative report offers an example of how one personal care home in Kentucky failed to protect and adequately meet the needs of our citizens with mental health diagnoses and with intellectual and developmental disabilities. Due to the nature of their disabilities, oftentimes including life circumstances, placement at a personal care home may be the only available option. Additionally, once placed in PCHs, individuals often have little to no support for finding somewhere else to live, finding a job, and being involved in their community including interacting with people who do not have disabilities.

As alarming as the living conditions and numerous rights violations of residents found at GYRH, P&A also found the response of the system responsible for providing oversight of licensed PCHs equally

alarming. Four Type A Citations, as well as multiple Statements of Deficiencies, were issued by the OIG since 2009, yet acceptable POCs were never submitted to the OIG. Allegations of abuse and neglect were unsubstantiated by DCBS because resident witnesses were discounted due to their mental health diagnoses.

While residents with intellectual disabilities who previously lived at GYRH are now receiving appropriate services and supports in the community, many other residents who lived at GYRH moved to another PCH and do not have access to services and supports in the community. The closure of GYRH does not address or change the current service system in place in Kentucky, a system that does not adequately and appropriately support persons with mental illness.

P&A represented several of the residents who lived at GYRH to ensure they received appropriate services and supports upon the closure of the facility. Despite the significant disruption to the lives of many long-term residents, the vast majority reported they were appreciative of those who forced this closure and assisted them with finding a new place to live. The following are first-hand accounts as provided by former residents of GYRH to P&A advocates.

## Life after Golden Years


**David Noble**

David Noble, age 38, was born and raised in Letcher County. He has seven brothers and five sisters. David attended and graduated from Fleming-Neon High School in 1994.

After both of his parents passed away, David, one of his brothers, and their step-mother lived in several different rented properties. David said the landlord at the last house they rented "got on to him" all the time. David said the house needed repairs, which the landlord would not complete, but the landlord pressured them about paying the rent. He said this caused him a lot of stress, so he, his brother, and his step-mother decided to move again. David said James "Chum" Tackett, whom he knew, told them they should move into GYRH where they would not have to worry about repairs and problems with landlords. David said they all three moved in, but his stepmother did not stay long because she thought it was nasty. David and his brother remained at GYRH for the next 12 years.

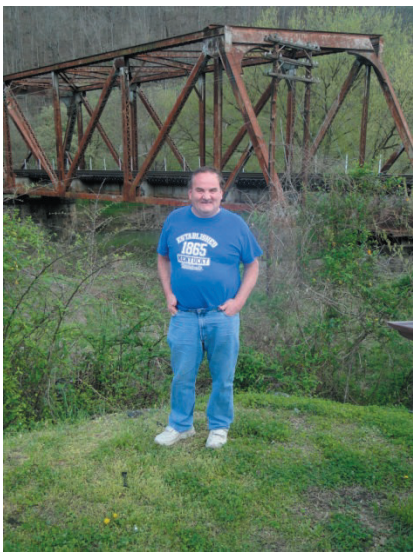
When P&A first met with David in 2010, he was asked if he had a legal guardian. David, like many other residents of GYRH, was not sure if he had a guardian, but assumed Chum Tackett was his guardian because Chum handled his money. GYRH staff was uncertain about guardianship status for David. This confusion, along with other factors, kept him from exploring other living arrangements.

David described life at GYRH by saying "there were good days and bad days". He attributed the good days to the friends he made while living there. He attributed his bad days to times, during the winter, when there was no heat in the facility and times when there was no toilet paper at the facility. He said he shared a bedroom with three other men and did not have any privacy. He mentioned an incident when a former roommate destroyed his personal property and tried to fight him. David described former Administrator Chum Tackett as "mean and nasty" in his conversations with both residents and staff. He said Jonah Tackett, named Administrator in 2009, treated them better, but was hardly ever around.

David said activities, when offered, would be things like bingo or going outside to play basketball. The basketball playing ended after the metal poll broke knocking a resident unconscious and requiring transport to the emergency room.

David was asked how life has been like since leaving Golden Years. He stated "things are 100% better now". He now receives residential and other supports via the SCL waiver. He has been to events, including a concert to see Travis Tritt at the Mountain Arts Center in Prestonsburg. A trip to Gatlinburg was planned on the weekend following the interview to celebrate his birthday. He attends his church of 16 years at least two days per week. He chooses his own meals and has three times the amount of spending money he had when living at GYRH. He now has his own bedroom, and shares a house with two other housemates. He says he and his housemates go out shopping, to the parks, and have cookouts. He received monetary compensation from Chum Tackett, restitution as ordered by the Court due to Chum taking residents' money while they lived there. David now has a cell phone, a laptop, and internet access. He hopes to join Facebook and find some of his old friends from high school. He is appreciative to all those who stepped in to make sure the residents of GYRH found new places to live and were reimbursed for the money stolen from them.

Regina



Kenneth

Kenneth, age 62, lived in Hazard before attending the Upward Bound Program at Alice Lloyd College from 1974-78. Kenneth got married, divorced, and has one daughter. He worked a variety of jobs in

restaurants, installing satellite dishes, and odd jobs in Isom and Whitesburg, Kentucky. About eleven years ago, he was hospitalized at Appalachian Regional Hospital in Hazard. He stated Chum Tackett visited him at ARH and asked him if he would like to live at GYRH. Kenneth stated that he didn't have anywhere else to live at the time and agreed to live at GYRH.

At GYRH, Kenneth met Regina Mullins, who was also a resident. He stated he and Regina wanted to get married for many years, but was told by Chum that Regina was "under state guardianship"; therefore, she could not get married or leave GYRH. They had a relationship for ten years prior to getting married in May 2010.

While living at GYRH, Kenneth stated he was depressed the majority of the time. There was little to do outside of attending the day program operated by KRCC. He said he wanted to leave GYRH for many years. He was given $60.00 a month for spending money out of his social security benefits check. He was not aware that he could leave GYRH and have access to his entire check.

Kenneth talked of the conditions at GYRH. Prior to marrying Regina, he shared a room with two other men. He stated the staff served food past the expiration date and administered medications that were expired. The bathrooms were dirty, often stained with feces, adding that often time there was no toilet tissue at the facility. Kenneth said there were never enough towels, soap, or shampoo for the residents. Kenneth said he often saw rats and snakes inside the facility. He said one time he killed a snake.

Kenneth went to a pain clinic in Somerset, where he had a previous surgery, to obtain prescriptions for medications at a pain management clinic. Kenneth stated he would hide some of the pills because Chum Tackett would take the prescriptions away from him. He stated that Chum claimed to have had relatives that developed a dependency on these drugs, and he did not want this to happen to Kenneth. Kenneth does not know what Chum did with the medications.

Regina, age 33, lived at Golden Years for almost 15 years. Regina could not recall who placed her at GYRH. She stated that she wished she could have left sooner. Regina also talked about having two children. While living at GYRH she was never able to visit with her children, but she always gathered school supplies when she had an opportunity. Regina stated "GYRH was nasty", and there were rats, snakes, and roaches there. The food was cold and there was never enough food. She said she was told she was not allowed to leave the facility because she had a state guardian. Regina stated she stayed in her room. She said "Chum would not let you off the hill."

She also stated she was sexually assaulted by one of the former residents at GRYH. Both she and Kenneth stated that they feel strongly that this same resident sexually assaulted other residents at GYRH.

Once GYRH closed, Regina and Kenneth moved to a SCL residence in Hazard, Kentucky. They live in a staffed residence and share the home with another person. While they would prefer to have their own home, they are glad to no longer be living at GYRH. The home is clean and the furnishings are new. They can select the food they eat and can cook their food. Regina attends a day program in Vicco, Kentucky and Kenneth attends a day program in Jeff, Kentucky. When they are not attending the day program during the week, Regina and Kenneth go to the park, watch sporting events, participate in Special Olympics, go to yard sales and flea markets, and visit with family members. Both like the staff who works for the SCL and state they are treated well. Regina and Kenneth stated that "Chum should be ashamed of himself" for taking their money and for the living conditions at GYRH. They have

expressed gratitude on several occasions for all of the people who advocated for the residents of GYRH and for the investigations that led to the closure of the facility.

**William Gramps**

William, age 63, lived at GYRH for over 12 years. In 1999, he was travelling to Michigan to visit his sister, when he stopped at a store in Letcher County to buy a beer. When he was told that it was a dry county, two police officers who were in the store thought he was drunk. He was not given a breathalyzer, but was asked to blow in one of the officer's face and walk a straight line. William was taken to the Letcher County Jail. His car was towed to Grant Tackett's (brother of James Tackett) junk yard. William stated a court appointed attorney encouraged him to plead guilty. He was given a 30 day sentence and served 25 days. He had only 10 dollars when he was released from jail. He immediately went to the junk yard to retrieve his car. He was told that he owed $150.00 in towing fees. William did not have the money to pay the fees and did not have anywhere to stay so he slept inside of his car for two weeks. His sister told him that she did not have the money to give him to pay the fees. William stated Grant Tackett knew that he was living inside of his car. He said that he brought him a meal on Thanksgiving. He stated he went for one week without eating anything. The night after Thanksgiving, William stated someone paid for a room in a hotel and the following day he was taken to GYRH.

William said he did not have anywhere else to go so he stayed at GYRH. He said everyone living at GYRH got up at a certain time and ate at a certain time. He said there were no activities. He stated that he never went out of the facility to visit a doctor, but a doctor did visit the facility to take his blood pressure. He said living with so many other people depressed him. Over 15 people shared the same bathroom. William said "I felt I was between a rock and a hard place because Chum took my money, and I couldn't get any money to leave." He said Chum took advantage of him and the other people who lived at GYRH by taking their money.

When GYRH closed, William moved to the Bailey Center operated by KRCC in Jackson, Kentucky. He lived there until December 2011 when it closed. He now lives in an apartment by himself in Jackson, Kentucky. William is responsible for paying his own bills, doing his laundry, cooking and housekeeping. William has a KRCC case manager who assists him with doctors' appointments and grocery shopping. William stated he feels free and not "closed in."

## Margaret Smith

Margaret Smith is a 43 year old woman who lived at GYRH for approximately 10 years. On August 21st, 2010, she attended the P&A training on guardianship and resident rights, but initially did not request any assistance from those conducting the training. Only after another resident approached the P&A representative and told him of how Margaret had been treated by GYRH staff did she begin to provide information about her experiences at the PCH.

As reported by her fellow resident of GYRH, Margaret confirmed that a staff person had grabbed a snack bag of animal crackers out of her hands, threw it to the floor, stomped on it, and then proceeded to call her a "God damned whore". She explained the staff person waited till the two of them were on the elevator before she verbally attacked her. Per her account, this incident had happened a few weeks prior, yet the staff person was still employed and working at GYRH as of the interview. The P&A advocate asked if she would like to live somewhere else and she gave an emphatic "yes". She did not know if she had a legal guardian and, therefore, did not know if she could move of her own accord.

Ms. Smith grew up in a home with her mother and two sisters. She was later removed from her family home and was told that GYRH was her only option for a residence. While living there, she was not allowed to move freely about her community and was financially exploited by Chum Tackett. She also stated there was never enough food at GYRH. After moving into the GYRH, she lost contact with both of her sisters, as well as her parents.

While living at GYRH Margaret did attend the TRP operated by KRCC. Staff at the TRP became aware that Margaret did not have any money, underwear, or access to feminine hygiene products. Staff at the TRP began assisting her with obtaining these and other things she needed. Upon closure of GYRH, Margaret was approved for funding via the SCL Waiver program and moved into a home operated by KRCC. She shares a home with two housemates and attends the TRP during the week. She says

she is very happy with the services she receives and is especially happy to have tripled the amount of spending money she had when living at GYRH. She loves going shopping and out to eat. She was particularly happy to know that she would be receiving compensation as a result of the prosecution of the former administrator of GYRH for financially exploiting her and the other former residents. Ms. Smith now understands that she does not have a legal guardian and can make decisions regarding where to live, who provides her services and supports, and how to spend her money.

**(Footnotes)**

[1] KRS 216.765(2)
[2] KRS 216.765(2)
[3] 902 KAR 20:036 §4
[4] KRS 216.515(5)
[5] KRS 216.515


P&A
PROTECTION
& ADVOCACY