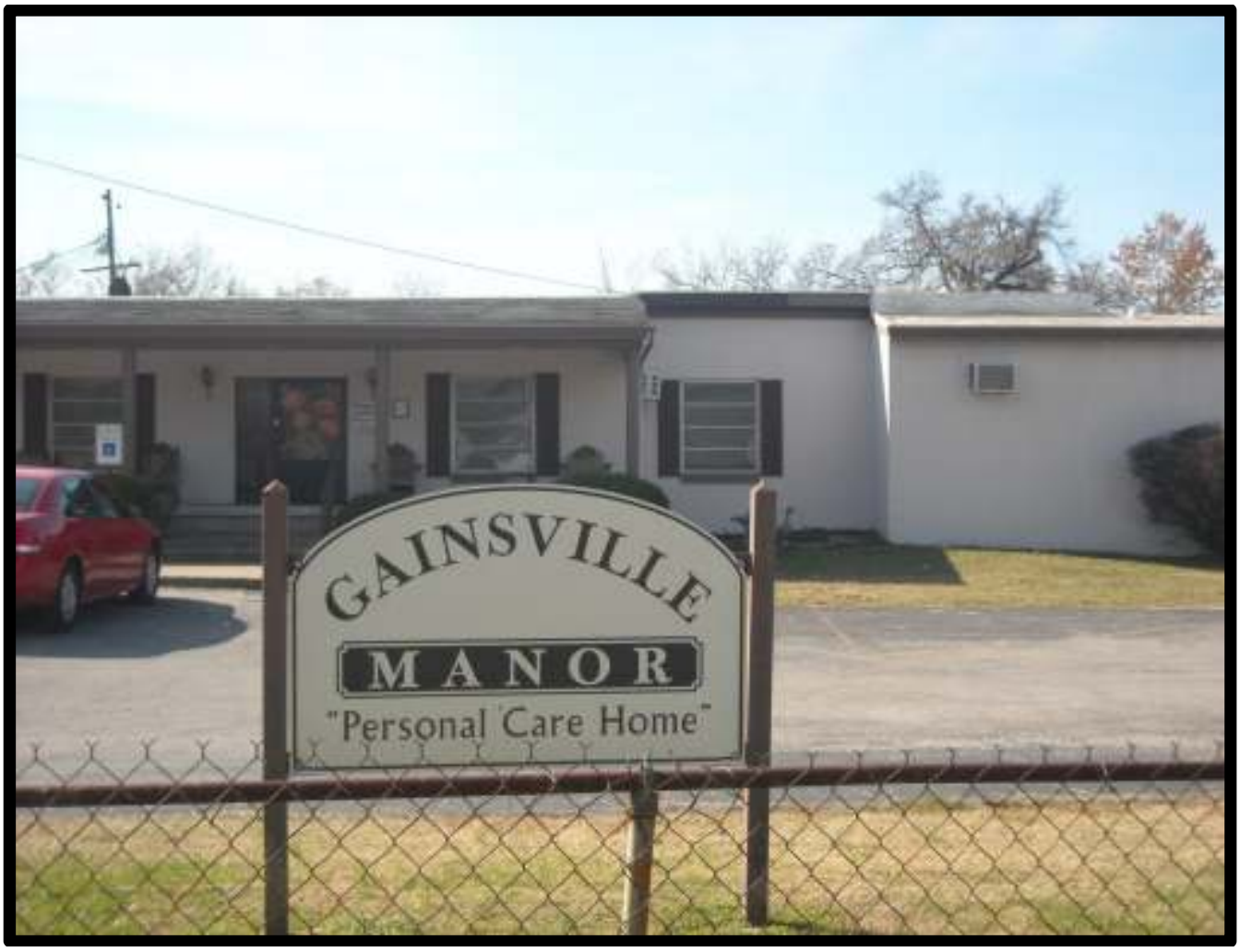
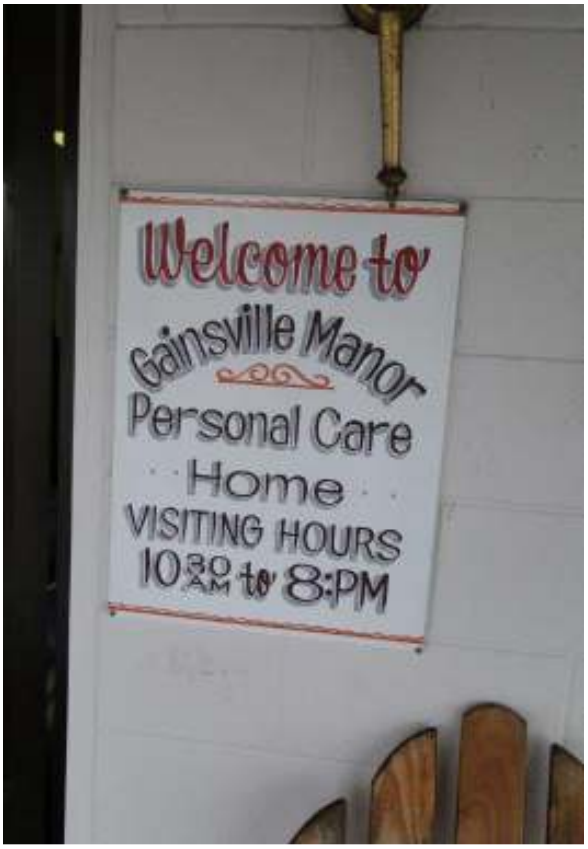
Personal Care Home:
An Investigative Report of Gainsville Manor Hopkinsville, Kentucky



A Report by Kentucky Protection & Advocacy

Personal Care Home:
An Investigative Report
of Gainsville Manor
Hopkinsville, KY

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



Protection and Advocacy Executive Director	Marsha Hockensmith
Project leaders	Jan Powe and Rebekah Cotton
Legal oversight or Legal Director	Heidi Schissler Lanham
Layout and Design	Amy Marlatt

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 Statutes (KRS) 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 U.S.C. § 15043 (a) (2) (B); 42 U.S.C. § 10805(a) (1) (A)). Congress also gave P&As the authority to monitor facilities where persons with disabilities receive services, including where they reside. The laws are designed 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.

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.

Personal Care Homes in Kentucky

Personal Care Homes (PCHs) are one of seven types of long term care facilities in Kentucky. Kentucky law states that 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." [1]It also defines 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." [2] A resident in a personal care home must be 18 years of age or older, [3] and 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." [4]

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

The services provided to residents of PCHs are:

- Room accommodations
- Housekeeping, including laundry
- Maintenance services
- Three meals a day and three snacks provided between meals and before bedtime with substitutes offered for meals
- Soap, clean towels, washcloths, and linens
- Planned individual and group activities
- Recreational room or space
- Reading materials, radios, games, and television sets[5]

"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." [6] Further, "all residents shall be free from mental and physical abuse." [7] Other rights of individuals in a personal care home include, but are not limited to, the right to:

- Be safe
- Be treated with respect and dignity
- Have privacy
- Receive and send unopened mail
- Access the telephone for making and receiving calls
- Participate in social, religious, and community groups of choice
- Go outdoors and leave the premises unless the facility documents why this should not occur
- Be free from chemical or physical restraints
- Keep and wear one's own clothing

- Have visual privacy in multi-bedrooms and in tub shower and toilet rooms[8]

Personal care homes are licensed and regulated by the Kentucky Office of Inspector General (OIG), which is located within the Cabinet for Health and Family Services (CHFS). 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. P&A does not function in the same manner as the OIG which has the statutory and regulatory power to cite facilities for regulatory violations and to require corrective actions. However, P&A can and does refer instances of abuse or neglect to the OIG when necessary.

As of June 1, 2013, there are 4,538 licensed Personal Care Home beds in Kentucky located in 83 free-standing PCHs that are not part of a nursing facility. [9] Those 83 free standing PCHs accept residents who are recipients of Supplemental Security Income (SSI) and use their monthly benefits checks plus a state supplement to cover costs. As of January 2013, these PCHs receive $1,230 for each resident ($710.00 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.[10]

Many PCHs also receive a rate certified by the OIG to provide additional supplementation for individuals who have a mental illness or intellectual disability.[11] This supplement is in addition to the regular $1,230 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.

An earlier report by P&A, "Person Care Homes in Kentucky: Home or Institution?" found that the majority of the persons living in PCHs have a mental illness. Many of them are under guardianship with both private and state guardians. The state guardians are employed by the Department for Aging and Independent Living (DAIL) within the Cabinet for Health and Family Services.

Gainsville Manor Personal Care Home

Gainsville Manor Personal Care Home is a one-story building located in a rural area of Hopkinsville. The facility is licensed for 102 beds. There are 72 semi-private rooms and 6 rooms that house three or more residents. The dining room accommodates only 44 residents and meals are served at 7a.m., noon and 5 p.m.

There are two Licensed Practical Nurse and they both work the morning shift. It was previously owned by Jeffries Health Care Group. On August 1, 2012, it was sold to Vaught and Seaver Properties, LLC. Gainsville Manor is surrounded by a concrete parking lot and a chain link fence. There is one entrance at the front of the property where a security guard is stationed. There is a gazebo to the left of the entrance where

residents are permitted to congregate and to smoke. There is a basketball rim on the property. Within walking distance of the facility, there is a dollar store, convenience store and a liquor store. Gainsville Manor receives the additional supplementation rate.

The above picture shows a hallway at Gainsville Manor

Rights Training provided at PCHs in 2009 and 2010

P&A staff and members of the Protection & Advocacy for Individuals with Mental Illness (PAIMI) Advisory Council (PAC) conducted rights trainings at forty-four Personal Care Homes throughout the state in 2009 and 2010. Residents were given rights training on long term care rights, psychiatric advance directives, guardianship, petitions for restoration of rights, and voting. Rights' training was presented to residents at Gainsville Manor during the summer of 2010.

Investigation Concerning Residents' Rights 2011-2012

Protection and Advocacy receives reports of abuse and neglect from various sources—including private individuals, state agencies and officials, media reports, and anonymous reports. On May 31, 2011, P&A received a report from the Office of the Inspector General (OIG) that a resident at Gainsville Manor had reported that a staff member had put his hands on a resident and then pushed her down the hall. The resident told the OIG that she had reported the abuse to the Administrator, but nothing had been done and the alleged abuser was still working at the facility. Per OIG's investigation, a review of the facility's policies revealed that reporting suspected resident abuse was the responsibility of every staff person. The Gainsville Manor policy further stated that the employee allegedly involved would either be re-assigned to different duties or sent home immediately following any allegations of abuse/neglect. The OIG

determined that the facility failed to protect residents from physical abuse and that this failure placed residents in the facility in imminent danger and created substantial risk that death or serious mental or physical harm would occur.

Because the OIG investigation did not indicate what happened to the alleged perpetrator, P&A staff decided to make a visit to Gainsville Manor and talk to the victim.

On June 21, 2011, a P&A staff member visited this facility. At the time of the visit, there were 88 residents living at Gainsville Manor. Upon entering the facility and introducing herself as staff from Protection and Advocacy, the staff member asked to see a copy of the last three annual surveys performed by the OIG. A Kentucky statute requires that all long-term care facilities, including personal care homes, "shall retain . . . in the office of the administrator and in the lobby of the facility: A complete copy of every inspection report of the facility received from the cabinet during the past three (3) years, including the most recent inspection report…" [12] The Gainsville Manor staff person did not know the location of the report. Eventually, the P&A staff member was sent to the office of the administrator. The administrator directed her staff to the reports and the P&A staff person was given several loose sheets of paper that contained annual surveys and investigatory reports from 2008, 2009, 2010 and one from 2011. Those showed:

2008

- water temperature too low
- not enough food to eat
- resident reported being stalked by another resident without an investigation by the facility

2009

- staff person report of another staff person with her hands around the throat of a resident without any investigation by the facility
- sanitary issues including bathroom odors, kitchen walls, stove and microwave oven dirty
- lack of proper immunizations of staff as well as residents
- no refrigerator thermometer
- 29 residents with restricted diets with no indication that staff was following the restrictions
- medication errors
- resident report of being raped by a janitor without an investigation by the facility

2010

- report of fire marshal deficiencies surrounding needed repairs to doors including hardware to ensure their proper operations

2011

- resident report of abuse of staff member without an investigation by the facility

During the visit, the P&A staff member talked to ten residents. Many expressed a concern about their inability to leave the premises. To ensure that no one left the facility, some residents were required to wear Wanderguard Bracelets, tracking devices that alerted staff if the residents tried to leave. The residents had access to minimal or no planned activities and thus were forced to remain in the facility with nothing to do.

Wanderguard Bracelet
Picture from http://www.stanleyhealthcare.com/node/104

According to Kentucky law, PCH residents have the right to leave the institution "unless a legitimate reason can be shown and documented for refusing such activity."[13] Kentucky law also requires a PCH to provide social and recreational activities both inside and outside the institution.[14] P&A was concerned that the movement restrictions combined with the lack of planned activities resulted in few residents ever leaving the building or doing anything meaningful if they could not leave the building. P&A reviewed the files for two individuals with state guardians and there were no documented reasons for the movement restrictions.

P&A staff discussed the issue with the administrator who maintained it was in the best interests of these residents that they not be allowed to leave the building. P&A asked that these residents be permitted to leave the premises immediately since there was no current documentation justifying the rights restrictions being placed on the residents. Again, citing best interests, the administrator refused and said that the state guardianship field worker for the residents had told her that none of the residents who were clients of state guardianship could go into the community because the PCH was located in a drug infested area. As a result of this conversation with the state guardianship field worker, the administrator decided that most of the residents, regardless of guardianship status, would be restricted to the facility.

During the course of the visit, P&A staff did learn that the original victim of the abuse allegation was no longer a resident at Gainsville Manor. A visit to that resident, then a patient at Western State Hospital, confirmed that she had not felt safe living at Gainsville Manor, and she had no desire to ever live there again. The alleged perpetrator was terminated following an OIG investigation. Upon the original finding, the OIG report directed the staff at the PCH to revise their policy on reporting abuse/neglect, and all were given in-service training on the subject.

On July 21, 2011, the state guardianship field worker whose responsibility is to ". . . act with respect to the ward in a manner which limits the deprivation of civil rights and

restricts his personal freedom only to the extent necessary to provide needed care and services to him", called the P&A staff who had visited Gainsville Manor and told her that as the guardian of forty-seven residents, she had instructed the administrator of the facility that all the state wards could not leave. She had also approved the Wander-guards. The state guardianship field worker stated it was her job to act in the best interests of the individuals, and it was her opinion they should not to be allowed to venture further than the front porch of the facility. She further stated that it had been difficult to secure residential placement for these residents, but that Gainsville Manor was always willing to accept "hard to place" individuals.

P&A made another visit to Gainsville Manor on July 26, 2011.

During the visits P&A:

- interviewed eleven residents and three staff members
- reviewed the activity schedule and food menus
- toured the facility and observed the day-today living activities of the residents
- had meetings with clients
- photographed the facility and requested documents

These are some of the results derived from the resident interviews:

- All eleven residents interviewed had a diagnosis of mental illness.
- Ten residents reported they had a roommate they did not choose and of those ten, three had multiple roommates they did not choose.
- Six residents reported they never have visitors; two reported that they have visitors once a month, and two reported that they have visitors one to three times per year.
- In response to questions about whether they are allowed to cook for themselves, clean their rooms or do their own laundry, ten responded that staff does these tasks for them. These are services that the PCHs are required by regulation to provide, but some PCHs allow residents to choose to perform these housekeeping chores if they so desire.
- Seven residents reported they are not allowed to leave the facility. Three residents reported they can leave sometimes.
- Nine residents reported that they wanted to do more things in the community and each gave examples including: going to the store, going to Wal-Mart, walking to the Dollar Store to buy coffee, traveling to Louisville, taking a walk, going to a therapeutic rehabilitation program and going to church.
- When asked whether the facility ever plans an outing for the residents, ten reported that Gainsville never plans outings for the residents.

Other Findings

Freedom of Movement

The most egregious issue that P&A discovered was that few residents were allowed to leave the facility; the vast majority could not even leave the porch. The few who had been assessed to go outside the PCH with staff sat in the gazebo area under the watch of a security guard. When P&A staff returned from lunch on the day of our visit, one resident attempted to leave the porch to greet us. The guard started screaming that the resident was not to leave the porch. When P&A staff questioned him, he said that he was afraid that the resident would run into the parking lot and get hit by a car. P&A staff explained that there were no moving cars anywhere in sight, but the guard still maintained that the resident could not leave the porch. In his interview with P&A staff, the security guard told us that he had previously worked at Western State Hospital and that he knew how to control the residents.

Activities

There were no posted activities. The PCH relied on volunteers to provide some activities. On the day of our visit, three residents were sitting with the volunteer coloring. The volunteer did not know what other activities had been done earlier that day or if anything was planned for later that day.

The residents reported that they spend their time watching TV or sitting on the porch. None were aware of any day treatment programs nearby and none had been offered the opportunity to attend such a program. While the residents agreed that they could control the channels on the TV, during our visit, it was apparent that one resident had appointed herself in charge of the TV, and she would not allow anyone else to change any channels.

Meals

Meals are served at 7a.m., noon and 5 p.m. The dining room of Gainsville Manor is too small to handle all 88 residents at the same time. The facility devised meal times for women and one for male residents. The women eat first and are allowed thirty minutes to finish eating so that the men can come into the dining room. If one is late, then he/she will not receive that particular meal that day. Substitute food choices are not always available; if a resident does not like the menu item that day, then that resident does not eat.

Guardianship

Over half of the residents at Gainsville Manor have the same state guardianship field worker. The state guardianship field worker had informed the facility that none of her wards were to be allowed to leave Gainsville Manor. The state guardianship field worker had also authorized the use of the Wanderguard bracelets. When she was told by her

supervisor that the devices had to be removed, the state guardianship field worker agreed to do so, but then told the administrator that she should take the shoes of the residents and confine them to the porch.

Medication

P&A staff observed residents lined down the hallway waiting to receive medication. All medication was dispensed at the same time.

Phone and Mail

At the time of P&A initial visit to Gainsville Manor, the only phone in the facility for resident's use was at the nurse's station and afforded no privacy to the residents. Only one resident said that she had received some mail since living at Gainsville Manor, and it had been delivered to her opened. The administrator acknowledged that she had opened the mail, but denied reading the letter. According to the administrator, sometimes she opens the mail just to make sure there is nothing in the envelope that can cause harm to the recipient. The administrator further said that few of the residents receive any mail.

The above picture shows the phone made available for residents' use after P&A began its investigation.

Maintenance and Physical Environment

The facility is institutional with traditional nursing home features including grab bars and nursing carts in the hallways. The bedrooms and the bathrooms had no privacy curtains.

The above picture shows one bedroom for three residents with no privacy curtains.

The above pictures show a lack of visual privacy. Persons using the toilet have no visual privacy from those using the shower.

There were sixteen toilets total and six working showers for all the residents. The census was eighty-eight residents during this visit, so there was one toilet per five residents and one shower per thirteen residents. Regulation requires that there be one shower per twelve residents.

Residents Rights Violations

After our visits, P&A staff found numerous resident rights were being violated including;

- the right to receive and send unopened mail; at least one person's mail was opened before it was delivered to the residents
- the right to participate in social, religious and community groups of choice; there were few planned activities
- the right to go outdoors and leave the premises as they wish, unless there is a documented legitimate reason not to allow such; most of the residents were restricted to the porch or the gazebo area without, at that time, any documented legitimate reason
- the right to keep and wear own clothing; some resident's shoes were kept by staff
- the right to privacy; all telephone calls could be overheard by staff and residents, and there were no privacy curtains in the rooms or the showers

Follow Up

In an attempt to address P&A's concerns about residents not being allowed to leave the facility and the other issues, P&A requested a state-wide systems meeting on the issue.

On August 4, 2011, P&A Director, Legal Director, Federal Program Coordinator, and a Staff Attorney met with the DAIL Commissioner. DAIL is the agency for all state guardianship field workers. Also present at that meeting were a guardianship branch manager, representatives from the Long Term Care Ombudsman office, and representatives from the OIG.

We discussed the ability of clients of state guardianship living in personal care homes to be kept safe and to exercise their rights. P&A advocated that while persons under guardianship may be considered disabled regarding certain rights, many wards are capable of deciding where and when they can go out and that this decision making capacity has not necessarily been taken away from them by court orders.

What P&A discovered at Gainsville is that the state guardianship field worker had placed a blanket restriction on all the clients of state guardianships' rights to leave without required legitimate reasons being documented. At our meeting, DAIL agreed that any decision by a state guardian restricting movement of a ward outside of their PCH should be made on an individual basis. DAIL further discussed developing a uniform assessment that state guardians could use to help them make this individual determination. The OIG agreed to look into the other rights issues by visiting the facility and doing a complete investigation.

Conclusion

P&A made additional visits on September 8, 2011, September 20, 2011, January 11, 2012, January 25, 2012, February 1, 2012, February 22, 2012, June 27, 2012, November 2, 2012, and January 3, 2013.

At all the above visits P&A advocated that the following rights be afforded to all residents and monitored the progress Gainsville Manor was making towards affording its residents the rights to which they are entitled.

- The right to receive and send unopened mail
    - The residents are given their mail unopened
- The right to access the telephone for making and receiving calls
    - On our November 2, 2012, visit, a dedicated phone for the use of the residents had been installed on a wall far away from the nurses' station and residents could use it at any time. At the January, 3, 2013, visit, the phone had been removed from the wall because the facility is in the process of building a room where residents can receive visitors in privacy. The resident phone is also scheduled to be installed in this room
- The right to participate in social, religious and community groups of choice
    - Gainsville Manor has hired a full time activities director who is charged with designing activities for each resident.
- The right to go outdoors and leave the premises as they wish
    - The use of Wanderguard was discontinued and resident's shoes are no longer taken
    - Some residents who had been inappropriately restricted for years were allowed to leave the premises
    - While many of the residents still have movement restrictions in place, the facility is in the process of doing individual assessments
- The right to keep and wear one's own clothing
    - The resident's shoes have been returned
- The right to privacy
    - Plans are in place for the residents to have access to a phone that is in a separate room from the nurses' station
    - Residents are now given a choice as to whether they want a privacy curtain in their room. Gainsville Manor keeps an adequate supply of the curtains on hand for the use of the residents

In addition, two residents of Gainsville Manor requested P&A's help in moving out of the PCH. P&A, through contact with the Community Mental Health Center, assisted them in moving into their own home with services and supports.

[1] KRS 216.750
[2] 902 KAR 20:036 §2
[3] KRS 216.765(2)
[4] 902 KAR 20:036 §2
[5] 902 KAR 20:036
[6] KRS 216.515 (5)
[7] KRS 216.515 (6)
[8] KRS 216.515
[9] Kentucky Office of Inspector General http://chfs.ky.gov/os/oig/directories.htm (accessed June 17, 2013)
[10] 921 KAR 2:015 §8
[11] 921 KAR 2:015 §12(1)(c)(5)
[12] KRS 216.547
[13] KRS 216.515(13)
[14] 922 KAR 20:036 §4(4)