STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185344	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perkins Country Manor	5269 Asbury Road Augusta, KY 41002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood as soon as practicable. The facility further failed to ensure the notice included the reason, date, and location for the transfer, as well as a statement of the resident's appeal rights and the contact information for the state Long-Term Care Ombudsman. The deficient practice was identified for 9 out of 9 residents investigated for transfer and/or discharge, Resident (R) 31, R5, R14, R2, R25, R17, R10, R12, and R15. The findings include: Review of the facility's policy titled, Transfer and Discharge, dated [DATE], revealed the facility was to provide the resident and their representative with a notice of transfer if the resident required emergency transfer to an acute care facility. Further review revealed the notice was to be in a language and manner the resident and their representative could understand. Continued review revealed the notice was to include the specific reason and location for the transfer, effective date of the transfer, as well as an explanation of the right to appeal a transfer with the contact information for the Ombudsman and appropriate state agencies. 1. Review of R31's admission Record revealed the facility admitted the resident on [DATE] with diagnoses including vascular dementia, anxiety, and osteoporosis. Review of R31's Discharge Summary, dated [DATE], revealed the facility transferred R31 to the hospital for increased aggression toward staff, exit seeking, and refusing care. Further review revealed the facility documented Family Member (F) 31 as the resident's caretaker. However, the facility failed to provide evidence they provided F31 with written information related to R31's transfer. In an interview on [DATE] at 1:42 PM, F31 stated she was not notified of R31's transfer to the hospital until after the facility had already transferred her. She further stated she was notified by text message, but never received written information detailing the reason for the transfer in a manner she could understand. F31 also stated she did not receive information regarding her appeal rights related to the transfer. 2. Review of R2's admission Record revealed the facility admitted the resident on [DATE] with current diagnoses, as of [DATE], including hemiplegia (partial paralysis) following cerebral infarction (stroke), neuromuscular dysfunction of the bladder, and infection due to indwelling urinary catheter. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R2's Nurse's Note, dated [DATE], revealed the facility transferred the resident to the hospital on that date for blood pressure changes, pallor, and low oxygen saturations. In an interview on [DATE] at 11:21 AM, R2's Power of Attorney (POA) stated she did not receive paperwork from the facility related to his hospitalization, but the facility did notify her over the phone they were sending him to the hospital. In an interview on [DATE] at 4:12 PM, Licensed Practical Nurse (LPN) 1 stated she was the nurse who sent R2 to the hospital after she noted in her assessment R2 had increased tremors, shortly followed by high blood pressure and low blood oxygen saturations. LPN1 further stated she notified the Nurse Practitioner (NP) and the POA by phone, but she did not provide the POA with paperwork that described the location and reasons for the transfer or information on the resident's appeal rights. LPN1 stated it was not part of her process to provide the resident and their representative with paperwork related to their transfer, and she did not know who would be responsible for that. 3. Review of R15's admission Record revealed the facility admitted the resident on [DATE] with current diagnoses, as of [DATE], including spina bifida (malformation of the spine present at birth), neuromuscular dysfunction of the bladder, and urinary tract infection. Review of R15's Transfer Form, dated [DATE], revealed the facility transferred the resident to the hospital for low blood oxygen saturations and low blood pressure. Further review of the record revealed no evidence the resident or the resident's representative received written transfer information. In an interview on [DATE] at 5:32 PM, R15 stated he had been hospitalized recently. He stated he did not recall the reasons for transfer nor did he receive any paperwork related to his hospitalization. 4. Review of R25's admission Record revealed the facility admitted the resident on [DATE] with diagnoses including cirrhosis of the liver and hepatorenal syndrome (injury to kidneys caused by liver failure). Review of R25's Nurse's Note, dated [DATE], revealed the facility transferred the resident to the hospital for increased ascites (abdominal swelling) and significant decline in activities of daily living function. Further review revealed the note stated R25's Family Member (F) 25 was aware of the transfer; however, the facility failed to provide evidence R25 and/or F25 received written information about her transfer to the hospital. In an interview on [DATE] at 2:44 PM, F25 stated he did not receive paperwork describing the reasons for F25's transfer to the hospital. He further stated R25 was discharged home from the hospital with hospice and had since died. 5. Review of R5's admission Record revealed the facility admitted the resident on [DATE] with diagnoses of pneumonia, acute respiratory failure, and chronic obstructive pulmonary disease (COPD). Review of R5's Nurse's Note, dated [DATE] at 2:36 PM, revealed staff observed her to be lethargic and hard to arouse, with blue fingers and a low blood oxygen saturation reading of 69 percent, which was significant for hypoxia (very low oxygen level in the tissue). Further review revealed R5 was transferred to a local hospital emergency room for evaluation, and a family member was called and verbally informed of the situation. However, the facility failed to provide evidence R5 and/or R5's (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Family Member (F) 5 received written information about her transfer to the hospital. Review of R5's Nurse's Note, dated [DATE], revealed she returned to the facility from the hospital admission. Telephone interview was attempted with F5 on [DATE] at 11:13 AM, and a second attempt was made [DATE] at 8:42 AM. However, on both attempts there was no answer and no voicemail available. 6. Review of R12's Facesheet revealed the facility admitted the resident on [DATE] with diagnoses of depression, anxiety disorder, and dementia. Review of the facility's document Census revealed R12 was sent to the hospital on [DATE] and [DATE]. However, the facility failed to provide evidence R12 and/or R12's responsible party received written information about her transfer to the hospital for both events. Telephone interview was attempted with R12's responsible party on [DATE] at 9:05 AM, [DATE] at 2:58 PM, and [DATE] at 6:39 PM. However, these three attempts were unsuccessful. 7. Review of R14's Facesheet revealed the facility admitted the resident on [DATE] with diagnoses of vascular dementia with behavioral disturbances and schizoaffective disorder. Review of the facility's document Census revealed R14 was sent to the hospital on [DATE]. However, there was no documentation by the facility stating written information was sent to R14's responsible party. Review of R14's Transfer Form, dated [DATE], revealed R14's transfer was unplanned related to intermittent tremors-full body, and the resident's responsible party was notified via telephone. Review of R14's Progress Note, dated [DATE], revealed R14 returned to the facility via emergency medical services (EMS) from the hospital with a diagnosis of seizures. In an interview with R14's responsible party on [DATE] at 4:50 PM, she stated she did not recall getting anything in writing from the facility regarding the reason for R14 being transferred to the hospital. 8. Review of R10's Facesheet revealed the facility admitted the resident on [DATE] with diagnoses of end stage renal disease (ESRD), cerebral infarction, and convulsions. Review of the facility's document Census revealed R10 was sent to the hospital on [DATE] and [DATE]. However, there was no documentation by the facility for either transfer stating written information was sent to R10's responsible party. Review of R10's Progress Note, dated [DATE], revealed R10 was transferred to the hospital from the dialysis clinic because of a clotted dialysis access site. The note also stated the dialysis clinic spoke to R10's family member for notification of the transfer. Review of R10's Transfer Form, dated [DATE], revealed R10 was having an unplanned transfer to the hospital for abdominal pain, and R10's responsible party was notified of the transfer via telephone on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Telephone interview with R10's responsible party was attempted on [DATE] at 8:57 AM. However, this attempt was unsuccessful. 9. Review of R17's Facesheet revealed the facility admitted R17 on [DATE] with diagnoses of cerebral infarction, major depressive disorder, and COPD. Review of the facility's document Census revealed R17 was sent to the hospital on [DATE] and [DATE]. However, there was no documentation by the facility for either transfer stating written information was sent to R17's responsible party. Review of R17's Long Term Care Transfer Form, dated [DATE], revealed R17's reason for transfer was medical emergency, and R17's representative gave verbal consent via telephone authorizing the transfer. Review of R17's Progress Note, dated [DATE], revealed R17 was sent to the hospital from a scheduled doctors appointment. Telephone interview was attempted with R17's representative on [DATE] at 12:08 PM. However, this was unsuccessful. A voicemail was left, but a telephone call was not returned. In an interview with the Director of Nursing (DON) on [DATE] at 4:52 PM, she stated the nurse assigned to a resident was the person responsible for calling and notifying a family member of a change in condition and transfer to the hospital. In an interview on [DATE] at 11:48 AM, the Administrator stated the facility identified during the course of the survey that they had been inconsistent in implementing their process to ensure residents and their representatives received required transfer paperwork. She stated they would address the process failures through their quality assurance program.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 5. Review of R5's admission Record revealed the facility admitted the resident on [DATE] with diagnoses of pneumonia, acute respiratory failure, and chronic obstructive pulmonary disease (COPD). Review of R5's Nurse's Note, dated [DATE], revealed staff observed her to be lethargic, hard to arouse, with blue fingers and a low blood oxygen saturation reading of 69%, significant for hypoxia, meaning very low oxygen level in the tissues. Further review revealed R5 was transferred to a local hospital emergency room for evaluation, and a family member was called and verbally informed of the situation. Review of R5's Nurse's Note, dated [DATE], revealed she returned to the facility from the hospital admission. Review of R5's Bed Hold Agreement, dated [DATE], revealed the BOM signed to verify she obtained verbal consent to hold the resident's bed. Further review revealed no evidence the form was sent to the resident or the resident's representative. Telephone interview was attempted with R5's representative on [DATE] at 11:13 AM and [DATE] at 8:42 AM. However, on both attempts there was no answer and no voicemail available. 6. Review of R12's Facesheet revealed the facility admitted the resident on [DATE] with diagnoses of depression, anxiety disorder, and dementia. Review of the facility's document Census, revealed R12 was sent to the hospital on [DATE] and [DATE]. However, R12's Bed Hold Agreement was requested for both events but never produced, and there was no documentation by the facility stating these written notices were sent to R12's responsible party. Telephone interview was attempted with R12's responsible party on [DATE] at 9:05 AM, [DATE] at 2:58 PM, and [DATE] at 6:39 PM. However, none of these three attempts were successful. 7. Review of R14's Facesheet revealed the facility admitted the resident on [DATE] with diagnoses of vascular dementia with behavioral disturbances and schizoaffective disorder. Review of the facility's document Census revealed R14 was sent to the hospital on [DATE]. However, no documentation by the facility stating written information was sent to responsible party was in the medical record. Review of R14's Transfer Form, dated [DATE], revealed R14's transfer was unplanned and related to intermittent tremors-full body. Review of R14's Bed Hold Agreement, dated [DATE] and signed by the BOM, stated, Called guardian, she is aware of the 14-day bed hold for Medicaid, wants me to call her if she gets close to the 14 days and she will decide at that point. Review of R14's Progress Note, dated [DATE], revealed R14 returned to the facility via emergency medical services (EMS) from the hospital with a diagnosis of seizures. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with R14's representative on [DATE] at 4:50 PM, she stated she did not recall getting anything in writing from the facility regarding the resident's bed hold. 8. Review of R10's Facesheet revealed the facility admitted the resident on [DATE] with diagnoses of end stage renal disease (ESRD), cerebral infarction, and convulsions. Review of the facility's document Census revealed R10 was sent to the hospital on [DATE] and [DATE]. However, although requested, no documentation by the facility of R10's Bed Hold Agreement for both transfers was ever produced. Review of R10's Progress Note, dated [DATE], revealed R10 was transferred to the hospital from the dialysis clinic because of a clotted access site. Per the note, staff at the dialysis clinic spoke with the son for notification. Review of R10's Transfer Form, dated [DATE], revealed R10 was having an unplanned transfer to the hospital for abdominal pain, and R10's representative was notified of the transfer via telephone on [DATE]. Telephone interview with R10's responsible party was attempted on [DATE] at 8:57 AM. However, this attempt was unsuccessful. 9. Review of R17's Facesheet revealed the facility admitted R17 on [DATE] with diagnoses of cerebral infarction, major depressive disorder, and COPD. Review of the facility's document Census revealed R17 was sent to the hospital on [DATE]. Review of R17's Progress Note, dated [DATE], revealed R17 was sent to the hospital from a scheduled doctor's appointment. Review of R17's Bed Hold Agreement, dated [DATE], revealed the BOM signed to verify she obtained verbal (telephone) consent from R17's representative to hold the resident's bed. Further review revealed no evidence the form was sent to R17 or R17's representative. Telephone interview was attempted with R17's representative on [DATE] at 12:08 PM. However, this was unsuccessful. A voicemail was left, but a telephone call was not returned. In an interview with the Director of Nursing (DON) on [DATE] at 4:52 PM, she stated the nurse assigned to a resident was the person responsible for calling and notifying a family member of a change in condition and transfer to the hospital. She stated bed holds were determined by a resident's payor source, and that was handled through the business office. In an interview on [DATE] at 7:02 PM, the BOM stated her process for obtaining bed hold consents was to call the family or talk about it with the family. She further stated she did not provide written copies or mail a copy of the bed hold policy or agreement to the resident or the representative related to hospitalizations. In an interview on [DATE] at 6:09 PM, the Administrator stated she believed the BOM mailed a copy of the bed hold policy and agreement to the resident's representative, but she was not sure. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In further interview on [DATE] at 11:48 AM, the Administrator stated the facility identified the need to fix inconsistencies in their process with transfer paperwork. Based on interview, record review, and facility policy review, the facility failed to provide to the resident and the resident's representative a written notice which specified the duration of the bed hold policy. The deficient practice was identified for 9 out of 9 residents investigated for hospitalizations, Resident (R) 31, R5, R14, R2, R25, R17, R10, R12, and R15. The findings include: Review of the facility's policy titled, Transfer and Discharge, dated [DATE], revealed the facility was to provide the resident and their representative with a notice of the facility's bed hold policy as indicated. 1. Review of R31's admission Record revealed the facility admitted the resident on [DATE] with diagnoses including vascular dementia, anxiety, and osteoporosis. Review of R31's Discharge Summary, dated [DATE], revealed the facility transferred R31 to the hospital for increased aggression toward staff, exit seeking, and refusing care. Further review revealed the facility documented Family Member (F) 31 as the resident's caretaker. Review of R31's Bed Hold Agreement, dated [DATE], revealed the Business Office Manager (BOM) signed to verify she obtained verbal consent from F31 to release the resident's bed. Further review revealed no evidence the form was sent to F31. In an interview on [DATE] at 1:42 PM, F31 stated she was notified by text message of the resident's transfer, but she never received any paperwork detailing her options for holding R31's bed if she so chose. 2. Review of R2's admission Record revealed the facility admitted the resident on [DATE] with current diagnoses, as of [DATE], including hemiplegia (partial paralysis) following cerebral infarction (stroke), neuromuscular dysfunction of the bladder, and infection due to indwelling urinary catheter. Review of R2's Nurse's Note, dated [DATE], revealed the facility transferred the resident to the hospital on that date for blood pressure changes, pallor, and low blood oxygen saturations. Review of R2's Bed Hold Agreement, dated [DATE], revealed the BOM signed to verify she obtained verbal consent from R2's Power of Attorney (POA) to hold the resident's bed. Further review revealed no evidence the form was sent to the POA. In an interview on [DATE] at 11:21 AM, R2's POA stated she did not receive paperwork from the facility related to the facility's bed hold policy, but the facility did notify her over the phone that they were sending him to the hospital and verbally confirmed her wishes related to holding the resident's bed. In an interview on [DATE] at 4:12 PM, Licensed Practical Nurse (LPN) 1 stated she was the nurse who sent R2 to the hospital after she noted in her assessment R2 had increased tremors, shortly followed by high blood pressure and low blood oxygen saturations. LPN1 further stated she notified the Nurse Practitioner (NP) and the POA by phone, but she did not provide the POA with paperwork related to (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the transfer, including a bed hold notice. 3. Review of R15's admission Record revealed the facility admitted the resident on [DATE] with current diagnoses, as of [DATE], including spina bifida (malformation of the spine present at birth), neuromuscular dysfunction of the bladder, and urinary tract infection. Review of R15's Transfer Form, dated [DATE], revealed the facility transferred the resident to the hospital for low blood oxygen saturations and low blood pressure. Review of R15's Bed Hold Agreement, dated [DATE], revealed the BOM signed to verify she obtained verbal consent to hold the resident's bed. Further review revealed no evidence the form was sent to the resident or the resident's representative. In an interview on [DATE] at 5:32 PM, R15 stated he had been hospitalized recently. He stated he did not recall the reasons for transfer nor did he receive any paperwork related to his hospitalization. 4. Review of R25's admission Record revealed the facility admitted the resident on [DATE] with diagnoses including cirrhosis of the liver and hepatorenal syndrome (injury to kidneys caused by liver failure). Review of R25's Nurse's Note, dated [DATE], revealed the facility transferred the resident to the hospital for increased ascites (abdominal swelling) and significant decline in activities of daily living function. Review of R25's Bed Hold Agreement, dated [DATE], revealed the BOM signed to verify she obtained verbal consent from F25 to release the resident's bed. Further review revealed no evidence the form was sent to the resident or F25. In an interview on [DATE] at 2:44 PM, F25 stated he did not receive paperwork describing the facility's bed hold policy. He further stated he verbally confirmed with the facility that they did not wish to hold the resident's bed space because he already expected R25 to be going home under hospice care following the transfer to the hospital for evaluation. He stated R25 was discharged home from the hospital with hospice and had since died.