



Personal Care Homes In Kentucky

Research Report No. 438

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Personal Care Homes In Kentucky

Program Review and Investigations Committee

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Research Report No. 438

Legislative Research Commission

Frankfort, Kentucky

lrc.ky.gov

Adopted December 13, 2012

Abstract

Personal care homes are facilities for aged or invalid persons who do not require the intensive care normally provided in a hospital or nursing home but who do require care in excess of room, board, and laundry. As of September 2012, there were 81 personal care homes in Kentucky. This study focused on 50 facilities that serve low-income groups who receive public assistance in the form of state supplementation payments. These supplement personal care homes currently house 2,361 residents, most of whom have severe and persistent mental illness. This report addresses how personal care homes operate and the services they provide, payments by residents, state oversight, and alternatives to personal care homes. This report makes nine recommendations to the Cabinet for Health and Family Services.

Foreword

Program Review staff thank the numerous officials and staff of the Cabinet for Health and Family Services who assisted with this study, especially those in the Office of the Secretary; Office of Inspector General; Department for Community Based Services; Department for Behavioral Health, Developmental and Intellectual Disabilities; Department for Aging and Independent Living; State Long-Term Care Ombudsman; Department for Medicaid Services; and Office of Health Policy. The Kentucky Housing Corporation, Kentucky Protection and Advocacy, Kentucky Board of Nursing, Kentucky Department of Veterans Affairs, Office of the Attorney General, and Administrative Office of the Courts provided valuable assistance, as did the federal Department of Veterans Affairs and Social Security Administration.

Staff also thank the officials of the Kentucky Association of Health Care Facilities for their assistance. Staff particularly acknowledge the administrators and owners of personal care homes who received unannounced visits, many of whom later discussed personal care home issues at length. Seven Counties, Wellspring, and New Beginnings provided valuable information about their alternatives to personal care homes.

LeadingAge Kentucky, Kentucky Association of Regional Mental Health and Mental Retardation Programs, Kentucky Community and Technical College System, Brain Injury Alliance of Kentucky, Advocates for Community Options, Pam Teaster of the University of Kentucky, and Robert McClelland also provided important background information for the study.

At the Legislative Research Commission, Alice Lyon compiled legal information and the Project Center and the Office of Legislative Economic Analysis assisted with the personal care home survey and other aspects of the study.

Robert Sherman
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Legislative Research Commission
Frankfort, Kentucky
December 2012

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Summary

On August 4, 2011, Joseph Larry Lee Jr. left a personal care home (PCH) without telling the staff. He had an acquired brain injury and schizophrenia. Four weeks later, Lee's remains were found. This case and others raised questions about the safety of PCH residents and the appropriateness of PCHs for residents with certain needs.

The Cabinet for Health and Family Services' Office of Inspector General issues PCH licenses to typical freestanding facilities and to some nursing homes and other facilities with personal care beds. This report covers freestanding PCHs, which can be divided roughly into two groups: those that serve primarily elderly people with private resources and those that serve a variety of low-income groups that receive public assistance in the form of state supplementation payments. Private-pay PCHs are clustered in Kentucky's three main population centers. Most PCHs, including the one where Lee stayed, are supplement PCHs, which are mostly in rural areas. This report focuses on supplement PCHs.

There were 81 freestanding PCHs in Kentucky as of September 2012, 50 of them supplement PCHs. There were 4,387 usable beds (2,660 in supplement PCHs) and 3,777 residents (2,361 in supplement PCHs). The estimated average cost to the state to support supplement recipients in PCHs is \$9,600 per year. This includes the state supplement itself, the state portion of Medicaid services provided to recipients, and state support for three specialized mental health PCHs.

The main group that supplement PCHs serve is people with severe and persistent mental illness. People in this group are considered to have a disability and receive federal disability payments as well as the state supplement. Another group is people with intellectual or developmental disabilities, who also receive disability assistance and state supplementation. Other supplement PCH residents are elderly people who receive federal assistance and state supplementation. Supplement PCHs have a few low-income private-pay residents.

The differences between private-pay PCHs and supplement PCHs are dramatic. Private-pay PCHs typically charge \$2,500 to \$4,000 per month, averaging \$3,330. PCHs have to accept only \$1,158 from residents receiving state supplementation, so private-pay PCHs do not have any supplement recipients. Private-pay PCHs usually offer private rooms and often offer small apartments; bathrooms are either private or shared between two rooms. Supplement PCHs offer rooms for double, triple, or quadruple occupancy; bathrooms and showers are almost always shared for an entire hall, wing, or floor. The private-pay PCHs that Program Review staff visited were relatively new, spacious, well appointed, and designed for providing personal care services. The visited supplement PCHs were in older buildings, most of them originally motels, schools, offices, or other facilities not designed for health services. The two types of PCH differed significantly in the variety and quality of food, appearance of the residents, cleanliness, and activities.

In the current system of care, according to many PCH administrators, ombudsmen, and others, the only alternative for many supplement PCH residents is homelessness, interrupted from time

to time by involuntary hospitalization or time in jail. Nevertheless, there are opportunities for improvement in the facilities and practices of supplement PCHs.

Supplement PCH administrators cited the low reimbursement rate as the major reason for the sometimes unsatisfactory conditions in their facilities. The state has the option of increasing the rate, and the cabinet reported that it had requested increased funding. More information about the finances of PCHs would be useful for making funding decisions.

Recommendation 2.1

The Cabinet for Health and Family Services should propose a state supplementation rate-setting process that would involve a periodic financial audit of personal care homes accepting state supplementation recipients. The cabinet should present the proposal, including its projected costs, to the Program Review and Investigations Committee by October 1, 2013.

State supplementation recipients receive \$60 monthly for personal needs including clothing, transportation, off-site entertainment, soft drinks, tobacco, and anything else the resident wants to buy. The recipient also has to pay any debts or expenses, including copayments for medical services and prescriptions. Most recipients receive Medicaid, which covers most health and behavioral health services. Some PCH residents receive both Medicaid and Medicare; these residents have to pay small prescription copayments that might consume much of their allowance. If residents have insufficient funds to pay for all needed items, PCHs have to discharge them or agree to pay their excess expenses out of PCH funds.

Recommendation 2.2

The Cabinet for Health and Family Services should propose a method for setting the personal needs allowance for state supplementation recipients based on a periodic assessment of personal expenses. The cabinet should present the proposal, including its projected costs, to the Program Review and Investigations Committee by October 1, 2013.

Personal care services include some assistance with activities of daily living such as feeding, bathing, and grooming oneself; dressing and undressing; and toileting. PCHs perform some daily tasks for their residents, such as cooking, cleaning, laundry, and assistance with medications. PCHs are required to provide basic hygiene supplies.

PCHs are licensed health facilities and, when nurses are available, may provide limited health services under medical orders. Program Review staff determined that if a PCH has no nurses, it may keep the residents' medications in a central, secure location and assist with self-administration of medications but may not administer them or provide any other health services. There have been discussions among the PCHs, the cabinet, and the Kentucky Board of Nursing about what services are appropriate for PCHs to provide, but the regulations are not explicit.

Regulations mention a "certified medication technician," but there is no regulatory definition of such a title. Regardless of the title, such staff would be able to provide health services only under the delegation and supervision of a nurse.

Recommendation 3.1

The Cabinet for Health and Family Services, through regulation or written guidance referenced in regulation, should

- **clarify the health services that personal care homes may provide, including what staff may do when there is or is not a nurse to delegate nursing tasks, consistent with nursing laws and practice, and**
- **uniformly define the title, education, and certification requirements for certified medication aides in personal care homes and other long-term care facilities.**

Some private-pay PCH administrators reported that regulations made it difficult to keep residents who were dying with hospice care, even when the residents and their families would prefer for the residents to remain at the PCH until death. The cabinet at this time has no specific regulation or policy on this matter.

Recommendation 3.2

The Cabinet for Health and Family Services should consider specifying how personal care home residents who receive hospice services may die in place if they wish to do so and if it is medically appropriate.

Most PCH residents have the same rights as a typical citizen, including the right to come and go as they please. A resident may have a condition that would make it hazardous to leave unaccompanied, as Lee did. The PCH is responsible for ensuring that it has a plan and adequate staffing to supervise residents and meet their needs, including any risk of what is called elopement. However, a PCH is limited in its options to prevent residents from leaving.

The population of supplement PCHs is predominantly those with severe and persistent mental illness, along with smaller numbers of residents who have intellectual, developmental, or physical disabilities or are elderly. PCHs do not provide any therapy or activities that are likely to improve residents' ability to function or increase their independence. In practice, many supplement PCH residents receive some behavioral health services from community mental health centers, but these services appear to achieve maintenance rather than improvement, and some residents might not receive mental health services at all. Most administrators expressed skepticism that their residents were able to function any more effectively or would be able to succeed outside the PCH. Supplement PCHs appear to provide custodial care for residents with little prospect for independence.

Recommendation 3.3

The Cabinet for Health and Family Services should ensure that personal care homes serving people with mental illness or intellectual or developmental disabilities increase their efforts to encourage healthy lifestyles, provide stimulating activities, teach skills that could lead to greater independence, and facilitate meaningful integration with people in the community at large.

Recommendation 3.4

The Cabinet for Health and Family Services should develop a proposal to ensure that community mental health centers demonstrate that their clients in personal care homes who have mental illness or intellectual or developmental disabilities achieve increased integration into the community and engage in more independent activities. The cabinet should present the proposal, including its projected costs, to the Program Review and Investigations Committee by October 1, 2013.

One way to reduce the likelihood of tragedies like elopement would be to determine whether it is appropriate for someone to stay at a PCH. Regulations simply state that a PCH must meet its residents' needs or transfer or discharge them. The cabinet offers no guidance except to say that the PCH is responsible for determining whether it can meet the resident's needs. The decision whether or not to admit someone is crucial because it often is difficult to transfer or discharge residents. Program Review staff did not find any reliable method of determining appropriateness, but the clinical literature suggested that a method might be developed.

There are a few situations in which it is likely that a PCH is not the appropriate setting. These involve applicants for admission who have already been determined eligible for certain Medicaid waiver programs. Qualifying for these programs means that the recipient needs services that a PCH probably cannot provide. People on waiting lists for the waivers have applied for but might not need that level of service; eligibility is determined only after a slot opens.

Recommendation 3.5

The Cabinet for Health and Family Services should inform personal care homes that they should not admit anyone who is eligible to receive services under any relevant Medicaid waiver unless the facility is capable of providing or arranging for any specialized services the applicant requires. For any such individual already residing in a personal care home inappropriately, the cabinet and facility should make every effort to transfer the individual to a more appropriate setting. Personal care homes should carefully screen applicants and current residents who are on a waiver waiting list but not yet determined eligible. Currently, the relevant waivers are the Home and Community Based Waiver, Acquired Brain Injury Waiver, Acquired Brain Injury Long-Term Care Waiver, Michelle P. Waiver, and Supports for Community Living Waiver.

Recommendation 3.6

The Cabinet for Health and Family Services should develop a proposal to identify and assess personal care home applicants and current residents who might qualify for one of the relevant Medicaid waiver programs or the new Medicaid program for people with severe and persistent mental illness and to divert anyone qualifying for those programs from a personal care home. The cabinet also should explore ways to assess all personal care home applicants and residents for appropriateness. The cabinet should present the proposal, including its projected cost and options for payment, to the Program Review and Investigations Committee by October 1, 2013.

Several cabinet agencies exercise oversight of PCHs. The Office of Inspector General is key because it issues and can revoke PCH licenses. The office conducts relicensure inspections, called “surveys,” approximately once a year and investigates complaints as they are received. There have been issues in the past few years in the timely completion of these surveys and in the consistent application of regulatory requirements. There have been cases in which a series of correction plans have been rejected and resubmitted over an extended period and other cases in which numerous instances of noncompliance have not resulted in licensure action.

Recommendation 4.1

The Office of Inspector General should ensure that personal care home relicensure surveys are conducted in the time frame mandated by KRS 216.530 and should adhere to its established targets for timely investigations of complaints. All relicensure surveys should uniformly verify compliance with all applicable requirements and document the evidence used to find compliance or noncompliance on each requirement. The office should monitor the cycle of correction plans and the number of serious violations that may occur before it takes licensure or injunctive action.

Adult Protective Services in the Department for Community Based Services investigates reports of adult abuse, neglect, and exploitation in PCHs. The department and the Office of Inspector General stated that they work closely together, but there appeared to be some cases in which one did not inform the other about a complaint. The cabinet has also assigned Adult Protective Services to conduct an independent semiannual assessment of all PCHs, but most of the assessments have not been done.

More than 600 PCH residents have state guardians; an unknown number have private guardians. Full guardianship removes all the ward’s rights, and the guardian makes all important choices on behalf of the ward, including where to live, and assists in developing the PCH’s plan of care. A guardian, however, has no more options to control a resident’s behavior than the PCH does. The Guardianship Branch in the Department for Aging and Independent Living has one guardianship worker for every 68 wards, which is many more wards than nationally recommended and even more than in 2008. The branch is hiring more workers, but the number of wards is also increasing.

The state Long-Term Care Ombudsman program is an independent program that uses volunteers to visit long-term care facilities, including PCHs. Ombudsmen represent the residents in resolving complaints about care. They have no enforcement authority and may report complaints to other authorities only with the resident’s permission. It appears that the ombudsmen visit PCHs more frequently than any other oversight agency does.

Deinstitutionalization is the process of treating more people with severe and persistent mental illness and other behavioral health conditions in settings in the community or as closely integrated into the community as possible, rather than in hospitals and other institutions. Part of the motivation was financial—community-based services generally are less expensive than institutional services. Much of the motivation was the belief that people with these conditions wanted to and should be able to interact with others in the community as much as they could. In 1990, Congress codified this belief in the Americans With Disabilities Act, and the US Supreme

Court applied the Act to people with behavioral health disabilities in its 1999 *Olmstead v. L.C.* decision. Kentucky Protection and Advocacy has published its opinion that state support of people with disabilities in PCHs violates the Act and the *Olmstead* decision.

Along with the financial and legal motivations for deinstitutionalization, the behavioral health profession developed successful methods of supporting people with these disabilities in more integrated settings in the community using a variety of intensive services. Changes in Medicaid laws have created the opportunity to cover these services for people with severe and persistent mental illness, and Kentucky is in the process of initiating a program to do so. Funding was appropriated in the 2012–2014 budget to serve 200 clients in FY 2013 and expand to 600 clients by the end of FY 2014. The challenge most often mentioned was the cost of shelter—rent and food—that Medicaid will not cover. In the near term, the cabinet plans to cover shelter costs using state *Olmstead* funds that have accumulated over the past several years.

Even with the availability of intensive community supports, some people with severe disabilities like Lee might not be successful in their own homes. Other living arrangements in a future spectrum of services might include small group homes, small short-term crisis intervention facilities, and a few small secured facilities for intermediate- and long-term care when necessary. There are other possible models, but the role of PCHs in serving people with disabilities will probably decline significantly as intensive community services become more available.

Chapter 1

Personal Care Homes In Kentucky

The death of personal care home (PCH) resident Larry Lee raised questions about PCH safety and the appropriateness of these homes for residents with certain needs.

On August 4, 2011, Joseph Larry Lee Jr. left the Falmouth Nursing Home, actually a personal care home, without telling the staff. Lee had an acquired brain injury and schizophrenia. He had been there for 3 weeks; it was the second time he had been a resident at Falmouth. On August 4, Falmouth staff reported Lee's absence within 4 hours, and a search began. Four weeks later, on September 3, his remains were found. As of May 2, 2012, the cause of death had not been determined.^{a 1} Lee's case and others raised questions about the safety of personal care home residents and the appropriateness of these facilities for residents with certain needs.

Personal Care Homes In The Spectrum Of Services

KRS 216.750(2) defines a PCH as "a place ... 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."

KRS 216.750(2), regarding health facilities and services, defines a personal care home (PCH) as
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.

PCHs provide a range of services from boarding homes or assisted living to nursing homes. PCHs are both health facilities and long-term care facilities.

The definition covers the range of services from boarding homes and assisted living to nursing homes. PCHs can serve people needing different levels of care in different settings under the same license.

The licensing regulation lists 35 types of health facility, including medical clinics of various kinds, community mental health centers, hospitals, and nursing homes (902 KAR 20:008).^b Health facilities provide health services, behavioral health services, or both.

PCHs are also considered long-term care facilities, of which the statute defines seven categories (KRS 216.510(1)). Some long-term care facilities specialize in health services, and others

^a Unless otherwise noted, the information about Lee in this report was obtained from state guardianship records.

^b A few of the 35 types are not in use.

specialize in behavioral health services. Table 1.1 shows key differences among PCHs and other types of facilities.

Table 1.1
Comparison Of Personal Care Homes To Other Types Of Facilities

Facility Type	Medication	Nursing Services			Duration Of Care	
	Administration	Full	Limited	None	Short-Term	Long-Term
Hospital	√	√			√	
Nursing home	√	√				√
Skilled nursing	√	√			√	
Intermediate care	√		√			√
Personal care home	√*		√*			√
Assisted living				√		√

*PCHs can provide some nursing services, including medication administration, if a nurse is on staff.

Source: 902 KAR Chapter 20.

Personal Care Within Long-Term Care Facilities

There are two broad categories of PCHs. The first comprises long-term care facilities that also have a personal care home license. The other category is the freestanding PCHs. Some freestanding facilities may be part of larger campuses that include independent or assisted-living services.

There are two broad categories of PCHs. One category comprises long-term care facilities, such as nursing homes, that also have a PCH license. The facilities offer multiple types of services, usually in separate areas. As of February 2012, there were 1,753 licensed beds for people receiving personal care services in these facilities. This report does not address personal care beds that are within a higher-level facility.

Freestanding Personal Care Homes

The other broad category is the freestanding PCHs. Although they are licensed as freestanding by the Office of Inspector General (OIG), some are part of larger facilities or campuses that offer independent or assisted-living services. The office considers them freestanding because their other offerings are residential and are not licensed as health facilities.

As of September 2012, there were 81 freestanding PCHs. Of these, 65 were operated as businesses, and 13 were run by nonprofit organizations. The three other PCHs specialized in mental health treatment and were operated under state contract.

Freestanding PCHs can be distinguished as to whether they serve residents with higher or low incomes.

The major distinction among freestanding PCHs is the residents they serve: those who have higher incomes or assets and those who have low incomes. The sections below describe the two types of freestanding PCHs based on the groups of people they serve.

Private-Pay Personal Care Homes

Private-pay PCHs include residents who have adequate income to pay for their own care. On average, these personal care homes charge more than \$3,330 per month.

Residents of private-pay PCHs have adequate income and resources to pay for their own care. These PCHs charge on average more than \$3,330 per month. Very few of their residents have severe and persistent mental illnesses (SPMI) or intellectual or developmental disabilities (ID/DD).^c Generally, they are retired elderly people who need some assistance with daily activities but not nursing home services.

Several private-pay PCHs specialize in caring for residents with dementia, such as Alzheimer's disease. Often called "memory units," these facilities usually charge significantly more than other private-pay PCHs. Dementia usually occurs in old age and is not considered a mental illness or intellectual or developmental disability.

State Supplement Personal Care Homes

State supplement PCHs primarily serve residents who receive public assistance. Total monthly income for these residents is less than \$1,218. PCHs admitting such residents are required to accept \$1,158, leaving \$60 as a needs allowance for the resident. This report focuses on supplement PCHs.

For PCH residents who receive federal benefits from Supplemental Security Income or Social Security and whose total available income is below \$1,218 a month, Kentucky provides a supplement to bring their total income to that amount.^d PCH regulations require any PCH that admits such a resident to accept \$1,158 as payment in full, leaving a \$60 personal needs allowance for the resident.

This report refers to the 50 PCHs that serve primarily state supplementation residents as "supplement PCHs." Most state supplementation recipients live in these facilities because few other PCHs are willing to accept the \$1,158 payment. This report focuses on supplement PCHs.

According to the staff survey of PCHs, most supplement PCH residents were reported to have a disability, usually SPMI and

^c Most people with mild to severe mental illness live and work in the community using services traditionally provided by community mental health centers and similar providers. In this report, the term *severe and persistent mental illness* is used to refer to conditions that have prevented people from living in the community without intensive supports beyond those offered by traditional programs. Intellectual disability used to be known as "mental retardation." This report, Kentucky statutes, and the current literature use the term *intellectual disability* instead (KRS 446.013). In this report, *mental retardation* is used only in direct quotations and in the names of agencies.

^d The amount is adjusted for cost of living. The amount as of 2012 was \$1,218. State supplementation is available at lower amounts for recipients in other settings who need assistance.

often a psychotic disorder such as schizophrenia. Smaller numbers were reported as having an intellectual, developmental, or physical disability or being elderly with no other disability. Supplement PCHs reported that 2 percent of residents have dementia.

The three state-contracted supplement PCHs specialize in mental health treatment for people with severe and persistent mental illnesses (SPMI).

The three state-contracted supplement PCHs specialize in mental health treatment for people with SPMI. The Department for Behavioral Health, Developmental and Intellectual Disabilities contracts with regional mental health programs to operate them. These specialized PCHs usually accept residents discharged from the state psychiatric hospitals and prepare them to stay in their own homes, other PCHs, or other settings.

A few freestanding PCHs accept a mix of state supplement and private-pay residents. Program Review staff found eight PCHs that could not be classified as private-pay or supplement PCHs. Five of these PCHs reported being operated by nonprofit organizations. Table 1.2 shows the numbers of facilities, beds, and residents for the three groups of PCHs. Some PCHs reported that they had reduced the number of beds below the licensed number; this is reflected under “Usable Beds.”

Table 1.2
Capacity And Usage Of Personal Care Homes By Type

Type Of Personal Care Home	Facilities	Licensed Beds*	Usable Beds	Residents**	Occupancy
Private pay	23	1,299	1,291	1,054	81.6%
Mixed	8	452	436	362	83.0
State supplement***	50	2,682	2,660	2,361	88.8
Total	81	4,433	4,387	3,777	86.1%

*As of June 2012.

**This is the total number of residents in each type of PCH, not the number paying by a particular method.

***Includes the three state specialized PCHs, accounting for 158 licensed beds, 137 usable beds, and 119 residents.

Source: Program Review staff survey of personal care homes.

Study Procedures And Conclusions

On February 13, 2012, the Program Review and Investigations Committee authorized a study of personal care homes. Program Review staff obtained documents from the Cabinet for Health and Family Services and interviewed cabinet officials for this study. Staff also visited 13 PCHs and conducted a survey of all freestanding PCHs. Other state and federal agencies were consulted, along with industry groups and resident advocates. Appendix A describes the study procedures in more detail.

Major Conclusions

This report has eight major conclusions.

This report has eight major conclusions about supplement PCHs.

- Supplement PCH operators reported that the amount they are required to accept is too low to support their operations. Staffing levels at supplement PCHs are minimal, and staff generally have no credentials and are paid minimum wage or slightly more. Some facilities have been in disrepair, but some were improved in recent years.
- Residents at supplement PCHs have few organized activities and almost no organized outings. Although most residents are free to come and go, they usually have no transportation except to go to appointments. Many supplement PCHs are not within easy walking distance of places to work, shop, or seek recreation. The \$60 personal allowance is insufficient for many residents to obtain the things they need.
- Supplement personal care homes serve primarily residents with severe and persistent mental illness and a few residents who have intellectual or developmental or other disabilities or who are low-income elderly. These PCHs provide personal care assistance, manage residents' medications, and arrange for medical and behavioral health care as needed. Some provide additional nursing services such as medication administration. They do not provide direct behavioral health services, and their plans of care are not designed to improve residents' functioning or transition residents out of the PCHs.
- Regulators do not routinely verify that a PCH is the appropriate placement for all its residents. PCHs are responsible for determining whether they can meet the needs of the residents they accept. PCHs must transfer any residents whose needs they cannot meet, including the need to be supervised in order to ensure safety, but it is often difficult to discharge a resident once admitted. There are no reliable assessment tools to determine appropriateness, but the cabinet should advise PCHs that, unless specialized services can be provided, they should not admit anyone who has qualified for one of the Medicaid waivers that serve these populations.
- The Office of Inspector General is the primary state oversight agency. There have been inconsistencies in PCH oversight by the office. There was a period during which responses to complaints were slow and licensure surveys were not done on time, but the office has taken steps to improve responsiveness and timeliness. Several other agencies are involved. This oversight requires coordination among agencies, which has sometimes been problematic.

- The Americans with Disabilities Act and the Supreme Court's *Olmstead* decision require state-supported services for people with disabilities to be provided in the setting most integrated into the community at large.^e Use of facilities like PCHs in other states has been found to be in violation of the Act.
- Given the current array of housing options and treatment services, most residents of supplement PCHs would likely be homeless, in need of frequent hospitalization, or in jail if they were not in PCHs.
- People with severe and persistent mental illness have been unable to benefit from Medicaid funding for intensive support services in individual homes. The General Assembly provided funds for a new support service program for people with mental illness, and the Cabinet for Health and Family Services is working to implement the program under Medicaid options that recently became available. Clients must pay shelter expenses from their own funds with the help of limited housing subsidies.

Spectrum Of Living Arrangements By Type Of Need

Service options are not necessarily tied to living arrangements. In some situations, intensive services can be arranged at home or in other residential settings.

Living arrangements and service options and the progression through them will vary according to each person's type of need and the available services. This section describes the options available for people with limited income and resources who might at some point live in supplement PCHs.

The many service options are not necessarily tied to the living arrangements. It is possible in some situations to receive intensive services at home as well as in other residential settings. The cost of services in a given living arrangement varies, and the cost does not always increase when moving up to the next level.

As Table 1.3 shows, the elderly are the primary residents of private-pay PCHs. Supplement PCH residents are primarily those with disabilities. The number of state supplementation recipients in personal care beds has declined in each of the past 6 fiscal years, but the number of supplement recipients with disabilities overall remained stable.^{f 2} The following sections describe the needs of

^e In keeping with legal and clinical understandings, this report uses the word *community* to refer to the people, institutions, and structures in a geographic area. The residents and staff of a PCH are not considered a community in themselves.

^f The number of recipients with disabilities includes some in family care homes and some with caretaker services, but those numbers are relatively small.

and options available for the elderly and people with certain types of disability.

Table 1.3
Percentage Of Resident Groups
By Type Of Personal Care Home

	Private Pay	Mixed	State Supplement
Elderly*	98%	71%	15%
Disability**	2	29	85
Other	0	0	>0

*The Elderly group includes elderly residents with no other disability and residents with dementia regardless of age.

**The Disability group is primarily residents with severe and persistent mental illness but also includes residents with intellectual or developmental disabilities and physical disabilities.

Source: Program Review staff survey of personal care homes.

Elderly Residents

The elderly accounted for 15 percent of supplement PCH residents in 2012. Residents with disabilities accounted for 85 percent.

This study counted as elderly only those PCH residents who did not have a disability that would have required personal care services. The staff survey placed people with disabilities in the disability group even if they were currently elderly. This study also counted people with Alzheimer’s or dementia as elderly, even though a few of them might not be over 64. Elderly people residing at supplement PCHs generally needed assistance with some activities of daily living. The elderly accounted for 15 percent of supplement PCH residents.

Independent and assisted living are not accessible to state supplementation recipients because none of the public benefit programs for the elderly cover independent or assisted living.

The most integrated and independent setting for the elderly is support in their own residences. Medicaid long-term in-home supports are limited in scope unless the person would otherwise need to be in a nursing home. Independent and assisted living are not accessible to state supplementation recipients because none of the public benefit programs for the elderly cover independent or assisted living. Supplement PCHs are the next setting that is affordable for the low-income elderly, though the intensity of certain services may be lower than that of home-based Medicaid services. Nursing homes and skilled nursing facilities paid through Medicaid or Medicare offer more intensive services and less independence. A hospital is the least independent setting but offers the most intensive services. Hospice care for the dying is available in all settings.

PCH administrators reported that the elderly tended to move toward less independence and more intensive services as a result of aging.

Because aging is usually the primary cause of their needs, the needs of the elderly tend to increase over time. As a result, PCH administrators reported that the usual sequence for the elderly was

toward less independence and more intensive services. The occasional exception was an elderly person who was recovering from an accident, illness, or operation and who improved enough to leave.

Residents With Intellectual And Developmental Disabilities

Intellectual and developmental disabilities by definition begin during or after pregnancy and before adulthood and are usually permanent.^{g 3} Kentucky Protection and Advocacy's survey found that approximately 10 percent of supplement PCH residents had ID/DD as their primary reason for being in that setting.⁴

Private residences are the most integrated setting for people with intellectual and developmental disabilities (ID/DD), supported through community mental health centers to some degree and by Medicaid waivers. Some people with ID/DD live in supplement PCHs because of a lack of group home availability.

The setting in which people with ID/DD live will depend on their ability to function in society. The most integrated and independent setting is support in their own residences, which is available to some degree through community mental health centers and, for those needing much more intensive services, through Medicaid waivers. Group homes, also covered by Medicaid, offer more intensive services with some independence. Largely because of limited group home availability, some people with ID/DD live in supplement PCHs with less community integration, less independence, and less intensive services. For those who need additional services, there are so-called intermediate care facilities that offer little community integration or independence. People with these disabilities do not require intensive services at the level of nursing homes and hospitals unless they are also elderly or ill, or have some other need.

People with intellectual or developmental disabilities should progress toward more independence and integration with supports.

People with ID/DD may sometimes require more intensive services and lose some independence, but their overall ability to function in society should remain the same or improve with support. The progression for people with ID/DD generally should be toward the most integration and independence that they can achieve.

Residents With Severe And Persistent Mental Illness

People with SPMI live in settings that are determined by their ability to function in society. Private residence and group home settings are rare in Kentucky for people with these conditions.

SPMI usually begins in childhood or young to middle adulthood.⁵ Kentucky Protection and Advocacy's survey found that approximately 78 percent of supplement PCH residents had SPMI as their primary reason for being in that setting.⁶

^g The Department for Income Support indicated that for benefit purposes, an intellectual disability can be acquired in adulthood through a brain injury.

The setting in which people with SPMI live will depend on their ability to function in society. The most integrated and independent setting is intensive support in their own residences, but this level is rare in Kentucky. Supplement PCHs offer some services with less community integration and less independence. Staffed residences like the group homes for people with ID/DD are also rare for those who need additional services. The state operates three PCHs specialized for treatment of SPMI, but these are not intended for long-term residence. For intensive services to avoid hospitalization, there are short-term psychiatric crisis intervention units that usually return their patients to their previous setting. People with SPMI do not qualify for nursing home care unless they also are elderly or ill, or have a severe physical disability. Psychiatric hospitals offer the most intensive services and the least integration and independence. The state operates four psychiatric hospitals. Most psychiatric hospital patients are released after a short time.

People with SPMI should progress toward more independent living and integration with supports.

For many people with SPMI, symptoms sometimes are minimal and at other times require intensive services or hospitalization. Although many people with SPMI occasionally require temporary intensive services and lose some independence, their baseline ability to function in society should remain the same or improve with support. The progression for people with SPMI should be mostly toward lower levels of service and greater independence, but the current spectrum of options is limited.

Residents With Acquired Brain Injuries

Sufferers of acquired brain injuries require living situations that are determined by the severity of their condition. Some with these injuries may have additional symptoms of mental illness or intellectual or physical difficulties.

People with acquired brain injuries may experience any of a variety of symptoms of various levels of severity. Their living situation and type of services are usually determined case by case. Some, like Larry Lee, also have symptoms of mental illness. Others may have intellectual or physical difficulties. In-home services and group residential services are available through Medicaid waivers for those who otherwise would need nursing home services, but there are not enough waiver slots. Some people with acquired brain injury live in supplement PCHs.

Observations Of Living Conditions

Private-Pay Personal Care Homes

Private-pay PCHs usually offer well-appointed private rooms and often small apartments. They appeared clean, with numerous snack and dining options and available transportation. Nurses are typically on duty at all times.

Private-pay PCHs usually offer private rooms and often offer small apartments. Bathrooms are either private or shared between two rooms. The private-pay PCHs that Program Review staff visited were relatively new, spacious, well appointed, and designed for providing health services. They appeared immaculately clean, provided numerous meal and snack options, offered outings and some transportation for activities and shopping, and had on-site hairdressers and other amenities. Residents were dressed in casual clothing that appeared to fit properly. These PCHs typically have nurses on duty at all times.

Supplement Personal Care Homes

Supplement personal care homes offer rooms with double, triple, or quadruple occupancy and shared bathrooms. Most are converted motels, schools, offices, or other facilities not designed for health services.

Supplement PCHs offer rooms for double, triple, or quadruple occupancy.^h Bathrooms and showers are almost universally shared for an entire hall, wing, or floor. The supplement PCHs that Program Review staff visited were in older buildings, most of them originally motels, schools, offices, or other facilities not designed for health services. Although there have been reports of buildings in disrepair, the PCHs visited were mostly in reasonable condition for their age. Some that specifically had reported significant roof, wall, and floor damage had replaced roofs and repaired or replaced damaged walls and floor coverings.

The supplement PCHs that Program Review staff visited varied in cleanliness. Dining options and transportation were limited. Most supplement personal care homes have no nurses on staff.

The visited supplement PCHs varied but typically had limited space, small rooms, and older furniture. Cleanliness varied, with some PCHs having noticeable odors and bed linens that did not appear to have been laundered recently. There was usually one menu offering per meal with limited alternatives and a limited variety of snacks and drinks. Only one of the visited supplement PCHs provided organized off-site recreational outings; that PCH reported one such outing monthly. Residents often were dressed in ill-fitted clothing that PCH administrators acknowledged was donated or obtained through clothing banks. According to the Program Review staff survey, most supplement PCHs have no nurses on staff.

OIG records showed some substantiated reports of inappropriate behavior by supplement PCH staff toward residents. However, many supplement PCH administrators to whom Program Review

^h When they accept private-pay residents, supplement PCHs sometimes offer them private rooms at a monthly rate above the state supplementation standard.

staff spoke reported that they attempted to ensure that their staff treated residents appropriately and with respect.

Program Review staff heard from mental health professionals and guardians who praised the efforts of supplement PCHs to care for residents who presented significant risks. One supplement PCH that staff visited stood out as cleaner and more pleasant than the norm, suggesting that improvements in other facilities are possible.

Supplement PCHs represent the only alternative for many residents who might otherwise be homeless, hospitalized, or in jail.

In the current system of care, according to many PCH administrators, ombudsmen, and others, the only alternative for many supplement PCH residents is homelessness, interrupted from time to time by involuntary hospitalization or time in jail. Nevertheless, there are opportunities for improvement in the facilities and practices of supplement PCHs.

Chapter 2

Finances Of Personal Care Homes And Residents

A personal care home that accepts state supplementation must use the \$1,158 it receives for each state supplementation resident to pay for all costs of owning and maintaining the personal care home.

With \$1,158 per month per resident, a supplement PCH must pay for all costs of owning and maintaining the building and grounds, utilities, staff, furniture, linens, meals and snacks, activity supplies, certain toiletry supplies, and transportation if provided (although PCHs are not required to provide it). Almost all PCH operators who spoke with Program Review staff stated that it was difficult to afford repairs and maintenance. They also said that banks would not grant mortgages for new facilities and that the operators would not be able to make the payments if mortgages were available.

Residents with state supplementation receive a personal needs allowance of \$60 per month to cover all personal expenses.

Although PCHs are not responsible for paying for clothes, medications, or medical and behavioral health services, they are responsible for assisting residents in obtaining any necessary items or services. Residents with state supplementation generally receive \$60 per month to cover all personal expenses including clothes, tobacco, soft drinks, outside meals or entertainment, and copayments for prescriptions, if applicable. Many PCHs reported that church groups and charities donated clothing and holiday gifts.

If a resident's necessary expenses are greater than \$60 or the resident chooses not to pay for them, there is little the PCH can do. The PCH must either pay for things the resident really needs or determine that it cannot meet the resident's needs and discharge or transfer the resident. Many supplement PCH operators told Program Review staff that they used their own funds to supplement the personal allowances of some residents.

All state supplementation recipients have Medicaid coverage, and some also have Medicare. Almost all of their medical and behavioral health expenses are covered. Properly licensed and qualified PCH staff would be permitted to provide some nursing and behavioral health services but would not be able to bill for them. This prevents supplement PCHs from offering such services and means that they are limited to the payments they receive from residents.

Some personal care homes accepting state supplementation have private-pay residents. These residents generally pay a higher rate averaging \$1,269 per month.

Some supplement PCHs also have private-pay residents. In the Program Review staff survey, the rate charged to private-pay residents ranged from less than \$1,158 to more than \$2,000, but the average was \$1,269.

Costs Of Living In Personal Care Homes

For 2012, the state supplementation payment standard for personal care homes is \$1,218 per month. After deducting the \$60 monthly personal needs allowance, this leaves \$1,158 for payment to the personal care home.

In this discussion, the “private-pay rate” is the amount the PCH charges to someone who does not receive state supplementation. The “state supplementation rate” is the rate set by Kentucky regulation that a PCH must agree to accept when it admits a supplement recipient. For 2012, this is \$1,158 per month—the \$1,218 payment standard minus a \$60 monthly personal needs allowance.

Private-Pay Personal Care Home Rates

Private-pay personal care homes charge the highest rates. The average rate for private-pay personal care homes was \$3,330 per month in 2012.

Private-pay PCHs do not accept residents who receive the supplement. The Program Review staff survey of licensed freestanding PCHs found that the average rate for private-pay PCHs was \$3,330. At many such PCHs, the monthly price depends on the size of the unit. One typical PCH’s rates ranged from \$3,300 for a studio or efficiency unit to \$3,950 for a “deluxe” two-bedroom unit for one person. An additional person was \$1,500. At another facility specializing in memory care for residents with dementia, residents paid \$6,000 per month. Four private-pay PCHs, accounting for only 132 beds, charged rates at or below \$2,600.

State Supplement Personal Care Home Rates

Residents with the supplement pay the same amount, \$1,158, at all PCHs. At PCHs where most residents are supplement recipients, private-pay rates equal or moderately exceed the amount of the supplement standard. Most supplement PCHs accept the state supplement rate of \$1,158 from their private-pay residents, though some charged up to \$1,870. A few reported that they would charge as much as \$2,800 for a private room, but generally supplement PCHs acknowledged that they had no residents paying the higher rates.

Methods Of Payment

Private Payment Sources

Private payment sources include pensions, retirement savings, Social Security benefits, and long-term care insurance.

People may pay with their own resources at private-pay PCHs and supplement PCHs. According to the Program Review staff survey and discussions with PCH administrators, sources of payment include one or a combination of

- public, private, military, and veterans’ pensions;

- retirement savings and other investments;
- Social Security benefits;
- long-term care insurance;
- assistance from family members;
- sale of property; and
- other sources of income.

Public Assistance

State supplementation is the public assistance program that is a source of payment so that people with low incomes who are elderly or blind or have a disability may live in PCHs.ⁱ The supplement program is based on eligibility for Supplemental Security Income (SSI).

Supplemental Security Income. The SSI program makes payments to people with low incomes who are age 65 or older or are blind or have a disability. The maximum federal SSI benefit changes yearly; the maximum monthly benefit rate is \$698 for an individual in 2012.⁷

Someone with no income would receive the maximum Federal Supplemental Security Income (SSI) monthly benefit of \$698. Someone can receive both SSI and Social Security.

SSI considers income such as money earned from work or from other sources like Social Security benefits, workers compensation, unemployment benefits, and the Department of Veterans Affairs. Someone with no countable income would receive the full \$698. As countable income approaches the allowable limit, the amount of SSI will decline. If countable income exceeds the allowable limit, the person cannot receive SSI benefits.⁸

Social Security. SSI is based on need, but Social Security benefits are based on the number of work credits an individual has earned. A person might not receive Social Security at all or might receive only a small amount. People receiving Social Security benefits less than the SSI allowable limit will receive both benefits.⁹

In Kentucky, state supplementation payments are made to aged, blind, or disabled individuals 18 years or older who have insufficient income to meet special needs for care in a licensed personal care home or family care home or to purchase caretaker services to prevent institutionalization.

State Supplementation. Along with 45 other states and the District of Columbia, Kentucky provides monthly supplements to help persons meet needs not fully covered by federal SSI payments.¹⁰ In Kentucky, supplement payments are made to aged, blind, or disabled individuals who are age 18 years or older and have insufficient income to meet special needs for care in a licensed personal care home or a licensed family care home or to purchase caretaker services to prevent institutionalization.¹¹

ⁱ State supplementation is also available at lower rates to assist people living in family care homes or in their own homes with a caretaker.

For 2012, the supplement payment standard is \$1,218 for a resident of a personal care home. This includes a \$60 personal needs allowance, leaving \$1,158 for the PCH. The amount of the state supplement is the difference between the standard and the person's countable income.¹²

Individuals who are not SSI recipients can get the supplement if they meet the technical eligibility criteria for age, blindness, or disability.¹³ Cabinet staff explained that they may apply, for example, if they would qualify for SSI except for having Social Security benefits or other income greater than the SSI allowable limit but below the supplementation standard. For instance, if an applicant received Social Security of \$900 per month, the supplement would be \$318 to equal the standard of \$1,218.

A person who has not applied for SSI, or who has applied for SSI or Social Security benefits and not yet been approved, also might receive the supplement without SSI. In that case, the state would determine whether the applicant was aged, blind, or disabled and, if so, would provide the state supplement. Eligibility workers would make sure the applicant also applied for SSI and Social Security. In this situation, the state might temporarily pay much more than the typical supplement amount, up to the full \$1,218.

State Supplementation Recipients And Payments. Table 2.1 indicates the number of state supplementation recipients in personal care beds in June 2012 in both freestanding and nonfreestanding facilities. Of the nearly 2,700 people who received state supplementation, 76 percent were disabled, 24 percent were aged, and less than 1 percent were blind. Overall, nearly 64 percent of the state supplementation recipients received SSI.^j

Table 2.1
State Supplementation Recipients In Personal Care Homes By Eligibility Factor
June 2012

Eligibility Factor	Recipients	Percentage Receiving SSI
Aged	636	43%
Blind	3	100
Disabled	2,038	70
All recipients	2,677	64%

Note: These data include freestanding and nonfreestanding personal care homes.

Source: Special PA-264 report provided by Dept. for Community Based Services.

^j A higher percentage of disabled (70 percent) than aged (43 percent) recipients received SSI.

The average monthly payment for all state supplementation recipients was \$471 in June 2012.

Table 2.2 shows payment information for state supplementation recipients in personal care beds from June 2012, also including freestanding and nonfreestanding facilities. The average monthly payment for all state supplementation recipients was \$471. The average payment for SSI recipients was \$537, compared to \$356 for those not receiving SSI.

Table 2.2
State Supplementation Payments To Recipients
In Personal Care Homes By Eligibility Factor
June 2012

Eligibility Factor	Payments	Payment Per Recipient	Payments For Recipients	
			Receiving SSI	Not Receiving SSI
Aged	\$272,781	\$429	\$147,974	\$124,807
Blind	1,520	507	1,520	0
Disabled	986,785	484	766,035	220,750
Total/average	\$1,261,086	\$471	\$915,529	\$345,557

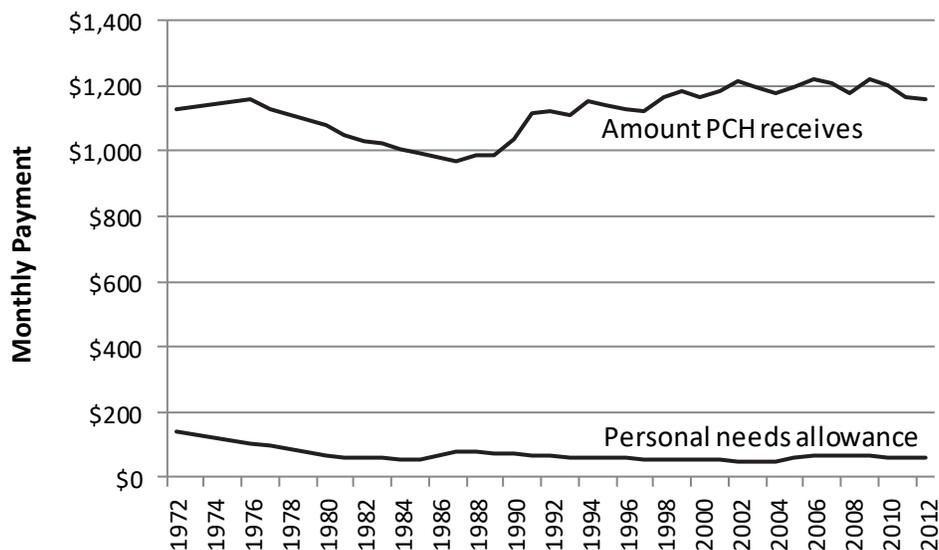
Note: These data include freestanding and nonfreestanding personal care homes.

Source: Special PA-264 report provided by Dept. for Community Based Services.

In 2012 dollars, the amount received by supplement PCHs has averaged \$1,190 since 1998, compared with its current value of \$1,158.

History Of State Supplementation Amounts. Figure 2.A shows the history of supplementation payment standards for personal care homes in constant 2012 dollars. The chart contains the amount the PCH receives (the difference in the supplementation payment standard and the personal needs allowance), which in 2012 is a maximum of \$1,158, and the personal needs allowance, which in 2012 is \$60. Since 1990, the amount received by PCHs has been more than \$1,000 and has averaged \$1,164 in constant 2012 dollars. Since 1998, the average has been \$1,190. Appendix B shows the amounts from 1972 to 2012 in nominal and constant dollars.

Figure 2.A
State Supplementation Payment Standards For Personal Care Homes
1972 To 2012
(2012 Dollars)



Note: Appendix A contains an explanation of the calculation of the pre-1980 supplement. Weighted amounts were calculated for the state supplementation payment standards for the years in which the rate changed midyear (1990, 1991, 1998, 2001, and 2005) and for the personal needs allowance for the years in which the allowance changed midyear (1986 and 2005). Dollar amounts were converted to 2012 constant dollars using the Consumer Price Index All Urban Consumers (CPI-U), US city average, All items, 1982-84=100. Sources: Kentucky. Governor's Advisory Council on Mental Retardation. *Survey Report On Personal Care Facilities*. Frankfort: GACM, 1972. Pp. 8, 40-41; Kentucky. Legislative Research Commission. *Nursing Homes In Kentucky*. Research Report No. 146. Frankfort: LRC, 1977. Pp. 36, 53; Kentucky. Cabinet for Health and Family Services. Dept. for Community Based Services. "PA-264-St. Suppl. Part B. State Supplementation To Aged, Blind, And Disabled Persons." "June." Frankfort: DCBS. From years 2007-2012.; United States. Dept. of Labor. Bureau of Labor Statistics. "Consumer Price Index All Urban Consumers (CPI-U). U.S. City Average. All Items. 1982-84=100. October 16, 2012." Oct. 17, 2012.

Mental Illness Or Mental Retardation Supplement Program

State supplementation payments are made directly to the recipient. A related program, the Mental Illness or Mental Retardation Supplement Program (MI/MR Program), makes payments to the PCH.

A personal care home may qualify to receive the Mental Illness or Mental Retardation Supplement Program (MI/MR Program) payment of 50 cents per day for each state supplementation recipient.

A PCH may qualify, to the extent that funds are available, for a payment of 50 cents per day for each state supplementation recipient in the PCH's care. One of the certification criteria for eligibility to participate in the MI/MR Program is to care for residents at least 35 percent of whom have a

- primary or secondary diagnosis of intellectual disability;
- primary or secondary diagnosis of mental illness; or
- medical history that includes a previous hospitalization in a psychiatric facility, regardless of diagnosis (921 KAR 2:015, sec. 12).^k

As of June 2012, more than 90 percent of residents had mental illness or intellectual disability in all but 3 of the 27 participating PCHs. In nearly half the PCHs, all residents had mental illness or intellectual disability.

In June 2009 and June 2010, 33 freestanding PCHs received payments. Participating PCHs declined to 31 in June 2011 and 27 in June 2012. Some PCH administrators told Program Review staff that they did not consider the amount of reimbursement from the program enough to justify the added expense to meet its requirements.

Donations

According to interviews with PCH operators, their main funding source was residents' payments. In the Program Review staff survey, seven of the freestanding homes reported receiving donations of money or items needed for their operation. In conversations, many PCH administrators reported donations of clothing, toiletries, and gifts for their residents.

Mixed PCHs receive significant payments from both state supplement and private-pay sources. Five PCHs from this group reported that they were nonprofit organizations. These personal care homes also reported donations for operating expenses and supplies. If these are tax-exempt nonprofits, they would be eligible to receive tax-deductible contributions, so this might be a means to enhance revenue.

At some supplement PCHs, revenues are not a significant source of income for the owners. Two supplement homes reported that they operated as a service to the community. In these cases, the owners

^k The population percentage is calculated based on all PCH residents, but the supplement amount is based on the number of state supplementation recipients only. All supplementation recipients are included, regardless of diagnosis.

reported putting their own money into the PCH when repairs were needed or operating costs were not met.

Guardianship

Guardians, including state guardians, do not provide funds to support their wards. Wards have only their own income and resources, and when they have enough resources, they are obligated to reimburse their guardians' expenses. Officials with the cabinet's Guardianship Branch reported that some judges and members of the public incorrectly expected that state wards would receive additional funds or access to additional services.

Medicaid And Personal Care Homes

Medicaid does not pay for any services provided by personal care home staff. By federal law, Medicaid cannot pay for shelter expenses except at nursing homes, hospitals, and similar facilities that "assume total care" of their patients.

Medicaid does not pay for any services provided by PCH staff. The industry and the cabinet have considered ways to obtain Medicaid coverage but have not received federal approval.

By federal law, Medicaid cannot pay for shelter expenses—rent and food—except at nursing homes, hospitals, and similar facilities that "assume total care" of their patients.¹⁴ PCHs do not assume total care because they depend on outside providers for health and behavioral health services. This limitation is important not only for PCHs but also for any alternative living arrangements for PCH residents who are Medicaid members.

Federal Medicaid rules permit states to cover personal care services; Kentucky does not offer that benefit. If Kentucky wanted to offer the benefit for supplement PCH residents, it could not be limited to those residents but would become available to all Medicaid members generally. Even if Kentucky offered the benefit generally, it could not be used to pay for services in a PCH because the state is already committed to paying for personal care services through the state supplement, and it would be improper to use Medicaid funds to pay for the same services.

Kentucky can provide personal care services to specific populations through Medicaid waivers, but PCHs do not meet the individual home or small group setting requirements.

Kentucky is able to provide personal care services to specific populations through Medicaid waivers. The waivers, however, cover services in individual homes or small group settings. PCHs do not meet that requirement, so waivers are not a way to cover their personal care services.

The Centers for Medicare and Medicaid Services rejected the cabinet's proposal to use state supplementation funds as the state's match to cover Medicaid payments for personal care services provided to supplement PCH residents.

The cabinet proposed to the Centers for Medicare and Medicaid Services (CMS) to use state supplementation funds as the state's match to cover Medicaid payments for existing and enhanced personal care services provided to supplement PCH residents. If the state had been able to do so for all state supplementation residents of personal care beds in FY 2011, the \$16.4 million in state general funds would have resulted in a total of approximately \$57.4 million in state and federal funds.¹ In May 2011, CMS rejected the proposal.

Instead of paying state supplementation directly to PCH residents, the plan would have paid the same amount directly to the PCHs and used the state funds to match federal Medicaid funds to cover "existing and enhanced services (excluding residential services)." The proposal did not describe the scope of the enhanced services but did refer to them as "enhanced personal care services."¹⁵

CMS asked the Social Security Administration to review the proposal. The administration asserted that Kentucky must continue to make supplement payments directly to PCH residents under its agreement. CMS concluded that payments made to PCH residents were not available to the state to use as a Medicaid match and turned down the proposal. CMS also stated that PCHs are not recognized as Medicaid providers under the Social Security Act.¹⁶

At this time, there does not appear to be a practical plan to apply Medicaid funds to PCHs.

Medicaid Costs For Residents

Medicaid pays for health and behavioral health services for most state supplementation recipients. In FY 2011, Medicaid paid a total of \$14 million for services for 1,800 personal care home residents.

Medicaid pays for health and behavioral health services for most state supplementation recipients in PCHs. The Department for Medicaid Services reported that in FY 2011, Medicaid paid a total of \$14 million for coverage of 1,800 PCH residents. The state's share was approximately \$4 million, or \$2,226 per Medicaid member.^m Table 2.3 lists the categories of service used by at least 25 percent of the eligible members. The categories with the highest percentage utilizations were pharmacy and physician services—each with approximately 93 percent—and outpatient hospital with nearly 69 percent.

¹ This includes both freestanding and nonfreestanding personal care facilities. Program Review staff applied the Federal Medical Assistance Percentage of 71.49 percent for Kentucky for FY 2011.

^m Program Review staff applied the Federal Medical Assistance Percentage of 71.49 percent for Kentucky for FY 2011.

There are Medicaid costs in addition to covered services. The state Medicaid program pays some Medicare premiums for residents who are eligible for both programs, called the Medicare Buy-in Program. In FY 2011, the premiums for Part A were \$78,454 for 15 recipients. The premiums for Part B were \$1.42 million for 1,170 recipients.

Table 2.3
Personal Care Home Medicaid Recipient Service Utilization
Most Frequently Used Categories Of Service
FY 2011

Category Of Service	Total Paid	Claims	Recipients	Percent Utilization
Pharmacy	\$5,995,637	101,827	1,680	93.3%
Physician	687,988	20,353	1,671	92.8
Outpatient hospital	547,254	6,452	1,234	68.6
Community mental health	2,061,412	30,144	1,031	57.3
Independent lab	59,688	5,766	999	55.5
Podiatry	39,262	1,930	789	43.8
Durable medical equipment	188,521	3,756	604	33.6
Transportation	67,532	1,849	605	33.6
Preventive care	26,124	845	502	27.9

Note: This includes data for all PCH recipients—those in freestanding and nonfreestanding PCHs.

Source: Dept. for Medicaid Services.

Kentucky's Costs Associated With PCH Residents

The state's estimated costs associated with personal care home residents were approximately \$28 million in FY 2011.

Many of the funding sources listed above consist wholly or partly of state general funds. Table 2.4 presents an overview of the state's costs associated with PCH residents.

Table 2.4
Costs To The State Related To Personal Care Homes
FY 2011

Item	Cost
State supplementation paid for PCH residents	\$16,356,598
Mental Illness or Mental Retardation Supplement Program	285,692
Amounts paid to contractors of specialized PCHs (state-owned PCHs)*	
• Caney Creek	4,449,138
• Bluegrass PCH	1,400,963
• Center for Rehabilitation and Recovery	1,561,265
State expenditures for Medicaid services**	4,006,935
Kentucky Medicare Buy-in premiums**, ***	427,657
Total	\$28,488,248

Note: All amounts except those for specific PCHs include both freestanding and nonfreestanding PCHs.

*These funds are paid to PCHs in addition to any state supplementation funds and help pay for the care of all residents, not just state supplement recipients. A portion of the Center for Rehabilitation and Recovery funding was spent supporting some clients who resided in the community. Their PCH beds were not used.

**This is based on information provided by the Department for Medicaid Services. These amounts were calculated by applying the Federal Medical Assistance Percentage of 71.49 for FY 2011 to the Medicaid services expenditure of \$14,054,489 and the Medicare Buy-In premiums of \$1,500,025.

***This may slightly overvalue state payments because federal funds might pay a few recipients' premiums.

Sources: Kentucky. Cabinet for Health and Family Services. Dept. for Community Based Services. "PA-264-St. Suppl. Part B. State Supplementation To Aged, Blind, And Disabled Persons." "July 2010 – June 2011." Frankfort: DCBS; Information provided by Dept. for Community Based Services; Eric Friedlander. Letter to Bruce Scott. March 16, 2012; Information provided by Dept. for Medicaid Services.

The state's FY 2011 cost per supplementation recipient was approximately \$9,600.

Because these costs were associated almost exclusively with state supplementation recipients, dividing the total for FY 2011 by the number of personal care supplement recipients that year gives a rough estimate of \$9,600 per recipient.ⁿ This number is not exact because specialized PCH funds paid for some residents who are not supplement recipients. Medicaid officials also acknowledged that the dates showing when a recipient moved in or out of a PCH might not be accurate, leading to additional uncertainty.

ⁿ Program Review staff used 2,964, the number of personal care recipients for FY 2011 from the cabinet's annual PA-264 report. The cabinet acknowledged that the report had included 75 more cases in June 2012 and that this overcount had affected multiple years. Assuming a similar overcount in 2011, the estimated cost per recipient might be nearly \$9,900.

Costs To Operate A PCH

The information in Table 2.5 is from a national cost of care survey that presented the median annual costs of various types of long-term care in the country and by state. The table also includes the charges of Kentucky's PCHs for comparison.

Table 2.5
Median Costs For Various Types Of Long-Term Health Care In Kentucky
2012

Type Of Care	Monthly Cost
Homemaker services	\$3,241
Home health aide services	3,241
Adult day health care	1,274
Assisted-living facility (one bedroom, single occupancy)	2,741
Kentucky private-pay personal care home*	3,330
Kentucky supplement personal care home**	1,158
Nursing home semiprivate room	5,750
Nursing home private room	6,296

Note: The monthly costs except those noted below are calculations by Program Review staff based on median annual costs in the Genworth survey.

*Average This amount is the average based on the Program Review staff survey of PCHs.

**This amount is the Kentucky state supplementation rate.

Source: Genworth Financial Inc. *2012 Cost of Care Survey*. Richmond: Genworth, 2012. P. 38.

Administrators of PCHs that accept the state supplement often reported that they were unable to improve their services or residents' living conditions with only the \$1,158 they received each month for each resident.

The assisted-living facility shown in the table would be the entity most comparable to a Kentucky PCH. Its monthly cost was reported at \$3,300, which is similar to the cost of a private-pay PCH in Kentucky. Supplement PCH administrators often told Program Review staff that they were unable to improve their services or residents' living conditions with only the \$1,158 per resident they received each month. They also stated that they could not afford to renovate their buildings and that banks would not make loans to build new supplement PCHs.

One PCH operator provided a monthly operation cost breakdown. Table 2.6 shows the breakdown of this PCH's costs by types of expenses. Salaries represent the largest cost. The operator reported that food and utilities costs were increasing.

Table 2.6
Example Of Personal Care Home Operating Costs
2011

Cost Item	Percentage
Salaries	46.5%
Food	18.5
Utilities	10.0
Insurance	8.5
Other*	16.5

Note: The table does not include costs for interest, debt retirement, or unexpected expenses, or return on investment.

* "Other" includes medical expenses paid for residents, transportation cost to doctors, phone, office and janitorial supplies, and professional fees such as retainers for doctors and dietitians.

Source: Information provided by a PCH owner.

As will be discussed in Chapter 3, Program Review staff noticed a distinctly lower level of service and quality of life for residents at supplement PCHs compared to those in private-pay PCHs. The cabinet reported that it had requested increased funding in its 2008 and 2012 budgets, but the increases were not appropriated. The 1977 LRC report recommended that the state

should annually perform on-site financial audits of those long term care facilities [including personal care homes] ... receiving reimbursement either through the Medicaid program or from persons who receive State Supplementation funds An annual field audit should benefit both the facility operator and the taxpayer. Audits may reveal that current reimbursement rates are inappropriate. Similarly, the audit would assure taxpayers that state monies were being properly spent for services rendered.¹⁷

The information from such an audit would be helpful to cabinet officials and members of the General Assembly.

Recommendation 2.1

Recommendation 2.1

The Cabinet for Health and Family Services should propose a state supplementation rate-setting process that would involve a periodic financial audit of personal care homes accepting state supplementation recipients. The cabinet should present the proposal, including its projected costs, to the Program Review and Investigations Committee by October 1, 2013.

Costs Paid By Personal Care Home Residents

PCH residents must pay for their own medical and other expenses. State supplement recipients receive a \$60 monthly personal needs allowance with which they must pay medical and other expenses.

PCH residents must pay for their own medical and other expenses. State supplement recipients receive a personal needs allowance and Medicaid benefits. They may also have other sources of payment for medical care, such as Medicare or veterans' medical benefits. Private-pay residents of supplement PCHs have low incomes and sometimes high medical expenses. This section discusses some of the issues related to PCH residents' costs.

Personal Expenses

Personal expenses at supplement PCHs include clothing, transportation, off-site entertainment, soft drinks, tobacco, and anything else the resident wants to buy with the \$60 allowance. Most supplement PCH administrators reported that residents who smoked usually ran out of money before the end of the month. Some administrators said they made arrangements to purchase low-cost cigarettes in bulk for their residents.

Health And Behavioral Health Services— Supplement Recipients

Federal laws and regulations require states to provide Medicaid to at least some SSI recipients.^o Most states, including Kentucky, make Medicaid automatic upon qualification for SSI. Kentucky also automatically provides Medicaid eligibility to everyone receiving the supplement, even if they do not also receive SSI (907 KAR 1:011, sec. 2(1)).¹⁸

States administer their Medicaid programs within broad federal guidelines. They are required to cover certain benefits but can choose whether to provide other optional benefits. The Kentucky Medicaid program covers services such as physician, behavioral health, pharmacy, medical transportation, and care in hospitals and nursing homes.

According to the cabinet, residents of personal care homes should not be subject to Medicaid copayments. Previously, some were, but that should have been corrected. Affected providers and recipients may recover these overpayments.

Coverage for some Kentucky Medicaid groups includes copayments, but according to the cabinet, residents of PCHs should not be subject to cost sharing. However, there have been many documented cases of PCH residents' being charged copayments. Medicaid officials stated that all known cases had been corrected and that in the future all PCH residents should have

^o An agency must provide Medicaid to aged, blind, and disabled people receiving or deemed to be receiving SSI (42 CFR, sec. 435.120). However, an agency may choose to apply more restrictive eligibility requirements (42 CFR, sec. 435.121).

no copayments. Affected providers and recipients should contact the cabinet to ensure that the problem is corrected in the Medicaid system, then reverse and resubmit the affected claims in order to recover the copayments.

The institution for mental diseases (IMD) exclusion prohibits Medicaid from paying for any covered services for people who are patients at IMDs.

Institutions For Mental Diseases. Medicaid’s coverage of services for people with SPMI is limited by a federal mandate that the states must pay the entire cost of care for residents of psychiatric institutions. Historically, states paid for psychiatric hospital care, and Congress enacted an exclusion to ensure that states continued to do so. The institution for mental diseases (IMD) exclusion prohibits Medicaid from paying for any covered services for people who are patients at IMDs, whether provided at the facility or off site and whether provided by the facility or by other providers. It applies to adults from age 22 to 64 in institutions with more than 16 beds (42 CFR, secs. 435.1009(a) and 435.1010).

Kentucky’s three specialized mental health PCHs, four state psychiatric hospitals, and two state psychiatric nursing facilities are IMDs. Therefore, Medicaid does not cover any expenses for members from 22 to 64 years old while they are residents of these facilities.

As part of the Eastern State Hospital replacement, one specialized PCH is being replaced with four distinct 16-bed facilities that are smaller than the IMD exclusion requires. In order to avoid the exclusion, however, the state would have to demonstrate that the smaller facilities were not operated in any way as a single entity.¹⁹

Some residents with Medicare and Medicaid (“dual eligibles”) were reported as having difficulty paying for medical expenses.

Medicare With Medicaid. Some PCH administrators and state guardians reported that some residents with Medicare and Medicaid had trouble paying for medical expenses. For these “dual eligibles,” Medicaid is the secondary payer and picks up the remainder of covered expenses after Medicare pays. Those expenses may include copayments and coinsurance for medical expenses under Medicare. Medicaid also pays any premiums for Medicare’s hospital and medical insurance programs.

Medicaid is not permitted to pay for the prescription costs of dual-eligible members. However, all state supplement recipients qualify for some level of Medicare low-income “Extra Help,” meaning that Medicare prescription plans are available with no premium, no deductible, and small copayments. Dual eligibles with monthly incomes of \$931 or less pay \$1.10 for generics and \$3.30 for brand-name drugs; those with higher incomes pay \$2.60 and \$6.50.²⁰

Copayments for a large number of brand-name prescriptions might consume a significant portion of a resident's \$60 monthly allowance. If a resident had insufficient funds to pay for prescriptions and needed items such as clothing, the PCH would have to discharge the resident or agree to pay the excess expenses out of PCH funds.

Recommendation 2.2

Recommendation 2.2

The Cabinet for Health and Family Services should propose a method for setting the personal needs allowance for state supplementation recipients based on a periodic assessment of personal expenses. The cabinet should present the proposal, including its projected costs, to the Program Review and Investigations Committee by October 1, 2013.

Health And Behavioral Health Services— Private-Pay Residents

Private-pay residents must pay their medical expenses using whatever resources they have.

Private-pay residents must pay their medical expenses using whatever resources they have, such as Medicare, other retirement insurance, or other resources. The PCH is not responsible for those expenses and must discharge residents who cannot afford to obtain necessary medical care unless the PCH is willing to cover the medical expense itself.

Medicaid Spend Down. Individuals who have significant health care costs but income that is too high to otherwise qualify for Medicaid can still become temporarily eligible by “spending down” the amount of income that is above the medically needy income standard.²¹ Individuals spend down by incurring and paying expenses for medical and remedial care. After they have paid enough to bring their income below the Medicaid standard, they can apply for Medicaid to cover the remaining expenses.

Some supplement PCHs' administrators reported that some residents with Medicare had difficulty paying for the personal care home and their medical expenses.

Medicare Alone. Some supplement PCHs accept low-income private-pay residents, and the administrators reported that some of these residents with Medicare had difficulty paying for the PCH along with their medical expenses. Typically, these residents would be recipients of Social Security retirement or disability benefits that exceeded the state supplementation standard of need. The difference is that without Medicaid, the resident is responsible for all Medicare premiums and cost sharing for all Medicare-covered services.

Low-income Medicare recipients with significant health care expenses might qualify for the Medicaid spend-down benefit described above. However, Medicaid cannot cover Medicare prescription expenses even with the spend-down benefit. Some PCH administrators and state guardianship reported that they assisted residents in applying for spend-down coverage.

Chapter 3

Personal Care Home Operations

This chapter describes how PCHs operate and the services they provide. It focuses primarily on supplement PCHs and the residents who live in them.

Where Residents Come From

Residents with severe and persistent mental illness made up the largest group in supplement personal care homes. Most are referred by a psychiatric hospital, another personal care home, or a general hospital.

Although the exact numbers of residents with different conditions living in supplement PCHs are unknown, most of them have a severe and persistent mental illness. Smaller numbers have intellectual or developmental disabilities, are elderly, have physical disabilities, or have an acquired brain injury (ABI). Data from the Cabinet for Health and Family Services for FY 2012 showed that, in 24 of the 27 PCHs that participated in the MI/MR Program, over 90 percent of residents had SPMI or ID/DD.

Many residents, especially those with SPMI, were referred to the PCH by another facility. Data from a Program Review staff survey of residents suggested that psychiatric hospitals were the most frequent referral source, followed by other PCHs and general hospitals. A significant number of residents were reported to have come from home, but it was not known whether they were referred by someone like a therapist, case manager, or guardian.

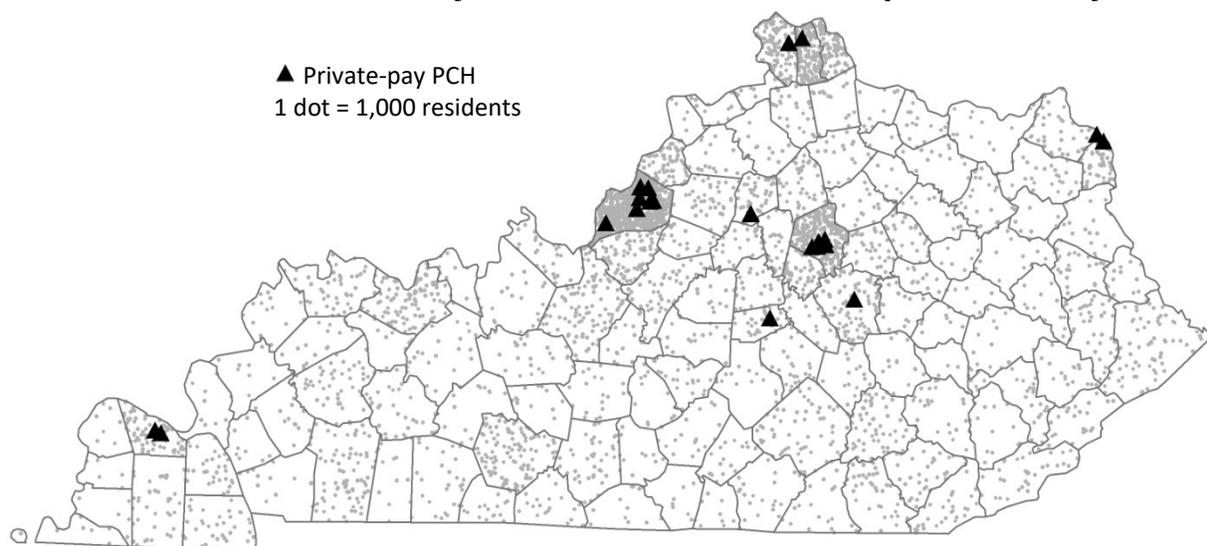
Many residents of supplement PCHs have guardians, mostly state guardians. The cabinet reported that 621 PCH residents were state wards, at least 83 percent of whom lived in supplement PCHs. That represents at least 22 percent of all supplement PCH residents reported in the Program Review staff survey.

Locations Of PCHs

Private-pay PCHs are concentrated in urban areas.

Using the OIG personal care home directory, Program Review staff mapped the locations of private-pay and supplement PCHs. Figure 3.A shows private-pay PCHs on a map along with the 2010 general population density for each county. Private-pay PCHs are clustered in Kentucky's urban areas. Of the 23 private-pay homes, 16 are in Fayette County, Jefferson County, and northern Kentucky. There are only two such homes east of Madison County or west of Jefferson County.

Figure 3.A
Locations Of Private-Pay Personal Care Homes And Population Density



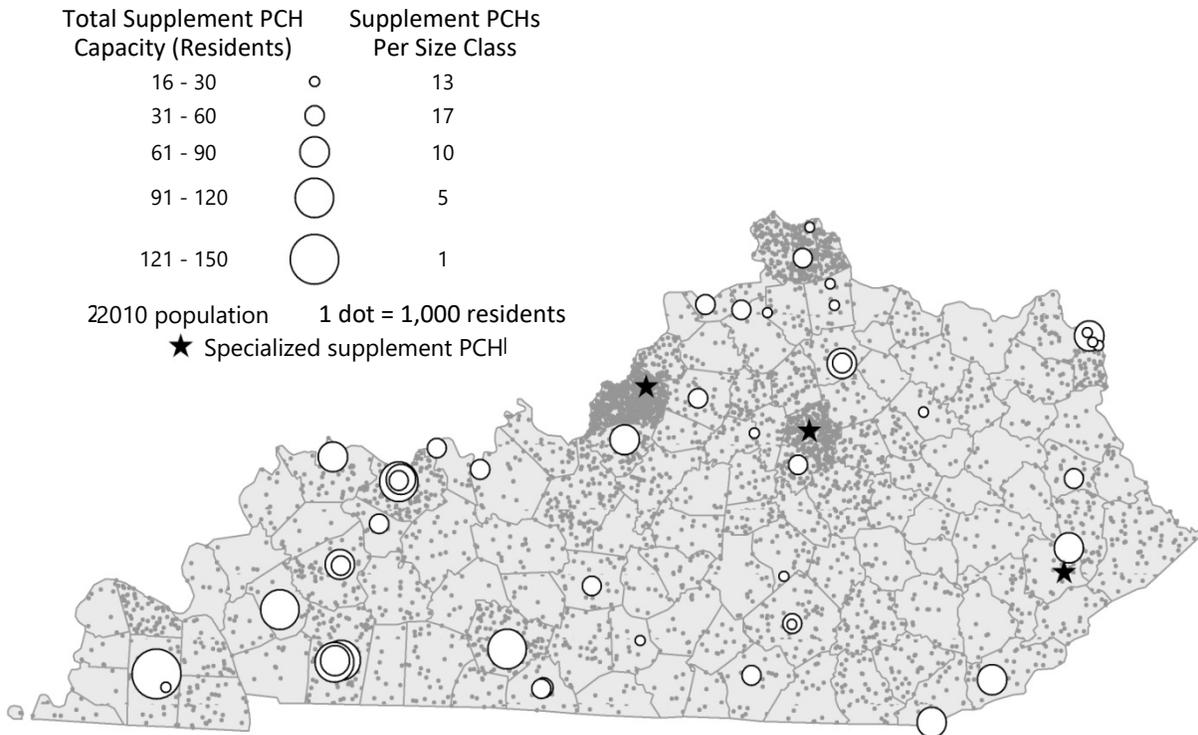
Note: Not all private-pay personal care homes are visible because some icons overlap.

Source: Compiled by Program Review staff from its survey of personal care homes; data from the 2010 US Census; Kentucky. Cabinet for Health and Family Services. Office of Inspector General. "Personal Care Homes." June 2012. Web. June 21, 2012.

Supplement PCHs are almost exclusively located in rural areas or small towns. Prospective residents may have to move far from home, and services might not be readily available.

Supplement PCHs, which have significant resident populations suffering from mental illness, are almost all located in rural areas or small towns. The only supplement PCHs in Jefferson and Fayette Counties are specialized state-contracted PCHs; all others there have closed. Figure 3.B shows the total capacity of supplement PCHs, the number of PCHs per size class, and population density. The greatest capacity is in western and north central Kentucky. South central and eastern Kentucky have comparatively less capacity and large gaps where there are no PCHs.

Figure 3.B
Locations And Total Capacity Of Supplement Personal Care Homes
And Population Density



Note: The three specialized supplement PCHs do not show capacity because they are not intended as long-term residences.

Source: Compiled by Program Review staff from its survey of personal care homes; data from the 2010 US Census; Kentucky. Cabinet for Health and Family Services. Office of Inspector General. "Personal Care Homes." June 2012. Web. June 21, 2012.

In locations with few or no PCHs, prospective residents may have to move far away from their home communities. Rural PCH residents may have limited access to needed services.

In locations with few or no PCHs, prospective residents may have to move far away from their home communities, placing additional stress on people who may already be in a compromised mental or physical state. For PCH residents, location affects the availability and quality of outside health care services, social opportunities, and transportation options. This is especially true for residents requiring behavioral health services. Program Review staff's interviews and observations indicate that behavioral health treatment and services are sometimes not readily accessible to rural supplement PCHs.

Personal Care Services

To be eligible to stay at a PCH, the resident must be able to walk or to move about with assistive devices and to manage most daily activities.

The primary responsibility of PCHs is provision of personal care services. The basic criterion for staying at a PCH is that the resident must be

ambulatory or mobile nonambulatory, and able to manage most of the activities of daily living. Persons who are nonambulatory or nonmobile shall not be eligible for residence ... (902 KAR 20:036, sec. 2).

Ambulatory means able to walk without assistance. *Mobile nonambulatory* means able to move about and exit the building using assistive devices and able to transfer in and out of bed with minimal assistance (902 KAR 20:036, sec. 1).

PCHs are permitted to assist only minimally with mobility. Other personal care services include some assistance with activities of daily living like feeding, bathing, and grooming oneself; dressing and undressing; and toileting. PCHs are required to provide basic hygiene supplies (902 KAR 20:036, sec. 4(3)).

PCHs are not obligated to encourage residents to perform daily tasks, such as cooking, cleaning, and laundry. PCHs allowing these activities first obtained medical orders stating that there was a therapeutic purpose.

PCHs perform some daily tasks for their residents, such as cooking, cleaning, laundry, and assistance with medications. PCHs are not obligated to encourage residents to do these tasks for themselves. Some supplement PCH administrators told Program Review staff that they were hesitant to permit residents to do any of these things because it might appear that residents were being forced to do so. The administrators who did permit residents to perform some of these tasks reported that for the PCHs' protection they first obtained medical orders stating that it was therapeutic for the residents.^p

PCHs also are not required to encourage or assist residents with other tasks that are normally associated with independent living, such as managing money, shopping, using a telephone, and driving or using transportation. Many supplement PCH administrators reported providing some assistance with these tasks, particularly with managing money.

People with SPMI average much shorter life spans than the general population. Supplement PCHs did not appear to encourage residents to adopt healthy lifestyles.

According to research, people with SPMI average much shorter life spans than the general population; various factors, including lifestyle, were suggested.²² Observations by Program Review staff suggested that some supplement PCHs at least occasionally encouraged residents to go outside to walk or play outdoor games.

^p Regulation does specifically permit residents to do their own laundry if they want and if the PCH provides that option (902 KAR 20:036, sec. 4(2)(b)3).

However, it appeared that residents generally exercised very little. Most supplement PCH administrators who spoke with staff reported a high demand for cigarettes among residents, and Program Review staff observed several residents smoking outside supplement PCHs. It does not appear that these PCHs make consistent efforts to encourage residents to adopt healthy lifestyles.

Medical Orders

Regulations say that a PCH must have a medical order for anything that might be considered a therapeutic activity or special diet, whether it is provided by PCH staff or an outside provider.

Regulations say that a PCH must have a medical order for anything that might be considered a therapeutic service or activity or a special diet, whether it is provided by PCH staff or an outside provider (902 KAR 20:036, secs. 4(1)(b), and 4(2)(c)4.b). Some personal care services might fall within this requirement, and all the health and behavioral health services described in the following sections do. Although PCH administrators asserted that they would never use restraints, any kind of restraint also requires a specific time-limited medical order and may be used only for specified purposes (KRS 216.515(6); 902 KAR 20:036, sec. 4(1)(h)).

Health Services In Personal Care Homes

Under Kentucky law, PCHs are health facilities and long-term care facilities.

Because residents of PCHs either are elderly or have a disability, they often have health care needs in addition to personal care needs. Under Kentucky law, personal care homes are health facilities and long-term care facilities. They operate primarily under KRS Chapter 216 and Chapter 216B and related regulations. In 902 KAR 20:036, sec. 4(1), the cabinet set the minimum service requirements. The language does not explicitly mention additional services, but it implies that additional health services such as medication administration are permitted.

All personal care homes shall provide basic health and health related services including: continuous supervision and monitoring of the resident to assure that the resident's health care needs are being met, **supervision of self administration** of medications, storage and control of medications, when necessary, and making arrangements for obtaining therapeutic services ordered by the resident's physician which are not available in the facility [emphasis added].

Personal Care Homes And Other Residential Settings

PCHs and assisted-living communities help residents with various activities. However, assisted-living staff cannot administer medications or perform any nursing tasks. A PCH may hire nurses and provide some nursing services.

The PCH as a living arrangement overlaps with assisted living. Assisted-living communities are not health facilities, so they cannot administer medications or perform any nursing tasks. Both assisted-living communities and PCHs, on the other hand, provide assistance with various activities such as bathing, grooming, shopping, providing meals, and remembering to take medications. Generally, assisted-living residents need less assistance with these activities than PCH residents do.

Kentucky's statutory definition of *assisted living* differs from that of other states. Private-pay PCH administrators told Program Review staff that they needed to have a Kentucky PCH license in order to provide the intensity of nursing assistance they provided in other states under the label of assisted living. Private-pay PCHs generally employ nurses and provide basic health services such as administering medications, monitoring vital signs like blood pressure, and assessing health status.

As a health facility with intensity of services below that of a nursing home, a PCH may hire nurses and may have a medical director. The Program Review staff survey showed that all but one of the private-pay PCHs had nursing staff, but only 44 percent of supplement PCHs did. However, a PCH must ensure that its health services do not reach the intensity of nursing home services.

Permitted Health Services

Health services provided by a PCH are limited largely by nursing laws and regulations.

The health services that a PCH may provide are limited largely by nursing laws and regulations. A review of nursing laws and cabinet regulations and discussions with the Kentucky Board of Nursing, Kentucky Board of Medical Licensure, and the cabinet indicated the following:

- Nursing laws and regulations determine the health care tasks that constitute the practice of nursing. Anyone who performs nursing tasks, except by personal and private arrangement with the patient, is practicing nursing.
- Nursing rules determine who may and may not perform nursing tasks and what kinds of supervision are required, but they do not specify which tasks may be performed in a PCH.
- The cabinet, working within the laws that govern nursing and medicine, may limit the health care services that a PCH may provide.

- All health services that PCHs provide must be at the order of a physician or other licensed medical professional. The orders may be time-limited or standing orders.
- PCHs that do not employ or contract with nurses may not provide any nursing services. In particular, they may only assist with self-administration of medications. It does not matter whether the PCH employs staff with titles similar to “certified medication technician” or “Kentucky medication aide.” Such PCHs in effect may provide only the services that assisted-living communities are permitted to provide with the addition of keeping medications locked in a central location.
- PCHs that employ or contract with nurses may carry out medical orders for health services that do not reach the intensity of nursing home care. These services may be performed by the nurses themselves and by PCH staff who are formally trained, delegated, and supervised by nurses.
- It is the responsibility of PCHs to ensure that their staff are qualified to carry out medical orders properly.
- If a PCH receives an order for a health service that it cannot perform, it is obligated to arrange for the service from another provider or to transfer the resident to another facility, depending on the type of service required (902 KAR 20:036, sec. 3(6)(b)).

Some of these conclusions and others below are based on Kentucky Board of Nursing advisory opinions and do not carry the force of law.

PCH residents may receive services from outside health providers as long as the level of care does not exceed that of a nursing home.

PCH residents may receive services from outside providers, including home health agencies, physical therapists, dentists, medical providers, behavioral health providers, and others as long as the intensity of services remains below that of a nursing home. Several supplement PCH administrators reported making arrangements for physicians or other medical professionals to visit residents on a regular basis at the facility. One administrator also reported arrangements with an ophthalmologist and a podiatrist. The PCHs do not pay these providers, but the providers bill the residents’ insurance, usually Medicaid.

When a resident requires health services off site, the PCH is required to set up appointments if necessary and arrange transportation. Usually supplement PCHs try to use Medicaid transportation services, but administrators reported that the providers usually required a 72-hour notice and imposed other limitations that made it difficult to use the service. The administrators reported that PCH staff often transported residents instead.

Medication Administration. A service that PCH administrators mentioned frequently was medication administration. As defined in statute,

Components of medication administration include but are not limited to:

1. Preparing and giving medications in the prescribed dosage, route, and frequency ... (KRS 314.011(6)).

Kentucky Board of Nursing Advisory Opinion Statement 15 states that

the administration of medication is the practice of nursing. The administration of medication to patients in health care facilities is both the responsibility of nurses and an integral part of the nursing care rendered to patients.²³

Nurses may train and delegate unlicensed staff to perform some types of medication administration. The Kentucky Board of Nursing explained the distinction between assistance with self-administration and actual administration of medications.

Nurses may train unlicensed staff and delegate them to perform some types of medication administration. Unlicensed staff who are not so delegated may not perform these tasks and may only assist with self-administration.

Kentucky Board of Nursing officials indicated that the distinction between assistance with self-administration and actual administration of medications considers the following:

- If a resident were aware and able to decide what medications to take and when to take them, and if the resident requested assistance, then actions by PCH staff to remind the resident about medications, open bottles, place medications in the resident's hand, and even guide the resident's hand would be assistance with self-administration.
- If the resident were unaware or otherwise unable to make an informed decision to take a medication, and PCH staff gave it anyway, that would require nursing judgment and would constitute medication administration.
- If the amount of medication ordered were nonspecific—for example, “one or two tablets”—then PCH staff might remind the resident that it was time to take the medication, but advising the resident how many to take—effectively determining a dosage—would require nursing judgment and would constitute medication administration.
- If a medication were ordered “as needed,” then PCH staff might remind the resident that the medication was available, but advising the resident to take it—effectively determining when a medication was needed—would require nursing judgment and would constitute medication administration.

Nurses may delegate the administration of controlled substances to unlicensed staff. Regulations are unclear about whether unlicensed PCH staff may perform such administration.

Nurses are permitted to delegate the administration of controlled substances to unlicensed staff. The cabinet’s regulation suggests that unlicensed PCH staff may not administer controlled substances, although the wording is not clear:

There shall be a controlled substances bound record book with numbered pages, in which is recorded ... the name of the nurse who administered it, or staff who supervised the self-administration (902 KAR 20:036, sec. 4(1)(e)).

The conditions under which PCH staff with “medication aide” or similar titles may administer medications are potentially confusing. Cabinet regulations mention medication aides at PCHs—referred to as “certified medication technicians”—only for facilities that participate in a special program: the MI/MR Program. According to 921 KAR 2:015, sec. 12(1)(c)3,

[a participating PCH must have] a licensed nurse or an individual who has received and successfully completed certified medication technician training on duty for at least four (4) hours during the first or second shift each day.

Cabinet officials told Program Review staff that a certified medication technician is a state registered nurse aide with at least 6 months’ experience who has also completed the Kentucky medication aide (KMA) course offered by the Kentucky Community and Technical College System and has passed the corresponding exam. The nursing board, which maintains the database of nurse aides, stated that it does not keep records of KMA completion. College system staff explained that the system developed the current course and exam based in part on a national certification program, but the course is not nationally certified. College system staff reported that they have records of students’ results since the course was first offered in 2001 and records of a previous course since 1991.

The cabinet was unable to provide an authoritative description of the KMA certification in statute, regulation, or written policy. There also is no authoritative statement that the KMA certification represents the certified medication technician requirement in the PCH regulation or the similar titles used in regulations that apply to other long-term care facilities. The cabinet should define the KMA and related titles in regulation and at a minimum identify the course materials among the items included in regulation by reference.

The Kentucky Board of Nursing specifies that Kentucky medication aides are permitted to administer some medications only through delegation by and under supervision of a nurse.

KMAs are subject to the same nursing rules as other unlicensed PCH staff. The Board of Nursing’s Advisory Opinion Statement 15 states:

In Kentucky, unlicensed personnel known as medication aides or similar titles, may function by administering oral and topical medication in long-term care facilities only through delegation by and under the supervision of a ... nurse. Unlicensed personnel who function as medication aides must have successfully completed the state approved course for administration of medication as defined in the administrative regulations issued by the Cabinet for Health and Family Services, Office of the Inspector General.

The opinion implies that where there are KMAs, they must operate under nurse delegation in order to administer medications. Therefore, PCHs with KMAs must have a nurse who delegates to and supervises the aides. Otherwise, the aides may not administer medications.

Other staff at PCHs in the MI/MR Program may also administer medications if a nurse delegates the task to them. A KMA may not delegate any nursing tasks.

The board requires that only nurses calculate dosages, fill syringes, and administer injections.

An important health service for PCH residents is the administration of injectable medications, especially insulin for residents with diabetes. Some PCH residents also require injections of antipsychotic medications. Discussions with the Board of Nursing officials led to the understanding that

- only nurses may calculate dosages, fill syringes, and administer injections;
- unlicensed PCH staff, including KMAs, may not calculate dosages, fill syringes, or administer injections; and
- unlicensed PCH staff may, without delegation, take blood glucose readings for a resident and give the information to the resident along with a reminder of the physician’s order, but the resident must self-administer the insulin.

The Kentucky Association of Health Care Facilities issued a notice to PCHs in February 2012 asserting that the cabinet had agreed that “medication aides” could inject routine—predetermined—dosages of insulin but not dosages that required a calculation. OIG confirmed its understanding that the Board of Nursing was open to developing an insulin injection training program for PCH staff. Board officials told Program Review staff that training had been discussed contingent on the board’s changing its opinion

statement; however, the board reaffirmed its opinion in October 2012, so injections may not be delegated.

Recommendation 3.1

Recommendation 3.1

The Cabinet for Health and Family Services, through regulation or written guidance referenced in regulation, should

- **clarify the health services that personal care homes may provide, including what staff may do when there is or is not a nurse to delegate nursing tasks, consistent with nursing laws and practice, and**
- **uniformly define the title, education, and certification requirements for certified medication aides in personal care homes and other long-term care facilities.**

Hospice care at personal care homes is problematic. PCH administrators stated that, upon becoming immobile, a resident must be transferred to a nursing facility or hospital.

Hospice Care. Some PCH administrators, especially at private-pay PCHs, reported that hospice care is problematic. When a terminally ill person is living at home, hospice services often make it possible, if the person wishes, to die at home. In PCHs, hospices sometimes provide services to terminally ill residents, but regulations require the PCH to transfer a resident as soon as the resident is no longer mobile. According to PCH administrators, this has required the resident to move to a nursing facility or hospital a few days before dying, creating a significant emotional disruption for the resident and family. Some administrators felt strongly enough to say that if a dying resident wanted to stay, they would keep the resident and risk being cited.

OIG officials stated that the hospice issue has been under discussion, but there is no specific policy for it yet. In general, if a resident were nonmobile or needed hospice nursing services for an extended period, that would be problematic, but a brief period while actively dying, if clearly documented, would be acceptable. The time period is not defined.

The requirement that PCH residents must be mobile is not in statute but in regulation. The statute simply requires that no services be provided at the intensity of services found in a nursing home. Hospice services, which are often provided in private homes, would not necessarily reach that intensity. The cabinet appears to have the authority to create an exception for hospice services in PCHs.

Recommendation 3.2**Recommendation 3.2**

The Cabinet for Health and Family Services should consider specifying how personal care home residents who receive hospice services may die in place if they wish to do so and if it is medically appropriate.

Behavioral Health Services

PCH residents with SPMI or intellectual or developmental disabilities have additional needs. Because of the preponderance of these conditions among supplement PCH residents, this section describes the services available to address behavioral health needs. It specifically considers behavioral health treatment options and potential for improvement.

Behavioral health treatment attempts to achieve the highest level of functioning that each client is willing and able to achieve. Clients are free to make decisions about what goals to pursue and what treatment methods to use, except when there is imminent danger of death or serious harm to others.

An objective of behavioral health treatment is to achieve the highest level of functioning that each client is willing and able to achieve. The three elements in this process are the treatment, the client's potential, and the client's willingness.

Much literature in psychology deals with a client's reluctance to agree with treatment goals or to pursue them. For example, the diagnostic code V15.81 deals with noncompliance.²⁴ However, the law and professional ethics are clear that the client is free to make the decision about what goals to pursue and what treatment methods to use, except when there is imminent danger of death or serious harm to the client or others.²⁵ Unless otherwise noted in this report, it is assumed that the client agrees with treatment goals and is willing to participate.

No Treatment By Personal Care Home Staff

Regulation states that personal care homes shall provide social and recreational activities for residents. Office of Inspector General (OIG) surveyors did not appear to expect activities to assist residents toward more independence.

Regulation at 902 KAR 20:036, sec. 4(4) requires:

- (a) A personal care home shall provide social and recreational activities to: stimulate physical and mental abilities to the fullest extent; encourage and develop a sense of usefulness and self respect; prevent, inhibit or correct the development of symptoms of physical and mental regression due to illness or old age, be of sufficient variety that they meet the needs of the various types of residents in the home ...
- (b) 2. There shall be a planned activity period each day. The schedule shall be current and posted.

3. The program shall be planned for group and individual activities, both within and outside of the facility ...
5. A living or recreation room and outdoor recreational space shall be provided for residents and their guests.
6. The facility shall provide supplies and equipment for the activities program.
7. Reading materials, radios, games and TV sets shall be provided for the residents.

This regulation can be interpreted to require activities intended to assist residents toward more independence. However, it does not appear that OIG has enforced it in this manner. The office's surveyors occasionally noted that the activity schedule was not posted, but Program Review staff did not find any evidence that surveyors found deficiencies related to the quality and effectiveness of supplement PCH activities.

Typical activities at supplement personal care homes included "movie night," "coloring," and "take a walk." Kentucky Protection and Advocacy stated that a common resident complaint was that outings were rarely planned.

Program Review staff observed activity calendars at several supplement PCHs and found that activities such as "coloring," "movie night," and "take a walk" were typical. Movies were provided at the PCH, not at a theater. Activity supplies often included coloring books and some board games. Usually at least one local church group or minister visited the PCH weekly. Only one of the observed supplement PCHs offered organized offsite outings, and that was once per month. These observations were consistent with the findings of Kentucky Protection and Advocacy.²⁶

A 1972 report by the Governor's Advisory Council on Mental Retardation showed some activity calendars used at one PCH serving people with ID/DD. The calendars included a weekly outing to go bowling, a monthly fishing trip, a 4-hour unspecified activity period 4 days a week, and additional activities. There were church services or church visits at the PCH by three churches.²⁷ None of the supplement PCHs visited in 2012 had as many or as varied activities as those shown on the 1972 calendar.

Kentucky Protection and Advocacy reported similar observations of 20 supplement PCHs that it surveyed in 2011:

A common complaint that residents made was that the PCH rarely planned an outing. One PCH takes the residents out once a year to go shopping if the resident has any money. Residents stated church groups come to some of the PCHs weekly. Bookmobiles visit from the local library in several

PCHs instead of individuals going to the public library. Many residents remarked that they only went on outings into the community if they attended Therapeutic Rehabilitative Program²⁸

The Mental Illness or Mental Retardation Supplement Program allows participating PCHs to receive small supplemental payments and subjects them to additional requirements.

Mental Illness Or Mental Retardation Supplement Program.

As of June 2012, 27 freestanding supplement PCHs participated in the program known as the “MI/MR Program.” Those PCHs receive a small supplemental payment and are subject to some additional requirements. They must

- continuously serve residents, at least 35 percent of whom have a mental illness or intellectual disability (MI/ID);
- have a licensed nurse or KMA on duty at least 4 hours during the first or second shift each day;
- have at least one and up to five nurses or KMAs attend a basic training on MI/ID if the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) offers the training; and
- provide regular activities that meet the needs of residents, including individual activities such as reading if a resident does not participate in group activities (921 KAR 2:015, secs. 12 to 14).

The regulation is inconsistent regarding the purpose of required activities. Although it indicates that an activity should “meet the needs” of residents with MI/ID, it then gives an example of an activity—reading—that appears to have little likelihood of meeting the special needs of someone with one of those conditions. It also exempts PCHs from having to develop individual care plans related to the individual activities (921 KAR 2:015, sec. 14(2)(b)4).

The training information provided by DBHDID listed the following topics:

- Signs and symptoms of major types of mental illness and intellectual disability
- Common psychiatric medications and potential side effects
- Supervision and residents’ rights
- Therapeutic and rehabilitative activities, described as “leisure and recreational activities”
- Links between hospital and community behavioral health services²⁹

Primary objectives of activities appear to be improvement of mood, decrease in stress, and general stimulation of thinking. The goal of the MI/MR Program training seems to be to improve medication administration and resident-staff interactions.

The activities topic appears to be the only one that might engage PCH staff in helping residents to achieve greater independence. A review of handouts from two training sessions showed that the primary objectives of the activities were to improve mood, decrease stress, and stimulate thinking generally. Activities ranged from “games requiring minimal skill and mental perception,” alphabet blocks, and building blocks to skill-building activities such as cooking and sewing. Physical exercise was included. There was brief mention of activities to help residents learn how to recognize signs and symptoms of illness and relapse and how to handle crises. Overall, the training materials focused on simple leisure and recreational activities and spent little time on developing skills for independent living.

The effect of the MI/MR Program training seems to be to improve medication administration and resident-staff interactions at participating PCHs. One PCH administrator commented that the training helped staff learn to notice psychiatric issues and medication side effects and led to improved procedures and infection control. It is not clear how much it encourages supplement PCHs to assist residents toward more independence.

PCH residents with SPMI do not receive any kind of behavioral health treatment from staff except for assistance with psychiatric medications.

Care Planning For SPMI. Office of Inspector General officials reported that care plans found at supplement PCHs often consisted of checklists with items like assistance with bathing. Supplement PCH administrators reported that their care plans also included any physician’s orders. The information about care plans is consistent with the idea that supplement PCHs do not provide behavioral health treatment or interventions and do not plan for their residents with SPMI to move toward more independence.

In summary, supplement PCH residents with SPMI do not receive any kind of behavioral health treatment from PCH staff except for assistance with psychiatric medications. The observed, reported, and required activities appear to be uniformly unrelated to the residents’ therapeutic needs.

Treatment Options In The Community

Community mental health centers provide treatment options for many PCH residents.

Many PCH residents receive services from community mental health centers (CMHC). The services most frequently provided to personal care clients were individual psychotherapy and visits to a psychiatrist. Some supplement PCH administrators asserted that CMHCs had reduced the availability of services, particularly therapeutic rehabilitation programs and access to psychiatrists. Cabinet data indicated that the use of therapeutic rehabilitation

services by personal care residents declined from 31 percent to 24 percent from 2006 to 2011 but that overall the number of personal care clients taking part at least once in any CMHC service had increased over the same period.⁹

Supplement PCH administrators reported that CMHCs in previous decades had sent psychiatrists and therapists to see residents at the PCHs. One administrator stated that the regional CMHC now had no psychiatrist; several administrators reported making their own arrangements for non-CMHC psychiatrists to visit residents on a regular basis at the facility. The PCHs do not pay the psychiatrists, but the psychiatrists bill the residents' insurance, usually Medicaid. Some supplement PCHs made arrangements for general physicians to monitor residents and write refill prescriptions when CMHC psychiatrists were not available or residents refused to see them. More study of the adequacy and accessibility of behavioral health services is needed.

Even using the services of CMHCs, it is not clear that residents with SPMI receive coordinated treatment that is designed to achieve improved functioning and greater independence. According to supplement PCH administrators, it is rare that residents with SPMI move into the community successfully using the resources that are currently available.

Inadequate behavioral health treatment for supplement PCH residents may have negative long-term effects on their ability to function in society.

If behavioral health treatment for supplement PCH residents is inadequate, it might have a negative long-term effect on their ability to function in society. There is evidence that early and appropriate ongoing treatment of mental illness can prevent or limit worsening of symptoms and prevent additional mental disorders.³⁰

Crowding At Personal Care Homes

Some supplement PCH administrators stated that it was not economically feasible to maintain operations with the number of beds permitted by regulation. OIG has issued variances to permit additional beds.

Some supplement PCH administrators told Program Review staff that it was not economically feasible to operate their facilities with the number of beds permitted by regulation. One supplement PCH that Program Review staff visited seemed to be more crowded than the others; staff found that it had received a regulatory variance allowing increased occupancy. OIG has approved at least nine variances to permit rooms with more beds than the space normally

⁹ The cabinet data include clients living in both nonfreestanding and freestanding PCHs. There are no comparable data available on the number of residents who had SPMI or ID/DD, so it is not possible to measure any changes in the availability of services.

would permit and at least seven to permit additional rooms with three or four beds. The office acknowledged that there may be additional variances that are not in its database because not all variances issued on paper were converted to its digital database.

Staffing At Personal Care Homes

This section discusses regulatory requirements for PCH staffing and describes staffing practices.

Staffing Regulations

By regulation, a personal care home administrator must have a high school diploma or GED or be a licensed administrator. No formal training on administration is required.

PCH administrators must have sufficient education to: maintain adequate records; submit reports requested by the board; and interpret any written material related to all phases of facility operation and resident's care. The administrator shall: be literate; be a high school graduate or have passed the General Education Development Test; be twenty-one (21) years of age or older; or ... [be] licensed as a [long-term care] administrator as provided by KRS 216A.080 (902 KAR 20:036, sec. 1(3)).[†]

There is no requirement that administrators receive formal training on the administration of a PCH or long-term care facility.

Personal care homes may not hire anyone listed on the state nurse aide abuse registry or anyone who has been convicted of certain crimes. All staff must meet certain training requirements.

PCHs may not be operated by or hire anyone who is listed on the state nurse aide abuse registry (KRS 216.532). PCHs may not hire anyone who has been convicted of certain felonies and misdemeanors related to theft; sale or abuse of illegal drugs; neglect, abuse, or exploitation of an adult; or sexual crimes (KRS 216.789). The Office of Inspector General surveyors have cited some PCHs for violating these requirements.

The regulation specifies certain training requirements for all PCH staff. The Office of Inspector General surveyors verify that training has been done. Some PCHs have been cited for inadequate training.

The regulation regarding staffing is vague; it relies on the PCH administrator's judgment to ensure that an adequate number of staff is present at all times.

The regulation about the level of staffing at PCHs is vague and relies on the PCH administrator's judgment to ensure that an adequate number of staff is present at all times. It requires at least

[†] As of July 2012, "nursing home administration" was changed to "long-term care administration" in KRS 216A.080.

one staff member awake and on duty on each floor of the facility at all times, and

The number of personnel required shall be based on: the number of patients; amount and kind of personal care, supervision, and program needed to meet the needs of the residents as determined by the definitions of care and services required in this administrative regulation (902 KAR 20:036, sec. 3(8)(g)).

The regulation also states that

If the staff to resident ratio does not meet the needs of the residents, the [Office of Inspector General] Division [of Health Care] shall determine and inform the administrator in writing how many additional personnel are to be added and of what job classification

No PCH administrators reported having received such a determination from the Office of Inspector General, and office officials reported they had never used this provision.

The regulation lists certain tasks that the administrator must assign to someone on the staff, though a single staff member may perform more than one task. In addition, the PCH must have a full-time person responsible for the food service at the facility. If the PCH provides therapeutic diets, then either the person responsible for food service must be a dietitian or nutritionist, or the PCH must consult with a dietitian or nutritionist.

Staffing In Practice

PCH administrators reported having multiple staff on duty through dinner. Most reported one staff person at night, sometimes for 60 or more residents.

All the supplement PCHs that Program Review staff visited had multiple staff present on first shift. The administrators reported that there were multiple staff on duty through the dinner meal, after which most reported minimum staffing of one person per floor through the evening and night. Most PCHs have only one floor, so only one person might be on duty to ensure the health and safety of 60 or more residents.⁵

If a resident at risk of elopement left during the evening, a single staff person would have to remain with the other residents. Even though there might be procedures for informing the administrator, family, guardians, and law enforcement, the resident might be difficult to find after going out of sight of the staff. There also may be other situations requiring more than one staff member. It is the

⁵ Program Review staff visited one PCH with a license for more than 60 beds that had one floor and one staff member at night. Another PCH with a similar license reported always having at least two staff members on duty.

responsibility of the PCH to determine whether it needs more staffing.

Supplement PCH staff are generally paid minimum wage or slightly above. Even certified staff are paid below market rates.

Supplement PCH administrators reported paying staff minimum wage or slightly above. Several administrators mentioned that they try to screen their job applicants to ensure that they care about the residents. They reported that some staff are dedicated and remain for years despite the low pay.

Even certified staff such as KMAs were paid below market rates. Administrators reported that it was difficult to retain staff after they were trained and certified as KMAs because they could easily find better-paying jobs in nursing homes. Some administrators with nurses reported that the nurses were retired or were relatives of the owners and were paid less than a typical nursing salary.

Expectations Of Personal Care Homes

PCHs are not required to provide therapy, treatment, or services designed to improve residents' ability to function in society.

Statutes and regulations do not require PCHs to provide any therapy, treatment, or services designed to improve the residents' ability to function in society. In practice, many supplement PCH residents receive some behavioral health services from community mental health centers, but according to PCH administrators, these services appear to achieve maintenance rather than improvement. Most administrators expressed skepticism that their residents would function as effectively or be able to succeed outside a PCH. These PCHs appear to provide custodial care for residents with little hope of independence.

Recommendation 3.3

Recommendation 3.3

The Cabinet for Health and Family Services should ensure that personal care homes serving people with mental illness or intellectual or developmental disabilities increase their efforts to encourage healthy lifestyles, provide stimulating activities, teach skills that could lead to greater independence, and facilitate meaningful integration with people in the community at large.

Recommendation 3.4

Recommendation 3.4

The Cabinet for Health and Family Services should develop a proposal to ensure that community mental health centers demonstrate that their clients in personal care homes who have mental illness or intellectual or developmental disabilities achieve increased integration into the community and engage in more independent activities. The cabinet should present the proposal, including its projected costs, to the Program Review and Investigations Committee by October 1, 2013.

Appropriateness Of Personal Care Homes

Before his death, Larry Lee's placement in a PCH was questioned by his family and others. He had an acquired brain injury and was later diagnosed with severe schizophrenia, psychosis, and alcohol abuse. He also had a history of occasional threatening or violent behavior.

Before Larry Lee died, his family and others questioned whether it was appropriate for him to reside at a PCH. This section considers residents' rights and safety risks, how people are admitted to PCHs, and the type of supervision they receive while there.

Lee had suffered a severe head injury at age 10, and personality changes were reported within a year. He was later diagnosed with severe schizophrenia, severe psychosis, and alcohol abuse, and he had a history of occasional threatening or violent behavior.

Lee had been a ward of the state since December 8, 2008, while he was a patient at Central State Hospital, a psychiatric hospital. He was discharged to the Falmouth Nursing Home, actually a PCH, for the first time in February 2009, but the family and his guardianship worker attempted to find a placement closer to home with services specifically for people with acquired brain injuries. In August 2009, Lee moved to an ABI group home, Community Opportunities in Somerset. Over the next year and a half, he was a patient in a psychiatric ward or hospital five times, returning each time to the Somerset group home.

On December 23, 2010, Lee was reported to have attacked a Community Opportunities staff member. On January 10, 2011, the facility notified the guardianship worker that it could no longer meet his needs, and on January 19 the facility gave notice that it was going to close. The group home social worker, the guardianship worker, and a cabinet ombudsman contacted numerous facilities, but all declined to accept him until he moved to Somerview PCH in Somerset on April 20.

The guardianship worker continued to attempt to find a brain injury placement for Lee but had no success. At Somerview, he

was reported to have threatened another resident and later to have set a fire, though his father said he denied doing so. At the time of the alleged fire, June 13, he was sent to Eastern State Hospital, and Somerview gave notice of discharge. A month later, on July 13, he moved to the Falmouth Nursing Home for the second time. He left without informing staff on August 4, and his remains were found on September 3.

Larry Lee was not the only person to have died after leaving a PCH.

Lee was not the only person to have died after leaving a PCH. Cabinet records indicated that on January 8, 2007, Larry Huff, a resident at Letcher County Golden Years PCH in Jenkins, left the facility. The incident was reported 17 hours later, and he was found dead a few miles away on January 18. News reports indicated that he had died from exposure to the cold.³¹

The report by the Office of Inspector General also noted that “The resident left the facility on six occasions between December 28, , 2006, and January 6, 2007, without staff knowledge” but was found and returned each time unharmed.³²

Elopement is the term used when residents at risk of harm leave without staff’s knowledge. Selected cabinet records showed several reports of elopements in which the resident returned safely. PCH administrators also recounted such incidents.

A review of selected cabinet records showed several reports of residents’ leaving PCHs without the knowledge of staff but being found unharmed. PCH administrators also recounted such incidents to Program Review staff. It appears that elopements, as these incidents are called, are not rare, and most are resolved safely.

Elopements also are not unique to PCHs. For example, the cabinet reported that in April 2008, a state ward residing at a PCH left a therapeutic rehabilitation center that he was attending and was found dead in Montana about a week later. In another case, it was reported that a woman with an intellectual disability left a group home in Pulaski County on June 24, 2012, and was found unharmed the next day.³³

Responsibility For Resident Safety

PCHs are responsible for the safety of residents and staff. They must respect the rights of residents, including the right to come and go at will, which might present risks.

Many supplement PCH residents have severe mental illnesses or intellectual or developmental disabilities, and a few elderly residents have mild dementia. All are living at a PCH partly because they had difficulty managing their lives on their own. Even though from time to time they may make decisions that other people consider inappropriate or ill advised, most of them have the same rights as everyone living in their own homes. Those rights, established in state and federal law, include the right to come and go as they please. For some residents, like Lee and Huff, leaving may be hazardous. PCHs have to strike a balance between

residents' rights and the safety of residents and staff. PCH administrators who spoke with Program Review staff all expressed concern that it was not possible to ensure the safety of residents who might not be capable of taking care of themselves and who leave without telling anyone.

Besides elopement, there are other safety risks. Some residents may exhibit intermittent violence; may refuse to take medically necessary medications such as insulin; may eat foods to which they are allergic, or otherwise refuse to follow prescribed diets; may refuse all efforts at personal hygiene; or may engage in other behaviors that could be harmful to themselves or others. Yet most of them have the right to refuse any personal care services, health services, or behavioral health services.

Regulations require continuous supervision of residents, but the cabinet's training explains that the facility must determine how much supervision is necessary for each resident.

According to 902 KAR 20:036, sec. 2, "Services provided include continuous supervision of residents" Continuous supervision does not mean that PCH staff watch every resident every minute. The cabinet's PCH administrator training explains that one-on-one supervision is not necessarily required, but a PCH must assess the resident and decide how to provide adequate supervision. Cabinet officials also deferred responsibility to the PCH. According to PCH administrators, the regulation on supervision has been interpreted under normal conditions as requiring a procedure to check on the whereabouts and condition of each resident at certain intervals, usually every hour.

Other kinds of risk do not involve residents' choices. Risk of falling for the elderly or someone with a physical disability is an example. Medical risks, such as medication errors by staff, medication side effects, or the risk of hypoglycemia for someone with diabetes, can be serious. According to cabinet officials, a resident died in 2009 after being given another resident's medication. PCHs are also responsible as caretakers to ensure that their staff and other residents do not neglect, abuse, or exploit any resident.

According to regulations and cabinet officials, PCHs are responsible for ensuring that they have effective procedures in place to handle all risks. A PCH must assess all aspects of risk for each resident and develop a plan of care to minimize the risks. When dealing with risks related to residents' choices, the plan may include various noncoercive methods such as changing a schedule, negotiating an agreement, encouraging, explaining the risks, and providing rewards. In the end, however, a resident may choose to take a risk. Even though restraint is mentioned in the long-term

care statute and PCH regulation, supplement PCH administrators indicated that they would not consider asking their staff to attempt to restrain a resident.

PCHs are required to ensure that they have effective procedures in place to handle all risks. They are required to assess all aspects of risk for each resident and develop a care plan to minimize the risks.

Whether the risks involve residents' choices or not, the cabinet's administrator training recommends that a PCH should also consider environmental adjustments. To lessen the risk of suicide or assault, for example, a PCH might consider securing knives and other possible means of harm. For fall risks, the PCH should look at factors like tripping hazards.

To handle elopement risk, many supplement PCHs have a sign-out policy. This permits staff to know when the residents leave, and staff can take appropriate measures if someone who has been assessed to have an elopement risk asks to leave or leaves. It has the further advantage of helping staff handle evacuations in case of fire, another kind of risk.

A few supplement PCHs have locked their grounds. One such PCH was cited because none of the residents were able to leave unless the administrator was there, and the administrator was absent for days at a time. Another PCH had also locked its grounds but was not cited because there was a procedure to permit most residents to borrow a key and leave whenever they wanted to. Residents whose guardians had asked that they be restricted to the facility were told they could not have a key. The administrator told Program Review staff that if such a resident insisted on leaving, the PCH would provide a key and then follow its elopement procedure, including notifying the guardian and other authorities.

In the absence of an adequate individual care plan, the PCH can be found in violation of regulations. If the PCH has a plan and carries it out, but the plan fails, the PCH must assess the failure and make the plan effective or determine that the plan can no longer meet the resident's needs.

The PCH must also have policies and procedures that describe what to do if a care plan fails and a resident is exposed to harm. For example, if a resident at risk of elopement succeeds in leaving, the PCH should have a procedure to inform the appropriate people and authorities, including the family, guardian, physician, law enforcement, the Office of Inspector General, and adult protective services. If a resident exhibits behavior that creates imminent danger of harm to self or others, the PCH should have a plan to contact appropriate authorities to initiate an involuntary commitment and to inform the appropriate people and agencies.

Restrictions Imposed By Guardians

Residents have their full rights unless a court has determined that they are unable to be responsible for themselves.

Regardless of residents' actual ability to manage their own affairs and ensure their own safety and that of others, residents are accorded full rights unless a court has determined them unable to be responsible for themselves. A concerned party files a petition with a court, the court orders an evaluation by appropriate professionals, and a jury determines whether the person in question needs a guardian. If so, the person becomes a ward of the guardian.

When a personal care home resident has a guardian, the facility must follow the guardian's instructions and contact the guardian when a decision is needed or any significant event occurs. However, a PCH has no greater ability to enforce a guardian's decisions than to enforce any other aspect of care.

There are several degrees of guardianship, but this report considers only full guardianship. A full guardian assumes the right to make decisions on behalf of the ward, including where to live, whether to come and go unaccompanied, how to spend money, and almost all other significant choices. When a PCH resident has a guardian, the PCH must follow the guardian's instructions to the extent that it can and must inform the guardian when a decision about the resident's care or placement is needed and when any significant event occurs. However, the PCH has no greater ability to enforce a guardian's decisions than to enforce any other aspect of care.

Having a guardian can relieve the PCH of some responsibility. A guardian's decision that a resident should not have the right to come and go, for example, would relieve the PCH from having to determine that risk. The guardian is also a resource that the PCH may call on to talk to the resident or to assist if something happens to the resident.

Cabinet officials confirmed that one advantage of guardianship is that if all of a PCH's residents have guardians who do not want their wards to leave and who have medical orders to support that decision, the PCH may operate locked facilities. Private-pay PCHs that specialize in serving resident with Alzheimer's disease and dementia generally have locked units.

Admission Procedures And Screening

Regulations require that a personal care home must meet its residents' needs or transfer or discharge them. The administrator is responsible for determining whether the PCH can meet an applicant's needs.

Regulations simply state that a PCH must meet its residents' needs or transfer or discharge them. The decision whether or not to admit someone is crucial because, once admitted, residents can be difficult to transfer or discharge. The cabinet offers no guidance on the admission decision except to say that the PCH is responsible for determining whether it can meet an applicant's needs.

The passage of 2012 RS SB 115 required a medical examination to be completed before admission.

Prior to 2012, cabinet regulations required a "complete medical evaluation" upon admission (25 Ky.R. 1232, sec. 3). SB 115,

enacted in 2012, required a medical examination to be completed before admission. In neither case is there any assurance that the evaluation or examination would be able to determine the appropriateness of a PCH for the resident.

Program Review staff reviewed the clinical literature and asked cabinet officials and behavioral health providers about ways to measure appropriateness for admission to PCHs. Staff did not find any reliable method of determining appropriateness. The standard method is to apply clinical judgment to an applicant's history and interview. The literature suggests that there might be tools to assist in determining risk of certain types of behavior, and those tools might be more reliable than clinical judgment, but even so they would likely miss a significant amount of risk.³⁴

Some PCH administrators used interview checklists, and all attempted to use an applicant's history and diagnoses to judge whether the home could meet the applicant's needs.

Conversations with PCH administrators indicated that some of them used interview checklists, and all attempted to use an applicant's history and diagnoses to judge whether their PCHs would be able to meet an applicant's needs. They did not have a reliable way to measure an applicant's needs and likely behaviors prior to admission.

Screening Out Likely Inappropriate Placement

A PCH is likely an inappropriate setting when applicants have already been determined eligible for Medicaid waiver programs that require a need for nursing facility care.

There are situations in which it is likely that a PCH is not the appropriate setting. These involve applicants for admission who have already been determined eligible for certain Medicaid waiver programs.³⁵ Appendix C provides more detailed waiver information.

The following waivers require a need for "nursing facility" care. Cabinet officials asserted that the federal definition of *nursing facility* might not rise to the level of the state definition of *nursing home*.[†] However, qualifying for these waivers should raise questions about the appropriateness of PCH placement.

- Home and Community Based Waiver (907 KAR 1:160)
- Acquired Brain Injury Waiver (907 KAR 3:090)
- Acquired Brain Injury Long-Term Care Waiver (907 KAR 3:090)

[†] The Social Security Act, sec. 1919(a)(1)(C), includes among nursing facilities those that provide

on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities

Anyone qualified for the Home and Community Based Waiver probably would not be “able to manage most of the activities of daily living” and, therefore, would fall outside the regulatory scope of a PCH (902 KAR 20:036, sec. 2). Most supplement PCHs have no nursing staff, and those that do usually do not have registered nurses. If a waiver recipient needed health-related care greater than assistance with self-administration of medication, the recipient probably would be inappropriate for supplement PCH care.

Supplement PCHs with no nursing or behavioral health staff probably cannot meet the needs of Acquired Brain Injury (ABI) Waiver recipients. However, there are not enough ABI Waiver slots for those who need them, and there are few or no nursing homes willing to accept someone with severe ABI symptoms.

Supplement PCHs with no nursing or behavioral health staff probably cannot meet the needs of ABI waiver recipients, even with community mental health services. For example, Lee was covered by the Acquired Brain Injury Long-Term Care Waiver while he resided at Community Opportunities, after which he was admitted to two PCHs.

The dilemma for the state is that there are not enough ABI waiver slots for those who need them, and there are few or no nursing homes willing to accept someone with severe ABI. The 2012 waiting lists were 260 for the ABI Waiver and 62 for the ABI Long-Term Care Waiver. The cabinet reported that a few individuals with severe ABI are living in specialized secure facilities in other states.

Other potential PCH residents have intellectual or developmental disabilities that are severe enough to qualify for certain Medicaid waivers. It seems unlikely that a supplement PCH could ensure that these residents receive required services.

Other potential PCH residents have intellectual or developmental disabilities that are severe enough to qualify for the following Medicaid waivers:

- Michelle P. Waiver (907 KAR 1:835)
- Supports for Community Living Waiver (907 KAR 12:010)

These waivers do not require a need for nursing facilities but do require a need for intermediate care facility services targeted to people with those disabilities. It seems unlikely that a supplement PCH, even with assistance from community mental health centers, could ensure that these residents received services equivalent to those in an intermediate care facility. Therefore, these recipients probably would be inappropriate for a supplement PCH.

Although there is no waiting list for the Michelle P. Waiver, the waiting list for the Supports for Community Living Waiver as of 2012 was 2,259. The number of current PCH residents on the waiting list is unknown. However, after the 2011 closure of the Letcher County Golden Years PCH, Kentucky Protection and Advocacy reported four former residents who qualified for that waiver.³⁶ Currently, the cabinet has requested community mental health centers to screen their clients who live in PCHs to see

whether they are receiving appropriate services and whether they might qualify for the waiver.

People on waiting lists have applied for the waiver programs but have not yet qualified. That determination is done only after a slot has opened for the applicant. When someone on a waiting list is referred to a PCH, the PCH must determine whether admission is appropriate.

Recommendation 3.5

Recommendation 3.5

The Cabinet for Health and Family Services should inform personal care homes that they should not admit anyone who is eligible to receive services under any relevant Medicaid waiver unless the facility is capable of providing or arranging for any specialized services the applicant requires. For any such individual already residing in a personal care home inappropriately, the cabinet and facility should make every effort to transfer the individual to a more appropriate setting. Personal care homes should carefully screen applicants and current residents who are on a waiver waiting list but not yet determined eligible. Currently, the relevant waivers are the Home and Community Based Waiver, Acquired Brain Injury Waiver, Acquired Brain Injury Long-Term Care Waiver, Michelle P. Waiver, and Supports for Community Living Waiver.

As noted earlier, it might be possible to find an assessment method that would increase the reliability of admission decisions in general. One form of assessment might be determination of eligibility for one of the Medicaid waivers or the new SPMI benefit. If the costs of such assessments could be covered by Medicaid, it might make them affordable for the state.

Recommendation 3.6

Recommendation 3.6

The Cabinet for Health and Family Services should develop a proposal to identify and assess personal care home applicants and current residents who might qualify for one of the relevant Medicaid waiver programs or the new Medicaid program for people with severe and persistent mental illness and to divert anyone qualifying for those programs from a personal care home. The cabinet also should explore ways to assess all personal care home applicants and residents for appropriateness. The cabinet should present the proposal,

including its projected cost and options for payment, to the Program Review and Investigations Committee by October 1, 2013.

Discharge And Transfer Procedures

A personal care home must discharge or transfer any resident whose needs it cannot meet, following the same discharge and transfer rules as other long-term care facilities. It must have transfer arrangements with other facilities that can provide more intensive services when needed.

If a PCH resident's needs are greater than anticipated or become greater over time, and the PCH cannot meet those needs, then the PCH must discharge or transfer the resident. As long-term care facilities, PCHs must follow the discharge and transfer rules in 900 KAR 2:050. Discharge or transfer may occur mainly when

- it is necessary for the resident's welfare and the PCH cannot meet the resident's needs,
- the safety of others (staff or residents) is endangered,
- the health of others would otherwise be endangered, or
- the resident has failed to pay for a stay at the PCH (900 KAR 2:050, sec. 2).

In addition, a PCH is required to have transfer arrangements with hospitals and nursing facilities that can provide more intensive services when needed, unless unable to establish such arrangements after good-faith efforts (902 KAR 20:036, sec. 3(6)(a)). Cabinet officials did not know how many PCHs had functioning transfer agreements. PCH administrators did not mention transfer agreements, but one of the state psychiatric hospitals reported having informal agreements regarding transfer of specific patients that it had referred to PCHs.

Reasons must be documented satisfactorily, and there must be a 30-day notice except when the need is urgent or there is imminent danger. A PCH might have to discharge or transfer a resident whose needs are no longer within the scope of PCH services, exceed the PCH's ability to meet them, or require urgent medical or psychiatric treatment.

The reasons for discharge or transfer must be documented satisfactorily and, except where the need is urgent or there is imminent danger, the PCH must give a 30-day notice. The notice itself must state the location to which the resident will be discharged. If the resident has a guardian, the PCH will inform the guardian of the need for discharge or transfer. According to OIG officials, the PCH has final responsibility for finding a location for the resident.

The scope of services of a PCH requires that a resident be ambulatory or mobile nonambulatory, need assistance with only a few activities of daily living, and not require nursing home services. If a resident's condition exceeds that scope of service, the PCH must initiate a transfer through the resident's physician or appropriate agencies (902 KAR 20:036, sec. 3(6)(b)). OIG officials stated that the PCH may have up to 30 days to accomplish the transfer, depending on the resident's level of need and the PCH's ability to meet it in the meantime.

Other requirements might exceed a PCH's resources. For example, if a resident required staff checks three times an hour and a staff escort whenever leaving the facility, the PCH would have to establish appropriate procedures and hire sufficient staff to meet that need at any time of the day or night. If the PCH determined that it could not accept the risk or afford the cost, it would have to transfer or discharge the resident or face disciplinary action.

When a PCH resident appears to need psychiatric treatment, the PCH must inform the resident's physician, who will then determine whether to seek transfer. The regulation states that the physician will initiate transfer, but interviews with PCH administrators indicated that usually the PCH itself carries out most of the steps of obtaining a mental health commitment (902 KAR 20:036, sec. 4(1)(g)).

Supplement PCHs reported difficulty in transferring residents who have exhibited or have a history of behavior that was threatening, violent, or suicidal, or that otherwise presented a safety risk.

In practice, supplement PCHs reported that it is very difficult to transfer residents who have exhibited or have a history of behavior that was threatening, violent, or suicidal, or that otherwise presented a safety risk. Other PCHs and other long-term care facilities have been reluctant to accept such residents. This problem was corroborated by the discharge planners at the state psychiatric hospitals and state PCHs, who reported similar difficulty. Lee's records showed that requests for transfer from his ABI group home were sent to over 40 facilities, and all turned him down.

According to supplement PCH administrators, when a resident appears to present an imminent danger of harm to self or others the usual practice is to seek a mental health commitment under KRS Chapter 202A. Similarly, the actual practice when a resident appears to need urgent or emergency medical care is to seek care at a hospital emergency department. If the resident is admitted to either setting, the PCH has the option to give notice of discharge and refuse to accept the resident back, provided there is appropriate documentation of the reasons. OIG officials confirmed that this procedure is permissible.

It is not clear whether a personal care home may discharge a resident who has nowhere to go. A PCH may be forced to keep some residents whose needs it cannot meet.

It is not clear from the regulation whether the PCH may discharge a resident who has nowhere to go. OIG officials indicated that it would be undesirable for a PCH to give notice of discharge to a homeless shelter, but OIG surveyors would determine whether the PCH could show that it made an adequate attempt to find a better location. There are no objective standards for an adequate attempt.

However, supplement PCH administrators generally stated that they make every effort to find a suitable place, and they uniformly stated that they would not discharge anyone to the street. This means that PCHs are forced by regulations or their own policies to keep some residents whose needs they cannot meet and who, therefore, may be at risk of harm to themselves or others. Because of the difficulty of finding an appropriate place, administrators acknowledged sometimes taking advantage of the opportunity afforded by hospitalization to discharge a resident.

PCHs face the same dilemma when a resident does not pay the monthly charge or incurs medical expenses that exceed income.

PCHs face the same dilemma when a resident does not pay the monthly charge or incurs medical expenses in excess of income. PCH administrators described some scenarios in which they have taken losses or paid residents' expenses themselves:

- Residents whose state supplementation checks go a payee, such as a family member, who does not remit the full \$1,158 to the PCH
- Residents on state supplementation who receive both Medicaid and Medicare and whose expenses exceed \$60
- Private-pay residents who have Medicare and do not have the income to cover both the PCH's charges and their Medicare premiums and cost sharing

Chapter 4

State Involvement With Personal Care Homes

The Office of Inspector General has primary oversight of PCHs in Kentucky, but many other state agencies are also involved with these facilities and their residents. This chapter lists only the agencies that have significant involvement, and Appendix D lists all the agencies of which Program Review staff are aware. Appendix E lists the Kentucky statutes and regulations that relate to personal care homes.

Summary Of Oversight Agencies

Cabinet For Health And Family Services

The Office of Inspector General has primary oversight. The Division of Health Care issues PCH licenses, conducts annual relicensure inspections, and investigates complaints and incidents. OIG can issue citations, collect fines, and revoke licenses. Divisions within the Department for Community Based Services investigate allegations of abuse, neglect, or exploitation and handle eligibility for state supplementation benefits.

The agency with primary oversight is the Office of Inspector General. The Division of Health Care within OIG issues PCH licenses, conducts annual relicensure inspections, and investigates complaints and incidents. OIG has the authority to issue citations, collect fines, and revoke and suspend licenses.

The Department for Community Based Services plays two roles. The Division of Protection and Permanency's adult protective services workers conduct assessments of PCHs and investigate allegations of abuse, neglect, or exploitation. The Division of Family Support does not provide direct oversight, but it handles the eligibility of residents for the state supplementation benefit and manages the MI/MR Program.

The Department for Aging and Independent Living operates the state guardianship program and houses the State Long-Term Care Ombudsman.

The Department for Aging and Independent Living operates the state guardianship program. Guardianship workers oversee the welfare of over 600 state wards residing in PCHs.

The State Long-Term Care Ombudsman is also housed in the Department for Aging and Independent Living. It is responsible for protecting the rights of long-term care residents, including those in PCHs. The ombudsman is federally mandated and operates under the Older Americans Act. Volunteer ombudsmen visit long-term care residents regularly and provide training and information about residents' rights to facility residents and staff. Ombudsmen also investigate and negotiate resolutions to complaints made by residents.

The Department for Public Health's local health departments are responsible for inspecting PCHs' food service operations.

The Office of Health Policy considers the request for a certificate of need when a PCH opens or adds beds to an existing facility.

When someone wants to open a new PCH or add beds to an existing facility, the Office of Health Policy considers the request for a certificate of need. Certificates of need for PCHs are issued without a formal review, but members of the public may object to a certificate. The office also collects and publishes basic information from all long-term care facilities about their residents each year.

The Department for Behavioral Health, Developmental and Intellectual Disabilities manages or contracts for the operation of three specialized mental health PCHs, the state psychiatric hospitals, and the community mental health centers that serve PCH residents. The department is also working with Medicaid to develop a plan to offer services to people with SPMI in the community.

Other State Agencies

Kentucky Protection and Advocacy investigates complaints, visits PCHs, educates residents about their rights, and sometimes offers legal representation.

Federal laws mandate that every state have an agency to represent and advocate for people with disabilities. Kentucky Protection and Advocacy, housed in the Justice and Public Safety Cabinet's Department of Public Advocacy, operates independently with federal funding. Agency staff investigate complaints, visit PCHs, educate PCH residents about their rights, and sometimes offer legal representation in negotiations and in court. When the agency discovers possible regulatory deficiencies or harm to residents, it reports those situations to OIG and, if appropriate, to adult protective services.

Kentucky's courts play a role by determining when someone may be involuntarily committed on a temporary basis for treatment for mental illness or intellectual disability. PCHs frequently access the courts for this purpose. The courts also determine whether someone needs a guardian and who the guardian should be. Courts oversee guardians and consider petitions for restoration of rights. Many PCH residents are private or state wards.

Office Of Inspector General

OIG is responsible for licensing all health care, day care, and long-term care facilities in Kentucky, including personal care homes.

OIG must conduct an on-site inspection of a new PCH before it receives a license. KRS 216.530 mandates that the cabinet continue performing inspections no later than 7 to 15 months after the previous inspection. OIG refers to inspections as “surveys.”

Before a new personal care home receives a license, 902 KAR 20:008(2) requires that the cabinet conduct an on-site inspection of the facility to ensure compliance with all applicable laws and regulations. Once the initial licensure inspection is complete, KRS 216.530 mandates that the cabinet continue performing unannounced inspections of the facility no later than 7 to 15 months after the previous inspection. OIG also responds to and investigates complaints about PCHs. The office refers to its inspections and investigations as “surveys.”

OIG also assists the Department for Community Based Services by verifying initial and ongoing eligibility of PCHs for the MI/MR Program. Most of these verifications are completed during relicensure surveys.

Violations And Deficiencies

KRS 216.557 requires the cabinet to enforce regulations and establish degrees of noncompliance. The cabinet is also responsible for setting the criteria and specific acts that constitute violations. A Type A violation presents an imminent danger to any resident or staff person. A Type B violation presents a direct risk to the health, safety, or security of any resident but does not create an imminent danger to life.

KRS 216.557 requires the cabinet to enforce regulations and establish degrees of noncompliance. The cabinet is responsible through regulation for setting the criteria and specific acts that constitute violations. A Type A violation presents an imminent danger to any resident or staff person. A Type B violation presents a direct risk to the health, safety, or security of any resident but does not create an imminent danger to life. For these violations, the cabinet issues corresponding citations and imposes fines of \$1,000 to \$5,000 for Type A and \$100 to \$500 for Type B violations. If a Type B violation is corrected in a timely manner, no fine is collected. Additional fines may be imposed for failing to promptly correct a violation, but a PCH may apply the cost of remedying the violation toward either type of fine (KRS 216.560).

The cabinet is required to review the criteria for these violations at least quarterly to ensure they are as clearly defined as possible. According to OIG officials, there is a monthly review of all citations, and the criteria are considered at those reviews.

Noncompliance that does not rise to the level of a violation is considered a deficiency.

Noncompliance that does not rise to the level of a violation is considered a deficiency.^u There are no fines for deficiencies.

For violations or deficiencies, a PCH must submit a plan of correction, and the plan must be acceptable to OIG. The plan must include a schedule for the corrections and must be followed.

^u Regulations do not use the term *deficiency* consistently. In this report, it will be used to refer to regulatory noncompliance that does not rise to the level of a violation.

Relicensure Surveys

OIG conducted 246 relicensure surveys at 86 freestanding PCHs from July 2008 to June 2012.

Less than half of the relicensure surveys were conducted within the window of 7 to 15 months mandated by KRS 216.530.

In 2011, OIG implemented a multilevel procedure to ensure that the relicensure surveys did not exceed the 15-month limit in the future. Currently, 14.6 percent of PCHs have not had a relicensure survey conducted in the past 15 months.

OIG conducted 246 relicensure surveys at 86 freestanding personal care homes from July 2008 to June 2012; 5 of these PCHs have since closed. With the exception of two unusual cases, the average relicensure survey took 1½ days to complete.

Of the 160 relicensure surveys for which Program Review staff were able to determine the number of months that had elapsed since the last relicensure survey, less than half (76 cases, 47.5 percent) were conducted within the window of 7 to 15 months mandated by KRS 216.530. Twenty, 12.5 percent, were conducted more than 2 years after the previous survey.

Program Review staff also used the 15-month limit to determine that a minimum of four relicensure surveys should have been conducted at each of the 82 PCHs that were operating from July 2008 to June 2012.^v OIG failed to conduct the minimum number of relicensure surveys in 66 cases, more than 80 percent.

OIG officials said that they realized in December 2010 that relicensure surveys were behind schedule because of high staff turnover. In response, regional program managers were directed to ensure that all PCH relicensure surveys were up to date by January 15, 2011. A review of relicensure survey data provided to Program Review staff show that all but one PCH's survey was current by that date.

Following OIG's efforts to bring all relicensure surveys up to date, the division implemented a procedure to ensure that these surveys did not exceed the 15-month limit in the future. Officials noted that the division has multiple levels of tracking and review to ensure that surveys are scheduled and conducted appropriately.

To evaluate the effectiveness of OIG's new scheduling procedures, Program Review staff examined the number of months that had passed between the surveys that brought relicensures up to date as of January 15, 2011, and the next relicensure surveys.^w Staff found that 24 freestanding PCHs, 30 percent, were not surveyed within the 15-month mandatory period. On average, 16 of the relicensure surveys were about a month late; 8 still had not had a relicensure survey conducted as of June 2012 and so were 2 or more months late.

^v Adjustments were made for those PCHs that were operating for only a portion of this time.

^w These prior surveys could have occurred as much as 14 months prior to January 2011.

Program Review staff also looked at the current status of relicensure surveys as of June 2012. Eleven PCHs, 14.6 percent, had not had a relicensure survey conducted within the past 15 months.

From July 2008 to June 2010, PCHs were in full compliance for approximately 40 percent of relicensure surveys. Most surveys found minor noncompliance that resulted in a statement of deficiency. On 12 occasions, the surveyor found deficiencies and violations. Eleven of the 12 included Type A citations.

If upon inspection the cabinet determines that a PCH has not met the regulations, standards, or requirements governing such facilities, the cabinet issues a citation or a statement of deficiency for each failure to comply. Table 4.1 summarizes the findings of relicensure surveys conducted from July 2008 to June 2012. PCHs were in full compliance for approximately 40 percent of surveys. Most (136 cases, 55.3 percent) found minor noncompliance that resulted in a statement of deficiency. On 12 occasions, the surveyor found deficiencies and violations. Eleven of the 12 violations included a Type A citation, meaning there was an imminent danger to a resident or staff person.

Table 4.1
Findings Of All Relicensure Surveys Conducted
From July 2008 To June 2012 At 86 Freestanding PCHs

Finding	Count	Percent
Full compliance	98	39.8%
Deficiencies only	136	55.3
Violations:		
Types A and B	3	1.2
Type A only	8	3.3
Type B only	1	0.4

Note: A Type A violation represents an imminent danger to any resident or staff person. A Type B violation represents a direct risk to the health, safety, or security of a resident but does not create an imminent danger to life.

Source: Program Review staff analysis of information provided by the Cabinet for Health and Family Services, Office of Inspector General.

Table 4.2 shows that less than 12 percent of freestanding personal care homes were found to be in full compliance during every relicensure survey. The most common noncompliance was minor and resulted in a statement of deficiency; 20 percent of PCHs had such deficiencies on one occasion, 33 percent received statements of deficiency on multiple visits, and 22 percent received a statement of deficiency for all their relicensure surveys. The remaining PCHs, 14 percent, were issued Type A or Type B citations in addition to statements of deficiency.

Table 4.2
Number And Percentage Of Personal Care Homes
With Deficiencies Or Citations During Relicensure Surveys
July 2008 To June 2012

Relicensure Results	Surveys With Citations	
	None	One
No survey with deficiencies	10 (11.6%)	0 (0.0%)
One survey with deficiencies	17 (19.8)	1 (1.1)
More than one survey with deficiencies	28 (32.6)	7 (8.1)
All the PCH's surveys had deficiencies	19 (22.1)	4 (4.7)

Source: Program Review staff analysis of information provided by the Cabinet for Health and Family Services, Office of Inspector General.

Disputing Deficiencies And Violations

If deficiencies or violations are found, 906 KAR 1:120 provides PCHs a one-time opportunity to dispute the OIG's findings through an informal dispute resolution process. The PCH administrator must send a written request that specifies the issue in dispute along with supporting documentation to the OIG on or before the mandated return date for the plan of correction. After reviewing the results of the process, OIG may uphold, modify, or delete the deficiency.

The plan of correction process described in regulation permits the cabinet to enter into an unending sequence of rejecting plans of correction and receiving amended plans.

When a personal care home is found to be noncompliant, 902 KAR 20:008, sec. 2(5) requires the facility to submit an acceptable plan of correction to the cabinet within 10 days. The plan of correction process described in the regulation permits the cabinet to enter into an unending sequence of rejecting plans of correction and receiving amended plans. There are no specified limits on the overall time period or the number of proposed plans of correction that may be submitted. There are no criteria for when the cabinet should consider denying, suspending, or revoking a license. This appears to have been an issue preceding the closure of Letcher County Golden Years, which had submitted a series of unacceptable plans of correction over the course of several months.

Regulatory Variances

A variance is an exception to one of the regulatory requirements. The cabinet may issue variances to facility specifications only. OIG has a database of 102 variances; some additional variances are on file in regional OIG offices.

A variance is an exception to one of the regulatory requirements. The cabinet may issue variances to facility specifications only (902 KAR 20:008).^x A PCH may request a variance proactively or in response to a survey finding. OIG has a database of 102 variances, which represent both new variances granted since

^x For PCHs, facility specifications are in 902 KAR 20:031.

2001 and some earlier variances that were entered after the database was created. An unknown number of earlier variances remain in effect; they are on file in regional OIG offices. Table 4.3 shows the seven most common variances in the database; these represent slightly more than half of all variances listed.

Table 4.3
Most Common Variances To 902 KAR 20:031

Section	Number	Administrative Regulation Language
6(3)(b)	10	Staff lounge area. The area shall have personal storage space and a toilet room for staff.
6(1)(b)	9	Resident rooms shall be designed to permit not less than a 3 foot space between beds, and at least a 3 foot space between the side of the bed and the nearest wall, fixed cabinet, or heating/cooling unit. Beds shall be at least 36-inches wide. A minimum of 3 feet is required between the foot of the bed and opposite wall or foot of opposite bed in multibed rooms.
5(2)	7	At least 66 percent of the beds in the facility shall be located in rooms designed for one or two beds.
6(1)(d)	7	Lavatory. In single and two bed rooms with a private toilet room, the lavatory may be located in the toilet room. Where two residents' rooms share a common toilet, a lavatory shall be provided in each resident room.
6(2)(b)	7	Where a centralized toilet area is used, the facility shall provide for each sex on every floor the following: one toilet for each eight residents or fraction thereof and one lavatory for each 16 residents or fraction thereof is required. Toilets must be separated by a permanent partition and at least one toilet for each sex must be designed for wheelchair use.
6(1)(c)	6	Windows. All resident rooms shall have windows opening to the outside. The sill shall not be higher than 3 feet above the floor and shall be above grade. Window area shall be at least 8 percent of resident room floor area.
6(2)(1)	6	Where a centralized bathing area is used, the facility shall provide for each sex on every floor the following: one shower stall or one bathtub for each 12 residents or major fraction thereof is required. One shower stall shall be designed for wheelchair use.

Note: There are an unknown number of additional variances on paper that were not converted to the database.
 Source: Kentucky. Cabinet for Health and Family Services. , Office of Inspector General.

Investigation Of PCH Complaints

OIG is also responsible for the prevention, detection, and investigation of fraud, abuse, mismanagement, and misconduct at PCHs. This includes investigating all formal complaints against PCHs in Kentucky.

OIG is also responsible for the prevention, detection, and investigation of fraud, abuse, mismanagement, and misconduct at all health care facilities, including personal care homes. KRS 216.525(2) states that “[t]he cabinet shall take appropriate and necessary actions to insure that all of the rights of residents in long-term care facilities as defined by KRS 216.515 to 216.525 are upheld.” This includes investigating all formal complaints and allegations made against personal care homes in Kentucky.

There were 502 formal complaints filed with OIG from July 2008 to June 2012. The three most common topics of allegations were a facility’s failure to provide quality care/treatment, resident abuse, and a PCH’s physical environment.

There were 502 formal complaints filed with the OIG against freestanding PCHs from July 2008 to June 2012. The most common sources of complaints were other state agencies (30.7 percent), the PCH itself (21.2 percent), or an ombudsman (10.6 percent).^y Of the 86 personal care homes analyzed, 10 had no complaints filed against them during this period. More than half received five or fewer complaints, 15 had 6 to 10 complaints, and 16 had more than 15 complaints filed against them.

Many of the complaints involved multiple issues, resulting in 767 total individual allegations. The most common allegations were about a facility’s failure to provide quality care/treatment (34.6 percent). This category includes issues such as residents’ safety, problems with medication being administered correctly, and residents’ not being properly groomed or being dirty. The second most common allegations were those related to resident abuse, including instances of resident-to-resident conflict, PCH employee-to-resident abuse, verbal abuse, and sexual abuse (20.5 percent). Allegations about a PCH’s physical environment were the third most common (15.1 percent) and included claims about the facility’s not being clean and not providing a safe environment in which to live.

When a complaint arrives, the complaint coordinator assigns a priority level to each allegation. OIG uses four priority levels, ranging from immediate jeopardy to low priority.

When a complaint arrives, the complaint coordinator assigns a priority level to each allegation. OIG uses four priority levels.:

- **Immediate Jeopardy:** The alleged noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. It is policy that an on-site investigation be initiated within 2 working days of receipt.
- **High Priority:** The alleged noncompliance has caused, or is likely to cause, harm that negatively affects a resident’s mental, physical, or psychosocial status and is of such consequence to the person’s well-being that a rapid response is needed. It is

^y There are cases in which PCHs report incidents to OIG, which are then investigated.

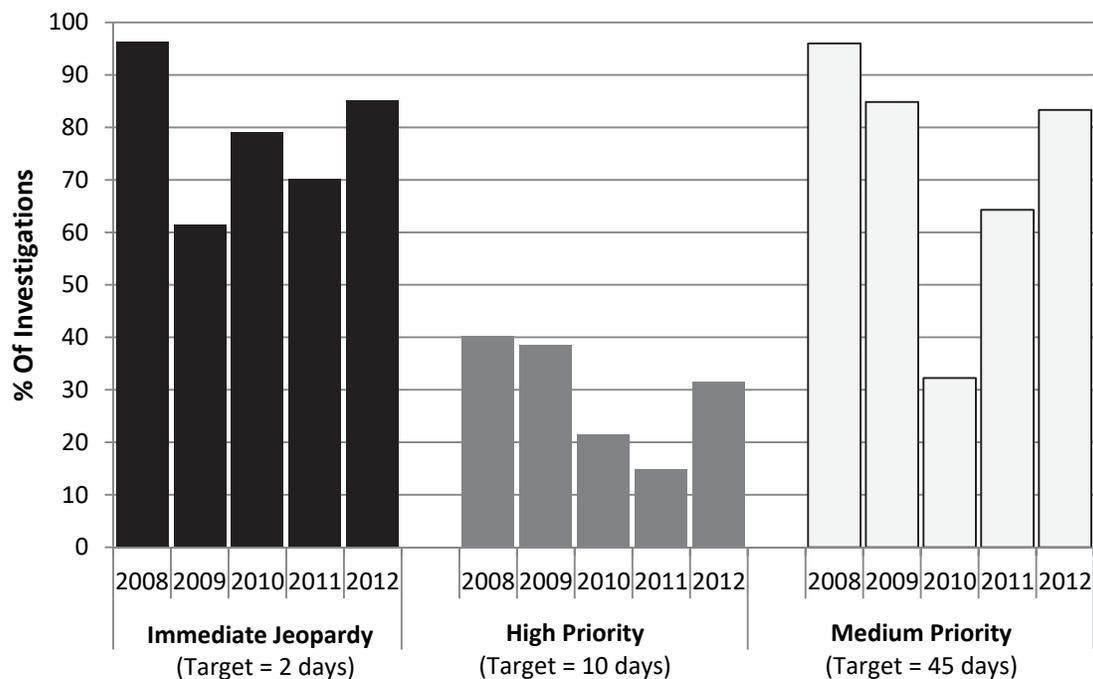
policy that an on-site investigation be initiated within 10 working days of receipt.

- Medium Priority: The alleged noncompliance caused, or may cause, harm that is of limited consequence and does not significantly impair the resident's mental, physical, or psychosocial status or function. It is policy that an on-site investigation be initiated within 45 calendar days of receipt.
- Low Priority: The alleged noncompliance causes, or may cause, physical, mental, or psychosocial discomfort that does not constitute injury or damage. It is policy that an investigation can wait until the next on-site survey, which might be the next relicensure survey.

Of the 767 allegations filed with OIG from July 2008 to June 2012, 21.4 percent were classified as immediate jeopardy, 61.7 percent as high priority, 16.2 percent as medium priority, and less than 1 percent as low priority. Figure 4.A shows the percentage of OIG complaint investigations that were initiated within the agency's target dates. In 2012, 85.2 percent of allegations that might place a resident in immediate jeopardy were investigated within 2 days, which is an improvement from the previous 3 years. A similar pattern is seen with medium priority investigations. More often than not, OIG failed to investigate high priority allegations within the 10 days prescribed by policy. In 2012, only 31.6 percent of high priority cases were investigated on time; the longest delay was 17 days after receipt of the complaint. This is an improvement from the previous 3 years, when high priority allegations sometimes took up to a year before an investigation was initiated.^z

^z Low priority allegations were not analyzed because there were so few.

Figure 4.A
Percentage Of OIG Complaint Investigations Initiated
Within The Agency’s Target Dates By Priority Level And Year
July 2008 To June 2012



Note: 2008 = July 1 to December 31, 2008.; 2012 = January 1 to June 30, 2012.

Source: Program Review staff analysis of information provided by the Cabinet for Health and Family Services, Office of Inspector General.

Of the 767 allegations filed against PCHs, 283 were substantiated.

Surveyors typically review PCH records and interview residents, staff, and administrators to determine whether there is enough evidence to substantiate a claim. Of the 767 allegations filed against PCHs, 283 (36.9 percent) were substantiated.

An allegation may be substantiated without any finding of noncompliance. For example, a surveyor may substantiate an abuse claim by finding evidence that a physical altercation did occur between two residents, but the surveyor may not find a deficiency because staff were appropriately monitoring the residents and took the correct steps to mitigate the situation. On the other hand, a surveyor may find an allegation unsubstantiated but still issue a citation or a statement of deficiency for unrelated issues observed during the survey.

In the OIG data, each allegation is substantiated or unsubstantiated individually, but any penalty for noncompliance is shown for the complaint as a whole, so it was not possible to determine which allegations were related to which penalties. Of the 502 complaints filed with OIG, surveyors found no deficiencies or violations in

39 percent of them. They issued statements of deficiency on 48 percent of complaints. Thirteen percent of complaints resulted in violations, with 57 Type A and 13 Type B citations issued.

Records Of Complaints And Relicensure Surveys

For seven selected PCHs, the cabinet provided all digital documents related to the past 4 years of relicensure and complaint surveys. DCBS provided complaint reports and investigations for the same PCHs. Inconsistencies were found in the thoroughness of relicensure surveys. There were several instances in which OIG surveyors found a PCH in compliance during a relicensure survey, only to find deficiencies or violations during a later visit that would have been present earlier.

For seven PCHs selected by Program Review staff, the cabinet provided all digital documents related to the past 4 years of relicensure and complaint surveys. The Department for Community Based Services' Adult Protection Branch provided its complaint reports and investigations for the same PCHs and time period.

Review of these documents confirmed earlier findings that prior to 2012, OIG was often slow to respond to complaints and that its relicensure inspections were often conducted more than 15 months apart.

Inconsistencies were also found in the thoroughness of relicensure surveys. OIG officials acknowledged that there is no agency-approved checklist or standardized form that surveyors use to ensure they have examined all the statutory and regulatory requirements, but they expressed hope that surveyors were going through the Personal Care Home Regulations book item by item. In at least some cases, surveyors were not doing so.

There were several instances in which OIG surveyors found a PCH in compliance during a relicensure survey, only to find deficiencies or violations during a later visit that would have been present earlier. An example of this came from a PCH for which relicensure surveys were conducted in December 2008 and January 2011, both finding full compliance. In September 2011, a complaint survey found 31 deficiencies. Many of these were structural deficiencies that would have been present during the previous surveys. For example, air inlets were not in the correct locations, and some residents' rooms did not have windows that opened to the outside. One deficiency was an ineffective policy related to supervision of residents; the policy in January was found to be compliant. There was no indication whether the policy had changed or not.

Revoking PCH Licenses

If the facility fails to correct the issue for which it was cited within the specified time, OIG has the authority to deny, suspend, or revoke that facility's license. This has occurred three times in the past 5 years.

If the facility fails to correct the issues for which it was cited within the specified time, or does not receive a variance through the informal review process, OIG has the authority under KRS 216B.105(2) to deny, suspend, or revoke that facility's license. This has occurred three times in the past 5 years.

OIG had received complaints about Hilltop Rest Home in Pulaski County over the years, but beginning in May 2010 the agency began to receive a complaint almost every month. By November, the cabinet had received nine formal complaints, mostly regarding quality of care and allegations of resident abuse. Surveys on these cases resulted in the issuance of eight Type A citations. OIG closed Hilltop effective December 9, 2010.

Letcher County Golden Years personal care home was closed effective October 4, 2011. OIG had received 21 formal complaints, with 36 individual allegations, between July 2008 and the closure of the facility. Most of these allegations were about abuse of the residents and quality of care. Over half of the allegations, 20, were substantiated; 12 were unsubstantiated; and 4 had no finding listed in the OIG database. Investigations into the complaints resulted in the issuance of 16 statements of deficiency and 3 Type A citations. The PCH also submitted several unacceptable plans of correction, sometimes taking as long as 4 months and four to five submissions before OIG accepted the plan. The PCH was closed ultimately for financial problems by a court receiver requested by the Attorney General, not through direct OIG action. Meanwhile, the Office of the Attorney General pursued criminal charges of theft from and exploitation of residents against the former PCH owner. The owner was sentenced to 2 years in prison on a related federal charge and 10 years on probation and restitution on the state charges.³⁷

Dry Ridge Personal Care Home voluntarily relinquished its license on February 4, 2012, rather than face revocation. OIG had issued three Type A citations and found multiple deficiencies, including failure to maintain the facility and to ensure that residents were provided a safe, clean, and comfortable environment.

Seeking Injunctive Relief

The cabinet has the authority to seek injunctions when PCHs fail to correct violations, but the statute does not apply to PCHs that commit a pattern of violations and correct them. The cabinet has used its authority to revoke licenses instead of this option.

The cabinet also has the authority under KRS 216.573 and 216.577 to seek injunctions to impose corrections or close long-term care facilities. Under KRS 216.573, injunctive actions can be taken if the PCH fails to correct a Type A or Type B violation or fails to abide by any final order of the cabinet. Under KRS 216.577, injunctive actions are mandated whenever the PCH fails to correct a Type A violation; the actions include the option to relocate certain residents.

The statute, however, would not apply if a PCH corrected the violations and abided by all final orders. For example, the statute would not permit the cabinet to take action against a PCH for a pattern of Type A violations over time. Cabinet officials reported that OIG had not used this statutory injunctive authority but had used its authority to revoke licenses instead.

Summary Of Licensure Oversight

It appears that OIG has improved its scheduling of relicensure surveys and its response times to complaints, but further improvement is needed. There is evidence that regulatory scrutiny is highly variable and should be tightened.

It appears that OIG has improved its scheduling of relicensure surveys and its response times to complaints, but further improvement is needed. There is evidence that regulatory scrutiny is highly variable and should be tightened.

Some research in long-term care regulation indicates that stricter regulations can result in better services, and that the improvement may depend on what regulators look at.³⁸ It is possible that some of the recent structural improvements noted at PCHs were related to improved regulatory oversight.^{aa} In a similar manner, PCH management might be more attentive to appropriateness of admission and care planning if surveyors reliably verified all aspects of PCH policies and procedures routinely. To the extent that better management can result in more effective use of limited resources, this would be a desirable goal.

^{aa} Three of the supplement PCHs that Program Review staff visited had made major repairs in the last 2 or 3 years.

Recommendation 4.1**Recommendation 4.1**

The Office of Inspector General should ensure that personal care home relicensure surveys are conducted in the time frame mandated by KRS 216.530 and should adhere to its established targets for timely investigations of complaints. All relicensure surveys should uniformly verify compliance with all applicable requirements and document the evidence used to find compliance or noncompliance on each requirement. The office should monitor the cycle of correction plans and the number of serious violations that may occur before it takes licensure or injunctive action.

Department For Community Based Services**Adult Protection Branch**

Investigations. The Adult Protection Branch in the Division of Protection and Permanency investigates allegations of abuse, neglect, and exploitation of adults, including those at PCHs. A division official stated that workers contact OIG on every investigation they conduct at a PCH, and OIG officials stated that they are in regular contact with division personnel regarding complaints that involve possible abuse, neglect, or exploitation.

Based on a comparison of complaint investigations by the Adult Protection Branch and by OIG, it appears that coordination between these agencies could be improved.

Program Review staff reviewed adult protective investigation documents for six personal care homes and compared them with OIG investigation records. Although there were a few complaints that both the Adult Protection Branch and OIG investigated, in most cases only one of the agencies had records of the investigation. It appears that coordination between these agencies could be improved.

Adult protection workers conduct semiannual assessments of PCH facilities, but department records indicate that very few have been done.

Semiannual Assessments. Adult protection workers conduct semiannual assessments of PCH facilities (922 KAR 5:100, sec. 3(4)). Findings are recorded on standardized forms that include general observations on the cleanliness and structural integrity of the facility, residents' meals and activities, and whether the investigator noted any residents who were in restraints or nonambulatory. Workers also interview at least four residents during their assessments.

Program Review staff requested assessment forms for six PCHs and received forms for three. For those three, many semiannual assessments had not been completed. Department records indicated

that very few semiannual assessments had been done. An official confirmed that workers in the field do not always complete this task.

A comparison of the Adult Protection Branch semiannual assessments and OIG survey findings showed discrepancies. The requirement for these assessments is not statutory and seems unnecessary.

Program Review staff examined the assessment forms for the three PCHs. In all cases, investigators found housekeeping to be in good to excellent condition, noted no other problems with the facility, and mentioned no reported complaints from residents during the one-on-one interviews. A comparison of these assessments and OIG surveyors' findings showed some discrepancies. For example, late in January 2008, an adult protection semiannual assessment found housekeeping in good condition and noted no other problems. Four months later, OIG surveyors found the facility in disrepair, with ceiling tiles missing, exposed electrical wire hanging from the ceiling, and heavy dust on wall vents. The following year, at the same facility, the adult protection assessment found housekeeping in excellent condition on March 23; 8 days later, OIG surveyors found the facility deficient for failure to ensure it was maintained in good repair and kept clean.

The cabinet created the requirement for semiannual assessments; they are not required by statute. Given the other priorities of adult protective services and the lack of significant findings, these assessments seem unnecessary.

Division Of Family Support

The Division of Family Support is responsible for determining the eligibility for state supplement and Medicaid. It also administers the state supplement program and MI/MR Program.

State Supplement. The division is responsible for determining eligibility for state supplementation and Medicaid. It also administers the state supplementation program, sending benefit checks to the recipients each month.

MI/MR Program. The division administers the MI/MR Program. It determines the quarterly supplemental payment to participating PCHs and sends payments to them. It receives monthly reports from PCHs to verify their residents' diagnoses in order to ensure continued eligibility in the program.

Department For Aging And Independent Living

Guardianship Branch

With more than 600 state wards and an unknown number of private wards in PCHs, guardianship is an important aspect of oversight. Guardians are responsible for the welfare and financial

affairs of their wards and serve as the wards' voice in decisions related to the PCH's plan of care.

A guardian may be a private citizen or the state. The Guardianship Branch of the Department for Aging and Independent Living is responsible for the welfare and financial affairs of state wards, more than 600 of whom live in PCHs.

A guardian may be a private citizen or the state. Kentucky's guardianship statutes specify that when no one is available and willing, the cabinet may apply for guardianship (KRS 210.290(2)). The question arose whether the cabinet could be appointed if it did not believe the prospective ward had a sufficient disability. The Kentucky Court of Appeals in 1984 determined that in a situation in which no one can be found to act as a limited guardian or conservator, the Cabinet ... can be appointed as a matter of last resort, regardless of whether it applied for or sought such appointment (*Com. v. Cabinet for Human Resources*, 686 S.W.2d 465 (Ky. App., 1984)).

According to the cabinet, courts have used this reasoning to appoint the state as full guardian many times when the cabinet has not sought appointment.

Guardianship workers in the Department for Aging and Independent Living handle the affairs of state wards. They are required to meet face to face with each ward at least quarterly, and officials said that workers meet some wards more frequently. However, the workers average 68 wards each, which is higher than the 58 wards per worker noted by the Auditor of Public Accounts in 2008. The auditor's report cited a national recommendation of 20 wards per worker and recommended that the cabinet work to establish a cap on guardianship caseloads. Cabinet officials pointed out then and in 2012 that courts have appointed the state as guardian to more and more wards, and the cabinet must accept them whether it has sufficient staff or not.³⁹ In the 2012–2014 biennium, the cabinet received additional funding, and the department was able to use some of those funds to increase the number of guardianship workers. Officials indicated, however, that the number of wards has continued to increase, making it difficult to reduce caseloads.

State Long-Term Care Ombudsman

The Long-Term Care Ombudsman uses trained volunteers to visit residents in PCHs to investigate and resolve complaints.

Mandated by the Older Americans Act, the long-term care ombudsman program is housed in the Department for Aging and Independent Living. It uses trained volunteer ombudsmen to visit residents in PCHs and other facilities to investigate and resolve complaints that are brought to the ombudsman's attention. The ombudsman has no enforcement authority and is not permitted to report complaints to other authorities without the resident's permission.

Discussions with ombudsmen indicated that the number of volunteers varies across the state. In some areas, volunteers reported visiting PCHs as often as weekly; in other places the interval was closer to monthly. In any case, it appears that the ombudsman is the agency with the most frequent contact with PCHs.

Chapter 5

Alternatives To Personal Care Homes

Deinstitutionalization And The *Olmstead* Decision

The original legislation creating PCHs focused on quality institutional care for vulnerable people.

The statutory definition of PCH has remained unchanged since 1960 (1960 Ky. Acts ch. 87, sec. 2; recreated in 1980 Ky. Acts ch. 188, sec. 214). The 1960 Act focused on quality institutional care for vulnerable people:

WHEREAS, the increased numbers of aged people in our society is resulting in an increase in the number of personal care homes, with the result that a more specific standard should be established for these homes in order that the residents therein may be properly protected (Preface).

... The general welfare of our aged, chronically ill or infirm citizens is of prime concern to the people of this state.

Therefore, the purpose of this Act is to protect and provide for the general welfare of said citizens by promoting safe and adequate accommodation, care, and treatment (sec. 1).

Since the 1950s, there has been an accelerating trend toward supporting people with disabilities in their own houses or apartments rather than in institutions.

Since the 1950s, there has been an accelerating trend toward supporting people with disabilities in their own houses or apartments rather than in institutions. In the 1950s, improved medications made it feasible for some patients in state psychiatric hospitals to move into the community. In the 1960s, federal funding was made available to support community mental health services, leading more patients to be discharged from hospitals. Since then, antipsychotic and other psychiatric medications have continued to improve, facilitating independence for more people with mental illness. During the same period, efforts were made to keep the elderly and people with physical disabilities out of nursing homes and to keep people with intellectual and developmental disabilities out of intermediate care facilities.

PCHs began to serve more people who had moved out of psychiatric hospitals and other facilities.

As patients with mental illness and other disabilities were released from psychiatric hospitals and other facilities over the next few decades, PCHs began to serve more and more people from that group. By 1972, the Governor's Advisory Council on Mental Retardation had concluded that the placement of people with intellectual disabilities in PCHs was widespread and inappropriate.⁴⁰ A 1977 Legislative Research Commission report stated that

Kentucky statutes and administrative regulations do not require personal ... care homes to provide psychiatric

services, habilitation plans, or that other restorative treatment regimen be instituted for the residents. Nor do these same statutes and regulations allow for these respective facilities to be reimbursed by state or federal dollars should they choose to provide such services to indigent residents. Thus, the end result for the poor and mentally retarded, developmentally disabled, or mentally ill residents in a personal ... care home is little more than a custodial arrangement.⁴¹

In 2012 as in 1977, PCHs appear to provide custodial care for residents with little prospect for independence.

In 2012, the population of supplement PCHs is predominantly low-income people, most of whom have severe and persistent mental illness, along with smaller numbers of residents who have intellectual, developmental, or physical disabilities or are elderly. As in 1977, these PCHs appear to provide custodial care for residents with little prospect for independence.

Legal Requirements For Community Supports

The Supreme Court ruled in its 1999 *Olmstead* decision that the Americans With Disabilities Act created a legal requirement to provide care in the setting most integrated into the community.

One motivation for deinstitutionalization has been financial. It has usually been less expensive to support someone at home than in an institution, and federal funds have been available. In 1990, Congress passed the Americans With Disabilities Act, which added a legal requirement for deinstitutionalization in some situations. In 1999, the Supreme Court, in its *Olmstead v. L.C.* decision, found that the Act required public entities that provide care for people with disabilities to do so in a setting that was as integrated into the community as feasible for the individual.

Kentucky and other states quickly developed *Olmstead* compliance plans indicating how they would support people with disabilities in the most integrated feasible setting. However, funding of community supports for people with SPMI has been limited, and many people with mental illness still reside in facilities like supplement PCHs in Kentucky and other states. Kentucky's *Olmstead* plan originally covered the period from FY 2003 to FY 2012 and has expired. Cabinet officials stated that no revised compliance plan has been developed.

Some states have faced lawsuits to enforce *Olmstead*. North Carolina recently signed an agreement to avoid a lawsuit.

The US Department of Justice has enforced the Act and the *Olmstead* decision. Some states have faced federal lawsuits asserting they were in violation of *Olmstead*. In August 2012, North Carolina signed an agreement with the Department of Justice to avoid a lawsuit on this issue.⁴²

Kentucky Protection and Advocacy has asserted that the practice of placing people with mental illness in personal care homes is a violation of *Olmstead*.

Kentucky Protection and Advocacy is an independent state agency, mandated by federal law, that monitors the rights of people with disabilities. In March 2012, the agency issued a report about PCHs.⁴³ Its press release asserted that continued placement of persons with mental illness in [personal care homes] is a violation of the Americans with Disabilities Act and the *Olmstead* decision.⁴⁴

Supportive Services In The Community

An alternative to living in facilities is living at home with support services as needed. Intensive supports have not been available for people with SPMI.

Advocates envision the elderly and people with disabilities as living in their own houses or apartments with support as needed from visiting nurses, therapists, case managers, and other providers. Over the past several years, this model has worked for many people in the community. Intensive support programs for people with SPMI have been unavailable.

Medicaid Coverage For Community Based Services

Kentucky Medicaid uses waivers to offer intensive in-home supports for several groups. Medicaid does not pay for shelter costs, so many recipients use federal housing subsidies.

Kentucky currently offers five Medicaid waiver programs that can provide services to help elderly or disabled persons stay in their homes. Because Medicaid does not cover shelter expenses, the participants pay for their own rent and food in a house, apartment, or staffed group home. They must use their retirement or disability benefits to pay shelter expenses, and many receive one of several types of housing subsidies from Housing and Urban Development and food assistance from the Supplemental Nutrition Assistance Program.

Medicaid waivers are not available for people with SPMI because of federal restrictions.

There are no waivers covering people with SPMI because a combination of federal laws prevents it. The two obstacles to obtaining a waiver for this purpose are budget neutrality and the Institution for Mental Diseases exclusion.

A Medicaid waiver is expected to cost less than or at least no more than the services currently being provided to the people who will be served under the waiver. For example, the five waivers serve residents who would otherwise need to be placed in an intermediate care facility or nursing facility. The waivers provide services that permit the covered members to live in a more integrated community setting, and the state may swap expensive institutional beds for less expensive community living slots.

Medicaid has never covered any institutional costs for people with SPMI because of the Institution for Mental Diseases exclusion.

Therefore, there is no expensive bed to trade for a less expensive community living slot, and no waiver is possible for this population.

Changes to the Social Security Act permit a state to use Medicaid to pay for in-home services for people with mental illness. The General Assembly funded and the cabinet is planning a new program for the 2012–2014 biennium.

Changes to the Social Security Act provide an opportunity to serve the SPMI population in a way similar to the others but without a waiver. Under section 1915(i) of the Act, states may amend their Medicaid plans to serve other groups in the community and may establish eligibility criteria in order to manage the number of recipients. The Department for Behavioral Health, Developmental and Intellectual Disabilities is working with the Department for Medicaid Services to submit such a plan to federal authorities. The General Assembly allocated \$600,000 in general funds to serve 200 clients in FY 2013 and \$1,200,000 to expand to serve 600 clients by the end of FY 2014. The total state and federal Medicaid funding for this new program is \$2,048,500 in FY 2013 and \$4,074,700 in FY 2014. Cabinet officials expect to start serving clients in January 2013. They explained that it was not yet possible to give a precise cost per client because they could not predict how quickly clients would be phased in and how quickly the funds would be used.

A Community Model For Intensive Behavioral Health Services

Assertive Community Treatment and similar programs have been successful supporting people with mental illness at home and reducing hospitalization.

The traditional model of providing intensive behavioral health treatment in institutional settings severely restricts independence and integration with others in the community. People with SPMI require active treatment programs that are sustained, focused, and cumulative. Arguably, traditional treatment approaches meet these requirements; however, proponents of assertive community treatment and similar programs state that traditional methods lack the ability to be customized, are inflexible, and are not comprehensive.⁴⁵

Assertive Community Treatment differs from traditional hospitalization in its setting, treatment of symptoms, and subsequent rehabilitation. A team of providers—consisting of professionals in a variety of fields such as social work, rehabilitation, employment coaching, counseling, nursing, and psychiatry—provides services in clients’ homes and neighborhoods and is available around the clock according to each client’s needs. This method of service delivery is much more intensive, responsive, and flexible than traditional services primarily provided in clinics during working hours. Caseloads are generally smaller than those in traditional practice, with 10 clients

per team member being common. There is an emphasis on living with psychiatric symptoms, avoiding dependency, and formulating an individualized care plan.

One of the primary goals is to reduce the frequency of hospitalization and associated inpatient care costs. After its initial implementation in 1970 at Mendota State Hospital in Madison, Wisconsin, the Assertive Community Treatment model developed to become one of the most replicated community health models.⁴⁶ The Wisconsin example exhibited great success in reducing the numbers of hospitalization cases, along with limited success in increasing social functionality.⁴⁷

Rural Barriers To Assertive Community Treatment

Community support programs must be designed differently in rural and urban areas.

Kentucky's predominantly rural character has direct impact on the organization, implementation, and delivery of health care programs. In their efforts to provide effective health care, rural areas face significant obstacles, notably inaccessibility and lack of trained professionals.

Little research has been conducted to address how community-based options might work in a rural setting. Some studies showed that significant compromises to full assertive community treatment had to be made in rural areas.⁴⁸ A study conducted in rural western Minnesota found that a similar program, called a community support program, lowered hospitalization rates, and the effectiveness of the program persisted over time.⁴⁹

Urban and rural Assertive Community Treatment teams are organized similarly but show several key differences. In general, the mobility and flexibility of the team must be enhanced to cover the greater distances in rural areas. Therefore, caseloads and team sizes might be smaller. The need for 24-hour service could be evaluated case by case.⁵⁰ A cabinet official explained that rural teams in Kentucky might have three or four members and serve 30 to 40 clients.

Paying Shelter Expenses

Paying the cost of housing may be the greatest challenge in supporting 600 SPMI clients in the community because Medicaid does not pay for shelter costs, and federal housing subsidies are limited.

If PCH residents with SPMI move into the community under the new Medicaid program, they will have to pay their shelter expenses: rent and food. Most of them will have disability benefits they may use toward these expenses, but the full Supplemental Security Income benefit is only \$698 per month. Cabinet officials and existing community service providers identified housing itself

as the most challenging obstacle to supported living in the community.

A limited amount of state *Olmstead* housing funds is available to support clients in the new program during this biennium.

According to cabinet and Kentucky Housing Corporation officials, the state *Olmstead* Housing Initiative fund could help subsidize program participants for this biennium. The initiative is a program run on contract between the cabinet and Kentucky Housing to support people who have had extensive psychiatric hospital stays; it has been funded at \$386,000 per year. Because the opportunities for community supports have been limited for this group, the fund has a balance of approximately \$1.2 million.

Kentucky Housing officials reported that currently, the average housing assistance payment for *Olmstead* participants is \$316 per month. Depending on how quickly new clients enter the new Medicaid program and how many of them need housing assistance, the current *Olmstead* funds might last until the end of the biennium. Even under optimistic assumptions, however, if the existing level of *Olmstead* funding were continued, it would be able to support only 100 clients on an ongoing basis.

The cabinet is examining what other funds might be available. Kentucky Housing officials noted that some waiver participants could access other housing resources in the community. For example,

- the Louisville Metro Housing Authority currently provides housing vouchers to eligible participants in the *Olmstead* Housing Initiative and
- other participants might find housing in existing subsidized rental properties as vacancies occur.

There are a variety of Housing and Urban Development housing programs; most of them in Kentucky are administered through the Kentucky Housing Corporation. Kentucky Housing has flexibility in prioritizing its use of US Department of Housing and Urban Development (HUD) funds to meet identified needs in its strategic plan. HUD support is not available to everyone who needs it, however, because of limited funding. In fact, federal funding for some housing programs has been reduced. Kentucky Housing reported that many of its programs operated at capacity and that funding at the federal and state levels was not available to meet the number of clients in need, which has recently risen significantly. Over 14,000 applicants were waiting to receive housing subsidies from just one Kentucky Housing program: the Section 8 Voucher Program.

Examples Of Community Services In Kentucky

A few local Kentucky projects use intensive community support models. All are small, and because of funding limitations, none have been able to expand.

A few local Kentucky projects have implemented ACT and similar approaches with limited Medicaid funding.^a All are small, and because of funding limitations, none have been able to expand.

Center For Rehabilitation And Recovery. The Center for Rehabilitation and Recovery is one of the three state-contracted psychiatric PCHs. It is operated by the Seven Counties regional behavioral health authority and accepts mostly patients discharged from Central State Hospital. It serves a group of residents with far greater needs than the typical freestanding personal care home, and it serves many of them successfully in community settings. The center has a license for 38 beds, but currently has only 17 residents on site. The remainder are supported in apartments in various locations. The objective is to move all of its residents into the community and to close the PCH.

The center uses the Assertive Community Treatment concept to support its community clients. Program Review staff were given a tour of supported apartments its residents occupied. Center staff noted that often a 2-bedroom apartment worked well; also, sometimes 1-bedroom or 3-bedroom units were used.

The cabinet has given the center permission to use its state funding for unused beds to cover the community support program and has granted an additional \$300,000 to assist with the transition. A financial obstacle is that when state supplement recipients move into the community, they lose the supplement that provided a portion of the center's income. Kentucky Housing supplies housing vouchers to help cover rent for the center's community clients' housing.

Wellspring. Wellspring is a private, nonprofit agency in Louisville that provides housing and rehabilitative services for adults with SPMI. It may be the largest supported community living provider in Kentucky.

Wellspring provides more than 100 units of deeply subsidized rental housing for adults with SPMI. The housing is coupled with support services from Wellspring and Seven Counties. It also provides scattered-site leased apartments and supportive services for 22 residents with mental illness who have been identified as chronically homeless.⁵¹

^a Some programs reported they could bill Medicaid for limited case management and therapy services.

Wellspring residents often live on Supplemental Security Income and need housing subsidies to live in the community. Wellspring uses various forms of housing assistance, including

- the HUD Supportive Housing Program,
- housing developments with HUD grants and funds from Kentucky Housing Corporation and the city of Louisville, and
- housing vouchers for homeless adults.

Clients at Wellspring pay some of the costs. For example, clients in independent housing programs pay about one-third of their incomes for housing. Wellspring uses a different formula for each program to calculate its program fees but generally charges 60 percent of what remains after the client's portion of rent.

New Beginnings. New Beginnings Bluegrass Inc. is a nonprofit program in Lexington that provides a variety of housing and support services for individuals with diagnosed mental illness. Residents pay no more than 30 percent of their incomes for rent.⁵² In FY 2012, a total of 41 clients were served.

New Beginnings has 28 units of independent housing that it oversees and manages. It has two full-time outreach workers who conduct home visits, provide transportation, arrange for access to medical care and mainstream services, and organize and facilitate community activities. They monitor residents' well-being and make appropriate referrals when necessary. They do not provide clinical services but assure that all residents have access and are encouraged to engage in therapeutic services. New Beginnings reported that most of its clients receive psychiatric treatment through Bluegrass community mental health centers and that most of its clients have Medicaid.

A Different Spectrum Of Services

In-home services might not be adequate for some people with severe behavioral health disabilities. There are options for more intensive services in other living situations.

At least four times while he was a ward of the state, Larry Lee asked if he could live in his own apartment, the last time on the day before he left Falmouth Nursing Home. Based on available information, it is not clear whether he could have lived independently, even with support services. One assessment indicated that he should be checked on every 20 to 30 minutes, suggesting that he would have difficulty on his own.

Assertive Community Treatment proponents acknowledge that not everyone could live in the community even with intensive support services. There are many models that could provide a complete

spectrum of services. The following summarizes a spectrum of services and living arrangements based around intensive community support as described by Seven Counties and The Center for Rehabilitation and Recovery staff. Their concept is just one possibility.

Those with less intensive needs are being served in the community now through the community mental health centers. For those with greater needs, Assertive Community Treatment or similar models could provide services at an intensity tailored to individual needs at any given time. Services might vary between low and high intensity as the client's needs changed, and the types of services could also vary as needed. Costs would vary, too, depending on the services provided at any time. According to Seven Counties and the Center for Rehabilitation and Recovery staff, these types of services, coupled with housing subsidies for those with limited income, might serve over 90 percent of people with SPMI.

A few people with SPMI would need more supervision, so there could be an option for small residential settings similar to ID/DD group homes. These would have no more than 8 to 12 residents, around-the-clock staffing, and staff-to-resident ratios of 1:4 or 1:6 in the daytime with fewer staff at night. These settings might be able to serve the majority of those who were not in their own homes.

A more intense level of service might be small secure regional facilities or small locked wards within regular hospitals. These would offer 48 to 72 hours of crisis stabilization. Perhaps small crisis step-down facilities would provide a transition from crisis stabilization to lower levels of service for some clients. A very few people might need a secure setting in the intermediate or long term, so there could be a few small secure facilities for that purpose rather than the large psychiatric hospitals that exist today.

The role of personal care homes in the care of people with disabilities in any scenario is likely to decline significantly as intensive community services become more available.

In this model, there are no traditional psychiatric hospitals, and personal care homes have no people with SPMI or other behavioral disabilities in them. It is only one of many possibilities, but the role of PCHs in the care of people with disabilities in any scenario will probably decline significantly as intensive community services become more available.

Appendix A

How This Study Was Conducted

Program Review staff obtained documents from the Cabinet for Health and Family Services and interviewed cabinet officials for this study. Staff also received information from the Kentucky Housing Corporation. Other state and federal agencies were consulted, along with industry groups and resident advocates. Staff visited 13 PCHs, of which 12 were freestanding and 1 was part of a nursing facility. Of the freestanding PCHs, 3 were private-pay PCHs and 9 were supplement PCHs.

Survey Of Personal Care Homes

Program Review staff conducted a phone survey of all freestanding PCHs. The instrument consisted of

- basic information about the PCH as a whole and
- information about a random sample of 10 percent of current residents.

Information was gathered from August 9 to October 3, 2012. All 81 licensed freestanding PCHs responded to the basic portion of the survey.

While Program Review staff were collecting the early responses, some questions were refined. The refinements involved clearer wording or consolidation of information. Earlier responses were recoded, if necessary, to match the final categories.

An initial phone call was made to inform the PCH of the survey, to identify the appropriate respondents, to confirm or obtain an email address, and to set up a time to conduct the survey. In some cases, the PCH respondent completed the entire survey during the initial call. In other cases, Program Review staff sent the PCH respondent an edited copy of the instrument and a list of random numbers with instructions on selecting residents as indicated below. Program Review staff then called the PCH to conduct the survey.

A different procedure was used for some PCH operators, particularly some with multiple PCHs. The PCH section was completed by phone, and the PCH operator was told how to complete the resident sections on paper, which were then faxed to Program Review staff. In some cases, the operators completed the entire survey on paper.

The question requesting the correct number of beds licensed was used in practice to capture significant capacity limitations. It recorded the actual capacity when it was less than the licensed capacity because of situations such as rooms closed for renovation or beds removed and not currently available.

Some PCHs indicated that they did not know whether or not certain residents received state supplementation because the state guardianship program received the residents' checks and

wrote another check to the PCH. About halfway through the survey, cabinet officials reported that 108 wards, or 17 percent of all wards living in PCHs, paid with their own resources and not with state supplementation. Some private-pay wards probably were counted incorrectly as being state supplementation recipients.

The number of residents represents the number present on the day of the survey; therefore, there probably is some difference between the totals accumulated over the 8 weeks of the survey and the actual total on any given day. The numbers associated with each reason or payment method may not be exact in all cases; respondents were asked to estimate if they were not certain.

Distinguishing Private-Pay From Supplement Personal Care Homes

Program Review staff examined the percentage of private-pay residents, the overall population, and the amount charged for private-pay residents. The PCH classification was based on the percentage of private-pay residents. Those above 70 percent were considered private-pay PCHs. Those below 40 percent were considered supplement PCHs. The rest were considered a mixed type. Those thresholds were chosen because the upper cutoff distinguished private-pay PCHs from the others and the lower cutoff divided the remainder into those with rates and populations most like state supplement recipients and those that were mixed.

None of the private-pay PCHs accepted any residents with state supplementation. Only one accepted residents who required a subsidy, and those were covered by an endowment.

All PCHs in the mixed group accepted both private-pay and supplementation residents in similar numbers. They ranged from 44 percent to 70 percent private-pay residents.

Of the supplement PCHs, two had 37 percent and 38 percent private-pay residents, but they had a mix of elderly and people with disabilities, and their private-pay rates were comparable to the supplementation rate. Of the 50 supplement PCHs, 32 had 10 percent or fewer private-pay residents.

Determining Average Rates

The survey asked PCHs for their range of private-pay charges. High-end rates often involved additional services and amenities. In some cases, the high-end rate was for an expensive memory care unit within a PCH that otherwise served mostly the elderly without dementia. For the purpose of determining average private-pay rates charged by PCHs, Program Review staff used the low-end rate, which is the least a resident could pay to stay at the PCH.

Resident Survey Data

The resident portion of the survey was found to be causing delays in completion of the basic survey, so the resident portion was suspended with a few exceptions in the interest of time. The available resident survey population was found to differ significantly from the populations described on the basic PCH form, primarily by showing far fewer elderly residents. For that

reason, resident survey data are not reported and are used only to support general statements for which there is additional evidence.

To select the 10 percent sample of residents, the number of licensed beds was rounded up to the nearest 10, the result was divided by 10, and that many random numbers were generated. The PCH operator was asked to select the “n”th resident from whatever list or filing system the PCH used. The procedure was adjusted if the number of residents was less than the number of beds.

When the exact date of admission was not known, the 15th of the month was used. If the month was not known, July 1 was used.

Calculation Of Pre-1980 Supplement Rates

The cabinet provided a list of state supplementation standards from 1980 to the present. The list noted the amount of the personal needs allowance at each point. The 1980 allowance was \$25.

Program Review staff found statements in a 1977 Legislative Research Commission report that the reimbursement rate for PCHs was \$320 in 1977 and \$310 in 1976. The report did not mention a personal needs allowance, so Program Review staff assumed that if there had been an allowance it would have been no more than the \$25 reported in 1980.

The 1972 *Survey Report On Personal Care Facilities* included a copy of the regulations for payment of PCHs. State supplementation was not in effect at that time. Those regulations identified three classes of PCHs, the amount paid by public assistance, and the maximum amount permitted including both public assistance and federal or private benefits:

- Class I—meets maximum standards. Public Assistance pays \$186 a month and will allow the use of Social Security benefits, Railroad Retirement, VA pension, etc. up to \$229.
- Class II—almost meets maximum standards. Public Assistance pays \$171 a month and will allow the use of Social Security, etc. up to \$214 a month.
- Class III—meets minimum standards. Public Assistance pays \$161 a month and will allow the use of Social Security, etc. up to \$199 a month.⁵³

The report stated that the number of Class I PCHs was 179 with 10,256 beds, while Classes II and III together accounted for 47 PCHs with 914 beds.⁵⁴ Therefore, Program Review staff used the predominant Class I rate. Assuming a model similar to current state supplementation, Program Review staff used the full amount of \$229. The report was ambiguous about whether residents kept any personal spending allowance, so Program Review staff assumed that if there had been an allowance it would have been no more than the \$25 reported by the cabinet for 1980.

Appendix B

State Supplementation Payment Standards

Personal Care Home Payment Standards And Personal Needs Allowances Nominal And Constant 2012 Dollars 1972 To 2012

Year	State Supplementation Payment Standard		Personal Needs Allowance		Amount Personal Care Home Received	
	Nominal	Constant	Nominal	Constant	Nominal	Constant
1972*	\$229	\$1,268	\$25**	\$138	\$204	\$1,129
1976*	310	1,261	25**	102	285	1,159
1977*	320	1,222	25**	95	295	1,126
1980	409	1,149	25	70	384	1,078
1981	436	1,110	25	64	411	1,046
1982	456	1,093	25	60	431	1,034
1983	466	1,083	25	58	441	1,025
1984	476	1,060	25	56	451	1,004
1985	487	1,047	25	54	462	994
1986	498	1,051	33	69	466	983
1987	517	1,053	40	81	477	972
1988	546	1,068	40	78	506	990
1989	568	1,060	40	75	528	985
1990	625	1,107	40	71	585	1,036
1991	698	1,185	40	68	658	1,117
1992	720	1,188	40	66	680	1,122
1993	732	1,172	40	64	692	1,108
1994	780	1,218	40	62	740	1,155
1995	792	1,203	40	61	752	1,142
1996	804	1,186	40	59	764	1,127
1997	818	1,179	40	58	778	1,122
1998	863	1,225	40	57	823	1,168
1999	894	1,242	40	56	854	1,186
2000	906	1,218	40	54	866	1,164
2001	946	1,237	40	52	906	1,184
2002	985	1,267	40	51	945	1,216
2003	992	1,248	40	50	952	1,197
2004	1,004	1,230	40	49	964	1,181
2005	1,059	1,255	50	59	1,009	1,196
2006	1,123	1,289	60	69	1,063	1,220
2007	1,143	1,276	60	67	1,083	1,209
2008	1,157	1,244	60	64	1,097	1,179
2009	1,194	1,288	60	65	1,134	1,223
2010	1,194	1,267	60	64	1,134	1,203

Year	State Supplementation Payment Standard		Personal Needs Allowance		Amount Personal Care Home Received	
	Nominal	Constant	Nominal	Constant	Nominal	Constant
2011	1,194	1,228	60	62	1,134	1,167
2012	1,218	1,218	60	60	1,158	1,158

Note: Weighted amounts were calculated for the state supplementation payment standards for the years in which the standard changed midyear (1990, 1991, 1998, 2001, and 2005) and for the personal needs allowance for the years in which the allowance changed midyear (1986 and 2005). Dollar amounts were converted to 2012 constant dollars using the Consumer Price Index All Urban Consumers (CPI-U), US city average, all items, 1982-84=100.

*Reimbursement rates were not available for 1973-1975 and 1978-1979. See Appendix A for an explanation of the 1972, 1976, and 1977 rates and personal needs allowances.

**Information about the personal needs allowance for these years was unavailable, so the allowance from 1980 was used to produce the most conservative estimate.

Sources: Kentucky. Governor's Advisory Council on Mental Retardation. *Survey Report On Personal Care Facilities*. Frankfort: GACMR, 1972. Pp. 40-41; Kentucky. Auditor of Public Accounts. *Kentucky's Adult Public Guardianship Services*. Frankfort: APA, June 2008; Kentucky. Legislative Research Commission. *Nursing Homes In Kentucky*. Research Report No. 146. Frankfort: LRC, 1977. Pp. 36, 53; information provided by the Cabinet for Health and Family Services for 1980 to 2012; United States. Dept. of Labor. Bureau of Labor Statistics. "Consumer Price Index All Urban Consumers (CPI-U). US city average. All items. 1982-84=100. October 16, 2012." Web. Oct. 17, 2012.

Appendix C

Kentucky Medicaid Waiver Programs

Overview Of Kentucky Waiver Programs

This appendix describes the Medicaid waiver programs that apply to the elderly and people with intellectual and developmental disabilities or acquired brain injuries. Some people in these groups reside in personal care homes.

Table C.1
Description Of Waivers

Waiver	Target Group	Brief Description
Acquired Brain Injury	Individuals with an acquired brain injury (ABI) between age 21-65 who meet nursing facility level of care	This rehabilitation waiver is designed to provide intensive services and supports to adults with acquired brain injuries as they work to re-enter community life.
Acquired Brain Injury Long-Term Care	Individuals at least 18 years old who have an ABI that necessitates <ul style="list-style-type: none"> • supervision, • rehabilitative services, and • long-term supports and have an ABI that involves cognition, behavior, or physical function	The purpose is to provide an alternative to institutional care to individuals with acquired brain injury who require maintenance services.
Home and Community Based	Aged or disabled individuals who meet nursing facility level of care, who without these waiver services may be admitted to a nursing facility	This waiver is designed to provide intensive services and support to aged or disabled individuals (children and adults) to enable them to remain in or return to their home.
Michelle P.	Individuals with intellectual or developmental disabilities who meet ICF/MR or nursing facility level of care*	The purpose is to provide services and supports to individuals (children or adults) with intellectual or developmental disabilities to enable them to remain in the community in the least restrictive setting.
Supports for Community Living	Individuals with intellectual and developmental disabilities who meet ICF/MR level of care*	This waiver is designed to provide intensive services and supports to individuals (children or adults) with intellectual or developmental disabilities to enable them to remain in the community in the least restrictive setting.

*“ICF/MR” = intermediate care facility for intellectual or developmental disabilities.

Source: Kentucky. Cabinet for Health and Family Services. Dept. for Medicaid Services. “Medicaid Waiver Programs. Current Waivers.” No date. Web. Oct. 1, 2012.

Table C.2
Numbers Served Under Kentucky Medicaid Waivers
Waiver Years 2008 To 2013

Waiver Year	Acquired Brain Injury	Acquired Brain Injury Long-Term Care	Home And Community Based	Michelle P.	Supports For Community Living
2008	181	N/A	11,659	N/A	3,189
2009	191	53	12,017	589	3,326
2010	182	163	12,050	2,511	3,442
2011	200	200	11,572	4,393	3,540
2012	200	224	10,955	4,440*	3,575*
2013	240*	320*	11,100*	4,480*	3,611*

Note: Most waivers operate on the state fiscal year. The Acquired Brain Injury waiver operates Jan. 1 to Dec. 31. The Supports for Community Living operates Sept. 1 to Aug. 31.

*Planned numbers were used where actual numbers were not available. The cabinet indicated that the information came from these federal waiver reports: Acquired Brain Injury (Dec. 31, 2011); Acquired Brain Injury Long-term Care (June 30, 2011); Home and Community Based (June 30, 2012); Michelle P. (June 30, 2011); and Supports for Community Living (Aug. 31, 2011).

Source: Information provided by the Cabinet for Health and Family Services.

Table C.3
Waiting Lists For Kentucky Medicaid Waivers
Waiver Years 2008 To 2012

Waiver Year	Acquired Brain Injury	Acquired Brain Injury Long-Term Care	Home And Community Based	Michelle P.	Supports For Community Living
2008	0	N/A	0	N/A	2,703
2009	0	0	0	0	2,734
2010	0	0	0	0	2,240
2011	222	15	0	0	2,236
2012	260	62	0	0	2,259

Note: Most waivers operate on the state fiscal year. The Acquired Brain Injury waiver operates Jan. 1 to Dec. 31. The Supports for Community Living operates Sept. 1 to Aug. 31. Waiting list information was not taken from federal waiver reports, so it is current for all waiver years.

Source: Information provided by the Cabinet for Health and Family Services.

Table C.4
Dollars Spent For Kentucky Medicaid Waivers
Waiver Years 2008 To 2013

Waiver Year	Acquired Brain Injury	Acquired Brain Injury Long-Term Care	Home And Community Based	Michelle P.	Supports For Community Living
2008	\$13,042,365	N/A	\$65,787,977	N/A	\$213,376,504
2009	14,750,318	\$1,187,216	72,857,584	\$3,466,495	231,322,006
2010	15,054,334	6,526,392	77,703,194	29,813,202	242,071,980
2011	15,738,422	10,525,826	79,810,820	77,636,917	251,133,731
2012	18,090,141*	11,730,275*	81,088,016	78,473,887*	253,695,069*
2013	21,708,168*	16,757,536*	82,161,295*	79,258,625*	256,181,518*

Note: Most waivers operate on the state fiscal year. The Acquired Brain Injury waiver operates Jan. 1 to Dec. 31. The Supports for Community Living operates Sept. 1 to Aug. 31. All dollar amounts shown are combined state and federal funds as reported in the federal CMS 372 report.

*Budgeted numbers were used where actual numbers were not available. The cabinet indicated that the information came from federal waiver reports with the following dates: Acquired Brain Injury (Dec. 31, 2011); Acquired Brain Injury Long-Term Care (June 30, 2011); Home and Community Based (June 30, 2012); Michelle P. (June 30, 2011); and Supports for Community Living (Aug. 31, 2011).

Source: Information provided by the Cabinet for Health and Family Services.

Appendix D

State And Local Agencies Related To Personal Care Homes

Cabinet For Health And Family Services

The Office of Inspector General's Division of Health Care

- issues licenses;
- ensures that PCHs follow all applicable laws and regulations; and
- takes action to enforce correction of violations, including denying, revoking, and suspending licenses.

The Office of Health Policy is responsible for reporting basic long-term care census information. The office's Division of Certificate of Need determines whether new PCH beds are needed.

The Department for Aging and Independent Living's Long-Term Care Ombudsman visits and educates PCH residents and advocates for their interests. The department's Division of Guardianship provides guardianship services for wards of the state, and the Traumatic Brain Injury Program helps people with brain injuries find services.

The Department for Community Based Services' Division of Family Support administers the state supplementation fund for recipients of public assistance residing in PCHs. It also is responsible for the administration of the Mental Health or Mental Retardation Supplement Program for PCHs that participate.

The department's Division of Protection and Permanency provides adult protective services for PCH residents who experience abuse, neglect, or exploitation. The division also conducts semiannual inspections of PCHs.

The Department for Behavioral Health, Developmental and Intellectual Disabilities

- operates specialized PCHs through regional boards,
- operates state psychiatric hospitals directly or through regional boards,
- contracts with regional boards for therapeutic services to PCH residents by community mental health centers, and
- assists with alternative living options for persons with mental illness and intellectual and developmental disabilities.

The Department for Medicaid Services

- covers health and behavioral health services for many PCH residents;
- covers community alternatives to institutionalization for elderly members and members with intellectual, developmental, and physical disabilities; and
- in 2013, will cover community alternatives to institutionalization for members with severe and persistent mental illness.

The Department for Income Support determines whether an applicant meets the criteria for disability under Supplemental Security Income or Social Security Disability Insurance.

The Department for Public Health locally regulates PCH food service facilities through local and regional health departments.

Justice And Public Safety Cabinet

PCH residents with disabilities are visited by and receive education from Kentucky Protection and Advocacy, an independent division of the Department of Public Advocacy. The division also advocates for the interests of PCH residents with disabilities.

The Department of Corrections is responsible for finding places for released prisoners to live.

Public Protection Cabinet

The Department of Insurance regulates insurers who cover long-term care expenses, including PCH stays.

In some counties the Department of Housing, Buildings, and Construction enforces building and fire codes.

Labor Cabinet

The Department of Workplace Standards educates PCHs about occupational safety and health rules for PCH employees and enforces those rules.

Finance And Administration Cabinet

Federal and state housing assistance that can be used for community alternatives is administered by the Kentucky Housing Corporation.

Office Of The Governor

The Department of Veterans Affairs assists veterans in obtaining benefits that may be used to cover PCH expenses.

Independent Agency

The Kentucky Board of Nursing establishes rules governing the practice of nursing and the delegation of nursing tasks to unlicensed personnel.

Judicial System

Kentucky's courts hear requests for commitment to psychiatric hospitals or intermediate care facilities, along with petitions for private and state guardianship.

Local Government Agencies

When residents fail to return, become violent, or exhibit threatening behavior, or when PCH staff request involuntary commitment of residents, local law enforcement and prosecutors can provide assistance.

In most counties, local code enforcement offices enforce building and fire codes.

Appendix E

Kentucky Laws And Regulations Related To Personal Care Homes

Statutes

Public Assistance And Medical Assistance

KRS 205.245 Establishes state supplementation of federal Supplemental Security Income benefits

Adult Protective Services

KRS 209.550 Exempts personal care homes from definition of “long-term care facility” just for purposes of KRS 209.550 to 209.554

State And Regional Mental Health Programs

KRS 210.271 Requires cabinet to visit boarding homes where discharged patients of state mental health facilities reside and report any that are suspected of operating as unlicensed personal care homes

Health Facilities And Services Including Long-Term Care

KRS 216.2920–
KRS 216.2929 Require facilities and providers to collect and report health data to cabinet

KRS 216.510 Defines long-term care to include personal care homes

KRS 216.515 Defines minimum rights of long-term care residents; creates legal cause of action if rights are infringed

KRS 216.520 Supplements rights of long-term care residents, including developing individual care plans with each resident’s participation

KRS 216.525 Allows cabinet to enforce rights of residents in long-term care

KRS 216.530 Requires inspections of long-term care facilities to be unannounced

KRS 215.532 Denies employment to persons on nurse aide abuse registry

KRS 215.533 Requires employment background checks for applicants

KRS 216.535 Defines long-term care to include and personal care homes; specifies information to be disclosed to patients on admission

KRS 216.537	Specifies minimum visiting hours for long-term care facilities
KRS 216.540	Specifies persons who may visit and persons who have unrestricted access
KRS 216.541	Prohibits retaliation against whistle-blowers and interference with long-term care ombudsman
KRS 216.543	Establishes information-posting requirements
KRS 216.545	Lists additional posting requirements
KRS 216.547	Lists information that must be available to public on demand
KRS 216.546	Requires disclosure to residents when rooms lack sprinkler systems
KRS 216.555	Mandates written citations for each violation; sets format for citation
KRS 216.557	Defines Type A and Type B violations
KRS 216.560	Provides penalties for violations
KRS 216.563	Designates cabinet as responsible for establishing and reviewing actions that constitute Type A and Type B violations
KRS 216.565	Lists factors for cabinet to consider in applying penalties
KRS 216.567	Establishes appeal process regarding citations
KRS 216.573	Authorizes cabinet to seek injunction to compel corrections or terminate operations of facilities with violations
KRS 216.575	Allows discipline of cabinet employees who give facilities advance notice of inspections
KRS 216.577	Mandates injunctive actions for uncorrected Type A violations; allows transfer of residents
KRS 216.580– KRS 216.587	Creates and lists duties of Long-Term Care Coordinating Council
KRS 216.590	Provides for training of cabinet surveyors and investigators
KRS 216.595	Requires disclosure regarding purported specialized services for persons with brain disorders, including Alzheimer’s disease
KRS 216.750	Defines <i>personal care home</i>

- KRS 216.765 Requires medical examination prior to admission to personal care home; prohibits admission of those under 18 years of age
- KRS 216.770 Establishes nursing home and personal care home loan fund^a
- KRS 216.789 Requires preemployment checks with Justice and Public Safety Cabinet for all prospective employees
- KRS 216.925 Prohibits “midlevel health practitioners” from providing treatment in personal care homes and other licensed facilities

Licensure And Regulation Of Health Facilities And Services

- KRS 216B.015 Defines *health facilities* to include personal care homes
- KRS 216B.020 States which health facilities require certificates of need; exempts personal care homes from formal review of certificates of need
- KRS 216B.042 Establishes licensing procedures for health facilities
- KRS 216B.072 Requires training and continuing education on treating Alzheimer’s disease and other brain disorders; excludes personal care homes
- KRS 216B.105 Explains hearing procedures for denial, suspension, or revocation of licenses
- KRS 216B.155 Mandates development of quality assurance standards; exempts personal care homes

Hotel And Food Service

- KRS Chapter 219 Includes certain hotel statutes that apply to personal care homes, per the Office of Inspector General^b
- KRS 219.011 Provides definitions for KRS 219.011 to 219.081
- KRS 219.031 Establishes right of cabinet and local health department employees to inspect facilities
- KRS 219.051 Allows fire marshal to enforce regulations against hotels

^a According to cabinet officials, no funds have been appropriated to this fund in the recollection of anyone currently with the cabinet.

^b The statutes listed here were included in the Office of Inspector General booklet “Personal Care Home Regulations.”

Registered Nurses—Practical Nurses

- KRS 314.011 Defines terms for chapter regarding registered and practical nurses, including scope of practice of nursing and definition of *medication administration*
- KRS 314.031 Defines unlawful acts related to practice of nursing

Guardianship Generally

- KRS 387.330 Allows nondisabled adults to petition for the appointment of guardian

Guardianship Of Disabled Persons

- KRS 387.500 Declares purpose of full and partial guardianship for disabled persons
- KRS 387.510 Provides definitions for KRS 387.500 to 387.770 and 387.990 (penalties)
- KRS 387.520 Places jurisdiction in District Courts and sets venue
- KRS 387.530 Establishes contents for petition of guardianship
- KRS 387.540 Requires interdisciplinary evaluation team to review petitions for guardianship
- KRS 387.550 Sets length of time between petitions and hearings
- KRS 387.570 Defines procedure and evidentiary burden for guardianship hearings
- KRS 387.580 Explains role of jury in determining disability, and role of judge in setting guardianship powers
- KRS 387.590 Separates personal affairs from financial affairs in guardianship and conservatorship orders
- KRS 387.600 Directs court to consider ward's preferences in appointing guardian
- KRS 387.605 Lists qualifications to be considered in appointing guardian
- KRS 387.620 Establishes procedures to review, modify, or remove guardianship; can be initiated by ward or another interested person
- KRS 387.640 Defines general duties of guardians and limited guardians
- KRS 387.650 Allows court to assign additional duties to those of limited guardian

KRS 387.660	Assigns specific powers and duties to guardian
KRS 387.670	Requires guardian to file annual report with court
KRS 387.730	Allows guardian to nominate successor in case of guardian's death
KRS 387.740	Allows for emergency petition for limited guardianship
KRS 387.750	Permits courts to designate stand-by guardian; sets out procedure
KRS 387.760	Explains payment limits on guardians; allows courts to approve additional payments
KRS 387.790	Establishes procedure for guardian to seek court approval of controversial expenditures

Administrative Regulations

Board Of Nursing

201 KAR 20:400	Governs delegation of nursing tasks to unlicensed persons and paramedics
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Long-Term Care Insurance

806 KAR 17:081	Sets minimum standards for long-term care insurance policies
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Long-Term Care Facilities

900 KAR 2:040	Details criteria and specific acts that constitute regulatory violations in long-term care facilities
900 KAR 2:050	Explains transfer and discharge rights of residents in long-term care
900 KAR 2:060	Explains process for appealing involuntary transfers or discharges from long-term care
900 KAR 6:060	Describes timetable for applications for certificates of need
900 KAR 6:125	Establishes requirements for long-term care facilities to provide annual survey information related to certificates of need

Health Services And Facilities

902 KAR 20:008	Establishes requirements for health facility licensing and procedure for obtaining a variance
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- 902 KAR 20:031 Provides construction and maintenance specifications for personal care homes
- 902 KAR 20:036 Details operations and scope of services in personal care homes
- 902 KAR 20:200 Regulates tuberculosis testing in long-term care facilities; specifies necessary actions upon positive results
- 902 KAR 45:005 Contains Kentucky food code that applies to food service operations

Office Of Inspector General

- 906 KAR 1:120 Establishes informal dispute resolution process for findings of deficiency at long-term care facilities

Medicaid

- 907 KAR 1:006 Describes Medicaid coverage for Medicare recipients, including recipients of state supplementation
- 907 KAR 1:011 Describes eligibility for Medicaid, including recipients of Supplemental Security Income and state supplementation
- 907 KAR 1:160 Prohibits home and community-based waiver services from being provided in a personal care home
- 907 KAR 1:640 Describes Medicaid-Medicare dual eligibility for state supplement recipients

Institutional Care

- 908 KAR 3:030 Includes personal care facilities as less confining environments when involuntarily committed mentally ill patients or those with intellectual disabilities are released to convalescent care

Guardianship

- 910 KAR 2:020 Establishes criteria under which cabinet may serve as guardian for adult
- 910 KAR 2:030 Provides guidelines for handling adult ward's finances when cabinet serves as guardian
- 910 KAR 2:040 Establishes guidelines for provision of services to adult ward when cabinet serves as guardian
- 910 KAR 2:050 Sets procedures for compensation when cabinet serves as guardian

State Supplementation

- 921 KAR 2:015 Establishes provisions of the Supplemental Security Income supplementation program, including Mental Illness or Mental Retardation Supplement Program (MI/MR Program)
- 921 KAR 2:035 Describes application and reapplication procedures for state supplementation and other programs
- 921 KAR 2:040 Describes eligibility determination procedures for state supplementation and other programs
- 921 KAR 2:050 Describes time and manner of payments for state supplementation and other programs, including MI/MR Program
- 921 KAR 2:055 Establishes hearing and appeals procedures for state supplementation and other programs

Adult Services

- 922 KAR 5:100 Establishes Alternate Care for Adults Program; includes personal care homes

Appendix F

Personal Care Home Survey

These are the questions and basic quantified information from the Program Review staff survey of personal care homes.

1. Which of these best describes the facility?	
a. Personal care only (stand-alone)	69
b. Multiple levels of care including personal care (describe):	12
Total:	81
2. The personal care home directory shows that you have a license for ____ beds.	4,433
a. Is that correct? [If not, ask...] What is the correct number? ^a	4,387
b. How many residents do you currently have?	3,777
3. Which types of residents does the PCH serve? ^b	
a. Elderly, not otherwise disabled	1,093
b. Alzheimer's or other forms of dementia	554
c. Other disability—mental illness, intellectual disability, or physical disability (describe):	2,130
d. Other reason (describe):	2
Total:	3,779 ^c
4. Which of the following ways do your residents pay for the cost of staying at your PCH? Choose as many as apply: ^d	
a. State supplement	2,317 ^e
b. Personal or family income, assets, insurance, or pensions	1,448
c. Other (describe):	13
Total:	3,778 ^f

^a During the interviews, Program Review staff also recorded the number of usable beds if that was less than the number of licensed beds. The result is the usable capacity of PCHs.

^b Respondents were asked to count each resident in only one category. Of the 81 respondents, 64 responded with numbers and 17 responded with percentages. Percentages were applied to the number of current residents (question 2.b) to calculate the estimated number for each group.

^c The total here does not match question 2.b because of rounding introduced by the use of percentages.

^d Respondents were asked to count each resident in only one category. Of the 81 respondents, 68 responded with numbers and 13 responded with percentages. Percentages were applied to the number of current residents (question 2.b) to calculate the estimated number for each group.

^e It is possible that some state wards who should have been counted as private pay were counted in the state supplement group. See Appendix A for an explanation.

^f The total here does not match question 2.b because of rounding introduced by the use of percentages.

- 5. What are your monthly charges for private pay PCH residents?**^g
- N/A
 - Range _____ to _____ based on occupancy and amenities (describe):
\$1,158 to \$15,000
 - Sliding scale based on ability to pay _____ to _____ (describe):
\$1,158 to \$2,328
 - Other (describe): No PCHs in the Other category
- 6. Does the PCH employ or contract with any nurses (LPN or RN)?** Yes: 51
No: 30
- Describe if needed:
Total: 81
- 7. Some PCHs receive donations of money or items you would otherwise have to buy. How much would you estimate you receive each year for the following?**
- Money toward operations or other expenses: \$ _____
Seven respondents reported donations from \$100 to \$22,000
 - Supplies, materials, or services the PCH would otherwise have to purchase: \$ _____
Eleven respondents reported in-kind donations valued from \$300 to \$8,957^h
- 8. Is the PCH operated by a**
- Privately owned business 65
 - Nonprofit organization (describe): 13
 - Other (describe):ⁱ 3
- Total: 81

^g Program Review staff sometimes asked what a PCH would charge for private-pay residents even if it did not have any. That information was also recorded in question 5.

^h Program Review staff did not count gifts intended for residents. Some of the 11 respondents for question 7.b did not know the value of the in-kind donations.

ⁱ The three specialized state-contracted PCHs were assigned to the Other (8.c) category. All other respondents selected either 8.a or 8.b.

Endnotes

- ¹ Stevie Lowery. "Larry's Law—Legislation Aimed At Improving The Care And Safety Of Those In Personal Care Homes." *Lebanon Enterprise*. May 2, 2012. NewsBank. May 3, 2012.
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- ³ United States. Dept. of Health and Human Services. Natl. Institutes of Health. "Fact Sheet-Intellectual And Developmental Disabilities." Oct. 2010. Web. Sept. 23, 2012; Amer. Assn. on Intellectual and Developmental Disabilities. "FAQ On Intellectual Disability." Web. Oct. 16, 2012.
- ⁴ Kentucky. Justice and Public Safety Cabinet. Dept. of Public Advocacy. Kentucky Protection and Advocacy. *Personal Care Homes In Kentucky, Home Or Institution?* Frankfort: P&A, 2012. P. 9.
- ⁵ Ronald C. Kessler et al. "Age Of Onset Of Mental Disorders: A Review Of Recent Literature." *Current Opinion in Psychiatry* 20:4 (2007): 359-364.
- ⁶ Kentucky. Justice and Public Safety Cabinet. Dept. of Public Advocacy. Kentucky Protection and Advocacy. *Personal Care Homes In Kentucky, Home Or Institution?* Frankfort: P&A, 2012. P. 9.
- ⁷ United States. Social Security Administration. *Understanding Supplemental Security Income*. 2012 Ed. Web. Oct. 30, 2012. Pp. 10-11, 17.
- ⁸ *Ibid.*, Pp. 12, 21-24.
- ⁹ *Ibid.*, Pp. 22, 70.
- ¹⁰ *Ibid.*, P. 17.
- ¹¹ Kentucky. Cabinet for Health and Family Services. Dept. for Community Based Services. Division of Family Support. *Operation Manual Volume IVA Medicaid (MA) And State Supplementation*, section MS 4900. Web. Oct. 30, 2012.
- ¹² *Ibid.*, sections MS 4900 to MS 4910.
- ¹³ *Ibid.*, section MS 4960.
- ¹⁴ United States. Dept. of Health and Human Services. Centers for Medicare and Medicaid Services. "Long-Term Services And Support." Web. Nov. 1, 2012.
- ¹⁵ Neville Wise. Acting commissioner, Dept. for Medicaid Services, Cabinet for Health and Family Services. Letter to Jackie Glaze. Dec. 28, 2010.
- ¹⁶ Jackie Glaze. Associate regional administrator, Division of Medicaid and Children's Health Operations, Centers for Medicare and Medicaid Services, US Dept. of Health and Human Services. Letter to Neville Wise. May 24, 2011.
- ¹⁷ Kentucky. Legislative Research Commission. *Nursing Homes In Kentucky*. Research Report No. 146. Frankfort: LRC, 1977. P. 125.
- ¹⁸ United States. Dept. of Health and Human Services. Centers for Medicare and Medicaid Services. "Individuals With Disabilities." Web. Nov. 1, 2012.
- ¹⁹ United States. Dept. of Health and Human Services. Centers for Medicare and Medicaid Services. *The State Medicaid Manual (Publication #45)*. "Chapter 4—Services." Baltimore: CMS, 2000. Web. Nov. 1, 2012.
- ²⁰ United States. Dept. of Health and Human Services. Centers for Medicare and Medicaid Services. *Your Guide To Medicare Prescription Drug Coverage*. Baltimore: CMS, 2012. Web. Nov. 1, 2012.
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- ²² Chin-Kuo Chang et al. "Life Expectancy At Birth For People With Serious Mental Illness And Other Major Disorders From A Secondary Mental Health Care Case Register In London." *Plos ONE* 6.5 (2011): 1-6. Academic Search Premier. Oct. 22, 2012.
- ²³ Kentucky Board of Nursing. "Roles Of Nurses In The Supervision And Delegation Of Nursing Tasks To Unlicensed Personnel." Web. Oct. 22, 2012.
- ²⁴ American Psychiatric Association. *Quick Reference To The Diagnostic Criteria From DSM-IV*. Washington: APA, 1994.
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