	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		200 NUR	ADDRESS, CITY, STATE, ZIP CODE RSING HOME LANE LLE, KY 41501	1 03/	30/2021	
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{F 600}	6). Interview with the 3:53 PM revealed shresident diets on 08/2 that she implemented recommendations for loss and/or wound he documentation revealed all residents DON reviewed all die Interview with the RD revealed she comple and recommendation 7). A review of facility 08/13/2021 revealed with a diagnosis of D signs and symptoms hyperglycemia and thintervention. Interview 09/30/2021 at 4:17 P the residents and did concerns. Observation 09/28/2021 at 11:52 signs/symptoms of hyperglycemia and the review of facility as 08/12/2021 revealed diagnosis of Chronic Disorder (COPD), As assessed by Respira with Respiratory The at 12:45 PM revealed with diagnoses of Chronic with diagnoses of Chronic with diagnoses of Chronic Position 12:45 PM revealed with diagnoses of Chron	Dietician on 09/30/2021 at a began reviewing all 18/2021. She further stated if new and/or additional residents to address weight bealing. A review of the led the Registered Dietician of diets, and the Regional at and recommendations. To on 09/30/2021 at 4:17 PM led the review of all diets s.  The assessments completed by thirty-nine (39) residents is abetes were assessed for of hypoglycemia/ he need for immediate with the Regional DON on M revealed she assessed not identify immediate with the Regional DON on M, Resident #348 on M, Resident #320 on AM, and Resident #311 on AM revealed no visible proglycemia/hyperglycemia.  Sessments completed on fifty (50) residents with a Obstructive Pulmonary thma and Pneumonia were tory Therapist #1. Interview rapist (RT) #1 on 09/30/2021 if she assessed all residents ronic Obstructive Pulmonary thma, and pneumonia	{F 6	00)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			T	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		<u> </u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION	SHOULD BE		(X5) COMPLETION DATE
{F 600}	Observation of Resident #43 PM, Resident #45 PM, and Resident #45 revealed no respirator 8). Interview with the on 09/30/2021 at 3:40 all residents with a dia resident's orders for g stated the facility ame include mandatory en MAR. Review of Resident's revealed each the glucose value on review revealed no containing glucose levels than 400.  9). A review of audits revealed meals were with the Regional Cer (RCDM) on 09/28/2020 09/30/2021 at 1:52 PM observed on 09/11/20 within five (5) to ten (1 scheduled times.  10). A review of the face of	ent #45 on 09/28/2021 at 1:40 3 on 09/28/2021 at 1:40 3 on 09/28/2021 at 2:03 PM. By distress.  Regional Nurse Consultant Depth revealed she reviewed agnosis of Diabetes and the plucose monitoring. She ended all resident orders to try of glucose values on the dent #3, #41, and #357's order required staff to enter the resident's MAR. Further bucerns with residents less than 60 and/or greater.  Completed on 09/11/2021 delivered timely. Interview tified Dietary Manager 21 at 2:26 PM, and M revealed lunch was 121 and arrived at the unit 10) minutes of the end facility's staffing for AM to 6:00 PM revealed es and three (3) nursing duled for each floor of the end facility's staffing revealed end two (2) certified each floor from 6:00 PM to 19/29/2021 and 19/29/29/2021 and 19/29/2021 and 19/29/2021 and 19/29/29/2021 and 19/29/29/2021 and 19/29/29/29/29/29/	{F 6	600}			
	10). A review of the fa 09/28/2021 from 6:00 two (2) licensed nurse assistants were sched facility. A review of the one (1) licensed nurse nursing assistants for 6:00 AM.  A review of the staffing 09/30/2021 revealed to	AM to 6:00 PM revealed es and three (3) nursing duled for each floor of the a facility's staffing revealed e and two (2) certified each floor from 6:00 PM to					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	30/2021
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 600) Continued From page 158 from 6:00 AM to 6:00 PM. Further review of staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM.  Observation of facility staffing on 09/28/2021 from 1:20 PM to 5:30 PM; on 09/29/2021 from 8:11 AM to approximately 6:00 PM and 09/30/2021 from 7:55 AM to 5:17 PM, revealed call lights were being answered timely, residents appeared clearn/well-groomed, staff was offering and assisting residents with baths/showers, turning/repositioning was being conducted timely, and meal trays were passed timely.  Interviews with RN #1 on 09/29/2021 at 11:55 AM and on 09/30/2021 at 12:58 PM; RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM; LPN (Licensed Practical Nurse) #6 on 09/30/2021 at 12:44 PM; LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM; LPN #10 on 09/30/2021 at 1:54 PM; LPN #10 no 09/30/2021 at 1:54 PM; LPN #10 no 09/30/2021 at 3:04 PM; SRNA #11 on 09/29/2021 at 3:40 PM; SRNA #11 on 09/29/2021 at 3:23 PM; SRNA #7 on 09/29/2021 at 3:29 PM; SRNA #19 on 09/29/2021 at 3:04 PM; SRNA #22 on 09/29/2021 at 3:31 PM and SRNA #23 on 09/29/2021 at 3:31 PM and SRNA #22 on 09/29/2021 at 3:31 PM and SRNA #2	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION	(X3) DATE	SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER			67	POCET ADDRESS CITY OF THE SECTION	09	/30/2021
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{F 600}	Continued From page	159	{F6	00}			
	schedule. Interview w at 1:12 PM, and Dieta 2:10 PM revealed kito	ing was accurate per the ith Cook #3 on 09/29/2021 at you Aide #3 on 09/30/2021 at then staffing had improved, complete their duties during					
	conducted for Resider 08/11/2021. No conce review of skin assessi	other abuse symptoms was nts #64, #86, and #322 on erns were identified. A ments completed revealed					
	and 09/30/2021 revea with psychosocial and including observations	on 09/28/2021, 09/29/2021, lled no identified concerns l/or physical abuse, s of Residents #64, #86,					
	with abuse. Interview 9 09/30/2021 at 1:39 PM	ith Resident #322 on M revealed no concerns with MDS Nurse #1 on I revealed all residents with tia had their care plans					
	reviewed and revised with the RDON on 09/ revealed she complete	as necessary. Interview 30/2021 at 4:17 PM ed skin assessments on					
	of licensed nursing stated identified. A review of Social Service Directory	idents, with the assistance aff. No concerns were audits completed by the r (SSD) for residents with a s) or above revealed no					
	wander, revealed all re wandering risk assess Review of the elopeme each nursing station o binder on each floor th	sments for residents that esidents had received a ment by 08/16/2021. ent/wandering binder at n 09/29/2021 revealed a pat contained information of a photo and potential					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (X4) DATE (X5) MULTIPLE CONSTRUCTION (X5) DATE (X6) MULTIPLE CONSTRUCTION (X7) DATE (X7) DATE (X8) DATE (X9) MULTIPLE CONSTRUCTION (X9) (X9) MULTIPLE CONSTRU		SURVEY LETED					
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{F 600}	14). Review of Reside and #332's medical reresidents had been with the Reg 09/30/2021 at 3:53 Pt comprehensive nutrition Residents #39, #65, #Review of the medical completed a comprehensive not on 109/16/2021 for Resident #81, 09/16/2021 for Resident #81, 09/16/2021 for Resident #81, 09/16/2021 for Resident #81, 09/16/2021 for Resident recommendations madischarged. Interview Dietician on 09/30/202 Nurse Consultant on Regional DON on 09/DON #2 on 09/30/202 resident had received assessment and review by nursing staff. Furth and Regional DON retray card were review information.  15). Observation of that 2:22 PM, the fourth PM and the fifth floor revealed snacks inclusioatmeal pies, goldfish drinks were present, i juice. Observations of revealed snacks were Review of Resident #Resident #14's record	ent #39, #65, #81, #90, #330 ecord revealed all of the eighed by 09/17/2021. gistered Dietician on M revealed she completed a onal assessment on #81, #90, #330 and #332. I record revealed the RD lensive nutritional /2021 for Resident #39, ent #65, 09/16/2021 for 2021 for Resident #90 and ent #330 with no dietary ide. Resident #332 was with the Registered 21 at 3:53 PM, the Regional 09/30/2021 at 4:17 PM and 21 at 3:20 PM revealed each a comprehensive nutritional ew of the recommendations her interview with the RD evealed both the record and ed to reflect accurate	{F 6	00}			

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{F 600}	yellow zone on 09/28 no identified concerning residents.  17). Review of Residing revealed the resident guidance. Observation 09/29/2021 at 11:41 / 8/30/2021 at 10:36 A or symptoms of COV been discharged from 18). Review of facility staff working on 09/1 COVID-19 with no idereview of resident test 09/17/2021, revealed 19). Interview with M at 1:39 PM, MDS Nu PM, Maintenance As 2:56 PM, Therapy Mit 1:18 PM, Housekeep 09/30/2021 at 1:24 PD irector (HR) on 09/3 Marketing Liaison on Medical Records on Central Supply on 09 on 09/29/2021 at 1:11 12:58 PM, RN #4/W0 09/30/2021 at 2:54 P 12:44 PM, LPN #7 or 09/30/2021 at 1:54 P at 12:50 PM, LPN #1	M revealed she was netation of snacks.  The facility's red zone and /2021 at 2:12 PM revealed so the zones contained no sents #327, #328 and #329 so were isolated per CDC in of Resident #328 on AM and Resident #329 on M revealed no obvious signs ID-19. Resident #327 had in the facility.  To staff testing revealed all 6/2021 were tested for entified new cases. Further string for COVID-19 on in onew cases.  The staff testing revealed all 6/2021 were tested for entified new cases. Further string for COVID-19 on in onew cases.  The staff testing revealed all 6/2021 were tested for entified new cases. Further string for COVID-19 on in onew cases.  The staff testing revealed all 6/2021 were tested for entified new cases. Further string for COVID-19 on in onew cases.  The staff testing revealed all 6/2021 were tested for entified new cases. Further string for COVID-19 on in onew cases.  The staff testing revealed all 6/2021 at 1:31 sistant #1 on 09/30/2021 at 1:31 sistant #1 on 09/3	{F 6	00}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 500 NURSING HOME LANE PIKEVILLE, KY 41501	03/	30/2021
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{F 600}	o9/29/2021 at 3:29 Pi at 4:10 PM, SRNA #2 SRNA #22 on 09/29/2021 at 09/29/2021 at 1:12 Pi 09/30/2021 at 2:10 Pi Director/Dietary Mana 1:30 PM revealed the (2) times weekly. Inte Control Nurse on 09/3 she was conducting to following CDC guidar tested revealed tested times weekly.  20). Review of Reside and #90's medical recresident had COVID-implemented. In additive resident's MAR revealmented in additive resident #321, Resident #321, Resident #321, Resident #351's for usage and approphe physician on 09/20/2021 at 4:35 Pi 09/30/2021 at 4:35 Pi 09/30/2021 at 8:09 Al identified concerns we addition, observation floor on 09/30/2021 at identified concerns. In 09/29/2021 at 11:55 All in the sident in the concerns we addition, observation floor on 09/30/2021 at identified concerns. In 09/29/2021 at 11:55 All in the sident in the concerns in 09/29/2021 at 11:55 All in the concerns. In 09/29/2021 at 11:55 All in the concerns we addition, observation floor on 09/30/2021 at 11:55 All in the concerns. In 09/29/2021 at 11:55 All in the concerns. In 09/29/2021 at 11:55 All in the concerns we addition, observation floor on 09/30/2021 at 11:55 All in the concerns. In 09/29/2021 at 11:55 All in the concerns we addition of the concerns we addition of the concerns we addition of the concerns	3:23 PM SRNA #7 on M, SRNA #19 on 09/29/2021 t1 on 09/29/2021 at 3:04 PM, 2021 at 3:17 PM and SRNA t4:10 PM, Cook #3 on M, Dietary Aide #3 on M, Former Activities ager #3 on 09/30/2021 at tacility is testing staff two review with Interim Infection 30/2021 at 3:10 PM revealed testing two (2) times weekly fice. Review of facility staff d is being conducted two (2)  ent #329, #328, #311, #65 cord revealed that each 19 monitoring orders tion, review of each alled staff was completing the d by the physician.  e Medical Director on M revealed Resident #9, dent #324, Resident #326 medications were reviewed triate administration times by 3/2021.  medication pass on	⟨F 6	600}			

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	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE			200	REET ADDRESS, CITY, STATE, ZIP CODE D NURSING HOME LANE KEVILLE, KY 41501	09	/30/2021
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{F 600}	LPN #7 on 09/29/202 09/30/2021 at 1:54 Pt	09/30/2021 at 12:44 PM, 1 at 3:00 PM and M, LPN #10 on 09/30/2021 #11 on 09/30/2021 at 10:31 erns with unavailable	{F €	600}			
	Operations on 09/30/2 Co-Owner/President of at 3:11 PM revealed be agreement that the phracility with a three-darequiring cost review, pharmacy agreement requiring a cost review the facility a minimum medication while being would communicate a guidance to the pharm Director of Operations	2021 at 4:10 PM and of Pharmacy on 09/30/2021 both parties made a formal marmacy will supply the by supply for medication Review of the facility's revealed for any medication of the pharmacy would send of a three-day supply of the g reviewed. The facility ny changes or continuance macy within 72 hours. The of Guardian Pharmacy and Operations of the facility					
	AM and 09/30/2021 at 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 revealed they had recaware of the process from the pharmacy. In they were aware that the physician if the pharmadication to the facility. Interview with the	A, LPN #6 on 09/30/2021 at 09/29/2021 at 3:00 PM and A, LPN #10 on 09/30/2021 on 09/30/2021 at 10:31 AM eived education and was for obtaining medications addition, they revealed the nurse would notify the acy could not deliver a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 00	30,2021	
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{F 600}	completed of all resid and verified all medic facility by 09/25/2021 pass on 09/29/2021 at and 09/30/2021 at 8:0 concerns with missing 26). Review of a QAP the facility conducted with the Regional DO Consultant, Human R Records, the Housek Supply, MDS Nurse # Therapy Manager, the Administrator, the Dietary Manager, and administration team.  27). Interview with the Operations on 09/30//Interview with the Interview with the Interview with the Interview with the Interview with the Conjunct of the Current 09/13/2021 at 5:05 Plappointed the current 09/13/2021. Further in Operations revealed shadministrator with dai 09/10/2021.  28). Interview with the 09/30/2021 at 3:40 Pl 09/30/2021 at 3:25 Pl committee, including Consultant on 09/30/2 procedures for contact answering call lights, delivering meal trays	M revealed an audit was ents' ordered medications ations were available in the Observation of medication at 4:35 PM on the third floor DP AM revealed no identified gradients.  It signature sheet revealed a meeting on 08/12/2021 N, Regional Nurse esources, SSD #2, Medical eeping Supervisor, Central et MDS Nurse #2, the et Admissions Coordinator, et Activities Director, the et other members of the et Vice President of 2021 at 4:10 PM and erim Administrator on M revealed the facility Interim Administrator on the even with the VP of the had provided the Interim aly oversight since et Interim Administrator on M, the Medical Director on M and members of the QAPI the Regional Nurse 2021 at 3:40 PM, revealed	{F 6	600}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u>  09/</u>	30/2021
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{F 600}	29). Interview with the Operations on 09/30/7. Nurse Consultant on the Med-Net Concept 09/28/2021 at 3:00 Pl conducted a conferent following: (1) the outcexpectations and role outlined in the Rules a determined a plan for communication/monitrand COVID-19 isolatificatility to monitor/asse reposition residents, prepare and distribute residents with eating, effective Pharmacy Scand neglect effectively appropriate ADLS, an QAPI committee.  30). Interview with the 09/30/2021 at 3:40 Pl Consultant on 09/30/2 reviewed and revised presented the reviews Committee during the facility developed a stall topics were review meetings. The plan in Foley catheters, enter contractures, physical usage, risk management, social significance, activities, recouncil concerns and/	e Vice President of 2021 at 4:10 PM, Regional 20/30/2021 at 3:40 PM, and is Nurse Consultant on of revealed the facility ce call to review the omes of the survey, (2) is of the Governing Body as and Regulations, (3) the following oring tools: Infection Control on, enough staff at the ess residents, turn and provide incontinent care, is meals, and assist caring for pressure wounds, ervices, dealing with abuse of sufficient staff, providing did providing a functioning in and Regional Nurse 2021 at 3:40 PM revealed the QAPI Plan and is and/or revision to the QAPI 09/16/2021 meeting. The andardized plan to ensure end as needed at the QAPI cluded pressure ulcers, al feeding tubes, restraints, medication ent, infection control, the rate, rehabilitation	{F 6	500)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
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{F 600}	dietary variance tray a work injuries, terminal medical leave of absenew hires, medical repharmacy reports, resoffice, and admission Committee and Medic standardized agenda but not be limited to the the meeting. Interview 09/30/2021 at 1:39 Pt 09/30/2021 at 1:31 Pt Manager on 09/28/20. 09/30/2021 at 1:52 Pt Director/Dietary Mana 1:30 Pt, Medical Rec AM, Human Resource 09/30/2021 at 1:18 Pt Supervisor on 09/30/2 Respiratory Therapist 12:45 Pt Am Central 2:40 Pt, revealed the at the QAPI meeting but the QAPI meeting but an 09/30/2021 at 3:20 Director on 09/30/202 meeting was conducted the duties of the Government of the Gapillary in participate regularly in participate regularly in	an, employee orientations, audit report, weight losses, tions, employees on family ence or leave of absence, cord compliance review, storative nursing, business actions. The QAPI cal Director approved the on 09/16/2021 to include the topics presented during with MDS Nurse #1 on M, MDS Nurse #2 on M, Regional Certified Dietary 21 at 2:26 PM and M, Former Activities ager #3 on 09/30/2021 at cords on 09/29/2021 at cords on 09/29/2021 at cords on 09/29/2021 at cords on 09/29/2021 at cords on 09/30/2021 at cords on 09/30/2021 at 1:24 PM, (RT) #1 on 09/30/2021 at 2:340 PM, busing the line of the lin	{F €	600}			

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{F 600}	systems per the QAP  32). Interview with the O9/30/2021 at 3:40 P monitoring reports be and reviewed the dat QAPI attendance she conducted meetings and O9/30/2021. Inte of Operations on O9/3 Regional Nurse Cons PM revealed they we governing body, and forwarded to them.  33). Interview with the Operations on O9/30/Regional Nurse Cons PM revealed the govent Administrator with rematerial for QAPI. Further administrator on O9/30/Regional Nurse Cons PM revealed the govent attendance of Operations on O9/30/Regional Nurse attendance of O9/30/2021 at 3:40 PW were conducted were ensure the quality of complied with the state compliance. Further President of Operations OPM, Regional Nurse 3:40 PM, MDS Nurse OPM,	ny" approach and auditing of Calendar were reviewed.  It Calendar were review of excited all set of excited and were revealed the deal of excited and were revealed the deal of excited and were revealed the deal were revealed the	(F 6	00)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT	ION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP CODE	09	30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING PIKEVILLE, H	HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROFILE OF THE APPROPROFILE OF THE APPROPROFILE OF THE APPROPROFILE OF T			(X5) COMPLETION DATE
{F 600}	PM, Former Activities #3 on 09/30/2021 at 1 on 09/29/2021 at 8:34 Director (HR) on 09/3 Therapy Manager on Housekeeping Supers PM, Respiratory Therat 12:45 PM and Cen 2:40 PM revealed the weekly QAPI meeting and 09/23/2021. In ac Medical Director/Phys 3:25 PM revealed he QAPI meetings on 09 Further interview with 09/30/2021 at 3:40 PM meeting had been correview of the facility C sheet reflected the abidentified concerns.  35). Interview with RN AM and 09/30/2021 at 3:40 PM PM, LPN #10 on 09/30/00 09/29/2021 at 3:00 PM PM, LPN #10 on 09/30/2021 at 09/29/2021 at 3:40 PM 09/29/2021 at 3:40 PM 09/29/2021 at 3:29 PM, SRNA #11 SRNA #21 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PM education on 09/17/20 staff revealed they verweighing residents, of	M and 09/30/2021 at 1:52 Director/Dietary Manager 1:30 PM, Medical Records 4 AM, Human Resource 0/2021 at 10:48 AM, 09/30/2021 at 1:18 PM, visor on 09/30/2021 at 1:24 apist (RT) #1 on 09/30/2021 tral Supply on 09/29/2021 at y had participated in the s conducted on 09/16/2021 didition, an interview with the sician #1 on 09/30/2021 at participated in the weekly /16/2021 and 09/23/2021. the Interim Administrator on M revealed the weekly QAPI inducted on 09/30/2021. A tAPI meeting attendance ove interviews with no  I #1 on 09/29/2021 at 11:55 t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 t4 PM, LPN #7 on M and 09/30/2021 at 1:54 80/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on	{F €	00)			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) (X3) OF CORRECTION (X3	(X3) DATE SURVEY	
A. BUILDING	COMPLETED	
185256 B, WING	R 09/30/2021	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  200 NURSING HOME LANE PIKEVILLE, KY 41501	0010012021	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
(F 600)  Continued From page 169 (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician.  36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and timely nutritional assessments to ensure diet order accuracy. When staff enter diet orders into the electronic medical record, the nurse entering the order sends written communication to the dietary staff, which includes diet and texture. She further revealed that she entered the order into the tray card system to reflect the resident's diet orders. She stated that all diet orders from the previous day would be reviewed in the clinical meeting, Interview with the Regional CDM on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she completed education with Former Activities Director/Dietary Manager #3. In addition, she stated that she had been on site to provide additional assistance during the transition to her new role.  37). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4//Wound Care Nurse on 09/30/2021 at 12:58 PM, LPN #6 on 09/30/2021 at 10:31 AM, SRNA#11 on 09/29/2021 at 3:39 PM SRNA#11 on 09/29/2021 at 3:33 PM SRNA#11 on 09/29/2021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	1 09/3	0/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
{F 600}	on 09/29/2021 at 3:17 09/29/2021 at 4:10 Pl education on turning/ motion and transferrir chair and from chair to turning, positioning, a on 09/29/2021 at 10:2 revealed no identified Therapy Manager on revealed she provided beginning on 08/19/20 turning/repositioning, transferring a residen  38). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/ on 09/30/2021 at 12:4 09/29/2021 at 3:00 Pl PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 Pl 09/29/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2 on 09/29/2021 at 3:17 09/29/2021 at 4:10 Pl education on pressure turning and reposition nutrition, Positioning of and document a head and how to notify the RP of a new skin impa or email the Registere and the resident's rep changes. Interview wi	2021 at 3:04 PM, SRNA #22 7 PM and SRNA #23 on M, revealed they received repositioning, range of a residents from bed to o bed. Observations of and wound care with RN #11 21 AM for Resident #65 1 concerns. Interview with the 09/30/2021 at 1:18 PM at staff with education 021 regarding range of motion, and at from bed.  2 #1 on 09/29/2021 at 11:55 2 t 12:58 PM, RN #4/Wound 12021 at 2:54 PM, LPN #6 24 PM, LPN #7 on 25 M and 09/30/2021 at 1:54 26 M and 09/30/2021 at 1:54 27 PM and SRNA #1 on 28 M SRNA #11 on 29 M SRNA #11 on 20 M SRNA #23 on 20 M revealed they received a ulcer prevention including ling, adequate hydration and devices, how to complete 1-to-toe skin assessment, registered dietician, MD and airment. The nurse will call and Dietitian, the physician, aresentative with any th Regional Nurse 2021 at 3:40 PM and the	{F €	500}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD	1110			R
		185256	B. WNG	_			30/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		00,2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		Ι.	200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID.	_	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
(F 600)	Continued From page revealed they educate	ed staff on pressure ulcer	{F 6	500)	}		
	prevention including to adequate hydration and devices, how to comp	nd nutrition, Positioning					
		ssment, and how to notify					
		n, physician and RP of a					
	new skin impairment.	With any change to skin					
	impairment, the nurse	will call or email the					
		or new recommendations,					
	MD, and resident's re	presentative.					
	39) Interview with MC	OS Nurse #1 on 09/30/2021					
		se #2 on 09/30/2021 at 1:31					
	PM, Maintenance Ass	istant #1 on 09/30/2021 at					
	2:56 PM, Therapy Ma	nager on 09/30/2021 at					
	1:18 PM, Housekeepi	ng Supervisor on					
	09/30/2021 at 1:24 PM	մ, Human Resource					
	Director (HR) on 09/3	0/2021 at 10:48 AM, Senior					
		09/30/2021 at 10:55 AM,					
		9/29/2021 at 8:34 AM,					
		29/2021 at 2:40 PM, Cook :12 PM, Dietary Aide #3 on					
	09/30/2021 at 2:10 PM						
		iger #3 on 09/30/2021 at					
		y received education on					
		ise. In addition, interviews					
	with RN #1 on 09/29/2						
	09/30/2021 at 12:58 F	M, RN #4/Wound Care					ĺ
		at 2:54 PM, LPN #6 on					
		PM, LPN #7 on 09/29/2021					
		/2021 at 1:54 PM, LPN #10					
	on 09/30/2021 at 12:5						
		M, SRNA#1 on 09/29/2021					
		1 on 09/29/2021 at 3:23 PM 21 at 3:29 PM, SRNA #19					
	on 09/29/2021 at 4:10						
		/I, SRNA #22 on 09/29/2021					
		1, 3(114) #22 011 03/29/2021 1, #23 on 09/29/2021 at 4:10					
		eived education on timely					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL' A. BUILDI		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501	09	/ <u>30/2</u> 021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{F 600}	resident plan of care, staff dress residents is clothing and timely de interview with Cook # Dietary Aide #3 on 09 Former Activities Directory on the ducation on meal set 40). Interview with MD at 1:39 PM, MDS Nurse PM, RN #1 on 09/29/2 09/30/2021 at 12:58 PN Nurse on 09/30/2021 at 12:58 PN Nurse on 09/30/2021 at 12:44 Pat 3:00 PM and 09/30/0 on 09/30/2021 at 12:50/30/2021 at 10:31 A education on ensuring entered into the electrobservation of RN #1 revealed the nurse ware possible participation of the electrobservation of RN #1 revealed the nurse ware possible participation of the electrobservation of RN #1 revealed the nurse ware possible participation of the electrobservation of RN #1 revealed the nurse ware possible participation of the electrobservation of RN #1 revealed the nurse ware possible participation of the electrobservation of RN #1 revealed the nurse ware possible participation of the electrobservation of RN #1 revealed the nurse ware possible participation of the electrobservation of RN #1 revealed the nurse ware possible participation of the electrobservation of RN #1 revealed the nurse ware possible participation of the electrobservation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware possible participation of RN #1 revealed the nurse ware participation of RN #1 revealed the nurse participation of RN #1	oviding timely hygiene per timely toileting, ensuring in their choice of clean livery of meal trays. Further 3 on 09/29/2021 at 1:12 PM, //30/2021 at 2:10 PM, and ctor/Dietary Manager #3 on // revealed they received rvice times.  OS Nurse #1 on 09/30/2021 at 1:31 2021 at 11:55 AM and revealed they received rvice times.  OS Nurse #1 on 09/30/2021 at 1:31 2021 at 11:55 AM and revealed they received at 2:54 PM, LPN #6 on reverse at 2:54 PM, LPN #6 on reverse reverse received in new care plans were onic medical record.  On 09/29/2021 at 11:55 AM	{F 6	00}			
	AM and 09/30/2021 at Care Nurse on 09/30/2021 at 12:4 09/29/2021 at 3:00 PM PM, LPN #10 on 09/30/2021 at 109/29/2021 at 3:40 PM 09/29/2021 at 3:23 PM at 3:29 PM, SRNA #15 SRNA #21 on 09/29/2021 at 3:17	1 and 09/30/2021 at 1:54 0/2021 at 12:50 PM, LPN 10:31 AM, SRNA#1 on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		3	200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	residents with a changon identifying signs/sy hyperglycemia/hypogl protocol, documenting condition, documental medical record, notific following physician or revealed they receive documentation of gluc 42). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/ on 09/30/2021 at 12:4 09/29/2021 at 3:00 PN PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PN 09/29/2021 at 3:23 PN at 3:29 PM, SRNA #15 SRNA #21 on 09/29/2 on 09/29/2021 at 4:10 PN education on completi with interventions and diagnosis of diabetes within forty-eight hours reviewing and providir resident/responsible p 44). Interview with MD at 1:39 PM, MDS Nurs PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepii 09/30/2021 at 1:24 PN Director (HR) on 09/36	ation and assessment of ge in respiratory status and amplement of grein respiratory status and amplement of gresident change in the station of blood sugar in the station of the physician and ders. In addition, interviews deducation on cose levels.  If #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 and 09/30/2021 at 1:54 and 09/30/2021 at 1:54 and 09/30/2021 at 1:54 and N. SRNA #1 on the series of series of admission, and a great on 09/30/2021 at 1:0 PM, great of great on 09/30/2021 at 1:31 istant #1 on 09/30/2021 at 1:31 istant #1 on 09/30/2021 at 1:31 intervals on 09/30/2021 at 1:32 intervals on 09/30/	{F 6	500)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021	
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		2	100 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	r	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
{F 600}	Central Supply on 09/on 09/29/2021 at 11:5 12:58 PM, RN #4/Wo 09/30/2021 at 2:54 PI 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PI at 12:50 PM, LPN #1: AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 09/29/2021 at 3:29 PI 09/29/2021 at 3:29 PI 09/29/2021 at 4:10 PI at 3:04 PM, SRNA #2 and SRNA #23 on 09/ #3 on 09/29/2021 at 1:09/30/2021 at 2:10 PI Director/Dietary Mana 1:30 PM revealed the process of identifying abuse as well as iden immediate interventio 45). Interview with RN AM and 09/30/2021 at 12:4 09/29/2021 at 3:00 PI PM, LPN #10 on 09/30/20/201 LPN #11 on 09/30/20/201 they received educatification, Manager on 09/30/20/20 had received education, Manager on 09/30/20/20/20/20/20/20/20/20/20/20/20/20/20	19/29/2021 at 8:34 AM, 1/29/2021 at 2:40 PM, RN #1 15 AM and 09/30/2021 at 10 Und Care Nurse on 10 M, LPN #6 on 09/30/2021 at 10 09/29/2021 at 3:00 PM and 11 M, LPN #10 on 09/30/2021 11 on 09/30/2021 at 10:31 12 12 12 12 13:40 PM, SRNA 13:23 PM SRNA #7 on 10 M, SRNA #19 Aide on 11 M, SRNA #21 on 09/29/2021 12 on 09/29/2021 at 3:17 PM 12 12 12 12 12 13 13 17 PM 12 14 10 PM, Cook 13:12 PM, Dietary Aide #3 on 14 M, Former Activities 15 12 PM, Dietary Aide #3 on 16 M, Former Activities 17 19 19 19 19 19 19 19 19 19 19 19 19 19	{F 6	600}				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		C. 0938-0391 E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					PLETED
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		185256	B. WING			09	0/30/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		Ι.	200 NURSING HOME LANE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	100	'	PIKEVILLE, KY 41501		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 600}	diet and texture. She orders from the previous clinical meeting, which Friday, to ensure accordada, and the use of restablished diets to ensure nutritional needs of restablished national goultural, and ethnic needs of the established national goultural, and ethnic needs and/or portion sizes, so carts and snacks and 48). Interview with RN AM and 09/30/2021 at 12:409/29/2021 at 3:00 PN PM, LPN #10 on 09/30/2021 at Activities Director/Diet 09/30/2021 at 1:30 PN education on the procumendations for 49). Interview with the	dietary staff that will include further revealed all diet ous day are reviewed in the hoccurs Monday through uracy.  Dietary Manager on Morevealed she received solicy regarding meal service recipes, including recipes for the all meals meet the sidents in accordance with suidelines to reflect religious, and seds of the population.  Dietary Manager on Morevealed she received good preference, facility for placement for meals, appropriate scoop sizes stocking snack/hydration hydrations.  Homeone Morevealed she received good preference, facility for placement for meals, appropriate scoop sizes stocking snack/hydration hydrations.  Homeone Morevealed she received good preference, facility for placement for meals, appropriate scoop sizes stocking snack/hydration hydrations.  Homeone Morevealed she received good good good good good good good go	{F €	500)			
	3:20 PM, Interview with						

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING.			(X3) DATE SURVEY COMPLETED			
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		185256	B. WNG	_		09/	30/2021
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HADII ITATION CENTED			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE		
		TABILITATION CENTER		F	PIKEVILLE, KY 41501		
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{F 600}	on 09/30/2021 at 2:56 09/30/2021 at 1:18 PN Supervisor on 09/30/2 Resource Director (HI AM, Senior Marketing 10:55 AM, Medical Re 8:34 AM, Central Sup PM, RN #1 on 09/29/09/30/2021 at 12:58 PN Warse on 09/30/2021 at 12:58 PN Warse on 09/30/2021 at 12:44 PA at 3:00 PM and 09/30/000/2021 at 12:50 09/30/2021 at 10:31 PM at 3:40 PM, SRNA #1 SRNA #7 on 09/29/20 on 09/29/2021 at 3:04 PM at 3:17 PM and SRNA PM, Cook #3 on 09/29/2021 at 1:30 PM received education on policy/guidelines, hand Personal Protective Ered zones. Observation and yellow zone on 09/20/20/20/20/20/20/20/20/20/20/20/20/20/	M, MDS Nurse #2 on M, Maintenance Assistant #1 B PM, Therapy Manager on M, Housekeeping B021 at 1:24 PM, Human R) on 09/30/2021 at 10:48 Liaison on 09/29/2021 at 2:40 2021 at 11:55 AM and PM, RN #4/Wound Care at 2:54 PM, LPN #6 on PM, LPN #7 on 09/29/2021 M, LPN #7 on 09/29/2021 M, SRNA #1 on 09/29/2021 M, SRNA #1 on 09/29/2021 M, SRNA #2 on 09/29/2021 M, SRNA #21 on M, SRNA #22 on 09/29/2021 M, SRNA #23 on 09/29/2021 M, SRNA #3 on 09/29/2021 M, SRNA #3 on 09/29/2021 M, SRNA #4 Detary M, SRNA #4 Detary M, SRNA #4 Detary M, SRNA #4 Detary M, SRNA #5 Detary M, SRNA #6 Detary M, SRNA #6 Detary M, SRNA #7 Detary M, SRNA	{F 6	600}			
_	50). Interview with RN	#1 on 09/29/2021 at 11:55					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
NAME OF P	ROVIDER OR SUPPLIER	100230	J. WIII .		777657 100000	09/	/30/2021
	W POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		E NTE	(X5) COMPLETION DATE	
{F 600}	Care Nurse on 09/30/(LPN) #6 on 09/30/20 #7 on 09/29/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/202 they had received edusymptom monitoring of admissions. A review #355 on 09/10/2021 recovID-19 symptom resident orders. Resident orders. Resident #355 revealed COVID-19 symptom resident orders. In additional edges and the covID-19 symptom resident orders. In additional edges #329, #328, #311, #65 records revealed each monitoring orders impleaded the covID-19 symptom resident orders. In additional edges #329, #328, #311, #65 records revealed each monitoring orders impleaded to find the covID-19 symptom resident orders. In additional edges #329, #328, #311, #65 records revealed each monitoring orders impleaded to find on the process of old they had received eduction of the process to follow the process to follow the process to follow the pharmacy to obtaining the physician would either be omitted.	at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN 21 at 12:44 PM, LPN (LPN) 2:00 PM and 09/30/2021 at 09/30/2021 at 12:50 PM, 21 at 10:31 AM revealed ucation entering COVID-19 orders on all new of newly admitted Resident evealed the resident had nonitoring entered in the elent #355 was discharged radmitted to the facility on of re-admission for ed the resident had a nonitoring entered in the dition, a review of Resident 5, and #90's medical n resident had COVID-19 lemented.  #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN 21 at 12:44 PM, LPN (LPN) 1:00 PM and 09/30/2021 at 09/30/2021 at 12:50 PM, 21 at 10:31 AM revealed acation on the five (5) rights	{F 6	00}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROFILITION DEFICIENCY)			(X5) COMPLETION DATE
{F 600}	new orders from the New record.  52). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/2021 they had received education floor three (3) on 09/29 four (4) on 09/29/2021 at 3 medication administration with an emergency multiple LPN (LPN) #9 on 09/2 she was a new hire to received education remedication kit.  53). Interview with DO PM, MDS Nurse #1 on MDS Nurse #2 on 09/29/2021 at 10:48 AM Liaison on 09/30/2021 Records on 09/29/2021 Records on 09/29/2021 09/29/2021 at 11:55 AM PM, RN #4/Wound Ca 2:54 PM, LPN (LPN) #3	w orders given by the ng the conversation, and MD in the electronic medical II #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN (LPN) 21 at 12:44 PM, LPN (LPN) 2:00 PM and 09/30/2021 at 09/30/2021 at 12:50 PM, 21 at 10:31 AM revealed acation on the use of the n kit (e-kit). Observation of 19/2021 at 3:10 PM, floor 1 at 2:57 PM, and floor five 2:50 PM revealed each edication kit. Interview with 30/2021 at 2:27 PM revealed of the facility and had garding the emergency 2:00 #2:50 PM, 20/30/2021 at 1:39 PM, 20/30/2021 at 1:31 PM, 20/30/2021 at 1:31 PM, 20/30/2021 at 1:31 PM, 20/30/2021 at 1:34 PM, 20/30/2021 at 1:24 at Director (HR) on	{F €	600}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	09	30/2021
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROVIDENCY)		TION SHOULD BE THE APPROPRIA	E ATE	(X5) COMPLETION DATE
{F 600}	09/30/2021 at 1:54 Pt at 12:50 PM, LPN #11 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 09/29/2021 at 3:29 Pt at 4:10 PM, SRNA #2 SRNA #22 on 09/29/2 #23 on 09/29/2021 at were educated on the contact information ar Coordinator. Observa 09/28/2021, 09/29/20; revealed signage post Administrator's contact Abuse Coordinator post 54). Review of audits weekly head-to-toe sk no identified concerns #27 skin and wound at 10:20 AM revealed review of the medical #324, #45, #14, #357, revealed the weekly we completed with physic notifications. Interview 09/30/2021 at 3:53 PM of new and/or worsenir eviewed the residents with Medical Director or revealed that he was reverseled that he was reverseled that he partic and discussed ongoing residents. Interview with 09/30/2021 at 5:05 team discussed all auditscussed	M. LPN #10 on 09/30/2021 l on 09/30/2021 at 10:31 l on 09/30/2021 at 10:31 l on 09/30/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M. SRNA #19 on 09/29/2021 1 on 09/29/2021 at 3:04 PM, 021 at 3:17 PM and SRNA 4:10 PM revealed they Interim Administrator's ind role as Abuse tion of the facility on 21, and 09/30/2021 led with the Interim at information and title of sted throughout the facility. beginning 09/17/2021 of in assessments revealed Cobservation of Resident ssessment on 09/30/2021 no identified concerns. A record for Resident #65, #27, #74, and #358 ound assessments ian and responsible party with the Dietician on If revealed she was notified ing pressure ulcers and is as indicated. Interview on 09/30/2021 at 3:25 PM notified of new and/or ments and new int decline. He further ipated in QAPI meetings ig audits and care of the Interim Administrator PM revealed the QAPI	{F €	600}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R 09/30/2021	
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	1 03/	30/2021
(X4) ID PREFIX TAG				TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
{F 600}	at 2:40 PM revealed sall laboratory supplies revealed that the audifor four (4) weeks and months. A review of a Observation of floor the (5) supplies and review identified concerns.  56). Interview with the 09/30/2021 at 4:17 PM 09/30/2021 at 3:20 PM were audited during mensure all new areas of been care planned with the area of concerns.  57). Interview with the on 09/30/2021 at 10.5 completed visual round hygiene, toileting, incompleted visual round hygiene, toileting, incompleted visual round hygiene, colleting, incompleted as request hair clean and comber clean, call light within applicable and turned 58). Interview with the Operations on 09/30/2 Senior Marketing Liais AM revealed they part monitoring, and monitoring, and monitoring, and monitoring fill and revealed they part monitoring, and monitoring and monitorin	Intral Supply on 09/29/2021 The completed the audits of on 08/28/2021. She further its were conducted weekly if then monthly for three (3) udits revealed no concerns.  There (3), four (4), and five work the audits revealed no concerns.  There (3), four (4), and five work the audits revealed no concerns.  There (3), four (4), and five work the audits revealed no concerns norning clinical meetings to of skin impairment had the interventions to address the review of audits revealed continued to the ding of residents assessing continence, and resident on to other leadership staff, alled staff were auditing for, incontinent clean and continuent clean and co	{F €	600}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF S	PROVIDER OR SUPPLIER	103238	B. WING			09	/30/2021
	W POST-ACUTE AND RE	HABILITATION CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) COMPLETION DATE	
{F 600}	and different shifts.  59). Interview with the 4:17 PM revealed she respiratory assessme communication Mond clinical meeting. She if assessed to ensure the respiratory status and completed had physic implementation of phy Resident #315 SBAR #324 SBAR complete completed on 08/15/2 physician notification, plans updated as indicated in identified.  60). Review of Reside admitted on 09/10/2021 and revealed no identified.  60). Review of Reside admitted on 09/10/2021 and revealed on 09/25/2021 and revealed on 09/25/2021. Further refor Resident #355 revealed in the comprehensive care position of the comprehensive care position for Resident had a baselin 09/28/2021. Interview 09/30/2021 at 1:39 PM 09/30/2021 at 1:31 PM 09/30/2021 at 1:31 PM	ws revealed any call ve (5) minutes were aff. A review of audits completed on different units at RDON on 09/30/2021 at a completed audits of ints and SBAR ay through Friday in the further revealed that she inat any acute change in for SBAR assessments ian notification and/or visician orders. Review of completed on 09/26/2021, d on 09/27/2021, and #326 021 revealed assessment, interventions, and care cated. A review of audits concerns.  ant #355, who the facility 21, revealed the resident lan developed on #355 was discharged on mitted to the facility on eview of the medical record ealed staff completed the lan on 09/21/2021 (eleven ion). A review of fent #355 revealed the e care plan developed on with MDS Nurse #1 on If and MDS Nurse #2 on If revealed all new missions to the facility were the morning clinical	{F €	600)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL.  SC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
	days from 07/16/2021 concerns with baselin-MDS Nurse #1 on 09/revealed new/admissibeing updated as nee 62). Interview with MD at 1:39 PM revealed replans were being audit completion, accuracy, was conducted with the responsible party with admission/re-admission revealed the audits we through Friday. A review revealed they included date, baseline care pladelivered to resident a and education as need revealed no identified dates as indicated. 63). Review of the audit and/or CDM revealed stated with no identified the Regional Certified 09/28/2021 at 2:26 PMPM, and Dietary Mana 1:30 PM revealed tray ensure they arrived on timely.	missions for the last thirty -08/16/2021 revealed no e care plans. Interview with 30/2021 at 1:39 PM on baseline care plans were ded in morning meetings.  OS Nurse #1 on 09/30/2021 bew admission baseline care ted Monday-Friday for and to ensure a review the resident and/or in 48 hours of on. Further interviews are conducted Monday bew of the audits completed of resident name, admission can completion, care plan and/or responsible party, ded. A review of the audits concern with completion  It is completed by the DM they were completed as and concerns. Interview with Dietary Manager on of and 09/30/2021 at 1:52 and ger #3 on 09/30/2021 at s were audited for to of the unit and were passed  quizzes revealed ten (10) uizzed for one (1) week	{F €	00}			
	education. Further rev	iew of verbal quizzes					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE DO NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	four (4) weeks from 0 on 09/13/2021 with no review of the verbal quizzed on respiratory hypo/hyperglycemia, notification. Interview Consultant on 09/30/2 Regional DON on 09/#2 on 09/30/2021 at 3 on 09/30/2021 at 1:31 performed verbal quiz assessment of reside respiratory status, ide hyperglycemia/hypog protocol, documenting condition, notification following physician or on 09/29/2021 at 11:512:58 PM, RN #4/Wo 09/30/2021 at 2:54 Pt 09/30/2021 at 12:44 F participated in verbal 65). Interview with the 09/30/2021 at 4:17 Pt audits of documented Monday through Frida She further revealed to Responsible Party, ar follow physician order stated she identified co 08/12/2021 to have a and one (1) on 09/20/glucose level of 465 wevidence the licensed	members were quizzed for 8/22/2021 and completed of identified concerns. A uiz revealed staff was y status, and SBAR/physician with the Regional Nurse 2021 at 3:40 PM, the 30/2021 at 4:17 PM, DON 3:20 PM, and MDS Nurse #2 I PM revealed they tzes for identification and ints with a change in entifying signs/symptoms of lycemia, facility diabetic g a change in a resident's of the physician and ders. Interviews with RN #1 55 AM and 09/30/2021 at und Care Nurse on M, LPN (LPN) #6 on PM, revealed they quizzes with facility staff.  Regional DON on M revealed she completed blood glucose levels ay in the clinical meeting. That with any blood sugar reater than 40, the facility of notify the physician, and Registered Dietician and res. The Regional DON on blood glucose level of 430 2021 to have a blood	{F €	(00)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	1 03/	30/2021
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCES		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTION SHOULD BE COM			
{F 600}	further concerns. A R RN #2 and LPN #5 re the facility process.  66). Review of verbal was verbally asked si when to report, signs and wandering interverbal quizzes reveal quizzed daily for one 08/19/2021 with no id review revealed verbal three (3) times a wee 08/21/2021 to 09/02/2 concerns. A review of that verbal quizzes we per week for four (4) to 09/03/2021 to 09/24/2 concerns. Interview we Consultant on 09/30/2021 at 1:39 Pt the completion of vertinterview revealed that verbally quizzed on the tool (signs and symptolic report, signs and symptolic symptoli	w of audits revealed no eview of education revealed received education regarding staff quizzes revealed staff gns and symptoms of abuse and symptoms of wandering entions. A review of the ed five (5) staff were verbally (1) week from 08/13/2021 to entified concerns. Further al quizzes were conducted for two (2) weeks from 2021 with no identified verbal quizzes revealed ere conducted one (1) time weeks from the week of 2021 with no identified with the Regional Nurse 2021 at 3:40 PM, RDON on M, and MDS Nurse #1 on M revealed each assisted in oral staff quizzes. Further at each staff member was be areas listed on the audit oms of abuse, when to eptoms of wandering and ons), and any need for eted immediately with each SRNA #11 on 09/29/2021 at 12:44 to 09/29/2021 at 3:00 PM and M, RN #1 on 09/29/2021 at 2:54 PM, 19/29/2021 at 8:34 AM, 19/29/2021 at 8:34 AM,	{F €	600}			

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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	1 03/	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
{F 600}	PM, Human Resource 09/30/2021 at 10:48 Assistant #1 on 09/30 they participated in values, when to report interventions.  67). Review of Resid revealed the resident wandering risk asses 09/10/2021. Residen 09/25/2021 and re-ac 09/28/2021. A review Resident #355 reveal admission wandering on 09/28/2021. The ribe at risk for wandering on 09/28/2021. The ribe at risk for wandering Nurse #1 on 09/30/20 MDS staff will schedul assessments to ensure Regional Nurse Consecutive PM and DON #2 on Consecutive PM and DON #2 on Consecutive PM and DON #2 on Consecutive PM and DON #3 on Consecutive PM and DON #4 on Consecutive PM and DON #4 on Consecutive PM and DON #5 on Consecutive PM and	e Director (HR) on AM and Maintenance 0/2021 at 2:56 PM revealed erbal quizzes regarding t, wandering and wandering that a same to completed on the facility o	{F 6	00)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTI	RUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER		J		DDRESS, CITY, STATE, ZIP CODE	09	/30/2021
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PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION;	ID PREF TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
revealed they were as with residents with no of audits initiated on 0 random weekly skin as with a BIMS score of lethere are no injuries of no identified concerns. Nurse Consultant on 0 DON #2 on 09/30/202 were completing audits identified concerns. Ol assessment on 09/30/9:23 AM and on 09/30/9:23 AM and on 09/30/9:23 AM and on 09/30/Resident # 27 revealet of unknown origin.  69). Interview with the 09/30/2021 at 3:53 PM audits on 08/25/2021 celectronic medical recoin the diet/tray card sof Review of Resident #3 09/29/2021 at 12:04 Pl on 09/29/2021 at 12:04 Pl on 09/29/2021 at 12:04 Pl on 09/29/2022 diets were served as oreview of audits reveal weekly for four (4) weeks 70). Review of complete meals were audited twis beginning 08/23/2021. random meals were obweek for two (2) weeks 09/13/2021 for one (1) Former Activities Direct	in 09/30/2021 at 1:39 PM is isting in completing audits concerns identified. Review 8/13/2021 for review of sessments for residents ess than eight (8) to ensure funknown origin revealed. Interview with Regional 19/30/2021 at 3:40 PM, and 1 at 3:20 PM revealed they is as indicated with no interview with resident #45 at 1/2021 of Resident #45 at 1/2021 at 10:20 AM of id no concerns with injuries.  Registered Dietician on the revealed she started for resident diet orders from ords against orders entered fitware to ensure accuracy. 1/208's tray card on the month of the physician. A red audits were conducted exist.  It at 12:30 PM revealed rendom ince daily for one (1) week starting 08/30/2021, the served two (2) times per is and then weekly from month. Interview with tor/Dietary Manager #3 on Regional Certified Dietary	{F €	00}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/30/2	2021_
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) OMPLETION DATE
{F 600}	performed as indicate revealed that meals wincluding breakfast at PM, and dinner at 5:00 09/28/2021 at 5:03 PM had been served on the on 09/29/2021 lunch that the third floor at ap fourth floor at 12:16 PM fifth floor at 12:34 PM 71). Review of Reside 09/29/2021 at 12:04 PM on 09/29/2021 at 12:04 PM on 09/29/2021 at 12:04 PM on 09/29/2021 at 12:05 tray card on 09/29/2020 meals honored reside likes and dislikes. Interview and is likes and dislikes. Interview of all were audited daily for 09/15/2021 to 09/21/2 audits revealed snack beginning on 09/22/20 Regional Certified Die 09/28/2021 at 2:26 PM revealed she audit not identified any condition on 09/30/2021 at 09/30/2021 at 09/30/2021 acompleted audits for completed audits for complete	M revealed audits were ad. Further interviews were served as scheduled, 7:00 AM, lunch at 12:00 0 PM. Observation on M revealed the evening meal the third floor. Observation meal revealed meals arrived proximately 12:16 PM, the M and 12:24 PM, and the and 12:49 PM.  ant #308's tray card on PM, Resident #39's tray card 16 PM, and Resident #334's 21 at 12:30 PM revealed the int preferences, including serview with the Dietary 21 at 1:30 PM revealed she for obtaining food and is within seventy-two hours of the preferences into the udits revealed snack intakes one (1) week from 10:21. Further review of the is were audited weekly 021. Interview with the etary Manager on M and 09/30/2021 at 1:52 ited snack intake and had cerns.  Human Resource Director it 10:48 AM revealed she laily staff screening against the revealed no identified in of entry doors on 21, and 09/30/2021	{F 600			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			S	TREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
					IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	Continued From page	188	{F 6	00}			
	on 09/30/2021 at 3:40 at 4:17 PM, DON #2 cand Interim Infection (09/30/2021 at 3:10 PM being conducted with handwashing, isolation donning/doffing PPE, variance or identified cimmediately. A review were conducted beginshifts and units.  74). Interview with the on 09/30/2021 at 3:40 responsible in addition review all residents on pharmacy to ensure the beginning 09/23/2021, no identified concerns 11:55 AM and 09/30/202 (LPN) #6 on 09/30/202 (LPN) #6 on 09/30/202 (LPN) #10 on LPN #11 on 09/30/202 concerns with obtaining and/or receiving medication pass on the third floor and 09/3 revealed no identified concerns in additionarcotic count on the financotic count on the financotic count on the financotic count on the financotic count with the on 09/30/2021 at 3:40 responsible for comple	A revealed audits were observations of a signage and zones, mask compliance. Any concerns will be addressed of the audits revealed they ming 09/17/2021 on random  Regional Nurse Consultant PM revealed she was to other members to an arcotics with the last an active script is on file. A review of audits revealed. RN #1 on 09/29/2021 at 021 at 12:58 PM, LPN (LPN) 100 PM and 09/30/2021 at 10:31 AM revealed no g scripts for medications cations timely. Observation 09/29/2021 at 8:09 AM concerns with missing n, observation of the lifth floor on 09/30/2021 at identified concerns.  Regional Nurse Consultant					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	<u> </u>	200 NUF	ADDRESS, CITY, STATE, ZIP CODE RSING HOME LANE LLE, KY 41501	031	00/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE	
{F 600}	residents not having recounts. A review of au utilized the Centers for Element Pathway for conduct the medication twenty-five medication revealed a minimum of were observed daily from the first observations revealed administration was obtained in the first observations revealed administration was obtained in the first observations of the first on 09/30/2021 at 3:40/09/30/2021 at 3:20 Pt delivery tickets were the meetings Monday throm the first observations. A review identified concerns.  77). Interview with the first op/30/2021 at 4:17 Pt 09/30/2021 at 3:20 Pt being audited daily be ensure adequate staff review of the audits reconcerns.  78). Interview with the 09/30/2021 at 5:05 Pt concerns.	entified any concerns with medications or narcotic adits revealed the facility or Medicare Services Critical Medication Administration to an pass observation of as. A review of audits of twenty-five medications from 09/25/2021 with no partner review of medication of that medication of that medication of the audit revealed medication of the audit revealed no medication of the medication o	{F 6	00}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_				R 30/2021
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
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{F 600}	Continued From page	190	{F 6	00}			
(F 609) SS=D	79). Intervi Reporting of Alleged \ CFR(s): 483.12(c)(1)(		{F 6	09}			12/30/21
	§483.12(c) In respons neglect, exploitation, on must:	e to allegations of abuse, or mistreatment, the facility	:				
	involving abuse, negle mistreatment, includin source and misappropare reported immediate hours after the allegate that cause the allegate serious bodily injury, of the events that cause abuse and do not result the administrator of the officials (including to the adult protective service for jurisdiction in long-	g injuries of unknown briation of resident property, tely, but not later than 2 ion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve alt in serious bodily injury, to e facility and to other the State Survey Agency and the state state law provides					
	designated representa accordance with State Survey Agency, within	dministrator or his or her ative and to other officials in law, including to the State 5 working days of the eged violation is verified					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B, WNG_			R	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09	/30/2021	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				D BE	(X5) COMPLETION DATE	
{F 609}	by:	is not met as evidenced record review, and review of	{F 6				
	the facility's policy, it is failed to ensure all all abuse or neglect, wern no later than two (2) is was made, if the ever allegation involved ab Agency and Adult Profifty-seven (57) sampl and Resident #64).  Review of a facility in 05/26/2021, revealed of hip pain on 05/26/2 and revealed a Left F (fractured left hip). To fracture as an injury of to report the allegation addition, on 06/04/202 Resident #64's arm a facility failed to report the state agencies.  The findings include:  Review of the facility's Investigation and Report abuse of the facility's Investigation and Report in the state agencies.	was determined the facility eged violations involving the reported immediately, but mours after the allegation of that caused the muse, to the State Survey stection for two (2) out of the residents (Resident #206 of the residents (Resident #206 of the facility investigated the of unknown source but failed on to the state agencies. In 21, Resident #82 grabbed on the allegation of abuse to		Criteria 1: a) Resident #64, remain the facility, has no recall of the 6/4/2 event, and reports they feel safe in facility as interviewed by the Region Nurse Consultant on 8/13/21.  b) Resident, #82, was discharged from the facility on 8/9/2 c) Resident #206 was discharged from the facility on 5/26  Criteria 2: a) All in house resident were reassessed by the Regional D of Nursing, wound nurse, or design observation for new skin impairment withdrawn and/or crying behaviors in physical signs of abuse on 8-11-20. There were none identified.  b) The Administrator/Designee completed review of all incident reports of injurunknown origin in the last 90 days of 11/23/2021 to determine if there we that had not been reported. There wone identified.  Criteria 3: a) All staff were re-eduby the administrator and/or designee.	us in 21 the call 021. 2021. 2021. ats irector ee via ts, and 21. a ies of en re any vere cated		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING	B, WING			₹ 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	,	20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501		0012021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 609}	neglect, exploitation, property, mistreatmer origin shall be reported agencies and thorough management. Finding reported. The policy would assign the investindividual. The policy involving abuse, negligible mistreatment, or injurnisappropriation of responsed by the Admit to the state licensing Ombudsman, the Research Adult Protective Service Officials, the resident Director within two (2).  1. Review of Resident record, revealed the fon 05/19/2021, with the polyarthritis, Vascula Coordination, Atrial For Paranoid Personality Syndrome, Osteoport Incontinence. The minesident had been disting the facility on 05/26/2021, revealed resident to have a Bristatus (BIMS) score of indicating cognitive in MDS had been compiled.	misappropriation of resident and/or injuries of unknown and to local, state, and federal phly investigated by facility gs of abuse would also be stated the Administrator estigation to an appropriate a stated all alleged violations ect, exploitation, ies of unknown origin, or esident's property would be inistrator or his/her designee a/certification agency, the sponsible Party of record, ices, Law Enforcement is physician, and the Medical hours.  It #206's closed medical facility admitted the resident diagnoses which included in Dementia, Lack of ibrillation, Insomnia, Disorder, Chronic Pain ibrillation, Insomnia,	{F 6	609)	beginning on 8-12-2021 on the process identifying, preventing, and reporting abuse as well as identifying and implementing immediate interventions wandering residents.  b) Beginning 11/24/2021 to CMS Hand in hand Module 1 -5- 1.Understandig the world of Dementia: person and the disease 2.Being with a person with Dementia: Listening and Speaking 3. Being with a person with Dementia: Actions and reactions 4.Being with a person with Dementia: Making a difference 5. Preventing and responding to abuse has been added to all staff selectronic training system and to the new hire training requirement. The training will be required for all Parkview staff annually. staff will complete all 5 modules by 12/29/2022. The DON/ designee will monitor completion. New hires will complete modules 1-5 in the first 90 day of hire.  c) By 11/30/2021 all staff will tall a re- test on recognizing abuse and reporting abuse which will be graded by the NHA/DON or designee to establish staff competency. Staff not working will take the quiz on their next scheduled si Staff (including agency and new hires), who do not pass the test with a 100% where-educated and re-take the test unit score of 100% is achieved.  Criteria 4: a) Beginning 11/24/2021 to DON/Designee will audit incident report to determine any newly identified skin	for the the c e All ys ke y hift.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG		<del></del>	l	R
NAME OF P	ROVIDER OR SUPPLIER		1 5			09	/30/2021
					TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER		2	00 NURSING HOME LANE		
				P	IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 609)	Continued From page	193	(F 6	Λαι			
	Review of nurses note		1 10	UBJ			
		ted 05/26/2021 at 7:35 AM,			area is assessed for injury and reported	t	
	by DN #1 which state	d the resident complained			timely, if indicated per policy, audits will	be	
	his/her head stomach	n and left hip hurt. Per the			weekly until substantial compliance is		
	note the left his pain	was diffuse, and the hip was			achieved. Audits will be reviewed at Q	4PI	
	tender to touch. The r	was diffuse, and the hip was esident's physician was			monthly x3 months and then quarterly		
	notified with an order	received for an X-ray of the			until in substantial compliance		
	left hip.	received for an X-ray of the			b) Beginning 11/01/2021 th	е	
	ion mp.				Administrator or designee will audit all		
- 1	Review of an Y cau ro	port of Resident #206's left			state reported incidents weekly until		
	hin dated 05/26/2021	at 6:54 PM, revealed the		}	substantial compliance, to determine the	at	
	resident had an Acuto	Displaced Left Femoral		- 1	a confirmation email and or fax receipt	is	
	Neck Fracture.	Displaced Left Femoral			attached indicating the incident was		
	reck i lacture.		İ		reported timely to all required agencies.	,	
	Further review of Peci	ident #206's nurses notes			Audits will continue weekly and will be		
		ed 05/26/2021 at 7:44 PM,		ĺ	reviewed at QAPI monthly x 3 moths ar	ıd	
	by the Director of Nurs	sing (DON) which stated the			then quarterly until in substantial		
	resident was transferre	ad to the bessite! vie			compliance		
	ambulance for evaluat	ed to the hospital via			c) Starting 7-26-2021 the		
	ambalance for evalual	non or a nactured rup.		-	Social Services Director or designee		' I
	Review of a facility inv	petigotion Idotod			began performing random interviews of	10	İ
	05/26/2021, revealed	Pasident #206 was			residents a week for 4 weeks the 5		]
	observed by staff to ha	nesideni #200 was			residents a week for 8 weeks of residen	its	i
	quarding Registered	Nurse (RN) #1 notified the			with a BIMS score of 8 or greater to		I
	physician and an X-ray	v was obtained. The		ļ	ensure they feel safe in the facility and		ĺ
	investigation revealed	upon the nurse notification			have not witnessed or been subjected to	D	
	of the Responsible Pa	rty (RP) the RP had			abuse. Audits of a minimum of 5 resider	nts	
İ	alleged to the nurse he	e/she felt the resident had			a week will continue until compliance is		
	been neglected. The i	investigation revealed			achieved. Any reports of abuse will be		I
	Resident #206 had sur	stained a Left Femoral		-	immediately reported to the Administrate	or	
XC		ed left hip) which was an			with initiation of the investigation.		1
	injury of unknown origi	in According to the			Audits will continue weekly and will be		
	investigation Resident	t #206 had initially told staff			reviewed at QAPI monthly x 3 months a	nd	
	she had fallen and the	en later denied he/she had			then quarterly until in substantial		
	fallen. However, there	was no documented			compliance.		1
	evidence the facility ha	ad notified the state			d) Beginning 12/3 /2021 a		
	agencies, per the facili	ty's noticy		1	member of the governing body is on site	;	
	-3-110100, per tile idetti	ry a policy,			daily. The governing body member will		
	Intensions conducted	ith State Begintered			review the resident interviews to ensure		
	Interview conducted w	iui otate Registered	1	- 1	that any interviews indicating abuse or		i

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			l .	R /30/2021
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501	, 55.	332021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 609}	1:30 PM, and SRNA # PM, revealed when the Resident #206 to the approximately 7:30 All complaining of pain in stated RN #1 was not Interview conducted wapproximately 1:40 Pl notified by SRNA #3 a #205 was complaining stated she assessed to resident was complained thip pain. The RN stounds at approximate resident was sleeping pain. The RN stated shy physician and had obtoof the left hip. Continue had initially attempted unsuccessfully, but had initially attempted unsuccessfully, but had initially asked the resident had told her had stated when she had a Practical Nurse (LPN) stated he/she had not resident was very concevealed the resident the resident was neglicated immediately information. Interviews conducted at 7:55 PM, SRNA #10 and SRNA #11 on 06/	ANA) #7, on 06/18/2021 at 43, on 06/18/2021 at 1:35 bey went in to assist bathroom, on 05/26/2021 at 44, the resident was 4 his/her left hip. The SRNAs ified.  Aith RN #1, on 06/18/2021 at 44, revealed she had been and SRNA #7 that Resident 47 of left hip pain. The RN 48 he resident, and the 49 of left hip pain. The RN 49 he resident, and the 49 and no apparent signs of 58 he had notified the 49 and no apparent signs of 58 he had notified the 49 and no apparent signs of 59 he had notified the 49 and 1	{F 6	09}	neglect has been investigated and reported as required.  Criteria 5: Date of compliance: 12/30/2021		
		/2021. The staff revealed					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		185256	B. WNG		R	
NAME OF P	ROVIDER OR SUPPLIER		10	STREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
	W POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
(F 609)	not been aware of any revealed Resident #2t any pain until SRNA # into the resident's roo AM, and the resident I pain which they imme However, when LPN # resident had already f LPN had observed no Interview conducted w Community Based Se 06/18/2021 at 3:30 PN evidence DCBS had be allegation of neglect o source.  Interview conducted w (DON), on 06/19/2021 had assisted with the istated she was now the the Abuse Coordinator former Administrator. faxed the report to the have a confirmation the The DON stated she he needed a confirmation on previous occasions ambulating in his/her restated she felt at some fallen but nothing had Attempted to reach the 06/19/2021 at 8:30 AM AM were unsuccessful Interview conducted w	ept all night and they had y falls. The staff further 06 had not complained of 10 and SRNA #11 had went m at approximately 5:00 had complained of back diately reported to LPN #7. #7 went into the room, the allen back asleep, and the signs of pain.  with Department of rices (DCBS) Worker, on M, revealed there was no been notified of the rof the injury of unknown with the Director of Nursing at 9:00 AM, revealed she investigation. The DON the Abuse Coordinator, but rhad previously been the The DON stated she had State Agencies but did not be report had went through, and not been aware she had to observed Resident #206 from unassisted. The DON to 11 and 06/19/2021 at 9:30	{F 6	509}		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_				R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		W	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFI TAG		HOULD BE	Ē	(X5) COMPLETION DATE
{F 609}	Administrator stated a should be reported to (2) hours. The Admininow be using both fax allegations of abuse a had a confirmation.  2. Review of the facil "Facility Investigation' RN #1 on 06/04/2021 coming from the hallw RN #1 found Residen room holding onto Re After trying to redirect success, RN #1 and S Resident #82's hand f Immediately after the Resident #64 were as contacted the Abuse (Administrator) and represident #82 was plan supervision by staff ur have the resident #64 his/her arm and was for Review of the medical revealed the resident in 04/28/2021 with dia Unspecified Dementia Disturbance, Anxiety I Review of the Admissi (MDS) Assessment, d Resident #64, reveale resident to have a Brief Status (BIMS) score of the Resident (BIMS) score of the Resident (BIMS) score of the Resident (BIMS) score of the Resident to have a Brief Status (BIMS) score of the Resident to have a Brief Status (BIMS) score of the Resident to have a Brief Status (BIMS) score of the Resident #64, reveale resident to have a Brief Status (BIMS) score of the Resident #64, reveale resident to have a Brief Status (BIMS) score of the Resident #64, reveale resident to have a Brief Status (BIMS) score of the Resident #64, reveale resident to have a Brief Status (BIMS) score of the Resident #64 revealed r	or for two (2) weeks. The state Agencies within two strator stated she would and email to report all and would ensure the facility strator stated she would and email to report all and would ensure the facility strator stated of the facility strator stated she would and email to report all and would ensure the facility strator strato	{F 6	(09)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	TIPLE CONSTRUCTION			SURVEY
		185256	B. WNG				R (30/2024
PARKVIE	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	E	1 03/	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
{F 609}	revealed the resident on 05/12/2021 with diparkinson Disease, U Behavioral Disturbance. Review of Resident #4 Assessment, dated 05 facility assessed the rescore of zero (00) out determined the reside impaired.  Interview with the DCE 11:46 AM, revealed the an abuse report from the Resident #64 and Resident Resident #64 and Resident Re	I record for Resident #82 was admitted by the facility agnoses including respectified Dementia with the and Alzheimer's Disease.  B2's Admission MDS b718/2021, revealed the tesident to have a BIMS of fifteen (15), and the was severely cognitively  BS worker, on 06/18/2021 at the agency had not received the facility regarding bident #82.  The incident happened and the and secure, she phoned of (former Administrator) and the was responsible to report  I, on 06/19/2021 at 12:27 the rediministrator was the dishe was the Assistant of the state agencies that is witnessed or tate agencies; however, tonfirmation showing it had	{F 6	609}			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	TIPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021	
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE		(X5) COMPLETION DATE
(F 623) SS=D	2:14 PM, revealed she Administrator for the production and the Administrator further of the properties of the Administrator further of the production occurring of an allegal Notice Requirements CFR(s): 483.15(c)(3)-\$483.15(c)(3) Notice I Before a facility transform resident, the facility most resident, the facility most representative(s) of the the reasons for the molanguage and manner facility must send a correpresentative of the Cong-Term Care Omb (ii) Record the reason discharge in the residuaccordance with paragraph (c)(5) of this \$483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, the discharge required unimade by the facility at resident is transferred (ii) Notice must be mathefore transfer or discontinuity of the production of the pro	ninistrator, on 06/19/2021 at e had only been the past two (2) weeks. The revealed it was the buse Coordinator to notify two (2) hours of the abuse tion of abuse.  Before Transfer/Discharge (6)(8)  Defore transfer.  Defore transfer of discharge and buse transfer or discharge and buse in writing and in a stream they understand. The buy of the notice to a Diffice of the State budsman.  Is for the transfer or ent's medical record in graph (c)(2) of this section;  Detect the items described in section.  In paragraphs (c)(4)(ii) and the notice of transfer or der this section must be a least 30 days before the or discharged.  In de as soon as practicable tharge when-iduals in the facility would	{F 6	609}			11/30/21
	be endangered under	paragraph (c)(1)(i)(C) of					

AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3)	) DATE SURVEY COMPLETED	
		185256	B. WING_			R	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021	_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
(F 623)	be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days.  §483.15(c)(5) Content notice specified in parmust include the follow (i) The reason for tran (ii) The effective date of (iii) The location to what transferred or discharge (iv) A statement of the including the name, and telephone number receives such requests to obtain an appeal for completing the form an hearing request; (v) The name, address telephone number of the Long-Term Care Ombot (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and advelopmental disabilities of the Developmental disabili	riduals in the facility would reparagraph (c)(1)(i)(D) of alth improves sufficiently to the transfer or discharge, ()(i)(B) of this section; in the facility for 30 of the section; or resided in the facility for 30 of the notice. The written agraph (c)(3) of this section wing: insfer or discharge; of transfer or discharge; in the resident is god; resident's appeal rights, and information on how mand assistance in and submitting the appeal of (mailing and email) and the Office of the State address with intellectual	{F 6.	23}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	20	(3) DATÉ SURVEY COMPLETED
		185256	B. WNG			R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	COMPLETION DATE
{F 623}	disorder or related disemail address and tel agency responsible for advocacy of individual established under the for Mentally III Individual established under the for Mentally III Individual established under the for Mentally III Individual S483.15(c)(6) Change III the information in the effecting the transfer of must update the recipiant as practicable once the becomes available.  §483.15(c)(8) Notice if In the case of facility of the administrator of the written notification prict to the State Survey Agenta State Long-Term Care the facility, and the rewell as the plan for the relocation of the residual at the plan for the relocation of the residual at the plan for the relocation of the residual at the plan for the facility's policies, it failed to provide one (sampled residents (Redischarge notice.  On 08/09/2021, Resid the hospital due to tack breathing). On 08/13/	15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy uals Act.  es to the notice.  e notice changes prior to or discharge, the facility ients of the notice as soon are updated information  advance of facility closure closure, the individual who is e facility must provide or to the impending closure gency, the Office of the combudsman, residents of sident representatives, as e transfer and adequate ents, as required at §  is not met as evidenced  ecord review, and review of a was determined the facility 1) of fifty-seven (57) esident #82) with a written  ent #82 was transferred to hypnea (abnormally rapid 2021, the hospital case inted that the facility was	{F 6	F 623 Notice Requirements bettransfer.  Criteria 1: Resident #82 no long at the facility.  Criteria 2: An audit of discharge last 30 days was completed by the Director of Social Services/Adm or designee on 11/3/21 to identify which a discharge notice was notice was notice was notice.	ger resides es in the the inistrator fy any for	S

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			1	R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE TKEVILLE, KY 41501	09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
{F 623}	facility discharged the without issuing the rest without issuing the rest The findings include:  Review of the facility's Discharge, Preparing December 2016, reve prepared in advance for resident was scheduled the business office woof the transfer or discharge plan word the transfer or discharge plan word the policy revealed nuresident prior to his/her family, are sident's discharge of the policy revealed nuresponsible for obtaining or transfer, completing medical record, and pusummary and post disservices was also respresident or the resident required documents, in summary and plan.  Review of the facility's dated December 2016 address resident rights discharge.  Review of Resident #8 revealed the facility ad 05/12/2021, with diagree.	pehavior of wandering. The resident on 08/09/2021, sident a discharge notice.  Is policy "Transfer or a Resident for" revised aled residents would be for discharge. When a red for transfer or discharge, and notify nursing services marge so that appropriate emplemented. A as developed for each for transfer or discharge. Viewed with the resident, at least 24 hours before the ransfer. Further review of rising services was any orders for the discharge of the discharge plan. Nursing consible for providing the transfer he discharge plan. Nursing consible for providing the transfer.  It is representative with including the discharge.  policy "Resident Rights", revealed the policy did not as concerning resident.  It is medical record imitted Resident #82 on loses that included Alzheimer's Disease, and	{F 6	523}	provided. Discharge notice was provide to any resident that was discharged in October that has yet to return on 11/22/2 Criteria 3: On 11/19/21 an in-service we provided to the Licensed nursing staff to the DON or designee on the use of the transfer/discharge notice being sent with residents when transferring or discharge from the facility.  Criteria 4: Beginning on 11/22/21 at dastand-up meeting Social Service Director designee will monitor all discharges the ensure transfer discharge notice was sex 4 weeks then monthly x2 months. Aud will be reviewed at monthly QAPI meeting x3 months then quarterly until in substantial compliance.  Criteria 5: Date of compliance: 11/30/2021	/21.  as by  h ing  illy or or on ent dits	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			1	R /30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE			STREET ADDRESS ( 200 NURSING HOM PIKEVILLE, KY 4		<u>  03</u>	3072021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	IVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
{F 623}	Data Set (MDS) Asservealed the facility as a Brief Interview for M of zero (0) out of fiftee resident had severe conception of a Situation Review (SBAR), dated revealed Resident #82 respiratory distress and to a hospital.  Review of Resident #82 revealed a Case Mana 08/13/2021. Per the mending discharge base facility, the resident we to wandering behavior Interview with Resider attempted on 08/30/20 message left to return return call was received Interview with the Socion 09/01/2021 at 2:40 aware that she was rehis/her family, or the Conotice. She stated she position approximately ago and was not trained Interview with the Adm 6:49 PM, revealed Residischarge notice but si	B2's Quarterly Minimum syment, dated 07/14/2021, seessed the resident to have ental Status (BIMS) score in (15), indicating the organitive impairment.  Background Assessment of 08/09/2021 at 12:45 PM, 2 was experiencing and needed to be transferred agement Note, dated note, the resident was cook to the facility and per the ould not be readmitted due in the call. However, noted.  It #82's family member was noted.  It all Services Director (SSD), PM, revealed she was not quired to send the resident, or pubudsman a discharge as was employed in this one (1) and a half months and on discharge notices.  In inistrator, on 09/10/2021 at sident #82 did not receive a hould have. She stated the	{F 6	23}			
	SSD was responsible	to ensure appropriate					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION		(3) DATE SURVEY COMPLETED
		185256	B. WNG			R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	COMPLETION DATE
{F 623} {F 641} SS=D	notices were sent to reparties. Accuracy of Assessment	esidents and responsible ents of Assessments.	{F 6			11/16/21
	by: Based on interview, r the facility's policy, it v failed to ensure the M assessment was accu fifty-seven (57) sample and Resident #323).  Review of Resident #6 revealed on 04/06/202 36.6 pound, or 20.289 thirty (30) days. Furth resident developed a c coccyx/sacrum while a However, the facility c 05/05/2021 that stated sustained a weight los was present on admis completed an MDS on pressure ulcer was pre Review of Resident #3 revealed the resident #3 revealed the resident #3 revealed an MDS as	21, the resident sustained a weight loss in less than er on 05/02/2021, the deep tissue injury to the a resident at the facility. completed an MDS on a the resident had not a and the pressure ulcer sion. The facility also 08/05/2021 that stated the esent on admission.		F 641 Accuracy of Assessments  Criteria 1: a) Corrections were completed to the 5/5/21 and 8/5/21 for Resident #65 to accurately refleresident's wound and weight status completed by the MDS Coordinator 9/17/21  b) Resident #323 was discharged from facility on 7/20/21  Criteria 2: An audit was completed MDS Staff, Dietary Manager, Regis Dietician, Corporate Nurse Consult or designees of the last 2 MDS assessments for all current in-hous residents to determine that their wo and weight status is accurately addressed, as completed on 11/1/2  Criteria 3: Inservice education was provided by the Corporate Nurse consultant for the MDS staff, and by Corporate CDM consultant for the comanager on the need to accurately resident wound status and weights	ct the a second by the tered ants, e und 1.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		E CONSTRUCTION		SURVEY
		185256	B. WNG			R	
	(EACH DEFICIENC)	HABILITATION CENTER  STEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	S 2 P	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
{F 641}	revised November 20 Interdisciplinary Asses Minimum Data Set (M mandated by Federal conduct the resident at 1. Review of the MDS Federal and State regrevealed the facility m pressure ulcer was "prinstructions stated," "Foulcer/injury, determine was present at the time reentry and not acquire the care of the nursing and historical levels of Further review of the M K0300, revealed when MDS assessment for Smust answer whether weight loss of five perclast month or less or a or more in the last six the manual, staff were indicating yes, when the physician-prescribed whad experienced a wethe past 30 days or 10	Resident Assessments", 19, revealed, "The sement Team must use the DS) form currently and State regulations to assessment".  Manual, mandated by ulation, Section M0300, ust determine whether a resent on admission". The per each pressure ulcer/injury e of admission/entry or ed while the resident was in home. Consider current it issue involvement".  MDS Manual, Section completing a resident Section K0300, the facility the resident had sustained cent (5%) or more in the loss of ten percent (10%) (6) months. According to required to code "2", he resident was not on weight-loss regimen and ight loss of 5% or more in % or more in the last 180 per more in the last 180 p	{F 6	441}	on the MDS, as completed on 10/29/21  Criteria 4: Audits will be completed on randomly selected MDS assessments weekly X 4 weeks, monthly X 2 months the DON/ADON/Corporate Consultants tor designee to monitor for coding accuracy. Audits will be reviewed at QA monthly x3 months and then quarterly until in substantial compliance  Criteria 5: Date of compliance: 11/16/2021	5 by	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	<u></u>
		185256	B. WING			R	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	09/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREF TAG		ION SHOULD B! HE APPROPRIA	COMPLETIC TE DATE	ON
{F 641}	Chronic Obstructive F Paraplegia.  Review of Resident 6: Data Set (MDS) asserevealed the resident two (2) staff with Activoccasionally incontine indwelling catheter, are Further review revealed 179 pounds and had resident's weight historesident's weight historesident's medical recident's medical recident's medical recident's medical recident's medical recident's medical recident resident's medical recident resident resident for shortness of breath resident's medical recident recident upon readmits of an Admission/Readfor Resident #65, date revealed the resident bilateral buttocks upor hospital, with no other noted.  Review of Resident #6 on 04/06/2021, the respounds (a weight loss admission or 20.28% I	ysphagia, Polyarthritis, Pulmonary Disease and 5's Admission Minimum asment, dated 03/30/202,1 was totally dependent on itities of Daily Living, was ent of bowel, had an and had no pressure ulcers. And Resident #65 weighed no weight loss/gain or the bry was unknown.  I record revealed Resident to the hospital on 04/08/2021 at Continued review of the ord revealed Resident #65 a facility on 4/29/2021 with and Sepsis, Pneumonia, lure, and Urinary Tract revealed the was no at the facility weighed the asion to the facility. Review mission Nursing Evaluation and 04/29/2021 at 6:00 PM, and "scratches" to his/her in readmission from the impaired skin integrity  is5's weight record revealed sident weighed 142.7 of 36.6 pounds since oss).	{F €	541)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		TE SURVEY
		185256	B. WING			R 19/30/2021
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD 8E	(X5) COMPLETION DATE
{F 641}	intact skin or blood-fill underlying soft tissue shear) to the coccyx. was obtained to "clear water, pat dry, apply a border gauze every da Continued review of Revealed on 05/04/202 135 pounds, another in one month and 24.5 However, review of ReMDS assessment, dat the facility documente ulcer was present upor resident had sustained Review of Resident #6 assessment, dated 08 facility identified the reweight loss. However document that Reside present upon admission Interview with MDS Notes 155 PM, revealed she Assessment Instrumer guide for coding reside was responsible for concept the state of Resident #65. She state code Resident #65's per was not present upon also failed to accurate March 2021 MDS regarders.	lized area of discolored ed blister due to damage of from pressure and/or A new physician's order of coccyx with soap and cinc oxide and cover with ay".  Itesident #65's weight record 21, the resident weighed 7.7 pound weight loss (5.4% 68% in less than 180 days).  Itesident #65's Quarterly ed 05/05/2021, revealed do the resident's pressure on admission and the dino weight loss.  Itesident had sustained a sustained a sustained a the facility continued to not the facility.	{F 6	41}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD B		(X5) COMPLETION DATE
(F 641)	Federal and State regrevealed the facility m "Current number of ur ulcers/injuries at each Review of Resident # revealed the resident on 07/06/2021 with di Metabolic Encephalor Failure, Autistic Disord Diabetes, Dysphagia, Review of progress not revealed Resident #3: pressure ulcer to the releft buttock. However #323's Admission MD on 07/13/2021, reveal in Section M0300 that current unhealed press Interview with the MD at 1:53 PM, revealed: Assessment Instrume of resident MDS asses she was responsible of Resident #323. She sand failed to accurate pressure ulcers on the Interview with the Ass Nursing/Interim Direct on 08/18/2021 at 9:50 been the ADON at the one year, and was pla position, a few weeks Nursing (DON) resigna	S Manual, mandated by pulation, Section M0300, nust answer the question, shealed pressure a stage".  323's medical record was admitted by the facility agnoses that included bothy, Acute Respiratory der, Sepsis, Type 2 Pneumonia and Aphasia.  10tes, dated 07/12/2021, 23 had an "Unstageable" right buttock and one to the particular and the facility documented at the facility documented at the resident had one (1) issure ulcer/injuries.  S Nurse #1, on 08/09/2021 she utilized the Resident int (RAI) manual for coding assments. She revealed that for completing Section M for stated that she overlooked by code the resident's a Admission MDS.	{F €	541}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		SURVEY PLETED
		185256	B. WNG			1	R /30/2021
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u>, o</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 641}	she had never monitor in the facility, includin had worked as a staff Interview with the Adr 6:00 PM, revealed she facility operated within and stated MDS asse accurate. However, a Administrator, she had	accurately to ensure for they required. She stated bred any clinical processes g assessments because she inurse "all the time."  ministrator, on 08/11/2021 at e was responsible for the in the regulatory guidelines essments should be according to the d had no systems in place	{F €	i41 <b>}</b>			
(F 655) SS=D	to monitor accuracy of Baseline Care Plan CFR(s): 483.21(a)(1)- §483.21 Comprehens Planning §483.21(a) Baseline (§483.21(a)) The factimplement a baseline that includes the instruction of the baseline care plated (i) Be developed with admission.  (ii) Include the minimula necessary to properly including, but not limit (A) Initial goals based (B) Physician orders.  (C) Dietary orders.  (D) Therapy services.  (E) Social services.	f assessments.  (3)  live Person-Centered Care  Care Plans cility must develop and care plan for each resident uctions needed to provide centered care of the resident al standards of quality care, n must- n 48 hours of a resident's  am healthcare information care for a resident ed to- on admission orders.	{F 6	55}			11/30/21
	(D) Therapy services. (E) Social services. (F) PASARR recommo	endation, if applicable.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	IPLE CONSTRUCTION	(X	(3) DATE SURVEY COMPLETED
		185256	B. WING_			R
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIA			(X5) COMPLETION DATE
{F 655}	care plan if the compr (i) Is developed within admission. (ii) Meets the requirent (b) of this section (exception this section).  §483.21(a)(3) The fact resident and their reprof the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the facility (iv) Any updated informations.	plan in place of the baseline ehensive care plan- 1 48 hours of the resident's ments set forth in paragraph (epting paragraph (b)(2)(i) of cility must provide the esentative with a summary an that includes but is not the resident.  The resident in the resident's medications and the treatments to be cility and personnel acting	{F 65	55}		
	by: Based on interview, refacility policy, it was de to have an effective sy baseline care plans we instructions and minim necessary to provide ecare and failed to provide and treatment facility for two (2) of fift residents (Resident #321 was ad 07/16/2021 with diagnets).	um healthcare information iffective person-centered ide a summary of the is to be provided by the y-seven (57) sampled 21 and #323). mitted to the facility on		F 655 Baseline Care Plan  Criteria 1: a) Resident #321 ar no longer reside in this facility.  Criteria 2: a) All residents adm within the last thirty days 9 7/16/2 through 8-16-2021 with a diagnostiabetes and COPD, Asthma, curpneumonia have had their baselin Plan reviewed by MDS  Coordinator/designee and update needed.	itted 2021 sis of rrent ne Care	

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B. WNG				R 30/2021	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	U31.	30/2021	
5.00463.4653				2	00 NURSING HOME LANE			
PARKVIEV	N POST-ACUTE AND RE	HABILITATION CENTER		F	PIKEVILLE, KY 41501			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		1041	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 655}	Continued From page	210	(F 6	i55}				
,	facility failed to develo	op a baseline care plan	`	•	Criteria 3: a) The DON/ADON or			
	related to the resident	's diabetes diagnosis and			designee educated all Licensed nurse	s to		
	monitoring of the resid	dent's blood sugar.			include MDS, new hires, and agency o			
	Subsequently, the fac	ility failed to monitor the			their responsibility to complete a baseli			
		r to ensure the resident's			care plan with interventions and goal to			
	blood sugar was stabl	le. At approximately 12:00			include diagnosis of diabetes and			
	AM to 12:30 AM on 0	7/19/20201, a laboratory			respiratory diagnosis within 48 hours of			
	staff person found Re	sident #321 unresponsive.			admission and reviewing and providing			
	the resident's blood st	ugar was 32. Staff	ł		copy to the resident and or responsible			
	ducase. The residen	on again and attempted oral t began having trouble			party beginning on 8-12-2021.			
	breathing and EMS w	as notified. The resident			b) Beginning 11/24/2021	.		
		hospital where he/she was			education on creating a baseline care particle is included in new hire licensed nurse	ııan		
		metabolic Encephalopathy	Ì		education. Beginning 11/24/2021 post			
	secondary to hypogly	cemia and hypoxia. The			test on completing a baseline care plan			
	record stated there wa	as also some concern for			was administered to licensed nursing s			
		mpted administration of oral			and graded by DON/designee to ensur	e		
	glucose gel. Residen	t #321 was non-responsive,			competency, staff not working will take	the		
	had hypoxic respirator intubation.	ry failure, and required			test on next scheduled shift.			
					Criteria 4:TheMDS	i		
i		dmitted to the facility on			coordinator/DON/Designee will monitor	·		
		a hospital admission for			new admissions/re-admission to audit			
	Respiratory Failure.	According to the resident's			baseline care plan for: completion,			
		quired BiPAP to assist the			accuracy, and review with resident and			
	to devolop a baseline	g at night. The facility failed	i		responsible party weekly x 4 weeks the			
		care plan for Resident #323 's history of respiratory	İ		monthly x 2 months starting 11/24/2021			
		ovide a summary of the			Any variance or identified concerns will addressed immediately.	be		
	care to be provided to	the resident's responsible			Audits will be reviewed at QAPI monthly			
		the facility failed to ensure		j	x3 months and then quarterly until in	<i>*</i>		
	the resident received				substantial compliance	]		
		days after admission and						
	failed to monitor/asses	ss Resident #323's			Criteria 5: Date of compliance			
	respiratory status. On	07/20/2021, Resident			11/30/2021			
	#323's family visited a	ind found the resident was						
	having difficulty breath	ning. They requested the						
	resident be transferred	d to the hospital. Resident						
_	#323 was admitted to	the hospital with diagnoses						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE COMP	SURVEY
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		03/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE		(X5) COMPLETION DATE
{F 655}	Respiratory Insufficier cannula with Vapothei Lower Lobe Pneumor Elevated Lactate. Re upon admission to the the resident had mild accessory muscle for respiratory effort and a The facility's failure to place to ensure baseli developed and implen likely to cause serious death to a resident. In identified, on 08/11/20 exist on 03/06/2021, a Rights (F580), 42 CFF Abuse (F600), 42 CFF Person-Centered Care CFR 483.25 Quality of (F692), 42 CFR 483.4 (F755) and 42 CFR 483.4 (F755) and 42 CFR 483.4 (F7880). The facility was received on 09/03 removal of the Immedio 109/02/2021. However verified based on obse and review of facility of Minmediate Jeopardy was 483.35 Nursing Service Administration (F835) Quality Assurance and	a, Stridor, Acute Hypoxic acy requiring high flow nasal rm (high flow oxygen), Left aid versus Atelectasis, and view of the nurses notes a emergency room revealed wheezes bilateral, use of breathing, increased audible Stridor.  have an effective system in the care plans were mented, has caused or is a injury, harm, impairment or annediate Jeopardy was 121, and was determined to at 42 CFR 483.10 Resident R 483.12 Freedom from R 483.12 Comprehensive Plans (F655) (F656), 42 F Care (F684) (F686) F Pharmacy Services R 3.80 Infection Control is notified of Immediate 21.  Ion of Compliance (AOC) R 12021, which alleged interviews, occumentation. Additional vas identified at 42 CFR es (F725), 42 CFR 483.70 (F837), 42 CFR 483.75 I Performance The facility was notified of dry on 09/10/2021. The	{F 6	55}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		E CONSTRUCTION		SURVEY
		185256	B. WNG		.—		R
NAME OF D	ROVIDER OR SUPPLIER	100250	D. VIII.	,		09/	/30/2021
TANAL OF F	MOVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE\	N POST-ACUTE AND RE	HABILITATION CENTER		2	200 NURSING HOME LANE		
				F	PIKEVILLE, KY 41501		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
(F 655)	Continued From page	212	(F 6	55}			
	A second acceptable :	allegation of compliance					
	was received on 09/2	5/2021, which alleged					
	removal of the Immed	liate Jeopardy on					
	09/26/2021. The Stat	e Survey Agency					
	determined the Immed	diate Jeopardy was					
	removed as alleged d	uring a revisit conducted on					
	09/28-30/2021, which	lowered the scope and	İ				
	severity to "D" 42 CFF	R 483.10 Resident Rights					
	(F580), 483.12 Compi	rehensive Person-Centered					
	Care Plans (F655) (F6	656), 42 CFR 483,25					
	Quality of Care (F684)	) (F686), 42 CFR 483.35					
	Nursing Services (F72	25), and 42 CFR 483.45					
	Pharmacy Services (F	755); and to "E" at 42 CFR					
	483.12 Freedom from	Abuse (F600), 42 CFR					
	483.25 Quality of Care	e (F692), 42 CFR 483.70					
	Administration (F835)	(F837), 42 CFR 483.75					
	Quality Assurance and	l Performance					l l
j	Improvement (F867), a	and 42 CFR 483.80					
i	Infection Control (F88)	0), while the facility					l
	monitors the effectiver	ness of systemic changes					
	and quality assurance	activities.					
	The findings include:	100 M					
	Review of a facility pol	licy titled "Care					
	Plans-Raseline " date	December 2016, revealed		ł			
	a baseline care plan to						
	immediate needs would						i
	forty-eight (48) hours o	of the resident's admission.		ļ			
	Further review reveals	ed the Interdisciplinary Team		ŀ			
	(IDT) would implement	t a baseline care plan to					
	meet the resident's im	r a paseine care pian (0 mediate care pacds					- 1
	including but not limite	d to, initial goals based on					
	admission orders, phys	sician ordere dietas:					
	orders, therapy service	e encial carriers					
	Preadmission Serooni-	ng, and Resident Review					
	(PASARR) The neller	ng, and Resident Review  stated resident and their					
	representative would b	e provided a summary of					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED			
		185256	B, WNG_				R	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 200 NURSING HOME LANE PIKEVILLE, KY 41501	P CODE	09	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE	
{F 655}	limited to, the initial gray summary of the reside dietary instructions, a to be administered by updated information be comprehensive care particles. In Review of Resider revealed the facility at 07/16/2021 with diagr Mellitus, and Invasive Review of Admission assessment, dated 07 facility assessed their Interview for Mental Sthirteen (13) out of fifter resident was cognitive Review of the Physicia 07/16/2021, revealed Resident #321 for sign hypoglycemia (high be times daily) for diabetic complete finger stick particles further review revealed notify the physician if it was below seventy (76 three-hundred and fifty Review of Resident #3 dated 07/16/2021, revealed notify the physician if it was below seventy (76 three-hundred and fifty Review of Resident #3 dated 07/16/2021, revealed notify the physician if it was below seventy (76 three-hundred and fifty Review of Resident #3 dated 07/16/2021, revealed notify the physician if it was below seventy (76 three-hundred and fifty Review of Resident #3 dated 07/16/2021, revealed notify the physician if it was below seventy (76 three-hundred and fifty Review of Resident #3 dated 07/16/2021, revealed notify the physician if it was below seventy (76 three-hundred and fifty Review of Resident #3 dated 07/16/2021, revealed notify the physician if it was below seventy (76 three-hundred and fifty Review of Resident #3 dated 07/16/2021, revealed notify the physician in physici	an that included, but not coals of the resident, a cent's medications and my services and treatments the facility, and any cased on the details of the colan as necessary.  It #321's medical record dimitted the resident on coses of Urosepis, Diabetes Bladder Cancer.  Minimum Data Set (MDS) 7/19/2021, revealed the esident to have a Brief tatus (BIMS) score of cen (15), indicating the cely intact.  Can's order, dated an order to monitor as and symptoms of cod sugar) and cod sugar) and conditioning, and may cer required need (PRN). Center of the resident's blood glucose control of the resident's blood glucose control of the resident care plantated there was not to identify the resident had	{F 6	55}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		185256	B. WING				₹
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER				j 09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 655}	Interview with License on 07/28/2021 at 6:52 assigned to care for F 07/16/2021, when the the facility. She state the resident for a few completed the admiss care of the resident at day shift nurses compand she did not know process or developmental plan.  Interview with LPN #6 AM, revealed she proon 07/16/2021 and 07 shift (7:00 AM to 7:00 admission paperwork admitting nurse was rethe baseline care plan should includiabetes; however, the that information on the Review of nursing not 3:20 PM, revealed at LPN #6 obtained a bid #321 of 67 mg/dL, the	ed Practical Nurse (LPN) #2, 2 AM, revealed she was desident #321 at 3:00 AM on resident was admitted to dishe only provided care for hours then LPN #6 sion process and took over a 7:00 AM. LPN #2 stated eleted resident admissions a lot about the admission ent of the baseline care  6, on 07/30/2021 at 11:30 wided care to Resident #321 //17/2021 during the day PM) and completed his/her LPN #6 stated the esponsible for completing as She stated the baseline de information regarding ere was no place to add a baseline care plan form.  es, dated 07/18/2021 at approximately 7:30 AM, and glucose on Resident in delivered a tray to the a repeat blood glucose of 139 mg/dL. Further lent #321 had a visitor	{F 6			NTE .	DATE
	at 5:30 PM, revealed : 10:45 AM on 07/18/20 She stated Resident #	Member #3, on 08/02/2021 she arrived to the facility at 21 for a scheduled visit. 321 was awake and alert al during the visit. She					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B. WNG				R	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	_1,	200	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501	_  09	/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION:	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	)E	(XS) COMPLETION DATE	
{F 655}	sugar had dropped to per deciliter (mg/dL) to stated she left at appro	told her that his/her blood sixty-seven (67) milligram hat morning. However, she oximately 3:00 PM and staff peat blood sugar during her	{F €	55}				
	at 2:19 PM, revealed at 2:19 PM, revealed at Resident #321 on the was aware the resider that morning. She fur #321 told staff his/her repeatedly on 07/18/2 07/18/2021 when she taken staff an hour to a	phone on 07/18/2021 and nt's blood sugar was low ther stated that Resident						
	she entered Resident after lunch, late aftern of exact time), and for non-responsive. She and the resident's bloc further stated that she	2021 at 3:19 PM, revealed #321's room sometime oon on 07/18/2021 (unsure und the resident stated she alerted LPN #6 od sugar was low. She did not recall what the vas at that time, but that the or to shift change that						
	at 11:30 AM, revealed hypoglycemic episode 07/18/2021, (could not stated when she enterwas not responsive an sugar was approximate	late afternoon on recall the exact time). She ed the room, the resident						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DISTRUCTION	(X3) DATE	SURVEY
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	EHABILITATION CENTER		200 N	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 655}	(quickly raises the bloth The LPN stated she came up to approximation thirty-nine (139) mg/c Continued review of record revealed no dand no further docume monitored the resider incident.  Review of nursing not 12:23 AM, revealed was alerted to Reside and the resident was non-responsive, a bload and was thirty-two (3 administering Glucage resident continued to resident began experimental to the nursity transferred to the host 07/19/2021.  Review of emergence 07/19/2021, revealed emergency room at 1 and unable to follow revealed Resident #3 following arrival to the the Intensive Care Ut Altered Mental Status with Acute Metabolic the brain caused by collood) most probable hypoxic respiratory fallowing with MDS (08/10/2021 at 11:30 and and provided in the Interview with MDS (08/10/2021 at 11:30 and and provided in the Interview with MDS (08/10/2021 at 11:30 and and provided in the Interview with MDS (08/10/2021 at 11:30 and and provided in the Interview with MDS (08/10/2021 at 11:30 and and provided in the Interview with MDS (08/10/2021 at 11:30 and and provided in the Interview with MDS (08/10/2021 at 11:30 and and provided in the Interview with MDS (08/10/2021 at 11:30 and and provided in the Interview with MDS (08/10/2021 at 11:30 and and provided in the Interview with MDS (18/10/2021 at 11:30 and and provided in the Interview with MDS (18/10/2021 at 11:30 and and provided in the Interview with MDS (18/10/2021 at 11:30 and and provided in the Interview with MDS (18/10/2021 at 11:30 and and provided in the Interview with MDS (18/10/2021 at 11:30 and and provided in the Interview with MDS (18/10/2021 at 11:30 and and and and and and and and and and	cood sugar) and oral glucose. Ithought the blood sugar hately one hundred and dil., but was unsure. Resident #321's medical ocumentation of the incident mented evidence the facility nt's blood sugar after the stes, dated 07/19/2021 at Registered Nurse (RN) #7 ent #321's room by a SRNA found to be clammy and bood glucose was obtained 2) mg/dL. After gon and oral glucose, the see the non-responsive and the riencing labored breathing. Sing notes, the resident was spital at 1:00 AM on a spital at 1:00 AM on the riencing labored breathing. Sing notes, the resident was spital at 1:00 AM on the riencing labored breathing. Sing notes, the resident was spital at 1:00 AM on the riencing labored breathing. Sing notes, the resident was spital at 1:00 AM on the riencing labored breathing. Sing notes, the resident was spital at 1:00 AM on the resident #321 arrived to the laboration of the laboration of the factor of the laboration of the factor of the laboration of the mical imbalance in the factor of the promise and silure.	{F 6	555}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	1		ONSTRUCTION		SURVEY PLETED
		185256	B. WNG		_		R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501	09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 655}	specific diagnoses/co further stated that if a would not be on the comprehensive care properties and they were not reviewed representatives, and hattention of the Direct Interview with Assistan (ADON)/Acting Direct 08/11/2021 at 12:05 Punsure if all nursing stregarding admissions She stated she was an on the baseline care problems such as Dial Interview with Adminis 1:50 PM, revealed base reviewed with the residence with the residence care problems and implemented admitting nurse.  2. Review of Resident revealed the resident on 07/06/2021 after a failure. The resident he Metabolic Encephalop Failure, Autistic Disord	d the form did not ask about notitions like Diabetes. She resident was a Diabetic, it are plan until the plan was developed. MDS and had also identified that the with residents/resident and brought it to the por of Nursing (DON).  In Director of Nursing or of Nursing (DON), on the Market was not a place and baseline care plans. Ware there was not a place alian to include resident betes.  Intrator, on 08/10/2021 at seline care plans were not dent or resident tated care plans were not dent or family until a lan was developed. The esident diagnoses, such as cluded in the baseline care on admission by the #323's medical record was admitted by the facility hospital stay for respiratory and diagnoses that included athy, Acute Respiratory	{F 6	55}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(X3) DATE	SURVEY
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NAME OF D	ROVIDER OR SUPPLIER	103230	B. WIING.			09/	/30/2021
		EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD 8 THE APPROPRIA		(X5) COMPLETION DATE
(F 655)	Continued From pag	e 218	{F 6	55)			
	revealed prior to adm Resident #323 was a Care Unit (ICU) after home. The summary diagnosis of Autism a hand sanitizer resulti Intoxication. The res with Pneumonia and while in the ICU. Acc summary, the resider skilled nursing facility for nebulizer treatme. Emergency Departmet to the discharge sum were clear upon discl Review of Resident # developed by the fact 07/06/2021 at 5:19 P regarding Resident # interventions/instructi for the resident one the resident's respirar machine. According care plan was review however, a copy was  Review of Resident # Data Set (MDS) asse revealed the facility ic	idmitted to the Intensive being found unresponsive at a stated the resident had a send drank an entire bottle of ang in severe Alcohol ident was also diagnosed had Cardiopulmonary Arrest cording to the discharge at was discharged to the afor rehabilitation with orders and to return to ent if worsening. According mary, the resident's lungs harge from the hospital.  1323's baseline care plan, sility and effective on M, revealed no information 323's care needs or ions for staff to use to care set his/her needs regarding tory status or BiPAP to the form, the baseline ed with the resident's family; not provided.  1323's Admission Minimum ssment, on 07/13/2021, lentified the resident emechanical ventilation					
	facility developed/imp	323's medical record o documented evidence the elemented a care plan to 23's respiratory status until					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u> </u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
(F 655)	the facility). There was the facility provided R machine until date 07. Interview with Resider 08/02/2021 at 8:50 AN to the facility, she noting resident required BiPA non-invasive ventilation added oxygen, under Continued interview was revealed the facility dispaseline care plan with a copy. Subsequently resident did not receivadmission.  Interview with LPN #3 nurse assigned to Resident that at apprealized "something were resident. She stated that at apprealized in the stated that and using accession breathing. She stated breathing treatment are	resident discharged from as no documented evidence esident #323 with a BiPAP //14/2021.  Int #323's family member, on M, revealed upon admission fied nursing staff the AP (a machine that provides on via a mask, usually with positive pressure) at night, with the resident's family d not review the resident's h them, nor did they receive w, they were not aware the re a BiPAP machine upon revealed she was the sident #323, on 07/20/2021. roximately 7:30 AM she as going on" with the he resident was breathing	{F 6	555)			
	revealed the resident's	s family came to visit at 0 11:00 AM and requested					
	nurses notes upon addroom revealed the resibilateral, use of access	was admitted on					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION			SURVEY
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	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	1 03/	3072021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
{F 655}	10:44 PM, revealed did Hypoxic Respiratory I flow nasal cannula wi oxygen), Left Lower Linterview with Interim on 08/11/2021 at 12:00 expected staff to develop baseline care plan upfacility, within twenty-facility, bseline care plan accurate DON, she was not away to complete a baseline (48) hours of a resident summary of care to the representative. She ficare plan summary of properly, it could have facility's failure to time BiPAP for the resident Interview with the Admitate PM, revealed she the pertinent baseline resident care needs we revealed that she was required to complete a forty-eight (48) hours of provide a summary of resident/resident representative alleged to the pertinent facility alleged to the provide a summary of resident/resident representative alleged to the provide a summary of resident/resident representative.	iagnosis that included Acute insufficiency requiring high th Vapotherm (high flow obe Pneumonia versus ted Lactate.  Director of Nursing (DON), 5 PM, revealed she elop and implement a on resident admission to the four (24) hours of admission, evealed she was ing baseline care plans were to recall reviewing Resident plan to ensure it was included a care plan within forty-eight int's admission, or provide a care plan within forty-eight int's admission, or provide a care was completed in potentially identified the lay obtain wound care and inistrator, on 08/10/2021 at the expected staff to develop care plans to ensure ere met. She further not aware the facility was a baseline care plan within of a resident's admission, or care to the exentative.	{F 6	55)			

	COMPLETED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER  (X4) ID PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  PREFIX  (EACH CORRECTION SHOULD BE COMPLET  (EACH CORRECTION SHOULD BE COMPLET	R		e _	E MANU	195256		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER  200 NURSING HOME LANE PIKEVILLE, KY 41501  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE COMPLETED COMPL	09/30/2021			D, WIN	165256	DDU/IDED OD SUDDUED	NAME OF D
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET		00 NURSING HOME LANE	20		HABILITATION CENTER		
TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	OULD BE COMPLETION	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	FIX	PRE	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC	
(F 655)  Continued From page 221 effective 09/26/2021:  1). Braden Scale Assessments were completed on all residents by facility nurses on 08/28/2021 and comprehensive full body skin assessments were completed on all residents on 09/11/2021. The facility utilized the Braden Scale Assessment and comprehensive full body skin assessment to review and update care plans of residents who had pressure injuries by 09/17/2021.  2). The wound care physician evaluated Resident #65 on 08/25/2021. Staff assessed and measured all pressure injuries, and staff evaluated all current treatments and reported them to the Medical Director/Physician #1 by 09/17/2021.  3). Beginning 09/17/2021, upon admission a skin assessment and Braden Scale assessment will be completed, and the baseline care plan will be developed within 48 hours to include any pressure ulcer and the baseline care plan will be developed within 21 days of admission to include pressure ulcer. A comprehensive care plan will be developed within 21 days of admission to include pressure ulcers or potential pressure ulcers and include interventions to prevent pressure ulcers.  4). Residents #45, #65, #308, #309, #311, #314 and #320 were bathed including a shower, nail care and moisturizing lotion applied post shower, and assisted with dressing in clean appropriate clothing. Clean linens were placed on the residents' beds on 09/11/2021. The residents were evaluated by social services on 09/15/2021.  5). All residents were offered a shower and interviewed to obtain shower/hygiene preferences			655}	{F	essments were completed sility nurses on 08/28/2021 all body skin assessments of residents on 09/11/2021. The Braden Scale Assessment all body skin assessment to be plans of residents who be by 09/17/2021.  The plans of residents who be by 09/17/2021.  The plans of residents who be open of the plans of residents and reported in the plans of resident and reported irector/Physician #1 by  The plans of residents who be open of the plans of resident and reported irector/Physician #1 by  The plans of resident who be open of the plans of	effective 09/26/2021:  1). Braden Scale Asson all residents by fact and comprehensive for were completed on all The facility utilized the and comprehensive for review and update cat had pressure injuries.  2). The wound care placed and pressure all pressure evaluated all current to the Medical Dressure updated, and the developed within 48 hressure ulcer or potential pressure ulcer or potential pressure uniterventions to prevent development or worse development or worse 4). Residents #45, #65 and #320 were bathed care and moisturizing and assisted with drest clothing. Clean linens residents' beds on 09/ were evaluated by soc 5). All residents were expected and moisture of the pressure	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				₹ <b>30/2021</b>
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	007	0012021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 655}	New bath/shower sch by nursing staff to acc preference. Resident were obtained and inc plans and State Regist care plans by the Regist care plans by the Regist care plans by the Regist care plans by the Regist care plans by the Regist care plans by the Regist care plans by the Register completed on 05 care plans are viewing all reference mendations for supplements to promany weight loss issue commendations for supplements to promany weight loss issue commendations. The Register care and with no concerns were 08/13/2021.  8). The Register and Successful Care and orders were ameentry of glucose value Administration Record (CDM) observed the funch and dinner on 0 care delivered on time considered through age Direct care nursing stagy will be reviewed to the reviewed of the r	sing (DON) or designee. edules were implemented commodate resident preferences for hygiene corporated into resident care stered Nurse Aide (SRNA) gional Nurse Consultant 2/13/2021.  Re Registered Dietitian (RD) residents' diets and made meal changes or rote healing and to address s.  The diagnoses of Diabetes rive Pulmonary Disorder Pneumonia were assessed for Respiratory Therapist re identified completed  Re reviewed all residents re monitoring by 07/30/2021 red to include mandatory res on the Medication red (MAR).  Residents Manager meal service for breakfast, 19/11/2021, all three meals red.	{F €	655}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	SURVEY PLETED
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE		1	S'	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 655}	residents. The staff with on the unit at the start Director of Nursing, N Administrator or design staff call offs will be requalified staff to see if and/or calling agencie qualified staff to fill the cannot be replaced the Assistant Director of Nursing management appropriate staffing leventer will prioritize reachieved during emergrequired task including medication, no shower provided to incontinenthat cannot turn self, no assist residents with must a faffing levels have be meals are prepared and the staffing levels have be meals are prepared and physical forms of a for Mental Status (BIM above and skin integrit BIMS less than eight (Licensed Nurse, Resid Dementia had their Calling staffing levels have the staffing levels have be meals are prepared and physical forms of a for Mental Status (BIM above and skin integrit BIMS less than eight (Licensed Nurse, Resid Dementia had their Calling staff to see in the staf	o meet the acuity of the ill be validated as present of each shift by the ursing Supervisor, mee. Direct care nursing splaced by calling other they can fill the opening, so to see if they have expening. If direct care staff expening, or member of the team will fill the shift. If expending the properties of the sident care that can be gency staffing, prioritize and administration of the served timely, and meal if needed.  Creased dietary staffing forts and appropriate the nachieved to ensure and delivered timely.  It residents including #64, the sassessed for psychosocial abuse with Brief Interview (S) score of eight (8) or the ty reviews for residents with 8) were completed by lents with a diagnosis of the Plan reviewed and by the Minimum Data Set 09/07/2021. No new and as indicating any	{F €	655}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		ONSTRUCTION	(X3) DATE	SURVEY PLETED
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NAME OF COOKINGS OF CHARLES	103230	B. WING		<del></del>	09	/30/2021
PARKVIEW POST-ACUTE AND REH			200 (	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501		
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CE IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	36	(X5) COMPLETION DATE
wandering risk assessm 08/16/2021. All residen at risk for wandering ha updated by the MDS Co identified active wander placed at each nursing potential interventions f  14). Residents #39, #65 #332 were weighed by Registered Dietician (R) comprehensive nutrition recommendations were recommendations by th (DON) or designee, spok Medical Doctor (MD) an and recommendations. entered into the electror the tray card. The Regis Director of Nursing (DO in electronic medical rec record and tray card ref information on 09/17/20  15). Beginning 09/15/20 snacks to all residents of afternoon by the restora aides, or designee. Sna physician will be docum aide, dietary aides and/o  16). The facility evaluate 08/11/2021, located on to for compliance with CDO implemented yellow and identified two (2) resider	see Consultant completed a ment on all residents by all who were identified as ad care plans reviewed and coordinator. A list of all r risk residents were station with a list of for nursing to reference.  5, #81, #90, #330 and 09/17/2021. The ED) completed a massessment and RD excivered for the Director of Nursing 09/17/2021. Further, the excite with the attending and validated the diet orders Recommendations were nic medical record and on stered Dietician and EDN), reviewed diet orders cord to ensure both the flected accurate 021.  D21, staff began offering daily in the morning and attive nurse aide, activity acks ordered by a mented by the restorative for licensed nursing staff.  Bed the COVID-19 unit on the 5th floor of the facility C guidelines and dired zones. The DON	{F 6	55)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL'	TIPLE CONSTRUCTION			SURVEY
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	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		03/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	SHOULD BE		(X5) COMPLETION DATE
(F 655)	barrier and those two this zone on 08/11/20  17). The facility had the in the red zone on 08/#328 and #329). Resistance completed quaraphysician orders. Rescompleted quarantine physician's order. Rescompleted quarantine physician's order. Rescompleted quarantine physician's order. Rescompleted quarantine physician's order. Resconding in isolation.  18). All staff eligible for COVID-19 on 09/16/2021 tested for COVID-19 or 09/16/2021 tested for COVID-19 did not identify any new cases testing on 09/16/2021 tested for COVID-19. Positive CovID-19. Positive CovID-19. Positive CovID-19 procedures all staff must days. If the employee designated days effect requires all staff must days. If the employee designated days effect requires all staff must days. If the employee designated days effect requires all staff must days. If the employee designated days effect requires all staff must days. If the employee designated days effect requires all staff must days. If the employee designated days effect requires all staff must days. If the employee designated days effect requires all staff must days. If the employee designated days effect requires all staff must days. If the employee designated days effect requires all staff must days.	erection of a plastic zip wall (2) residents were moved to 21.  Pree (3) residents who were (11/2021(Residents #327, dents #327, #328 and #329 antine per facility policy and idents #311 and #314 per COVID-19 policy and idents #311 and #314 were  Presidents eligible were (11/2021) The facility did not (12/21) The facility did not (13/21) The facility did not (13/21) The facility were (13/21) The facility (	{F 6	555}			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE	SURVEY PLETED
		185256	B. WING			I	R
PARKVIE	PROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	1 09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TON SHOULD BE THE APPROPRIA	E NTE	(X5) COMPLETION DATE
	negative COVID-19 to employee will be tested facility by the Infection designee. All testing consted to the employer common areas.  20). The facility screet for signs and/or symptocumented on the MRecord (MAR). The famonitoring for signs are residents on 09/17/20.  21). Resident #9, Res Resident #326 and Rewere reviewed for usa administration times b 09/23/2021.  22). The facility stated their medication as ordand implemented phanotification if any medication if any medication if any medication regarding the physician regarding the physician regarding the second submitted to pharmacy weekends will have disentered into the electrosubmitted to pharmacy	est. During testing, the ed prior to entering the ed prior to entering the ed prior to entering the ed prior to entering the ed prior to entering the ed prior to entering will be ed page, time clock and edecation and edication are stated and edication.  All residents will receive edered beginning 09/23/2021 edication was unavailable, by new orders from the elementary end physician edication.  All residents will receive edered beginning 09/23/2021 edication was unavailable, by new orders from the elementary endication.  All residents will receive element on edicity's pharmacy to provide (3) day supply of resident edications entering endications entering endications entering endication on edication endication record and endication received endication endication received endication endication received endication endic	{F 6	(55)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION			SURVEY
		185256	B. WNG				R / <b>30/2021</b>
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE		30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	(	TON SHOULD BE THE APPROPRIA	E TE	(X5) COMPLETION DATE
	electronic medical recility does not timely manner the phathe facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the kit. If an emergency and unavailable, the physic substitution and/or new 25). The Regional Nur Nursing, and licensed audit of all residents' of verified all medications facility by 09/25/2021.  26). The facility condured Performance Improved 08/12/2021. The facility facility process, and an ensure compliance with The Administrator over The QAPI committee of Nursing. Administrator Services Director, Actil Maintenance, Dietary and Services.  27). The facility appoint Administrator on 09/13 current Administrator will receive guidance from the Reg Regional Director of O Clinical Nurse for 30 dethe thirty-day oversight Administrative Team will receive the facility downsight	ackup to the electronic by entering the order in the ord to receive medications. receive medications in a armacy will be notified, and the emergency medication rises and medication is cian will be notified for w orders.  The Consultant, Director of nursing staff completed an ordered medications and the were available in the  Coted a Quality Assurance ment (QAPI) meeting on the y reviewed education, the AOC and all audits. The sees the QAPI committee. Consists of the Director of the Medical Director, Social wities, Clinical, Therapy, and Environmental  Acted an Interim the daily oversight and the daily oversight and the Regional and the Regional and the Regional and audit the Administrator to daily oversight is needed,	{F 6	55}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		<u>09/30/2</u> 021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	COMPLETION DATE	
(F 655)	improvement.  28). The Administrato QAPI Committee revice contact person for cal Activities of Daily Livit timeliness of meal traturning and reposition  29). The Vice Preside Clinical Operations are Consultants conducte 09/15/2021 with a core consultation to review outcomes of the survey roles of the Governing Rules and Regulation the following communification Control (CO staff at the facility to naturn and reposition recare, prepare and discresidents with eating, effective Pharmacy Standing Pharmacy Standing Committee.  30). The Administrato Consultant reviewed a beginning 09/16/2021 and/or revisions to the the 09/16/2021 meetic standardized plan to ereviewed as needed a agenda included revisions.	r, Medical Director, and ewed procedures for a fins, answering call lights, and (ADL) Care, serving, and ing on 09/15/2021.  Int of Operations, Director of a conference call on a the following: (1) the ey; (2) expectations and a Body as outlined in the s; (3) determined a plan for a conference call on the si, (3) determined a plan for a conference call on the sy; (2) expectations and a Body as outlined in the s; (3) determined a plan for a conference call on the sy; (2) expectations and a plan for a conference call on the sy; (3) determined a plan for a conference call on the sy; (4) expectations and a plan for a conference call on the sy; (5) determined a plan for a conference call on the sy; (6) determined a plan for a conference call on the sy; (7) determined a plan for a conference call on the sy; (8) determined a plan for a conference call on the sy; (9) determined a plan for a conference call on the sy; (1) determined a plan for a conference call on the sy; (1) determined a plan for a conference call on the sy; (1) determined a plan for a conference call on the sy; (1) determined a plan for a conference call on the sy; (1) determined a plan for a conference call on the sy; (2) expectations and great the sy (3) determined a plan for a conference call on the sy; (2) expectations and great the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan for a conference call on the sy (3) determined a plan f	{F 6	555}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE	C. 0936-0391 E SURVEY PLETED
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NAME OF F	ROVIDER OR SUPPLIER	100200	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
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{F 655}	social services, conceresident council, and orientation, dietary valueight loss, work injuremployees on family rabsence, new hires, no review, pharmacy republishes office, and a Committee and Medical standardized agendate but not limited to, the office President of Ope Administrator, the DOI on 09/16/2021 regarding Governing Body, inclusted and procedures to be imple communicating informative Governing Body. Equal to QAPI processes, the rain the Q	edication usage, risk n control, hospital abilitation management, erns of grievance, activities, family council concerns, ns, discharges, census, staff positions, employee riances, tray audit report, ries, terminations, medical leave, a leave of medical record compliance orts, restorative nursing, dmission actions. The QAPI rial Director approved the on 09/16/2021 to include, topics presented during the ector of Operations and rations met with the N, and the Medical Director ng the duties of the ding setting policy and emented in the facility and ation to other members of During the meeting, the need to participate regularly the need to identify root tion of the five (5) why ting systems per the QAPI istrator will notify the ure QAPI Committee  will collect all monitoring API Committee meeting	{F 65	55}		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DAT	E SURVEY IPLETED
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PARKVIE	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			STREET ADDRESS, CITY 200 NURSING HOME L PIKEVILLE, KY 4150	ANE	05	<del>9/30/2021</del>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	X EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)	E ATE	COMPLETION DATE
	interventions to removimplemented QAPI model (4) weeks, as needed. Administrator will forward minutes to the Governincluding the Vice Pre Regional Vice Preside Regional Nurse Conscresults. The QAPI consults at the QAPI mereview. The Administration of Nursing, Active Clinical, Therapy, Mair Environmental Service (2) The Governing Bound of the Construction of QAPI and QAPI Tool Kit, QAPI and QAPI Tool Kit, QAPI and QAPI Tool Kit, QAPI and QAPI Tool Kit, QAPI and QAPI Tool Kit, QAPI and QAPI Tool Kit, QAPI and QAPI Tool Kit, QAPI and QAPI Tool Kit, QAPI and QAPI Tool Kit, QAPI and QAPI Tool Kit, QAPI and QAPI Tool Kit, QAPI and QAPI Committee medical services (4) weeks and, as need to ensure the quality of complies with the standard complies with the standard complies with the standard consults and complies with the standard consults are serviced to the standard complies with the standard consults are serviced to the standard complies with the standard consults are serviced to the standard complies with the standard consults are serviced to the	a abatement and develop we the jeopardy. The facility eetings weekly, times four , and monthly. The yeard all QAPI Meeting sing Body members, sident of Operations, and the ultant, to review the audit mittee will review the etings. Committee for ator oversees the QAPI I Committee consists of the diministrator, Medical yes Director, Activities, intenance, Dietary and es.  Dody will provide the facility's purces and education cluding but not limited to the at a Glance, and a resource plement the QAPI plan The Governing Body will upcoming year and cy after one (1) year.  will increase the frequency petings to weekly for four ded effective 09/16/2021, and care is monitored and dard of care and and Federal requirements  ere educated by the DS Coordinator, or	{F €	55}			
	obtaining, documenting	g, and reporting weight					

AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		10. *******	_	STREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
	W POST-ACUTE AND RE			;	200 NURSING HOME LANE PIKEVILLE, KY 41501		
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	Manager on the provisassessment to ensure diet order accuracy, a orders into the electro CDM educated the Direction of the nurse enters the ownitten communication including diet and text meetings, staff will rev previous day to ensure 37). Therapy provided staff on turning and poand transfer of resident chair to bed beginning completed on 09/17/20 and assigned additionand agency contracts furn and reposition all reposition themselves.  38). The Regional Direction all nursing staff on presincluding turning and rehydration and nutrition to complete and documassessment, and how dietician, physician, an impairment by 09/17/20 staff will call or email the	the Regional Certified M) educated the Dietary sion of timely nutritional diet order accuracy, on and on when to enter diet nic medical record. The etary Manager to enter to the tray care system. If order, the nurse will send a to the dietary staff, ure. In the morning clinical fiew diet orders from the etacuracy.  education to all nursing sitioning range of motion, at from bed to chair and on 08/19/2021 and 021. The facility employed all staff through recruitment to ensure adequate staff to residents who cannot  ector of Nursing educated ssure ulcer prevention, epositioning, adequate to positioning devices, how ment a head-to-toe skin to notify the registered	{F 6	655)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501	09	/30/2021
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{F 655}	39). The DON or desitimely call light responstaff, including nurses assistants, were provitimely hygierie per the timely toileting, dressi of clean clothing, and trays. The DON or defacility staff not working the timely toileting, and trays. The DON or defacility staff not working the timely towers.  40). On 08/31/2021, The timely towers and the MDS Nurses into the electronic meand interventions. In Director of Nursing edexisting care plan in the with new goals and intimpairments identified the timely and/or designee education and/o	gnee educated all staff on ase. In addition, direct care and certified nursing ded education on providing e resident's plan of care, and residents in their choice timely delivery of meal signee will educate any and during education upon the Regional Director of icensed nursing staff, the she Social Service Director, on entering new care plans addition, the Regional ucated staff to update the are electronic medical record derventions for any new skin during their shift.  Directory Therapist educated entifying and assessing are in respiratory status on an, on 08/12/2021, the DON ated all licensed nurses on toms of a power of the great o	{F €	555}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION	N .		SURVEY PLETED
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER				<u>  09</u>	/30/2021
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	licensed nurses on co Plan with intervention: diabetes and a respirate hours of admission, recopy to the resident at Licensed nursing staff education was notified will not be allowed to veceived this education 43). Beginning 08/12/2 staff on the facility's "call-off procedure for the event a person needs dayshift, they are to not supervisor two hours to the staff needs to call off to notify their immediate before the start of their not have appropriate simmediate supervisor staff Administrator and/or diassistance from staffin working will be in-servisor.	and goals relevant to atory diagnosis within 48 eviewing and providing a and/or the responsible party. In ot working during a form of ongoing education and work until they have and.  2021, the DON educated all sall off" procedure. The facility included: in the to call out of work for otify their immediate before the start of the shift. If on the night shift, they are all esupervisor four hours or shift. If the facility does taffing levels, the and/or designee will call replace the person calling ing is required, the esignee will call for g companies. Staff not ced upon return to work.  Ided re-education by the esignee on 08/12/2021 on ang, preventing, and all as identifying and the interventions for ere educated by the OS Coordinator, or ighing techniques.	{F 6	55}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		185256	B, WING			1	R 30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TON SHOULD B		(X5) COMPLETION DATE
{F 655}	the Dietary Manager timely nutritional asse accuracy. When staff electronic medical recorder will send the writing dietary staff. The Dietary staff. The Dietary staff. The Dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary dietary staff. The Manager on 09/13/20 regarding meal service recipes including recipes including recipes including recipes including recipes including recipes and ethnic new detartional needs of restablished national goultural and ethnic new detartion obtaining food prefers system, ordering food snack/hydration carts procedures, appropriation sizes.  48). The Director of Nof Nursing educated in Manager on the process and/or implementing recommendations for 09/17/2021.	tered Dietician by 8/2021, the CDM educated on diet order accuracy and essment to ensure diet order enters diet orders into the cord, the nurse entering the itten communication to the stary Manager will enter the re system. The facility will m the previous day in the sure accuracy.  OM educated the Dietary 121 on facility policy re times and the use of pes for those requiring re all meals meet the esidents in accordance with guidelines to reflect religious, reds of the population.  In the Regional CDM with the dietary manager on ences, the facility's tray card is based on menus, stocking in snacks, and hydrations are scoop sizes, and/or  Jursing or Regional Director nurses and the Dietary ess for entering, activating, the registered dietician's dietary orders on	{F 6	55}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		ECONSTRUCTION	(X3) DATE	O. 0938-0391 E SURVEY
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		185256	B. WING			l .	R 12012024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09	/30/2021
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER		ľ	00 NURSING HOME LANE		
W 41 18	CHANA			F	PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
	(PPE), yellow and red DON/designee educate monitoring residents for beginning. 08/12/202 educated all staff, inclivere not working. Dur 08/12/2021, the Covid handwashing policy, dired and yellow zones, for signs/symptoms of reviewed.  50). Staff were provide 08/20/2021 by the DO Regional Nurse Consusymptom monitoring of admissions into the residucated on the five (Stadministration, including patient, right dose, right Regional DON/DON/delicensed nursing staff with the process to follow was available for administration education included call the medication delivery time ordered medication will outside of the ordered education also included given by the MD, docurand new orders from the medical record. All other will be provided training will be provided training will be provided training medical record. All other will be provided training will be provided training will be provided training the staff of the ordered will be provided training will be provided training will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be provided training the staff of the ordered will be staff or the ordered will be staff or the ordered will be staff or the ordered will be staff or the ordered will be staff or the ordered will be staff or the ordered will be staff or the ordered will be staff or the ordered will be staff or the ordered will be staff or the ordered will be staf	anal Protective Equipment zones. In addition, the led, licensed staff on or Covid-19 symptoms 1, the DON/designee uding contract staff, who ing the QAPI meeting on 1-19 policy, the lonning and doffing PPE, and monitoring residents if the Covid-19 were led re-education on N, Regional DON, or altant to enter COVID-19 raders on all new sident's record.  In g staff have been so right medication ing right medication, right not time, and right route. The esignee educated all evorking on 09/23/2021 on when a medication was not action as ordered. The ling the pharmacy to obtain the pharmacy to obtain the entire pharmacy to obtain the entire patent in the entire patent in the electronic medication time. The diffollowing new orders menting the conversation, the MD in the electronic er licensed nursing staff g as scheduled for shifts.	{F 6	55}			
	52). On 09/25/2021, the	e DON /Regional Nurse					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	TIPLE CONSTRUCTION		(3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF COR  X (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	including new hires ar use of the emergency in place for ensuring r notifying the physiciar re-admitting residents after-hours.  53). The Interim Admit on his contact informat Coordinator from 09/1 In addition, education who to notify if unable shift.  54). The facility will authead-to-toe skin assess through Friday, for through Friday, for through Friday, for through Friday, for through Friday, for through Friday on each reside will notify the physician Responsible Party of a and those new interve place to prevent decline spiration date on 08/2 conducted weekly for a weeks effective 09/17/three (3) months.  56). The Director of Nu Nursing (ADON), or Nursing (ADON), or Nursident progress note effective 09/13/2021, timonth. Staff will review Saturday and Sunday Supervisor conducted	all licensed nursing staff, and/or agency staff, on the medication kit, the system nedications are in-house, or a for new orders for new or including on weekend and mistrator educated all staff atton and role as the Abuse 3/2021 through 09/17/2021. On staffing schedules and to work their scheduled dit weekly resident assments daily, Monday see (3) months effective they have been completed and. In addition, the facility in, Registered Dietician, and any new skin impairment intions have been put in see.  dited all lab supplies for the 28/2021. Audits will be all lab supplies for four (4) 2021 and then monthly for arising, Assistant Director of arising Supervisor will audit is for daily four (4) weeks then weekly for one (1)	{F 6	55)		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	.TJPL!	E CONSTRUCTION		E SURVEY	Ì
		IDENTIFICATION NUMBER	A. BUILD	ING_			PLETED	
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NAME OF P	ROVIDER OR SUPPLIER		_!	5	STREET ADDRESS CITY, STATE, ZIP CODE	09	/30/2021	4
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		2	200 NURSING HOME LANE			
				F	PIKEVILLE, KY 41501			ı
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
(F 655)	Continued From page	237	{F 6	355}				1
	plan implemented to in	nclude new interventions.		,				ļ
	rounding of residents incontinence, and resi residents will be visua shift daily for two (2) we residents each shift for twenty-five percent of (4) weeks. The facility to 6:00 PM and 6:0	r designee began visual assessing hygiene, toileting, ident repositioning. All ally rounding on once each weeks, fifty percent of the r four (4) weeks, and residents each shift for four has two (2) shifts, 6:00 AM PM to 6:00 AM.  The facility's leadership staffing and timing of call light ling the length of time call cross all shifts. Leadership 10) call light observations weeks and then five (5) call in shift for eight (8) weeks.						
	began monitoring resp Situation Background & Recommendation (SB acute change in respir	AR) communications for				į		
	The facility reviewed a respiratory status for P implementation of any Plans were reviewed a	ny acute change in hysician notification and physician order. Care and updated as needed. one (1) week, then five (5)						
	60). The MDS Nurse, I began audits on 09/15 completion for all new re-admissions to ensur	DON, and/or Designee /2021 of baseline care plan admissions and						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185256	B. WING	_			₹
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE		10. 11.11.	STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DDE	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTIO	ON SHOULD BE HE APPROPRIA	E ATE	(X5) COMPLETION DATE
(F 655)	days with a diagnosis Obstructive Pulmonar Asthma, or current Pn Care Plan reviewed a the MDS Nurse(s) and interventions will be a morning meeting by the nursing designee.  62). Beginning on 08/DON, and/or Designee admissions and re-adicare plans for complet with the resident and/o variance or identified of immediately. Audits we through Friday for all ato the facility for four (admissions for a week then ten percent of adweeks.  63). On 09/11/2021, the designee began auditioneal trays to residents All three (3) meals will (3) units daily for two (all three (3) units daily (1) meal on all three (3) weeks.  64). On 08/15/2021, the began audits of staff's quiz of identification ar with a change in respin	itted within the last thirty of Diabetes, Chronic y Disease (COPD), eumonia had their baseline nd updated as needed by dor designee. New dded to the care plan in the ne DON, ADON, and/or  19/2021, the MDS Nurse, will monitor new missions to audit baseline tion, accuracy, and review or responsible party. Any concern was addressed ill be conducted Monday admissions/re-admissions 4) weeks, fifty percent of for two (2) weeks, and missions weekly for four (4)  the Dietary Manager and/or ng how long it took to pass after arriving at the unit. be observed on all three 2) weeks, two (2) meals on for two (2) weeks, and one b) units daily for four (4)  the DON and/or Designee knowledge with a verbal and assessment of residents ratory status, identifying perglycemia/hypoglycemia,	{F 6	555}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		5 2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 09	9/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERÊNCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
	change in a resident's physician and followin Leadership will quiz sishifts; ten (10) staff for staff a week for four (4) to staff a week for four (4) began monitoring all coresults Monday through morning meeting. The any blood sugar result range for MD notification any Physician's Order reviewed and updated designee will complete diabetic residents acro (3) units to identify any signs and symptoms of hypoglycemia/hyperglyresident was immediated one (1) week, then five (4) weeks.  66). On 08/13/2021, the designee implemented questionnaire on abust residents with wandering the proper reporting of units. The employee of completed for five (5) sithen three (3) times a vand then weekly for for or identified concerns vimmediately.	a condition, notification of the algophysician's orders. Itaff randomly across all or one (1) week and five (5) (4) weeks.  The DON and/or Designee documented blood sugar ghteriday in the clinical of EDON/designee will review its outside of the normal ion and implementation of s. Care plans will be a sneeded. The DON or ea a visual rounding on loss both shifts and all three or resident with apparent of each of the concerns will be stelly assessed by licensed identified concerns will be good to be a concerns will be good to be and identification of the concerns and identification of the concerns will be staff daily for one (1) week, week for two (2) weeks, ar (4) weeks. Any variance will be addressed	{F 6	655}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
_		185256	B. WNG			R 09/30/2021	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 200 NURSING HOME LANE PIKEVILLE, KY 41501	IP CODE		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{F 655}	Set (MDS) assessme wandering will be discomporning meeting to reinterventions. Any variable addressed immovil be addressed immovil be care planned in the Director of Nursing, or nursing do 68). Beginning on 08/Services Director or drandom interviews of of eight (8) or greater the facility and have now interview and the moving and the services of the services of the services of the facility and have now interview and the services of the servic	risk assessment upon rly with their Minimum Data nt. Any resident identified as cussed in the clinical eview and initiate new fiance or identified concerns nediately. New interventions in the morning meeting by g, Assistant Director of esignee.  13/2021, the Social designee will perform residents with a BIMS score to ensure they feel safe in not been subject to or e DON or designee will by skin assessments for a score of less than eight (8) of unknown origin beginning ance or identified concerns mediately.  The Registered Dietician esident diet orders from the cord against orders entered oftware to ensure accuracy.	{F 6	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
		DENTIFICATION NUMBER  185256  VIDER OR SUPPLIER  POST-ACUTE AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ontinued From page 241  ays to residents after they arrive on the unit eginning 09/11/2021. All three (3) meals will be beeved on each unit daily for two (2) weeks, vo (2) meals on each unit daily for two (2) eeks, one (1) meal on each unit daily for four (4) eeks.  1). The dietary manager or designee will review dimitted/re-admitted residents' food and everage preferences within 72 hours of dimission and enter them into the diet/tray card extern for listing on their tray cards beginning (2)/16/2021. Review of food preferences will be impleted bi-annually and as needed for all sidents. Physician-ordered snack intakes will be audited by the Dietary Manager daily for one of the property of the pr				R	
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE P!KEVILLE, KY 41501	1 09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ITE	(X5) COMPLETION DATE
	trays to residents afte beginning 09/11/2021 observed on each unit two (2) meals on each weeks, one (1) meal of weeks.  71). The dietary mana admitted/re-admitted reverage preferences admission and enter the system for listing on the 09/16/2021. Review of completed bi-annually residents. Physician-obe audited by the Dieta (1) week, weekly for for after that for four (4) mog/15/2021.  72). Daily COVID-19 saudited beginning on CResources (HR) Direct punches to ensure scretter shift. Audits will be through Friday for four Director, and weekend staff not screened will immediately on the CO by the HR Director. The educated on the COVII Nurse, an infection cordoors will remain locked.	r they arrive on the unit  All three (3) meals will be t daily for two (2) weeks, t unit daily for two (2) on each unit daily for four (4)  ger or designee will review esidents' food and within 72 hours of them into the diet/tray card their tray cards beginning of food preferences will be and as needed for all bordered snack intakes will ary Manager daily for one their (4) weeks, and monthly the south beginning  creenings for staff will be 18/25/2021 by the Human tor against time clock the seening before beginning the completed Monday (4) weeks by the HR s audited on Mondays. Any the re-educated to VID-19 Screening Policy	{F 6	55)			
	designee will round se\	7/2021, the DON and/or /en (7) times each week (5) times weekly for four					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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PARKVIE	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	09/30/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	differing shifts and un observation of handw and zones; donning/d PPE; and mask comp identified concerns wi by the auditor.  74). The DON, ADON review all residents or pharmacy to ensure a beginning 09/23/2021 physician within two (2 expiration.  75). The Regional Nurand/or Director of Nurand/or Director of Nurand/or Director of Nurand/or Director of School of the pharmacy of medication pass observation pass observation of twenty-follows Critical Element Administration to cond observation of twenty-follows critical element Administration deliver medications daily to erneeding a renewal have pharmacy. Audits will commedicate Jeopardy is followed to the pharmacy of the pharmacy o	ection control compliance on its. Audits will include ashing; isolation signage offing (putting on/taking off) liance. Any variance or ill be addressed immediately in active script is on file. Staff will notify the in active script is on file. Staff will notify the individual conduct random vations effective in shifts daily until immediate insure timeliness and ins. The facility utilized the Pathway for Medication pass five medications.  1021 Monday through N, and/or Designee will ary tickets against ordered issure that all narcotics in been sent to the continue until the removed.  1021, the Administrator ponsible for monitoring our (4) weeks to ensure	{F 6	55)				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	100200	3, 11,110		TOEST ADDOCAGE OFFICE	09	/30/2021
	W POST-ACUTE AND RE			2	TREET ADDRESS, CITY, STATE, ZIP CODE OO NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
;	Dietary Manager will be dietary staffing daily for adequate staffing.  79). Beginning 09/11/2 President of Operation monitor and audit the days to ensure compliance of the days to ensure compliance of the days to ensure compliance of the days to ensure compliance of the days to ensure compliance of the days to ensure compliance of the days to ensure compliance of the days to ensure of the days to ensure of the days to ensure of the designee performed in BIMS score of eight (8 felt safe in the facility at the days of	per responsible for reviewing for four (4) weeks to maintain 2021, the Divisional Vice is and/or designee will Administrator daily for 30 ance.  Will be conducted beginning for residents' change of action of need for "Stop and addition) communication.  2021, the Administrator or atterviews of residents with a a) or greater to ensure they and had not been subjected. No residents had any will continue to be a by the Administrator or a time and immediate jeopardy is subjected in the facility's alminediate Jeopardy on by:  Toe Skin Assessments and all residents in the facility when the skin assessments are the skin as	{F 6	55}			
	pressure injuries of two comprehensive care pl #324, #45, #14, #357,	enty (20). A review of the ans for Residents #65, #27, #74, and #358 the care plans to reflect					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	09/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	JD PREF TAG	IX (EACH CORRECTIVE ACT)	ION SHOULD BE HE APPROPRIA	COMPLETION OATE	
	A review of the facility revealed staff assesse pressure ulcers with the with the Regional DOI revealed she complete assessment on all resturther revealed that the (20) total pressure injusted facility completed assessments on all recontinued interviews a Interdisciplinary Team assessments and Brau update the residents of Resident #65, #324, # and #358's care plans current pressure injuried with MDS Nurse #1 or revealed she updated reflect current pressure addition, she complete rounds on 09/15/2021 the Registered Dieticia DON, and the MDS Nutreviewed each resident's orders, care plan, and implementation of the Medical Eresident on 08/25/2021 Stage four (4) pressure deep tissue injury (DTI	review on 09/17/2021.  's census on 08/28/2021 ed all residents at risk for the Braden Scale. Interview N on 09/30/2021 at 4:17 PM ed head-to-toe skin idents on 09/11/2021. She the facility identified twenty uries. She further stated that the Braden Scale sidents on 08/28/2021. revealed the utilized the skin den Scale assessments to care plans. She stated that 45, #14, #357, #27, #74 were updated to reflect tes by 09/17/2021. Interview to 09/30/2021 at 1:39 PM all residents' care plans to the injuries by 09/17/2021. In the da review of walking with Therapy Personnel, the Medical Director, the turse for Residents #65, #27, #74 and #358. A terdisciplinary Team the Medical record director assessed the I at 1:45 PM and noted a te ulcer on the sacrum; a ) to the left and right heels; teft inner leg. Review of	{F €	655}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
ı		18525 <del>6</del>	B. WNG			R	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	)E	09/30/2021	
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIAT		E COMPLETION DATE	
{F 655}	wound measured, "13 12.3 cm width and 0.2 at 10 o'clock measurin 12 o'clock that measu No palpable bone, slo removed with wound o continued to treat the ulcer with Aquacel Ag. evaluation completed Resident #65 had six including a stage two measuring 1.2 cm (ler 0.1 cm (depth), stage measuring 2.5 cm by 3 stage two (2) to left hij cm x less than 0.1 cm scapula measuring 1 c 0.1 cm, unstageable to cm by 0.6 cm. and for measuring 12 cm by 1 Interventions in place heel protectors while in weekly documentation mattress to bed, nutriti turning/repositioning. (for the sacral pressure 10:21 AM revealed the by 11 cm by 0.3 cm wi drainage and 95 perce Resident #65 declined observation of other pr record review revealed PM, Physician #1 dete weight loss and wound 09/28/2021, Resident a in-house wound care w record revealed on 09/	M, revealed the sacrum C cm (centimeter) (length) by C cm depth with undermining and 2 cm and undermining at tres 1 cm, muscle exposed. The facility resident's sacral pressure The facility resident's sacral pressure The facility resident's sacral pressure The facility resident's sacral pressure The facility resident's sacral pressure The facility resident's sacral pressure The facility resident's sacral pressure The facility resident's sacral pressure The facility resident's sacral pressure The facility resident's sacral pressure The facility resident's by The facility resident's by The facility resident's by The facility resident's by The facility resident's by The facility resident's The facility resident's by The facility The facility resident's The facility The facility resident's The facility Th	{F 6	i55}			

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	!	185256	B. WNG				R /30/2021
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 031	30/2021
(X4) ID PREFIX TAG	EX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
(F 655)	with Failure to Thrive.  3). The facility admitte 09/10/2021, complete 09/10/2021, complete 09/10/2021, and compon 09/10/2021. Reside 09/25/2021 and re-add 09/25/2021 and re-add 09/28/2021. Further revealed staff developplan on 09/21/2021. A re-admission revealed admission skin asses: 09/28/2021, Braden S baseline care plan de  4). Observation of Re 1:48 PM, Resident #308 on Resident #309 on 09/Resident #311 on 09/Resident #314 on 09/Resident #320 on 09/revealed the residents well-kempt, and clean residents' beds. Interview during the time of the identified concerns. A for Residents #45, #6 and #320) revealed the Director interviewed the and had no concerns Interview with the ISS revealed she interview #308, #309, #311, #3 with no identified concerns.	the resident was diagnosed and Resident #355 on and a skin assessment on an a Braden Scale on pleted a baseline care plan ent #355 was discharged on mitted to the facility on eview of the medical record and the comprehensive care a review of Resident #355's at the resident had an asment completed on a sment completed on a sment completed on 09/28/2021, and a veloped on 09/28/2021 at 1:40 an 09/29/2021 at 11:26 AM, 29/2021 at 11:52 AM, 29/2021 at 11:30 AM and 29/2021 at 11:13 AM appeared clean,	{F 6	355)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG			SURVEY
		185256	B. WNG			R 09/30/2021	
PARKVIE	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
(F 655)	no identified concerns reviews revealed Res #309, #311, #314, and shower preference an obtained and included review of the resident' the comprehensive caplan, revealed staff up to reflect the resident' the Vice President of at 4:10 PM revealed's resident preferences. was interviewed for ship preference, and the faresident's care plan. A interviews revealed the preference was obtain shower schedule reveshower/hygiene preference whower/hygiene preference was obtain shower schedule reveshower/hygiene pref	33 PM to 2:32 PM revealed in Interviews and record idents #45, #65, #308, in #320 each had their id hygiene preference in on their care plan. A is medical record, including the plan and SRNA care ideated each resident's plan is preference. Interview with Operations on 09/30/2021 the assisted with obtaining She stated each resident nower and hygiene cility updated each review of resident in eight shower/hygiene ided. A review of the facility's alled that the resident rences were honored.  Dietician on 09/30/2021 at began reviewing all 3/2021. She further stated new and/or additional residents to address weight aling. A review of the ided the Registered Dietician diets, and the Regional is and recommendations. On 09/30/2021 at 4:17 PM ided the review of all diets in assessments completed by nirty-nine (39) residents is betes were assessed for flypoglycemia/	{F 6	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	09/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		70		E COMPLETION DATE DATE	
	intervention. Interview 09/30/2021 at 4:17 Pl the residents and did concerns. Observation 09/28/2021 at 1:36 Pl 09/29/2021 at 11:35 A 09/29/2021 at 11:52 A signs/symptoms of hy A review of facility ass 08/12/2021 revealed diagnosis of Chronic Chisorder (COPD), Ast assessed by Respirat with Respiratory There at 12:45 PM revealed with diagnoses of Chronic Chisorder (COPD), Ast 08/12/2021 with no id-Observation of Resident #43 revealed no respirator 8). Interview with the fon 09/30/2021 at 3:40 all residents with a diaresident's orders for gistated the facility ame include mandatory end MAR. Review of Residenter revealed no cohaving glucose levels than 400.	with the Regional DON on M revealed she assessed not identify immediate ins of Resident #348 on M, Resident #320 on AM, and Resident #311 on AM revealed no visible registered in the resident with a Distructive Pulmonary than and Pneumonia were ory Therapist #1. Interview apist (RT) #1 on 09/30/2021 she assessed all residents onic Obstructive Pulmonary hma, and pneumonia entified concerns. Ent #45 on 09/28/2021 at 1:40 story of 09/28/2021 at 2:03 PM. By distress.  Regional Nurse Consultant PM revealed she reviewed agnosis of Diabetes and the lucose monitoring. She inded all resident orders to try of glucose values on the dent #3, #41, and #357's order required staff to enter the resident's MAR, Further	{F 6	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	100200	I D. MING.	,	TREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER			00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	≣ ITE	(X5) COMPLETION DATE
{F 655}	(RCDM) on 09/28/202 09/30/2021 at 1:52 PN observed on 09/11/20 within five (5) to ten (1 scheduled times.  10). A review of the fa 09/28/2021 from 6:00 two (2) licensed nurse assistants were sched facility. A review of the one (1) licensed nurse nursing assistants for 6:00 AM.  A review of the staffing 09/30/2021 revealed to three (3) certified nurse from 6:00 AM to 6:00 staffing revealed one (2) certified nursing as 6:00 PM to 6:00 AM.  Observation of facility 1:20 PM to 5:30 PM; of to approximately 6:00 7:55 AM to 5:17 PM, rebeing answered timely clean/well-groomed, sassisting residents with turning/repositioning wand meal trays were purposed in the process of the staffing wand meal trays were purposed in the process of the proce	tified Dietary Manager 21 at 2:26 PM, and M revealed lunch was 21 and arrived at the unit 10) minutes of the  cility's staffing for AM to 6:00 PM revealed is and three (3) nursing luled for each floor of the e facility's staffing revealed e and two (2) certified each floor from 6:00 PM to  g for 09/29/2021 and wo (2) licensed nurses, and ing assistants on each floor PM. Further review of (1) licensed nurse and two esistants for each floor from staffing on 09/28/2021 from en 09/29/2021 from 8:11 AM PM and 09/30/2021 from evealed call lights were r, residents appeared taff was offering and h baths/showers, has being conducted timely, assed timely.  on 09/29/2021 at 11:55	{F 6	55)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE		13.11	STF	REET ADDRESS, CITY, STATE, ZIP CODE D NURSING HOME LANE	09	/30/2021
				PIK	KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
{F 655}	and 09/30/2021 at 1:50 Pat 10:31 AM; State Re (SRNA/certified nurse 3:40 PM; SRNA #11 GSRNA #7 on 09/29/200 on 09/29/2021 at 4:10 09/29/2021 at 3:04 PM at 3:17 PM and SRNA PM, revealed staffing staff member revealed duties as assigned.  11). Review of the state of	A PM; LPN #10 on PM, LPN #11 on 09/30/2021 egistered Nurse Aide aide) #1 on 09/29/2021 at on 09/29/2021 at on 09/29/2021 at 3:29 PM; SRNA #19 PM; SRNA #21 on M; SRNA #22 on 09/29/2021 at 4:10 had improved, and each at they had time to perform fing schedule for 21, and 09/30/2021 at 2:26 ng was accurate per the th Cook #3 on 09/29/2021 at 2:26 ng was accurate per the th Cook #3 on 09/29/2021 at nen staffing had improved, complete their duties during staffing had improved, complete their duties during staffing had improved, complete their duties during at #86, #86, and #322 on ans were identified. A nents completed revealed Observation and on 09/28/2021, 09/29/2021, ed no identified concerns or physical abuse, of Residents #64, #86, th Resident #322 on M revealed no concerns	{F 6	555}			

NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   200 NURSING HOME LANE   PIKEVILLE, KY 41501	STATEMENT OF AND PLAN OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (F 655)  Continued From page 251  O9/30/2021 at 1:39 PM revealed all residents with a diagnosis of Dementia had their care plans reviewed and revised as necessary. Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed skin assessments on 08/11/2021, for all residents, with the ability of advices of eight (8) or above revealed no identified concerns.  13). A review of assessments for residents with a BIMS score of eight (8) or above revealed an wandering risk assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021.			185256	B. WING				
PARKVIEW POST-ACUTE AND REHABILITATION CENTER  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 655)  Continued From page 251  09/30/2021 at 1:39 PM revealed all residents with a diagnosis of Dementia had their care plans reviewed and revised as necessary. Interview with the RDON on 09/30/2021 at 4:7 PM revealed she completed skin assessments on 08/11/2021, for all residents, with the ability score of eight (8) or above revealed no identified. A review of audits completed by the Social Service Director (SSD) for residents with a BIMS score of eight (8) or above revealed no identified concerns.  13). A review of assessments for residents that wander, revealed all residents had received a wandering risk assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident identified at risk.  14). Review of Resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021.	NAME OF PRO	OVIDER OR SUPPLIER		1			09/30/2021	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 655)  (F 655)  (F 655)  (F 655)  Continued From page 251  O9/30/2021 at 1:39 PM revealed all residents with a diagnosis of Dementia had their care plans reviewed and revised as necessary. Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed by the Social Service Director (SSD) for residents with a BIMS score of eight (8) or above revealed no identified. A review of assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021.	PARKVIEW	POST-ACUTE AND DE	WADE STATION CONTES		100 100			
REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   P		———————						
09/30/2021 at 1:39 PM revealed all residents with a diagnosis of Dementia had their care plans reviewed and revised as necessary. Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed skin assessments on 08/11/2021, for all residents, with the assistance of licensed nursing staff. No concerns were identified. A review of audits completed by the Social Service Director (SSD) for residents with a BIMS score of eight (8) or above revealed no identified concerns.  13). A review of assessments for residents that wander, revealed all residents had received a wandering risk assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident identified at risk.  14). Review of Resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	ULD BE	COMPLETION	
09/30/2021 at 3:53 PM revealed she completed a comprehensive nutritional assessment on Residents #39, #65, #81, #90, #330 and #332. Review of the medical record revealed the RD completed a comprehensive nutritional assessment on 09/16/2021 for Resident #39, 09/16/2021 for Resident #65, 09/16/2021 for Resident #90 and 09/16/2021 for Resident #330 with no dietary recommendations made. Resident #332 was discharged. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM, the Regional Nurse Consultant on 09/30/2021 at 4:17 PM and	results of the second of the s	09/30/2021 at 1:39 PM a diagnosis of Demen reviewed and revised with the RDON on 09/30/2021 at 1:39 PM a diagnosis of Demen revealed and revised with the RDON on 09/30/202 Wurse Consultant on 09/30/202 Vurse Consultant on 09/30/202 virthe diagnosis of Demendant on 09/30/202 Nurse Consultant on 09/30/202 virthe diagnosis of Demendant on 09/30/202 Nurse Consultant on 09/30/202 Vurse Consultant o	M revealed all residents with thia had their care plans as necessary. Interview /30/2021 at 4:17 PM ed skin assessments on idents, with the assistance aff. No concems were audits completed by the or (SSD) for residents with a sign or above revealed no sements for residents that esidents had received a sment by 08/16/2021. ent/wandering binder at on 09/29/2021 revealed a nat contained information in, a photo and potential resident identified at risk.  Ent #39, #65, #81, #90, #330 incord revealed all of the eighed by 09/17/2021, instered Dietician on of revealed she completed a onal assessment on 81, #90, #330 and #332. Incord revealed the RD ensive nutritional (2021 for Resident #39, and #65, 09/16/2021 for 021 for Resident #39 and the first was with the Registered 11 at 3:53 PM, the Regional 19/30/2021 at 3:40 PM, the	{F 6	555}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  200 NURSING HOME LANE  PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 655}	DON #2 on 09/30/202 resident had received assessment and revie by nursing staff. Furth and Regional DON retray card were review information.  15). Observation of that 2:22 PM, the fourth PM and the fifth floor revealed snacks incluoatmeal pies, goldfish drinks were present, i juice. Observations or revealed snacks were Review of Resident #Resident #14's record intake of snacks. Inte 09/29/2021 at 4:10 Pleducated on documer 16). Observation of thy ellow zone on 09/28 no identified concerns residents.  17). Review of Resident guidance. Observation 09/29/2021 at 11:41 A 8/30/2021 at 10:36 Al or symptoms of COV been discharged from 18). Review of facility staff working on 09/16	at 3:20 PM revealed each a comprehensive nutritional ew of the recommendations her interview with the RD evealed both the record and ed to reflect accurate  the third floor on 09/28/2021 at 2:00 on 09/28/2021 at 2:06 PM ding but not limited to a crackers, cookies and including soda, milk, and in 09/29/2021 at 10:30 AM is being passed on third floor.  331, Resident #65 and if revealed documented exiew with SRNA #19 on if it is in the facility's red zone and it is revealed she was intation of snacks.  The zones contained no is swere isolated per CDC in of Resident #328 on it is in the facility.  Staff testing revealed all is it is staff	{F 6	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	LTIPLE CONSTRUCTION DING	(X3) D.	ATE SURVEY DMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	100200	D. WIING			09/30/2021
PARKVIE	W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	IX (EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
	09/17/2021, revealed  19). Interview with ME at 1:39 PM, MDS Nurselection PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepin 09/30/2021 at 1:24 PM Director (HR) on 09/30 Marketing Liaison on 0 Medical Records on 0 Central Supply on 09/20 on 09/29/2021 at 11:5 12:58 PM, RN #4/Woo 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #21 OP/29/2021 at 3:29 PM at 4:10 PM, SRNA #21 OP/29/2021 at 2:10 PM Director/Dietary Manage 1:30 PM revealed the	no new cases.  2S Nurse #1 on 09/30/2021 se #2 on 09/30/2021 at 1:31 istant #1 on 09/30/2021 at nager on 09/30/2021 at ng Supervisor on  6, Human Resource 0/2021 at 10:48 AM, Senior 09/30/2021 at 10:55 AM, 9/29/2021 at 8:34 AM, 29/2021 at 2:40 PM, RN #1 5 AM and 09/30/2021 at und Care Nurse on  6, LPN #6 on 09/30/2021 at 09/29/2021 at 3:00 PM and 16, LPN #10 on 09/30/2021 on 09/30/2021 at 10:31 19/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on 10, SRNA #19 on 09/29/2021 11 on 09/29/2021 at 3:04 PM, 1021 at 3:17 PM and SRNA 4:10 PM, Cook #3 on 11, Dietary Aide #3 on 11	⟨F 6	655}		
	20). Review of Resider and #90's medical reco resident had COVID-19 implemented. In addition	9 monitoring orders				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG	<u> </u>		R 09/30/2021	
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTIVE ACTION SHOULD DEFICIENCY)		(X5) COMPLETION DATE	
{F 655}	monitoring as ordered 21). Interview with the 09/30/2021 at 3:25 PN Resident #321, Resident #351's in for usage and approphine physician on 09/21 22). Observation of a 09/29/2021 at 4:35 PN 09/30/2021 at 8:09 AN identified concerns with addition, observation of floor on 09/30/2021 at 11:55 APM, N #4/Wound Card 2:54 PM, LPN #6 on 0 LPN #7 on 09/29/2021 at 1:54 PM at 12:50 PM and LPN AM revealed no concerned ications.  23. Interview with the Operations on 09/30/2021 at 3:11 PM revealed be agreement that the phenoistic pharmacy agreement requiring cost review, pharmacy agreement requiring a cost review the facility a minimum medication while being the side of the control of t	led staff was completing the I by the physician.  Medical Director on Medical Prector on Medical Prector on Medical Prector on Medical Resident #9, ent #324, Resident #326 medications were reviewed riate administration times by 3/2021.  I medication pass on Me	{F 6	355}			
	guidance to the pharm	nacy within 72 hours. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
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NAME OF PROVIDER OR SUPPLIER	100200	B. WNG_			09/	30/2021
PARKVIEW POST-ACUTE AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP  200 NURSING HOME LANE  PIKEVILLE, KY 41501	CODE		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BI	E NTE	(X5) COMPLETION DATE
the Vice President of Opsigned the agreement.  24). Interview with RN # AM and 09/30/2021 at 1 09/30/2021 at 2:54 PM, 12:44 PM, LPN #7 on 05 09/30/2021 at 1:54 PM, at 12:50 PM, LPN #11 or revealed they had receivaware of the process for from the pharmacy. In act they were aware that the physician if the pharmac medication to the facility.  25). Interview with the R on 09/30/2021 at 3:40 Pl 09/30/2021 at 4:17 PM r completed of all resident and verified all medication facility by 09/25/2021. Of pass on 09/29/2021 at 4:	of Guardian Pharmacy and perations of the facility  21 on 09/29/2021 at 11:55 2:58 PM, RN #4 on LPN #6 on 09/30/2021 at 29/29/2021 at 3:00 PM and LPN #10 on 09/30/2021 n 09/30/2021 at 10:31 AM yed education and was obtaining medications ddition, they revealed a nurse would notify the ey could not deliver a cy could not deliver a cy could not medication sons were available in the bservation of medication: 35 PM on the third floor AM revealed no identified medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.  ignature sheet revealed medications of medications.	{F 6				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R (20/2024
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	. 09/	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		COMPLETION DATE	
{F 655}	Operations on 09/30// Interview with the Interview with the Interview with the Interview with the Consultant on 09/13/2021. Further in Operations revealed and Administrator with dair 09/10/2021.  28). Interview with the 09/30/2021 at 3:40 Pt 09/30/2021 at 3:25 Pt committee, including and Consultant on 09/30/2021 at 3:25 Pt committee, including and turning/reposition 09/15/2021.  29). Interview with the Operations on 09/30/2021.   2021 at 4:10 PM and erim Administrator on M revealed the facility Interim Administrator on interview with the VP of she had provided the Interim Ity oversight since  a Interim Administrator on M, the Medical Director on M and members of the QAPI the Regional Nurse 2021 at 3:40 PM, revealed thing staff for call-ins, ADL Care, serving and timely, incontinence care ing were reviewed on  a Vice President of 2021 at 4:10 PM, Regional 29/30/2021 at 3:40 PM, and is Nurse Consultant on M revealed the facility ce call to review the omes of the survey, (2) is of the Governing Body as and Regulations, (3) the following pring tools: Infection Control on, enough staff at the less residents, turn and rovide incontinent care,	{F 6	555}				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	09/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTI	ION SHOULD BE HE APPROPRIA	E COMPLETION THE DATE	
{F 655}	QAPI committee.  30). Interview with the 09/30/2021 at 3:40 Pi Consultant on 09/30/2 reviewed and revised presented the reviews Committee during the facility developed a st all topics were review meetings. The plan in Foley catheters, enter contractures, physical usage, risk management, social s grievance, activities, recouncil concerns and/discharges, census, s by department/position dietary variance tray a work injuries, terminat medical leave of absenew hires, medical recopharmacy reports, resioffice, and admission a Committee and Medical standardized agenda of but not be limited to the the meeting. Interview 09/30/2021 at 1:39 PM 09/30/2021 at 1:52 PM Director/Dietary Manager on 09/28/2020 09/30/2021 at 1:52 PM Director/Dietary Manager OPM, Medical Record AM, Human Resource	e Interim Administrator on M, and Regional Nurse (2021 at 3:40 PM revealed the QAPI Plan and and/or revision to the QAPI 09/16/2021 meeting. The andardized plan to ensure ed as needed at the QAPI cluded pressure ulcers, al feeding tubes, restraints, medication ent, infection control, the rate, rehabilitation ervices, concerns of esident council, and family or grievances, admissions, taff development, openings in, employee orientations, udit report, weight losses, ions, employees on family ince or leave of absence, cord compliance review, torative nursing, business actions. The QAPI al Director approved the on 09/16/2021 to include e topics presented during with MDS Nurse #1 on II, MDS Nurse #2 on II, Regional Certified Dietary in at 2:26 PM and II, Former Activities ger #3 on 09/30/2021 at 8:34 Director (HR) on III, Therapy Manager on III.	{F €	655}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R <b>30/2021</b>
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	109/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 655}	12:45 PM and Centra 2:40 PM, revealed the at the QAPI meeting It at the QAPI meeting It at the QAPI meeting It at the QAPI meeting It at the QAPI meeting It at the QAPI meeting It at the QAPI meeting was conducted the duties of the Government of the Government of the Gapility and communic members of the Gapility and communic members of the Gapility and communic members of the Gapility and communic members of the Gapility and communic members of the Gapility and communic members of the Gapility and communic members of the Gapility and communic members of the Gapility and communic members of the Gapility and communic members of the Gapility and Capility 21 at 1:24 PM, (RT) #1 on 09/30/2021 at I Supply on 09/29/2021 at information was presented held on 09/16/2021.  2 Vice President of 2021 at 4:10 PM, the Interim 20/2021 at 3:40 PM, DON #2 2 PM, and the Medical 1 at 3:25 PM revealed a ed on 09/16/2021 regarding trining Body including setting at to be implemented in the ating information to other rming Body. During the accesses, the need to the QAPI process, the auses of system problems, y" approach and auditing Calendar were reviewed.  Interim Administrator on A revealed he collected all fore each QAPI meeting for compliance. A review of ets revealed the facility on 09/16/2021, 09/23/2021, view with the Vice President 0/2021 at 4:10 PM and ultant on 09/30/2021 at 3:40 e members of the DAPI meetings had been  Vice President of	{F 6	55}				
	Regional Nurse Consi	2021 at 4:10 PM and the ultant on 09/30/2021 at 3:40 rning body provided the					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	IO. 0938-0391 FE SURVEY MPLETED
		185256	B. WING				R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			S 2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	0:	9/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		E	(X5) COMPLETION DATE
	Administrator with res material for QAPI. Fur governing body would upcoming year. Interv Administrator on 09/3/he had been provided education regarding C 34). Interview with the 09/30/2021 at 3:40 PN were conducted week ensure the quality of c complied with the stan compliance. Further in President of Operation PM, Regional Nurse C 3:40 PM, MDS Nurse #2 on Regional Certified Diet 09/28/2021 at 2:26 PM PM, Former Activities #3 on 09/30/2021 at 1:00 09/29/2021 at 8:34 Director (HR) on 09/30 Therapy Manager on C Housekeeping Supervi PM, Respiratory Thera at 12:45 PM and Centra 2:40 PM revealed they weekly QAPI meetings and 09/23/2021. In add Medical Director/Physical 3:25 PM revealed he p QAPI meetings on 09/5 Further interview with t 09/30/2021 at 3:40 PM meeting had been conceptions.	cources and education of ther interviews revealed the interview revealed the interview with the Interim 0/2021 at 3:40 PM revealed with resources and 0API.  Interim Administrator on interview education interview of care and of care and of care and of care and of care and interview with the Vice of consultant on 09/30/2021 at 1:39 of 09/30/2021 at 1:31 PM, of consultant on 09/30/2021 at 1:32 Director/Dietary Manager on interview interview Manager on interview Manager on interview interview Manager on interview interview Manager on interview	{F €	955}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE	SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	100200	J	STREET ADDRESS, CITY, STATE, ZIP CODE		09/	30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
{F 655}	AM and 09/30/2021 at Care Nurse on 09/30/on 09/30/2021 at 12:4 09/29/2021 at 3:00 PM PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PM 09/29/2021 at 3:40 PM 09/29/2021 at 3:29 PM, SRNA #15 SRNA #21 on 09/29/2 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PM education on 09/17/20 staff revealed they ver weighing residents, observed the weights of the weights of the weight of the weigh	I #1 on 09/29/2021 at 11:55 t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 4 PM, LPN #7 on M and 09/30/2021 at 1:54 30/2021 at 12:50 PM, LPN 10:31 AM, SRNA#1 on M SRNA#11 on M SRNA#11 on M SRNA#22 9 on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA#22 PM and SRNA#23 on M revealed they received 021. Interview with nursing totalized understanding of obtaining, documenting, and to the Registered Dietician egional DON on 09/30/2021 taff was provided with 121 on proper weighing documenting, and ges to the Registered  mer Activities Director and ter on 09/30/2021 at 1:30 tived education on gional Certified Dietary et order accuracy and	{F 6	655}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	185256	B, WING		R
NAME OF PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	09/30/2021
PARKVIEW POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
PREFIX (EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
meeting. Interview wit 09/28/2021 at 2:26 PN PM revealed she com Former Activities Direct addition, she stated the provide additional assist to her new role.  37). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/2021 at 12:4 09/29/2021 at 3:00 PN PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PN 09/29/2021 at 3:29 PM, SRNA #15 SRNA #21 on 09/29/2021 at 3:17 09/29/2021 at 3:17 09/29/2021 at 3:17 09/29/2021 at 3:17 09/29/2021 at 3:17 09/29/2021 at 3:17 09/29/2021 at 10:22 revealed no identified of the total	e reviewed in the clinical th the Regional CDM on A and 09/30/2021 at 1:52 pleted education with ctor/Dietary Manager #3. In that she had been on site to istance during the transition  #1 on 09/29/2021 at 11:55 to 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 4 PM, LPN #7 on A and 09/30/2021 at 1:54 0/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on A SRNA #1 on A SRNA #1 on A SRNA #7 on 09/29/2021 B on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA #22 PM and SRNA #23 on A revealed they received epositioning, range of g residents from bed to bed. Observations of and wound care with RN #11 1 AM for Resident #65 concerns. Interview with the 19/30/2021 at 1:18 PM staff with education 21 regarding ange of motion, and from bed.  #1 on 09/29/2021 at 11:55 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6	{F 65	5)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  A. BUILDING			(X3) DATE SURVEY COMPLETED		
ı		_	185256	B. WNG			l	R
	PARKVIEV	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, 2 200 NURSING HOME LANE PIKEVILLE, KY 41501	IP CODE	<u>  0</u>	9/30/2021
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	PREF TAG		ACTION SHOULD BI TO THE APPROPRIA	E NTE	(X5) COMPLETION DATE
		#11 on 09/30/2021 at 09/29/2021 at 3:40 PM 09/29/2021 at 3:23 PM at 3:29 PM, SRNA #15 SRNA #21 on 09/29/20 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PM education on pressure turning and repositioninutrition, Positioning d and document a headand how to notify the rRP of a new skin impaor email the Registere and the resident's reprehanges. Interview with Consultant on 09/30/20 Regional DON on 09/30 revealed they educated prevention including ture adequate hydration and evices, how to complehead-to-toe skin assess the registered dietician new skin impairment. Wimpairment, the nurse of Registered Dietitian for MD, and resident's representation including ture and the registered dietician new skin impairment. Wimpairment, the nurse of Registered Dietitian for MD, and resident's representation and the resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and the registered Dietitian for MD, and resident's representation and document and the resident's representation and document and document and document and document and document and document and document and document and document and document and document and document and doc	30/2021 at 12:50 PM, LPN 10:31 AM, SRNA#1 on M, SRNA#11 on M SRNA#7 on 09/29/2021 9 on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA#22 PM and SRNA#23 on M revealed they received 9 ulcer prevention including 10 ng, adequate hydration and 10 evices, how to complete 10-toe skin assessment, 10 egistered dietician, MD and 10 irment. The nurse will call 11 dietitian, the physician, 12 desentative with any 13 h Regional Nurse 10 11 at 3:40 PM and the 10/2021 at 4:17 PM 10 dietition, Positioning 11 diet and document a 12 sment, and how to notify 13 n, physician and RP of a 14 Nith any change to skin 15 will call or email the 16 new recommendations, 17 resentative. 18 Nurse #1 on 09/30/2021 19 de #2 on 09/30/2021 at 1:31 10 stant #1 on 09/30/2021 at 10 supervisor on 17 Human Resource 18 Supervisor on 18 revealed they received 19 supervisor on 19 supervis	{F 6	655)			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI LAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDIN		TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
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PARKVIE	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		<u>9/30/2021</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
	Central Supply on 09/43 on 09/29/2021 at 1 09/30/2021 at 2:10 PM Director/Dietary Mana 1:30 PM revealed they timely call light respor with RN #1 on 09/29/2009/30/2021 at 12:58 PM urse on 09/30/2021 at 12:58 PM at 3:00 PM and 09/30/00 09/30/2021 at 12:50 09/30/2021 at 10:31 At 3:40 PM, SRNA #1 SRNA #7 on 09/29/200 on 09/29/2021 at 3:04 PM at 3:17 PM and SRNA PM, revealed they recall light response, proresident plan of care, to staff dress residents in clothing and timely delinterview with Cook #3 Dietary Aide #3 on 09/Former Activities Directory and the staff dress residents in clothing and timely delinterview with Cook #3 Dietary Aide #3 on 09/Former Activities Directory 30/2021 at 1:30 PM education on meal senting the staff of the staf	29/2021 at 2:40 PM, Cook :12 PM, Dietary Aide #3 on M, Former Activities ger #3 on 09/30/2021 at y received education on ise. In addition, interviews :021 at 11:55 AM and M, RN #4/Wound Care at 2:54 PM, LPN #6 on M, LPN #7 on 09/29/2021 :2021 at 1:54 PM, LPN #10 0 PM, LPN #11 on M, SRNA #1 on 09/29/2021 1 on 09/29/2021 at 3:23 PM 21 at 3:29 PM, SRNA #19 PM, SRNA #21 on 1, SRNA #22 on 09/29/2021 #23 on 09/29/2021 at 4:10 eived education on timely eviding timely hygiene per imely toileting, ensuring their choice of clean ivery of meal trays. Further i on 09/29/2021 at 1:12 PM, 30/2021 at 2:10 PM, and tor/Dietary Manager #3 on I revealed they received wice times.  S Nurse #1 on 09/30/2021 e #2 on 09/30/2021 at 1:31 021 at 11:55 AM and M, RN #4/Wound Care at 2:54 PM, LPN #6 on M, LPN #7 on 09/29/2021 2021 at 1:54 PM, LPN #10 0 PM, LPN #11 on M revealed they received	{F 6	155}		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
185256 B. WING		R	
	T ADDRESS, CITY, STATE, ZIP CODE	09/30/2021	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NU	URSING HOME LANE VILLE, KY 41501		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
(F 655) Continued From page 264 entered into the electronic medical record. Observation of RN #1 on 09/29/2021 at 11:55 AM revealed the nurse was able to demonstrate knowledge of the education with no identified concerns.  41). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:29 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #11 on 09/29/2021 at 3:29 PM, SRNA #10 on 09/29/2021 at 3:29 PM, SRNA #10 on 09/29/2021 at 3:10 PM revealed they received education on identification and assessment of residents with a change in respiratory status and on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documentation of blood sugar in the medical record, notification of the physician and following physician orders. In addition, interviews revealed they received education on documentation of glucose levels.  42). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:58 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:40 PM, SRNA#1 on 09/29/2021 at 3:40 PM, SRNA#1 on 09/29/2021 at 3:40 PM, SRNA#1 on 09/29/2021 at 3:40 PM, SRNA#11 on 09/29/2021 at 3:40 PM, SRNA#11 on			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R	
NAME OF P	ROVIDER OR SUPPLIER			_		09	/30/2021
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
{F 655}	at 3:29 PM, SRNA #19 SRNA #21 on 09/29/2 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PM education on completi with interventions and diagnosis of diabetes within forty-eight hours reviewing and providir resident/responsible p  44). Interview with MD at 1:39 PM, MDS Nurs PM, Maintenance Assi 2:56 PM, Therapy Mai 1:18 PM, Housekeepir 09/30/2021 at 1:24 PM Director (HR) on 09/30 Marketing Liaison on 0 Medical Records on 09/20 on 09/29/2021 at 11:54 12:58 PM, RN #4/Wou 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 3:29 PM o9/29/2021 at 3:29 PM o9/29/2021 at 4:10 PM at 3:04 PM, SRNA #22 and SRNA #23 on 09/2 #3 on 09/29/2021 at 1: 09/30/2021 at 2:10 PM Director/Dietary Manag 1:30 PM revealed they process of identifying,	9 on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA #22 PM and SRNA #23 on M, revealed they received ing a baseline Care Plan goals relevant to the and a respiratory diagnosis of admission, and ing a copy to the arty.  9 S Nurse #1 on 09/30/2021 at 1:31 istant #1 on 09/30/2021 at inager on 09/30/2021 at inager on 09/30/2021 at inager on 09/30/2021 at inager on 09/30/2021 at inager on 09/30/2021 at 10:55 AM, 29/2021 at 10:48 AM, Senior 29/30/2021 at 10:55 AM, 29/2021 at 2:40 PM, RN #1 55 AM and 09/30/2021 at ind Care Nurse on 1, LPN #6 on 09/30/2021 at ind Care Nurse on 1, LPN #6 on 09/30/2021 at 09/29/2021 at 3:00 PM and 1, LPN #10 on 09/30/2021 on 09/30/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on 1, SRNA #19 Aide on 1, SRNA #19 Aide on 1, SRNA #21 on 09/29/2021 at 3:17 PM 29/2021 at 4:10 PM, Cook 12 PM, Dietary Aide #3 on 1, Former Activities ger #3 on 09/30/2021 at ger #3 on 09/30/2021	{F 6	55}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER			STREET ADDRESS, CI 200 NURSING HOME PIKEVILLE, KY 41	LANE	09/30/2021		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		E COMPLETION DATE	
(F 655)	immediate interventio  45). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/ on 09/30/2021 at 12:4 09/29/2021 at 3:00 PN PM, LPN #10 on 09/3 LPN #11 on 09/30/202 they received education they received education and provision of timely ensure diet order accurate put into the electronurse entering the ord communication to the diet and texture. She forders from the previoclinical meeting, which riday, to ensure accurate accurate to ensure accurate and the use of refortified diets to ensure accurate to the diet and texture. She forders from the previoclinical meeting, which riday, to ensure accurate accurate and the use of refortified diets to ensure accurational needs of reseatablished national ground training tray card system, orde	I #1 on 09/29/2021 at 11:55 t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 t4 PM, LPN #7 on M and 09/30/2021 at 1:54 0/2021 at 12:50 PM and 21 at 10:31 AM revealed on on proper weighing documenting, and anges to the Registered an interview with the Dietary 21 at 1:30 PM revealed she on on diet order accuracy or nutritional assessment to arracy. When the diet orders onic medical record, the er will send a written dietary staff that will include further revealed all diet us day are reviewed in the occurs Monday through arracy.  Dietary Manager on I revealed she received coilicy regarding meal service excipes, including recipes for exall meals meet the sidents in accordance with uidelines to reflect religious, eds of the population.  Dietary Manager on I revealed she received I food preference, facility	{F €	55)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R		
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER			200 NL	T ADDRESS, CITY, STATE, ZIP CODE JRSING HOME LANE /ILLE, KY 41501	09	/30/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 655}	and/or portion sizes, s carts and snacks and 48). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/ on 09/30/2021 at 12:4 09/29/2021 at 3:00 PM PM, LPN #10 on 09/3 #11 on 09/30/2021 at 1:30 PM education on the proc and/or implementing t recommendations for 49). Interview with the 09/30/2021 at 1:30 PM on 09/30/2021 at 1:31 PM on 09/30/2021 at 1:31 PM on 09/30/2021 at 1:31 PM on 09/30/2021 at 1:18 PM Supervisor on 09/30/2021 at 1:18 PM Supervisor on 09/30/2021 at 1:55 PM Supervisor on	stocking snack/hydration hydrations.  I #1 on 09/29/2021 at 11:55 t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 4 PM, LPN #7 on M and 09/30/2021 at 1:54 00/2021 at 12:50 PM, LPN 10:31 AM and Former ary Manager #3 on M revealed they received ess for entering, activating, the registered dietician's dietary orders.  Interim Administrator on M, DON #2 on 09/30/2021 at the MDS Nurse #1 on M, MDS Nurse #1 on M, MDS Nurse #2 on M, Maintenance Assistant #1 PM, Therapy Manager on M, Housekeeping 021 at 1:24 PM, Human R) on 09/30/2021 at 10:48 Liaison on 09/30/2021 at cords on 09/29/2021 at 2:40 2021 at 11:55 AM and M, RN #4/Wound Care at 2:54 PM, LPN #6 on M, LPN #7 on 09/29/2021 2021 at 1:54 PM, LPN #10 00 PM, LPN #11 on M, SRNA #1 on 09/29/2021 1 on 09/29/2021 at 3:23 PM 21 at 3:29 PM, SRNA #19	{F 6	55}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(XC	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R 09/30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		03/30/2021	
(X4) ID PREFIX TAG				X (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 655}	PM, Cook #3 on 09/2 Aide #3 on 09/30/202 Activities Director/Die 09/30/2021 at 1:30 Pl received education or policy/guidelines, han Personal Protective E red zones. Observatio and yellow zone on 0 revealed no identified were in the red or yell conducted on 09/28/2 09/30/2021 revealed the COVID-19 policy/donning/doffing Perso (PPE), or the yellow/r 50). Interview with RN AM, and 09/30/2021 at 3 Care Nurse on 09/30/2 (LPN) #6 on 09/30/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/20; they had received edi symptom monitoring of admissions. A review #355 on 09/10/2021 r COVID-19 symptom r resident orders. Resid on 09/25/2021 and re 09/28/2021. A review Resident #355 reveal COVID-19 symptom r resident orders. In ad #329, #328, #311, #6	A #23 on 09/29/2021 at 4:10 9/2021 at 1:12 PM, Dietary 1 at 2:10 PM, Former tary Manager #3 on M revealed they had in the COVID-19 idwashing, donning/doffing Equipment (PPE), yellow and on of the red facility zone 9/28/2021 at 2:12 PM concerns. No residents low zones. Observations 1021, 09/29/2021, and ino identified concerns with guidelines, handwashing, onal Protective Equipment ed zones.  If #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 12021 at 2:54 PM, LPN 121 at 12:44 PM, LPN (LPN) 13:00 PM and 09/30/2021 at 109/30/2021 at 12:50 PM, 21 at 10:31 AM revealed ucation entering COVID-19 orders on all new of newly admitted Resident evealed the resident had monitoring entered in the dent #355 was discharged -admitted to the facility on of re-admission for ed the resident had a monitoring entered in the dition, a review of Resident 5, and #90's medical in resident had COVID-19	{F 6	555)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R 09/30/2021		
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u>                                       </u>	30/20/21		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 655}	AM, and 09/30/2021 at 2 Care Nurse on 09/30/20 (LPN) #6 on 09/30/20 #7 on 09/29/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/20 they had received edu of medication administ medication, right patie and right route. In ad on the process to follonot available for admicalling the pharmacy obtaining the anticipal notifying the physician would either be omitted ordered medication timicluded following new physician, documenting the ordered medication timicluded following new physician, documenting orders from the Marcord.  52). Interview with RN AM and 09/30/2021 at 3 Care Nurse on 09/30/20 #7 on 09/29/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/20 they had received educemergency medication floor three (3) on 09/29/2021 at 2 (5) on 09/29/2021 at 2 (5) on 09/29/2021 at 2	I #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN 21 at 12:44 PM, LPN (LPN) 2:00 PM and 09/30/2021 at 09/30/2021 at 12:50 PM, 21 at 10:31 AM revealed acation on the five (5) rights stration including right time, dition, they were educated aw when a medication was nistration, which included to obtain the medication, led medication delivery time, at fan ordered medication at or given outside of the me. The education also	{F 6	\$55)				
	with an emergency me	edication kit. Interview with 60/2021 at 2:27 PM revealed						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	185256	B, WING_		00	R	
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		)/30/2021 	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
medication kit.  53). Interview with DCPM, MDS Nurse #1 or MDS Nurse #2 on 09/Maintenance Assistant PM, Therapy Manage Housekeeping Superview PM, Human Resource 09/30/2021 at 10:48 A Liaison on 09/30/2021 Records on 09/29/2021 09/29/2021 on 09/29/2021 on 09/29/2021 on 09/29/2021 on 09/29/2021 at 11:55 APM, RN #4/Wound Ca 2:54 PM, LPN (LPN) #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 09/29/2021 at 09/29/2021 at 09/29/2021 at 09/29/2021 at 09/29/2021 at on 09/29/2021 at were educated on the contact information ar Coordinator. Observa 09/28/2021, 09/29/2021 revealed signage post Administrator's contact Abuse Coordinator post of the second of the contact information ar Coordinator of 54). Review of audits weekly head-to-toe skino identified concerns	o the facility and had garding the emergency  ON #2 on 09/30/2021 at 3:20 in 09/30/2021 at 1:39 PM, 130/2021 at 1:31 PM, 15 pt	{F 6:	55}			

		IDENTIFICATION NUMBER		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		0.00	R 1/30/2024	
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 0:	0/30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{F 655}	review of the medical #324, #45, #14, #357 revealed the weekly version completed with physical notifications. Interview 09/30/2021 at 3:53 Profession of the resident with Medical Director revealed that he was worsening skin impair interventions to preversed that he partiand discussed ongoing residents. Interview won 09/30/2021 at 5:05 team discussed all actincluding new and/or and interventions impostically interventions impostically serve and that the audit for four (4) weeks and months. A review of a Observation of floor to (5) supplies and review identified concerns.  56). Interview with the 09/30/2021 at 4:17 Prog/30/2021 at 3:20 Programmer and the wareas been care planned with the care of the care planned with the care of the care planned with the care of the care planned with the care of the care planned with the care of the care planned with the care of the care planned with the care of the care planned with the care of the care planned with the care of the care planned with the care of the care planned with the care of the care planned with the care of the care	In no identified concerns. A record for Resident #65, 7, #27, #74, and #358 wound assessments cian and responsible party with the Dietician on M revealed she was notified hing pressure ulcers and its as indicated. Interview on 09/30/2021 at 3:25 PM notified of new and/or rements and new ent decline. He further cipated in QAPI meetings and gaudits and care of with the Interim Administrator 5 PM revealed the QAPI udits in QAPI meetings, worsening pressure injuries elemented.  Sentral Supply on 09/29/2021 she completed the audits of so on 08/28/2021. She further its were conducted weekly define monthly for three (3) audits revealed no concerns. There (3), four (4), and five the work the audits revealed no M, and DON #2 on M revealed progress notes morning clinical meetings to of skin impairment had ith interventions to address A review of audits revealed	(F 65:	5}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_			R 09/30/2021	
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		03/30/2021	
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE APP  DEFICIENCY)	OULD BE	COMPLETION DATE	
{F 655}	on 09/30/2021 at 10:5 completed visual rour hygiene, toileting, incompositioning in additional repositioning repos	e Senior Marketing Liaison 55 AM revealed he iding of residents assessing continence, and resident on to other leadership staff, aled staff were auditing dor, incontinent clean and sted or every two (2) hours, d, sheets and blankets reach, facial hair shaved if and repositioned.  e Vice President of 2021 at 4:10 PM and the son on 09/30/2021 at 10:55 ticipated in visual toring call light response night of time call lights go ws revealed any call ve (5) minutes were aff. A review of audits completed on different units	{F 6				
	respiratory status and completed had physic implementation of phy Resident #315 SBAR #324 SBAR complete completed on 08/15/2 physician notification,	nat any acute change in lor SBAR assessments ian notification and/or sician orders. Review of completed on 09/26/2021, d on 09/27/2021, and #326 021 revealed assessment, interventions, and care cated. A review of audits					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501	09/	/30/2021
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
{F 655}	admitted on 09/10/20 had a baseline care p 09/10/2021. Resident 09/25/2021 and re-ad 09/28/2021. Further of resident #355 revices for Resident #355 revices for Resident #355 revices for Resident had a baselin 09/28/2021. Interview 09/30/2021 at 1:39 Pl 09/30/2021 at 1:31 Pl admissions and re-adbeing reviewed during meeting Monday throcompletion.  61). Review of the addays from 07/16/2021 concerns with baselin MDS Nurse #1 on 09/20/2021 cerns with baselin MDS nurse #1 on 09/20/2021 concerns with baselin MDS nurse #1 on 09/	ent #355, who the facility 21, revealed the resident ilan developed on il #355 was discharged on Imitted to the facility on eview of the medical record realed staff completed the plan on 09/21/2021 (eleven sion). A review of dent #355 revealed the ne care plan developed on with MDS Nurse #1 on M and MDS Nurse #2 on M revealed all new Imissions to the facility were go the morning clinical ugh Friday to ensure  missions for the last thirty 1-08/16/2021 revealed no ne care plans. Interview with (30/2021 at 1:39 PM ion baseline care plans were reded in morning meetings.  OS Nurse #1 on 09/30/2021 new admission baseline care ited Monday-Friday for and to ensure a review ne resident and/or in 48 hours of	{F 6	55)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R 09/30/2021		
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  200 NURSING HOME LANE  PIKEVILLE, KY 41501			30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	CEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE	
{F 655}	and education as need revealed no identified dates as indicated.  63). Review of the autinour comments and/or CDM revealed stated with no identified 09/28/2021 at 2:26 PPM, and Dietary Mand 1:30 PM revealed traigensure they arrived of timely.  64). Review of verbal staff members were obeginning on 8/15/20 education. Further revealed five (5) staff four (4) weeks from 0 on 09/13/2021 with no review of the verbal of quizzed on respirator hypo/hyperglycemia, notification. Interview Consultant on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/30/3 Regional DON on 09/3 Regional DON on 09/30/3 Regiona	and/or responsible party, aded. A review of the audits concern with completion dits completed by the DM they were completed as ed concerns. Interview with Dietary Manager on M and 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 1/52 ager #3 on 09/30/	{F 6		0			
	on 09/30/2021 at 1:3: performed verbal quiz assessment of reside respiratory status, ide hyperglycemia/hypog protocol, documenting condition, notification following physician or	PM revealed they exes for identification and ints with a change in intifying signs/symptoms of lycemia, facility diabetic g a change in a resident's of the physician and ders. Interviews with RN #1 is AM and 09/30/2021 at						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	ELE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
{F 655}	65). Interview with the 09/30/2021 at 4:17 Pl audits of documented Monday through Frida She further revealed to less than 60 and/or graff were expected to Responsible Party, ar follow physician order stated she identified to 08/12/2021 to have a and one (1) on 09/20/glucose level of 465 wevidence the licensed process. She provider and LPN #5. A Review further concerns. A Re RN #2 and LPN #5 re the facility process.  66). Review of verbal was verbally asked sign when to report, signs and wandering interve verbal quizzes revealed quizzed daily for one (08/19/2021 with no idereview revealed verbathree (3) times a weel 08/21/2021 to 09/02/2 concerns. A review of that verbal quizzes we per week for four (4) w 09/03/2021 to 09/24/2021.	M, LPN (LPN) #6 on PM, revealed they quizzes with facility staff.  Regional DON on M revealed she completed blood glucose levels ay in the clinical meeting. That with any blood sugar reater than 40, the facility onotify the physician, and Registered Dietician and res. The Regional DON one (1) resident on blood glucose level of 430 2021 to have a blood with no documented nurse followed the facility of education to both RN #2 or of audits revealed no eview of education regarding staff quizzes revealed staff gns and symptoms of wandering entions. A review of the ed five (5) staff were verbally (1) week from 08/13/2021 to entified concerns. Further all quizzes were conducted of for two (2) weeks from 1021 with no identified verbal quizzes revealed ere conducted one (1) time weeks from the week of	{F 65	5}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
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NAME OF B	ROVIDER OR SUPPLIER	103230	B. WING.			09/30/2021
		HABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 200 NURSING HOME LANE PIKEVILLE, KY 41501	IP CODE	
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{F 655}	09/30/2021 at 4:17 Pl 09/30/2021 at 1:39 Pl the completion of verl interview revealed the verbally quizzed on the tool (signs and symptoper, signs and sympt	2021 at 3:40 PM, RDON on M, and MDS Nurse #1 on M revealed each assisted in pal staff quizzes. Further at each staff member was be areas listed on the audit oms of abuse, when to ptoms of wandering and ans), and any need for eted immediately with each SRNA #11 on 09/29/2021 at #6 on 09/30/2021 at 12:44 on 09/29/2021 at 12:58 PM, RN et on 09/30/2021 at 2:54 PM, 19/29/2021 at 2:54 PM, 19/29/2021 at 2:40 PM, 19/29/2021 at 1:18 PM, 19/29/2021 at 1:18 PM, 19/29/2021 at 1:18 PM, 19/29/2021 at 2:56 PM revealed et al. 2021 at 1:39 PM revealed that 2021 at 1:39 PM revealed that 2021 at 1:39 PM revealed that 2021 at 1:39 PM revealed that 2021 at 1:39 PM revealed that 2021 at 1:39 PM revealed that 2021 at 1:39 PM revealed that 2021 at 1:39 PM revealed that 2021 at 1:39 PM revealed that 2021 at 1:39 PM revealed that 2021 at 1:39 PM revealed that 2021 at 1:39 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:29 PM revealed that 2021 at 1:	{F 6	555}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER.			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		185256	B. WING_			09/30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DOE	, 33,33,24
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{F 655}	Regional Nurse Con PM and DON #2 on revealed all-new admin the morning clinical appropriate assessment on O9/30/2021 at 3:53 PM and OON #2 on O9/30/2021 at 3:53 PM and DON #27 revealed they were completing and the properties of unknown origin.	are completion. Interview with sultant on 09/30/2021 at 3:40 09/30/2021 at 3:20 PM nissions would be reviewed at meeting to ensure tents, including the issment, had been completed. Exempted and appropriate ented.  It was performed for residents or wandering would be a meeting and appropriate ented.  It was performed for residents at 8 or greater revealed no continued review revealed ted on 08/13/2021 with ten was completed for four (4) esidents for eight (8) weeks. On 09/30/2021 at 2:23 PM, on 09/30/2021 at 1:39 PM issisting in completing audits of concerns identified. Review 08/13/2021 for review of assessments for residents at less than eight (8) to ensure of unknown origin revealed s. Interview with Regional 09/30/2021 at 3:40 PM, and 21 at 3:20 PM revealed they its as indicated with no	{F 6	55)		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		557	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	100000000000000000000000000000000000000	JLD BE		(X5) COMPLETION DATE
{F 655}	in the diet/tray card so Review of Resident # 09/29/2021 at 12:04 F on 09/29/2021 at 12:04 F on 09/29/2021 at 12:04 tray card on 09/29/20: diets were served as a review of audits reveal weekly for four (4) we 70). Review of comple meals were audited to beginning 08/23/2021 random meals were of week for two (2) week 09/13/2021 for one (1 Former Activities Directory 09/30/2021 at 1:30 PM Manager on 09/28/20/ 09/30/2021 at 1:52 PM performed as indicate revealed that meals weincluding breakfast at PM, and dinner at 5:00 09/28/2021 at 5:03 PM had been served on the on 09/29/2021 lunch or at the third floor at app fourth floor at 12:16 PM fifth floor at 12:34 PM 71). Review of Reside 09/29/2021 at 12:04 F on 09/29/2021 at 12:04 F	cords against orders entered offware to ensure accuracy. 308's tray card on PM, Resident #39's tray card 16 PM, and Resident #334 21 at 12:30 PM revealed ordered by the physician. A alled audits were conducted eks.  eted audits revealed random vice daily for one (1) week . Starting 08/30/2021, abserved two (2) times per as and then weekly from ) month. Interview with ctor/Dietary Manager #3 on M, Regional Certified Dietary 21 at 2:26 PM, and M revealed audits were ad. Further interviews were served as scheduled, 7:00 AM, lunch at 12:00 0 PM. Observation on M revealed the evening meal he third floor. Observation meal revealed meals arrived proximately 12:16 PM, the M and 12:24 PM, and the and 12:49 PM.  ent #308's tray card on PM, Resident #39's tray card 16 PM, and Resident #334's 21 at 12:30 PM revealed the int preferences, including erview with the Dietary 21 at 1:30 PM revealed she	{F 6	555}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	1 03/	GUIZUZI
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BI HE APPROPRIA	_	(X5) COMPLETION DATE
{F 655}	admission and enterin system. A review of a were audited daily for 09/15/2021 to 09/21/2 audits revealed snack beginning on 09/22/2 Regional Certified Die 09/28/2021 at 2:26 Pl PM revealed she aud not identified any con 72). Interview with the (HR) on 09/30/2021 at completed audits for otime clock punches. Sconcerns. Observatio 09/28/2021, 09/29/20 revealed no concerns 73). Interview with the on 09/30/2021 at 3:40 at 4:17 PM, DON #2 and Interim Infection 09/30/2021 at 3:10 Pl being conducted with handwashing, isolatio donning/doffing PPE, variance or identified immediately. A review were conducted begin shifts and units.	s within seventy-two hours of the the preferences into the sudits revealed snack intakes one (1) week from 2021. Further review of the stary Manager on Mand 09/30/2021 at 1:52 ited snack intake and had cerns.  Human Resource Director at 10:48 AM revealed she daily staff screening against She revealed no identified of entry doors on 21, and 09/30/2021 at 3:20 PM, RDON on 09/30/2021 at 09/30/2021 at 3:20 PM, Control Nurse on M revealed audits were observations of an signage and zones, mask compliance. Any concerns will be addressed of the audits revealed they noting 09/17/2021 on random at Regional Nurse Consultant of PM revealed she was not other members to	{F 6:	55)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTION SH	HOULD BE		(X5) COMPLETION DATE
{F 655}	11:55 AM and 09/30/20 (LPN) #6 on 09/30/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/20 concerns with obtaining and/or receiving medication pass or the third floor and 09/revealed no identified medications. In additionarcotic count on the 12:50 PM revealed no 12:50 PM revealed no 12:50 PM revealed no 13:40 responsible for complipass observations be stated she had not ideresidents not having recounts. A review of auxilized the Centers for Element Pathway for conduct the medication revealed a minimum of were observed daily from the 12:50 PM.	s. RN #1 on 09/29/2021 at 2021 at 12:58 PM, LPN (LPN) 3:00 PM and 09/30/2021 at 09/30/2021 at 12:50 PM, 21 at 10:31 AM revealed no ng scripts for medications cations timely. Observation of 09/29/2021 at 4:35 PM on 30/2021 at 8:09 AM concerns with missing on, observation of the fifth floor on 09/30/2021 at 0 identified concerns.  Regional Nurse Consultant of PM revealed she was eting random medication ginning 09/25/2021. She entified any concerns with medications or narcotic udits revealed the facility or Medicare Services Critical Medication Administration to on pass observation of ns. A review of audits of twenty-five medications from 09/25/2021 with no urther review of medication di that medication served on random shifts, 3:00 PM and 6:00 PM to	{F 6	655}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	L 1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE			S1 20	TREET ADDRESS, CITY, STATE, ZIP CODE 30 NURSING HOME LANE IKEVILLE, KY 41501	1 09/	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	Ε	(X5) COMPLETION DATE
(F 655)	identified concerns.  77). Interview with the 09/30/2021 at 5:05 Pl Consultant on 09/30/209/30/2021 at 4:17 Pl 09/30/2021 at 3:20 Pl being audited daily be ensure adequate staff review of the audits reconcerns.  78). Interview with the 09/30/2021 at 5:05 Pl on 09/30/2021 at 1:30 being monitored daily staffing. A review of tidentified concerns.  79). Interview with the Operations on 09/30/2021 at 09/30/2021 at 1:30 being monitored daily staffing. A review of tidentified concerns.  80). Interview with the on 09/30/2021 at 10:50 completed observation identify any change in interviews revealed if identified, staff would An audit review reveal change of conditions facility staff.	e Interim Administrator on M, Regional Nurse 2021 at 3:40 PM, RDON on M, and the DON on M revealed staffing was eginning 09/11/2021, to fing was maintained. A evealed no identified  e Interim Administrator on M, and the Dietary Manager of PM revealed staffing was to ensure adequate the audits revealed no every ward of the audits revealed no e	{F 6	:55}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL1 A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	, 551	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	, , , , , , , , , , , , , , , , , , , ,	TION SHOULD B	E ATE	(XS) COMPLETION DATE
(F 655) (F 656) SS=D	review of the question interviews revealed re everyone treating you here? Do you have at the Medical Records: AM revealed she commesidents on 09/25/20 identified no concerns	o identified concerns. A maire completed during esidents were asked: Is well? Do you feel safe my concerns? Interview with Staff on 09/29/2021 at 8:34 upleted the interviews with 21, and she stated she	{F 6				12/30/21
3	§483.21(b) Comprehe §483.21(b)(1) The fact implement a comprehe care plan for each respectives and timeframedical, nursing, and needs that are identificant assessment. The complement of the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that wunder §483.24, §483. provided due to the resunder §483.10, includit treatment under §483 (iii) Any specialized sere provide as a result of	cility must develop and lensive person-centered sident, consistent with the sident, consistent with the sident, consistent with the sident, consistent with the sident, consistent with the sident set of measurable ames to meet a resident's mental and psychosocial sed in the comprehensive apprehensive care plan must prehensive care plan must plan must plan must prehensive care plan must plan must plan must					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09/	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
{F 656}	resident's representa (A) The resident's go desired outcomes. (B) The resident's pre- future discharge. Fact whether the resident' community was asseled contact agencie entities, for this purpo (C) Discharge plans in plan, as appropriate,	th the resident and the tive(s)- als for admission and eference and potential for cilities must document s desire to return to the ssed and any referrals to es and/or other appropriate	{F 6	56}			
	by: Based on interview, the facility's policies, failed to develop a co one (1) of five (5) sar #65) who had pressu fifty-seven (57) samp	record review, and review of it was determined the facility emprehensive care plan for npled residents (Resident are ulcers, and for one (1) of eled residents at risk for ident #66). The facility failed		F 656 Develop/Implement Comprehensive Care Plan  Criteria 1: a) Resident #65 was discharged from the facility on 10-3 b) Resident #66 was discharged from the facility on	1-2021		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER				IDEET ADDRESS CITY STATE TIP CORE	09/	30/2021
	THE STATE OF THE S				REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE AND RE	HABILITATION CENTER			0 NURSING HOME LANE		
				PI	KEVILLE, KY 41501		
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(F 656)	Continued From page	e 284	{F 6:	56}			
	to implement the care	e plan for one (1) of	, ,	-,	c) Resident #82 was		
		led residents (Resident #82)			discharged from the facility on 8-9-202		
	who exhibited abusiv	e behaviors towards other			d) Resident #14 has had	•	
		ed himself/herself to other		- 1	wound assessments completed weekly		
		also failed to implement the			beginning 9/15/21. Resident #14 had h		
	care plan for one (1)	of fifty-seven (57) sampled			pressure ulcer and pressure ulcer	13	
	residents (Resident #	14) who had a pressure			prevention care plan reviewed and revi	hea	i I
	ulcer.	•			on 11/22/2021.	scu	
	The facility admitted	Resident #65 on 03/23/2021			Criteria 2: On 9-11-21 head to toe ski	n	
		ers. According to the Braden		ĺ	assessments were completed on all		
		21, the resident was at risk			residents, and the Braden Scale was		
	for pressure ulcers di	ue to being chair fast, limited			completed on all residents by facility		
	mobility, potential for	triction and shearing.		- 1	nurses 8-28-2021. Using both the		
		nt's Minimum Data Set			head-to-toe skin assessment and Brade	en	
	(MDS), also revealed	the resident was at risk for			scale, comprehensive care plans were		
	pressure dicers. How	vever, the facility failed to			reviewed to ensure residents with		
		ent a comprehensive care			pressure injuries had a care plan by		
	plan, including measu timeframes to meet the			- 1	9-17-21. By 12/20/2021 residents with		
İ	pressure ulcers.	ie resident's risk for		1	behaviors had their care plans reviewed	d to	
	pressure dicers.				ensure that interventions were care		
	On 05/02/2021 Resid	dent #65 developed a deep			planned.		
	tissue injury (DTI) to t	the coccyx. On 05/11/2021,			Criteria 3: On 11/24/2021 all licensed		
	staff documented the	pressure ulcer had			nursing staff and the dietician, social		
	worsened and was ur	nstageable. On 05/26/2021			service director, MDS coordinators were	,	
	the pressure ulcer ha	d increased in size			educated by the Director of Nursing or	=	
		meters (cm) long by 10 cm			designee on entering a new care plan in	l	
		itinued to fail to develop a			PCC including goals and interventions	110	
		the resident's pressure ulcer			and updating an existing care plan in P	nn	
	and risk for pressure				with new goals and interventions for an	,	
	-				new skin impairments and behavior	<i>'</i>	
		dent #65's pressure ulcer			assessments that are identified during		
	had worsened and he	e/she was transferred to the			their shift. Licensed staff not working wi	<sub>II</sub>	
		he resident's hospital record			be educated on or by their next schedu		
	revealed the resident	had a pressure ulcer that			shift. This will be added to new licensed		
	"smells like dead flesi	h". The resident was			nursing staff employee orientation. A		
	admitted due to "clinic	cally septic with large			post-test was administered to ensure st	aff	
	decubitis [pressure] u	Icer with associated			competency on entering a new care pla		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	EHABILITATION CENTER		S'	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 656}	infection including ce abscess". Resident idebridement on 05/30 was removed and exinfected decubitis [progangrene".  In addition, Resident facility on 05/24/2018 for pressure ulcers. (developed a compreh Resident #14 was at pressure ulcer due to Diabetes Mellitus (DM Peripheral Vascular Ecomprehensive care included to follow faci prevention/treatment Observe/document/rechanges in skin statu healing, signs and sysize (length x width x Resident #14 develop and on 06/22/2021, d Resident #14 had nesstage II (two) pressure (hip). However, the fipressure ulcers week to a wound clinic/speciphotograph Resident weekly as required by Interviews with staff a Residents' rooms, expother residents and extowards other resident	Illulitis and possible #65's pressure ulcer required D/2021, "all necrotic tissue cision was down to the bone essure ulcer] with gas  #14 was admitted to the and assessed to be at risk Dn 09/10/2020, the facility nensive care plan stating that risk for development of a decreased mobility, A), and a diagnosis of Disease (PVD). The plan listed interventions that dility policies/protocols for the of skin breakdown. eport as needed (PRN) any s: appearance, color, wound mptoms of infection, wound depth), and stage.  Deed abrasions to the left hip ocumentation revealed w skin impairment, three (3) re ulcers the left trochanter acility failed to assess the ly, failed to refer the resident cialist, and failed to #14's pressure ulcers y the resident's care plan.  and record review revealed ed in and out of other osed himself/herself to exhibited abusive behaviors	{F 6	556}	and updating goals and interventions. Test will be graded with a passing score 100%. Staff not passing the test will be re-educated and the test will be re-administered until a passing score is achieved.  Criteria 4: Beginning 11/24/2021 the Director of Nursing, Assistant Director of Nursing or Nursing supervisor will audit minimum of 5 residents progress notes for a day to ensure any new areas of slimpairment and/or new behaviors that a identified have a care plan implemented that includes new interventions. Audits be weekly x 4 weeks then monthly x 2 month. Audit results will be reviewed monthly in QAPI meeting x3 months the quarterly until in substantial compliance.  Criteria 5: Date of compliance: 12/3/2021	of a are d will	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R	
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE			2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	However, the facility fresident's plan of care decrease/prevent Resident's plan of care decrease/prevent Resident facility further fail comprehensive care pinterventions for Resident repositioning the ulcers.  The facility's failure to plans were developed pressure ulcers has care serious injury, harm, in resident. Immediate 303/06/2021, and was 03/06/2021, at 42 CFR (F580), 42 CFR 483.1 (F600), 42 CFR 483.1 Person-Centered Care CFR 483.25 Quality of (F692), 42 CFR 483.4 (F755) and 42 CFR 483.4	At 8/2021 and 07/31/2021.  ailed to implement the in an attempt to sident #82's behaviors.  Bed to develop a colan with measurable dent #66 regarding turning resident to prevent pressure  The prevent and/or treat aused or is likely to cause in mpairment or death to a determined to exist on R 483.10 Resident Rights 2 Freedom from Abuse 2 Comprehensive Plans (F655) (F656), 42 of Care (F684) (F686) of Pharmacy Services B3.80 Infection Control as notified of Immediate	{F €	556}			
	was received on 09/02/removal of the Immed 09/02/2021. However verified based on obseand review of the facil Additional Immediate 42 CFR 483.35 Nursin 483.70 Administration 483.75 Quality Assuration (F867).	iate Jeopardy on r, the AOC could not be ervations, staff interviews,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	185256	R MANG			R	
NAME OF PROJECT OF CURRY FOR	103236	B. WNG			09/30/2021	
PARKVIEW POST-ACUTE AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE		
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			
09/28-30/2021, which loseverity to "D" 42 CFR (F580), 483.12 Compre Care Plans (F655) (F65 Quality of Care (F684) Nursing Services (F725 Pharmacy Services (F725 Pharmacy Services (F7483.12 Freedom from A483.25 Quality of Care Administration (F835) (Quality Assurance and Improvement (F867), at Infection Control (F880) monitors the effectivene and quality assurance at The findings include:  Review of the facility's properties and implemented acomperson-centered care provided implemented acomperson-centered care provided implemented acomperson-centered within several comprehensive person-be developed within several completion of the required assessment (MDS). Acomprehensive person-be developed within several completion of the required assessment (MDS).	llegation of compliance /2021, which alleged ate Jeopardy on survey Agency iate Jeopardy was ring a revisit conducted on owered the scope and 483.10 Resident Rights schensive Person-Centered 56), 42 CFR 483.25 (F686), 42 CFR 483.35 5), and 42 CFR 483.45 (F59); and to "E" at 42 CFR Abuse (F600), 42 CFR (F692), 42 CFR 483.70 F837), 42 CFR 483.75 Performance and 42 CFR 483.80 ), while the facility cess of systemic changes activities.  policy, "Care Plans, acceptable of the resident and appresentative, developed apprehensive, alan for each resident. and each resident's accentered care plan would apprehensive red comprehensive	{F €	556}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R 09/30/2021	
	ROVIDER OR SUPPLIER  POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	031	30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
{F 656}	Review of the facility's Injuries Policy, revised purpose of the policy for specific risk factors were required to keep hydrated, clean prompincontinence, and repat risk of pressure ulcoschedule as determinated (IDT).  1. Review of Resident revealed the facility as 03/23/2021 with diagrinfarction, Dysphagia, Obstructive Pulmonar Review of a Braden S Sore Risk form dated revealed Resident #63 ulcers with a score of chair fast, having slight adequate nutrition, frict potential problem.  Review of Resident 63 (MDS) admission asservealed the resident two (2) staff with Activ occasionally incontine indwelling catheter, ar Further review revealed for pressure ulcers ba	s information about the dents' condition changed.  S Prevention of Pressure d April 220, revealed the was to provide interventions s. The policy revealed staff to the skin clean and obly after episodes of osition all residents with or ers on an individualized ed by the Interdisciplinary  Staffs's medical record dmitted the resident on hoses that included Cerebral Polyarthritis, Chronic by Disease and Paraplegia.  Scale for Predicting Pressure 03/23/2021 at 3:03 PM, 5 was "at risk" for pressure eighteen (18), due to being only limited mobility, with oction, and shearing being a server of bowel, had a and had no pressure ulcers. Seed the resident was at risk sed on a formal of the MDS dated	{F 6	56)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		185256	B. WING			l '	R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		<u>                                     </u>	50/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 656}	on a turning/reposition have nutrition or hydrological skin problems. Further resident weighed 179 loss/gain or his/her wounknown, and the residifficulty or pain when revealed Resident #6 chronic disease that rexpectancy of less the According to the MDS malnutrition or was at Review of Resident #7 revealed no document developed a comprehesident with intervent resident's pressure ulcono evidence the facility and address the risk.  Review of Resident #7 the resident weighed admission to the facility of addressed Resident #7 interventions to prevent prevent prevent prevent pressure ulcono evidence the facility of addressed Resident #7 interventions to prevent preventions entions to prevent preventions to prevent preventions to prevent preventions to prevent preventions to prevent preventions to prevent preventions to prevent preventions to prevent	evice for the chair; was not ning program, and did not ation intervention to manage er review revealed the pounds and had no weight eight loss/gain history was ident had complaints of a swallowing. Further review 5 did not have a condition or may result in a life an six (6) months.  6. Resident #65 had risk for malnutrition.  65's medical record ated evidence the facility tensive care plan for the ations to address the cer risk in an attempt to eas. Further review revealed by addressed the resident's on risk with interventions to 179.3 pounds upon the ation of the ation of the eight loss.  65's weight record revealed 179.3 pounds upon the ation of the eight loss).  65's weight loss, with an attempt to ease plan that the eight loss, with an attempt loss, charged to the hospital on	{F 6	56}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501	<u>  09/</u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 656)	Infection. The record resident was weighed facility.  Review of the Situation Assessment and Recommunication form PM revealed Resident tissue injury (DTI) to the ormaroon localized a communication form pressure injury (DTI) to the ormaroon localized a communication or pressure from from from from from from from from	illure and Urinary Tract revealed no evidence the I upon admission to the  on, Background, commendation (SBAR) dated 05/02/2021 at 5:29 t #65 developed a deep the coccyx (a DTI is a purple rea of discolored intact skin due to damage of underlying ure and/or shear) to the the Licensed Practical Nurse 21 at 4:00 PM revealed she sue injury to Resident #65's She stated that the area und and approximately the wever, there was no the facility developed a the resident's pressure  I record revealed the facility Resident #65 on 05/04/2021 the of a Nutrition Data the facility's Registered the resident's weight was down 24.7% in 60 days. The	{F €	556}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		S'	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	J 09 <i>i</i>	30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE CONTROL OF THE APP			(X5) COMPLETION DATE
{F 656}	facility documented the pounds. According to resident had not lost a malnutrition or was at addition, the facility do an unhealed pressure and was at risk for de According to the asset a pressure reducing of and received pressure there was no docume developed a compreh MDS assessment with on the care needs of the Review of a Head to Resident #65 dated 0 revealed the resident injury measured 6.5 cm 9.3 cm wide, with no cm Review of a Change of 05/11/2021 at 2:40 Ph pressure ulcer to the information with the covered by slough (yeand/or eschar (tan, broad) that measured 6. Review of a Head to Resident #65, revealed at 3:17 PM, the unstated at 3:17 PM, the unstated fill resident #65, revealed at 3:17 PM, the unstated fill resident #65, revealed at 3:17 PM, the unstated fill resident #65, revealed at 3:17 PM, the unstated fill resident #65, revealed at 3:17 PM, the unstated fill resident #65, revealed at 3:17 PM, the unstated fill resident #65, revealed at 3:17 PM, the unstated fill resident #65, revealed at 3:17 PM, the unstated fill resident #65, revealed at 3:17 PM, the unstated fill resident #65, revealed at 3:17 PM, the unstated fill resident #65, revealed at 3:17 PM, the unstated fill resident #65, revealed at 3:17 PM, the unstated fill resident #65 is revealed at 3:17 PM, the unstated fill resident #65 is revealed at 3:17 PM, the unstated fill resident #65 is revealed at 3:17 PM, the unstated fill resident #65 is revealed at 3:17 PM, the unstated fill resident #65 is revealed at 3:17 PM, the unstated fill resident #65 is revealed at 3:17 PM, the unstated fill resident #65 is revealed at 3:17 PM, the unstated fill resident #65 is revealed at 3:17 PM, the unstated fill resident #65 is revealed at 3:17 PM, the unstated fill resident #65 is revealed at 3:17 PM, the unstated fill resident #65 is revealed at 3:17 PM is revealed the resident #65 is revealed at 3:17 PM is revealed the resident #65 is revealed at 3:17 PM is revealed the resident #65 is revealed the resident #65 is revealed the resident #65 is revealed	65's Quarterly MDS /05/2021 revealed the re resident weighed 135 of the assessment the risk for malnutrition. In rocumented the resident had risk for malnutrition. In rocumented the resident had reducer, a deep tissue injury veloping pressure ulcers. ressment, Resident #65 had reducer care. However, reducer care. However, reducer care plan after the resident for the resident.  Foe Weekly Skin Check for 5/08/2021 at 3:38 PM, resuspected deep tissue rentimeters (cm) in length by redepth.	{F €	556}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NURSING HOME LANE PIKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	Record review revealed documented evidence comprehensive care p. #65's pressure ulcer v. worsening.  Review of the Nutrition 05/18/2021 at 10:46 F. weighed 142.6 pound weight loss of 3% in 7 days.  Continued review of R. Weekly Skin Checks of pressure ulcer to the continued review of the continued review of the continued review of the continued review of the continued review of the continued revealed the residual sacrum increased in solong and 17.7 cm wide revealed the physician and laboratory testing of condition form, "MD decided to send resided."	ed there was no e the facility developed a plan to address Resident with interventions to prevent  In Progress Note on PM revealed Resident #65 s, which was a significant days and 20.5% in 90  Resident #65's Head to Toe revealed on 05/19/2021, the coccyx now included the d 9.5 cm in length and 10 ad review of the Head to Toe dated 05/26/2021 at 5:37 lent's pressure ulcer to the dize, measuring 16.5 cm e.  of Condition form on M revealed Resident #65 and". Review of the form ordered a wound culture However, per the change	{F 6	56}	DEFICIENCY)	TE	DATE
	05/28/2021. Review of	admitted to the hospital on of a Progress Note dated If revealed Resident #65 with large decubitus					

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			(X3) DATE SURVEY COMPLETED
	185256	B. WING		R
ROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE	09/30/2021
W POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
including cellulitis and abscess". The record "smells like dead flest Review of Resident ## Department (ED) nurs at 5:36 PM revealed the decubitus (pressure) to cm with central skin she necrosis, the wound hwith mild purulent drait of the wound pictures AM revealed the resid with red wound edges measured 14 cm long the Infectious Disease revealed the resident 05/30/2021, per operatissues were removed	possible developing stated the pressure ulcer "."  55's Emergency se's notes dated 05/28/2021 the resident had a "large ulcer proximally 15 cm by 8 loughing and underlying as surrounding erythema inage to bandage". Review dated 05/29/2021 at 5:40 ent's sacrum was black . The pressure ulcer by 15 cm wide. Review of c Consult on 06/01/2021 "underwent debridement on tive note, all necrotic and the excision was down	{F 656		
to the bone. Intraoper grew gram-negative ro ESBL".  Interview with Surgeor PM revealed Resident (4) pressure ulcer to the slough, necrotic arpressure ulcer on 05/3 surgeon stated failure improper nutrition and could contribute to pre progression of the wor. "Nutrition is a big key" development/worsenin.  Continued review of Record revealed the rest the facility on 06/09/20	rative specimen culture ods/Proteus mirabilis  n #1 on 08/31/2021 at 1:30 r #65 had a large stage IV ne sacrum. He debrided on non-viable tissue in the 80/2021 to bone depth. The to turn and reposition, an improper mattress assure ulcers and the und. Surgeon #1 stated, in the neg of pressure ulcers.  esident #65's medical sident was readmitted to 121. Further review of			
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From page including cellulitis and abscess". The record "smells like dead flest  Review of Resident # Department (ED) nurs at 5:36 PM revealed the decubitus (pressure) to come with central skin sinecrosis, the wound himid purulent drait of the wound pictures AM revealed the resident with red wound edges measured 14 cm long the Infectious Disease revealed the resident to 5/30/2021, per operatissues were removed to the bone. Intraoper grew gram-negative received to the bone. Intraoper grew gram-negative received to the slough, necrotic are pressure ulcer on 05/3 surgeon stated failure improper nutrition and could contribute to pre progression of the wou "Nutrition is a big key" development/worsenim  Continued review of R record revealed the rethe facility on 06/09/20	TOURITIES TO NUMBER  185256  ROVIDER OR SUPPLIER  W POST-ACUTE AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 293 including cellulitis and possible developing abscess". The record stated the pressure ulcer "smells like dead flesh".  Review of Resident #65's Emergency Department (ED) nurse's notes dated 05/28/2021 at 5:36 PM revealed the resident had a "large decubitus (pressure) ulcer proximally 15 cm by 8 cm with central skin sloughing and underlying necrosis, the wound has surrounding erythema with mild purulent drainage to bandage". Review of the wound pictures dated 05/29/2021 at 5:40 AM revealed the resident's sacrum was black with red wound edges. The pressure ulcer measured 14 cm long by 15 cm wide. Review of the Infectious Disease Consult on 06/01/2021 revealed the resident "underwent debridement on 05/30/2021, per operative note, all necrotic tissues were removed and the excision was down to the bone. Intraoperative specimen culture grew gram-negative rods/Proteus mirabilis	ROVIDER OR SUPPLIER  W POST-ACUTE AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 293 including cellulitis and possible developing abscess." The record stated the pressure ulcer "smells like dead flesh".  Review of Resident #65's Emergency Department (ED) nurse's notes dated 05/28/2021 at 5:36 PM revealed the resident had a "large decubitus (pressure) ulcer proximally 15 cm by 8 cm with central skin sloughing and underlying necrosis, the wound has surrounding erythema with mild purulent drainage to bandage". Review of the wound pictures dated 05/29/2021 at 5:40  AM revealed the resident's sacrum was black with red wound edges. The pressure ulcer measured 14 cm long by 15 cm wide. Review of the Infectious Disease Consult on 06/01/2021 revealed the resident "underwent debridement on 05/30/2021, per operative note, all necrotic tissues were removed and the excision was down to the bone. Intraoperative specimen culture grew gram-negative rods/Proteus mirabilis ESBL".  Interview with Surgeon #1 on 08/31/2021 at 1:30 PM revealed Resident #65 had a large stage IV (4) pressure ulcer to the sacrum. He debrided the slough, necrotic and non-viable tissue in the pressure ulcer on 05/30/2021 to bone depth. The surgeon stated failure to turn and reposition, improper nutrition and an improper mattress could contribute to pressure ulcers and the progression of the wound. Surgeon #1 stated, "Nutrition is a big key" in the development/worsening of pressure ulcers.  Continued review of Resident #85's medical record revealed the resident was readmitted to the facility on 06/09/2021. Further review of	TOENTIFICATION NUMBER  185256

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B, WNG			l	R
NAME OF P	ROVIDER OR SUPPLIER	100200	10, 11,110		STREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
PARKVIE	W POST-ACUTE AND RE			2	200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	(X5) COMPLETION DATE
{F 656}	comprehensive care p 06/16/2021. The facil had a stage IV (4) pre- over two (2) months a developed. Further re- 06/21/2021, over two resident sustained a s- facility identified the re- weight concerns and/or related to a history of. Interview with Minimus on 08/27/2021 at 11:1 responsible for initiating residents were admitted responsible for and up. She revealed Resident comprehensive care praccording to the Resident comprehensive care praccording to the Resident (RAI) that the facility upractice. She stated to was utilized to provide should have been in p. Resident #65's needs. Resident #65's needs.	e the facility developed a plan for the resident until ity identified the resident until ity identified the resident until ity identified the resident until ity identified the resident until ity identified the sacrum, after the pressure ulcer eview revealed on (2) months after the significant weight loss, the esident had a potential for or at risk for malnutrition weight loss.  Im Data Set (MDS) Nurse #1 0 AM revealed she was an geare plans when ed and re-admitted and was edating/revising care plans. It #65 did not have a ulan completed timely dent Assessment Instrument untilized for standard of the comprehensive care are for the residents and lace to allow staff to know. She further stated enhensive care plan was ecause she was the only os assessments and care the further revealed that the process for communicating pressure ulcers, weight the information was not the care plan to reflect the	{F €	\$56}			
	perform skin assessments weekly.	She stated she had not					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			l	R /30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE KEVILLE, KY 41501		30/20/21
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 656)	not being performed usuas identified. She starm (IDT) reviewed weekly to ensure they implemented. She starm plans in mid Juncare plans were not usuappropriately.  2. Review of Resident on 05/24/2018 and was on 05/21/2021 with disconsisted the resident on 05/24/2018 and was on 05/21/2021 with disconsisted the potentic Kidney Diseas Disease, and a Histor Review of a comprehe 09/10/2020 revealed in potential for pressure to decreased mobility, and a diagnosis of Pe (PVD). The facility definctude: follow facility prevention/treatment of conserve/document/repchanges in skin status healing, signs and synsize (length X width X Review of Head to Tot dated 05/10/2021, revideveloped an abrasion received barrier cream that measurements or drainage, odor, etc) of	wound assessments were antil immediate jeopardy lated the Interdisciplinary comprehensive care plans awere up to date and lated she began reviewing to 2021 and identified that podated and implemented was admitted to the facility as readmitted to the facility agnoses of Type II Diabetes Polyneuropathy, Stage III se, Peripheral Vascular by of COVID-19.  The sive care plan dated Resident #14 had the lucer development related Diabetes Mellitus (DM), ripheral Vascular Disease veloped interventions to policies/protocols for the of skin breakdown; and laptoms of infection, wound depth), and stage.	{F 6	56}			

STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MI II 2	CIDLE (	CONSTRUCTION		0. 0936-0391
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDI			(X3) DATE SURVEY COMPLETED	
			7001001				
		185256	B. WNG		234		R
NAME OF P	ROVIDER OR SUPPLIER			eT.	REET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
					0 NURSING HOME LANE		
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER					
(74) 15	FUNMARY CT	17511717 05 0771171		FII	KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
				_			
{F 656}	Continued From page	296	(5.0				
		Head to Toe Weekly Skin	{F 6	26}			! !
	Checks dated 05/24/2	2021 and 05/31/2021					- W
	06/07/2021, 06/14/20	21. and 06/21/2021		- i			
	revealed Resident #1	4 continued to have an					
	abrasion to his/her let	t hip; however, there was no					} [
	documented evidence	the appearance of the area					, ,
	was assessed.						
	Review of a Head to	Toe Weekly Skin Check					
	dated 06/22/2021, rev	/ealed Resident #14					
	the left trochanter (b)	itage II (two) pressure ulcers b). The pressure ulcers	İ				
	measured as follows:	wound one (1) was 1.4					
	centimeters (cm) long	by 1.4 cm wide, wound two					
	(2) was 1.4 cm x 2 cm	n, and wound three (3) was					
	1 cm x 1 cm. Howeve	er, there was no description					1
	of the wound's color, v	whether odor or drainage					1 1
	was present, etc. as r	equired by the resident's					
	care plan.						1 1
	Further review of a W	eekly Head to Toe Skin					1 1
	Check forms dated 07	7/05/2021, 07/12/2021, and					1 1
	07/19/2021, revealed	the facility continued to					
	document Resident #	14 had skin					1
	impairment/pressure u	ulcers to the left hip.					l 1
	However, there was n	o documented evidence the					
	facility assessed the p	ressure ulcer's size, color,	1				
	nor whether odor/drain	nage was present.					1
	Review of Resident #:	14's Comprehensive Care					
	Plan dated 07/23/202			}			
		care plan to include the					
		ry (ulcer) to the left hip and					
	the new physician ord	ers. Review of					
	interventions revealed	the facility was required to					
	arrange for evaluation	at outpatient wound clinic					
	as needed; encourage	frequent position changes					
	when up in chair, if po	ssible; encourage resident					
ĺ		to side while up in chair:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B. WING_				R /30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	Ē	109/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO ( EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
{F 656}	encourage the use pil off affected area; mea status progression or notify MD and family follow up weekly and head to toe skin asse needed; weekly photo wounds-refer to skin locations; and may co Clinic to screen, evaluand Wound clinic as rephysician.  However, continued remedical record reveal evidence the facility a ulcer's size, color, nor present; took weekly wound Clinic/Physician physician and/or requiplan.  Review of Resident # Skin Check dated 07/resident had one (1) Stitle three areas became asured 4.0 cm long deep to the left hip. Five weekly Head to Toe Stitle weekly Head t	g; limit time out of bed; llows to help with positioning asure and monitor wound deterioration every week; of changes; wound care to as needed; nurse to perform assment weekly and as an assessment for specific ansult with Wound Physician uste, and treat as indicated; needed/as prescribed per eview of Resident #14's ed no documented assessed the pressure whether odor/drainage was photos, nor consulted with a an as ordered by the ired by the resident's care  14's Weekly Head to Toe 26/2021 revealed the Stage II (2) pressure ulcer me one pressure ulcer me one pressure ulcer) that g by 4.5 cm wide by 0.5 cm wither review revealed a skin Check dated 21, 08/23/2021, and he facility documented the have a Stage II (2) to the re was no documented essure ulcer as required by	{F 6	56}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R  20/2024
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE ON NURSING HOME LANE PIKEVILLE, KY 41501	03/	30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 656}	told the wound nurse wound measurements really don't know who the wounds. We have she is going to do tread day."  Interview with Register 08/27/2021 at 8:30 PM #4) was responsible for measurements/assess was told she would be measurements and whired."  Interview with RN #4/08/25/2021 at 8:30 PM Physician #1/Medical 07/23/2021 and since consult the wound clir not to consult the clini pressure ulcer. She for not been taken of Res According to the RN, is supposed to purchase Administrator had not she worked the floor juthan performing her dishe stated she though performing weekly ski measurements when services and to the stated she though performing weekly ski measurements when services and to the stated she though performing weekly ski measurements when services and the stated she she stated she stated she stated she stated she stated she stated she stated she stated she stated she stated she stated she she stated she stated she stated she stated she stated she stated she stated she stated she stated she stated she stated she stated she stated she stated she stated she stated she stated she state	A's pressure ulcer, but was was responsible for weekly as. LPN #5 stated, "So, I is responsible to measure e to ask the wound nurse if atments or not on any given ared Nurse (RN) #3 on the wound care nurse (RN for completing weekly wound sments. RN #3 stated, "I e doing the wound ound care when I was awound care when I was awound sments. The wound ound care when I was awound care when I was awound side or the order stated "May" aic, she made the decision of for Resident #14's pressure ulcer.	{F 6	56)			
	5:02 PM revealed she perform skin assessm	ninistrator on 09/03/2021 at expected nursing staff to ents and wound She stated she had not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			l .	R
	NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER			ST 20	TREET ADDRESS, CITY, STATE, ZIP CODE ON NURSING HOME LANE IKEVILLE, KY 41501	09/	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 656)	not being performed uses identified.  3. Review of the medifacility admitted Residuagnoses, which including being a seen of the facility assessment and assessment period the as	wound assessments were until immediate jeopardy  cal record revealed the lent #82 on 05/12/2021 with uded Unspecified Dementia bances and Parkinson's  2's Quarterly Minimum Data nt, dated 07/14/2021, ad assessed the resident to izero (00) out of fifteen (15), not interviewable.  The MDS revealed the facility ident to have physical wards others, rejected to three (3) days during d.  82's Baseline Care Plant id he/she had Dementia and red on 05/12/2021 insister medications and ffectiveness, call the st name, staff to identify racting with the resident, use/reorient and supervise  82's Comprehensive Care 11, revealed staff identified symptoms that were not is: agitation, wandering, and diverbally abusive to others. are plan, he/she wandered	(F 6	56}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	Æ		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE APPROPRIA		(X5) COMPLETION DATE
(F 656)	to approach him/her of discover reason for be needs or toileting, adr review medications as consults and send to Continued review of Findicated staff revised on 06/16/2021 with the ask him/her yes/no que routine consistent/promonitor/document/rephis/her cognitive funct.  The care plan review revision to Resident #07/14/2021, when intestaff to check for toiled hunger.  Review of Resident #4 revealed on 05/21/2021 at 3:29 AM in/out of other residen "becoming verbally ab Interview with Registe 07/30/2021 at 9:50 AM documented in Reside 05/21/2021 regarding abusive with other resident was wandering in other and argue back" with were asking Resident space. The RN acknowledge of the series of the resident space. The RN acknowledge of the resident space.	ed on 05/20/2021 included calmly/quietly, attempt to chavior such as pain, wants, minister medications and a needed, psychiatric hospital as needed. Resident #82's care plan e following interventions: restions, keep the resident's vide consistent caregivers, nort as needed changes in ion.  The revealed the only other 82's care plan was on erventions were added for ing needs, thirsts and eventions were added for ing needs, thirsts and eventions was wandering t's rooms and was pusive with other residents."  The Nurse (RN) # 1, on the first stated he/she ent #82's medical record on him/her being verbally idents. She stated he/she ers rooms and would "yell the other residents, as they #82 to exit their personal wledged the staff failed to it's plan of care and attempt e of the resident's	{F 6	656)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185256	B. WNG				30/2024
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/-	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		(X5) COMPLETION DATE
(F 656)	8:02 AM, revealed Rereported to staff anoth his/her bathroom while When Resident #322 other resident, he/she arm and caused a 1 otear to his/her arm.  Interview with Register 07/30/2021 at 9:50 All the incident report for resident reported Resident reported Resident #82 grabbed skin tear.  Further review of Resident #82 Resident #82 grabbed skin tear.  Further review of Resident #84 and estimated to remove the staff "ran toward the staff" around "Resident #84 and estimated to remove his so "staff had to remove Resident #64 and estimated #64 and e	report, dated 05/18/2021 at esident #82 Resident #322 her resident wandered into e he/she was "in there". attempted to remove the e "grabbed" Resident #322's sentimeter (cm) by 1 cm skin ered Nurse (RN) #1, on M, revealed she completed Resident #322 when the sident #82 wandered into d when he/she attempted to from his/her bathroom d his/her arm and caused a sident #82's MAR/Behavior 021, revealed no e the resident wandered or esident #322.  82's medical record and an ed 06/04/2021 revealed at someone yelling" and when sound" the resident was in and he/she had his/her ent #64's right forearm and port indicated Resident #82 i/her hands off the resident, we" his/her hands off the resident, we" his/her hands off tort him/her back to his/her	{F 6	556}			
	his/her record, Reside the hospital for an "ov	ent report and review of ent #82 was transferred to ernight" evaluation at 8:25 When he/she returned from					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		185256	B. WING	_			R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501	1 09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	the hospital the follow report indicated Residincreased level of supchecks for 7 hours, exhours, and every hour approximately thirty-osign was placed over facility psychiatrist was Resident #82's behave According to Resident resident returned to the 6:30 AM. Even though he/she should have be supervision, documer continued to wander it rooms and was difficut.  Further review of the on 06/05/2021, Resid front of other resident both male and female to wander into other restart yelling and scream record also indicated in/out of other resident and again on 06/10/20 Interview with Registe 07/30/2021 at 9:50 All working when the incit #64 on 06/04/2021 and Administrator. She staresident was transferr returned the following continued.  Review of Resident #8	ring day (06/05/2021) the fient #82 was placed on an everyision; every 15 minute very 30 minutes for 12 r for 12 hours (for ne (31) hours and a stop Resident #64's door and the sordered to evaluate iors.  It #82's medical record, the ne facility on 06/05/2021 at the the report indicated een on an increased level of station indicated he/she in/out of other resident's lit to redirect.  It to redirect.  It was "walking in so and trying to grab them and as he/she continued esidents rooms and "they iming." Resident #82's he/she continued to wander its rooms on 06/07/2021 over the continued was dent occurred with Resident id she notified the inted even though the	{F €	556)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .		CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WNG				R
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER		S1 20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 656)	wandering/inapproprishard to redirect, talkerhad a history of violer According to the evaluation the reported he/she had a staff reported the residual buck," was hard to rinto other resident rocur "uncomfortable" around evaluation also indicate treatment recommence medication managem medication changes with the evaluation.  Review of another fact 06/30/2021, revealed Resident #317's room Resident #317 was as his/her room and Resonto" Resident #82's Resident #82 out of his/her resident was transferr psychiatric stay on 07 the facility on 07/08/20 interviews with Regist 07/29/2021 at 9:30 PM at 9:50 AM there were #82's behaviors when hospital.  Continued review of the "medical condition of Disease" Resident #8 room, looking for his/	s/her chief complaints were ate behaviors, he/she was d to him/herself and he/she nce towards others, uation, the resident's family a history of violence and dent would become "wild as redirect and he/she went oms and residents were nd Resident #82. The ted Resident #82's dations were "psychiatric ent." However, no were recommended during  cility reported incident, dated Resident #82 wandered into a. According to the report, sking the resident to leave ident #317 was "holding wrist. Staff escorted is/her room, and the	{F 6	56}			

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WNG			· ·	₹ 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	revealed staff were m wandering/agitation; indicated no documer monitored the resider behaviors directed to Review of Resident # 07/13/2021 at 11:15 / State Police because his/her room and was However, the record informed by RN #1 th Dementia and some of the RN informed the I been exposing him/he others. The RN also the Police Resident # exaggerate."  Interview with Registe 07/30/2021 at 9:50 Al working on 07/13/202 contacted the State P incident was reported however, the RN took cause of the resident prevent further behav the only way to monit behaviors, to ensure provide the resident v supervision; however behavior was unable because the facility w Review of Resident #	82's Medication d (MAR) dated June 2021, onitoring the resident for nis/her behavior monitoring nted evidence staff of for his/her abusive wards other residents.  86's record revealed on NM, Resident #86 called the Resident #82 came in exposed him/herself. revealed the police were at "95% of our residents had do wander". Per the record, Police a resident had not erself to Resident #86 or documented she informed 86 "has been known to  ered Nurse (RN) # 1, on M, revealed she was 11, when Resident #86 tolice. The nurse stated the to the Administrator; a no action to determine the s behaviors in an attempt to iors. The RN also stated or Resident #86's ongoing the safety of others, was to with an increased level of a stated the residents to be properly monitored as short staffed.	{F €	556}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII	IPLE CONSTRUCTION			SURVEY
		185256	B. WING				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS 200 NURSING HOP PIKEVILLE, KY		09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	"picked up" the resider report, Resident #86 alarm provided by the unknown) and threw Documentation also is been implemented to wandering into his/hed #86 "frequently takes indicated the investig #82 was abused by Fither water on him/hed residents room and sabuse was that the fare Resident #86 to keep he/she was in his/hed Interview with SRNA PM, revealed Resider into other resident's retheir personal belong him/herself to other rethese behaviors had was admitted. However of any interventions in residents from Resider Market PM of Resident #86 r	ent #86's room again and ents shoes. According to the pressed his/her personal e facility (exact date water on Resident #82. Indicated a stop sign had prevent residents from room, however Resident it down." The incident report ation determined Resident Resident #86 because he/she er when he/she entered the resident stop sign up when room.  # 18, on 07/27/2021 at 10:00 at #82 frequently wandered booms, attempted to take residents. The SRNA stated because desidents. The SRNA stated because he/she residents. 2 residents and exposed because he/she resident #82 residents. The same resident #82 resident #86 raised arge bruise red/purple in 8 x 8 inches was observed	{F 6	56}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY PLETED
		185256	B. WING		_		R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STA 200 NURSING HOME LANE PIKEVILLE, KY 41501	C 104	1031	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)	_	(X5) COMPLETION DATE
{F 656}	staff were not observed the cause of the reside to determine if the resident determine if the resident was not observed to it of his/her behaviors, at the resident #82's war was not observed to it of his/her behaviors, at the resident #82 entered 07/31/2021 at approximation that the residents when Resident #64 at room, Resident #64 at room, Resident #82 himst. According to the was observed to his/humst. According to the was observed to his/humst. According to the was observed to his/humst. According to the was observed to his/humst. According to the was observed to his/humst. According to the was observed to his/humst. According to the was observed to his/humst. According to the cared for Resident #80 has repidents had been continued that the resident and continued that the resident and resident #82 would be behaviors; however, the monitor the residents safety of others.  Review of nursing documents and the residents safety of others.	esident's rooms. Facility and to attempt to determine dent's behaviors or attempt sident was hungry, thirsty or stroom. After observations indering was observed, staff implement further monitoring as outlined in the care plan.  64's record revealed his/her room again on imately 4:50 AM, was going personal belongings and sked him/her to exit his/her it Resident #64 on the right re record, a small red area ier right wrist.  on 07/29/2021 at 9:30 PM 021 at 2:00 PM, revealed at #82 since he/she was in May 2021, and his/her ards staff and other ontinuous since admission. ent #82 had wandered in/out ims, "yelled/growled" at reated fear in others. RN #9 #64, Resident #322 and orted they were afraid of N stated she felt the only	{F 6	56}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	·		CONSTRUCTION		SURVEY
		185256	B. WING				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	<u> </u>	20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	1 09/	30/2021
(X4) ID PREFIX TAG				х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 656)	Review of Resident # revealed no document monitored him/her and document devidence him/herself to others, behavior toward Resident #2, on 08/10/2021 at the staff nurses responsare plans were imple MDS nurse also state to ensure resident carbut stated she expect implemented as requishe was unaware why had not been implement it should have been.  Interview with the ADO Nursing, on 08/11/202 Resident #82 had exh which affected other readon ADON also stated state on ensure resident car in the facility. According had no process in plan plans were implement linterview with the Adn 6:00 PM, revealed she implement care plan in further behaviors from Administrator stated sto monitor/ensure resident care sto monitor/ensure resident stated sto monitor/ensure resident.	ent #64 for the second time.  82's MAR, dated July 2021, ted evidence staff of the MAR provided no en he/she exposed or he/she displayed abusive dent #86 or Resident #64.  Im Data Set (MDS) Nurse 12:00 PM, revealed it was insibility to ensure resident emented in the facility. The did the facility had no process replans were implemented, and staff to ensure they were red. The MDS Nurse stated of Resident #82's care plan ented as required, but stated  DN/Interim Director of 21 at 12:00 PM, revealed albited ongoing behaviors, esidents in the facility. The fir nurses were responsible to plans were implemented bing to the ADON, the facility ce to ensure resident care ted as required.  Ininistrator, on 08/11/2021 at the expected nursing to interventions, to prevent a occurring. However, the he had no system in place	{F €	556}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCT		(X3) DATE COMP	SURVEY
		185256	B. WNG		_		R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRE		J 09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	( E/	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	Resident #66 to the fadiagnoses to include: Dementia, and Athero without Angina Pector Review of Resident #(MDS) Annual assess revealed the resident Mental Status (BIMS) moderate cognitive im assessed the resident staff members for bed the MDS revealed the care during the look b  Review of Resident #6 04/23/2021, revealed Living (ADL) Care Pla the resident required a related to decreased in condition, and receiving facility developed an in resident was totally de for repositioning and to review of the resident' facility identified the re pressure ulcers and d included following facility identified the re prevention/treatment of care plan did not include the resident required to Review of Resident #6 Kardex," not dated, re	ealed the facility admitted acility on 02/15/2021 with Adult Failure to Thrive, esclerotic Heart Disease ris.  66 Minimum Data Set ament dated 05/05/2021 had a Brief Interview for score of nine (9), indicating apairment. The facility had a to be total assist of two (2) mobility. Further review of facility had no rejection of ack period.  66 Care plan, dated under Activities of Daily in focus the facility identified assistance with ADL's mobility, multiple medicaling hospice services. The intervention that stated the expendent upon two (2) staff urning in bed. Further is care plan revealed the esident was at risk for eveloped interventions that lity policies/protocols for the of skin breakdown. The de specifics on how often urning and repositioning.	{F 6	56}	DEFICIENCY)		
	assistance of two (2) stated "Resident does	staff for bed mobility, and n't get up". There was no aff should turn/reposition					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE			20	REET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	dated 06/02/2021 revibedridden incontinent more than 2 years." Athe resident's skin wa Interview with State R (SRNA) #5, on 06/17/Resident #66 "should hours to keep from de The SRNA stated she location or content of Kardex (nurse aide cathe SRNA knew the cashe was unable to pro "thought all residents hours".  Interview with the MD 06/18/2021 at 3:50 PN responsible for develom MDS Coordinator state assistance with bed m with interventions to to (2) hours as the resident pressure ulcer develom Coordinator reviewed and could not find the reposition the resident stated the care plan for included that interventions to the State Registered Nurstherefore, because the	ealed the resident was of bowel and bladder for According to the plan of care intact.  Registered Nursing Assistant 2021 at 10:15 AM, revealed be turned ever two (2) eveloping skin breakdown." was unaware of the Resident #66's care plan or are plan). When asked how are the resident required, ovide details and stated, she should be turned every 2  S Coordinator, on M, revealed she was oping the care plan. The ed residents requiring nobility needed a care plan urn and reposition every two ent would be at high risk for pment. The MDS Resident #66's care plan intervention to turn and t. The MDS Coordinator or Resident #66 should have the find (turn and reposition).  Care Plan would trigger the se Aide (SRNA) care plan; entervention was not on are Plan, the intervention	{F 6	556}			

			(X3) DATE COMP	SURVEY LETED			
		185256	B. WING	<u> </u>			R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	001	5072521
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
{F 656}	o6/19/2021 at 12:29 F should be turned and hours. She stated if r repositioned, the outobreakdown. The DOI have turned Resident and the RN should have turned Resident with the RN should have turned Resident with the RN should have turned Resident with the RN should have turned Resident with the RN should have turned and reposition.  **The facility alleged to implemented to remove and comprehensive for the facility utilized the and comprehensive for the facility utilized the and comprehensive for the facility utilized the and comprehensive for the facility utilized the and comprehensive for the facility utilized the and comprehensive for the facility utilized the and comprehensive them to the Medical Englishment of the Medical Englishment and Brade be completed, and the developed within 48 his pressure ulcer or pote comprehensive care processing the facility of the f	r of Nursing (DON) on PM revealed all residents repositioned every two (2) esidents were not ome could be skin N stated the SRNA should #66 every two (2) hours we been observing to as turned. She further are of any concerns with ing residents. the following was we Immediate Jeopardy  essments were completed cility nurses on 08/28/2021 all body skin assessments I residents on 09/11/2021. E Braden Scale Assessment all body skin assessment to re plans of residents who by 09/17/2021.  hysician evaluated Resident taff assessed and e injuries, and staff reatments and reported birector/Physician #1 by  021, upon admission a skin len Scale assessment will e baseline care plan will be	{F 6	356)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCT	TION		SURVEY
		185256	B. WING			1	R /30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER			RESS, CITY, STATE, ZIP CODE 3 HOME LANE KY 41501	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD I COSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 656}	4). Residents #45, #6 and #320 were bather care and moisturizing and assisted with dresclothing. Clean lineau residents' beds on 09 were evaluated by so 5). All residents were interviewed to obtain by the Director of Nur. New bath/shower sch by nursing staff to accordence. Resident were obtained and incorplans and State Register plans by the Register	ulcers and include nt pressure ulcer ening of pressure ulcers.  5, #308, #309, #311, #314 d including a shower, nail lotion applied post shower, ssing in clean appropriate s were placed on the //1/2021. The residents cial services on 09/15/2021.  offered a shower and shower/hygiene preferences sing (DON) or designee. edules were implemented commodate resident preferences for hygiene corporated into resident care stered Nurse Aide (SRNA) inional Nurse Consultant //13/2021.  Registered Dietitian (RD) esidents' diets and made meal changes or ote healing and to address s.  the diagnoses of Diabetes we Pulmonary Disorder Pneumonia were assessed //or Respiratory Therapist	{F 6	56}			
	and orders were amer	e monitoring by 07/30/2021 aded to include mandatory					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R /30/2021	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI; TAG	X (EACH CORRECTIVE ACTION SHOL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 656}	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(F 6	56)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		031	GGIZGZ
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	IX (EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 656}	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		{F 6	656}			