STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE	SURVEY		
		185256	B. WING			1	R /30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE D NURSING HOME LANE KEVILLE, KY 41501	, 30,	00/2021
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	N SHOULD BE COMPLE APPROPRIATE DA		
{F 656}	snacks to all resident afternoon by the restraides, or designee. Sphysician will be doct aide, dietary aides and 16). The facility evaluated of the facility evaluated for compliance with Complemented yellow a dentified two (2) residentified two (3) residentified two (4) residentified two (5) residentified two (6) residentified two (7) residentified two (8) residentified two (9) residentified two (9) residentified two (1) residentified t	/2021, staff began offering is daily in the morning and brative nurse aide, activity macks ordered by a sumented by the restorative ad/or licensed nursing staff. Interest the COVID-19 unit on the 5th floor of the facility cDC guidelines and and red zones. The DON dents who had been esidents and a yellow zone erection of a plastic zip wall (2) residents were moved to 121. Interest (3) residents who were 1/11/2021 (Residents #327, idents #327, #328 and #329 antine per facility policy and sidents #311 and #314 et per COVID-19 policy and sidents #311 and #314 were 1/12 the facility did not the shased on the employee 1. All residents eligible were on 09/17/2021. The facility ew positive cases.	{F €	556)			
	droplet precautions w						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		185256	B. WNG_			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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)			
{F 656}	physician notification, plan revisions. The Drawly positive COVID isolation precautions addition, any resident droplet precaution in a facility will provide phynotification and care pemployee testing protidesignated days effect requires all staff must days. If the employee not allow the employee not allow the employee negative COVID-19 to employee will be testefacility by the Infection designee. All testing oposted to the employe common areas. 20). The facility scree for signs and/or symp documented on the MRecord (MAR). The famonitoring for signs a residents on 09/17/20 21). Resident #9, Res Resident #326 and Rewere reviewed for use administration times be 09/23/2021.	The facility will provide family notification and care ON or designee will review 0-19 residents to ensure have been initiated. In exposed will be placed in exposed will be placed in exposed will be placed in exposed will be the facility olan revisions. The facility olan revisions. The facility ocol will be twice weekly on extive 08/16/2021. The facility be tested on designated is not tested, the facility will be to work without a current ext. During testing, the end prior to entering the end prior to entering the end prevention Nurse or eates and times will be end page, time clock and ens all residents once a shift atoms of COVID-19 and dedication Administration excility implemented end/or symptoms on all 21. esident #321, Resident #324, esident #351, medications age and appropriate by the physician on	{F 6:	56}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED		
		185256	B. WING				R 09/30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY 200 NURSING HOME L. PIKEVILLE, KY 4150	ANE	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	(EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 656}	23). The facility formulo9/23/2021, with the facility with a thremedications that required for cost authorization. 24). New admissions the facility after normal weekends will have dentered into the electronic submitted to pharmaci integration. The facility fax transmittal as a bapharmacy integration electronic medical recomplished in the facility will utilize the facility manner the phase unavailable, the physical substitution and/or new control of all residents of all residents of all residents of all medication facility by 09/25/2021. 26). The facility conduperformance Improve 08/12/2021. The facility process, and a ensure compliance will facility process, and a ensure compliance will the QAPI committee Nursing, Administrator over the QAPI committee Nursing, Administrator.	the unavailable medication. Islated an agreement on facility's pharmacy to provide e (3) day supply of sires the facility's approval while pending cost review. and re-admissions entering all business hours and on ischarge orders submitted, ronic medical record and by through pharmacy sity implemented the use of ackup to the electronic by entering the order in the cord to receive medications. The receive medications in a sarmacy will be notified, and the emergency medication wrises and medication is ician will be notified for the orders. The Consultant, Director of I nursing staff completed an ordered medications and is were available in the	{F 6	56}				

185256 B. WNG 09/3				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	3072021			
(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-REFERÊNCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION			
(F 656) Continued From page 317 Maintenance, Dietary and Environmental Services. 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the current Administrator. The facility's Interim Administrator will receive daily oversight and guidance from the Regional Vice President or Regional Director of Operations and Regional Clinical Nurse for 30 days. Upon completion of the thirty-day oversight, the Regional Administrative Team will audit the Administrator to determine if continued daily oversight is needed. The administration has direct oversight and responsibility to direct, discipline, and communicate areas of concern and process improvement. 28). The Administrator, Medical Director, and QAPI Committee reviewed procedures for a contact person for call-ins, answering call lights, Activities of Daily Living (ADL) Care, serving, and timeliness of meal trays incontinence care and turning and repositioning on 09/15/2021. 29). The Vice President of Operations, Director of Clinical Operations and Regional Nurse Consultants conducted a conference call on 09/15/2021 with a contract company for a consultation to review the following: (1) the outcomes of the survey; (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; (3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incombinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds,				

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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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE	
{F 656}	and neglect effectively appropriate ADLS, an QAPI committee. 30). The Administrato Consultant reviewed a beginning 09/16/2021 and/or revisions to the the 09/16/2021 meeting standardized plan to ereviewed as needed a agenda included reviewed as needed a agenda included reviewed as restraints, memanagement, infection readmission rate, rehassocial services, conceresident council, and agrievances, admission development, vacant orientation, dietary value weight loss, work injuremployees on family repubusiness office, and a Committee and Medication agenda but not limited to, the impeting. 31). The Regional Direvice President of Ope Administrator, the DO on 09/16/2021 regarding Governing Body, incluprocedures to be implemented.	ervices, dealing with abuse y, sufficient staff, providing d providing a functioning and revised the QAPI Plan and presented the reviews e QAPI Committee during ng. The facility developed a ensure all topics were at the QAPI meetings. The ewing pressure ulcers, Foley ding tubes, contractures, edication usage, risk in control, hospital abilitation management, and of grievance, activities, family council concerns, ins, discharges, census, staff positions, employee riances, tray audit report, ries, terminations, medical leave, a leave of medical record compliance ports, restorative nursing, dmission actions. The QAPI al 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	⟨F €	556}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUILDI		CONSTRUCTION	(X3) DATE	SURVEY		
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE ON NURSING HOME LANE IKEVILLE, KY 41501	09/	30/2021		
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{F 656}	QAPI processes, the in the QAPI process, causes with the utiliza approaches and, audi Calendar. The Admin medical Director of fur meetings. 32). The Administrator reports before each Obeginning 09/15/2021 compliance with the divided on the discussion of the discu	During the meeting, the need to participate regularly the need to identify root ation of the five (5) why iting systems per the QAPI distrator will notify the ture QAPI Committee If will collect all monitoring the ture QAPI Committee meeting for review to ensure deficiencies cited during the API Meetings were held on a abatement and develop we the jeopardy. The facility deetings weekly, times four and monthly. The fard all QAPI Meeting hing Body members, sident of Operations, and the cultant, to review the audit numittee will review the detings. Committee for ator oversees the QAPI PI Committee consists of the dministrator, Medical ces Director, Activities, intenance, Dietary and desc. Ody will provide the facility's ources and education cluding but not limited to the it a Glance, and a resource plement the QAPI plan. The Governing Body will	{F 6	56}					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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(F 656)	of QAPI Committee m (4) weeks and, as need to ensure the quality of complies with the start compliance with State is demonstrated. 35). All nursing staff with Director of Nursing, Midesignee on proper with obtaining, documenting thanges to the Regist 09/17/2021. 36). On 09/13/2021, the Dietary Manager (CDI Manager on the provisus assessment to ensure diet order accuracy, a orders into the electron CDM educated the Direction of the nurse enters the communication including diet and text meetings, staff will recommunication and transfer of resider chair to bed beginning completed on 09/17/2 and assigned additional agency contracts	r will increase the frequency leetings to weekly for four eded effective 09/16/2021, of care is monitored and dard of care and e and Federal requirements were educated by the IDS Coordinator, or eighing techniques, and reporting weight tered Dietician by the Regional Certified (M) educated the Dietary sion of timely nutritional ediet order accuracy, on and on when to enter diet whice medical record. The etary Manager to enter to the tray care system. If order, the nurse will send a not the dietary staff, ure. In the morning clinical view diet orders from the e accuracy. I education to all nursing ositioning range of motion and from bed to chair and	{F 6	556}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING COMPL							
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	ATE, ZIP CODE				
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(F 656)	all nursing staff on pre- including turning and hydration and nutrition to complete and docu- assessment, and how dietician, physician, a impairment by 09/17/2 staff will call or email of Physician, and Residenew skin changes. 39). The DON or desi- timely call light responstaff, including nurses assistants, were provi- timely hygiene per the timely toileting, dressi- of clean clothing, and trays. The DON or de- facility staff not working returning to work. 40). On 08/31/2021, The Nursing educated all If Registered Dietician, and the MDS Nurses into the electronic menand interventions. In Director of Nursing ed existing care plan in the with new goals and in- impairments identified 41). The facility's Resilicensed nurses on id-	ector of Nursing educated essure ulcer prevention, repositioning, adequate not positioning devices, however, positioning devices, however, positioning devices, however, to notify the registered and RP of a new skin 2021. The facility nursing the Registered Dietitian, ent Representative of any gnee educated all staff on the seal of the second certified nursing ded education on providing the resident's plan of care, and certified nursing ded education on providing the resident's plan of care, and resident a	{F 6	56)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING	(X3) DATE SURVEY COMPLETED R 09/30/2021			
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	09/30/2021			
PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE PIKEVILLE, KY 41501				
(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 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
(F 656) Continued From page 322 08/12/2021. In addition, on 08/12/2021, the DON and/or designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a resident's change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. The facility licensed nursing staff will not be allowed to work until they have received this education. The DON educated all clinical staff on documentation of glucose levels on 08/19/2021 and 08/20/2021 during mandatory in-services. 42). Beginning 08/12/2021, the DON educated licensed nurses on completing a baseline Care Plan with interventions and goals relevant to diabetes and a respiratory diagnosis within 48 hours of admission, reviewing and providing a copy to the resident and/or the responsible party. Licensed nursing staff not working during education was notified of ongoing education and will not be allowed to work until they have received this education. 43). Beginning 08/12/2021, the DON educated all staff on the facility's "call off" procedure. The call-off procedure for the facility's "call off" procedure. The call-off procedure for the facility included; in the event a person needs to call out of work for dayshift, they are to notify their immediate supervisor for he start of the shift. If staff needs to call off on the night shift, they are to notify their immediate supervisor four hours before the start of their shift. If the facility does not have appropriate staffing levels, the immediate supervisor row does not have appropriate staffing levels, the immediate supervisor and/or designee will call other qualified staff to replace the person calling off. If emergency staffing is required, the Administrator and/or designee will call				

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working will be in-serv 44). All staff were prov. Administrator and/or of the process of identify reporting abuse, as we implementing immedia wandering residents. 45). All nursing staff w Director of Nursing, Midesignee on proper we obtaining, documentin changes to the Registroly17/2021. On 09/13, the Dietary Manager of timely nutritional assess accuracy. When staff electronic medical recorder will send the writidietary staff. The Diet order into the tray care review diet orders from clinical meeting to ensure 146). The Regional CDI Manager on 09/13/202 regarding meal service recipes including recip fortified diets to ensure nutritional needs of resestablished national greatly. As of 09/15/2021, completed education wo obtaining food preferen	riced upon return to work. rided re-education by the designee on 08/12/2021 on ing, preventing, and ell as identifying and ate interventions for rere educated by the DS Coordinator, or eighing techniques, and reporting weight ered Dietician by /2021, the CDM educated on diet order accuracy and assment to ensure diet order enters diet orders into the ord, the nurse entering the ten communication to the tary Manager will enter the existem. The facility will in the previous day in the sure accuracy. M educated the Dietary 21 on facility policy entires and the use of these for those requiring enall meals meet the sidents in accordance with uidelines to reflect religious, eds of the population.	{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		
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501				
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{F 656}	procedures, appropri portion sizes. 48). The Director of Nof Nursing educated Manager on the processor and/or implementing recommendations for 09/17/2021. 49). All staff were processor of Nording Person and/or designer COVID-19 policy/guid donning/doffing Person (PPE), yellow and resultant policy, yellow and resultant policy, reducated all staff, incomer not working. Du 08/12/2021, the Covinandwashing policy, red and yellow zones for signs/symptoms of reviewed. 50). Staff were provided the processor of the provided and yellow zones for signs/symptoms of reviewed. 50). Staff were provided and yellow zones for signs/symptoms of reviewed. 51). All licensed nurse educated on the five administration, including patient, right dose, rig Regional DON/DON/DON/DON/DON/DON/DON/DON/DON/DON/	state scoop sizes, and/or Sursing or Regional Director nurses and the Dietary ess for entering, activating, the registered dietician's dietary orders on Swided re-education by the eby 09/17/2021 on the delines, handwashing, onal Protective Equipment dizones. In addition, the ated, licensed staff on for Covid-19 symptoms 21, the DON/designee cluding contract staff, who ring the QAPI meeting on de-19 policy, the donning and doffing PPE, and monitoring residents of the Covid-19 were	{F 6	56}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRU	CTION		DATE SURVEY COMPLETED R 09/30/2021	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200 NURSIN	DRESS, CITY, STATE, ZIP CODE IG HOME LANE E, KY 41501	, 03/	00/2021	
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{F 656}	available for administ education included cathe medication, obtain medication delivery till ordered medication woutside of the ordered education also including given by the MD, doc and new orders from medical record. All ot will be provided training the provided training the provided training the emergency in place for ensuring an otifying the physicial re-admitting residents after-hours. 53). The Interim Adminited in the contact information of the emergency in place for ensuring an otifying the physicial re-admitting residents after-hours. 53). The Interim Adminited in the contact information of the emergency in addition, education who to notify if unable shift. 54). The facility will all head-to-toe skin asset through Friday, for the O9/17/2021 to ensure weekly on each resid will notify the physicial Responsible Party of	when a medication was not ration as ordered. The alling the pharmacy to obtain hing the anticipated me, notify the MD if an ill either be omitted or given if medication time. The ed following new orders umenting the conversation, the MD in the electronic her licensed nursing staffing as scheduled for shifts. The DON /Regional Nurse all licensed nursing staff, and/or agency staff, on the medication kit, the system medications are in-house, or in for new orders for new or in the staffing as the Abuse 13/2021 through 09/17/2021. On staffing schedules and to work their scheduled at the work their scheduled and the saments daily, Monday ree (3) months effective they have been completed ent. In addition, the facility in, Registered Dietician, and any new skin impairment entions have been put in	{F 6	56}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE		<u> </u>	STF 200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501	09/	30/2021
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{F 656}	expiration date on 08/conducted weekly for weeks effective 09/17 three (3) months. 56). The Director of Nursing (ADON), or Nresident progress not effective 09/13/2021, month. Staff will revie Saturday and Sunday Supervisor conducted areas of skin impairm plan implemented to i 57). Beginning on 09/leadership staff and/orounding of residents incontinence, and residents will be visual shift daily for two (2) wresidents each shift for twenty-five percent of (4) weeks. The facility to 6:00 PM and 6:00 F	dited all lab supplies for the /28/2021. Audits will be all lab supplies for four (4) /2021 and then monthly for fursing, Assistant Director of Jursing Supervisor will audit es for daily four (4) weeks then weekly for one (1) w Progress notes for on Monday. The Nursing audits to ensure any new ent identified had a care include new interventions. 11/2021, the facility's r designee began visual assessing hygiene, toileting, ident repositioning. All silly rounding on once each weeks, fifty percent of the or four (4) weeks, and residents each shift for four has two (2) shifts, 6:00 AM PM to 6:00 AM.	{F €	556}			
Ξ	began visual monitoring response times, including lights are answered, a staff will conduct ten (each shift for two (2) with the conduct ten (each shift for two (2) with the conduct ten (each shift for two (2) with the conduct ten (each shift for two (2)).	the facility's leadership staff ing and timing of call light ding the length of time call incross all shifts. Leadership 10) call light observations weeks and then five (5) call th shift for eight (8) weeks.					
12	began monitoring resp Situation Background	ne DON and/or Designee piratory assessments and Assessment and (AR) communications for				4 0	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER	·	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		831	5072521
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{F 656}	The facility reviewed respiratory status for implementation of any Plans were reviewed Audits will be daily for times a week for four 60). The MDS Nurse, began audits on 09/15 completion for all new re-admissions to ensubaseline Care Plan w. 61). All residents admidays with a diagnosis Obstructive Pulmonar Asthma, or current Pr Care Plan reviewed a the MDS Nurse(s) and interventions will be a morning meeting by thoursing designee. 62). Beginning on 08/DON, and/or Designe admissions and re-adcare plans for comple with the resident and/variance or identified immediately. Audits we through Friday for all to the facility for four (admissions for a weel then ten percent of acceeding the status of t	ratory status Monday clinical morning meeting, any acute change in Physician notification and y physician order. Care and updated as needed. one (1) week, then five (5) (4) weeks. DON, and/or Designee 5/2021 of baseline care plan y admissions and ure staff completed the ithin 48 hours of admission. whitted within the last thirty of Diabetes, Chronic y Disease (COPD), neumonia had their baseline and updated as needed by d/or designee. New dded to the care plan in the ne DON, ADON, and/or	{F 6	556}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 037	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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	meal trays to resident All three (3) meals wil (3) units daily for two all three (3) units daily (1) meal on all three (weeks. 64). On 08/15/2021, the began audits of staff's quiz of identification a with a change in responding symptoms of hythe facility's diabetic prochange in a resident's physician and following Leadership will quiz shifts; ten (10) staff for staff a week for four (65). On 08/13/2021, the began monitoring all cresults Monday through morning meeting. The any blood sugar result range for MD notification and physician's Ordereviewed and updated designee will complet diabetic residents acri (3) units to identify an signs and symptoms hypoglycemia/hyperg resident was immediated staff. Any variance or addressed immediated	ting how long it took to pass its after arriving at the unit. Il be observed on all three (2) weeks, two (2) meals on y for two (2) weeks, and one (3) units daily for four (4) the DON and/or Designee is knowledge with a verbal and assessment of residents irratory status, identifying preglycemia/hypoglycemia, protocol, documenting a is condition, notification of the ing physician's orders. It aff randomly across all or one (1) week and five (5) 4) weeks. The DON and/or Designee documented blood sugar gh Friday in the clinical in and implementation of its. Care plans will be do as needed. The DON or ite a visual rounding on its both shifts and all three by resident with apparent	{F €	556}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION		SURVEY
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE .	(X5) COMPLETION DATE
{F 656}	designee implemente questionnaire on abus residents with wander the proper reporting of units. The employee completed for five (5) then three (3) times a and then weekly for for or identified concerns immediately. 67). Beginning on 08/Nursing and/or design resident's wandering admission and quarte Set (MDS) assessment wandering will be discomorning meeting to reinterventions. Any variable be care planned in the Director of Nursing Nursing, or nursing defined the Director of Services Director or drandom interviews of of eight (8) or greater the facility and have now witnessed abuse. The review random weekly residents with a BIMS to ensure no injuries of 08/13/2021. Any variable will be addressed immediately.	the Administrator and/or d an employee se and identification of ring behavior to determine of abuse across all shifts and questionnaire will be staff daily for one (1) week, week for two (2) weeks, our (4) weeks. Any variance will be addressed 13/2021, the Director of the will review each risk assessment upon rily with their Minimum Data and the Any resident identified as existed in the clinical eview and initiate new itance or identified concerns an ediately. New interventions in the morning meeting by g, Assistant Director of esignee. 13/2021, the Social esignee will perform residents with a BIMS score to ensure they feel safe in ot been subject to or EDON or designee will y skin assessments for score of less than eight (8) of unknown origin beginning ince or identified concerns	⟨F €	56}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF D	ROVIDER OR SUPPLIER	103256	B, WING	_		09/	30/2021
	W POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE O NURSING HOME LANE IKÉVILLE, 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)		(X5) COMPLETION DATE
(F 656)	in the diet/tray card so 70). Beginning on 08/Manager will ensure a kitchen and reaching be conducted for rand one (1) week, twice pland then weekly for o trays arrive at the unit assist in passing trays meal trays, and certification residents promptly. To designee will audit the 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 beverage preferences admission and enter the system for listing on the completed bi-annually residents. Physician-toe audited by the Diet (1) week, weekly for for after that for four (4) mog/15/2021. 72). Daily COVID-19 saudited beginning on Resources (HR) Directions.	cord against orders entered offware to ensure accuracy. 23/2021, the Dietary and audit meals leaving the the units timely. Audits will lom meals twice daily for er week for two (2) weeks, ne (1) month. Once meal and management staff will as to ensure residents receive ed nursing assistants assist the Dietary Manager or et time it takes to pass meal or they arrive on the unit and there (3) meals will be to daily for two (2) weeks, and unit daily for two (2) on each unit daily for four (4) on each unit daily for four (4) on each unit the diet/tray card their tray cards beginning of food preferences will be and as needed for all pordered snack intakes will lary Manager daily for one pur (4) weeks, and monthly nonths beginning	{F €	956}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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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	1 001	50/E521
(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 CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
{F 656}	Director, and weeken staff not screened will immediately on the Coby the HR Director. The ducated on the COV Nurse, an infection codoors will remain lock entry by staff and screentry. 73). Beginning on 09/designee will round sfor eight (8) weeks, fin (4) weeks to audit infediffering shifts and un observation of handwand zones; donning/oPPE; and mask compidentified concerns wiby the auditor. 74). The DON, ADON review all residents on pharmacy to ensure a beginning 09/23/2021 physician within two (expiration. 75). The Regional Nu and/or Director of Numedication pass observed to accuracy of medicatic CMS Critical Element	dr (4) weeks by the HR ds audited on Mondays. Any libe re-educated OVID-19 Screening Policy the HR Director was PID-19 policy by the Regional control preventionist. All entry ted. Visitors must be allowed deened by staff at the time of PIT/2021, the DON and/or even (7) times each week the (5) times weekly for four ection control compliance on its. Audits will include ashing; isolation signage loffing (putting on/taking off) which is addressed immediately It, and/or Designee will an active script is on file to Staff will notify the Cylical days of the prescription's arse Consultant, Pharmacy, resing will conduct random control control to the prescription of	(F 6	56)		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		INSTRUCTION		SURVEY
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200 N	ET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501	1 05	3012021
(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 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 656}	Friday, the DON, ADG audit medication deliving medications daily to eneeding a renewal hapharmacy. Audits will Immediate Jeopardy 77). Beginning 09/11/ and/or DON will be renursing staff daily for adequate staffing is more 78). Beginning 09/11/ Dietary Manager will dietary staffing daily fradequate staffing. 79). Beginning 09/11/ President of Operation monitor and audit the days to ensure complete was to ensure complete was to ensure complete was to ensure of condition and identified Watch" (change of condition and identified Watch" (change of condition and identified was some performed in BIMS score of eight (if felt safe in the facility to or witnessed abuse concerns. Interviews a conducted of resident designees weekly untremoved.	2021 Monday through DN, and/or Designee will very tickets against ordered ensure that all narcotics we been sent to the continue until the is removed. 2021, the Administrator sponsible for monitoring four (4) weeks to ensure naintained. 2021, the Administrator and be responsible for reviewing or four (4) weeks to maintain 2021, the Divisional Vice ns and/or designee will Administrator daily for 30 iance. vill be conducted beginning or for residents' change of ration of need for "Stop and notition) communication. 2021, the Administrator or interviews of residents with a bit or greater to ensure they and had not been subjected be. No residents had any	{F €	56}			

	OF DEFICIENCIES 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	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501		94/2021
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	1). Review of Head-to revealed staff assess on 09/11/2021. A revirevealed eight (8) res #324, #45, #14, #357 current pressure ulcerpressure injuries of two comprehensive care pressure injured the resident's current facility completed the resident's current facility completed the with the Regional DO revealed she complet assessment on all resturther revealed that the (20) total pressure injured interviews interdisciplinary Team assessments and Braupdate the residents' Resident #65, #324, # and #358's care plans current pressure injur with MDS Nurse #1 or revealed she updated reflect current pressure addition, she complet rounds on 09/15/2021	Immediate Jeopardy on d by: De-Toe Skin Assessments and all residents in the facility are of the skin assessments addents (Residents #65, #27, #74, and #358) had are with a total number of are venty (20). A review of the colans for Residents #65, #27, #74, and #358 and the care plans to reflect pressure injuries. The review on 09/17/2021. Described all residents at risk for the Braden Scale. Interview N on 09/30/2021 at 4:17 PM and head-to-toe skin sidents on 09/11/2021. She the facility identified twenty uries. She further stated that the Braden Scale asidents on 08/28/2021. revealed the	{F €	56}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
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		THAT I THE TENT OF		1	PIKEVILLE, KY 41501		
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{F 656}	#324, #45, #14, #357 review revealed the Ir reviewed each resident's orders care plan, and implem 2). Review of Resider revealed the Medical resident on 08/25/202 Stage four (4) pressur deep tissue injury (DT and a skin tear to the Resident #65's wound	urse for Residents #65, , #27, #74 and #358. A hterdisciplinary Team s, current skin breakdown, hented changes as needed. ht #65's medical record Director assessed the 21 at 1:45 PM and noted a re ulcer on the sacrum; a (1) to the left and right heels; left inner leg. Review of it care note dated	{F 6	556			
	wound measured, "13 12.3 cm width and 0.2 at 10 o'clock measurin 12 o'clock that measur No palpable bone, slo removed with wound 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 stage two (2) to left hi cm x less than 0.1 cm scapula measuring 1 0.1 cm, unstageable t cm by 0.6 cm. and fo measuring 12 cm by Interventions in place	resident's sacral pressure . A review of a wound on 09/15/2021 revealed (6) pressure ulcers, (2) to the left superior calf ngth) by 1.4 cm (width) by one (1) to the right hip 2 cm by less than 0.1 cm, p measuring 1.2 cm by 0.8 o, stage two (2) to left cm by 0.2 cm by less than o right heel measuring 0.6 ur (4) areas to the sacrum					
	weekly documentation						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(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 CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	00/00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIA	
(F 656)	for the sacral pressur 10:21 AM revealed the by 11 cm by 0.3 cm with drainage and 95 percent Resident #65 declined observation of other precord review revealed PM, Physician #1 detweight loss and woun 09/28/2021, Resident in-house wound care record revealed on 05 physician of the decline with no new orders. Twith Failure to Thrive. 3). The facility admitted 09/10/2021, completed 09/10/2021, completed 09/10/2021, and compon 09/10/2021, and compon 09/10/2021. Resided 09/28/2021 and re-addission skin asses 09/28/2021, Braden Seline care plan decent with the plan of the decline admission skin asses 09/28/2021, Braden Seline care plan decent with the plan of the	Observation of wound care en ulcer on 09/29/2021 at en wound measured 13 cm ith a scant amount of ent granulation tissue. It would not consent to the pressure areas. A medical did that on 09/21/2021 at 2:19 ermined the resident's discovered wisits. Further review of the president was diagnosed with the resident was diagnosed with the resident was diagnosed with the president was diagnosed with the president was diagnosed with the president was diagnosed with the resident was diagnosed with the president was diagnosed with the president was diagnosed with the resident was diagnosed with the president was diagnosed on one with the president was diagnosed with the president was diagnosed with the president was diagnosed on one with the president was diagnosed with the president was diagnose	{F 6	556}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY
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(F 656)	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 on 09/28/2021 from 1 no identified concerns reviews revealed Res #309, #311, #314, and shower preference and 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, and the faresident's care plan. A interviews revealed the preference was obtain shower schedule reversioner/hygiene preference.	linens were on the views with the residents observations revealed no review of Progress Notes 5, #308, #309, #311, #314, he Interim Social Service he residents on 09/15/2021 with resident hygiene. Do on 09/30/2021 at 2:23 PM yed Residents #45, #65, 14, and #320 on 09/15/2021 cerns regarding hygiene. Idents during the initial tour 1:33 PM to 2:32 PM revealed 1:33 PM to 2:32 PM revealed 1:34 PM revealed 1:35 PM revealed 1:35 PM revealed 1:36 PM revealed 1:36 PM revealed 1:36 PM revealed 1:37 PM revealed 1:38 PM revealed 1:38 PM revealed 1:38 PM revealed 1:39 PM	{F €	56}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		S'	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	1 09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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}	loss and/or wound he documentation reversely reviewed all resident DON reviewed all did Interview with the RI revealed she complete and recommendation of the revealed she complete and recommendation of the revealed with a diagnosis of Disgns and symptoms hyperglycemia and the intervention. Intervie 09/30/2021 at 4:17 Fithe residents and did concerns. Observation 09/28/2021 at 11:36 Fit 09/29/2021 at 11:36 Fit 09/29/2021 at 11:52 signs/symptoms of he are view of facility as 08/12/2021 revealed diagnosis of Chronic Disorder (COPD), At assessed by Respiration of the resident fit observation of Residual Resident #4 revealed no respirate revealed no respirate revealed no respirate revealed no respirate revealed and respirate revealed no respirate respirate revealed no respirate revealed	residents to address weight ealing. A review of the aled the Registered Dietician is' diets, and the Regional ets and recommendations. DO on 09/30/2021 at 4:17 PM eted the review of all diets ins. by assessments completed by I thirty-nine (39) residents biabetes were assessed for it of hypoglycemia/ he need for immediate w with the Regional DON on PM revealed she assessed in the identify immediate ons of Resident #348 on PM, Resident #320 on AM, and Resident #311 on AM revealed no visible hypoglycemia/hyperglycemia. I fifty (50) residents with a it Obstructive Pulmonary esthma and Pneumonia were eatory Therapist #1. Interview erapist (RT) #1 on 09/30/2021 at she assessed all residents in on 09/28/2021 at 1:40 at 30 on 09/28/2021 at 1:40 at 30 on 09/28/2021 at 2:03 PM.	⟨F €	556}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		E 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	1 03/	30/2021
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{F 656}	all residents with a dia resident's orders for g stated the facility ame include mandatory en MAR. Review of Resionders revealed each the glucose value on review revealed no co having glucose levels than 400. 9). A review of audits revealed meals were with the Regional Cer (RCDM) on 09/28/202 09/30/2021 at 1:52 Pt 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 schedacility. A review of the one (1) licensed nurse nursing assistants for 6:00 AM. A review of the staffin 09/30/2021 revealed three (3) certified nurs from 6:00 AM to 6:00 staffing revealed one (2) certified nursing as 6:00 PM to 6:00 AM.	PM revealed she reviewed agnosis of Diabetes and the agnosis of Diabetes on the dent #3, #41, and #357's order required staff to enter the resident's MAR. Further oncerns 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 22 and arrived at the unit 10) minutes of the accility's staffing for AM to 6:00 PM revealed as and three (3) nursing duled for each floor of the afacility's staffing revealed and two (2) certified each floor from 6:00 PM to	{F 6	556)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		185256	B. WING				R /30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	E		0012021
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH				RRECTION I SHOULD BI APPROPRIA		(X5) COMPLETION DATE
{F 656}	to approximately 6:00 7:55 AM to 5:17 PM, being answered timel clean/well-groomed, assisting residents wi turning/repositioning vand meal trays were p Interviews with RN # AM and on 09/30/202 #4/Wound Care Nurs LPN (Licensed Practic at 12:44 PM; LPN #7 and 09/30/2021 at 12:50 Pat 10:31 AM; State Re (SRNA/certified nurse 3:40 PM; SRNA #11 SRNA #7 on 09/29/20 on 09/29/2021 at 4:10 09/29/2021 at 3:04 Pl at 3:17 PM and SRN/ PM, revealed staffing staff member revealed duties as assigned. 11). Review of the sta 09/28/2021, 09/29/20 revealed each day co one (1) evening cook, day aides, and two (2 Observation of the kit PM reflected the staff schedule. Interview w at 1:12 PM, and Dieta 2:10 PM revealed kito	on 09/29/2021 from 8:11 AM DPM and 09/30/2021 from revealed call lights were y, residents appeared staff was offering and th baths/showers, was being conducted timely, passed timely. 1 on 09/29/2021 at 11:55 11 at 12:58 PM; RN e on 09/30/2021 at 2:54 PM; cal Nurse) #6 on 09/30/2021 on 09/29/2021 at 3:00 PM 64 PM; LPN #10 on PM, LPN #11 on 09/30/2021 egistered Nurse Aide e aide) #1 on 09/29/2021 at on 09/29/2021 at 3:23 PM; D21 at 3:29 PM; SRNA #19 D PM; SRNA #21 on M; SRNA #22 on 09/29/2021 A #23 on 09/29/2021 at 4:10 had improved, and each d they had time to perform offing schedule for 21, and 09/30/2021 nsisted of one (1) day cook, one (1) prep cook, two (2)	{F 6	556}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		(3) DATE SURVEY COMPLETED	
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	V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE OO NURSING HOME LANE REVILLE, KY 41501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 656}	Continued From page	340	{F €	56}		·		
	12). A review of assessments for being withdrawn, crying, or other abuse symptoms was conducted for Residents #64, #86, and #322 on 08/11/2021. No concerns were identified. A review of skin assessments completed revealed no identified concerns. Observation and interviews conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with psychosocial and/or physical abuse, including observations of Residents #64, #86, and #322. Interview with Resident #322 on 09/29/2021 at 11:54 AM revealed no concerns with abuse. Interview with MDS Nurse #1 on 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.							
	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. Interview with the Registered Dietician on							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 20/2024
	ROVIDER OR SUPPLIER V 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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(X5) COMPLETION DATE		
(F 656)	comprehensive nutriti Residents #39, #65, # Review of the medica completed a compreh assessment on 09/16/09/16/2021 for Reside Resident #81, 09/16/2 09/16/2021 for Reside recommendations madischarged. Interview Dietician on 09/30/2020 Nurse Consultant on Regional DON on 09/10/10/10/10/10/10/10/10/10/10/10/10/10/	of revealed she completed a conal assessment on the test of the RD and the RD and the RD and the test of the RD and the the RD an	{F 6	556}			
		The zones contained no					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY
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NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND RE	HARII ITATION CENTER		;	200 NURSING HOME LANE		
		INDICINION CENTER		1	PIKEVILLE, KY 41501		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		145)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		_	(X5) COMPLETION DATE
(F 656)	Continued From page 342 residents. 17). Review of Residents #327, #328 and #329 revealed the residents were isolated per CDC guidance. Observation of Resident #328 on 09/29/2021 at 11:41 AM and Resident #329 on 8/30/2021 at 10:36 AM revealed no obvious signs or symptoms of COVID-19. Resident #327 had been discharged from the facility.		{F 6	56)			
	staff working on 09/16	staff testing revealed all 6/2021 were tested for entified new cases. Further ting for COVID-19 on no new cases.					
	at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 PN Director (HR) on 09/3 Marketing Liaison on Medical Records on 0 Central Supply on 09/ on 09/29/2021 at 11:5 12:58 PM, RN #4/Wo 09/30/2021 at 2:54 PM	M, 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 i5 AM and 09/30/2021 at und Care Nurse on M, LPN #6 on 09/30/2021 at					
	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 3:29 PM at 4:10 PM, SRNA #2	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, Cook #3 on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE COMP	SURVEY
NAME OF PROVIDER OR SUPPLIER		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501		3072021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 656}	1:30 PM revealed the (2) times weekly. Inte Control Nurse on 09/3 she was conducting to following CDC guidant tested revealed tested times weekly. 20). Review of Reside and #90's medical recresident had COVID- implemented. In addit resident's MAR reveal monitoring as ordered 21). Interview with the 09/30/2021 at 3:25 PI Resident #321, Resid and Resident #351's if for usage and approp the physician on 09/2 22). Observation of a 09/29/2021 at 4:35 PI 09/30/2021 at 8:09 AI identified concerns with addition, observation floor on 09/30/2021 at identified concerns. In 09/29/2021 at 11:55 A PM, N #4/Wound Car 2:54 PM, LPN #6 on 0 LPN #7 on 09/29/202 09/30/2021 at 1:54 PI	M, Former Activities ager #3 on 09/30/2021 at facility is testing staff two rview with Interim Infection 80/2021 at 3:10 PM revealed esting two (2) times weekly ce. Review of facility staff d is being conducted two (2) ent #329, #328, #311, #65 cord revealed that each 19 monitoring orders ion, review of each led staff was completing the I by the physician. Medical Director on M revealed Resident #9, ent #324, Resident #326 medications were reviewed riate administration times by 3/2021. medication pass on M on 3rd floor and M on 3rd floor revealed no th missing medications. In of a narcotic count on 5th t 12:50 PM revealed no therview with RN #1 on M and 09/30/2021 at 12:58 e Nurse on 09/30/2021 at 19/30/2021 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	{F 6	56}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CON	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B. WNG				R 30/2021	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200 N	ET ADDRESS, CITY, STATE, ZIP CODE URSING HOME LANE VILLE, KY 41501	, 00	30/2021	
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{F 656}	at 3:11 PM revealed to agreement that the plot facility 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 the Vice President of signed the agreement 24). Interview with RN AM and 09/30/2021 at 2:54 Pl 12:44 PM, LPN #7 on 09/30/2021 at 1:54 Pl at 12:50 PM, LPN #1 revealed they had recaware of the process from the pharmacy. In they were aware that physician if the pharm medication to the facility by 09/30/2021 at 3:40 09/30/2021 at 4:17 Pl completed of all residiand verified all medicafacility by 09/25/2021 pass on 09/29/2021 at 3:40 19/30/2021 at 3:4	Vice President of 2021 at 4:10 PM and of Pharmacy on 09/30/2021 both parties made a formal narmacy will supply the my supply for medication. Review of the facility's revealed for any medication of a three-day supply of the greviewed. The facility my changes or continuance macy within 72 hours. The sof Guardian Pharmacy and Operations of the facility the facility that the facility the sof Guardian Pharmacy and Operations of the facility of the f	{F €	556}				
	pass on 09/29/2021 a							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		A. BUILDING 185256 B. WING			₹		
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		S 2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	<u> 09/</u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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}	the facility conducted with the Regional DO/Consultant, Human R Records, the Houseke Supply, MDS Nurse # Therapy Manager, the the Administrator, the Dietary Manager, and administration team. 27). Interview with the Operations on 09/30/2/21 at 5:05 PN appointed the current 09/13/2021. Further in Operations revealed s Administrator with dail 09/10/2021. 28). Interview with the 09/30/2021 at 3:40 PN committee, including the Consultant on 09/30/2 procedures for contact answering call lights, adelivering meal trays than diversity and turning/reposition 09/15/2021.	I signature sheet revealed a meeting on 08/12/2021 N, Regional Nurse esources, SSD #2, Medical peping Supervisor, Central 1, MDS Nurse #2, the end Admissions Coordinator, end Activities Director, the other members of the content of 2021 at 4:10 PM and rim Administrator on an an arm Administrator on the end provided the Interim Administrator on the end provided the Interim by oversight since content and members of the QAPI has a safe for call-ins, ADL Care, serving and imely, incontinence care ing were reviewed on the end of 2021 at 4:10 PM, Regional 20/30/2021 at 3:40 PM, and so Nurse Consultant on the end of 2021 at 4:10 PM, Regional 20/30/2021 at 3:40 PM, and so Nurse Consultant on the end of 2021 at 4:10 PM, Regional 20/30/2021 at 3:40 PM, and so Nurse Consultant on the end of 2021 at 3:40 PM and	{F 6	56}			

INAME OF PROVIDER OR SUPPLIER PARKYLEW POST-ACUTE AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PROVIDERS PREVILLE, RY 42 STATE AND F CORRECTION IN PROVIDERS PLAN OF CORRECTION IN SIGNAL PROVIDERS PLAN OF CO	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER A. BUIL		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER (K4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX DORESC. CITY, STATE, JP. CODE 200 NURSING POMPLE LANE PIKEVILLE, KY 41501 (F 656) Continued From page 346 conducted a conference call to review the following: (1) the outcomes of the survey, (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations. (3) determined a plan for the following communication/monitoring tools: Infection Control and COVID-19 isolation, enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, carring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed reviewed and revised the QAPI Plan and presented the reviewed as readed at the QAPI meetings. The plan included pressure utclers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, the hospital re-admission rate, rehabilitation management, social services, concerns of grievance, activites, resident council, and family council concerns and/ or grievances, admissions, discharges, census, staff development, openings by department/position, employee orientations, dietary variance tray audit report, weight losses, work injuries, terminations, employees on family medical leave of absence,			185256	B. WNG_				
FREFIX TAG			HABILITATION CENTER		200 NURSING HOME LANE	Ē	USF	30/2021
conducted a conference call to review the following; (1) the outcomes of the survey, (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations, (3) determined a plan for the following communication/monitoring tools: Infection Control and COVID-19 isolation, enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed reviewed and revised the QAPI Plan and presented the reviews and/or revision to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The plan included pressure utcers, Foley cathleters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, the hospital re-admission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns and/or grievances, admissions, discharges, census, staff development, openings by department/position, employee orientations, dietary variance tray audit report, weight losses, work injuries, terminations, employees on family medical leave of absence or leave of absence,	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE		COMPLETION
pharmacy reports, restorative nursing, business	{F 656}	conducted a conferer following: (1) the outoexpectations and role outlined in the Rules determined a plan for communication/monit and COVID-19 isolatifacility to monitor/ass reposition residents, prepare and distributeresidents with eating, effective Pharmacy S and neglect effectivel appropriate ADLS, ar QAPI committee. 30). Interview with the 09/30/2021 at 3:40 Pl Consultant on 09/30/2 reviewed and revised presented the review. Committee during the facility developed a stall topics were review meetings. The plan in Foley catheters, entere contractures, physical usage, risk management, social signievance, activities, it council concerns and discharges, census, signievance tray a work injuries, terminal medical leave of absence hires, medical resident in the position of the property of the property of the property of the property of the plan in Foley catheters, entered usage, risk management, social signievance, activities, it council concerns and discharges, census, significantly of the property of the pro	ance call to review the comes of the survey, (2) as of the Governing Body as and Regulations, (3) the following toring tools: Infection Control on, enough staff at the ess residents, turn and provide incontinent care, a meals, and assist caring for pressure wounds, tervices, dealing with abuse by, sufficient staff, providing and providing a functioning and function to the QAPI and and as and/or revision to the QAPI and and an end of the QAPI and and an end of the QAPI and and family of or grievances, concerns of resident council, and family of or grievances, admissions, and family and f	{F 6	56}			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(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}	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 10:48 At 09/30/2021 at 1:18 Pt Supervisor on 09/30/2 Respiratory Therapist 12:45 Pt and Central 2:40 Pt, revealed the at the QAPI meeting the Operations on 09/30/2 Administrator on 09/30/2 Administrator on 09/30/202 meeting was conducted the duties of the Government	actions. The QAPI cal Director approved the on 09/16/2021 to include ne 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 nger #3 on 09/30/2021 at cords on 09/29/2021 at 8:34 Director (HR) on M, Therapy Manager on M, Housekeeping 2021 at 1:24 PM, (RT) #1 on 09/30/2021 at I Supply on 09/29/2021 at I sinformation was presented neld on 09/16/2021. Vice President of 2021 at 4:10 PM, the Interim 20/2021 at 3:40 PM, DON #2 PM, and the Medical 1 at 3:25 PM revealed a and on 09/16/2021 regarding arning Body including setting to be implemented in the ating information to other ruing Body. During the	{F €	56}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	STRUCTION		(X3) DATE COMF	SURVEY
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	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		200 NU	TADDRESS, CITY, STATE, ZIP CODE IRSING HOME LANE /ILLE, KY 41501		1 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
{F 656}	QAPI attendance she conducted meetings of and 09/30/2021. Interior of Operations on 09/3 Regional Nurse Consider PM revealed they we governing body, and forwarded to them. 33). Interview with the Operations on 09/30/2 Regional Nurse Consider PM revealed the gove Administrator with resident for QAPI. Furgoverning body would upcoming year. Interview administrator on 09/3 he had been provided education regarding 034). Interview with the 09/30/2021 at 3:40 PM were conducted week ensure the quality of complied with the star compliance. Further in President of Operation PM, Regional Nurse 03:40 PM, MDS Nurse PM, MDS Nurse #2 on Regional Certified Die 09/28/2021 at 2:26 PM PM, Former Activities #3 on 09/30/2021 at 1 on 09/29/2021 at 8:34 Director (HR) on 09/36	a for compliance. A review of sets revealed the facility on 09/16/2021, 09/23/2021, view with the Vice President 80/2021 at 4:10 PM and ultant on 09/30/2021 at 3:40 re members of the QAPI meetings had been at 2021 at 4:10 PM and the ultant on 09/30/2021 at 3:40 reming body provided the cources and education of their interviews revealed the firm interviews revealed the firm with the Interim 0/2021 at 3:40 PM revealed with resources and education of the resources and education of their interviews revealed the firm of the revealed QAPI meetings also effective 09/16/2021 to care is monitored and of care and of care and of the revealed QAPI meetings are is monitored and of care and of the revealed QAPI meetings and of the revealed of the revealed QAPI meetings and revealed the revealed the revealed the r	{F 6	56}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE 21KEVILLE, KY 41501	U3/	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 656}	PM, Respiratory Ther at 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 PI meeting had been correview of the facility of sheet reflected the abidentified concerns. 35). Interview with RN AM and 09/30/2021 at 12:409/29/2021 at 3:00 PI PM, LPN #10 on 09/30/00 no 09/30/2021 at 12:409/29/2021 at 3:40 PI 09/29/2021 at 3:40 PI 09/29/2021 at 3:23 PI at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PI education on 09/17/20 staff revealed they we weighing residents, or reporting the weights (RD). Interview with Fat 4:17 PM revealed s	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 QAPI meeting attendance sove interviews with no over interviews with no with the sician #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound (2021 at 2:54 PM, LPN #6 (44 PM, LPN #7 on W and 09/30/2021 at 1:54 (30/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on M, SRNA #23 on M revealed they received 021. Interview with nursing rbalized understanding of obtaining, documenting, and to the Registered Dietician Regional DON on 09/30/2021 staff was provided with 021 on proper weighing, documenting, and	{F 6	556}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		185256	B. WING				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			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 656)	current Dietary Manae PM revealed she rece 09/13/2021 by the Re Manager (CDM) on ditimely nutritional assert order accuracy. When the electronic medical the order sends writted dietary staff, which industry staff, which	rmer Activities Director and ger on 09/30/2021 at 1:30 eived education on gional Certified Dietary iet order accuracy and essments to ensure diet in staff enter diet orders into I record, the nurse entering in communication to the cludes diet and texture. She she entered the order into oreflect the resident's diet at all diet orders from the erviewed in the clinical that the Regional CDM on M and 09/30/2021 at 1:52 inpleted education with ctor/Dietary Manager #3. In that she had been on site to distance during the transition M and 09/30/2021 at 11:55 the 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 the PM, LPN #7 on M and 09/30/2021 at 1:54 PM, LPN #7 on M and 09/30/2021 at 1:54 PM, SRNA #1 on M, SRNA #7 on 09/29/2021 et 1:00 PM, O21 at 3:04 PM, SRNA #22 PM and SRNA #23 on M, revealed they received	{F 6	556}			

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		HABILITATION CENTER		STREET ADDRESS, CITY, STA' 200 NURSING HOME LANE PIKEVILLE, KY 41501	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFII TAG	((EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION FIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
turr on revi The revi beg turr trar 38) AM Cai on 0 09// PM #11 09// 09// at 3 SRi on 0 09// edu turr nuti and and RP or e and cha Cor Reg revi pre- ade dev hea	o9/29/2021 at 10:2 realed no identified erapy Manager on realed she provided ginning on 08/19/20 ning/repositioning, nsferring a resident on 09/30/2021 at 12:4 (29/2021 at 3:00 PM, LPN #10 on 09/30/2021 at 12:4 (29/2021 at 3:23 PM, SRNA #1:4 NA #21 on 09/29/2021 at 3:17 (29/2021 at 4:10 PM, LPN #10 on 09/29/2021 at 3:17 (29/2021 at 3:17 (29/2021 at 3:17 (29/2021 at 4:10 PM, at 21 on 09/29/2021 at 3:17 (29/2021 at 4:10 PM, at 21 on 09/29/2021 at 3:17 (29/2021 at 4:10 PM, at 21 on 09/29/2021 at 3:17 (29/2021 at 4:10 PM, at 21 on 09/29/2021 at 3:17 (29/2021 at 4:10 PM, at 21 on 09/29/2021 at 4:10 PM, at 21 on 09/29/2021 at 3:17 (29/2021 at 4:10 PM, at 21 on 09/29/2021 at 4:10 PM, at 21 on 09/29/29/2021 at 4:10 PM, at 21 on 09/29/2021 at 4:10 PM, at 21 on 09/29/2021 at 4:10 PM, at 21 on 09/29/2021 at 3:17 (29/2021 at 4:10 PM, at 21 on 09/29/2021 at 3:17 (29/2021 at 4:10 PM, at 21 on 09/29/2021 at 3:17 (29/2021 at 3:17 (29/	and wound care with RN #11 21 AM for Resident #65 concerns. Interview with the 09/30/2021 at 1:18 PM distaff with education 021 regarding range of motion, and diffrom bed. I #1 on 09/29/2021 at 11:55 tt 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 t4 PM, LPN #7 on di and 09/30/2021 at 1:54 80/2021 at 12:50 PM, LPN 10:31 AM, SRNA#1 on diffrom SRNA#22 diffrom Yellow PM, SRNA#22 diffrom Yellow PM, SRNA#22 diffrom Yellow PM, SRNA#23 diffrom Yellow PM, SRNA#24 diffrom Yellow PM, SRNA#4 diffrom Yell	{F 6	56}			

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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		0012021
(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 CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 656}	impairment, the nurse Registered Dietitian for MD, and resident's resident in the nurse Registered Director (HR) on 09/3 Marketing Liaison on Medical Records on Ocentral Supply on 09/43 on 09/29/2021 at 2:10 Pl Director/Dietary Manas 1:30 PM revealed the timely call light responsith RN #1 on 09/29/20/209/30/2021 at 12:58 PN Murse on 09/30/2021 at 12:58 PN Murse on	With any change to skin will call or email the or new recommendations, presentative. OS Nurse #1 on 09/30/2021 at 1:31 sistant #1 on 09/30/2021 at mager on 09/30/2021 at 10:55 AM, 19/29/2021 at 10:55 AM, 19/29/2021 at 2:40 PM, Cook 1:12 PM, Dietary Aide #3 on M, Former Activities ager #3 on 09/30/2021 at y received education on mase. In addition, interviews 1:2021 at 11:55 AM and 1:54 PM, LPN #6 on PM, RN #4/Wound Care at 2:54 PM, LPN #6 on PM, LPN #7 on 09/29/2021 1:54 PM, LPN #10 in PM, SRNA #1 on 09/29/2021 1:10 on 09/29/2021 at 3:23 PM in 121 at 3:29 PM, SRNA #19	{F 6	56}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	1 09/	30/2021
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	09/30/2021 at 1:30 Pl education on meal set 40). Interview with MI at 1:39 PM, MDS Nur PM, RN #1 on 09/29//09/30/2021 at 12:58 PN Nurse on 09/30/2021 at 12:44 Pat 3:00 PM and 09/30 on 09/30/2021 at 10:31 /education on ensuring entered into the electrobservation of RN #1 revealed the nurse with knowledge of the education on ensuring entered into the electrobservation of RN #1 revealed the nurse with knowledge of the education on ensuring entered into the electrobservation of RN #1 revealed the nurse with RN AM and 09/30/2021 at 12:409/29/2021 at 3:00 Pl	ctor/Dietary Manager #3 on M revealed they received rivice times. DS Nurse #1 on 09/30/2021 at 1:31 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 1/2021 at 1:54 PM, LPN #10 60 PM, LPN #11 on AM revealed they received g new care plans were ronic medical record. on 09/29/2021 at 11:55 AM as able to demonstrate cation with no identified N #1 on 09/29/2021 at 11:55 it 12:58 PM, RN #4/Wound 1/2021 at 2:54 PM, LPN #6	{F 6	556}			
	#11 on 09/30/2021 at 09/29/2021 at 3:40 Pl 09/29/2021 at 3:23 Pl at 3:29 PM, SRNA #1 SRNA #21 on 09/29/20 on 09/29/2021 at 3:17 09/29/2021 at 4:10 Pl education on identific residents with a changon identifying signs/sy hyperglycemia/hypog protocol, documenting	10:31 AM, SRNA#1 on M, SRNA#11 on M, SRNA#11 on M SRNA#7 on 09/29/2021 9 on 09/29/2021 at 4:10 PM, 2021 at 3:04 PM, SRNA#22 7 PM and SRNA#23 on M revealed they received ation and assessment of ge in respiratory status and ymptoms of lycemia, facility diabetic					

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			1	R
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		200 NURSIN	DRESS, CITY, STATE, ZIP CODE IG HOME LANE E, 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	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 656)	following physician or revealed they receive documentation of glud 42). Interview with RN	cation of the physician and ders. In addition, interviews deducation on	{F €	56}			
	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 #1! SRNA #21 on 09/29/2 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PN education on completi with interventions and	2021 at 2:54 PM, LPN #6 4 PM, LPN #7 on M and 09/30/2021 at 1:54 0/2021 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 FPM and SRNA #23 on M, revealed they received ing a baseline Care Plan goals relevant to the and a respiratory diagnosis					
	reviewing and providir resident/responsible p 44). Interview with ME at 1:39 PM, MDS Nurs PM, Maintenance Ass 2:56 PM, Therapy Maintenance Ass 2:56 PM, Central Supply on 09/30/2021 at 1:55 PM, RN #4/Wot 09/30/2021 at 2:54 PM	ng a copy to the party. 25 Nurse #1 on 09/30/2021 25 #2 on 09/30/2021 at 1:31 25 istant #1 on 09/30/2021 at 1:31 25 istant #1 on 09/30/2021 at 10:45 at 10:					

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 IKEVILLE, 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	at 12:50 PM, LPN #11 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 09/29/2021 at 3:29 Pl 09/29/2021 at 4:10 Pl at 3:04 PM, SRNA #2 and SRNA #23 on 09/30/2021 at 1:09/30/2021 at 2:10 Pl 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 12:409/29/2021 at 3:00 Pl PM, LPN #10 on 09/30/00 09/30/2021 at 12:409/29/2021 at 3:00 Pl PM, LPN #10 on 09/30/2021 they received educati techniques, obtaining reporting of weight ch Dietician. In addition, Manager on 09/30/20 had received education and provision of timel ensure diet order accurate put into the electronurse entering the order strom the previous from the previous from the previous condensure from the previous conden	M, LPN #10 on 09/30/2021 I on 09/30/2021 at 10:31 29/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 Aide on M, SRNA #21 on 09/29/2021 2 on 09/29/2021 at 3:17 PM //29/2021 at 4:10 PM, Cook I:12 PM, Dietary Aide #3 on M, Former Activities ager #3 on 09/30/2021 at y were educated on the h, preventing, and reporting tifying and implementing ns for wandering residents. I #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 I4 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 h, documenting, and langes to the Registered an interview with the Dietary 21 at 1:30 PM revealed she on on diet order accuracy y nutritional assessment to uracy. When the diet orders onic medical record, the diet will send a written dietary staff that will include further revealed all diet ous day are reviewed in the h occurs Monday through	{F €	556}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		IDENTIFICATION AN MADED		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021		
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u></u> <u>037</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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
(F 656)	education on facility primes and the use of refortified diets to ensur nutritional needs of reestablished national groultural, and ethnic needs of reestablished national grounds on obtaining tray card system, order snack/hydration pass, and/or portion sizes, so carts and snacks and with the needs of the nee	e Dietary Manager on M revealed she received policy regarding meal service recipes, including recipes for reall meals meet the esidents in accordance with pudelines to reflect religious, reds of the population. Dietary Manager on M revealed she received g food preference, facility replacement for meals, appropriate scoop sizes stocking snack/hydration hydrations. H #1 on 09/29/2021 at 11:55 tt 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 the PM, LPN #7 on M and 09/30/2021 at 1:54 0/2021 at 12:50 PM, LPN 10:31 AM and Former tary Manager #3 on M revealed they received ress 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 #2 on M, Maintenance Assistant #1 or PM, Therapy Manager on	{F €	356}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		185256	B. WING_				R 30/2021
	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. 001	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI. TAG		TON SHOULD B		(XS) COMPLETION DATE
{F 656}	10:55 AM, Medical Re 8:34 AM, Central Sup PM, RN #1 on 09/29/09/30/2021 at 12:58 F Nurse on 09/30/2021 at 12:44 F at 3:00 PM and 09/30 on 09/30/2021 at 10:31 / at 3:40 PM, SRNA #7 SRNA #7 on 09/29/20 on 09/29/2021 at 3:04 Pf at 3:17 PM and SRN/PM, Cook #3 on 09/29/2021 at 3:04 Pf at 3:17 PM and SRN/PM, Cook #3 on 09/29/2021 at 1:30 Pf received education or policy/guidelines, han Personal Protective E red zones. Observationand yellow zone on 09/29/2021 revealed in the red or yell conducted on 09/28/209/30/2021 revealed in the red or yell conducted on 09/28/209/30/2021 revealed in the COVID-19 policy/guidelines with RN AM, and 09/30/2021 at 3:04 PK), or the yellow/risponsional/solutiona	Liaison on 09/30/2021 at ecords on 09/29/2021 at eply on 09/29/2021 at eply on 09/29/2021 at eply 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 (2021 at 1:54 PM, LPN #10 60 PM, LPN #11 on AM, SRNA #1 on 09/29/2021 at 3:23 PM (21 at 3:29 PM, SRNA #19 DPM, SRNA #21 on AM, SRNA #22 on 09/29/2021 at 4:10 PM, SRNA #22 on 09/29/2021 at 2:10 PM, Former tary Manager #3 on AM revealed they had at the COVID-19 dwashing, donning/doffing equipment (PPE), yellow and con of the red facility zone 9/28/2021 at 2:12 PM concerns. No residents ow zones. Observations (021, 09/29/2021, and no identified concerns with guidelines, handwashing, anal Protective Equipment	{F 6	556}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		9/30/2021	
(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 COR ((EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 656}	they had received edic symptom monitoring admissions. A review #355 on 09/10/2021 r COVID-19 symptom resident orders. Resident orders. Resident orders. Resident #355 reveal COVID-19 symptom resident orders. In ad #329, #328, #311, #6 records revealed each monitoring orders important orders. In ad #329, #328, #311, #6 records revealed each monitoring orders important orders. In ad #329, #328, #311, #6 records revealed each monitoring orders important orders on 09/30/2021 at 31.54 PM, LPN #10 on LPN #11 on 09/30/2021 at 31.54 PM, LPN #10 on LPN #11 on 09/30/2021 they had received edic of medication, right patic and right route. In ad on the process to follow the process to fo	production 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 resident had COVID-19 elemented. If #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN (LPN) 2:00 PM and 09/30/2021 at 09/30/2021 at 10:31 AM revealed ucation on the five (5) rights extration including right ent, right dose, right time, dition, they were educated ow when a medication was nistration, which included to obtain the medication, ted medication delivery time, if an ordered medication also	{F 6:	56}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 200 NURSING HOME LANE PIKEVILLE, KY 41501	IP CODE	09/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B		ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE	
{F 656}	Care Nurse on 09/30/2 (LPN) #6 on 09/30/2 #7 on 09/29/2021 at 1:54 PM, LPN #10 of LPN #11 on 09/30/2 they had received edemergency medication floor three (3) on 09/29/2021 at medication administ with an emergency to LPN (LPN) #9 on 09 she was a new hire received education administ with an emergency to LPN (LPN) #9 on 09 she was a new hire received education administ with an emergency to LPN (LPN) #9 on 09 she was a new hire received education administ with an emergency to LPN (LPN) #9 on 09 she was a new hire received education at medication kit. 53). Interview with DPM, MDS Nurse #1 MDS Nurse #2 on 09 Maintenance Assista PM, Therapy Manag Housekeeping Supe PM, Human Resourt 09/30/2021 at 10:48 Liaison on 09/30/2021 at 10:48 Liaison on 09/29/2020 09/29/2021 at 1:55 PM, RN #4/Wound (2:54 PM, LPN (LPN) #7 of 09/30/2021 at 1:54 PM, LPN #4 AM, SRNA #1 on 09 #11 on 09/29/2021 at 3:29 PM, LPN #4 AM, SRNA #1 on 09 #11 on 09/29/2021 at 3:2	at 12:58 PM, RN #4/Wound 0/2021 at 2:54 PM, LPN (021 at 12:44 PM, LPN (121 at 12:44 PM, LPN (122) at 12:44 PM, LPN (122) at 12:50 PM, 122 at 12:50 PM, 122 at 12:50 PM, 123 AM revealed ducation on the use of the on kit (e-kit). Observation of (129/2021 at 3:10 PM, floor 121 at 2:57 PM, and floor five 12:50 PM revealed each ration room was equipped medication kit. Interview with (1/30/2021 at 2:27 PM revealed to the facility and had regarding the emergency (1/20) at 1:39 PM, 12/2021 at 1:31 PM, 12/2021 at 1:32 PM, 12/2021 at 1:34 PM, 12/2021 at 1:24	{F 6	56}			

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NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	9/30/2021
(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 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 656) Continued From page 360 SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they were educated on the Interim Administrator's contact information and role as Abuse Coordinator, Observation of the facility on 09/28/2021, 09/29/2021, and 09/30/2021 revealed signage posted with the Interim Administrator's contact information and title of Abuse Coordinator posted throughout the facility. 54). Review of audits beginning 09/17/2021 of weekly head-to-loe skin assessments revealed no identified concerns. Observation of Resident #27 skin and wound assessment on 09/30/2021 at 10:20 AM revealed no identified concerns. A review of the medical record for Resident #65, #324, #45, #14, #357, #27, #74, and #358 revealed the weekly wound assessments completed with physician and responsible party notifications. Interview with the Distician on 09/30/2021 at 3:35 PM revealed she was notified of new and/or worsening pressure ulcers and reviewed the residents as indicated. Interview with Medical Director on 09/30/2021 at 3:25 PM revealed that he was notified of new and/or worsening skin impairments and new interventions to prevent decline. He further revealed that he participated in OAPI meetings and discussed ongoing audits and care of residents. Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the QAPI team discussed ongoing audits and care of residents. Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the QAPI team discussed all audits in QAPI meetings, including new and/or worsening pressure injuries and interventions implemented. 55). Interview with Central Supply on 09/29/2021 at 2:40 PM revealed she completed the audits of all laboratory supplies on 08/28/2021. She further revealed that the audits were conducted weekly	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	051	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 656}	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 Pt 09/30/2021 at 3:20 Pt were audited during mensure all new areas been care planned withe area of concerns. Ano identified concerns 57). Interview with the on 09/30/2021 at 10:5 completed visual rour hygiene, toileting, incompleted visual rour hygiene, toileting, in additional revenues and turned to the complete of the position of the part monitoring, and monit times including the let unanswered. Interview activated more than fladdressed with the st	d then monthly for three (3) audits revealed no concerns. In the concerns with the audits revealed no expected the audits revealed progress notes from the audits revealed the interventions to address a review of audits revealed as. See Senior Marketing Liaison and the audit of residents assessing continence, and resident for to other leadership staff. It is alled staff were auditing dor, incontinent clean and sted or every two (2) hours, and, sheets and blankets reach, facial hair shaved if and repositioned. Evice 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 we revealed any call	{F 6	56}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE	(X3) DATE SURVEY COMPLETED		
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 656}	4:17 PM revealed sharespiratory assessme communication Mond clinical meeting. She 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 indirevealed no identified 60). Review of Reside admitted on 09/10/202 had a baseline care p 09/10/2021. Resident 09/25/2021 and re-ad 09/28/2021. Further of resident #355 reversident had a baseline care p (11) days after admission for Resident had a baseline 09/28/2021. Interview 09/30/2021 at 1:39 Pt 09/30/2021 at 1:31 Pt admissions and re-ad being reviewed during meeting Monday through the state of the add days from 07/16/2021.	e RDON on 09/30/2021 at a completed audits of ints and SBAR ay through Friday in the further revealed that she nat any acute change in lor SBAR assessments can notification and/or visician orders. Review of completed on 09/26/2021, don 09/27/2021, and #326 0021 revealed assessment, interventions, and care cated. A review of audits concerns. ent #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 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 missions to the facility were in the morning clinical uph Friday to ensure	{F 6	56}			
	concerns with baselin MDS Nurse #1 on 09/	e care plans. Interview with 30/2021 at 1:39 PM					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE TIKEVILLE, 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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	being updated as need 62). Interview with Mi at 1:39 PM revealed in plans were being and completion, accuracy was conducted with it responsible party with admission/re-admiss	ion baseline care plans were ided 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 in 48 hours of in Further interviews ere conducted Monday ew of the audits completed diresident name, admission an completion, care plan and/or responsible party, ided. A review of the audits concern with completion dits completed by the DM they were completed as ed concerns. Interview with I Dietary Manager on in and 09/30/2021 at 1:52 ager #3 on 09/30	{F €	556}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING				₹ 30/2021
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER			DO NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETION DATE
{F 656}	Consultant on 09/30// Regional DON on 09/ #2 on 09/30/2021 at 3:30 performed verbal quizassessment of reside respiratory status, ide hyperglycemia/hypog protocol, documenting condition, notification following physician or on 09/29/2021 at 11:58 PM, RN #4/Vo 09/30/2021 at 2:54 Pf 09/30/2021 at 12:54 Pf 09/30/2021 at 12:44 participated in verbal 65). Interview with the 09/30/2021 at 4:17 Pf audits of documented Monday through Frida She further revealed less than 60 and/or g staff were expected to Responsible Party, at follow physician order stated she identified to 08/12/2021 to have a and one (1) on 09/20/ glucose level of 465 v evidence the licensed process, She provide and LPN #5. A Reviet further concerns. A R RN #2 and LPN #5 rethe facility process.	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 zes 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 iders. Interviews with RN #1 is 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 in revealed she completed I 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 irs. The Regional DON one (1) resident on blood glucose level of 430 i/2021 to have a blood	{F €	656}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND MADED		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING_		0.0	R 9/30/2021	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		70012021	
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	when to report, signs and wandering interversel quizzes reveale quizzed daily for one 08/19/2021 with no id review 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) to 09/03/2021 to 09/24/2 concerns. Interview we Consultant on 09/30/2021 at 1:39 Ph the completion of verbinterview revealed that Care Plan Timing and CFR(s): 483.21(b)(2)(s) \$483.21(b)(2) A completion of the comprehensive as (ii) Prepared by an intincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practine resident and the r	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 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 1021 with no identified ith the Regional Nurse 1021 at 3:40 PM, RDON on 104 And MDS Nurse #1 on 105 And MDS Nurse #1 on 105 And MDS Nurse #1 on 105 And Staff quizzes. Further at each s Revision Revision i)-(iii) ensive Care Plans brehensive care plan must adays after completion of the sessment. Endisciplinary team, that afted to-sician.	{F 6			12/30/21	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE 5 COMPL	
		185256	B. WING_		R	0/2021
	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>	012021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 657)	and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determi or as requested by the (iii)Reviewed and revi	participation of the resident resentative is determined development of the staff or professionals in ned by the resident's needs a resident. sed by the interdisciplinary asment, including both the	{F 65	57}		
	by: Based on interview, r the facility policies, it v failed to revise the car fifty-seven (57) sampl #65); and failed to ens (57) sampled resident #27, and Resident #1' representative was inv resident's care plan as his/her care. Resident #65 develop The facility failed to re	is not met as evidenced ecord review, and review of was determined the facility re plan for one (1) of ed residents (Resident sure three (3) of fifty-seven s (Resident #57, Resident 7) and/or the resident's volved in developing the nd making decisions about ed five (5) pressure ulcers. vise the resident's care plan of each pressure ulcer to		F 657 Care Plan Timing and Revision Criteria 1 a) Resident #65 was discharged from the facility on 10/31/20 b) The care plan for Residen #57 has been reviewed with the resider by 10/28/2021. c) The care plan for Resident #27 has been reviewed with the resider by 11/17/2021. d) The care plan for Residen #17 has been reviewed with the resider by 10/14/2021.	021 it int	

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 PE	ROVIDER OR SUPPLIER			SI	FREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
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				Р	IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)					(X5) COMPLETION DATE
{F 657}	Continued From page	e 367	{F €	57}		İ	
	address treatment for	the ulcer and interventions					
	to prevent the develop		1	- 1	Criteria 2: a) All current residents with	, I	
		ed a Stage I (one) pressure		- 1	wounds have had review/revision of the		
		n 06/23/2021, a DTI (deep			care plan to determine that it addresse		
		ght heel on 06/26/2021, an		- 1	their current skin/wound status, as	"	
		ulcer to the back of the left,			completed by the MDS		
		21, and two (2) Stage II (2)	1		Coordinator/Designee on 10/27/2121.		
		left hip on 08/26/2021.			b) All residents and their		
		•			representatives are invited to the		
	The findings include:		}		scheduled care plan meetings by mail,		
	-				phone, and letter. They are offered the		
	1. Review of the facil	ity's policy, "Care Plans,			option to attend either in person, or by		
	Comprehensive Person	on-Centered", revised			phone, with their choice documented in	.	
	December 2016 rever	aled assessments of			the resident record.		
	residents were ongoing	ng and care plans were					
		about the residents and			Criteria 3: a) On 11/24/2021 The IDT		
	the residents' condition	ens changed.			Care Plan team received in-service education by the Nurse		
	Review of the facility's	s Prevention of Pressure			Consultant/Designee on: the need to		
	Injuries Policy, revise	d April 2020, revealed the			address all residents care plans to		
	purpose of the policy	was to provide information			include skin status accurately on the ca	are	
	regarding identificatio	n of pressure ulcer risk			plan with the indicated interventions	i	
		ons for specific risk factors.			necessary to promote healing/prevent	1	
		facility should evaluate			breakdown; and the need to invite and		
		potential changes in the			include all residents and their		
		ventions and strategies for	-		representatives in their care plan		
	effectiveness on an o	ngoing basis.			meetings to encourage their participation	on	
					in care plan development. All licensed		
	Review of Resident #				staff including new hires and agency st		
		dmitted the resident on	1		will be educated prior to starting work of		
		noses that included Cerebral	1		care plans. Beginning 11/24/2021 a po		
		, Polyarthritis, Chronic			test was administered and will be grade	ed ∣	
		ry Disease (COPD) and			by the DON/designee to ensure staff		
	Paraplegia.				competency, licensed nursing staff not		
					working will take the test on their next		
		65's Quarterly Minimum			scheduled day .		
		ssment dated 05/05/2021					
		ocumented the resident			Criteria 4: a) Beginning 11/24/2021		
	weighed 135 pounds	and had an unhealed			progress notes will be reviewed weekly	x	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING_				₹ 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	1 637	30/2021
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 657}	resident had a Stage sacrum. The facility of address the pressure and repositioning app hours; weekly treatme measurement of each width, length, depth, the and any other notable encourage good nutriplood work (including any open wounds as and, follow the facility. Review of a change of #65 dated 06/23/2021 resident had acquired ulcer to the left heel the (centimeters) (length) resident's physician of protectors while in beheel daily". However, evidence that the facilicare plan to reflect the and no documented erevised to include the bilateral heel protecto. Review of Resident #1 note dated 06/26/202 resident had acquired (DTI) pressure ulcer to received a new order pressure ulcer; however evise the care plan to revise the care plan to rev	deep tissue injury. 65's care plan dated the facility identified the IV (4) pressure ulcer to the developed interventions to ulcer that included turning roximately every two (2) ent documentation to include a area of skin breakdown; ype of tissue and exudate e changes or observation; tion and hydration; obtain culture and sensitivities) of ordered by the physician; is protocols for treatment. If condition note for Resident at 10:30 AM revealed the la new Stage one pressure that measured 6.5 cm by 4 cm (width). The redered, "Bilateral heel d, apply sure prep to left there was no documented lity revised the resident's enew area to the left heel, evidence the care plan was new Physician's Orders for rs while in bed. 65's change of condition 1 at 10:10 PM revealed the a new deep tissue injury to the right heel. The facility	{F 6	57}	4 weeks then monthly x 2 month by the Director of Nursing, Assistant Director of Nursing or Nursing supervisor to ensurany new areas of skin impairment and/behaviors that are identified have a carplan implemented/ revised that includenew interventions and or treatments. A results will be reviewed monthly in QAF meeting x3 months then quarterly until substantial compliance. B) Beginning 11/24/2021 the DON/Nurse Consultant/Designee will audit the monthly Care plan calendar against residents interdisciplinary care plan meeting assessment to ensure each resident with a care plan meeting has he the meeting and the resident and/or responsible party if applicable, have attended and/or been invited. Audits who weekly x 4 weeks then monthly x 2 months. Audits will be reviewed monthl QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 12/30/2021	of e or e s udit Pl in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRU	(X3) DATE SURVEY COMPLETED		
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			200 NURSIN	RESS, CITY, STATE, ZIP CODE IG HOME LANE , KY 41501	1 031	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{F 657}	revealed on 07/14/20; a new care plan for the ulcer to the sacral are care plan to include in treatments as ordered effectiveness; assess wound perimeter, wou progress; report improfession; monitor as needed to ensure it loose dressings to the (2) staff were required resident at least every as needed or requested was totally dependent facility continued to fawith interventions to a ulcer to Resident #65' Tissue Injury (DTI) to Review of Resident #65' Tissue Injury (DTI) to the MDS revealed the resident had one Stag Stage IV pressure ulce that was unstageable, documented evidence Resident #65's care proposed intervention pressure ulcers.	Resident #65's care plan 21, the facility implemented e Stage IV (4) pressure a. The facility revised the sterventions to administer I and monitor for and document status of and bed and healing evernents and declines to redressings every shift, and antact and adhering; report to treatment nurse; and two I to turn and reposition the red because the resident on staff. However, the fill to revise the care plan ddress the Stage I pressure is left heel and the Deep the right heel. 65's Quarterly MDS (05/2021 revealed the resident had a weight loss, or was at risk. In addition, facility was aware the left (1) pressure ulcer, one er, and one pressure ulcer However, there was no the facility revised lan with interventions to ressure ulcers to the heels vidence the facility	{F 6	57}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	-	CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WNG			1	R 30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, 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 657}	Resident #65 revealed eveloped an unstage back of his/her left, ke obtained a Physician's with Santyl Ointment no documented evide care plan to reflect the ulcer to Resident #65' facility revise the care prevent further pressure. Review of a change of dated 08/26/2021 at 6 revealed the resident pressure ulcer to the liphysician was notified received to treat the a Continued review of the revealed no document revised the care plan developed pressure uplan to prevent new publication with MDS Notice and the resident worsening pressure ut According to MDS Nu have a system/process and/or worsening present. Subsequently, rebeing revised to accuments.	18/12/2021 at 11:52 AM, for d the resident had eable pressure ulcer to the ower leg. The facility is Order to treat the ulcer daily. However, there was ince the facility revised the enew unstageable pressure is lower left leg, nor did the enew unstageable pressure is lower left leg, nor did the enew unstageable pressure is lower left leg, nor did the enew unstageable pressure is lower left leg, nor did the enew uncers. If condition assessment is 39 PM for Resident #65 developed a Stage II (2) left hip. The resident's and new orders were urea with sure prep. The resident's care plan atted evidence the facility to reflect the newly licer nor revised the care ressure ulcers. If condition assessment is and new orders were uncereated the care from the resident's care plan atted evidence the facility to reflect the newly licer nor revised the care ressure ulcers. If condition assessment is and the resident's care plan and the resident's care plan atted evidence the facility to reflect the newly licer nor revised the care ressure ulcers.	{F 6	(557)			

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 N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE		30/20/21
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	, , , , , , , , , , , , , , , , , , , ,	TION SHOULD B	_	(X5) COMPLETION DATE
{F 657}	pressure ulcers. MDS facility did not have a communicate this info stated if she was not a loss and/or pressure in the care plan. Interview with the Adr 5:02 PM revealed the reviewed comprehensensure they were accustated she began revious June 2021 and identify updated appropriately 2a). Review of the far Plans, Comprehensive revised in December 1 resident's comprehensive revised in December 1 resident's comprehensive revised in December 1 resident's comprehensive revised in the developmentation of his including the right to: process." Record review reveals Resident #57 on 04/2 completed a Minimum Assessment dated 04 facility assessed their Interview for Mental Sindicating no cognitive review of the resident documented evidence resident to the care plant interview on 06/16/20	dated to reflect the resident's Solverse #2 also stated the process/procedure to simulation to MDS staff. She aware a resident had weight alcers she could not revise ministrator on 09/03/2021 at Interdisciplinary Team (IDT) sive care plans weekly to urate and up-to-date. She ewing care plans in midied that care plans were not of the plans of care, participate in the planning plant in the planning of the facility admitted 3/2021. The facility in Data Set (MDS) Admission of 29/2021 in which the esident to have a Brief status (BIMS) sore of 15 a impairment. Further is record revealed no the facility invited the an meeting.	{F €	557}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B, WNG				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE			STREE	ET ADDRESS, CITY, STATE, ZIP CODE URSING HOME LANE VILLE, KY 41501	1 09)/30/20 <u>21</u>
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 657}	meetings at another far. However, the facility he/she had not attend since admission to the 2b). Record review received the facility as a BIMS score of 15, in impairment. Further record revealed no do facility invited Resider for this assessment. Interview on 06/16/202 Resident #27 revealed remember anyone talk plan of care 2c). Record review revealed an Admission 03/21/2021, and the fato have a BIMS score cognitive impairment, resident's record revealed remember in the progresidence in the progresident #17 revealed a care plan meeting was a care pla	acility where he/she lived. and not invited him/her and led a care plan meeting a facility. I vealed the facility admitted 0/2015. Review of a sment dated 03/30/2021, assessed the resident to have adicating no cognitive eview of the resident's cumented evidence the at #27 the care plan meeting 21 at 9:27 AM, with at the resident could not king to him/her about their I vealed the facility admitted acility assessment dated acility assessed the resident of 15, indicating no Further review of the aled no documented ass notes of the resident plan meeting. 21 at 9:55 AM, with I he/she was not sure what as and when explained, the staff had not discussed	{F 6	57}			
	Interview with the MDS 06/18/2021 at 3:50 PM not had care plan mee	I, revealed the facility had					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE	SURVEY PLETED
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	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 PREF TAG	IX (EACH CORRECTIVE ACTIO	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
(F 657) (F 684) SS=D	December 2020, the a BIMS of eight (8) or they would like to hav the care plan meeting did not wish to attend them, staff was require conversation in the relative with the Adri 1:30 PM, revealed she facility for two (2) wee whether the facility was meetings. The Admin problem with not havin would be missed or un Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fun applies to all treatment facility residents. Base assessment of a residents receive accordance with professions.	9. She stated prior to facility invited residents with above, or asked them if e a family member attend it. She stated if the resident or had someone attend for ed to document the sident's medical record. Ininistrator, on 06/19/2021 at e had only been at the eks and was not aware as having care plan instrator stated a potential ring care plan meetings indentified problems. In the facility must ensure treatment and care in essional standards of ensive person-centered		684}			12/30/21

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY
		185256	B IMNIC			1	R
NAME OF D	ROVIDER OR SUPPLIER	105256	B. WNG			09/	30/2021
	W POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE O NURSING HOME LANE KEVILLE, 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 TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
{F 684}	Continued From page	374	{F 6	84}			
	by: Based on interview, recommendate the facility's policies, if ailed to ensure two (2 sampled residents (Ref. #323) received treatments with professional stan	esident #321 and Resident ent and care in accordance dards of practice.			F 684 Quality of Care Criteria 1: a) Resident #321 was discharged from this facility on 7-19-202 b) Resident #323 was discharged from this facility on 7-20-202		
	staff obtained Resider level, which was 67 m deciliter) (normal rang Although the nurse he injection, she adminishypoglycemic medical after breakfast she reblood glucose level, whowever, there was not continued to monitor the resident's blood glucose level of staff revealed they adhoth, injectable and or regained consciousned documentation made in record regarding the rehypoglycemia, including unresponsive. In addit the staff continued to a re-check the resident's	the 70 mg/dL to 110 mg/dL). In the resident's insuling the resident's insuling the resident and oral tion. The nurse stated that the checked the resident's which was then 139 mg/dL. The resident or re-check the selevel, until sometime of the resident or re-check the selevel, until sometime of the resident or re-check the selevel, until sometime of the resident or selevel, until sometime of the resident with a selevel, until sometime after 3:00 PM, and the resident with the resident was no in the resident's medical the resident's medical the resident of the resident or selevel, until			Criteria 2: a) All residents with diagnosis including COPD, Asthma, current pneumonia was assessed by licensed nurse and or respiratory therapist, no concerns were identified. Completed 8-12-2021. On 8-14-2021 a visual audit was conducted to assess all residents with diagnosis of diabetes for s/s of hypo/hyperglycemia. No concerns were observed. b) All residents with orders including glucose monitoring were reviewed by Regional Nurse and orders amended to include mandatory entry of glucose value on the MAR versus a che for completion by 7-30-21. Criteria 3: a) The Respiratory Therapis and/or designee educated Licensed nurses on identification and assessment of residents with a change in condition to include in respiratory status beginning 8-12-2021. Beginning 11/24/2021 DON/Designee will assess staff knowledge with verbal quizzing on	ck	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE	SURVEY
				_		١,	R
		185256	B, WING				30/2021
NAME OF P	ROVIDER OR SUPPLIER	-		s	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2021
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		2	00 NURSING HOME LANE		
		- INDIE INTOR CERTEIN		P	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 684}	Continued From page 375 clammy. Interviews and record review revealed the resident's blood glucose was 32 mg/dL. Staff again administered the resident injectable glucagon and oral glucose. Resident #321 remained unresponsive and developed difficulty breathing. The facility transferred Resident #321 to the hospital, where he/she was diagnosed with		{F 6	84}	identification and assessment of reside with a change in respiratory status,	nts	
					identifying signs/symptoms of		
					hyperglycemia/hypoglycemia, facility		
					diabetic protocol, documenting resident	t	
					change in condition, notification of		
	acute metabolic encer	phalopathy and hypoxia			physician and following physician order	s.	
	secondary to prolonge	ed hypoglycemia. Resident			Staff will be quizzed randomly across a	[
	#321 was admitted to	the Intensive Care Unit			shifts; 5 staff will be quizzed weekly x4 then monthly x 2.		
	(ICU).				b) The DON/Designee		į
					educated all licensed nurses on identify	ina	
	In addition, the facility	admitted Resident #323 on			signs/symptoms of	_	
	07/06/2021 after being	g on a ventilator at the			hyperglycemia/hypoglycemia, facility		- 1
	hospital. At approxim	ately 7:30 AM on			diabetic protocol, documenting resident	:	- 1
	0//20/2021, a nurse a	ide entered the resident's			change in condition, documentation of		
	clammy and baying d	the resident was sweaty, lifficulty breathing. Although			blood sugar in the medical record,		
		revealed she administered			notification of physician and following		- 1
		eathing treatments, there			physician orders beginning 8-12-2021.		i
	was no evidence staff	re-assessed the resident			Criteria 4:		
	until the resident's fam	nily came to visit and			c) On 9/19/2021 The DON/designee completed an SBAR		
	insisted the facility trai	nsfer the resident to the			communication Form audit to assess fo	_	
	hospital. Upon Reside	nt #323's arrival to the			documented blood sugar results outside		
	hospital, the resident r	equired high flow oxygen,			of normal range. Beginning on 11/24/20		- 1
	and was diagnosed with	ith acute hypoxic respiratory			SBAR Audits will be completed weekly	× 4	
	insufficiency, and left I	lower lobe pneumonia			weeks then monthly x 2 months or until	`	
	versus atelectasis (lun	ig collapse).			substantial compliance. Beginning		ľ
				ŀ	11/24/2021 all new staff will be educate	d	
		ensure residents received			on Change in condition and diabetic		i
	treatment and care in			-	protocol. Random visual audits of		
	professional standards	s of practice, has caused or		i	residents noted to have change in		
	or death to a resident	us injury, harm, impairment			condition per SBAR □s will be conducted	d	
	identified on 09/11/20	Immediate Jeopardy was 21, and was determined to			weekly x 4 weeks then monthly x 2		
		t 42 CFR 483.10 Resident			months to monitor accuracy of SBAR		
	Rights (F580) 42 CEE	R 483.12 Freedom from			documentation.		
	Ahuse (F600), 42 CFF	R 483.12 Comprehensive			d) Beginning	ŀ	
		Plans (F655) (F656), 42			11/24/2021 The DON or designee will monitor respiratory assessment and		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
							R
		185256	B. WNG_			09/	30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	: TE	(X5) COMPLETION DATE
{F 684}	(F755) and 42 CFR 44 (F880). The facility wa Jeopardy on 08/11/20 An acceptable Allegat was received on 09/02 removal of the Immed 09/02/2021. However verified based on obs and review of facility of Immediate Jeopardy va 483.35 Nursing Servic Administration (F835) Quality Assurance and Improvement (F867). The Immediate Jeopardy in A second acceptable in was received on 09/29 removal of the Immed 09/26/2021. The State determined the Immed 09/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compil Care Plans (F655) (F6 Quality of Care (F684) Nursing Services (F72 Pharmacy Services (F72 Pharmacy Services (F72 Pharmacy Services (F72 Pharmacy Services (F73 P13/12 Freedom from 483.25 Quality of Care	of Care (F684) (F686) IS Pharmacy Services IS 3.80 Infection Control as notified of Immediate IS 1. Ion of Compliance (AOC) Is 3/2021, which alleged Is 42 CFR Is 483.70 Is 42 CFR 483.75 Is 42 CFR 483.75 Is 42 CFR 483.75 Is 64 Performance In facility was notified of Is 64 on 09/10/2021. The Is ongoing. Is allegation of compliance Is allegation of compl	{F 6	84}	SBAR communications for acute chang in respiratory status and will be reviewed for MD notification and implementation any physician order. Care plan will be reviewed and updated as needed. Audi will be weekly until substantial compliance. Audits will be reviewed monthly in QAPI x3 months then quarte until in substantial compliance e) Beginning 12/18/2021 the DON/ADON or designe will conduct visual audits on 2 random residents a week to ensure that the plan of care is being implemented as written Audits will be weekly x 4 then monthly month or until substantial compliance is achieved. Audits will be reviewed month in QAPI x3 months then quarterly until i substantial compliance. Criteria 5: Date of compliance: 12/30/2021	ed of ts en 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		185256	B. WING				R /30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 200 NURSING HOME LANE PIKEVILLE, KY 41501	PCODE	<u>) 03</u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD B O THE APPROPRI		COMPLETION DATE
{F 684}	and quality assurance Findings include: Review of the facility's Condition Changes-C March 2018, revealed in condition, the nursi pertinent details to rep as the history of prese recent test results for revealed the nurse wo report baseline inform neurological status, or consciousness, cognit onset, duration and se labs, history of psychi- illness or depression, current medications. Review of the facility's of Hypoglycemia", dat revealed the facility ha protocol that classified Level 1 hypoglycemia below 70 mg/dL, but a hypoglycemia- was a 54 mg/dL, and a Leve altered mental and/or assistance for treatme review of the protocol Level 3 hypoglycemia should call 911, admir provider immediately, place resident in a cor monitor vital signs.	e activities. s policy titled, "Acute linical Protocol", dated linical Protocol", dated linical Protocol dated linical date li	{F 6	84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		SURVEY PLETED
		185256	B. WNG	_		1	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	1 03/	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 & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ΙE	(X5) COMPLETION DATE
{F 684}	O7/16/2021, with diag Diabetes Mellitus, and Review of Resident # (MDS) assessment do the facility assessed to Interview for Mental Sthirteen (13) indicating cognitively intact. Review of Resident # dated 07/16/2021, revinclude the resident's Mellitus. Review of Physician's revealed an order for #321 for signs and syr (low blood sugar) and sugar) every shift. Review of Nursing No 3:20 PM, and interview Nurse (LPN) #6 on 07 revealed at approxima 07/18/2021, LPN #6 or reading for Resident # (milligrams per decilite staff delivered the resitime unknown) and LF glucose level after bre documented as 139 m no further documental indicate LPN #6 continuidicate LPN #6 continuidic	dmitted the resident on noses of Urosepsis, of Invasive Bladder Cancer. 321's Minimum Data Set ated 07/19/2021, revealed the resident to have a Brief status (BIMS) score of gother resident was 321's Baseline Care Plan realed the care plan did not diagnosis of Diabetes Orders dated 07/16/2021, staff to monitor Resident mptoms of hypoglycemia hyperglycemia (high blood less dated 07/18/2021 at w with Licensed Practical (/27/2021 at 4:10 PM, ately 7:30 AM on btained a blood glucose (321, which was 67 mg/dL er). The note further stated dent's breakfast tray (exact PN #6 obtained a repeat takfast which was ng/dL. However, there was ion or evidence found to nued to monitor the obtain further glucose	{F 6	684			
	Resident #321's Nursi						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE COMP	SURVEY LETED
_		185256	B. WNG				R 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			OSIZOZI
(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 684}	stated the Spouse wainformation his/her da facility visiting the resiand reporting to him/h the Spouse requested regarding getting the and transferred to and documented she gave information for the Ad Nursing (DON) and m Spouse's call. Interview with Reside Member #3) on 08/02 she arrived at the faci 07/18/2021 at 10:45 A #321 was awake, aler normally during the vi Resident #321 told he had dropped to 67 mg Family Member #3 stat approximately 3:00 member obtained the level during her visit. not received a lunch m #3 left the facility. Cor Member #3 revealed won 07/18/2021, she bit mobile phone and left She stated she left the family attempted to ca resident, the facility's unanswered. Interview with Reside 07/28/2021 at 2:19 PM	spoke to LPN #6. The note is upset related to sughter, who was at the ident at the time, was calling iter. LPN #6 documented to speak with someone resident out of the facility other facility. The LPN is the Spouse the contact ministrator and Director of lade the DON aware of the int #321's Daughter (Family //2021 at 5:30 PM, revealed lity for a scheduled visit on item int item i	{F 6	584}			
		e daughter reported that the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY
	_	185256	B. WING			R 09/30/2021	
PARKVIE	PROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		21	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501		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 CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
{F 684}	resident's glucose wa facility smelled of urin washcloths were soile unemptied nephrostor urine drained from the and the daughter was clean blankets/washc. The Spouse further verside the spouse that he blood sugar was runn he/she felt. However, Spouse that as of 4:00 re-checked his/her blomorning prior to the difacility at 10:45 AM. The speaking with LPN #6 did not contact the DC the resident was sent Further interview reversident was sent Further interview reversions time unknown) and it is staff answered the lighthad only admitted Resident with State Resident some juice. The soil of the resident some juice. The soil of the spouse state of the lighthad only admitted Resident some juice. The soil of the spouse state of the lighthad only admitted Resident some juice. The soil of the spouse state of the lighthad only admitted Resident some juice. The soil of the spouse state of the lighthad only admitted Resident some juice. The spouse state of the spouse state of the lighthad only admitted Resident some juice. The spouse state of the spouse state of the lighthad only admitted Resident some juice. The spouse state of the spouse st	s low that morning, the e, the resident's blanket and d from the resident's my (bags that collected e kidney) bags were leaking, told the facility had no loths to give the resident e numerous times that day. evealed the resident had e/she could tell his/her ing low because of the way the resident told the D PM, the staff still had not load sugar since that aughter's arrival to the he Spouse confirmed fon 07/18/2021 but, he/she DN or Administrator because to the hospital that night, aled the spouse stated at M on 07/18/2021, was the e to Resident #321. The that time, the resident had rang the call light (exact had rang the call light (exact had rang the resident had le. egistered Nursing Assistant 2021 at 4:40 PM, and on	{F €	84}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(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			30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		SHOULD BE		COMPLETION DATE
(F 684)	and found the resident stated she immediate summonsed Registers other end of the unit, working with the reside did not recall what the at that time. However, resident was "better" I was between 6:00 PM. Continued interview was 11:30 AM, revealed #321 having another I during the late afternotime unknown). She s resident's room, she funresponsive. LPN #6 resident's blood gluco around 40 mg/dL". She Registered Nurse (RN the unit to assist her a #321 an injection of glused to treat a criticall #6 stated she also add glucose also after the LPN stated the be resident's blood gluco 139 mg/dL" but, she continued interview with twas nearing times the gave the resident was revealed no evidence resident's hypoglycem.	noon (exact time unknown) at non-responsive. SRNA #1 by notified LPN #6, who ed Nurse (RN) #1 from the and both nurses were ent. SRNA #1 stated she resident's blood sugar was a SRNA #1 stated the prior to shift change, which I-6:30 PM. With LPN #6, on 07/30/2021 If she did recall Resident mypoglycemic episode on on 07/18/2021 (exact tated when she entered the bound the resident is stated she obtained the se level and recalled it "was e stated she then got (a) #1 from the other end of and administered Resident for ucagon (Hormone injection by low blood glucose). LPN ministered the resident oral resident began to respond the se increased to "around ould not recall exactly. With LPN #6 revealed by that the for the supper meal, so an oatmeal pie to eat is arrived. 321's medical record the LPN documented the se levels. In addition, there	{F 6	84}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING	TRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 200 NURSING HOME LANE PIKEVILLE, KY 41501	PCODE	09/	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE	
{F 684}	remainder of her shift 07/30/2021 at 11:30 A was standard nursing staff found a resident resident had a hypogla a resident was admini Glucagon. However, the explain why she had noccurrences for Resident it was difficult to complete documentate. Interview with RN #8, revealed she was wor recalled LPN requesti Resident #321, due to unresponsive and have 40 mg/dL. She stated exact time the incident afternoon sometime pland 5:00 PM. She stated exact time the incident afternoon sometime pland 5:00 PM. She stated resident a glucage began to wake up. However and glucose administration of glucose administration of glucose increasions stated she stayed with was fully awake. RN # the kitchen and reque be brought up to the fluowever, RN #6 states of the unit and did not delivered the juice to the Review of Resident #3	r blood glucose levels the . Further interview, on M, with LPN #6 revealed it practice to document when unresponsive, when a ycemic episode, and when istered emergency the LPN was unable to not documented all these lent #321. LPN #6 stated care for all the residents and ion. on 07/30/2021 at 10:54 AM, rked on 07/18/2021, and ng her assistance with the resident being ring a blood glucose level of she could not recall the at occurred but, it was late probably between 4:00 PM ted LPN #6 administered on injection and the resident towever, RN #8 stated the se remained low, (unable to and LPN #6 administered one. RN #8 stated following nistration, the resident's ed to 111 mg/dL. She in the resident until he/she it8 stated she called down to sted orange juice with sugar loor for the resident. ied she returned to her side know if the kitchen the resident.	{F 6	84}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT		E CONSTRUCTION	(X3) DATE	SURVEY
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		185256	B. WING				30/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		:	200 NURSING HOME LANE		
- MINICALE	TOUT ACOIL MILD KE	HABILIATION CENTER		1	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 684}	and clammy. The docobtained the resident' 32 mg/dL. Staff admir glucagon, and the resident of the staff administered Residences, and the residences, and the residences, and the resident's blomg/dL. However, the un-responsive and exbreathing. Review of at 1:00 AM, Emergentarrived at the facility at 4321 to the hospital. If documentation reveal resident's family that the resident to the hospital of the resident to the hospital of the resident to the hospital of the resident's blood glucomg/dL earlier in the date remainder of day shift trays were late on 07/come out of the kitches PM. However, SRNA on the resident, emptiand changed the resident shated shift trays were stated shift trays shift trays were stated shift trays were shift	the resident un-responsive cumentation stated staff is blood glucose and it was nistered the resident a cident's blood glucose came documentation then stated sident #321 the oral dent's blood glucose. Continued review revealed econd glucagon injection od glucose came up to 110 resident remained perienced labored the Nursing Notes revealed by Medical Services (EMS) and transported Resident Further review of the ed staff notified the she facility had transferred spital. #4, on 07/28/2021 at 7:35 blood from 6:00 PM on AM on 07/19/2021, and was desident #321. SRNA #4 e on shift at 6:00 PM on old in report that the se level had dropped to 50 ay but was "good" the SRNA #4 stated supper 18/2021 and she did not en until sometime after 6:00 #4 stated she had checked ed the nephrostomy bags	{F 6	\$84)			
		she was about to begin her after 11:00 PM, when the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
DADIME	N 0007 A 01177 A 110 C				200 NURSING HOME LANE		
FARRVIE	W POST-ACUTE AND RE	HABILITATION CENTER			PIKEVILLE, KY 41501		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 684}	Continued From page	384	{F 6	84			
	laboratory technician	arrived on the floor to begin	,		'		
	drawing labs. SRNA #	44 stated soon after the					
	laboratory technician	arrived, she came and					1
	found SRNA #4, to re	port that Resident #321 was					l i
	not responding, SRN/	A #4 stated she found RN					
	#321.	nt to check on Resident					
	lataniau with DN 47.	-1 4-05 D14					
	revealed she was wor	at 4:25 PM, on 07/28/2021, king on 07/18/2021 from					
	7:00 PM until 07/19/2	021 at 7:00 AM, RN #7					
		shift report that Resident	·				
	#321's blood glucose	levels had been low during					
	the day, RN #7 stated	sometime between 7:30					
	PM and 8:00 PM, Res	ident #321 rang the call					
	light and reported he/s	she thought his/her blood					
	sugar was low. The nu	urse stated she checked the					
	resident's blood gluco	se level, and it was 106					
	mg/dL. However, RN	#7 stated she did not					
		tained the resident's blood n the resident's medical					
		that she and and one SRNA				,	
		rking the floor that night,					ĺ
	and she was busy and	i probably forgot to					
	document. Continued	interview revealed she took					
		nut butter and crackers.					
	and the resident state	d that he/she "just felt					
		at approximately 9:00 PM,					
		on the resident. The nurse					
	stated Resident #321	had not eaten the peanut					
	butter and crackers, se	o she offered the resident					i
	pudding or juice, but the	ne resident declined and					I
	re-check the resident's	The RN stated she did not					
	Continued interview w	ith RN #7 at 4:25 PM, on					
	07/28/2021 revealed s	he completed her					
	medication pass and s approximately 10:45 P	at down to chart at M-11:00 PM. RN #7 stated					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			LE CONSTRUCTION		SURVEY
		185256	B. WING			1	R
NAME OF P	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
					200 NURSING HOME LANE		
PARKVIE	V POST-ACUTE AND RE	HABILITATION CENTER			PIKEVILLE, KY 41501		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	_			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	_	(X5) COMPLETION DATE
{F 684}	Continued From page	± 385	(F 6	84	}		
	the laboratory technic	ian arrived on the unit. She					
	stated although she d	id not look at the clock, the					
	technician usually arri	ved around 12:00 AM, RN					
	#7 stated she had gor	ne into another resident's]				
		came in the room and told					
	her Resident #321 wo	ould not wake up. She stated					
		sident #321's room, the					
	resident was unrespon						
	immediately tell the re	sident's blood glucose was					
		lent was clammy. RN #7	ļ				
	and it was 32 mg/dL.	e resident's blood glucose.					
		on injection to the resident,					
	waited fifteen (15) min	nutes, and rechecked the					
	blood sugar, which wa	as then 52 mg/dl. She					
	stated the resident wa	is still not responding so					
		the resident oral glucose					
		#7 stated that she and					
	SRNA #4 worked the	entire floor, so she called					
		ors to assist her and call the					
	physician. Continued i						
	physician directed her	to administer the resident a					
		ction and call an ambulance					1
		the hospital for further					
		ted she administered the					
	second Glucagon inje	ction, while waiting for the					
		She stated Resident #321					
		sive and developed agonal					
	tried to obtain an intra	air). RN #7 stated they				i	
		se they thought the resident					
		quire cardiac resuscitation).					
		MS arrived to transport the					ľ
	resident to the hospita	ll, the resident's blood sugar					
	was "around 67 mg/dL	n					
	Interview with the Lab	oratory Technician (LT) #1,					
	on 08/02/2021 at 4:45 at Resident #321's uni	PM, revealed she arrived it on 07/19/2021, at					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONS	CONSTRUCTION (X3) DATE SUI		
		185256	B. WING				R
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		200 NUF	RSING HOME LANE LLE, KY 41501	1	
(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 684}	into Resident #321's resident would not resident would not resident was hard of the SRNA accompanied hard room and stated the resident did not rewas present, and the the resident's blood gistated she left the facilitation of the resident's blood gistated she left the facilitation of the resident #321's ED record date resident #321 arrived 1:36 AM, was non-resident #321 arrived 1:36 AM, was non-resident #321 arrived and admitted the resident (ICU) with diagnous on the resident with Administ 1:50 PM, she was not Resident #321 unresp 07/18/2021. She state her that the resident's Administrator stated sidocumented all hypog resident's medical recassessed Resident the resident's blood gli	AM. She stated she went from to obtain labs and the spond to her. She stated she refloor and asked if the hearing. She stated the hearing. She stated the hearing. She stated the her back into the resident's resident was not acting and the nurse. The LT stated spond at any time while she nurse stated she thought he hear back into the spond at any time while she nurse stated she thought he hear service was low. LT #1 lity before EMS arrived. The regency Department (ED) he hear service was low and review of Resident at the emergency room at ponsive and unable to the review revealed at the emergency room at ponsive and unable to the Intensive Care sees of hypoxemia (not tain life), Pneumonia, Acute hearthy, and acute respiratory rolonged hypoglycemia. The trator, on 08/10/2021 at aware that staff found onsive on the afternoon of hearthy was upset. The hearth should have hearthy have hearthy and have hearthy have hearthy and have hearthy have hearthy after hearthy have hearthy after hearthy have hearth	{F €	84}			

INME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER MAIL DESCRIPTION OF STATEMENT OF DEFICIENCES DAY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 684) Continued From page 387 2). Review of Resident # 323's medical record revealed the facility admitted the resident on O7706/2021 with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disporter, Sepais, Diabetes Mellitus, Dysphagia, Pneumonia and Aphasia. Review of Resident #323's Admission MDS assessment dated O711/3/2021, revealed the facility assessed the resident to have severely impaired cognition and rarely/never understands. In addition, the assessment stated Resident #323 utilized oxygen therapy and a Positive Anivary Pressure machine (Bi-pap/C-pap), Further review revealed Resident #323 did not exhibit shortness of breath with exertion, at rest, sitting, or when lying flat. Interview with SRNA (State Registered Nurse Aide) #14 on 07728/2021 at 11:43 AM, revealed on the morning of 07/20/2021 at approximately 7:00 AM to 7:30 AM, his found Resident #323 sweaty, clammy, and having difficulty breathing, and the nurse administered the resident a breathing treatment. However, SRNA #14 stated the resident and observed the resident to the hospital.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION		SURVEY
MANE OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER (A) 10			185256	B WING				R
PARKVIEW POST-ACUTE AND REHABILITATION CENTER 20 NURSING HOME LANE PRODUCES S. CHI. 7 ALD TO SERVICE S. CHI. 7 ALD T	NAME OF P	ROVINER OR SUPPLIED	100200	0. 111110			09	/30/2021
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (F 684) (F 684) Continued From page 387 2). Review of Resident # 323's medical record revealed the facility admitted the resident on 07/06/2021 with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Aufsito Disorder, Sepsis, Diabetes Mellitus, Dysphagia, Pneumonia and Aphasia. Review of Resident # 323's Admission MDS assessment dated 07/13/2021, revealed the facility assessed the resident to have severely impaired cognition and rarely/never understands. In addition, the assessment state Resident #323 utilized oxygen therapy and a Positive Ainway Pressure machine (Bi-papiC-pap). Further review revealed Resident #323 did not exhibit shortness of breath with exertion, at rest, sitting, or when lying flat. Interview with SRNA (State Registered Nurse Aide) #14 on 07/28/2021 at 11:43 AM, revealed on the morning of 07/20/2021 at approximately 7.00 AM to 7:30 AM, she found Resident #323 swealy, clammy, and having difficulty breathing. SRNA #14 stated she edid not see RN #6 go back into the resident's and breathing treatment. However, SRNA #14 stated the resident continued to have difficulty breathing, and she was "worried" about the resident's sond to check on the resident after the breathing treatment was administered the resident's family came to visit the resident around 10:30 AM. The SRNA stated when the family arrived and observed the resident the resident was administered the resident around 10:30 AM. The SRNA stated when the family arrived and observed the resident the resident the			HABILITATION CENTER		21	00 NURSING HOME LANE		
2). Review of Resident # 323's medical record revealed the facility admitted the resident on O7706/2021 with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Diabetes Mellitus, Dysphagia, Pneumonia and Aphasia. Review of Resident #323's Admission MDS assessment dated 07/13/2021, revealed the facility assessed the resident to have severely impaired cognition and rarely/never understands. In addition, the assessment stated Resident #323 utilized oxygen therapy and a Positive Airway Pressure machine (Bi-pap/C-pap). Further review revealed Resident #323 did not exhibit shortness of breath with exertion, at rest, sitting, or when lying flat. Interview with SRNA (State Registered Nurse Aide) #14 on 07/28/2021 at 11:43 AM, revealed on the morning of 07/20/2021 at approximately 7:00 AM to 7:30 AM, she found Resident #323 sweaty, clammy, and having difficulty breathing, SRNA #14 stated she notified Registered Nurse (RN) #6 of the change in the resident's condition, and the nurse administered the resident a breathing treatment. However, SRNA #14 stated the resident continued to have difficulty breathing, and she was "worried" about the resident, who was "breathing treatment. However, SRNA #14 stated she did not see RN #6 go back into the resident's room to check on the resident after the breathing treatment was administered, until the resident's family came to visit the resident around 10:30 AM. The SRNA stated when the family arrived and observed the resident ten by insisted the	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	E NTE	COMPLETION
Interview with SRNA #15 on 07/28/2021 at 2:35		2). Review of Resider revealed the facility at 07/06/2021 with diagr Metabolic Encephalor Failure, Autistic Disord Mellitus, Dysphagia, F Review of Resident #3 assessment dated 07/ facility assessed the reimpaired cognition and In addition, the assess utilized oxygen therap Pressure machine (Birevealed Resident #32 of breath with exertion lying flat. Interview with SRNA (Aide) #14 on 07/28/20 on the morning of 07/27:00 AM to 7:30 AM, s sweaty, clammy, and I SRNA #14 stated she (RN) #6 of the change and the nurse adminis breathing treatment. Hether resident continued and she was "worried" was "breathing pretty I she did not see RN #6 room to check on the retreatment was adminis family came to visit the AM. The SRNA stated and observed the reside facility send the reside	at # 323's medical record dimitted the resident on coses that included pathy, Acute Respiratory der, Sepsis, Diabetes Pneumonia and Aphasia. 323's Admission MDS (13/2021, revealed the esident to have severely diarely/never understands, sment stated Resident #323 y and a Positive Airway (19app/C-pap). Further review (23 did not exhibit shortness of at rest, sitting, or when (24) at 11:43 AM, revealed (20/2021 at approximately other found Resident #323 having difficulty breathing, notified Registered Nurse in the resident a (19appendict) about the resident and to have difficulty breathing, about the resident, who hard". SRNA #14 stated to have difficulty breathing about the resident, who hard". SRNA #14 stated to have difficulty breathing about the resident after the breathing differed, until the resident's resident around 10:30 when the family arrived dent, they insisted the nt to the hospital.	{F 6	684}			

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				٦
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	- <u> </u>		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 APPROPR DEFICIENCY)			(X5) COMPLETION DATE
{F 684}	AM to 7:30 AM, she of was having trouble briface was red. SRNA administered the resident difficulty breathing. Cotthat RN #6 administer treatment to the reside However, SRNA #15 acontinued with labored knowledge, RN #6 tood #15 stated she did no in the room to assess family came in to visit and requested the fact the hospital. Interview with RN #6 acrevealed on 07/20/20/2 to 7:30 AM, one of the her that Resident #32 stated she was not the Resident #323; however sident's room. She stoom, she could hear observed the resident to breathe (having to the diaphragm muscles she had last seen Resident RN #6 storeathing treatment to and it initially improved However, RN #6 stated she thought LP stated she thought LP stated she thought LP stated as the stated she thought LP stated and the resident stated she thought LP stated and it initially improved the resident stated she thought LP stated she stated she thought LP stated she st	b/2021 at approximately 7:00 bserved that Resident #323 eathing and the resident's et15 stated RN #6 fent a breathing treatment, still appeared to be having ontinued interview revealed ed a second breathing ent "a couple hours later." stated the resident d breathing, but to her ok no further action. SRNA t visualize any staff go back Resident #323 until the at approximately 10:30 AM, ility send Resident #323 to on 07/28/2021 at 3:45 PM 21 at approximately 7:00 AM e nursing assistants notified 3 was "congested". She e nurse assigned to care for ver, she went to the stated when she entered the the resident wheezing and using accessory muscles use more muscle than just to breathe). RN #6 stated sident #323 at M. The RN stated the lity breathing was "new" for tated she administered a the resident at 7:43 AM, d the resident's breathing. d the improvement did not lent's status declined. She	⟨F €	i84]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B, WING				R
NAME OF PI	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
PARKVIEV	V 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 CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
{F 684}	Interview with LPN #3 nurse assigned to Res She stated at approxim 07/20/2021, Resident However, at approxim "something was going stated the resident wa accessory muscles to stated she notified the Physician #1, around new order to obtain a LPN #3 stated followir administered by RN # condition "stayed abord stated Resident #323" facility at approximate the facility send the restated she notified Phyrequest and the facility hospital at approximate (approximately five ho having trouble breathin Interview with Resider	revealed she was the sident #323 on 07/20/2021. mately 6:30 AM on #323 "seemed ok". nately 7:30 AM she realized on" with the resident. She as breathing fast and using aide in breathing. LPN #3 resident's physician, 8:15 AM, and received a chest x-ray for the resident. ng the breathing treatments 6, Resident #323's but the same". LPN #3 s family arrived at the ly 10:30 AM, and insisted sident to the ED. The LPN ysician #1 of the family's y sent the resident to the tely 12:30 PM burs after the resident began ng).	{F €	684)			
	08/02/2021 at 8:50 AM the facility on 07/20/20 AM. She stated that up could hear the resident hallway approximately stated the breathing wif the resident was trying straw. The family mentithe resident had a narrairway. Continued inte	A, revealed she arrived at D21 at approximately 11:00 poor arriving to the unit, she at trying to breathe from the two (2) doors down. She was a high-pitched sound, as any to breathe through a aber stated it sounded as if row or partially blocked erview revealed she insisted sident to the hospital for					

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(20) 11111	TID: C			<u>J. 0936-039 I</u>
	CORRECTION	IDENTIFICATION NUMBER	A. BUILDI		ECONSTRUCTION		SURVEY PLETED
		ALC	74. 50125			1	
		185256	B. WNG		<u> </u>	1	R /30/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	13012021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		2	00 NURSING HOME LANE		
		THE PROPERTY OF THE PROPERTY O		F	PIKEVILLE, KY 41501		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	 X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	Æ	(X5) COMPLETION
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
			1				
(F 684)	Continued From page	390	{F €	84}			
	Further review of Res	sident #323's medical record					
		led after the family arrived					
	at the facility and requ	rested the resident be sent	İ				
	to the hospital, staff d	ocumented the resident was					
	naving snormess of a	ir, abnormal lung sounds,					
	Staff completed a cha	ning, and cough. In addition, nge of condition form at					
	12:12 PM, which state	ed they notified Physician #1					
	at 11:45 AM of the res	sident's assessment and					
		to send the resident to the					
	ED.						
	Review of Resident #	323's ED record revealed					
	the ED staff assessed		-				
	audible stridor, increa	sed respiratory effort, was			₹ -		
	using accessory must	cles to breathe and had mild					
	Resident #323's boso	lungs. Continued review of ital record revealed the					
		to the Intensive Care Unit					
		nosed with Acute Hypoxic					
	Respiratory Insufficier	ncy, Left Lower Lobe					
	Pneumonia versus Ate	electasis (collapsed lung),					ĺ
	flow of oxygen level).	ate level (results from low					
	now or oxygen levely.						
Ì	Interview with Physicia	an #1 on 08/04/2021 at 1:00					
	PM revealed he could	not recall if he spoke to					
		nt #323 once or twice on		Ì			
	to assess a resident w	, he stated he expected staff					
		e further stated that if a					
		cing respiratory distress, he					
	would expect staff to i	ncrease monitoring and					
	assessment of the res	sident and monitor for		Ì			
	further decompensation	on of respiratory status.					
	Interview with the Adra	ninistrator on 08/10/2021 at					
		rim Director of Nursing on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	' ' '	TIPLE CONSTRUCTION NG	0	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				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			5072521
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	E	(X5) COMPLETION DATE
{F 684}	staff to immediately a change in condition or revealed that they export that they export and the facility alleged implemented to remore 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 cath and pressure injuries 2). The wound care possessive and pressure all pressure evaluated all current to them to the Medical Diagram of the facility and the developed within 48 his pressure ulcer or potential pressure interventions to preve development or worse 4). Residents #45, #6	PM, revealed they expected ssess a resident when a courred. Further interview pected the staff to document in the medical record. The following was we Immediate Jeopardy The saments were completed cility nurses on 08/28/2021 all body skin assessments. I residents on 09/11/2021. The Braden Scale Assessment will body skin assessment to be plans of residents who by 09/17/2021. The saments and resident traff assessed and the injuries, and staff reatments and reported birector/Physician #1 by The saments are plan will be abaseline care plan will be abase	{F 6	84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			LE CONSTRUCTION		SURVEY PLETED
		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	1 03	1301202
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E.	(X5) COMPLETION DATE
{F 684}	and assisted with dresclothing. Clean lineaus residents' beds on 09, were evaluated by so 5). All residents were interviewed to obtain a by the Director of Nurse bath/shower sch by nursing staff to according preference. Resident were obtained and incording and State Register plans by the Regwere completed on 09. 6). On 08/28/2021, the began reviewing all resecommendations for supplements to promount any weight loss issues 7). All residents with thand Chronic Obstructi (COPD), Asthma and by licensed nurse and with no concerns were 08/13/2021. 8). The Regional Nurse with orders for glucose and orders were amerentry of glucose value Administration Record 9). The Regional Certification of the supplement of the condition of the supplement of the condition of the supplement of glucose value Administration Record 9). The Regional Certification of the supplement of the	lotion applied post shower, ssing in clean appropriate is were placed on the /11/2021. 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) gional Nurse Consultant 0/13/2021. Registered Dietitian (RD) esidents' diets and made meal changes or tote healing and to address is. The diagnoses of Diabetes we Pulmonary Disorder Pneumonia were assessed for Respiratory Therapist is identified completed. The reviewed all residents is monitoring by 07/30/2021 anded to include mandatory is on the Medication I (MAR).	{F €	584			
	lunch and dinner on 0	9/11/2021, all three meals					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ONSTRUCTION	(X3) DATE	SURVEY PLETED
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STR 200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE SEVILLE, 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 684}	recruitment efforts with provided through age. Direct care nursing staday will be reviewed of Nursing and the Admi levels are adequate to residents. The staff won the unit at the start Director of Nursing, Normal Administrator or design staff call offs will be requalified staff to see it and/or calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Noursing management appropriate staffing lecenter will prioritize reachieved during emer required task including medication, no showe provided to incontinent that cannot turn self, reassist residents with no 11). The facility has in through recruitment efforts are prepared at 12). On 08/11/2021, a #86 and #322, were reand physical forms of for Mental Status (BIM	ng was increased through hadditional staffing ney and travel contracts. aff schedules for the next daily by the Director of nistrator to ensure staffing of meet the acuity of the sill be validated as present to of each shift by the tursing Supervisor, the Direct care nursing eplaced by calling other if they can fill the opening, as to see if they have to opening. If direct care staff to e Director of Nursing, sursing, or member of the team will fill the shift. If they cannot be met, the sident care that can be gency staffing, prioritize gradministration of the tresidents, turn residents meals served timely, and meal if needed. Creased dietary staffing forts and appropriate the achieved to ensure	{F €	i84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		SURVEY
		185256	B. WING			1	R /30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 684)	Licensed Nurse. Resi Dementia had their Cirevised, as necessary (MDS) Coordinator or residents were identifi psychosocial and/or p 13). The Regional Nur wandering risk assess 08/16/2021. All reside at risk for wandering h updated by the MDS (identified active wand placed at each nursing potential interventions 14). Residents #39, ## #332 were weighed by Registered Dietician (comprehensive nutritir recommendations were recommendations by (DON) or designee, spo Medical Doctor (MD) a and recommendations entered into the electr the tray card. The Reg Director of Nursing (D in electronic medical r record and tray card r information on 09/17/2 15). Beginning 09/15/2 snacks to all residents	(8) were completed by dents with a diagnosis of are Plan reviewed and by the Minimum Data Set on 09/07/2021. No new led as indicating any shysical harm. The Consultant completed a sment on all residents by less that care plans reviewed and coordinator. A list of all ler risk residents were greated station with a list of a for nursing to reference. The RD) completed a long assessment and RD rereviewed for the Director of Nursing to 109/17/2021. Further, the loke with the attending and validated the diet orders are reviewed diet orders only reviewed diet orders ecord to ensure both the effected accurate	{F €	884}			
	aides, or designee. Sr physician will be docu	nacks ordered by a mented by the restorative					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING				R /30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER	'	2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 001	3372.021
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 684)	16). The facility evaluations of the compliance with Complemented yellow a identified two (2) residexposed to positive rewas designated with a barrier and those two this zone on 08/11/20 17). The facility had the inthe red zone on 08/11/20 17). The facility had the inthe red zone on 08/4328 and #329). Reside have completed quarantine physician orders. Rescompleted quarantine physician's order. Rescompleted quarantine physician of 09/16/2021 tested for COVID-19 or 09/16/2021 tested for COVID-19 or objective covided in isolation zor droplet precautions with protective equipment. Physician notification, plan revisions. The Donewly positive COVID isolation precautions is the protective equipment.	ated the COVID-19 unit on in the 5th floor of the facility DC guidelines and ind red zones. The DON fents who had been exidents and a yellow zone exection of a plastic zip wall (2) residents were moved to 21. There (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 sidents #311 and #314 were or testing were tested for 021. The facility did not is based on the employee. All residents eligible were on 09/17/2021. The facility ew positive cases. Conducting ongoing is recommended for OVID-19 residents will be the (red zone) and placed in the use of personal the facility will provide family notification and care DN or designee will review -19 residents to ensure have been initiated. In	{F €	684}			
	addition, any resident	exposed will be placed in	1				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE SEVILLE, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 684)	facility will provide phynotification and care pemployee testing prot designated days effect requires all staff must days. If the employee not allow the employee not allow the employee negative COVID-19 to employee will be testefacility by the Infection designee. All testing oposted to the employee common areas. 20). The facility scree for signs and/or symp documented on the MRecord (MAR). The famonitoring for signs a residents on 09/17/20 21). Resident #9, Res Resident #326 and Rewere reviewed for use administration times be 09/23/2021. 22). The facility stated their medication as or and implemented phanotification if any med The facility will abide I physician regarding the facility with a three facility with a facility with a facility with a facility with a facility with a facility with a facility with a facility with a facility with a facil	solation zone (yellow). The ysician notification, family plan revisions. The facility ocol will be twice weekly on citive 08/16/2021. The facility be tested on designated is not tested, the facility will be to work without a current est. During testing, the ed prior to entering the in Prevention Nurse or dates and times will be ee page, time clock and edication Administration acility implemented ind/or symptoms on all 21. Ident #321, Resident #324, esident #351, medications age and appropriate by the physician on the physician of the physician ication was unavailable. The prevention was unavailable in the physician of the physician of the physician ication was unavailable. The prevention was unavailable in the physician of the	{F €	884}			

	OF DEFICIENCIES CORRECTION	[Vol pure agree Indicate Indi					
		405256				F	₹
NAME OF D	ROVIDER OR SUPPLIER	185256	B. WING	_		09/	30/2021
	V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE ON NURSING HOME LANE PIKEVILLE, KY 41501		
(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 CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		_	(X5) COMPLETION DATE
{F 684}	24). New admissions the facility after norms weekends will have dentered into the electrosubmitted to pharmaci integration. The facility fax transmittal as a bapharmacy integration electronic medical recomplished in the facility does not timely manner the phathe facility will utilize the kit. If an emergency a unavailable, the physical substitution and/or new 25). The Regional Nu Nursing, and licensed audit of all residents' everified all medication facility by 09/25/2021. The facility process, and a ensure compliance with Administrator over The QAPI committee Nursing, Administrator Services Director, Act Maintenance, Dietary Services.	and re-admissions entering all business hours and on ischarge orders submitted, ronic medical record and by through pharmacy ty implemented the use of ackup to the electronic by entering the order in the cord to receive medications. The receive medications in a sarmacy will be notified, and the emergency medication will be notified for the orders. The Consultant, Director of a nursing staff completed an ordered medications and its were available in the control of th	{F €	684}			
		3/2021 to replace the					

	OF DEFICIENCIES CORRECTION	The state of the s			(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	,		00/2021
(X4) ID PREFIX TAG	FIX (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)		OULD BE		(X5) COMPLETION DATE
{F 684}	guidance from the Re Regional Director of C Clinical Nurse for 30 of the thirty-day oversight Administrative Team of determine if continued The administration has responsibility to direct communicate areas of improvement. 28). The Administration QAPI Committee revisionated person for call Activities of Daily Living timeliness of meal tracturning and reposition 29). The Vice Preside Clinical Operations are Consultants conducted 09/15/2021 with a corconsultation to review outcomes of the Survey roles of the Governing Rules and Regulation the following communification Control (CO staff at the facility to in turn and reposition recare, prepare and dis residents with eating, effective Pharmacy Sand neglect effectively	eive daily oversight and agional Vice President or Operations and Regional days. Upon completion of ht, the Regional will audit the Administrator to didaily oversight is needed. It is direct oversight and it, discipline, and of concern and process or, Medical Director, and ewed procedures for a ll-ins, answering call lights, ang (ADL) Care, serving, and ys incontinence care and bing on 09/15/2021. That of Operations, Director of and Regional Nurse and a conference call on intract company for a first the following: (1) the ey; (2) expectations and g Body as outlined in the is; (3) determined a plan for incation/monitoring tools: VID 19 Isolation), enough monitor/assess residents, sidents, provide incontinent tribute meals, and assist caring for pressure wounds, ervices, dealing with abuse y, sufficient staff, providing and providing a functioning	{F 6	584}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING_		,	R 19/30/2021	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		313012021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 684}	beginning 09/16/2021 and/or revisions to the the 09/16/2021 meetic standardized plan to a reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a genda included reviewed as needed a genda services, conceresident council, and grievances, admission development, vacant orientation, dietary vaweight loss, work injuture employees on family absence, new hires, or review, pharmacy repusiness office, and a Committee and Medic standardized agenda but not limited to, the meeting. 31). The Regional Dir Vice President of Open Op/16/2021 regard Governing Body, incluprocedures to be improcedures to be improcedures to be improcedures to be improcedures, the in the QAPI processes, the in the QAPI process,	and revised the QAPI Plan I and presented the reviews I and presented the reviews I and presented the reviews I and presented the reviews I and presented the reviews I and presented topics were I at the QAPI meetings. The I and pressure ulcers, Foley I ding tubes, contractures, I adication usage, risk I control, hospital I abilitation management, I and presented, activities, I anily council concerns, I ans, discharges, census, staff I positions, employee I ariances, tray audit report, I aries, terminations, I medical leave, a leave of I medical record compliance I ports, restorative nursing, I admission actions. The QAPI I cal Director approved the I on 09/16/2021 to include, I topics presented during the I rector of Operations and I and the Medical Director I ling the duties of the I duding setting policy and I lemented in the facility and I nation to other members of I During the meeting, the I need to identify root	{F 68	34}			
		ation of the five (5) why iting systems per the QAPI nistrator will notify the				:	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION		E SURVEY IPLETED
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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	1 08	0/30/2021
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{F 684}	meetings. 32). The Administratoreports before each Cobeginning 09/15/2021 compliance with the coog/10/2021 survey. Coog/16/2021 to discuss interventions to remoimplemented QAPI m (4) weeks, as needed Administrator will forwain the state of QAPI more than the Governincluding the Vice Preside Regional Vice Preside Regional Nurse Consideration of Nursing, A Director of Nursing, A Director, Social Servic Clinical, Therapy, Ma Environmental Servic Clinical, Therapy, Ma Environmental Servic GAPI Tool Kit, QAPI and guide to effectively imbeginning 09/16/2021 meet quarterly for the reevaluate for frequents.	or will collect all monitoring CAPI Committee meeting I for review to ensure deficiencies cited during the CAPI Meetings were held on a sabatement and develop we the jeopardy. The facility leetings weekly, times four II, and monthly. The ward all QAPI Meeting ning Body members, esident of Operations, and the cultant, to review the audit mmittee will review the eetings. Committee for reator oversees the QAPI PI Committee consists of the administrator, Medical ces Director, Activities, intenance, Dietary and es. Sody will provide the facility's sources and education cluding but not limited to the at a Glance, and a resource uplement the QAPI plan. The Governing Body will	{F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	71	185256	B. WING_		_	R 09/30/2021		
	ROVIDER OR SUPPLIER N POST-ACUTE AND RI	EHABILITATION CENTER		STREET ADDRESS, CITY, STA 200 NURSING HOME LANE PIKEVILLE, KY 41501	7,	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 684}	is demonstrated. 35). All nursing staff of Director of Nursing, Mesignee on proper wobtaining, documentichanges to the Regist 09/17/2021. 36). On 09/13/2021, Dietary Manager (CD Manager on the provassessment to ensur diet order accuracy, a orders into the electric CDM educated the Diresident diet orders in the nurse enters the written communication including diet and tex meetings, staff will reprevious day to ensure 37). Therapy providers staff on turning and pand transfer of reside chair to bed beginning completed on 09/17/2 and assigned additionand agency contracts turn and reposition all reposition themselves. 38). The Regional Dirall nursing staff on proincluding turning and	were educated by the MDS Coordinator, or veighing techniques, ng, and reporting weight stered Dietician by the Regional Certified of the Dietary ision of timely nutritional e diet order accuracy, on and on when to enter diet onic medical record. The ietary Manager to enter not the tray care system. If order, the nurse will send a into the dietary staff, ture. In the morning clinical view diet orders from the re accuracy. d education to all nursing ositioning range of motion, and from bed to chair and g on 08/19/2021 and 2021. The facility employed hal staff through recruitment is to ensure adequate staff to I residents who cannot	{F 6	84}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		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		05/00/2021
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		FULL PREFIX (EACH CORRECTIVE ACTION SHOU		OULD BE	COMPLETION DATE
{F 684}	assessment, and how dietician, physician, a impairment by 09/17/2 staff will call or email Physician, and Reside new skin changes. 39). The DON or desitimely call light resporstaff, including nurses assistants, were provitimely hygiene per the timely toileting, dressi of clean clothing, and trays. The DON or defacility staff not working the timely toileting to work. 40). On 08/31/2021, Thursing educated all I Registered Dietician, and the MDS Nurses into the electronic meand interventions. In Director of Nursing edexisting care plan in the with new goals and in impairments identified 41). The facility's Res Licensed nurses on id residents with a chango 8/12/2021. In additionand/or designee educidentifying signs/symptime.	ment a head-to-toe skin to notify the registered and RP of a new skin 2021. The facility nursing the Registered Dietitian, ent Representative of any gnee educated all staff on ase. In addition, direct care and certified nursing ded education on providing resident's plan of care, ang residents in their choice timely delivery of meal signee will educate any ag during education upon The Regional Director of icensed nursing staff, the the Social Service Director, on entering new care plans dical record, including goals addition, the Regional ucated staff to update the ne electronic medical record terventions for any new skin during their shift. Piratory Therapist educated entifying and assessing ge in respiratory status on n, on 08/12/2021, the DON ated all licensed nurses on storms of	{F 6			
	hyperglycemia/hypogl diabetic protocol, docu change in condition, d	imenting a resident's				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1, ,	IPLE CONSTRUCTION		OATE SURVEY OMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 684}	physician and followifacility licensed nursiwork until they have DON educated all cli of glucose levels on during mandatory induring mandatory induring mandatory induring mandatory induring mandatory induring mandatory indures on a Plan with intervention diabetes and a respit hours of admission, a copy to the resident adducation was notified will not be allowed to received this education was notified will not be allowed to received this education was notified will not be allowed to received this education the facility's call-off procedure for event a person need dayshift, they are to a supervisor two hours if staff needs to call to notify their immediate supervisor thave appropriate immediate supervisor thave appropriate immediate supervisor the qualified staff to off. If emergency staff working will be in-set 44). All staff were procedured to the procedure from staff working will be in-set 44). All staff were procedured to the procedure from staff working will be in-set 44). All staff were procedured to the procedure from staff working will be in-set 44). All staff were procedured to the procedure from staff working will be in-set 44). All staff were procedured to the procedure from staff working will be in-set 44). All staff were procedured to the procedure from staff working will be in-set 44). All staff were procedured to the procedure from staff working will be in-set 44).	record, notification of the ing physician orders. The ing staff will not be allowed to received this education. The nical staff on documentation 08/19/2021 and 08/20/2021 services. 7/2021, the DON educated ompleting a baseline Care in and goals relevant to ratory diagnosis within 48 reviewing and providing a rand/or the responsible party. If not working during ed of ongoing education and a work until they have on. 7/2021, the DON educated all call off" procedure. The interest the facility included: in the is to call out of work for notify their immediate is before the start of the shift. Off on the night shift, they are staffing levels, the rand/or designee will call or replace the person calling affing is required, the	{F 6	84}		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION		SURVEY
		185256	B, WING				R /30/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		ı	00 NURSING HOME LANE		
<u>.</u>			<u>.</u>	F	PIKEVILLE, KY 41501		
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{F 684}	Continued From page		{F €	84}			
	reporting abuse, as w implementing immedi wandering residents.						
	45). All nursing staff v Director of Nursing, N	IDS Coordinator, or					
	designee on proper w obtaining, documentir changes to the Regis	ng, and reporting weight					
	09/17/2021. On 09/13	3/2021, the CDM educated on diet order accuracy and					
	timely nutritional asse	essment to ensure diet order enters diet orders into the					
	order will send the wr	cord, the nurse entering the itten communication to the					
	order into the tray car	tary Manager will enter the e system. The facility will					
	clinical meeting to en	m the previous day in the sure accuracy.					
	46). The Regional CD Manager on 09/13/20	M educated the Dietary 21 on facility policy					!
	regarding meal service	re times and the use of pes for those requiring					
		sidents in accordance with					
	established national g cultural and ethnic ne	juidelines to reflect religious, eds of the population.					
	47). As of 09/15/2021 completed education	, the Regional CDM with the dietary manager on					
	obtaining food prefere	ences, the facility's tray card based on menus, stocking					
	snack/hydration carts	, snacks, and hydrations ate scoop sizes, and/or					
		ursing or Regional Director nurses and the Dietary					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 684}	and/or implementing recommendations for 09/17/2021. 49). All staff were pro DON and/or designed COVID-19 policy/guid donning/doffing Perso (PPE), yellow and rec DON/designee educated and staff, included and staff, included and yellow zones for signs/symptoms or reviewed. 50). Staff were provid 08/20/2021 by the DORegional Nurse Consistency admissions into the result of the process to follow available for administration, included available for administration, obtain medication delivery timedication d	ess for entering, activating, the registered dietician's dietary orders on vided re-education by the by 09/17/2021 on the lelines, handwashing, anal Protective Equipment discones. In addition, the sted, licensed staff on for Covid-19 symptoms and the DON/designee luding contract staff, who ring the QAPI meeting on di-19 policy, the donning and doffing PPE, and monitoring residents of the Covid-19 were deducation on DN, Regional DON, or sultant to enter COVID-19 orders on all new esident's record. Ing staff have been staff have been staff have been staff the dieting right medication, right the time, and right route. The designee educated all working on 09/23/2021 on when a medication was not ration as ordered. The alling the pharmacy to obtain	{F €	684)			

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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		510012021
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 684}	education also include given by the MD, doc and new orders from medical record. All off will be provided training to the provided training to the emergency in place for ensuring the notifying the physician re-admitting residents after-hours. 53). The Interim Admit on his contact information coordinator from 09/1 in addition, education who to notify if unables shift. 54). The facility will at head-to-toe skin asset through Friday, for the 09/17/2021 to ensure weekly on each reside will notify the physician Responsible Party of and those new interverplace to prevent declipation date on 08/2001 conducted weekly for	In medication time. The ed following new orders umenting the conversation, the MD in the electronic her licensed nursing staffing as scheduled for shifts. The DON /Regional Nurse all licensed nursing staff, and/or agency staff, on the medication kit, the system medications are in-house, or a for new orders for new or a, including on weekend and inistrator educated all staff ation and role as the Abuse 13/2021 through 09/17/2021. On staffing schedules and to to work their scheduled udit weekly resident assents daily, Monday ree (3) months effective they have been completed ent. In addition, the facility an, Registered Dietician, and any new skin impairment entions have been put in	{F 68	34}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		SURVEY
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{F 684}	Nursing (ADON), or Nesident progress not effective 09/13/2021, month. Staff will revies Saturday and Sunday Supervisor conducted areas of skin impairm plan implemented to it. 57). Beginning on 09/leadership staff and/orounding of residents incontinence, and residents will be visual shift daily for two (2) oresidents each shift for twenty-five percent of (4) weeks. The facility to 6:00 PM and 6:00 It began visual monitoring response times, incluinghts are answered, a staff will conduct ten each shift for two (2) tight observations each shift for two (2) to began monitoring response times, incluinghts are answered, a staff will conduct ten each shift for two (2) tight observations each shift for two (3) to began monitoring response times, incluinghts are answered, a staff will conduct ten each shift for two (2) to began monitoring response times, incluing the commendation (Seacute change in respitatory status for implementation of any included in the conduction of any included i	dursing, Assistant Director of dursing Supervisor will audit es for daily four (4) weeks then weekly for one (1) we Progress notes for on Monday. The Nursing diaudits to ensure any new tent identified had a care include new interventions. In 1/2021, the facility's or designee began visual assessing hygiene, toileting, ident repositioning. All ally rounding on once each weeks, fifty percent of the or four (4) weeks, and it residents each shift for four or has two (2) shifts, 6:00 AM PM to 6:00 AM. The facility's leadership staffing and timing of call light ding the length of time call facross all shifts. Leadership (10) call light observations weeks and then five (5) call the shift for eight (8) weeks. The DON and/or Designee piratory assessments and Assessment and BAR) communications for ratory status Monday clinical morning meeting.	{F 6	84}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
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{F 684}	times a week for four 60). The MDS Nurse, began audits on 09/1: completion for all new re-admissions to ensu baseline Care Plan w 61). All residents adm days with a diagnosis Obstructive Pulmonar Asthma, or current Pr Care Plan reviewed a the MDS Nurse(s) an interventions will be a morning meeting by the nursing designee. 62). Beginning on 08/DON, and/or Designe admissions and re-adcare plans for comple with the resident and/variance or identified immediately. Audits we through Friday for all to the facility for four (admissions for a weethen ten percent of acceptable and trays to resident All three (3) meals with 3). On 09/11/2021, the designee began audit meal trays to resident All three (3) meals with 3) units daily for two	r one (1) week, then five (5) (4) weeks. DON, and/or Designee 5/2021 of baseline care plan or admissions and ure staff completed the ithin 48 hours of admission. Antitled within the last thirty of Diabetes, Chronic by Disease (COPD), becumonia had their baseline and updated as needed by didor designee. New didded to the care plan in the the DON, ADON, and/or	{F 6	684}			
		y for two (2) weeks, and one 3) units daily for four (4)					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	30/00/2021
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(F 684)	began audits of staff's quiz of identification a with a change in resp signs/symptoms of hy the facility's diabetic pchange in a resident's physician and followin Leadership will quiz s shifts; ten (10) staff for staff a week for four (65). On 08/13/2021, the began monitoring all or results Monday through morning meeting. The any blood sugar result range for MD notificat any Physician's Ordereviewed and updated designee will complet diabetic residents acr (3) units to identify an signs and symptoms hypoglycemia/hyperg resident was immediated one (1) week, then fiv (4) weeks.	the DON and/or Designee is knowledge with a verbal and assessment of residents iratory status, identifying a perglycemia/hypoglycemia, protocol, documenting a condition, notification of the ag physician's orders. Itaff randomly across all ar one (1) week and five (5) (4) weeks. The DON and/or Designee documented blood sugar gh Friday in the clinical and implementation of as Care plans will be as needed. The DON or a visual rounding on loss both shifts and all three by resident with apparent of lycemia to ensure the ately assessed by licensed identified concerns will be ly. Audits will be daily for a (5) times a week for four the Administrator and/or dan employee se and identification of a fabuse across all shifts and	{F 684		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NURSING HOME LANE PIKEVILLE, KY 41501	1 931	00/2021
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{F 684}	then three (3) times a and then weekly for for or identified concerns immediately.	staff daily for one (1) week, week for two (2) weeks, our (4) weeks. Any variance	{F €	i84}			
	Nursing and/or design resident's wandering admission and quarte Set (MDS) assessme wandering will be disc morning meeting to re interventions. Any val will be addressed imm will be care planned in	nee will review each risk assessment upon orly with their Minimum Data nt. Any resident identified as cussed in the clinical eview and initiate new riance or identified concerns nediately. New interventions on the morning meeting by g, Assistant Director of					
	of eight (8) or greater the facility and have r witnessed abuse. The review random week! residents with a BIMS to ensure no injuries of	designee will perform residents with a BIMS score to ensure they feel safe in not been subject to or a DON or designee will by skin assessments for a score of less than eight (8) of unknown origin beginning ance or identified concerns					
	conducted audits of re electronic medical red in the diet/tray card so 70). Beginning on 08/ Manager will ensure a	he Registered Dietician esident diet orders from the cord against orders entered oftware to ensure accuracy. 23/2021, the Dietary and audit meals leaving the the units timely. Audits will					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501		313012021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	•	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
{F 684}	one (1) week, twice p and then weekly for o trays arrive at the unit assist in passing trays meal trays, and certific residents promptly. The designee will audit the trays to residents after 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 beverage preferences admission and enter the system for listing on the completed bi-annually residents. Physician-be audited by the Die (1) week, weekly for fafter that for four (4) mog/15/2021. 72). Daily COVID-19 audited beginning on Resources (HR) Director, and weeken staff not screened will immediately on the Coby the HR Director. To	dom meals twice daily for er week for two (2) weeks, ne (1) month. Once meal the meal that management staff will so to ensure residents receive ed nursing assistants assist the Dietary Manager or etime it takes to pass meal or they arrive on the unit. All three (3) meals will be to daily for two (2) weeks, no unit daily for two (2) on each unit daily for four (4) on each unit daily for four (4) ager or designee will review residents' food and so within 72 hours of them into the diet/tray card their tray cards beginning of food preferences will be and as needed for all ordered snack intakes will tary Manager daily for one our (4) weeks, and monthly nonths beginning screenings for staff will be 08/25/2021 by the Human ctor against time clock reening before beginning be completed Monday or (4) weeks by the HR ds audited on Mondays. Any libe re-educated OVID-19 Screening Policy	⟨F 6	884}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE C	(X3) DATE SURVEY COMPLETED		
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{F 684}	doors will remain lock entry by staff and screntry. 73). Beginning on 09 designee will round sfor eight (8) weeks, fit (4) weeks to audit inf differing shifts and unobservation of handwand zones; donning/oPPE; and mask compidentified concerns who the auditor. 74). The DON, ADON review all residents opharmacy to ensure a beginning 09/23/2022 physician within two expiration. 75). The Regional Numedication pass observation pass observation of medicatic CMS Critical Element Administration to conobservation of twenty 76). Beginning 09/25. Friday, the DON, ADON and screen and servation of twenty	control preventionist. All entry sed. Visitors must be allowed eened by staff at the time of virial visitors must be allowed eened by staff at the time of virial visitors must be allowed eened by staff at the time of virial visitors. And/or each week ve (5) times weekly for four ection control compliance on vits. Audits will include vashing; isolation signage doffing (putting on/taking off) oliance. Any variance or vill be addressed immediately villance. Any variance or villance will en narcotics with the en active script is on file villance. Staff will notify the villance	{F 6	84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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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		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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 684}	and/or DON will be renursing staff daily for adequate staffing is more adequate staffing is more adequate staffing of the staffing daily for adequate staffing daily for adequate staffing. 78). Beginning 09/11/President of Operation monitor and audit the days to ensure complete of the days to ensure complete of the days to ensure complete of the days to ensure complete of the days to ensure complete of the days to ensure complete of the days to ensure complete of the days to ensure complete of the days to ensure complete of the days to ensure complete of the days to ensure of the days to ensure of the designee performed its BIMS score of eight (if felt safe in the facility to or witnessed abuse conducted of resident designees weekly untremoved. **The State Survey at actions to remove the 09/26/2021 as alleged 1). Review of Head-to revealed staff assessing the days of t	2021, the Administrator sponsible for monitoring four (4) weeks to ensure naintained. 2021, the Administrator and be responsible for reviewing or four (4) weeks to maintain 2021, the Divisional Vice ms and/or designee will Administrator daily for 30 iance. vill be conducted beginning of ror residents' change of sation of need for "Stop and notition) communication. 2021, the Administrator or merviews of residents with a 3) or greater to ensure they and had not been subjected a. No residents had any will continue to be so by the Administrator or ill immediate jeopardy is	{F 6	684}			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	' '	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	U <i>ai</i>	30/2021
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{F 684}	#324, #45, #14, #357 current pressure ulce pressure injuries of tw comprehensive care p #324, #45, #14, #357 revealed staff updated the resident's current facility completed the A review of the facility revealed staff assess pressure ulcers with twith the Regional DO revealed she complete assessment on all residently completed assessments on all residently completed assessments on all residently completed assessments on all residently completed assessments and Braupdate the residents' Resident #65, #324, # and #358's care plans current pressure injur with MDS Nurse #1 or revealed she updated reflect current pressure addition, she complet rounds on 09/15/2021 the Registered Dietici DON, and the MDS N #324, #45, #14, #357 review revealed the Ir reviewed each resident's orders	idents (Residents #65, #27, #74, and #358) had res with a total number of yenty (20). A review of the plans for Residents #65, #27, #74, and #358 d the care plans to reflect pressure injuries. The review on 09/17/2021. It is census on 08/28/2021 and all residents at risk for the Braden Scale. Interview N on 09/30/2021 at 4:17 PM and head-to-toe skin didents on 09/11/2021. She he facility identified twenty wries. She further stated that the Braden Scale esidents on 08/28/2021. The revealed the interview of the skin den Scale assessments to care plans. She stated that the Braden Scale assessments to care plans. She stated that the scale assessments to care plans. She stated that the scale assessments to care plans. She stated that the scale assessments to care plans to re injuries by 09/17/2021. In the da review of walking with Therapy Personnel, and the Medical Director, the urse for Residents #65, #27, #74 and #358. A	{F 6	684}			

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{F 684}	Continued From page	2 415	(F 6	84}			
	revealed the Medical resident on 08/25/202 Stage four (4) pressur deep tissue injury (DT and a skin tear to the Resident #65's wound 08/26/2021 at 9:00 Al wound measured, "13 12.3 cm width and 0.2 at 10 o'clock measurin 12 o'clock that measur No palpable bone, slo removed with wound 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 stage two (2) to left hi cm x less than 0.1 cm scapula measuring 1 0.1 cm, unstageable tom by 0.6 cm. and fo measuring 12 cm by 1 Interventions in place heel protectors while in weekly documentation mattress to bed, nutrit turning/repositioning. for the sacral pressure 10:21 AM revealed the by 11 cm by 0.3 cm weekly 0.3 cm week	21 at 1:45 PM and noted a re ulcer on the sacrum; a left inner leg. Review of d care note dated M, revealed the sacrum 3 cm (centimeter) (length) by 2 cm depth with undermining at least 1 cm, muscle exposed. Ough is present, partially cleanser." The facility resident's sacral pressure. A review of a wound on 09/15/2021 revealed (6) pressure ulcers, (2) to the left superior calfungth) by 1.4 cm (width) by one (1) to the right hip 2 cm by less than 0.1 cm, ip measuring 1.2 cm by 0.8 or, stage two (2) to left cm by 0.2 cm by less than to right heel measuring 0.6 our (4) areas to the sacrum 11.6 cm by 0.4 cm. for the resident included in bed, diet as ordered, or of the wound, an air tional supplements, and Observation of wound care e ulcer on 09/29/2021 at e wound measured 13 cm with a scant amount of					
		ent granulation tissue. d would not consent to the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONS	STRUCTION		(X3) DATE SURVEY COMPLETED	
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{F 684}	record review revealer PM, Physician #1 detweight loss and woun 09/28/2021, Resident in-house wound care record revealed on 05 physician of the declin with no new orders. Twith Failure to Thrive. 3). The facility admitted 09/10/2021, completed 09/10/2021, completed 09/10/2021, and completed 09/10/2021, and completed 09/25/2021 and re-addission revealed staff develop plan on 09/21/2021. Are-admission revealed admission skin assess 09/28/2021, Braden State Care plan de 4). Observation of Reflect 1:48 PM, Resident #308 on Resident #310 on 09/2 Resident #311 on 09/2 Resident #314 on 09/2 Resident #320 on 09/2 Resident #320 on 09/2 Resident #320 on 09/2 Resident #320 on 09/2 Resident #320 on 09/2 Residents' beds. Interveduring the time of the identified concerns. A for Residents #45, #65	pressure areas. A medical and that on 09/21/2021 at 2:19 ermined the resident's adds were unavoidable. On a #65's family declined visits. Further review of the 8/29/2021, staff notified the me in the resident's wound the resident was diagnosed askin assessment on a glade 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 09/28/2021, and a veloped on 09/28/2021, and a veloped on 09/28/2021 at 1:10 AM, 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	84}	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	CONSTRUCTION	(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 ON NURSING HOME LANE PIKEVILLE, KY 41501	09/30/2021	
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{F 684}	and had no concerns Interview with the ISS revealed she interview #308, #309, #311, #3 with no identified concerns on 09/28/2021 from 1 no identified concerns reviews revealed Res #309, #311, #314, and shower preference and 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 sersident preferences, was interviewed for starting preference, and the faresident's care plan. A interviews revealed the preference was obtain shower schedule revealed shower/hygiene preference was obtain shower schedule revealed that she implemented recommendations for loss and/or wound he documentation reveal reviewed all residents DON reviewed all dief	with resident hygiene. D on 09/30/2021 at 2:23 PM wed Residents #45, #65, 14, and #320 on 09/15/2021 cerns regarding hygiene. didents during the initial tour didents during the initial tour didents during the initial tour didents #45, #65, #308, d #320 each had their d hygiene preference d on their care plan. A s medical record, including are plan and SRNA care dated each resident's plan s preference. Interview with Operations on 09/30/2021 dhe assisted with obtaining She stated each resident nower and hygiene decility updated each a review of resident deir shower/hygiene ded. A review of the facility's dealed that the resident rences were honored. Dietician on 09/30/2021 at de began reviewing all 8/2021. She further stated de new and/or additional dresidents to address weight	{F 684}			

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{F 684}	and recommendation: 7). A review of facility 08/13/2021 revealed with a diagnosis of Disigns and symptoms hyperglycemia and thintervention. Interview 09/30/2021 at 4:17 Pl the residents and did concerns. Observatio 09/28/2021 at 1:36 Pl 09/29/2021 at 11:32 A 09/29/2021 at 11:52 A signs/symptoms of hy A review of facility ass 08/12/2021 revealed diagnosis of Chronic Obsorder (COPD), Ast assessed by Respirat with Respiratory Ther at 12:45 PM revealed with diagnoses of Chronic Obsorder (COPD), Ast 08/12/2021 with no id Observation of Resident #4: revealed no respirator 8). Interview with the on 09/30/2021 at 3:40 all residents with a diagnose for g stated the facility ame include mandatory en	assessments completed by thirty-nine (39) residents abetes were assessed for of hypoglycemia/ e need for immediate with the Regional DON on M revealed she assessed not identify immediate ns of Resident #348 on M, Resident #320 on M, and Resident #311 on M revealed no visible poglycemia/hyperglycemia. Sessments completed on fifty (50) residents with a Obstructive Pulmonary thma and Pneumonia were ory Therapist #1. Interview apist (RT) #1 on 09/30/2021 she assessed all residents onic Obstructive Pulmonary thma, and pneumonia entified concerns. ent #45 on 09/28/2021 at 1:40 3 on 09/28/2021 at 2:03 PM.	{F 6	84}			

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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	1 09/	50/2021
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{F 684}	the glucose value on review revealed no contaving 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 Plobserved on 09/11/20 within five (5) to ten (1) scheduled times. 10). A review of the face of the	order required staff to enter the resident's MAR. Further oncerns 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 scility's staffing for AM to 6:00 PM revealed es and three (3) nursing duled for each floor of the efacility's staffing revealed each floor from 6:00 PM to g for 09/29/2021 and two (2) certified each floor Form 6:00 PM. Further review of (1) licensed nurse and two sistants for each floor from staffing on 09/28/2021 from	{F €	\$84}			
	to approximately 6:00	taff was offering and					

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE		(X5) COMPLETION DATE
{F 684}	and meal trays were plate interviews with RN # AM and on 09/30/202 #4/Wound Care Nurs-LPN (Licensed Practilat 12:44 PM; LPN #7 and 09/30/2021 at 12:50 F at 10:31 AM; State Re (SRNA/certified nurse 3:40 PM; SRNA #11 SRNA #7 on 09/29/20 on 09/29/2021 at 4:10 09/29/2021 at 3:04 Pl at 3:17 PM and SRN/PM, revealed staffing staff member revealed duties as assigned. 11). Review of the sta 09/28/2021, 09/29/2021 revealed each day co one (1) evening cook, day aides, and two (2 Observation of the kith PM reflected the staff schedule. Interview wat 1:12 PM, and Dieta 2:10 PM revealed kith and they were able to their shift. 12). A review of asses withdrawn, crying, or conducted for Resider 08/11/2021. No conce	was being conducted timely, bassed timely. 1 on 09/29/2021 at 11:55 (1 at 12:58 PM; RN) (2 on 09/30/2021 at 2:54 PM; cal Nurse) #6 on 09/30/2021 (3 on 09/29/2021 at 3:00 PM) (4 PM; LPN #10 on PM, LPN #11 on 09/30/2021 at 3:00 PM) (5 PM; LPN #10 on PM, LPN #11 on 09/20/2021 at 3:23 PM; cal at 3:29 PM; SRNA #19 (5 PM; SRNA #21 on 09/29/2021 at 3:29 PM; SRNA #21 on 09/29/2021 at 4:10 had improved, and each differ they had time to perform filing schedule for 21, and 09/30/2021 at 2:26 ing was accurate per the ith Cook #3 on 09/29/2021 at 4:10 had improved, complete their duties during sistents for being other abuse symptoms was not s #64, #86, and #322 on sistents #64, #86, and #322 on	{F 6.	84)			

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NAME OF PI	ROVIDER OR SUPPLIER	185256	B. WNG	-	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
	V POST-ACUTE AND RE	HABILITATION CENTER		20	IKEVILLE, KY 41501		
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{F 684}	and 09/30/2021 reveal with psychosocial and including observations and #322. Interview with abuse. Interview 09/29/2021 at 11:54 A with abuse. Interview 09/30/2021 at 1:39 Pl a diagnosis of Demer reviewed and revised with the RDON on 09 revealed she complet 08/11/2021, for all rest of licensed nursing stridentified. A review of Social Service Director BIMS score of eight (didentified concerns. 13). A review of assess wander, revealed all rewandering risk assess Review of the elopemeach nursing station of binder on each floor thincluding a description interventions for each 14). Review of Reside and #332's medical residents had been with the Reg 09/30/2021 at 3:53 Pl comprehensive nutritic Residents #39, #65, #Review of the medical completed a comprehensive and the state of the medical completed a comprehensive nutritice with the medical completed a comprehensive nutritice with the medical completed a comprehensive nutritice with the medical completed a comprehensive nutritice with the medical completed a comprehensive nutritice with the medical completed a comprehensive nutritice with the medical completed a comprehensive nutritical properties with the medical completed a comprehensive nutritical properties with the medical completed a comprehensive nutritical properties with the medical completed a comprehensive nutritical properties with the medical completed and completed and completed and completed and completed and completed and complete nutritical properties with the medical properties and completed and comple	s. Observation and on 09/28/2021, 09/29/2021, aled no identified concerns d/or physical abuse, s of Residents #64, #86, with Resident #322 on the revealed no concerns with MDS Nurse #1 on the revealed all residents with the had their care plans as necessary. Interview //30/2021 at 4:17 PM and skin assessments on the idents, with the assistance aff. No concerns were addits completed by the or (SSD) for residents with a second providents and received a sement by 08/16/2021. The interview of 09/29/2021 revealed a sement by 08/16/2021. The interview of 09/29/2021 revealed a sement identified at risk. The interview of the identified at risk. The interview of the identified at risk. The interview of the identified at risk. The interview of the identified at risk. The interview of the identified at risk. The interview of the identified at risk. The interview of the identified at risk. The interview of the identified at risk. The identified at risk of the identified at risk. The identified at risk of the identified at risk of the identified at risk. The identified at risk of the identified at risk of the identified at risk. The identified at risk of the identified at risk of the identified at risk. The identified at risk of the	{F €	84}			

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{F 684}	Resident #81, 09/16// 09/16/2021 for Resider 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 incluoatmeal pies, goldfish drinks were present, i juice. Observations or revealed snacks were Review of Resident #14's recordintake of snacks. Inter 09/29/2021 at 4:10 PM educated on documer 16). Observation of thy ellow zone on 09/28/no identified concerns residents. 17). Review of Resider revealed the residents guidance. Observation guidance. Observation	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 3:40 PM, the 30/2021 at 4:17 PM and 21 at 3:20 PM revealed each a comprehensive nutritional ew of the recommendations iter interview with the RD vealed 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 revealed documented exiew with SRNA #19 on M revealed she was intation of snacks. The zones contained no ents #327, #328 and #329 is were isolated per CDC in the solution of the contained for the solution of the solution of the contained for the solution of the solution o	{F 684			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII	RIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY
		185256	B. WING_				R 30/2021
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, 200 NURSING HOME LANE PIKEVILLE, KY 41501	ZIP CODE		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
{F 684}	or symptoms of COVI been discharged from 18). Review of facility staff working on 09/16 COVID-19 with no ide review of resident test 09/17/2021, revealed 19). Interview with MD at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 PM Director (HR) on 09/3 Marketing Liaison on Medical Records on 0 Central Supply on 09/0 on 09/29/2021 at 11:55 PM, RN #4/Wor 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 09/29/2021 at 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #2 SRNA #22 on 09/29/2021 at 09/29/2021 at 1:12 PM 09/30/2021 at 2:10 PM Director/Dietary Mana 1:30 PM revealed the (2) times weekly. Inter Control Nurse on 09/3/	M revealed no obvious signs D-19. Resident #327 had the facility. staff testing revealed all 6/2021 were tested for artified new cases. Further ting for COVID-19 on no new cases. OS Nurse #1 on 09/30/2021 at 1:31 istant #1 on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at 10:55 AM, 9/29/2021 at 10:48 AM, Senior 09/30/2021 at 10:55 AM, 9/29/2021 at 2:40 PM, RN #1 5 AM and 09/30/2021 at und Care Nurse on M, LPN #6 on 09/30/2021 at 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 on 09/30/2021 at 10:31 e9/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 on 09/29/2021 at 3:04 PM, 021 at 3:17 PM and SRNA 4:10 PM, Cook #3 on M, Dietary Aide #3 on	{F 6	84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WNG				30/2024
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	03/	30/2021
(X4) ID PREFIX TAG	(EACH DÉFICIENC)	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 684}	tested revealed tested times weekly. 20). Review of Reside and #90's medical recresident had COVID-1 implemented. In addit resident's MAR reveal monitoring as ordered 21). Interview with the 09/30/2021 at 3:25 PN Resident #321, Resident #321, Resident Resident #351's refor usage and appropriate physician on 09/23/2021 at 4:35 PN 09/30/2021 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 Care 2:54 PM, LPN #6 on 0 LPN #7 on 09/29/2022 09/30/2021 at 1:54 PN at 12:50 PM and LPN AM revealed no concernedications.	ce. Review of facility staff I is being conducted two (2) ent #329, #328, #311, #65 cord revealed that each 9 monitoring orders ion, review of each led staff was completing the I by the physician. Medical Director on I revealed Resident #9, ent #324, Resident #326 medications were reviewed riate administration times by 3/2021. medication pass on I on 3rd floor and I on 3rd floor revealed no th missing medications. In of a narcotic count on 5th 12:50 PM revealed no terview with RN #1 on IM and 09/30/2021 at 12:58 E Nurse on 09/30/2021 at 12:44 PM, I at 3:00 PM and III, LPN #10 on 09/30/2021 #11 on 09/30/2021 at 10:31 erns with unavailable Vice President of 1021 at 4:10 PM and 15 Pharmacy on 09/30/2021 oth parties made a formal	{F €	84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIÉR/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE	SURVEY
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		200	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501	1 03/	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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 684)	requiring cost review. pharmacy agreement requiring a cost review the facility a minimum medication while bein would communicate a guidance to the pharm Director of Operations the Vice President of signed the agreement 24). Interview with RN AM and 09/30/2021 at 09/30/2021 at 2:54 Pt 12:44 PM, LPN #7 on 09/30/2021 at 1:54 Pt at 12:50 PM, LPN #11 revealed they had recaware of the process from the pharmacy. In they were aware that physician if the pharm medication to the facility by 09/25/2021 at 3:40 09/30/2021 at 4:17 Ph completed of all reside and verified all medicafacility by 09/25/2021 and 09/30/2021 at 8:0 concerns with missing 26). Review of a QAP the facility conducted with the Regional DOI	Review of the facility's revealed for any medication when the pharmacy would send of a three-day supply of the greviewed. The facility any changes or continuance macy within 72 hours. The sof Guardian Pharmacy and Operations of the facility to the sof Guardian Pharmacy and Operations of the facility to the sof Guardian Pharmacy and Operations of the facility to the sof Guardian Pharmacy and Operations of the facility to the sof Guardian Pharmacy and Operations of the facility to the sof Guardian Pharmacy and Operations of the facility to the sof Guardian Pharmacy and Operations of the facility. If the sof Guardian Pharmacy and Operations of Operation of Marchael Pharmacy and Operation of Operations of the sof Operation of Marchael Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity. Regional Nurse Consultant of Pharmacy could not deliver a lity.	{F €	84}			

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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	1 00	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 CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE
{F 684}	Supply, MDS Nurse at 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 Coperations revealed and Administrator 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 a Consultant on 09/30/2021 at 3:25 Pl committee, including answering call lights, delivering meal trays and turning/reposition 09/15/2021. 29). Interview with the Operations on 09/30/2021 at 3:00 Pl conducted a conferent of the Med-Net Concept 09/28/2021 at 3:00 Pl conducted a conferent following: (1) the outce expectations and role outlined in the Rules a determined a plan for	eeping Supervisor, Central 21, MDS Nurse #2, the 22 Admissions Coordinator, 23 Activities Director, the 34 other members of the 35 Vice President of 36 2021 at 4:10 PM and 36 rim Administrator on 36 revealed the facility 37 Interim Administrator on 38 Interim Administrator on 39 Interim Administrator on 30 And members of the QAPI 31 She Regional Nurse 32 1 at 3:40 PM, revealed 31 Staff for call-ins, 36 ADL Care, serving and 36 timely, incontinence care 37 ing were reviewed on 38 Vice President of 39 20 21 at 4:10 PM, Regional 39 30 20 221 at 3:40 PM, and 30 Nurse Consultant on 30 A revealed the facility 31 Care and the survey, (2) 32 of the Governing Body as 33 and Regulations, (3)	{F 6	84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		E CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF P	ROVIDER OR SUPPLIER			- ;	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
					200 NURSING HOME LANE		
PARKVIEV	N POST-ACUTE AND RE	HABILITATION CENTER			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 684)	Continued From page	on, enough staff at the	{F 6	84}	}		
	facility to monitor/asse	ess residents, turn and provide incontinent care,					
	prepare and distribute	meals, and assist					
		caring for pressure wounds,					
		ervices, dealing with abuse					
		y, sufficient staff, providing d providing a functioning					
	QAPI committee.	a providing a functioning					
		e Interim Administrator on					
		M, and Regional Nurse 2021 at 3:40 PM revealed					
	reviewed and revised						
		and/or revision to the QAPI					
		09/16/2021 meeting. The					
		andardized plan to ensure					
	all topics were review	ed as needed at the QAPI	i				
		cluded pressure ulcers,	1				
	Foley catheters, enter						
		restraints, medication				-	
		ent, infection control, the					
	hospital re-admission						
	management, social s	resident council, and family					
		or grievances, admissions,					
		staff development, openings					
		n, employee orientations,					
		audit report, weight losses,					
		lions, employees on family					
	medical leave of abse	nce or leave of absence,	1				
		cord compliance review,					
		storative nursing, business					
	office, and admission						
		al Director approved the					
		on 09/16/2021 to include	-				
		ne topics presented during					
	o9/30/2021 at 1:39 PM	v with MDS Nurse #1 on M, MDS Nurse #2 on					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
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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			00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		HOULD BE		(X5) COMPLETION DATE
{F 684}	Manager on 09/28/20 09/30/2021 at 1:52 Pl Director/Dietary Mana 1:30 PM, Medical Rec AM, Human Resource 09/30/2021 at 10:48 A 09/30/2021 at 1:18 Pl Supervisor on 09/30/2 Respiratory Therapist 12:45 PM and Central 2:40 PM, revealed the at the QAPI meeting h 31). Interview with the Operations on 09/30/2 Administrator on 09/30/2 Administrator on 09/30/2 Director on 09/30/202 meeting was conducte the duties of the Gove policy and procedures facility and communic members of the Gove meeting, the QAPI pro participate regularly in need to identify root of utilization of the "5 wh systems per the QAPI 32). Interview with the 09/30/2021 at 3:40 PM monitoring reports befand reviewed the data QAPI attendance she conducted meetings of and 09/30/2021. Interview of Operations on 09/3	M, Regional Certified Dietary 21 at 2:26 PM and M, Former Activities ager #3 on 09/30/2021 at 20rds on 09/29/2021 at 8:34 EDirector (HR) on M, Therapy Manager on M, Housekeeping 2021 at 1:24 PM, (RT) #1 on 09/30/2021 at E information was presented aeld on 09/16/2021. Vice President of 2021 at 4:10 PM, the Interim 20/2021 at 3:40 PM, DON #2 PM, and the Medical 1 at 3:25 PM revealed a 2 and on 09/16/2021 regarding 2 aring Body including setting 2 to be implemented in the 2 ating Body. During the	{F 6	584}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF PI	ROVIDER OR SUPPLIER		1	_	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		21	00 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 684)	forwarded to them. 33). Interview with the Operations on 09/30// Regional Nurse Cons PM revealed the gove Administrator with res material for QAPI. Fur governing body would upcoming year. Interv Administrator on 09/3 he had been provided education regarding 0 34). Interview with the 09/30/2021 at 3:40 PM were conducted week ensure the quality of complied with the star compliance. Further in President of Operation PM, Regional Nurse 0 3:40 PM, MDS Nurse #2 of Regional Certified Die 09/28/2021 at 2:26 PM PM, Former Activities #3 on 09/30/2021 at 1 on 09/29/2021 at 8:34 Director (HR) on 09/30 Therapy Manager on Housekeeping Superv PM, Respiratory Themat 12:45 PM and Cent 2:40 PM revealed thematical revenues with them.	e Vice President of 2021 at 4:10 PM and the ultant on 09/30/2021 at 3:40 eming body provided the cources and education of the interviews revealed the dimeet quarterly for the riew with the Interim 0/2021 at 3:40 PM revealed I with resources and QAPI. Interim Administrator on of revealed QAPI meetings and education of the riew with the Vice of the Vice of the Vice of the Vice of the Vice of the Vice of the Vice of the Vice of the	{F €	84}			
		dition, an interview with the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI		DNSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501	03/	30/2021
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(F 684)	3:25 PM revealed he QAPI meetings on 09 Further interview with 09/30/2021 at 3:40 Pf meeting had been correview of the facility C sheet reflected the abidentified concerns. 35). Interview with RN AM and 09/30/2021 at 12:4 09/29/2021 at 3:00 Pf PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 Pf 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 3:17 09/29/2021 at 4:10 Pf education on 09/17/20 staff revealed they ve weighing residents, of reporting the weights (RD). Interview with Rat 4:17 PM revealed seducation on 09/17/20 techniques, obtaining reporting weight chan Dietician.	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 API meeting attendance rove interviews with no weekly CaPI meeting attendance rove interviews with no weekly CaPI 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 12:50 PM, LPN 10:31 AM, SRNA #1 on M, SRNA #1 on M, SRNA #1 on M, SRNA #1 on M, SRNA #22 on M, PM and SRNA #23 on M revealed they received 021. Interview with nursing rebalized understanding of obtaining, documenting, and to the Registered Dietician regional DON on 09/30/2021 staff was provided with 021 on proper weighing and ges to the Registered corn on 09/30/2021 at 1:30 are ron 09/30/2021 at 1:30	{F 6	84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE COMP	SURVEY
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		185256	B. WNG	_		09/	30/2021
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 684)	order accuracy. When the electronic medical the order sends writted dietary staff, which infurther revealed that is the tray card system to orders. She stated the previous day would be meeting. Interview with 09/28/2021 at 2:26 Pt PM revealed she comported from the provide additional assistation, she stated the provide additional assistation her new role. 37). Interview with RN AM and 09/30/2021 at 2:409/29/2021 at 3:00 Pt PM, LPN #10 on 09/30/00 09/30/2021 at 3:29 PM, LPN #10 on 09/39/20/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2001 at 3:17 09/29/2021 at 4:10 Pt education on turning/motion and transferring chair and from chair to turning, positioning, and 09/29/2021 at 10:2 revealed no identified	essments to ensure diet in staff enter diet orders into il record, the nurse entering in communication to the cludes diet and texture. She she entered the order into io reflect the resident's diet at all diet orders from the ie reviewed in the clinical the the Regional CDM on id and 09/30/2021 at 1:52 ipleted education with ctor/Dietary Manager #3. In inat she had been on site to iistance during the transition I #1 on 09/29/2021 at 11:55 it 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 id PM, LPN #7 on if and 09/30/2021 at 1:54 it 12:50 PM, LPN in and 09/30/2021 at 1:54 it 12:50 PM, LPN in and 09/30/2021 at 1:54 it 12:50 PM, LPN in and 09/30/2021 at 1:54 it 12:50 PM, LPN in and 09/30/2021 at 1:54 it 12:50 PM, LPN in and SRNA #1 on if it it it it it is	{F 6	84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY
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		185256	B. WING			09/	30/2021
NAME OF P	ROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE		
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		TABLETATION CENTER			PIKEVILLE, KY 41501		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 684}	AM and 09/30/2021 at Care Nurse on 09/30/0 n 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 3:40 PM 09/29/2021 at 3:40 PM 09/29/2021 at 3:23 PM at 3:29 PM, SRNA #11 SRNA #21 on 09/29/20 n 09/29/2021 at 3:17 09/29/2021 at 3:17 09/29/2021 at 4:10 PM education on pressure turning and reposition nutrition, Positioning and document a head and how to notify the RP of a new skin impaor email the Registere and the resident's repchanges. Interview with Consultant on 09/30/2 Regional DON on 09/2 revealed they educate prevention including the adequate hydration ard devices, how to comphead-to-toe skin asset the registered dietician new skin impairment, the nurse	range of motion, and I from bed. I #1 on 09/29/2021 at 11:55 I 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 I4 PM, LPN #7 on If and 09/30/2021 at 1:54 30/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on If SRNA #11 on If SRNA #11 on If SRNA #7 on 09/29/2021 If an on 09/29/2021 If an on 09/29/2021 If an on on on on on on one of the o	{F €	584)			
	39). Interview with MD	OS Nurse #1 on 09/30/2021					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		185256	B. WNG			09/	30/2021
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PARKVIEV	Y POST-ACUTE AND RE	HABILITATION CENTER		1	PIKEVILLE, KY 41501		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION
{F 684}	Continued From page	e 433	{F 6	384)			
	at 1:39 PM, MDS Nur	rse #2 on 09/30/2021 at 1:31		•			1
		sistant #1 on 09/30/2021 at					
		anager on 09/30/2021 at					
	1:18 PM, Housekeepi						
	09/30/2021 at 1:24 PI						
		0/2021 at 10:48 AM, Senior					
		09/30/2021 at 10:55 AM					
	Medical Records on 0	09/29/2021 at 8:34 AM					
	Central Supply on 09	/29/2021 at 2:40 PM, Cook					
	#3 on 09/29/2021 at 1	1:12 PM, Dietary Aide #3 on					
	09/30/2021 at 2:10 PI					}	
		ager #3 on 09/30/2021 at					
		y received education on				j	İ
	timely call light respon	nse. In addition, interviews					
	with RN #1 on 09/29/	2021 at 11:55 AM and					
	09/30/2021 at 12:58 F	PM, RN #4/Wound Care					
	Nurse on 09/30/2021	at 2:54 PM, LPN #6 on					
		PM, LPN #7 on 09/29/2021					
)/2021 at 1:54 PM, LPN #10	1				
	on 09/30/2021 at 12:5						
		AM, SRNA #1 on 09/29/2021					
		11 on 09/29/2021 at 3:23 PM	1				
		021 at 3:29 PM, SRNA #19					
	on 09/29/2021 at 4:10						
		M, SRNA #22 on 09/29/2021					
		A #23 on 09/29/2021 at 4:10					
		ceived education on timely					
		oviding timely hygiene per					
		timely toileting, ensuring					
		n their choice of clean					
		elivery of meal trays. Further					
		3 on 09/29/2021 at 1:12 PM,					
		0/30/2021 at 2:10 PM, and					
		ctor/Dietary Manager #3 on					
		M revealed they received					
	education on meal se	rvice times.					
	40) Intentious with \$40	OS Nurse #1 on 09/30/2021					
		rse #2 on 09/30/2021 at 1:31					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE OO NURSING HOME LANE PIKEVILLE, 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
{F 684}	Nurse on 09/30/2021 09/30/2021 at 12:44 F at 3:00 PM and 09/30 on 09/30/2021 at 12:5 09/30/2021 at 10:31 A education on ensuring entered into the electrobservation of RN #1 revealed the nurse was knowledge of the education on ensuring entered into the electrobservation of RN #1 revealed the nurse was knowledge of the education on 09/30/2021 at 2:40 09/29/2021 at 3:00 PM AM and 09/30/2021 at 12:40 09/29/2021 at 3:00 PM AM #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 #15 SRNA #21 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PM education on identificates with a changon identifying signs/sy hyperglycemia/hypogl protocol, documentate medical record, notification following physician or revealed they received documentation of gluctered for the process of	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 /2021 at 1:54 PM, LPN #10 io PM, LPN #11 on AM revealed they received g new care plans were ronic medical record. on 09/29/2021 at 11:55 AM as able to demonstrate cation with no identified 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, LPN 10:31 AM, SRNA#1 on M SRNA#1 on M SRNA#1 on M SRNA#1 on M SRNA#23 on M revealed they received ation and assessment of ge in respiratory status and imptoms of ycemia, facility diabetic g resident change in tion of blood sugar in the lation of the physician and ders. In addition, interviews dieducation on	{F 6	84}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
_		185256	B. WING_			₹ 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 684)	Care Nurse on 09/30/on 09/30/2021 at 12:4 09/29/2021 at 3:00 PP PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PP 09/29/2021 at 3:40 PP 09/29/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PP education on complet with interventions and diagnosis of diabetes within forty-eight hour reviewing and providing resident/responsible pp 44). Interview with MD at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 PM Director (HR) on 09/30/2021 at 1:24 PM Director (HR) on 09/30/2021 at 1:54 PM 12:58 PM, RN #4/Wor 09/30/2021 at 1:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 AM, SRNA #1 on 09/29/2021 at 09/29/2021 at 09/29/2021 at 3:29 PM	t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 14 PM, LPN #7 on M and 09/30/2021 at 1:54 0/2021 at 12:50 PM, LPN 10:31 AM, SRNA#1 on M SRNA#11 on M SRNA#1 on M SRNA#1 on M SRNA#2 on 09/29/2021 9 on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA#22 M PM and SRNA#23 on M, revealed they received ing a baseline Care Plan I goals relevant to the and a respiratory diagnosis s of admission, and ng a copy to the party. DS Nurse #1 on 09/30/2021 Se #2 on 09/30/2021 at 1:31 sistant #1 on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at 10:55 AM, 19/29/2021 at 2:40 PM, RN #1 15 AM and 09/30/2021 at und Care Nurse on M, LPN #6 on 09/30/2021 at 09/29/2021 at 3:40 PM, and M, 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	(F 6	34}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE S COMPL	
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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 0313	072021
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 684}	and SRNA #23 on 09 #3 on 09/29/2021 at 1 09/30/2021 at 2:10 Pl Director/Dietary Mana 1:30 PM revealed the process of identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying abuse as well as identifying on 09/30/2021 at 12:409/29/2021 at 3:00 Pl PM, LPN #10 on 09/30/2021 they received educatifying reporting of weight choletician. In addition, Manager on 09/30/2021 they received education of timelensure diet order according and provision of timelensure diet order according to the diet and texture. She orders from the previous clinical meeting, which is riday, to ensure according to the diet and the use of reducation on facility putines and the use of refortified diets to ensure	22 on 09/29/2021 at 3:17 PM //29/2021 at 4:10 PM, Cook 1:12 PM, Dietary Aide #3 on M, Former Activities ager #3 on 09/30/2021 at ry were educated on the g, preventing, and reporting stifying and implementing residents. N #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound /2021 at 2:54 PM, LPN #6 A4 PM, LPN #7 on M and 09/30/2021 at 1:54 60/2021 at 12:50 PM and 21 at 10:31 AM revealed on on proper weighing , documenting, and langes to the Registered an interview with the Dietary 21 at 1:30 PM revealed she on on diet order accuracy y nutritional assessment to uracy. When the diet orders onic medical record, the der will send a written dietary staff that will include further revealed all diet ous day are reviewed in the th occurs Monday through uracy. Dietary Manager on M revealed she received recipes, including recipes for	{F 6	84}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR IDENTIFICATION NUMBER: A. BUILDING COMPLET					
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NAME OF P	ROVIDER OR SUPPLIER	<u></u>		F	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	/30/2021
24 244					200 NURSING HOME LANE		
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER			PIKEVILLE, KY 41501		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTION		(X5)
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{F 684}	Continued From page	÷ 437	{F €	384	1		
	established national of	juidelines to reflect religious,	"`		'		
		eeds of the population.					
	47). Interview with the	Dietary Manager on	-				
		M revealed she received	1				
		g food preference, facility					
		er placement for meals,					
	and/or notion sizes	appropriate scoop sizes stocking snack/hydration					
	carts and snacks and						
	48) Interview with PN	I #1 on 09/29/2021 at 11:55					
		t 12:58 PM, RN #4/Wound					
:		2021 at 2:54 PM, LPN #6					
	on 09/30/2021 at 12:4						
		VI and 09/30/2021 at 1:54					
		0/2021 at 12:50 PM, LPN					l i
	#11 on 09/30/2021 at	10:31 AM and Former					
	Activities Director/Die						
		VI revealed they received					
		ess for entering, activating,					
	and/or implementing t recommendations for	he registered dietician's					
	recommendations for	dietary orders,					
	49). Interview with the	Interim Administrator on					
	3:20 PM Intention :::	M, DON #2 on 09/30/2021 at					
	3:20 PM, Interview wit 09/30/2021 at 1:39 PM						
		M, Maintenance Assistant #1					
		PM, Therapy Manager on					
	09/30/2021 at 1:18 PM						
		2021 at 1:24 PM, Human					
		R) on 09/30/2021 at 10:48					
İ		Liaison on 09/30/2021 at					
		ecords on 09/29/2021 at					
		ply on 09/29/2021 at 2:40					
		2021 at 11:55 AM and					
		M, RN #4/Wound Care					
	Nurse on 09/30/2021	at 2:54 PM, LPN #6 on	i				

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		;	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	(X5) COMPLETION DATE
{F 684}	at 3:00 PM and 09/30 on 09/30/2021 at 12:5 09/30/2021 at 10:31 At 3:40 PM, SRNA #1 SRNA #7 on 09/29/2021 at 4:10 09/29/2021 at 3:04 PM at 3:17 PM and SRNA PM, Cook #3 on 09/29/2021 Activities Director/Die 09/30/2021 at 1:30 PM received education or policy/guidelines, han Personal Protective Ered zones. Observation and yellow zone on 09 revealed no identified were in the red or yell conducted on 09/28/2 09/30/2021 revealed the COVID-19 policy/guidelines/(PPE), or the yellow/resonal protective Ered zones. Observation and yellow zone on 09/28/2 09/30/2021 revealed the COVID-19 policy/guidelines/(PPE), or the yellow/resonal protective with RN AM, and 09/30/2021 at 31:54 PM, LPN #10 on LPN #11 on 09/30/2021 at 31:54 PM, LPN #10 on LPN #11 on 09/30/2021 at 3355 on 09/10/2021 recovided admissions. A review #355 on 09/10/2021 recovided admissions.	PM, LPN #7 on 09/29/2021 //2021 at 1:54 PM, LPN #10 FO PM, LPN #11 on FM, SRNA #1 on 09/29/2021 It on 09/29/2021 at 3:23 PM FM, SRNA #21 on FM, SRNA #21 on FM, SRNA #22 on 09/29/2021 FM, SRNA #22 on 09/29/2021 FM, BRNA #23 on 09/29/2021 at 4:10 FM, SRNA #22 on 09/29/2021 FM, BRNA #23 on 09/29/2021 at 4:10 FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, Former FM, FORMER FM, FM, FORMER FM, FM, FM, FM, FM, FM, FM, FM, FM, FM,	{F 6	i84}			

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	PARKVIEW POST-ACUTE AND REHABILITATION CENTER			20	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501	007	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 684}	09/28/2021. A review Resident #355 reveals COVID-19 symptom resident orders. In add #329, #328, #311, #65 records revealed each monitoring orders imp 51). Interview with RNAM, and 09/30/2021 at 31.54 PM, LPN #10 on LPN #11 on 09/30/2021 at 31.54 PM, LPN #10 on LPN #11 on 09/30/2021 at 31.54 PM, LPN #10 on LPN #11 on 09/30/2021 at 31.54 PM, LPN #10 on the process to follow	-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 resident had COVID-19 elemented. I #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 10:31 AM revealed acation on the five (5) rights stration including right ent, right dose, right time, dition, they were educated by when a medication was nistration, which included to obtain the medication, and or given outside of the me. The education also	{F €	84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	E	,	0012021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	_	(X5) COMPLETION DATE
{F 684}	emergency medicatio floor three (3) on 09/29/2021 four (4) on 09/29/2021 at 2 medication administration with an emergency mulph (LPN) #9 on 09/3 she was a new hire to received education remedication kit. 53). Interview with DC PM, MDS Nurse #1 of MDS Nurse #2 on 09/Maintenance Assistant PM, Therapy Manage Housekeeping Super PM, Human Resource 09/30/2021 at 10:48 August Liaison on 09/30/2021 Records on 09/29/2021 Supply on 09/29/2021 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 09/29/2021 at 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #22 on 09/29/2021 at 2SRNA #22 on 09/29/2021 at #23 on 09/29/2021 at #23 on 09/29/2021 at 209/29/2021 at #23 on 09/29/2021 at #23 on 09/29/2021 at #23 on 09/29/2021 at 209/29/2021 at #23 on 09/29/2021 at #23 on 09/29/	acation on the use of the n kit (e-kit). Observation of 9/2021 at 3:10 PM, floor 1 at 2:57 PM, and floor five 2:50 PM revealed each ation room was equipped edication kit. Interview with 80/2021 at 2:27 PM revealed the facility and had garding the emergency ON #2 on 09/30/2021 at 3:20 in 09/30/2021 at 1:31 PM, 30/2021 at 1:31 PM, 30/2021 at 1:31 PM, at #1 on 09/30/2021 at 1:18 PM, visor on 09/30/2021 at 1:24 in Director (HR) on M, Senior Marketing 1 at 10:55 AM, Medical 21 at 8:34 AM, Central at 2:40 PM, RN #1 on M and 09/30/2021 at 12:58 are Nurse on 09/30/2021 at 12:58 are Nurse on 09/30/2021 at 12:44 in 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 at 10:31 in 09/30/2021 at 3:40 PM, SRNA #7 on M, SRNA #19 on 09/29/2021 on 09/29/2021 at 3:04 PM, O21 at 3:17 PM and SRNA 4:10 PM revealed they Interim Administrator's ad role as Abuse tion of the facility on	{F 6	584)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	O	X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	33/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATI	(X5) COMPLETION DATE
{F 684}	Abuse Coordinator policy is a constraint of the medical working and the weekly wound at 10:20 AM revealed review of the medical #324, #45, #14, #357, revealed the weekly wompleted with physic notifications. Interview 09/30/2021 at 3:53 Phof new and/or worsenize with Medical Director revealed that he was a worsening skin impair interventions to preverevealed that he particular and discussed ongoin residents. Interview won 09/30/2021 at 5:05 team discussed all aurincluding new and/or wand interventions implementations implementations in the construction of the auditor four (4) weeks and months. A review of at Observation of floor the	ted with the Interim ct information and title of sted throughout the facility. beginning 09/17/2021 of in assessments revealed . Observation of Resident ssessment on 09/30/2021 no identified concerns. A record for Resident #65, #27, #74, and #358 round assessments sian and responsible party with the Dietician on A revealed she was notified ing pressure ulcers and s as indicated. Interview on 09/30/2021 at 3:25 PM notified of new and/or ments and new nt decline. He further cipated in QAPI meetings g audits and care of ith the Interim Administrator PM revealed the QAPI dits in QAPI meetings, vorsening pressure injuries	{F 6	384}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TPLE CONSTI			X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200 NURS	DDRESS, CITY, STATE, ZIP CODE SING HOME LANE LE, 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)		COMPLETION DATE	
{F 684}	were audited during rensure all new areas been care planned withe area of concern. In oidentified concerns of the area of concerns of the area of concerns of the area of concerns of the area of concerns of the area of concerns of the area of concerns of the area of concerns of the area of the	e Regional DON on M, and DON #2 on M revealed progress notes norning clinical meetings to of skin impairment had ith interventions to address A review of audits revealed s. e Senior Marketing Liaison of AM revealed he nding of residents assessing ontinence, and resident on to other leadership staff. ealed staff were auditing dor, incontinent clean and sted or every two (2) hours, ed, 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 foring call light response ngth of time call lights go ws revealed any call ve (5) minutes were aff. A review of audits ompleted on different units e RDON on 09/30/2021 at e completed audits of	{F 6	84}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	i	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
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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		09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE		(X5) COMPLETION DATE
{F 684}	completed had physici implementation of phy Resident #315 SBAR #324 SBAR complete completed on 08/15/2 physician notification, plans updated as indirevealed no identified 60). Review of Reside admitted on 09/10/202 had a baseline care p 09/10/2021. Resident 09/25/2021 and re-ad 09/28/2021. Further refor Resident #355 rev comprehensive care p (11) days after admissive-admission for Resident had a baselin 09/28/2021. Interview 09/30/2021 at 1:39 PM 09/30/2021 at 1:31 PM admissions and re-ad being reviewed during meeting Monday through the completion. 61). Review of the add days from 07/16/2021 concerns with baselin MDS Nurse #1 on 09/revealed new/admissibeing updated as need to the side of the s	lor SBAR assessments cian notification and/or ysician orders. Review of completed on 09/26/2021, don 09/27/2021, and #326 lo21 revealed assessment, interventions, and care cated. A review of audits concerns. Lent #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 realed staff completed the plan on 09/21/2021 (eleven sion). A review of dent #355 revealed the recare plan developed on with MDS Nurse #1 on with MDS Nurse #2 on with revealed all new missions to the facility were of the morning clinical uph Friday to ensure	{F 6	84)			
:	at 1:39 PM revealed n	lew admission baseline care lited Monday-Friday for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[]	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY
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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	:	007	00/2021
(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 684}	was conducted with the responsible party with admission/re-admission revealed the audits withrough Friday. A revirevealed they include date, baseline care plied delivered to resident a and education as nee revealed no identified dates as indicated. 63). Review of the autand/or CDM revealed stated with no identified the Regional Certified 09/28/2021 at 2:26 Pl PM, and Dietary Manaliso PM revealed trayensure they arrived or timely. 64). Review of verbal staff members were question. Further review and five (5) staff four (4) weeks from 03 on 09/13/2021 with no review of the verbal quizzed on respiratory hypo/hyperglycemia, anotification. Interview Consultant on 09/30/2 Regional DON on 09/3/2 Regional DON on 09/3/2 on 09/30/2021 at 3 on 09/30/2021 at 1:31	and to ensure a review me resident and/or sin 48 hours of on. Further interviews ere conducted Monday ew of the audits completed d resident name, admission an completion, care plan and/or responsible party, ded. 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 09/30/2021 at 1:52 ager #3 on one of the unit and were passed quizzes revealed ten (10) uizzed for one (1) week 21 with no needed view of verbal quizzes 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 8/201 at 3:40 PM, the 30/2021 at 4:17 PM, DON 6:20 PM, and MDS Nurse #2	{F 6	84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE	SURVEY LETED
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	031	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 684}	hyperglycemia/hypogrotocol, documenting condition, notification following physician or on 09/29/2021 at 11:58 PM, RN #4/Wo 09/30/2021 at 2:54 PM 09/30/2021 at 12:44 Pparticipated in verbal 65). Interview with the 09/30/2021 at 4:17 PM audits of documented Monday through Frida She further revealed to less than 60 and/or grataff were expected 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 vevidence the licensed process. She provide and LPN #5. A Review further concerns. A Ren #2 and LPN #5 rethe facility process. 66). Review of verbal was verbally asked signal wandering interveverbal quizzes reveale quizzed daily for one	nts 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 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 onotify the physician, and Registered Dietician and its. The Regional DON one (1) resident on blood glucose level of 430 2021 to have a blood	{F 6	84}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER V 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				х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 684}	three (3) times a weel 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 09/30/2020 at 4:17 Pt 09/30/2021 at 1:39 Pt the completion of vertinterview revealed that verbally quizzed on the tool (signs and symptogeneous) wandering intervention education was completed to 19/30/2021 at 1:54 Pt 11:55 AM and 09/30/2021 at 1:54 Pt 11:55 AM and 09/30/2021 at 1:54 Pt 11:55 AM and 09/30/2021 at 10:48 AM Assistant #1 on 09/30/2021 at 10:48 AM Assistant #1 on 09/30/2021 at 10:48 AM Assistant #1 on 09/30/2021 at 10:48 AM AM AM AM AM AM AM AM AM AM AM AM AM	al quizzes were conducted k for two (2) weeks from 2021 with no identified for 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 W, and MDS Nurse #1 on W revealed each assisted in 2021 staff quizzes. Further at each staff member was at eareas listed on the audit 2021 of 2021 at 3:40 PM, and any need for 2021 at 3:40 PM, and any need for 2021 at 3:40 PM and 40, RN #11 on 09/29/2021 at 4:60 on 09/30/2021 at 12:54 PM, 2021 at 12:58 PM, RN 2021 at 12:58 PM, RN 209/20/2021 at 2:40 PM, 209/20/2021 at 2:40 PM, 209/30/2021 at 1:18 PM, 209/30/2021 at 1:18 PM, 209/30/2021 at 2:56 PM revealed 2021 at 3:55 on 09/10/2021	{F 6	\$84}			
	wandering risk assess						

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	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200 N	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501		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)		(X5) COMPLETION DATE
{F 684}	09/28/2021. A review Resident #355 reveals admission wandering on 09/28/2021. The rebe at risk for wandering Nurse #1 on 09/30/20 MDS staff will schedu assessments to ensur Regional Nurse Consiper Mand DON #2 on 0 revealed all-new admin the morning clinical appropriate assessme wandering risk assess Further interviews revidentified as at risk for discussed during this interventions implementately with a BIMS score of identified concerns. Continuous weeks then five (5) resident interview with ISSD of and MDS Nurse #1 or revealed they were as with residents with no of audits initiated on 0 random weekly skin a with a BIMS score of I there are no injuries on identified concerns Nurse Consultant on 0	mitted to the facility on of re-admission for ed the resident had an risk assessment completed esident was not identified to one. Interview with MDS 21 at 1:39 PM revealed that le wandering risk re completion. Interview with ultant on 09/30/2021 at 3:40 9/30/2021 at 3:20 PM issions would be reviewed meeting to ensure ents, including the sment, had been completed. ealed that residents readed that residents readed appropriate ented. Bews performed for residents on onlinued review revealed ed on 08/13/2021 with ten residents for eight (8) weeks. In 09/30/2021 at 2:23 PM, In 09/30/2021 at 1:39 PM issisting in completing audits concerns identified. Review 18/13/2021 for review of seessments for residents less than eight (8) to ensure of unknown origin revealed in the review with Regional 19/30/2021 at 3:40 PM, and 121 at 3:20 PM revealed they is as indicated with no	(F 6	84}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	33,33,
(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 CORREC PREFIX (EACH CORRECTIVE ACTION SHOI TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		
{F 684}	9:23 AM and on 09/31 Resident # 27 reveals of unknown origin. 69). Interview with the 09/30/2021 at 3:53 Plaudits on 08/25/2021 electronic medical regin the diet/tray card si Review of Resident # 09/29/2021 at 12:04 I on 09/29/2021 at 12:04 I on 09/29/2021 at 12:04 I on 09/29/2021 at 12:04 I on 09/29/2021 at 12:04 I on 09/29/2021 at 12:04 I on 09/29/2021 at 12:04 I on 09/29/2021 at 12:04 I on 09/29/2021 at 12:04 I on 09/29/2021 at 1:30 Pl Manager on 09/28/20 09/30/2021 at 1:52 Pl performed as indicate revealed that meals wincluding breakfast at PM, and dinner at 5:00 09/28/2021 lurich at the third floor at ap	2021 of Resident #45 at 202021 at 10:20 AM of ed no concerns with injuries are Registered Dietician on M revealed she started of resident diet orders from cords against orders entered oftware to ensure accuracy. 308's tray card on PM, Resident #39's tray card 26 PM, and Resident #334 21 at 12:30 PM revealed ordered by the physician. A alled audits were conducted teks. Starting 08/30/2021, abserved two (2) times per as and then weekly from month. Interview with ctor/Dietary Manager #3 on PM, Regional Certified Dietary 21 at 2:26 PM, and M revealed audits were as scheduled, 7:00 AM, lunch at 12:00 00 PM. Observation on prevention of the third floor. Observation meal revealed meals arrived proximately 12:16 PM, the PM and 12:24 PM, and the	{F 6	584}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PRÖVIDER/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			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		<u> 09/</u>	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 APPROPE DEFICIENCY)				COMPLETION DATE
(F 684)	09/29/2021 at 12:04 For 09/29/2021 at 12:04 For 09/29/2021 at 12:04 For 09/29/2021 meals honored reside likes and dislikes. Interview of an 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 PM revealed she audit not identified any concerns. Observation 09/28/2021, 09/29/2021 revealed no concerns. 72). Interview with the (HR) on 09/30/2021 at 3:40 at 4:17 PM, DON #2 of and Interview with the on 09/30/2021 at 3:40 at 4:17 PM, DON #2 of and Interview with the on 09/30/2021 at 3:10 PM being conducted with handwashing, isolation donning/doffing PPE, variance or identified of immediately. A review	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 ent preferences, including enview 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 10:21. Interview with the etary Manager on 10:21 Manager on 10:22 Manager on 21 Manager on 22 Manager on 23 Manager on 24 Manager on 25 Manager on 26 Manager on 27 Manager on 27 Manager on 28 Manager on 29:30:2021 at 1:52 Manager on 30:30:30:30:30:30:30:30:30:30:30:30:30:3	{F 6	584}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		(X3) DATE COMP	SURVEY PLETED
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PARKVIEW POST-ACUTE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501				
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
{F 684}	Continued From page shifts 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 09/30/20 (LPN) #6 on 09/30/20 #7 on 09/29/2021 at 3:54 PM, LPN #10 on LPN #11 on 09/30/20 concerns with obtaining and/or receiving medication pass or the third floor and 09/20 revealed no identified medications. In additionarcotic count on the 12:50 PM revealed no 09/30/2021 at 3:40 on 09/30/	e Regional Nurse Consultant DPM revealed she was In to other members to In narcotics with the hat an active script is on file I. A review of audits revealed III. RN #1 on 09/29/2021 at III. RN #1 on 09/29/2021 at III. RN #1 on 09/30/2021 at III. RN #1 on			T COPRIA		
	stated she had not ide residents not having na counts. A review of au utilized the Centers for Element Pathway for a conduct the medication twenty-five medication revealed a minimum of were observed daily fire	of twenty-five medications rom 09/25/2021 with no					
	observations revealed	urther review of medication that medication served on random shifts,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		200 N	ET ADDRESS, CITY, STATE, ZIP CODE URSING HOME LANE VILLE, KY 41501	1 00	00/2021
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{F 684}	6:00 AM. 76). Interview with the on 09/30/2021 at 3:40 09/30/2021 at 3:20 Pl delivery tickets were I meetings Monday thromedications. A review identified concerns. 77). Interview with the 09/30/2021 at 5:05 Pl Consultant on 09/30/2021 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 5:05 Pl on 09/30/2021 at 1:30 being monitored daily staffing. A review of the identified concerns. 79). Interview with the Operations on 09/30/2021 at 09/30/2021 at 09/30/2021 at 09/30/2021 at 1:30 being monitored daily staffing. A review of the identified concerns. 80). Interview with the on 09/30/2021 at 10:5 completed observatio	Regional Nurse Consultant PM. The DON on M revealed medication Deing reviewed in clinical Dough Friday against ordered Of the audit revealed no Interim Administrator on M, Regional Nurse 2021 at 3:40 PM, RDON on M revealed staffing was Eginning 09/11/2021, to Ding was maintained. A Evealed no identified Interim Administrator on M, and the Dietary Manager PM revealed staffing was to ensure adequate the audits revealed no EVice President of 2021 at 4:10 PM and Interim D/2021 at 5:05 PM revealed conducted daily from of the audits revealed no	{F 6	84}			

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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	VIDER OR SUPPLIER	HABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		/30/2021
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(F 686) SS=D CI S4 S4 S4 S4 S4 S4 S4 S4 S4 S4 S4 S4 S4	lentified, staff would on audit review reveal hange of conditions recility staff. 1). Review of interview 19/25/2021 for resider regreater revealed no exiew of the question atterviews revealed reveryone treating you have an exident and records of the compart o	a change in condition was complete a stop and watch. led no concerns with the not being addressed by ews performed on not with a BIMS score of 8 to identified concerns. A maire completed during sidents were asked: Is well? Do you feel safe by concerns? Interview with Staff on 09/29/2021 at 8:34 pleted the interviews with 21, and she stated she concerns. In the state of the interviews with 21 and she stated she concerns that it is of practice, to prevent ones not develop pressure ridual's clinical condition by were unavoidable; and source ulcers receives and services, consistent dards of practice, to ent infection and prevent	{F 6				12/30/21

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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(F 686)	Continued From page	453	(F 68	6}		
	by: Based on observation and review of the facility five (5) sampled reside Resident #66) receive ulcers and failed to en was provided for four with pressure ulcers (#45, Resident #14, and promote healing, previous pressure ulcers for the facility admitted for without pressure ulcers for the facility admitted for without pressure ulcers for the coccyx. The facility pressure ulcer (measure ulcer) ulcer (measure	rent infection and/or prevent from developing. Resident #65 on 03/23/2021 frs. The facility failed to turn ident. On 05/02/2021, fred a deep tissue injury to try failed to assess the facility the facility he pressure ulcer had 2021, Resident #65 was fregency Department (ED) free pressure ulcer and was farge decubitis [pressure] infection including cellulitis free free free free free free free fre		F 686 Treatment/Svcs to Prevent/He Pressure Ulcer Criteria 1: a) Resident #65 was discharged from the facility on 10-31-2 b) Resident #66 was discharged from the facility on 6-19-20 c) Resident # 323 was discharged from the facility on 7-20-20 c) Resident #14 and ,# continue to receive wound care service through Vohra wound care and have the assessed and treatment provided per orders. Criteria 2: a) On 9-11-21 head to to skin assessments were completed on a residents. Braden Scale was complete on all residents by facility nurses 8-28-2021. Using both the head-to-toe skin assessment and Braden scale, comprehensive care plans were review to ensure residents with pressure injurihad a care plan by 9-17-21. b) On 11/24/2021 reside with pressure injuries were assessed be the DON/ designee to ensure that the pressure injuries were receiving treatm per physician order. c) Beginning 08-28-2021 registered dietitian reviewed all resident diets. She made recommendations for meal changes or supplements to prome healing and to address any weight loss.	021 21 21 45 es leir ee all ed ed es nts y ent ote	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY
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{F 686}	In addition, the facility a Stage III (3) pressur the left sacrum. How documented evidence in accordance with the assessment form, incappearance, etc. On 06/30/2021, a work Resident #45 and not left buttock was a Statexcisional debrideme. The facility failed to a pressure ulcer during from 07/02/2021 through 13/2021, a foul-sm depth and drainage fronted. The resident where he/she require wound care. The prelevel of the left ischial Resident #45 was dia (infection of the bone). Review of Resident #45 was dia (infection of the sone). Review of Resident #45 was dia (infection of the sone). The resident's skin and as required. Further, the facility ad 07/06/2021 with Physhis/her pressure ulcer (collagenase). The facility and 07/06/2021 with Physhis/her pressure ulcer (collagenase). The facility and 07/06/2021 with Physhis/her pressure ulcer (collagenase). The facility and 07/06/2021 with Physhis/her pressure ulcer (collagenase). The facility and 07/06/2021 with Physhis/her pressure ulcer (collagenase).	ridentified Resident #45 had re ulcer on 06/01/2021 to ever, there was no e the wound was assessed e facility's wound duding measurements, und care specialist assessed ted the pressure sore to the to the level of the muscle. It is seen to see the resident's weekly skin assessments uph 08/08/2021. On helling odor and increased from the wound bed was was transferred to the ED dignosed with Osteomyelitis or increased with Osteomyelitis or incre	{F €	86)	issues. Criteria 3: a) Beginning 9-17-21 upgadmission a skin assessment and Brad Scale will be completed, and the baselicare plan will be developed within 48 hours to include any pressure ulcer or potential for pressure ulcer, a comprehensive care plan will be developed within 21 days of admission include pressure ulcers or potential pressure ulcer and include intervention to prevent pressure ulcer development worsening of pressure ulcers. b) All nursing staff were educated beginning 9-17-21 by the Director of Nursing, MDS coordinator of designee on proper weighing technique obtaining, documenting, and reporting of weight changes to the Registered Dietician. c) On 9-13-21 the Dietar Manager was educated by the Regional CDM on diet order accuracy and provis of timely nutritional assessment to ensure the transfer of resident from bed to chair and chair to be deginning 8-19-2021. e) Additional staff has been added through recruitment and agency contract to ensure the there are enough staff to turn and reposition all residents who are unable to reposition themselve f) Beginning 11-24-21 all nursing staff were educated by the Regional Director of Nursing, Regional	to s or r es, of ion ire	

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			S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
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{F 686}	facility. In addition, the facility Resident #66 on 06/1 after 4:14 PM. The facility's failure to care to prevent pressifailure to ensure a residence received the necessal promote healing and caused or is likely to dimpairment or death to Jeopardy was identified determined to exist or 483.10 Resident Right Freedom from Abuse Comprehensive Perso (F655) (F656), 42 CF (F684) (F686) (F692), Services (F755) and 4 Control (F880). The fall mmediate Jeopardy of the Immediate Jeopardy of the Immediate Jeopardy of the Immediate Jeopardy of 483.35 Nursing Service Administration (F835) Quality Assurance and Improvement (F867).	refailed to turn and reposition 6/2021 from 9:27 AM until ensure residents received ure sore development and sident with pressure ulcers ry care and treatment to prevent infection has cause serious injury, harm, or a resident. Immediate ed, on 08/11/2021, and was in 03/06/2021, at 42 CFR 483.12 (F600), 42 CFR 483.12 (F600), 42 CFR 483.12 (F600), 42 CFR 483.45 Pharmacy 42 CFR 483.80 Infection acility was notified of on 08/11/2021. It ion of Compliance (AOC) 3/2021, which alleged liate Jeopardy on ry, the AOC could not be ervations, staff interviews, documentation. Additional was identified at 42 CFR 2cs (F725), 42 CFR 483.75 d Performance The facility was notified of rdy on 09/10/2021. The	{F 6	886}	Nurse consultant or Director of nursing designee on pressure ulcer prevention including turning and repositioning, adequate hydration and nutrition, Positioning devices, and providing treatments per physician orders. This was be added to the new hire orientation. So not working will be educated on their not scheduled shift. A post test will be administered and graded by the DON of designee to ensure staff competency. g) Beginning 9-25-21 licensed nurses were additionally educated on how to complete and document a head-to-toe skin assessment in EMR, measuring and staging of pressure injuries per EPUAP (wound assessment) and how to notify the registered dietician, MD, and RP of an skin impairment. With any change to skimpairment the nurse will call or email to Registered Dietitian for new recommendations, MD, and resident is representative. New or worsening wounds/pressures that are identified either by the Weekly Wound Care rounding by the Wound Care nurse and Wound Care Doctor and/or by nursing staff during turning/repositioning and/or showers requires the notification to the MD and RP, intervention/treatment, update of the care plan, along with wee updates and review by the Weight Loss IDT which includes (Dietary Manager, Social Services, Activity Director, DON/ADON, Wound Care Nurse, Administrator, Dietician) for updates	vill taff ext ent ed ew kin he	

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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	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 PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	was received on 09/25 removal of the Immed 09/26/2021. The Stat determined the Immer removed as alleged d 09/28-30/2021, which severity to "D" 42 CFF (F580), 483.12 Comproduced Care Plans (F655) (F6 Quality of Care (F684 Nursing Services (F72 Pharmacy Services (F483.12 Freedom from 483.25 Quality of Care Administration (F835)	allegation of compliance 5/2021, which alleged liate Jeopardy on the Survey Agency diate Jeopardy was uring a revisit conducted on lowered the scope and R 483.10 Resident Rights rehensive Person-Centered 656), 42 CFR 483.25 () (F686), 42 CFR 483.35 (25), and 42 CFR 483.45 (755); and to "E" at 42 CFR Abuse (F600), 42 CFR the (F692), 42 CFR 483.70 (F837), 42 CFR 483.75	⟨F 68	36}	and/or recommendations. Criteria 4: a) Beginning 11/24/2021 the DON or designee will audit weekly heat to toe skin assessments that are completed by staff nurses to ensure the have been completed weekly on each resident and any new skin impairment thas been identified has had the MD, RI and RP notified and confirm any new interventions have been put in place to prevent decline and new intervention is care planned Audits will be reviewed monthly in QAPI x3 months then quarte until in substantial compliance b) Beginning 12/11/21 the	hat O	
	and quality assurance The findings include:	and 42 CFR 483.80 0), while the facility ness of systemic changes activities.			DON and/or designee began visual audof resident noted to be in need of assistance with turning and positioning. Random Audits will be be conducted weekly x 4 weeks then monthly x 2 months to include one resident per flooper shift to ensure turning and repositioning is done. Audits will be	lits	
	Injuries Policy, revised purpose of the policy regarding identification factors and intervention. The policy stated a riscompleted upon admichanges in condition. also required upon ad assessment, as indicated resident's risk factors. policy revealed staff with skin clean and hydrate	Further review of the vere required to keep the ed, clean promptly after noe, reposition all residents			reviewed monthly in QAPI x3 months the quarterly until in substantial compliance: Criteria 5: Date of compliance: 12/30/2021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (7)		IDENTIFICATION NUMBER		JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			1	R 30/2021	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE			
(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 686}	Interdisciplinary Team for repositioning base factors and current cli The policy further state evaluate, report and on the skin, and review strategies for effective Review of the facility's "Repositioning", dated "Repositioning is a contervention for prever promoting circulation, relief." Further review "Residents who are in an every two hour (queschedule". Interview with the Ass (ADON)/Acting Direct 08/11/2021 at 12:05 Finot have a policy regrassessment, but the assess pressure ulce weekly, including metafor changes in status residents should be to least every two (2) hoshould be provided experted by the should be provided experted by the same session of a Head Check form. In additing pressure ulcer, staff services and current staff services and current staff services and current should be to be should be provided experted by the same session of a Head Check form. In additing pressure ulcer, staff services and current staff	le as determined by the (IDT), choose a frequency of on the resident's risk inical practice guidelines. It is the facility should document potential changes or interventions and eness on an ongoing basis. Is policy titled, di May 2013, revealed, mmon, effective inting skin breakdown, and providing pressure of the policy revealed, in bed should be on at least 2 hour) repositioning It is tant Director of Nursing for of Nursing (DON) on one of Mind of the facility did arding pressure ulcer expectation was for staff to resupen admission and assurements and to assess a According to the ADON, all furned and repositioned at least overy two (2) hours. If the ADON, on 08/11/2021 did staff should conduct a lent and document the lad to Toe Weekly Skin on, if a resident had a should assess the wound, is, and notify the resident's	{F 6	86)				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	Œ	1 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC 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 686}			{F 6	DEFICIENCY)			
	Further review reveal for pressure ulcers bat assessment instrume assessment. According 03/30/2021, Resident pressure reduction de on a turning/reposition have nutrition or hydromanage skin problem.	and had no pressure ulcers. Iled the resident was at risk ased on a formal ent (Braden) and clinical ing to the MDS dated t #65 did not have a evice for the chair, was not ening program, and did not ration interventions to					

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				₹ 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
{F 686}	with a score of eighter fast; slightly limited madequate nutrition, frid Review of the Admiss Evaluation on 04/29/2 Braden Scale assess Resident #65. The re (14), indicating the respressure ulcers. The limited sensory proble confined to bed (bedfapotential problems with friction, and shearing. Review of Resident #6 dated 03/23/2021 at 1 though the resident wilcers, the facility didulcer prevention intervented and comprehensident with intervented resident's high risk for attempt to prevent pre April, or May 2021. Significant documented evidence individualized turning as required by the fact the resident's risk fact.	o3/23/2021 revealed risk" for pressure ulcers en (18), due to being chair obility; and, problems with ction, and shearing. ion/Readmission Nursing (22) at 6:00 PM revealed a ment was completed for sident scored a fourteen sident was at "high risk" for risk was due to slightly ems; occasionally moist; ast); very limited mobility; th adequate nutrition; and, 65's Baseline Care Plan (1:00 AM revealed even as at high risk for pressure not implement any pressure ventions. ident #65's medical record ted evidence the facility ensive care plan for the tions to address the ressure ulcers in March, ubsequently, there was no enthe IDT determined an and repositioning schedule, ility's policy, and based on ors. Resident #65's medical	{F €	686)			
		d Resident #65 was pital on 04/08/2021 for nd was re-admitted to the				:	

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 ** POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	Failure, and Urinary T Admission/Readmissi Resident #65 dated 0 revealed the resident bilateral buttocks upo hospital, with no other noted. Continued review of Frecord revealed no do facility turned/repositive every two (2) hours a requirement. Review of a change of 05/02/2021 at 10:35 A had developed a deep purple or maroon local intact skin or blood-fill underlying soft tissue shear) to the coccyx. obtained to "clean cocpat dry, apply zinc oxigauze every day". The evidence the facility a (measurements, apper completed a Weekly F05/02/2021, when the Interview with License on 08/25/2021 at 4:00 the deep tissue injury coccyx/sacrum area. was reddened, round of a quarter. LPN #4 measured the area but the complete and the area but the control of the deep tissue injury coccyx/sacrum area.	with diagnoses that umonia, Acute Respiratory fract Infection. Review of an on Nursing Evaluation for 4/29/2021 at 6:00 PM had "scratches" to his/her in readmission from the r impaired skin integrity Resident #65's medical ocumented evidence the oned the resident at least is the ADON stated was a If condition form dated AM revealed Resident #65 or tissue injury (DTI is a alized area of discolored ded blister due to damage of from pressure and/or A Physician's Order was ocyx with soap and water, ide and cover with border were was no documented ssessed the pressure ulcer earance, etc.) and Pressure Wound Note on DTI was identified. ad Practical Nurse (LPN) #4 DPM revealed she identified (DTI) to Resident #65's She stated that the area and approximately the size stated she should have	{F 6	886}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WNG	B. WNG			R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE		200 NURSING HOME LANE		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 PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)				(X5) COMPLETION DATE
{F 686}	education regarding in a pressure ulcer. Corprior to the "new compthe wound care nurse all pressure ulcers. He protocol for assessulcers. Review of a Head to 10 (skin assessment) for 05/08/2021 at 3:38 Pl measured the resident Injury" as 6.5 centimed deep, and 0 cm in dep documented evidence wound per the Weekly (assessment of the protocol of the	one had ever provided her neasuring and/or assessing national interview revealed pany" taking over the facility, assessed and measured lowever, she was unsure of sing, measuring pressure Toe Weekly Skin Check Resident #65 dated M, revealed the facility at's 'Suspected Deep Tissue aters (cm) in width by 9.3 cm on the however, there was no eather facility assessed the pressure Wound Note are succer including the agrees of the wound at, worsening, etc.]). of Condition" form on the revealed Resident #65's accocyx was "worsening".	{F €	886}			

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				₹ 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 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)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	resident's coccyx had long by 10 cm wide. 305/19/2021, the press coccyx/sacrum meast cm in width. Continue Weekly Skin Checks of PM revealed the reside sacrum increased in sacrum increased in sacrum increased in sacrum increased in sacrum increased in sacrum increased in sacrum increased in sacrum increased the wound's drainage or odor was facility continued to travith calcium alginate. documented evidence was notified that the prin size. Interview with License on 08/25/2021 at 7:45 #65's wound "progresshe worked the fourth Resident #65. Howevif she notified the phyresident's pressure ulcare nurse was respondented in a pressure ulcare nurse was respondented in a pressure ulcare she would notify should notify the physician. LPN #6 change in a pressure ulcer she would notify should notify the physician revealed the physician worrevealed the physician revealed revealed the physician revealed revealed the physician revealed revea	geable pressure ulcer to the increased in size to 10 cm Seven (7) days later, on sure ulcer to the ured 9.5 cm in length and 10 ed review of the Head to Toe dated 05/26/2021 at 5:37 dent's pressure ulcer to the size, measuring 16.5 cm e. Further review revealed inted evidence the facility is appearance, or whether present for any date. The eat Resident #65's wound However, there was no expressure ulcer had increased are pressure ulcer had increased and Practical Nurse (LPN) #6 is PM revealed Resident sed rapidly". She stated floor and provided care for ver, she was unable to recall sician of the decline in the cer. She stated the wound insible for measuring and dicers; therefore, she is care nurse was contacting 6 stated if she noticed a ulcer or a new pressure in the wound care nurse, who incian.	{F €	\$86}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER	· · ·	200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE REVILLE, KY 41501	1 00	3072021
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	decided to send reside evaluation and treat frarea." Interview with State R (SRNA) #4 on 08/26/2 Resident #65's presson about a month and not stated she knew their bad and smelled bad' provided care to Resident with the residents un Resident #65 and oth pressure ulcers, were but not every two (2) not enough staff. Interview with Registe 08/24/2021 at 3:49 PR Resident #65's presson resident being sent to She stated that she had resident's pressure ulcer. Review of Resident #revealed he/she was 05/28/2021. Review 05/28/2021 at 9:24 PR was "clinically septic with a including cellulitis and abscess". According ulcer "smells like dead including cellulitis and abscess". According ulcer "smells like dead including cellulitis and abscess". According ulcer "smells like dead including cellulitis and abscess".	Dilater called back and ent to Emergency Room for or possible debridement of propossible debridement of the possible developing to the record, the pressure diffesh".	⟨F €	86}			
	Review of Resident # Department (ED) Nur						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	- 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	В.	. WNG_				30/2024
	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)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
{F 686}	a "large decubitus (prom by 8 cm with centrunderlying necrosis, the erythema with mild published by the manufacture of the process of the pressure ulcer of the pressure ulcer metal by 10 cm in width and extensive. Surgeon # any terminal illness or to the pressure ulcer. and reposition, impropersite of the pressure ulcer. and reposition, impropersite of the pressure ulcer. and reposition, impropersite of the pressure ulcer. and reposition, impropersite of the pressure ulcer. and reposition, impropersite of the pressure ulcer. and reposition, impropersite of the pressure ulcer. and reposition, impropersite of the pressure ulcer.	A revealed the resident had essure) ulcer proximally 15 al skin sloughing and he wound has surrounding rulent drainage to to the record, the pressure of flesh". Review of the 05/29/2021 at 5:40 AM is sacrum was black with red essure ulcer measured 14 e. 65's Operative Report dated the resident presented with aring area on his/her are report stated, "It was own to the base large is was encountered as well the Operative Report further vitalized tissue down to the sacrum. He debrided the sacrum. He debrided the number of the sacrum area of that the wound was very 1 stated he was unaware of diagnosis that contributed. He stated failure to turn per nutrition and an all dhave contributed to the		{F 68	36}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	SURVEY
		185256	B. WING				R /30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	U9/	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)		COMPLETION DATE
{F 686}	Record review reveals Resident #65 on 06/0 facility, staff document pressure ulcer to the forder for calcium AG to Weekly Pressure Workerevealed the facility at to Resident #65's coordification with the pressure ulcer medical to the pressure ulcer medical to the pressure ulcer medical to the pressure ulcer medical to the pressure ulcer medical to the pressure ulcer medical to the pressure ulcer medical to the pressure ulcer medical to the pressure ulcer medical to the pressure ulcer medical to the pressure ulcer medical to the pressure ulcer medical to the pressure ulcer medical to the left heel. The pressure ulcer medical to the left heel. The pressure ulcer medical to the left heel.	ed the facility readmitted 9/2021. Upon return to the sted the resident had a 'coccyx" and a treatment to the wound. Review of a und Note dated 06/11/2021, ssessed the pressure ulcer cyx/sacrum for the first time the the pressure ulcer 021. According to the note, sasured 17 cm (length) by cm (depth), with three (3) and nine (9) 3.3 cm. Further review aged IV (4), described as It issue loss with slough the solution of the wound, with edges. The facility It's pressure ulcer to be free the signs of infection. The sure ulcer was changed to lix to the wound twice daily. The documented evidence the pressure Wound Note until A, approximately six (6) une ulcer developed. The facility of the condition It at 10:30 AM revealed the a new Stage I (1) pressure Review of the note revealed assured 6.5 cm long by 4 cm		886}	DEFICIENCY)		
	wide. The facility rece	eived a new order for ors while in bed, apply sure					

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	B. WING			R 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	j 0 <i>31</i>	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 CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
{F 686}	revealed no document assessed the resident days later, 06/26/2021. Toe Weekly Skin Che 06/26/2021 at 10:03 F Wound Note dated 06 revealed the Stage IV resident's sacrum me wide by 1.3 cm deep. cm (length) by 4.4 cm Continued review of the resident had a new deright heel that measure (width) and 0 cm (depnotified and an order for the right heel. Revealed the pressure sacrum was noted to 50% of the wound with serosanguinous drain revealed the note state rolled, wound progress three (3) areas were finifection. The facility dry kerlix dressings to wound. Continued review of F Weekly Skin Checks as Wound Notes revealed the facility assessed the facility as	Resident #65's assessments ated evidence the facility It's sacrum until fifteen (15) 1. Review of the Head to ock assessment dated PM and a Weekly Pressure 6/26/2021 at 10:25 PM, If (4) pressure ulcer to the assured 11 cm long by 15 cm The left heel measured 5.8 at (width) and 0 cm (depth), the assessment revealed the eap tissue injury (DTI) to the red 3.1 cm (length) by 3 cm of the Wound Note at ulcer to Resident #65's thave slough tissue covering the asmall amount of age. Further review ed the wound edges were s was improving, and all free of odor and signs of continued to provide wet to the resident's sacral	{F €	686)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. MNG	B. WNG			R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER	1	200 NURSII	DRESS, CITY, STATE, ZIP CODE NG HOME LANE E, KY 41501	1 09/	30/2021
(X4) ID PREFIX TAG	(EACH DÉFICIENC)	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)				(X5) COMPLETION DATE
{F 686}	and outer heel. The licm (length) by 2.8 cm the left outer heel med 1.3 cm (width) by 0 cm revealed the pressure measured 3 cm (lengtom (depth). Accordin Wound Note dated 07 Resident #65's pressuan odor, moderate am drainage, and signs of the control of the con	eft inner heel measured 3.2 (width) by 0 cm (depth) and asured 1.8 cm (length) by in (depth). Further review is ulcer to the right heel is by 2.5 cm (width) and 0 ig to the Weekly Pressure 7/05/2021 at 7:23 AM, are ulcer to the sacrum had abount of serosanguinous if infection. Of Condition form dated in A., revealed the resident's land a new order was culture with the next view of the Resident #65's tion Record (TAR) for July sident's next dressing inpleted on 07/06/2021 at eview of the Progress 5 revealed on 07/06/2021 at eview of the Progress 5 revealed on 07/06/2021 ent's family requested the e ED for evaluation of the ency Room record revealed to the hospital on all for "wound check". The isident "complained of mildicks but states it is no worse of the Physical Exam	{F 6	36}			

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			i	R
	NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		30/2021
					200 NURSING HOME LANE			
	PARKVIEV	N POST-ACUTE AND RE	HABILITATION CENTER		_			
_		51111111011011011				PIKEVILLE, KY 41501		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	(F 686)	Continued From page	468	{F6	861			
		Further review of the I	Progress Notes dated.	'	,			
			A revealed a wound care					
			le for Resident #65 on					
		07/15/2021 at 8:30 AM	M with Wound Care			1	İ	
		Advanced Practice Re	egistered Nurse (APRN) #1.					
		Review of the wound	oulture recent for					
			he facility obtained a wound					
			5's sacral pressure ulcer on					
			the laboratory noted the					
			ed since 02/28/2021." The					
			to complete the wound					
		culture. Further recor	d review revealed there was					
		no documented evide	nce the facility obtained a					
			ulcer as ordered by the					
		resident's physician.						
		Record review reveals	ed that on 07/08/2021 at					
			ompleted a Head to Toe	1				
		Weekly Skin Check as	ssessment. The pressure					
		ulcer to Resident #65'	s sacrum measured 14.5	1				
			(width) and 1.5 cm (depth),					
			ed 2.8 cm (length) by 2.5					
			depth), the left inner heel					
		measured 3 cm (lengt	h) by 2.5 cm (width) and 0					
			t outer heel measured 1.2					
		cm (length) by 1.5 cm	(width) and 0 cm (depth).					
			o documented evidence the		ļ			
		facility assessed the p						
		Weekly Pressure Wou						
			d staff to document the					
			cer; wound bed appearance	1				
		and percentage of wor						
			present and the amount;					
			nneling/undermining was					
		present; a description	or the wound edges; gns of infection; and the					
			i (improved, unchanged,					
		worsening, etc).	miproved, unchanged,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMPER		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B. WING			i '	R 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, 200 NURSING HOME LA PIKEVILLE, KY 4150	ANE	, 56,	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{F 686}	revealed no document assessed the resident until 08/12/2021; and the facility assessed in ulcers and completed Note from 07/05/2021. Review of the Wound Resident #65 dated 0 "context consists of brand infrequent position further revealed the sin size since the facility 07/05/2021, and mea 15 cm (width) and 1.8 note revealed modera with no foul odor. The have 67%-100% grannecrosis of muscle, with physician conducted at the level of the must issue, biofilm, slough wound bed to healthy physician changed the Aquacel Ag daily and Review of the Head to assessment dated 08 first skin assessment	ident #65's medical record ted evidence the facility t's skin from 07/08/2021 no documented evidence Resident #65's pressure a Weekly Pressure Wound	{F 6	86}	DEFICIENCY)		
	pressure ulcer to the I However, there was n facility assessed the r evidence the facility n	pack of the left, lower leg. o documented evidence the new pressure ulcer and no				:	

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 09/30/2021		
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER				2	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NURSING HOME LANE PIKEVILLE, KY 41501	1 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 THE APPROPRIA			(X5) COMPLETION DATE	
{F 686}	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		{F 6	686}			