	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		E CONSTRUCTION	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	 3012021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
(F 686)	with rolled edges of the o'clock. Per RN #4, the granulation tissue, 10 o'clock, and eschar and o'clock to 12 o'clock.  Review of the Change dated 08/26/2021 at 6 #65 had a new Stage the left hip. The reside and new orders were area with soap and with prep to area area and Review of Resident #4 08/26/2021 at 9:00 Alt consists of bed ridden changes." "Treatment positions frequently, dissue and Aquacel Aginclude blackened tiss fever, numbness and the note revealed the "13 cm (length) by 12 depth with undermining at cm, muscle exposed is present, partially recleanser." The facility resident's sacral press however, there was more provided "frequent positioned interview wat 7:56 PM revealed if she was required to continued interview wat required to continued interview wat 7:56 PM revealed if she was required to continued interview wat required to continue the revealed if she was required to continue the revealed	sined for depth. ed at 11 o'clock at 1.9 cm he wound from 12 to 4 he pressure ulcer had % slough, eschar at 6 hd undermining at 10  e of Condition assessment 6:39 PM revealed Resident two (2) pressure ulcer to lent's physician was notified received to cleanse the later, pat dry, apply sure le cover with a dressing.  65's wound care note dated of, revealed the "context la and infrequent position consists of changing lebridement of necrotic lebridement of necr	{F 6	386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		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	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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	Resident #65's pressithe same". The LPN unsure what the protomeasurements of the wound care nurse usine measurements and wound assessments and with SRNA and with SRNA #10 or revealed they provide The SRNAs stated through turn and reposition Rehours.  Interview with SRNA # 10 or revealed they provide The SRNAs stated through turn and reposition Rehours.  Interview with SRNA # PM, revealed she could (turning, repositioning two (2) hours when the (2) SRNAs to care for when they were short three (3) or four (4) he rounds.  Interview with RN #3 in revealed staff had not reposition residents enthey were so short stated they were so short stated they were so short stated they were so short stated and notified her they (including turning and hours. She stated she DON. RN #3 further she sident #65's wound resident #65's wound	ot identified a change in ure ulcer stating, "It looked further stated she was ecol was regarding wounds. She believed the ually completed wound as responsible for both the and measurements.  #1 on 8/5/2021 at 5:15 PM in 08/27/2021 at 11:15 AM in 08/27	⟨F €	686}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI		CONSTRUCTION		SURVEY
		185256	B. WING				R /30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	· ·	20	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501	1 031	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)		COMPLETION DATE
{F 686}	and on 08/24/2021 at worked the fourth floo stated there was not a reposition residents a revealed skin assess however, they were no because there was not confusion about where due. RN #7 further state was responsible to assessing wounds.  Interview with Register Care Nurse on 08/25/3 she became the wour returned from materning. She stated their regarding her responses RN #4 stated a should be measured a stated she worked the performed duties as the Wound Care Nurse stated she worked the performed duties as the Wound Care Nurse stated she worked the performed wound care/a staff nurses were provide wound care/a staff nurses were provide wound care/a staff nurses were provided wound care/a staff nurses were no system assessments were cowere not being complicated, "I'm not can't physically do the Interview with the ADC line in the provided wound further stated, "I'm not can't physically do the Interview with the ADC line in the provided wound further stated, "I'm not can't physically do the Interview with the ADC line in the provided wound further stated, "I'm not can't physically do the Interview with the ADC line in the provided wound further stated, "I'm not can't physically do the Interview with the ADC line in the provided wound further stated, "I'm not can't physically do the Interview with the ADC line in the provided wound further stated, "I'm not can't physically do the Interview with the ADC line in the provided wound further stated, "I'm not can't physically do the Interview with the ADC line in the provided wound further stated, "I'm not can't physically do the Interview with the ADC line in the provided wound further stated, "I'm not can't physically do the Interview with the ADC line in	on 08/01/2021 at 11:40 AM 3:49 PM revealed she in with one SRNA. She enough staff to turn and is required. She further ments were required weekly; of always being completed of enough staff and due to it skin assessments were ated she was unaware that for measuring and ared Nurse (RN) #4/Wound 2021 at 8:30 PM revealed and care nurse when she ty leave in the middle of a she knew nothing about the facility provided no the facility did not educate consibilities as the wound severy week; however, she afloor as much as she he wound care nurse. The ated since she could not sesses wounds as required, widing wound care and ments. However, she stated is in place to ensure the impleted; subsequently, they geted and it was hard to declined or improved. She tamonitoring the wounds, I am all."	{F 6	86)			
		issessing wounds, including					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		402020		_		ı	R
		185256	B. MNG	_		09/	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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					(X5) COMPLETION DATE	
(F 686)	of condition. She state had been working the provided to ensure we appropriately. She fut that Resident #65's we declined, but she was the resident to declined ADON/Interim DON resonated assessed.  Interview with Advance Nurse (APRN) #1, who Care Clinic on 08/27/2 Resident #65's pressure bony prominence. He appear to be able to the himself/herself and we his/her own when exastated that he evaluated 07/29/2021 and assessiough and fibrotic tiss infection could have contained the wound. Furthermore resident had to wait more positioned, it could a APRN #1 was unable illness or medical compalliative care.  Interview with Physicia 08/27/2021 at 1:18 PN Resident #65 had a pubottom, but was not at developed other pressure.	sing assessment, and and family with any change ed she and the former DON floor and no oversight was bunds were being managed other stated she was aware ound had significantly unaware of what caused at Further interview with the evealed the facility's IDT did and there was no system in ure ulcers were identified ed Practice Registered to worked at the Wound at 2021 at 3:14 PM, revealed are ulcer developed over a stated the resident did not urn and reposition as unable to move on mined. APRN #1 further ed Resident #65 on the seed the wound to have sue. He stated the wound ontributed to the decline of ore, APRN #1 stated if a core than two (2) hours to be cause wound decline. It is identify any terminal dition that would require	{F 6	886}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		DATE SURVEY COMPLETED
		185256	B. WNG			R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	. 227	OULD BE	(X5) COMPLETION DATE
{F 686}	to decreased staffing could develop and/or turned and reposition provided for more that was reasonable to expressure ulcers and/oulcers to be turned and hours and incontinent every two (2) hours. Was not aware that who to performed weekly to determine the statumeasurements.  Interview with the Adr 6:00 PM, revealed sharesident care was proprofessional standard facility operated within However, according to no systems in place to residents in the faculcers were prevented pressure ulcers received and a Right Above the Review of Resident # Data Set (MDS) asserevealed the facility as a Brief Interview for Mof 13, indicating that to intact. Further review were review were review were review work and a Right Above the Review of Resident # Data Set (MDS) asserevealed the facility as a Brief Interview for Mof 13, indicating that to intact. Further review	ed every two (2) hours due  He stated a pressure ulcer decline if a resident was not ed, or incontinence care n two(2) hours. He stated it pect residents at risk for or residents with pressure nd repositioned every two (2) ce care provided at least Furthermore, he stated he ound measurements were to he stated it would be hard as of a wound without weekly  ministrator on 08/11/2021 at the was responsible to ensure evided in accordance with s of practice and that the to the regulatory guidelines. To the Administrator she had to monitor the care delivered did to ensure pressure d or to ensure residents with the red the necessary care and  the #45's medical record dmitted the resident on thoses of Chronic tegia, History of COVID-19,	{F 6	586}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R / <b>30/2021</b>	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION 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 B	COMPLETION DATE	
(F 686)	Resident #45 to be at pressure ulcers, but he the assessment was a Review of Resident # Plan initiated 01/11/20 identified the resident pressure ulcer develoulcers, immobility, and Interventions in place resident/family/caregiphreakdown: transfer/pimportance of taking a ambulating/mobility, grepositioning.  Interview with Resided 4:50 PM revealed he/ulcer to his/her left low sliding board to transfresident stated the ambe/she liked to sit in b stated he/she could in his/her side. Resident #Assessment dated 06 III pressure ulcer was left sacral area. The sarea had minimal drait surrounding the wount to the skin assessment of a pressure ulcer in	sfers. The facility assessed risk for development of lad no pressure ulcers when conducted.  45's Comprehensive Care 021 revealed the facility had the potential for pressure due to a history of dincontinence. included: educate the vers as to causes of skin cositioning requirements, care during good nutrition, and frequent of the facility and frequent were buttock from utilizing a fer himself/herself. The lea worsened because led and color. The resident of color when positioned on the facility of the facility of the stated he/she did not the wound care.  45's Weekly Skin (701/2021 revealed a Stage lidentified to the resident's skin assessment noted the lange and the skin did bed was pink. According int, the resident had a history the same location. In documented evidence the for size, color, etc., in	{F 6	886}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
						R
		185256	8. WNG		09/	30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 686}	Review Form (SBAR) Resident #45 had a S his/her left sacral area resident preferred to I would not turn when e encouraged the reside two (2) hours and as a pressure from the affe orders were obtained cleanse the area with apply Aquacel to the w dry, sterile dressing d dislodgement or soiled  Interview with License on 08/27/2021, at 10: identified the pressure left, lower buttock on a should have assessed documented wound in stated she thought the measuring/assessing  Review of a Nurse's N 4:58 AM revealed whe to Resident #45's butt drainage were presen that the physician was SBAR dated 06/10/20 Resident #14's physic culture. However, the assessment of the res  Continued review of R record revealed no do	an Background Appearance dated 06/01/2021, stated tage III pressure ulcer to a. The SBAR stated the ie on his/her back and encouraged by staff. Staff ent to turn/reposition every needed (PRN) to relieve ected area. New treatment from Physician #1 to wound cleanser, pat dry, wound bed, and cover with a aily and, PRN if needed, for d dressing.  and Practical Nurse (LPN) #5 45 AM, revealed she ex ulcer to Resident #45's 06/01/2021. She stated she at the wound and neasurements. LPN #5 a wound care nurse was wounds weekly.  lote dated 06/10/2021 at en completing wound care ock, odor and yellowish t. The note further stated is notified. Review of a 21 at 12:28 PM revealed ian ordered a wound are was no further sident's pressure ulcer.  lesident #45's medical cumented evidence the	{F 686}			
		ther skin assessment until 11} days since the resident's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	<del>`</del>	20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501		001202.1
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	skin assessment reverexisting skin impairmed ulcer to his/her right to no documentation the pressure ulcer's appeared to his/her right to no documentation the pressure ulcer's appeared to his and the dependent #45's pressure ulcer's pressure ulcer's appeared to his and yellow/beige slow surrounding peri-woul and pink, and the dependent determined due to the note stated a wound ophysician was notified for treatment. Accord #45 was educated on and repositioning due ability/independence himself/herself, and the understanding.  Review of Resident # dated 06/14/2021 rev MRSA (Methicillin Revenus is a staph inferior because of resistance Enterococcus Faecali Agalactiae-Group B, If two (2) different Graminfections.  According to a Nurse' 1:28 PM, revealed Resordered Zyvox 600 m days to treat the wour	sed). Further review of the sealed the resident had ent with a Stage III pressure suttock. However, there was a facility assessed the arance.  Note dated 06/13/2021, at anges were noted to ure ulcer. The wound bed gh and drainage, the not tissue was blanchable at was unable to a present of slough. The culture was pending and the dimportance of turning to the note, Resident the importance of turning to the resident's to turn and reposition he resident verbalized  45's Wound Culture report ealed heavy growth of sistant Staphylococcus action that is difficult to treat a to antibiotics), s. Streptococcus Diphtheroid Bacillus, and a Negative Rod (GNR)	{F 6	(886)			

		MEDIO NO OCITATOCO				OIVI B IVIC	<u>, 0936-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE	
		185256	B. WING_				R
		103230				09/	30/2021
	ROVIDER OR SUPPLIER  **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 PREFIX TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	_	(X5) COMPLETION DATE
{F 686}	dated 06/16/2021, reseen by a wound care	e 479 Care Weekly Evaluation vealed the resident was e specialist. According to 5's pressure ulcer had	{F 68	36}			
	worsened. The speci pressure ulcer had be measuring 3.5 centim cm, with slough (yello adheres to the ulcer to	alist documented the ecome unstageable, leters (cm) by 2.5 cm by 0 lew or white tissue that led in strings or thick					
	bed, scant serosangu surrounding skin tissu tissue edema noted to	· ·		ļ		i	
	dated 06/25/2021, (the facility completed the Resident #45's skin) the resident's pressur	revealed the facility identified te ulcer was now a Stage IV leasured 3.3 cm long by 2.3					
	revealed Resident #4 the measurements ar longer present on wo the peri- wound was p	orm dated 06/26/2021, 5's physician was notified of ad that yellow slough was no und bed. The note stated bink and blanchable, and inage was noted. The					
	physician ordered a r	ormal saline (NS) wet- and to follow-up with the					
	06/30/2021 revealed by the wound clinic fo treatment of a Stage left buttock. The asset	Clinic Progress Note dated Resident #45 was assessed or the assessment and IV pressure ulcer to his/her essment stated the ration measured 3.5 cm x					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION NG	_	(X3) DATE COMP	SURVEY
		185256	B, WING				R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 200 NURSING HOME LANE PIKEVILLE, KY 41501			00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
{F 686}	granulation tissue. Do the resident stated he board when the injury over time. Review of excisional debridement was performed with re tissue, biofilm, slough wound bed to healthy care orders were to che normal saline, apply A a Mepilex border dress Progress Note reveals facility to obtain a word closure of a wound is wound that removes to to help the wound hea resident's wound. Re with the wound clinic in Review of the Head to for Resident #45 date 07/17/2021, and 07/2: documented evidence wound measurements appearance of the res (drainage, odor, or sto Review of a Wound C 07/28/2021, revealed wound prior to debride x 3.4 cm. Excisional of the muscle was performen-viable tissue, biof from the wound bed to Wound measurement debridement were 3.5	slough present and good occumentation revealed that when was utilizing a sliding occurred and worsened the patient plan revealed into the level of the muscle emoval of all non-viable, and exudate from the granular borders. Wound leanse the wound daily with equacel AG, and cover with sing. Further review of the end recommendations for the end vac (Vacuum-assisted a device placed on the he pressure over the area all more quickly) for the sident #45 was to follow up in four (4) weeks.  Toe Weekly Skin Checks d 07/02/2021, 07/09/2021, 3/2021, revealed no that the facility conducted is weekly, nor assessed the sident's pressure ulcer ough present, etc.).  Ilinic Progress Note dated measurements of the ement were 3.5 cm x 2.1 cm debridement to the level of the remediate of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement to the level of the ement were 3.5 cm x 2.1 cm debridement debrid	(F 6	86}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		185256	B. WING				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE		10,,,,,,	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	ATEMENT OF DEFICIENCIES Y 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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	Review of a Head to dated 07/30/2021 and documented Residen and a wound vac was there was no docume staff assessed the preasure ulcer (draina etc.)  Review of an SBAR of Resident #45 had a for wound bed. The depincreased and had drapresent at facility. He and transferred the redepartment (ED) for present at the ED due redness and drainage resident had a three (would likely need anticare. Review of the at the pressure ulceration the left ischial tuberos was cortical irregularii the finding was most component of Osteon bone). Resident #45 and Cefepime (antibio disease and wound care.	follow up with the wound ks.  Toe Weekly Skin Check of 08/06/2021, revealed staff at #45 had a pressure ulcer in use. However, again, ented evidence that facility essure ulcers' size, nor ance of the resident's age, odor, or slough present, alated 08/13/2021 revealed out-smelling odor from the thof the wound had ainage. Physician #1 was a sassessed Resident #45 esident to the emergency possible wound  If record History and (2021 revealed Resident #45 to a left buttock wound with each of a left buttock wound with each of esty of the ischial tuberosity, compatible with a myelitis (infection of the was started on Vancomycin otics), and had infectious	{F (	686}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				₹ 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501		
(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 686}	discharged back to the Osteomyelitis and Staresident had an order (antibiotic) two (2) gra and to continue local Review of the Admiss Evaluation dated 08/1 documented evidence Resident #45's pressite to the facility.  Further review of the Assessment forms redocumented Resident However, again, there evidence that facility sulcer's size, nor asseresident's pressure ul slough present, etc.)  Observation of wound buttock on 08/25/202 dressing was change Review of a Nursing Stasessment dated 08 Resident #45 had a Shis/her left buttock follom x 4.6 cm, with no within normal limits.  Interview with State F (SRNA) #11 on 08/27 Resident #45 often reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside bed so he/she could of the stated the reside the stated the reside bed so he/she could of the stated the reside the stated the	8/2021, the resident was e facility with diagnoses of age IV Pressure Ulcer. The to continue Ceftriaxone NA ams (GM) daily for 37 days wound care.  ion/Readmission Nursing 18/2021, revealed no ethe facility assessed are ulcer upon readmission  Head to Toe Skin wealed on 08/24/2021, staff to 445 had a pressure ulcer. It was no documented staff assessed the pressure seed the appearance of the cer (drainage, odor, or at 23:19 PM revealed the diper Physician's Order.  Services Basic Skin 1/26/2021, revealed stage IV Pressure Ulcer to dimeasuring 2.9 cm x 2.6 foul odor and moisture was degistered Nurse Aide 1/2021 at 3:00 PM revealed fused to turn and reposition. Int liked to sit straight up in	{F 6	886}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
_		185256	B. WING_			R 09/30/2021		
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
(F 686)	Care Nurse on 08/25/she often worked the could not measure/as weekly. She stated willoor, staff nurses wer assessments. However no systems in place to were completed.  Interview with Physici 08/27/2021 at 1:18 Plice Resident #45 was not repositioning and woustated the resident was position all the time. Inot aware wound measure wound measure wound measure not conducted without weekly measure without weekly measure of Resident #205/24/2018. Resident facility on 05/21/2021 Diabetes Mellitus with Stage III Chronic Kidrovascular Disease, and Review of Resident #Data Set (MDS) asserevealed the facility as a Brief Interview for Mof 9, which indicated to impaired. The facility independent with bed	ered Nurse (RN) #4/Wound 2021 at 8:30 PM revealed floor as a staff nurse and sess pressure ulcers then she was working the erequired to complete ter, she stated there were to ensure the assessments an #1/Medical Director on M revealed he was aware accompliant with turning and and vac treatment. He ented to stay in the same However, he stated he was assurements/assessments reekly. He stated it would the status of a wound	{F 6	86}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R 09/30/2021		
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  200 NURSING HOME LANE  PIKEVILLE, KY 41501					
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 686}	Review of a compreh- 09/10/2020 revealed of potential for pressure to decreased mobility and a diagnosis of Pe (PVD). The facility de included: follow the fathe prevention/treatmobserve/document/rechanges in skin status healing, signs and syrsize (length x width x  Observation of wound 08/24/2021 at 2:32 Pl a diabetic ulcer to his/amputation, and a Stahis/her left hip. Observedent #14 on 08/2 the resident #14 on 08/2 the resident #14 stated in his/her left side, even the resident.  Review of a Physician revealed an order to with soap and water, cream, and cover with (DPD) every shift for According to a Head to dated 05/10/2021, revenice of the resident of the dated 05/10/2021, reveniced to the decording to a Head to dated 05/10/2021, reveniced to the dated 05/10/2021 reveniced to the dated 05/10/2021 reveniced to the dated 05/10/2021 reveniced	cers, and no ulcers were essment was conducted.  ensive care plan initiated Resident #14 had the ulcer development related, Diabetes Mellitus (DM), ripheral Vascular Disease eveloped interventions that cility's policies/protocols for ent of skin breakdown; and port as needed (PRN) any s, appearance, color, wound mptoms of infection, wound depth), and stage.  I care for Resident #14 on of revealed the resident had ther left great toe, due to toe age II (2) pressure ulcer to exation and interview with 5/2021 at 9:19 AM revealed g on the side of the bed with left foot intact. The resident oned himself/herself.  The resident #14's left hip pat day, apply barrier and revealed resident #14's left hip pat day, apply barrier and revealed Resident #14 had and thip and received barrier evidence that	{F €	586)				

						CIVID IV	<del>/. 03</del> 30-033 [
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WNG				R
NAME OF P	ROVIDER OR SUPPLIER			_	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
		HABILITATION CENTER		20	DO NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	and documented.  Review of a Physician revealed an order to a Resident #14's left hip every shift.  Review of a Head to dated 05/24/2021 and 06/14/2021, and 06/2 #14 had an abrasion there was no docume appearance of the are Review of a Head to dated 06/22/2021, review skin impairment, pressure ulcers meas wound was 1.4 centification wide; wound #2 was #3 was 1 cm x 1 cm. description of the word drainage was present Review of a Situation Review Form (SBAR) Resident #14's physic pressure ulcers. Review dated 06/22/2021 and order to cleanse the trulcers with wound clewater, pat dry, apply daily and as needed.	of the area was completed  of the area was area was assessed.  Toe Weekly Skin Check was assessed.	(F 6	86}			
!	dated 07/23/2021, rev	vealed an order that stated, ound physicians to screen,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405255	P. MANG				R
		185256	B. MNG			09/	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		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 686)	measure and photo the hip every Monday.  Review of Resident # Plan dated 07/23/202 revised the resident's Stage II Pressure Injusted the new Physician's Conterventions revealed arrange for an evaluationic as needed; encourage when up in cresident to lift weight chair; avoid prolonged bed; encourage the upositioning off affecte monitor wound status every week; notify Michael wound care to follow nurse to perform head weekly and as needed measurement of wound assessment for specific consult with Wound Pevaluate, and treat as as needed/as prescril However, continued in medical record reveal evidence the facility a ulcer's size, color, no present; took weekly Wound Clinic/Physicia	sindicated and an order to the pressure ulcers to the left of the pressure ulcers to the left of the pressure ulcers to the left of the facility care plan to include the gry (ulcer) to the left hip and orders. Review of the facility was required to tion at an outpatient wound ourage frequent position chair, if possible; encourage from side to side while up in the disting; limit time out of se of pillows to help with did area; measure and progression or deterioration of and family of changes; up weekly and as needed; the toe skin assessment did to toe skin assessment did weekly photo and may thysician Clinic to screen, and indicated; and wound clinic obed per physician.  The progression of the pressure of Resident #14's led no documented the pressure of whether odor/drainage was photos, nor consulted with a	{F €	\$86}			
	Review of a Weekly F forms dated 07/05/20	lead to Toe Skin Check 21, 07/12/2021, and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R
	ROVIDER OR SUPPLIER			20	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROI DEFICIENCY)			(X5) COMPLETION DATE
{F 686}	Resident #14 had skir ulcers to the left hip. documented evidence pressure ulcer's size, odor/drainage was properties. Review of Resident #Skin Check dated 07/resident had one (1) Sthat measured 4.0 cmc meep to the left hip. Weekly Head to Toe \$08/02/2021, 08/11/20/08/24/2021 revealed resident had existing (2) to the left hip. How documented assessment on 00 no documented skin assessment for Review of a Nursing \$Assessment dated 08 #4/Wound Nurse com Resident #14's left hip 3.4 cm. Review of the documentation reveal was present.  Interview with License on 08/27/2021 at 10:4 measure Resident #1 told the wound nurse wound measurements really don't know who the wounds. We have	the facility documented in impairment/pressure However, there was no at the facility assessed the color, nor whether essent.  14's Weekly Head to Toe 26/2021 revealed the Stage II (2) pressure ulcer in long by 4.5 cm wide by 0.5 p. Further review revealed Skin Checks dated 21, 08/23/2021, and the facility documented the skin impairment, a Stage II wever, there was no ment of the pressure ulcer. ed the resident refused a 18/09/2021, and there was assessment or pressure 08/15/2021  Services Basic Skin I/26/2021, revealed RN inpleted measurements of the which measured 3.6 cm x	{F €	86}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		185256	B. WNG		· · · · · · · · · · · · · · · · · · ·		R	
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER	1	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERÊNCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
(F 686)	08/27/2021 at 8:30 Pl Nurse (RN #4) was re weekly wound measu #3 stated, "I was told wound measurements was hired."  Interview with RN #4/ 08/25/2021 at 8:30 Pl Physician #1/Medical 07/23/2021 and since consult the wound clir not to consult the clini pressure ulcer. She f not been taken of Res According to the RN, supposed to purchase Administrator had not she worked the floor j than performing her d She stated she thoug performing weekly ski measurements when stated she had not rec on wound care.  Interview with Physici 08/27/2021 at 1:18 Pl weekly pictures of Re pressure ulcer on 07/2 of the wound. He stat thing." He stated he e measured weekly to r of the wound. He stat	ered Nurse (RN) #3 on M revealed the Wound Care esponsible for completing rements/assessments. RN she would be doing the sand wound care when I Wound Nurse on M revealed she reviewed Director's orders for the order stated "May" nic, she made the decision of for Resident #14's urther stated pictures had sident #14's pressure ulcer. The Administrator was a camera; however, the purchased one. She stated ust as much, if not more, uties as the Wound Nurse. In the floor nurses were in assessments and wound she was not. She further ceived any formal education an #1/Medical Director on M revealed he ordered sident #14's left hip 23/2021 to track the healing ted, "Pictures are a good expected all wounds to be nonitor improvement/decline led a wound consult should	{F 6	86)				
	and he was not aware	as ordered on 07/23/2021 it had not been.						

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	
NAME OF PI	ROVIDER OR SUPPLIER		-,	S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		20	DO NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	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 686}	revealed the facility at 07/06/2021, with diag Metabolic Encephalog Failure, Autistic Disord Diabetes, Dysphagia, Review of Resident # Admission/Readmissidated 07/06/2021 at 5 resident had a pressur coccyx measuring six length and four (4) cm.  Review of Resident # Summary revealed or continue Santyl (colla for pressure ulcers) awound bed. However facility Admission Ord revealed the facility dipressure ulcer ointme.  Continued review of Frecord revealed on 07 admission, the facility physician for a treatm. The physician ordered cleansed with soap at Santyl Ointment topic tissue). Review of ReAdministration Record revealed no treatment resident's pressure ul 12:00 PM, five (5) day Further review of the	t #323's medical record dmitted the resident on noses that included bathy, Acute Respiratory der, Sepsis, Type 2 Pneumonia, and Aphasia.  323's ion Nursing Evaluation 5:06 PM revealed the gre ulcer (no stage) to the (6) centimeters (cm) in in width.  323's hospital Discharge ders for the facility to genase ointment treatment pply a thin layer to the review of Resident #323's ers, dated 07/06/2021, id not transcribe the ent to the admission orders.  Resident #323's medical 7/10/2021, four (4) days after contacted the resident's ent for the pressure ulcer. In the pressure ulcers be not water, pat dry, and apply ally to sloughed areas (dead esident #323's Treatment dry, and apply ally to sloughed areas (dead esident #323's Treatment dry, and apply ally to sloughed areas (dead esident #323's Treatment dry, and apply ally to sloughed for the cers until 07/11/2021 at ys after admission.	{F €	86}			
		rsened to an unstageable					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		R 09/30/2021	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL, TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
Wound to both sides of the buttocks. The note stated the pressure ulcer to the right buttock measured two (2) cm by three (3) cm and the left buttock pressure ulcer measured four (4) cm by five (5) cm.  Interview with Registered Nurse (RN) #6 on 07/28/2021 at 9:48 AM revealed the admitting nurse was responsible for transcribing and verifying physician's orders. She stated she was the nurse who admitted Resident #323 and was aware of the Physician's Order for Santyl ointment. RN #6 stated she wanted to evaluate the resident's pressure ulcer before the facility treated the wound with Santyl ointment. However, there was no documented evidence the RN ensured treatment was provided to the resident's pressure ulcer.  Interview with the Interim Director of Nursing on 08/11/2021 at 12:05 PM revealed the assigned nurse was responsible for obtaining and verifying physician's orders for residents admitted to the facility. She stated the nurse should have notified the physician to ensure there was an appropriate treatment in place and medications ordered. Continued interview revealed she attempted to check medical records for new admissions and re-admissions to ensure physician's orders were obtained and implemented. However, she stated she worked the floor as a floor nurse preventing her from having time for DON duties. She stated she did not recall reviewing Resident #323's admission record.  Interview with the Administrator on 08/11/2021 at 5:55 PM revealed nursing management was responsible for oversight of Admission Physician's Orders. She further revealed she			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501		30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		_	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE
{F 686}	5. Record review rev. Resident #66 on 02/included Adult Failure Atherosclerotic Heart Pectoris.  Review of Resident #(MDS) Annual assess revealed the facility at a Brief Interview for Mof nine (9), which indimpairment. The facility to total assist of two (Further review of the Mad no rejection of caperiod.  Review of Resident #04/23/2021, revealed Living (ADL) Care Plather resident required a (activities of daily living mobility, multiple med receiving Hospice ser developed an interver was totally dependent repositioning and turn care plan did not direct resident was to be turned Review of Resident #67 revealed Registered Mon 06/16/2021 at 9:04	issues related to physician's 323.  ealed the facility admitted 15/2021 with diagnoses that to Thrive, Dementia, and Disease without Angina  66 Minimum Data Set the tended 15/2021 seessed the resident to have dental Status (BIMS) score cated moderate cognitive ity assessed the resident to (2) staff for bed mobility.  MDS revealed the resident re during the look back  66 Care plan, dated under the Activities of Daily in focus the facility identified assistance with ADL's g) related to decreased ical conditions, and vices. The facility intion that stated the resident in upon two (2) staff for ing in bed. However, the cost staff how often the ned and repositioned.  66's Nursing Notes, Jurse (RN) #3 documented AM, that she observed a esident up to move" the	{F €	886}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		185256	B. WNG				₹ 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		200 NURS	DDRESS, CITY, STATE, ZIP CODE SING HOME LANE LE, 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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
{F 686}	9:27 AM revealed a Hithe resident a bath. I with care, the Assistantis/her right side and pillows. Continued of revealed the resident side on 06/16/2021 at 3:13 PM, and at 4:14  Observation on 06/17 Resident #66's skin reskin breakdown or president #5221 Pt 10:00 AM were unsugnot respond verbally to the resident with State R (SRNA) #5, on 06/17/she had not attempte on 06/16/2021, because on 06/16/2021, because on 06/16/2021 at 10:30 A aware Resident #66 Psi 30 AM until 4:14 PM stated "breakdown" or the resident lying on the of time.  Interview with the Direction of the president lying on the fill the president resident the president resident resident the president resident the president resident reside	lospice Assistant was giving When the Assistant finished in placed the resident on positioned the resident with observation of the resident remained on his/her right in 11:47 AM, at 1:40 PM, at PM.  1/2021 at 10:00 AM of evealed the resident had no essure ulcers.  Resident #66 on Wand on 06/17/2021 at cessful. The resident did to questions.  Registered Nursing Assistant 2021 at 10:15 AM, revealed do to reposition Resident #66 use the resident "seemed RNA stated the resident was imself/herself in bed.  Pered Nurse (RN) #2, on AM, revealed she was not had not been turned from AM, revealed sh	{F €	86}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_				R <b>30/2021</b>
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	have turned Resident She stated the RN she ensure the resident was tasted she was unawaturning and reposition.  **The facility alleged implemented to remore effective 09/26/2021:  1). Braden Scale Asson all residents by fact and comprehensive from the facility utilized the and comprehensive from the facility utilized the and comprehensive from the facility utilized the and pressure injuries.  2). The wound care puties and pressure dall pressure evaluated all current to the Medical Cog/17/2021.  3). Beginning 09/17/2 assessment and Brade be completed, and the developed within 48 him pressure ulcer or pote comprehensive care puties of admission or potential pressure interventions to prevedevelopment or worse development or worse develop	N stated the SRNA should #66 every two (2) hours. ould have been observing to as turned. The DON further are of any concerns with ing residents.  The following was we Immediate Jeopardy  The sessments were completed cility nurses on 08/28/2021 call body skin assessments I residents on 09/11/2021. The Braden Scale Assessment call body skin assessment to the plans of residents who are plans of resident will be injuries, and staff areatments and reported areatments and reported birector/Physician #1 by  O21, upon admission a skin areatments are plan will be areatments of include any areatments and include	{F 6	86}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
		185256	B. WNG			R 09/30/2021	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		200 1	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, 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 APPROPRIATE OF THE APPROPRIA			(X5) COMPLETION DATE
(F 686)	care and moisturizing and assisted with dresclothing. Clean linear residents' beds on 09 were evaluated by so 5). All residents were interviewed to obtain by the Director of Nur New bath/shower sch by nursing staff to acc preference. Resident were obtained and inceplans and State Registicare plans by the Regwere completed on 05 of 0. On 08/28/2021, the began reviewing all resecommendations for supplements to promount weight loss issues 7). All residents with thand Chronic Obstruction (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 amenentry of glucose value Administration Records.	d including a shower, nail 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 obte healing and to address is.  The diagnoses of Diabetes were Pulmonary Disorder Pneumonia were assessed lor Respiratory Therapist is identified completed.  The reviewed all residents is monitoring by 07/30/2021 anded to include mandatory is on the Medication if (MAR).	{F 6	86)			
	9). The Regional Cert (CDM) observed the r	ified Dietary Manager neal service for breakfast,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY
		185256	B. WNG				R
NAME OF P	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE	V POST-ACUTE AND RE	HABILITATION CENTER		2	200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
{F 686}	were delivered on time  10). Direct Care staffice recruitment efforts with provided through age. Direct care nursing staff and will be reviewed on the will be reviewed and the Admilevels are adequate to residents. The staff woon the unit at the start Director of Nursing, North 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 Nursing management appropriate staffing lecenter will prioritize reachieved during emer required task including medication, no shower provided to incontiner that cannot turn self, it assist residents with residents with residents with restaffing levels have be meals are prepared a 12). On 08/11/2021, a #86 and #322, were reand physical forms of	ang was increased through the additional staffing ancy and travel contracts. affirs schedules for the next daily by the Director of anistrator to ensure staffing a meet the acuity of t	{F €	686}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING				₹ 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	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	BIMS less than eight Licensed Nurse. Resi Dementia had their C revised, as necessary (MDS) Coordinator or residents were identification psychosocial and/or paychosocial p	ity reviews for residents with (8) were completed by idents with a diagnosis of are Plan reviewed and by the Minimum Data Set on 09/07/2021. No new ided as indicating any obysical harm.  It is a consultant completed a sment on all residents by ents who were identified as and care plans reviewed and Coordinator. A list of all ter risk residents were g station with a list of a for nursing to reference.  65, #81, #90, #330 and y 09/17/2021. The RD) completed a on assessment and RD re reviewed for the Director of Nursing to 09/17/2021. Further, the oke with the attending and validated the diet orders is. Recommendations were ronic medical record and on gistered Dietician and DON), reviewed diet orders record to ensure both the reflected accurate 2021.	{F 6	\$86}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		_		R 30/2021
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, ST 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	( (EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE
{F 686}	aide, dietary aides and 16). The facility evalue 08/11/2021, located of for compliance with Complemented yellow a identified two (2) reside exposed to positive rewas designated with a barrier and those two this zone on 08/11/2017). The facility had the in the red zone on 08/11/2017). The facility had the interest in the red zone on 08/13/28 and #329). Reside have completed quarantine physician orders. Residentification of the interest in the red zone on 08/13/28 and #329). Residented quarantine physician orders. Residented quarantine physician's order. Residented quarantine physician's order. Residented quarantine physician's order. Residented quarantine physician's order. Residented quarantine physician new case testing on 09/16/2021 tested for COVID-19 on 09/16/2021 tested for COVID-19 of did not identify any new case testing on 09/16/2021 tested for COVID-19 of did not identify any new case testing and covidented in isolation zon droplet precautions with protective equipment, physician notification, plan revisions. The Dinewly positive COVID-19 newly positive COVID-1	amented by the restorative d/or licensed nursing staff.  ated the COVID-19 unit on in the 5th floor of the facility in in the 5th floor of the 5th	{F 6	86}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				30,0004
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	EHABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501		30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	droplet precaution in facility will provide ph notification and care employee testing prodesignated days efferequires all staff must days. If the employee not allow the employee not allow the employee will be test facility by the Infectio designee. All testing posted to the employ common areas.  20). The facility screet for signs and/or symptocumented on the Necord (MAR). The fimonitoring for signs a residents on 09/17/20.  21). Resident #9, Resident #326 and Rivere reviewed for usadministration times 109/23/2021.  22). The facility state their medication as on and implemented phanotification if any med The facility will abide physician regarding to 23). The facility formula 23.	t exposed will be placed in isolation zone (yellow). The sysician notification, family plan revisions. The facility stocol will be twice weekly on ctive 08/16/2021. The facility it 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 ens all residents once a shift plant of COVID-19 and dedication Administration facility implemented and/or symptoms on all 021.  Sident #321, Resident #324, desident #351, medications age and appropriate by the physician on deal residents will receive refered beginning 09/23/2021 armacy and physician dication was unavailable. by new orders from the the unavailable medication.	{F 6	86}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			1	R 30/2021	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	,	20	REET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	1 00	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 686}	for cost authorization  24). New admissions the facility after normal weekends will have dentered into the electrosubmitted to pharmaci integration. The facilifax transmittal as a bapharmacy integration electronic medical recomplished in the facility does not timely manner the pharmacy integration electronic medical recomplished in the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility manner the pharmacy and an energency and an energency and an energency and the facility by 09/25/2021  25). The Regional Nu Nursing, and licensed audit of all residents and the facility by 09/25/2021  26). The facility condition facility process, and a ensure compliance with administrator over the Administrator over the QAPI committee Nursing, Administrator Services Director, Activation and the facility appoints and the facility and the facility appoints and the facility and the facilit	while pending cost review.  and re-admissions entering all business hours and on ischarge orders submitted, ronic medical record and by through pharmacy ity implemented the use of ackup to the electronic by entering the order in the cord to receive medications. The receive medications in a armacy will be notified, and the emergency medication is ician will be notified for the orders.  The Consultant, Director of a nursing staff completed an ordered medications and medications and medications and its were available in the control of the cont	{F 6	86}				

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  N POST-ACUTE AND RE	HABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	1	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
{F 686}	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 reviscontact person for call Activities of Daily Living timeliness of meal transiturning and reposition.  29). The Vice Preside Clinical Operations are Consultants conducted O9/15/2021 with a cord consultation to review outcomes of the survey roles of the Governing Rules and Regulation the following communification Control (CO staff at the facility to not turn and reposition recare, prepare and discresidents with eating, effective Pharmacy Sand neglect effectively	The facility's Interim eive daily oversight and gional Vice President or Operations and Regional days. Upon completion of ot, the Regional will audit the Administrator to d daily oversight is needed. is direct oversight and discipline, and f concern and process  or, Medical Director, and ewed procedures for a lins, answering call lights, or (ADL) Care, serving, and ys incontinence care and ing on 09/15/2021.  ont of Operations, Director of ord Regional Nurse d a conference call on otract company for a	(F 6	686}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		405000	-		<del></del>	1	₹
		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 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 686}	Consultant reviewed beginning 09/16/2021 and/or revisions to the the 09/16/2021 meeting standardized plan to reviewed as needed agenda included reviewed agenda included reviewed agenda, infection readmission rate, reh social services, concresident council, and grievances, admission development, vacant orientation, dietary vaweight loss, work injuited agendation of the possible of the meeting.  31). The Regional Direction of 09/16/2021 regard Governing Body, incluing procedures to be improcedures to be improcedures to be improcedures of the QAPI process, the in the QAPI process, causes with the utilizations.	and Regional Nurse and revised the QAPI Plan I and presented the reviews e QAPI Committee during ing. The facility developed a ensure all topics were at the QAPI meetings. The ewing pressure ulcers, Foley ding tubes, contractures, redication usage, risk on control, hospital rabilitation management, erns of grievance, activities, family council concerns, ins, discharges, census, staff positions, employee ariances, tray audit report, iries, terminations, medical leave, a leave of medical record compliance ports, restorative nursing, admission actions. The QAPI cal Director approved the in 09/16/2021 to include, topics presented during the ports, and the Medical Director and the Medical Dir	{F 6	\$86}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	00,1	5572021
(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 APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
(F 686)	meetings.  32). The Administrator reports before each Cobeginning 09/15/2021 compliance with the coopy of the	nistrator will notify the sture QAPI Committee  or will collect all monitoring the particle of the property of	{F €	\$86}			
		eded effective 09/16/2021,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY
					<del></del>	1	R
		185256	B. WNG_			09/	30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, C 200 NURSING HOME PIKEVILLE, KY 4			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF			(EACH C	IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	complies with the star compliance with State is demonstrated.  35). All nursing staff will resident on turning and transfer of reside chair to bed beginning completed on 09/17/2 and assigned addition and agency contracts turn and reposition the resident and reposition themselves.	of care is monitored and indard of care and redard of care and redard of care and redard of care and redard requirements.  Were educated by the MDS Coordinator, or reighing techniques, and, and reporting weight tered Dietician by  The Regional Certified (and the Dietary sion of timely nutritional rediet order accuracy, on and on when to enter diet onic medical record. The relatory Manager to enter and the tray care system. If order, the nurse will send a rediet order accuracy to the tray care system. If order, the nurse will send a rediet orders from the reaccuracy.  If deducation to all nursing ositioning range of motion, and from bed to chair and g on 08/19/2021 and rediet orders from the reaccuracy.  If the facility employed and staff through recruitment to ensure adequate staff to diresidents who cannot is.	{F 6	36}			
	all nursing staff on pre	essure ulcer prevention, repositioning, adequate					

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  N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE OO NURSING HOME LANE PIKEVILLE, KY 41501	031	30/2021
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{F 686}	to complete and docu assessment, and how dietician, physician, a impairment by 09/17/staff will call or email Physician, and Residence skin changes.  39). The DON or desitimely call light responstaff, including nurses assistants, were provitimely hygiene per the timely toileting, dression clean clothing, and trays. The DON or defacility staff not working returning to work.  40). On 08/31/2021, The Nursing educated all Registered Dietician, and the MDS Nurses into the electronic meand interventions. In Director of Nursing educated all resisting care plan in the with new goals and in impairments identified.  41). The facility's Rest Licensed nurses on ic residents with a chan 08/12/2021. In additionand/or designee educidentifying signs/symphyperglycemia/hypog	in, positioning devices, how ament 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 agnee educated all staff on ase. In addition, direct care and certified nursing ided education on providing eresident's plan of care, and residents in their choice timely delivery of meal signee will educate any and during education upon  The Regional Director of licensed nursing staff, the the Social Service Director, on entering new care plans dical record, including goals addition, the Regional ducated staff to update the he electronic medical record atterventions for any new skin d during their shift.  Expiratory Therapist educated dentifying and assessing ge in respiratory status on on, on 08/12/2021, the DON cated all licensed nurses on otoms of	{F 6	\$86}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		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 IKEVILLE, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 686}	sugar in the medical rephysician and following facility licensed nursing work until they have report of glucose levels on a during mandatory insections.  42). Beginning 08/12/licensed nurses on complete plan with intervention diabetes and a respiration of admission, recopy to the resident at Licensed nursing staff education was notified will not be allowed to received this education.  43). Beginning 08/12/staff on the facility's "call-off procedure for event a person needs dayshift, they are to not supervisor two hours of staff needs to call of the notify their immediate before the start of the not have appropriate immediate supervisor other qualified staff to off. If emergency staff Administrator and/or cassistance from staffic working will be in-sented.	documentation of blood ecord, notification of the ag physician orders. The ag staff will not be allowed to eceived this education. The aical staff on documentation (8/19/2021 and 08/20/2021 services.  2021, the DON educated completing a baseline Care is and goals relevant to eatory diagnosis within 48 eviewing and providing a and/or the responsible party. If not working during it of ongoing education and work until they have in.  2021, the DON educated all call off" procedure. The the facility included: in the isto call out of work for otify their immediate before the start of the shift. If on the night shift, they are sate supervisor four hours in shift. If the facility does staffing levels, the and/or designee will call replace the person calling thing is required, the	⟨F €	86}			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER. A. BUILDIN		PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 9/30/2021	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		7.00/2021	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE	
{F 686}	the process of identify reporting abuse, as wimplementing immedi wandering residents.  45). All nursing staff v Director of Nursing, M designee on proper wobtaining, documenting changes to the Regist 09/17/2021. On 09/13 the Dietary Manager of timely nutritional asses accuracy. When staff electronic medical recorder will send the windietary staff. The Dietary staff. The Dietary or review diet orders from clinical meeting to ensure the dietary staff. The Dietary staff or the tray car review diet orders from clinical meeting to ensure the dietary staff. The Dietary staff or the tray car review diet orders from clinical meeting to ensure the dietary staff of the tray car review diet orders from clinical meeting to ensure the dietary staff of the tray car review diet orders from clinical meeting to ensure the dietary staff. The Dietary staff of the tray car review diet orders from clinical meeting to ensure the dietary staff of the tray car review dietary staff. The Dietary staff of the tray car review dietary staff. The Dietary staff or the tray car review dietary staff or the tray car review dietary staff. The Dietary staff or the tray car review dietary staff or the tray car review dietary staff. The Dietary staff or the tray car review dietary staff	vere educated by the IDS Coordinator, or reighing techniques, and reporting weight tered Dietician by 1/2021, the CDM educated on diet order accuracy and assment to ensure diet order enters diet orders into the tord, the nurse entering the lary Manager will enter the e system. The facility will me the previous day in the sure accuracy.  Meducated the Dietary 21 on facility policy et imes and the use of the sidents in accordance with uidelines to reflect religious, eds of the population.	{F 68	6}			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING_				R <b>30/2021</b>
	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 PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	Manager on the proce and/or implementing to recommendations for 09/17/2021.	nurses and the Dietary ess for entering, activating, the registered dietician's	{F 6	86}			
	COVID-19 policy/guid donning/doffing Persot (PPE), yellow and red DON/designee educal monitoring residents for beginning. 08/12/202 educated all staff, includer were not working. Dur 08/12/2021, the Covid handwashing policy, of the covid handwashing policy.	telines, handwashing, anal Protective Equipment of zones. In addition, the sted, licensed staff on or Covid-19 symptoms 1, the DON/designee staff, who ring the QAPI meeting on 1-19 policy, the standard and monitoring residents					
	50). Staff were provid 08/20/2021 by the DO Regional Nurse Cons symptom monitoring of admissions into the results.	N, Regional DON, or ultant to enter COVID-19 orders on all new					
	administration, including patient, right dose, right d	5) rights of medication ng right medication, right ht time, and right route. The designee educated all working on 09/23/2021 on when a medication was not ration as ordered. The lling the pharmacy to obtain					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			1	R 30/2021	
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		200 N	ET ADDRESS, CITY, STATE, ZIP CODE JURSING HOME LANE EVILLE, KY 41501	, 00,	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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 686}	outside 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 a notifying the physician re-admitting residents after-hours.  53). The Interim Admit on his contact information on his contact information on his contact information on the condition, education who to notify if unables shift.  54). The facility will at head-to-toe skin asset through Friday, for the O9/17/2021 to ensure weekly on each reside will notify the physicial Responsible Party of and those new interversal place to prevent declipation date on 08 conducted weekly for	ill either be omitted or given de medication time. The ed following new orders urmenting the conversation, the MD in the electronic her licensed nursing staffing as scheduled for shifts.  The DON /Regional Nurse all licensed nursing staffind are including staffing as scheduled for shifts.  The DON /Regional Nurse all licensed nursing staffind are including staffing as including are included and inistrator educated all staffing including on weekend and inistrator educated all staffing ation and role as the Abuse 13/2021 through 09/17/2021.  The on staffing schedules and the towork their scheduled are including including the semantic staffing schedules and the towork their scheduled and the semantic staffing impairment entions have been put in	{F 6	86)				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING			1	٦ :
NAME OF S		185236	B, WING	_		09/	30/2021
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 686)	Continued From page	e 509	{F €	86}			
	Nursing (ADON), or Nesident 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) vesidents each shift for twenty-five percent of (4) weeks. The facility to 6:00 PM and 6:00 I 58). On 09/11/2021, the began visual monitoring response times, including the answered, a staff will conduct ten (each shift for two (2) verified in the staff will conduct ten (each shift for two (2) verified in the staff will conduct ten (each shift for two (2) verified in Background Recommendation (Seacute change in respit through Friday in the The facility reviewed at the staff will reviewed at the facility reviewed at the staff will reviewed at the facility reviewed at the staff will reviewed at the facility reviewed at the staff will reviewed at the facility reviewed at the staff will reviewed at the staff wil	on Monday. The Nursing daudits to ensure any new lent 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 if residents each shift for four (4) weeks, and if residents each shift for four (4) which weeks and 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.					
		Physician notification and physician order. Care					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	50 00	TIPLE CONSTRUCTION NG		(X3) DATE	SURVEY
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE 200 NURSING HOME LANE PIKEVILLE, KY 41501	, ZIP CODE	1 03	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
{F 686}	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 wi 61). All residents admidays with a diagnosis Obstructive Pulmonar Asthma, or current Procare Plan reviewed a the MDS Nurse(s) and interventions will be a morning meeting by the nursing designee.  62). Beginning on 08/DON, and/or Designeadmissions and re-adcare plans for comple with the resident and/variance or identified immediately. Audits withrough Friday for all a to the facility for four (admissions for a week then ten percent of adweeks.  63). On 09/11/2021, the designee began auditimeal trays to residents All three (3) meals will (3) units daily for two (3) units daily for two (4).	and updated as needed. (4) weeks.  DON, and/or Designee (5/2021 of baseline care plan (admissions and (are staff completed the (thin 48 hours of admission.  itted within the last thirty (of Diabetes, Chronic (y Disease (COPD), (eumonia had their baseline (nd updated as needed by (d/or designee, New (dded to the care plan in the (ne DON, ADON, and/or (19/2021, the MDS Nurse,	{F 6	86)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	<u>,                                     </u>	2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	031	5072021
(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 686}	weeks.  64). On 08/15/2021, the began audits of staff's quiz of identification a with a change in responsigns/symptoms of hy the facility's diabetic personal change in a resident's physician and following Leadership will quiz subject on the staff a week for four (65). On 08/13/2021, the gan monitoring all control of the staff a week for four (65). On 08/13/2021, the gan monitoring all control of the staff a week for four (65). On 08/13/2021, the gan monitoring all control of the staff and the staff and updated and updated and updated designee will completed in the staff. Any variance or addressed immediate one (1) week, then five (4) weeks.  66). On 08/13/2021, the designee implemented questionnaire on abuse residents with wander staff and the staff and the staff and the staff and the staff. Any variance or addressed immediate one (1) week, then five (4) weeks.	he DON and/or Designee knowledge with a verbal and assessment of residents iratory status, identifying perglycemia/hypoglycemia, protocol, documenting a condition, notification of the ag physician's orders. Itaff randomly across all prone (1) week and five (5) (4) weeks.  The DON and/or Designee documented blood sugar gh Friday in the clinical and implementation of its outside of the normal ion and implementation of its. Care plans will be it as needed. The DON or e a visual rounding on coss both shifts and all three y resident with apparent of lycemia to ensure the ately assessed by licensed identified concerns will be ly. Audits will be daily for e (5) times a week for four	(F 6	86}			

NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE  200 NURSING HOME LANE  PIKEVILLE, KY 41501  ID  PROVIDER'S PLAN OF CORRECTION	STATEMENT ( AND PLAN OF	DEFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE			185256	B. WING _			R 09/30/2021
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  [F 686] Continued From page 512 units. The employee questionnaire will be		=	HABILITATION CENTER		200 NURSING HOME LANE		83/30/2021
units. The employee questionnaire will be	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
then three (3) times a week for two (2) weeks, and then weekly for four (4) weeks. Any variance or identified concerns will be addressed immediately.  67). Beginning on 08/13/2021, the Director of Nursing and/or designee will review each resident's wandering risk assessment upon admission and quarterly with their Minimum Data Set (MDS) assessment. Any resident identified as wandering will be discussed in the clinical morning meeting to review and initiate new interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing, or nursing designee.  68). Beginning on 08/13/2021, the Social Services Director or designee will perform random interviews of residents with a BIMS score of eight (8) or greater to ensure they feel safe in the facility and have not been subject to or witnessed abuse. The DON or designee will review random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure no injuries of unknown origin beginning 08/13/2021. Any variance or identified concerns will be addressed immediately.  69). On 08/25/2021, the Registered Dietician conducted audits of resident diet orders from the electronic medical record against orders entered in the diet/tray card software to ensure accuracy.  70). Beginning on 08/23/2021, the Dietary Manager will ensure and audit meals leaving the	{F 686}	nits. The employee ompleted for five (5) nen three (3) times and then weekly for for identified concerns nediately.  7). Beginning on 08/25/2021, 10 onducted audits of relectronic medical records.	questionnaire will be staff daily for one (1) week, a week for two (2) weeks, our (4) weeks. Any variance is will be addressed  /13/2021, the Director of nee will review each risk assessment upon early with their Minimum Data ent. Any resident identified as cussed in the clinical eview and initiate new riance or identified concerns mediately. New interventions in the morning meeting by any, Assistant Director of esignee.  /13/2021, the Social designee will perform residents with a BIMS score to ensure they feel safe in not been subject to or e DON or designee will by skin assessments for S score of less than eight (8) of unknown origin beginning ance or identified concerns mediately.  the Registered Dietician esident diet orders from the cord against orders entered oftware to ensure accuracy.	(F 68			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	I ' '	IPLE CONSTRUCTION		(X3) DATE SURVE COMPLETED	
		185256	B. WING_			R 09/30/20	21
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	E	43/30/20	<u>- 1</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMP	XS) PLETION PATE
{F 686}	kitchen and reaching be conducted for rand one (1) week, twice pand then weekly for our trays arrive at the unit assist in passing tray meal trays, and certif residents promptly. It designee will audit the trays to residents afte beginning 09/11/2021 observed on each untwo (2) meals on each weeks, one (1) meals weeks, one (1) meals weeks.  71). The dietary mandadmitted/re-admitted beverage preferences admission and entersystem for listing on to 09/16/2021. Review completed bi-annually residents. Physician-be audited by the Die (1) week, weekly for after that for four (4) to 09/15/2021.  72). Daily COVID-19 audited beginning on Resources (HR) Direpunches to ensure so their shift. Audits will through Friday for four Director, and weeken staff not screened will	the units timely. Audits will dom meals twice daily for er week for two (2) weeks, me (1) month. Once meal it, management staff will is to ensure residents receive ied nursing assistants assist the Dietary Manager or etime it takes to pass meal er they arrive on the unit it. All three (3) meals will be it daily for two (2) weeks, in unit daily for two (2) on each unit daily for four (4) ager or designee will review residents' food and is within 72 hours of them into the diet/tray card heir tray cards beginning of food preferences will be and as needed for all cordered snack intakes will tary Manager daily for one four (4) weeks, and monthly months beginning  screenings for staff will be 08/25/2021 by the Human cordinated monday in (4) weeks by the HR ds audited on Mondays. Any I be re-educated OVID-19 Screening Policy	{F 6	86}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION ING		(X3) DATE S	
		185256	B. WNG			1973 1973	R 30/2021
1	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 200 NURSING HOME LANE PIKEVILLE, KY 41501	P CODE	1 0074	,o.,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	· ·	CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
{F 686}	educated on the COV Nurse, an infection codoors will remain lock entry by staff and screentry.  73). Beginning on 09/designee will round store eight (8) weeks, find (4) weeks to audit infediffering shifts and un observation of handwand zones; donning/deppe; and mask compidentified concerns with the auditor.  74). The DON, ADON review all residents or pharmacy to ensure a beginning 09/23/2021 physician within two (expiration.  75). The Regional Nutley and/or Director of Nutley (25/2021 on randor jeopardy removed to accuracy of medication deservation of twenty).  76). Beginning 09/25/Friday, the DON, ADO audit medication deliverselves.	ID-19 policy by the Regional antrol preventionist. All entry ed. Visitors must be allowed bened by staff at the time of a 17/2021, the DON and/or even (7) times each week we (5) times weekly for four ection control compliance on its. Audits will include ashing; isolation signage doffing (putting on/taking off) diance. Any variance or all be addressed immediately an active script is on file. Staff will notify the 2) days of the prescription's are Consultant, Pharmacy, using will conduct random envations effective an shifts daily until immediate ensure timeliness and ans. The facility utilized the Pathway for Medication duct the medication pass-five medications.	{F 6	886}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	<u> </u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	and/or DON will be renursing staff daily for adequate staffing is more adequate staffing is more adequate staffing op/11/2 Dietary Manager will be dietary staffing daily for adequate staffing.  79). Beginning 09/11/2 President of Operation monitor and audit the days to ensure complete of the designee performed in BIMS score of eight (a bild or witnessed abuse concerns. Interviews of the conducted of resident designees weekly untremoved.  **The State Survey agactions to remove the 09/26/2021 as alleged 1). Review of Head-to	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 for four (4) weeks to maintain for four (4) weeks to maintain for four (4) weeks to maintain for residents of ally for 30 iance.  2021, the Divisional Vice for and/or designee will for a for residents of cation of need for "Stop and for residents' change of four ation of need for "Stop and for indition communication.  2021, the Administrator or interviews of residents with a second for the subjected for the s	{F €	:			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE COMP	SURVEY
		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			5012021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		COMPLETION DATE
(F 686)	revealed eight (8) res #324, #45, #14, #357 current pressure ulcer pressure injuries of two comprehensive care pressure ulcare in the resident's current facility completed the A review of the facility revealed staff assess pressure ulcars with twith the Regional DO revealed she complete assessment on all residenther revealed that the (20) total pressure injurithe facility completed assessments on all recontinued interviews Interdisciplinary Team assessments and Braupdate the residents' Resident #65, #324, # and #358's care plans current pressure injurith MDS Nurse #1 or revealed she updated reflect current pressure addition, she complete rounds on 09/15/2021 the Registered Dietici DON, and the MDS N #324, #45, #14, #357 review revealed the Ir reviewed	ew of the skin assessments idents (Residents #65, #27, #74, and #358) had re with a total number of venty (20). A review of the plans for Residents #65, #27, #74, and #358 do the care plans to reflect pressure injuries. The review on 09/17/2021.  It's 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 the dead-to-toe skin sidents on 09/11/2021. She the facility identified twenty uries. She further stated that the Braden Scale esidents on 08/28/2021, revealed the autilized the skin iden 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. Interview in 09/30/2021 at 1:39 PM all residents' care plans to re injuries by 09/17/2021. In ed a review of walking with Therapy Personnel, an, the Medical Director, the lurse for Residents #65, #27, #74 and #358. A	{F 6	586}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		185256	B, WING			R
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	05	/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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE
{F 686}	2). Review of Resider revealed the Medical resident on 08/25/202 Stage four (4) pressure 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 0.3 at 10 o'clock measuring 2 o'clock that measured with wound continued to treat the ulcer with Aquacel Age valuation completed Resident #65 had six including a stage two measuring 1.2 cm (le 0.1 cm (depth), stage measuring 2.5 cm by stage two (2) to left his cm x less than 0.1 cm scapula measuring 1 0.1 cm, unstageable to cm by 0.6 cm. and for measuring 12 cm by Interventions in place heel protectors while weekly documentation mattress to bed, nutri turning/repositioning, for the sacral pressur 10:21 AM revealed the	nented changes as needed.  Int #65's medical record Director assessed the 21 at 1:45 PM and noted a re ulcer on the sacrum; a FI) to the left and right heels; left inner leg. Review of d care note dated M, revealed the sacrum B cm (centimeter) (length) by 2 cm depth with undermining at ares 1 cm, muscle exposed. Sugh is present, partially cleanser." The facility resident's sacral pressure a. A review of a wound on 09/15/2021 revealed (6) pressure ulcers, (2) to the left superior calf right) 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 in, stage two (2) to left cm by 0.2 cm by less than to right heel measuring 0.6 but (4) areas to the sacrum	{F 684	5)		
		ent granulation tissue.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	_	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WNG				₹ <b>30/2021</b>
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	, 031	3072021
(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 686)	observation of other precord review revealed PM, Physician #1 detweight loss and wound 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 compon 09/10/2021. Resided 09/25/2021 and re-addission skin asses 09/28/2021. Further revealed staff develop plan on 09/21/2021. Feradmission revealed admission skin asses 09/28/2021, Braden Seaseline care plan deceived and the seaseline care plan deceived and the seaseline care plan deceived and the seaseline the seaseline the seaseline the seaseline the seaseline the seaseline the resident well-kempt, and clear residents' beds. Intenduring the time of the identified concerns. A	d would not consent to the pressure areas. A medical of that on 09/21/2021 at 2:19 ermined the resident's dis were unavoidable. On #65's family declined visits. Further review of the 9/29/2021, staff notified the ne in the resident's wound the resident was diagnosed askin assessment on end a Braden Scale on pleted a baseline care plan ent #355 was discharged on mitted to the facility on eview of the medical record ped the comprehensive care a review of Resident #355's did the resident had an sment completed on 6cale on 09/28/2021, and a veloped on 09/28/2021 at 1:40 m 09/29/2021 at 11:10 AM, 29/2021 at 11:26 AM, 29/2021 at 11:30 AM and 29/2021 at 11:13 AM appeared clean,	{F 6	886)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_			R
NAME OF P	ROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	30/2021
				200 NURSING HOME LANE		
PARKVIE	W 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	Director interviewed thand 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 an obtained and included review of the resident the comprehensive caplan, revealed staff up to reflect the resident the Vice President of at 4:10 PM revealed s resident preferences. was interviewed for st preference, and the faresident's care plan. A interviews revealed the preference was obtain shower schedule reversident diets on 08/2 that she implemented recommendations for loss and/or wound he documentation revealed the revealed sendocumentation revealed the documentation	the Interim Social Service the residents on 09/15/2021 with resident hygiene. Don 09/30/2021 at 2:23 PM wed Residents #45, #65, 14, and #320 on 09/15/2021 terns regarding hygiene.  Idents during the initial tour 1:33 PM to 2:32 PM revealed Interviews and record Idents #45, #65, #308, Interv	(F 68			
		s and recommendations.				

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 <b>30/2021</b>
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER	<u>'</u>	2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE 2KEVILLE, KY 41501	, 03/	0012021
(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 OF THE APPROPRIA			(X5) COMPLETION DATE
{F 686}	revealed she complet 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 11:35 Pl 09/29/2021 at 11:35 Pl 09/29/2021 at 11:52 Pl signs/symptoms of hy A review of facility ass 08/12/2021 revealed diagnosis of Chronic Disorder (COPD), Ass assessed by Respirat with Respiratory Ther at 12:45 PM revealed with diagnoses of Chronic Observation of Reside 1:48 PM, Resident #6 PM, and Resident #4 revealed no respirato  8). Interview with the on 09/30/2021 at 3:40 all residents with a diagnose for greater the facility amediant's orders for greater the facility amediant and facility amediant's orders for greater the facility amediant and facility and facility and facility and facility amediant and facility and facili	o on 09/30/2021 at 4:17 PM ed the review of all diets s.  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 cory Therapist #1. Interview apist (RT) #1 on 09/30/2021 she assessed all residents conic 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	86}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED				
		185256	B. WING_				R <b>30/2021</b>
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BI IE APPROPRIA		(X5) COMPLETION DATE
{F 686}	orders 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 Pl observed on 09/11/20 within five (5) to ten (1) scheduled times.  10). A review of the face of the fac	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 M revealed lunch was 21 and arrived at the unit 10) minutes of the  citility's staffing for AM to 6:00 PM revealed as and three (3) nursing duled for each floor of the a facility's staffing revealed a and two (2) certified each floor from 6:00 PM to  g for 09/29/2021 and two (2) licensed nurses, and sing assistants on each floor PM. Further review of (1) licensed nurse and two assistants for each floor from staffing on 09/28/2021 from on 09/29/2021 from 8:11 AM PM and 09/30/2021 from revealed call lights were of residents appeared	{F 6	86}			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION  . BUILDING			(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 100 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 REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
{F 686}	Interviews with RN #AM and on 09/30/202 #4/Wound Care Nurs LPN (Licensed Practi at 12:44 PM; LPN #7 and 09/30/2021 at 12:50 I at 10:31 AM; State R: (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 P at 3:17 PM and SRN/ PM, revealed staffing staff member reveale 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 kite and they were able to their shift.	th baths/showers, was being conducted timely, passed timely.  1 on 09/29/2021 at 11:55 21 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 54 PM; LPN #10 on PM, LPN #11 on 09/30/2021 egistered Nurse Aide aide) #1 on 09/29/2021 at on 09/29/2021 at 3:23 PM; D21 at 3:29 PM; SRNA #19 D PM; SRNA #21 on M; SRNA #22 on 09/29/2021 At 4:10 had improved, and each d they had time to perform filling schedule for 21, and 09/30/2021 ensisted of one (1) day cook, one (1) prep cook, two (2) evening aides. The chem on 09/28/2021 at 2:26 ing was accurate per the with Cook #3 on 09/29/2021 at 2:26 ing was accurate per the with Co	{F 6	:86}				
	conducted for Reside	other abuse symptoms was nts #64, #86, and #322 on erns were identified. A						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		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 100 NURSING HOME LANE PIKEVILLE, KY 41501	<u> </u>	JU12021	
(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 APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
{F 686}	no identified concerns interviews conducted and 09/30/2021 revealed the psychosocial and including observation and #322. Interview v 09/29/2021 at 11:54 / with abuse. Interview 09/30/2021 at 1:39 Plas diagnosis of Demer reviewed and revised with the RDON on 09 revealed she complet 08/11/2021, for all resof licensed nursing stidentified. A review of Social Service Directed BIMS score of eight (identified concerns.  13). A review of assewander, revealed all wandering risk asses Review of the elopemeach nursing station obinder on each floor translation interventions for each 14). Review of Resident #332's medical residents had been wanterview with the Residents #39, #65, #65, #65, #65, #65, #65, #65, #65	ments completed revealed 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 AM revealed no concerns with MDS Nurse #1 on M revealed all residents with a necessary. Interview //30/2021 at 4:17 PM and sed skin assessments on sidents, with the assistance aff. No concerns were a undits completed by the or (SSD) for residents with a 8) or above revealed no sesments for residents that residents had received a sment by 08/16/2021. The network and potential a resident identified at risk.  The series of the resident at the concerns were a concerns with a second revealed and received a concerns were a concerns wer	{F 6	886}				

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_	<u></u>		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		13012021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOU  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)	TION SHOULD BE THE APPROPRIATE		
{F 686}	09/16/2021 for Reside Resident #81, 09/16// 09/16/2021 for Reside recommendations madischarged. Interview Dietician on 09/30/20 Nurse Consultant on Regional DON on 09/DON #2 on 09/30/20/2 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 recordinate of snacks. Inte 09/29/2021 at 4:10 Pl educated on documental pies, goldfish of the snacks were resident #14's recordinate of snacks. Inte 09/29/2021 at 4:10 Pl educated on documental field. Observation of the yellow zone on 09/28, no identified concerns residents.	pent #65, 09/16/2021 for 2021 for Resident #90 and 2021 for Resident #90 and 2021 for Resident #332 was 2021 with the Registered 21 at 3:53 PM, the Regional 209/30/2021 at 3:40 PM, the 20/2021 at 4:17 PM and 21 at 3:20 PM revealed each 21 at 3:20 PM revealed each 22 at 3:20 PM revealed each 23 acomprehensive nutritional 24 at 3:20 PM revealed each 25 acomprehensive nutritional 26 at 3:20 PM revealed each 32 acomprehensive nutritional 27 at 3:20 PM revealed each 33 acomprehensive nutritional 28 are interview with the RD 29 are interview with 100 are cackers, cookies and 30 are cackers, cookies and 30 are passed on third floor. 331, Resident #65 and 31 are vealed documented 31, Resident #65 and 31 are vealed she was	{F 6	86}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 686)	09/29/2021 at 11:41 A 8/30/2021 at 10:36 Al or symptoms of COVI been discharged from 18). Review of facility staff working on 09/16 COVID-19 with no ide review of resident tes 09/17/2021, revealed 19). Interview with ME 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 09/00 09/29/2021 at 11:54 PN 12:58 PM, RN #4/Wo 09/30/2021 at 2:54 PN 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PN at 12:50 PM, LPN #11 AM, SRNA #1 on 09/29/2021 at 09/29/2021 at 3:29 PN at 4:10 PM, SRNA #2 SRNA #22 on 09/29/2021 at 09/29/2021 at 1:12 PN 09/30/2021 at 2:10 PN Director/Dietary Mana 1:30 PM revealed the (2) times weekly. Inter	AM and Resident #329 on M revealed no obvious signs D-19. Resident #327 had a the facility.  staff testing revealed all 6/2021 were tested for entified new cases. Further ting for COVID-19 on no new cases.  OS Nurse #1 on 09/30/2021 at 1:31 sistant #1 on 09/30/2021 at mager on 09/30/2021 at 10:48 AM, Senior 09/30/2021 at 10:55 AM, 9/29/2021 at 10:48 AM, Senior 09/30/2021 at 2:40 PM, RN #1 is AM and 09/30/2021 at and 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 at 09/29/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 on 09/29/2021 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	686}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		185256	B, WING_			1	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		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 686}	following CDC guidant tested revealed tested times weekly.  20). Review of Reside and #90's medical recresident had COVID-implemented. In additivesident's MAR revealmenter and resident's MAR revealmenter and resident's MAR revealed and Resident #321, Resident #321, Resident #321, Resident #351's for usage and approping the physician on 09/2  22). Observation of a 09/29/2021 at 4:35 Pt 09/30/2021 at 8:09 At identified concerns with addition, observation floor on 09/30/2021 at identified concerns. In 09/29/2021 at 11:55 APM, N #4/Wound Car 2:54 PM, LPN #6 on CLPN #7 on 09/29/202 09/30/2021 at 1:54 Pt at 12:50 PM and LPN AM revealed no concernedications.	esting two (2) times weekly ace. Review of facility staff d is being conducted two (2)  ent #329, #328, #311, #65 cord revealed that each 19 monitoring orders sion, review of each led staff was completing the 1 by the physician.  Medical Director on M revealed Resident #9, lent #324, Resident #326 medications were reviewed riate administration times by 3/2021.  medication pass on M on 3rd floor and M on 3rd floor and M on 3rd floor revealed no 112:50 PM reve	{F 6	86}			
	Operations on 09/30/2 Co-Owner/President						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION		(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 CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI ( {EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE	
{F 686}	facility with a three-darequiring 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 agreemen 24). Interview with RN AM and 09/30/2021 a 09/30/2021 at 2:54 PM LPN #7 on 09/30/2021 at 1:54 PM 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 09/25/2021 at 3:40 09/30/2021 at 4:17 PM completed of all resid and verified all medic facility by 09/25/2021 and 09/30/2021 at 8:0 concerns with missing 26). Review of a QAF	harmacy will supply the ay supply for medication. Review of the facility's revealed for any medication with pharmacy would send to faither-day supply of the agreviewed. 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 at 12:58 PM, RN #4 on M, LPN #6 on 09/30/2021 at 10:31 AM serived education and was for obtaining medications of addition, they revealed the nurse would notify the nacy could not deliver a lity.  The Regional Nurse Consultant of PM, and Regional DON on M revealed an audit was ents' ordered medications attorns were available in the the third floor of the signature sheet revealed a meeting on 08/12/2021	(F 6)	86}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_				R <b>30/2021</b>
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	)Ę	007	50/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	IX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	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 Interview with the Interview with the Interview with the Interview with the Compositions revealed stadministrator with dai 09/10/2021. Further in Operations revealed stadministrator with dai 09/10/2021.  28). Interview with the 09/30/2021 at 3:40 Pt committee, including the Consultant on 09/30/2021 at 3:25 Pt committee, including the Consultant on 09/30/2021.  29). Interview with the Operations on 09/30/2021.  29). Interview with the Operations on 09/30/2021.  29). Interview with the Operations on 09/30/2021.	esources, SSD #2, Medical eping Supervisor, Central eping Supervisor,	{F 6	586}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(2	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021	
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			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 APPROPR DEFICIENCY)		OULD BE	E	(X5) COMPLETION DATE
{F 686}	and COVID-19 isolatic facility to monitor/assic reposition residents, prepare and distributed residents with eating, effective Pharmacy Scand neglect effectively appropriate ADLS, and QAPI committee.  30). Interview with the 09/30/2021 at 3:40 PI Consultant on 09/30/2021 reviewed and revised presented the reviews Committee during the facility developed a stall topics were review meetings. The plan in Foley catheters, entercontractures, physical usage, risk management, social significance, activities, in council concerns and discharges, census, so by department/position dietary variance tray a work injuries, terminal medical leave of absenew hires, medical repharmacy reports, resoffice, and admission Committee and Medic standardized agenda but not be limited to the	oring tools: Infection Control on, enough staff at the ess residents, turn and provide incontinent care, a meals, and assist caring for pressure wounds, ervices, dealing with abuse by, sufficient staff, providing diproviding a functioning diproviding diproviding a functioning diproviding diprovidi	{F 6	686}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING_				₹ 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			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG		OULD BE		(X5) COMPLETION DATE
{F 686}	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 Centra 2:40 PM, revealed the at the QAPI meeting b 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. Inter-	M, MDS Nurse #2 on M, Regional Certified Dietary 21 at 2:26 PM and M, Former Activities ager #3 on 09/30/2021 at cords on 09/29/2021 at 8:34 be Director (HR) on M, Therapy Manager on M, Housekeeping 2021 at 1:24 PM, (RT) #1 on 09/30/2021 at be information was presented and on 09/16/2021.  E Vice President of 2021 at 4:10 PM, the Interim 20/2021 at 3:40 PM, DON #2 20 PM, and the Medical 21 at 3:25 PM revealed a 22 and on 09/16/2021 regarding 23 are on 09/16/2021 regarding 24 are on 09/16/2021 regarding 25 are on 09/16/2021 regarding 26 are on 09/16/2021 regarding 27 are on 09/16/2021 regarding 28 are on 09/16/2021 regarding 29 are on 09/16/2021 regarding 29 are on 09/16/2021 regarding 20 are on 09/16/2021 regarding 21 at 0.0000000000000000000000000000000000	{F 6	386}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE	SURVEY
		185256	B. WNG			i	R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE		1	STI 200	REET ADDRESS, CITY, STATE, ZIP CODE  D NURSING HOME LANE  KEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	PM revealed they were governing body, and offorwarded to them.  33). Interview with the Operations on 09/30/3 Regional Nurse Conservations on 09/30/3 Regional Nurse Conservations on 09/30/3 Regional Nurse Conservations on 09/3 Method begins and provided education regarding Conservations of the compliance of the compl	ultant on 09/30/2021 at 3:40 re members of the QAPI meetings had been  e Vice President of 2021 at 4:10 PM and the ultant on 09/30/2021 at 3:40 eming body provided the ources and education rither interviews revealed the if meet quarterly for the iew with the Interim 0/2021 at 3:40 PM revealed with resources and QAPI.  Interim Administrator on M revealed QAPI meetings rity effective 09/16/2021 to care is monitored and riterview with the Vice ris on 09/30/2021 at 4:10 Consultant on 09/30/2021 at 1:39 rity 09/30/2021 at 1:31 PM, ritary Manager on M and 09/30/2021 at 1:52 Director/Dietary Manager :30 PM, Medical Records AM, Human Resource	{F €	886}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	le	(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 COD 200 NURSING HOME LANE PIKEVILLE, KY 41501		03/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	I	
{F 686}	Medical Director/Phys 3:25 PM revealed he QAPI meetings on 09 Further interview with 09/30/2021 at 3:40 PM meeting had been conceive of the facility 0 sheet reflected the abidentified concerns.  35). Interview with RM AM and 09/30/2021 at 3:50 PM, LPN #10 on 09/30/00 09/30/2021 at 12:409/29/2021 at 3:40 PM, LPN #10 on 09/3/29/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PM education on 09/17/20 staff revealed they we weighing residents, or reporting the weights (RD). Interview with Fat 4:17 PM revealed seducation on 09/17/20 techniques, obtaining reporting weight chand Dietician.	Idition, 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 on revealed the weekly QAPI inducted on 09/30/2021. A taPI meeting attendance ove interviews with no  I #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 at PM, LPN #7 on and 09/30/2021 at 1:54 at 2:50 PM, LPN 10:31 AM, SRNA #1 on and 09/30/2021 at 4:10 PM, SRNA #7 on 09/29/2021 at 3:04 PM, SRNA #22 and revealed they received 021. Interview with nursing rebalized understanding of obtaining, documenting, and to the Registered Dietician degral on 09/30/2021 at 3:04 PM on 09/30/2021 at 3:04 PM, SRNA #23 on and revealed they received 021. Interview with nursing rebalized understanding of obtaining, documenting, and to the Registered Dietician degral proper weighing and ges to the Registered preceived on 09/30/2021 at 1:30 are represented preceived preceived on 09/30/2021 at 1:30 are represented preceived preceiv	{F 6	86}			
	PM revealed she rece						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING				R
NAME OF P	ROVIDER OR SUPPLIER				CELL ADDRESS SIZE STATE TO BE A	09/	30/2021
					REET ADDRESS, CITY, STATE, ZIP CODE  NURSING HOME LANE		
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER			EVILLE, KY 41501		
	510000000000000000000000000000000000000			FIR			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 686)	Continued From page	÷ 533	{F 6	86}			
	Manager (CDM) on ditimely nutritional asset order accuracy. When the electronic medical the order sends writted dietary staff, which includes the tray card system to orders. She stated that previous day would be meeting. Interview with 09/28/2021 at 2:26 PM revealed she component of the property of the property of the previous day would be meeting. Interview with 09/28/2021 at 2:26 PM revealed she component of the property of	set order accuracy and assements to ensure diet orders into a staff enter diet orders into a record, the nurse entering an communication to the cludes diet and texture. She she entered the order into o reflect the resident's diet at all diet orders from the e reviewed in the clinical the the Regional CDM on M and 09/30/2021 at 1:52					
	AM and 09/30/2021 at Care Nurse on 09/30/ on 09/30/2021 at 12:4 09/29/2021 at 3:00 PM PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PM 09/29/2021 at 3:40 PM 09/29/2021 at 3:23 PM 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 PM education on turning/r motion and transferring chair and from chair to turning, positioning, at on 09/29/2021 at 10:2 revealed no identified	M and 09/30/2021 at 1:54 80/2021 at 12:50 PM, LPN 10:31 AM, SRNA#1 on M, SRNA#11 on M SRNA#7 on 09/29/2021 9 on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA#22 PM and SRNA#23 on M, revealed they received repositioning, range of g residents from bed to b bed. Observations of and wound care with RN #11 11 AM for Resident #65 concerns. Interview with the 09/30/2021 at 1:18 PM					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_				R 30/2021
	ROVIDER OR SUPPLIER  ** POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			40/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	. , , , , , , , , , , , , , , , , , , ,	SHOULD BI		COMPLETION DATE
(F 686)	AM and 09/30/2021 at Care Nurse on 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 3:40 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 3:17 09/29/2021 at 3:17 09/29/2021 at 4:10 Pf education on pressure turning and reposition nutrition, Positioning and document a head and how to notify the RP of a new skin impair or email the Registere and the resident's repchanges. Interview with Consultant on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/30/2 Regional book of the registered dieticia new skin impairment, impairment, the nurse impairment, the nurse	orange of motion, and at from bed.  If #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 at PM, LPN #7 on and 09/30/2021 at 1:54 at 10:54 at	{F 6	386)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .		CONSTRUCTION	(X3) DATE	SURVEY LETED
		185256	B. WNG_				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE			ST 20	REET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE KEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 689) (F 689) SS=D	S483.25(d)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	ards/Supervision/Devices 2)	{F 6	- 1			12/30/21
	by: Based on observation and facility policy revifacility failed to ensure as free from accident (1) of fifty-seven (57) (Resident #12) related resident's rooms.  Observation on 06/15 medication cup contain hundred and fifty (250)	d to medication found in  /2021, revealed a ining Valproic Acid two i) milligrams (mg) in), Metoprolol Tartrate fifty			F 689 Free of Accident Hazards/Supervision/Devices  Criteria 1: The identified medication was removed from the room of Resider #12.  Criteria 2: a) A review was complete of all resident rooms on 6/15/21 by DON/ADON to determine if there were any medications present. There were none identified.  b) Medication	nt	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185256	B, WNG_				R
NAME OF P	ROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
			ŀ		00 NURSING HOME LANE		
PARKVIEV	N POST-ACUTE AND RE	HABILITATION CENTER					
		<del></del>			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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 689}	Continued From page	÷ 536	{F6	89}			
:	medication) sitting on table.	e (25) mg (antipsychotic Resident #12's overbed		,	administration observations on all licensed nurses working was complete by the DON/Pharmacy Consultant/Nurs Consultant/Designee on 6/15/2021 to	se	
	The findings include:	P. du inc.			determine that medication administration staff are not leaving medication at	on	
	Medications", dated A medications were adnitimely manner, and as policy did not address ingested the medication resident.  Review of Resident # revealed the facility as 09/22/2017, with diag Cerebral Infarction, Is Hypertension, Seizure Brain Injury.  Review of the Quarter (MDS) assessment fo 03/10/2021, revealed	ninistered in a safe and sprescribed. However, the sensuring the resident had on prior to leaving the 12's medical record dmitted the resident on noses which included chemic Heart Disease, e Disorder, and Traumatic			bedside.  Criteria 3: On 6/15/21 and 6/16/21 all medication administration staff have received in-service education by the DON/Designee on the need to observe residents taking their medications before they leave the room.  Criteria 4 Beginning 11/24/2021 the DO or designee will complete 5 random resident room audits, the room environment will be visually inspected the ensure no medication are kept at bedsit Audits will be weekly x 4 week then monthly x 2 months. Audits will be reviewed monthly in QAPI x3 months they are reviewed monthly in QAPI x3 monthly in QA	o de.	
	out of fifteen (15), whi was interviewable.  Review of Resident # dated 06/01/2021, rev receive Metoprolol Tartwice daily (blood pres Quetiapine twenty-five twice daily (antipsychology).	AS) score of thirteen (13) ch indicated the resident  12's physician's orders, realed the resident was to ritrate seventy-five (75) mg saure lowering medication); e (25) mg one half tablet otic); and Valproic Acid two by mg twice daily (antiseizure ent #12's room, on			Consultant or designee will observe at least 4 nurses passing Medications monthly x 3 months. Audits will be reviewed monthly in QAPI x3 months the quarterly until in substantial compliance.  Criteria 5: Date of compliance: 12/30/2021	ien	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING			1	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		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)		COMPLETION DATE
{F 689}	cup containing Valpro (250) milligrams (mg) Metoprolol Tartrate fiff lowering medication), (25) mg (antipsychotic the resident's overbed interview with Resider 3:35 PM, revealed the medications on the ownot taken them yet.  Interview with License on 06/15/2021 at 3:40 supposed to observe resident swallowed the stated she did not knot observed the resident however, she should another resident could medication intended fit.  Interview with the Direct of 12:00 Pmedication administration intended from the properties of 15 pmedication administration and the medication as well as the medication and ta hazards which could be medication being left of literview with the Administrative with the medication being left of literview with the Administrative with the Administrati	M, revealed a medication ic Acid two hundred and fifty (antiseizure medication), by (50) mg (blood pressure and Quetiapine twenty-five c) one half tablet sitting on a table.  Int #12, on 06/15/2021 at enurse had set the verbed table and he/she had be defended and he/she had be defended and he/she had be defended and he/she had be medication. The LPN by why she had not taking the medications; have. The LPN stated do have picked up the for Resident #12 and taken be determined and had not so. The DON stated nurses are residents had ingested a to leaving the resident. The box stated had not so. The DON stated nurses are residents had ingested a to leaving the resident. The box stated had not so the country and had not	{F 6	89}			
		urses were required to taken their medication prior					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE S COMPLI	
		185256	B. WING_		R	
NAME OF P	ROVIDER OR SUPPLIER	100200	1 5	STREET ADDRESS, CITY, STATE, ZIP CODE	09/3	0/2021
-				200 NURSING HOME LANE		
PARKVIEV	W POST-ACUTE AND RE	HABILITATION CENTER		PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUND	JLD BE	(X5) COMPLETION DATE
(F 689)	medication at a reside medication being miss to the resident as well pick up the medication	t and should never leave a ent's bedside due to the sed it could be detrimental l as another resident could n and ingest it.	{F 68	9}		
{F 692} SS=E	1 1 1		{F 69	2}	1	12/23/21
	(Includes naso-gastric both percutaneous en percutaneous endosc enteral fluids). Based	and gastrostomy tubes, doscopic gastrostomy and opic jejunostomy, and on a resident's sment, the facility must			:	
	of nutritional status, so desirable body weight balance, unless the re	ns acceptable parameters uch as usual body weight or range and electrolyte esident's clinical condition is is not possible or resident otherwise;				
	§483.25(g)(2) Is offered maintain proper hydra	ed sufficient fluid intake to tion and health;				
		ed a therapeutic diet when roblem and the health care apeutic diet.				

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION			
AND FEAT OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG_	<del></del>	COMP	LETED	
		185256	B. WING_				R 30/2021	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 031	30/2021	
PARKVIEV	W POST-ACUTE AND RE	HARII ITATION CENTER		20	0 NURSING HOME LANE			
	TO THE PART OF THE			PI	KEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
{F 692}	Continued From page	e 539	{F 6	92}				
	by: Based on observatio and review of facility particles of facility falled to ensure sampled Residents (Resident #327, Resident #39, Resident #327, Resident #327, Resident #327, Resident #327, Resident #327, Resident #328, records revealed each significant weight loss failure to have a systemonitor resident weigh to notify the Registers resident sustained we dietary recommendati weight loss, failed to have a systemonitor resident weight to notify the Registers resident sustained we dietary recommendati weight loss, failed to have a systemonitor resident weight to notify the Registers resident sustained we dietary recommendati weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident's weight loss, failed to have a system to ensure resident weight loss, failed to have a system to ensure resident weight loss, failed to have a system to ensure resident weight loss, failed to have a system to ensure resident weight loss, failed to have a system to ensure resident weight loss, failed to have a system to ensure resident weight loss, failed to have a system to ensure resident weight loss, failed to have a system to ensure resident weight loss, failed to have a system to ensure resident weight loss, failed to have a system to ensure resident weight	65, Resident #90, Resident Resident #330, Resident and Resident #81's medical n of the residents sustained as a result of the facility's emic procedure in place to ht loss. The facility failed to its according to policy, failed ad Dietitian (RD) when a eight loss, failed to provide ions to prevent further monor resident food at weight loss, and/or failed were served adequate eight loss.  ensure residents e parameters of nutritional eight, has caused or is likely y, harm, impairment or			F 692 Nutrition/Hydration Status Maintenance  Criteria 1: a) Resident #332 was discharged from the facility on 9/1/2021 b)Resident # 82 was discharged from the facility on 8/9/2021 c)Resident # 327 was discharged from the facility on 8/14/202 d) Resident #65 was discharged on 10/31/2021 b) Residents #90, #39, #330, and #81 were weighed by 9-17-2021. c) The registered dietician complet a comprehensive nutrition assessment the residents by 9-17-2021. The Direct of Nursing or designee reviewed the comprehensive assessment recommendations by 09/17//2021, spok with the attending MD and validated the diet orders, and recommendations were entered into PCC and matched the Dirit RD tray card.  Criteria 2: a) The DON and Registere Dietician reviewed weights on 9-13-202 for all residents to identify any that had demonstrated significant weight change For any residents demonstrating	ed for or ee ee eng		
	death to a resident. In identified, on 08/11/20 exist on 03/06/2021, a Rights (F580), 42 CFI Abuse (F600), 42 CFI	mmediate Jeopardy was 121, and was determined to at 42 CFR 483.10 Resident R 483.12 Freedom from R 483.12 Comprehensive			significant weight changes, the register dietician completed a comprehensive nutrition assessment by 9202021.  Criteria 3: a) Resident who are weight		ļ	
	Person-Centered Car	e Plans (F655) (F656) 42			weekly are weighed every Monday by			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE	SURVEY
			A. DOILDI			ľ	
		185256	B. WING				2010004
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
					00 NURSING HOME LANE		
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER			IKEVILLE, KY 41501		
(24) 15	CI MAIA DV CT	ATEMENT OF OFFICIENCIES				_	
(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 692}	Continued From page	e 540	{F 6	92}			
	CFR 483.25 Quality of	of Care (F684) (F686)	,		CNAs.		
		15 Pharmacy Services			-CNAs report weights to the nurse w	/ho	
		83.80 Infection Control			reviews and enters the weight into PCC		
	(F880). The facility wa	as notified of Immediate			-Any 5lb weight change or more will		
	Jeopardy on 08/11/20	21.			verified by obtaining a re-weight by the		
					next day.		
		tion of Compliance (AOC)			-Once the weight is verified, any		
	was received on 09/0				significant change and/or 5 lbs weight l		
	removal of the Immed	nate Jeopardy on r, the AOC could not be			or gain will be reported to the MD and f	RD	
		ervations, staff interviews,	]		for recommendations/orders.		
		documentation. Additional			-New orders will be reflected on the		
		was identified at 42 CFR		i	care plan, with the resident and or RP notified.		
		ces (F725), 42 CFR 483.70			b) Monthly weights are obtain	ad	
		(F837), 42 CFR 483.75			in the same manner the first week of ea		
	Quality Assurance and	d Performance			month.	1011	
	Improvement (F867).	The facility was notified of			c) All weights are reviewed in t	the	
		rdy on 09/10/2021. The			weekly weight meeting by the IDT whic	h	
	Immediate Jeopardy i	s ongoing.			consists of: Registered Dietician, Direc	tor	
					of Nursing, MDS, Social Services,		
		allegation of compliance			Activities, Dietary, Therapy and Clinical		- 1
	was received on 09/2				Staff Representative. The DON is		1
	removal of the Immed 09/26/2021. The Stat				responsible for running this		
	determined the Imme				meeting/process.		
1		uring a revisit conducted on			<ul> <li>c) All nursing staff including</li> <li>CNA s were educated beginning 9-17-</li> </ul>	24	
	09/28-30/2021, which	lowered the scope and			by the Director of Nursing, MDS	121	
		R 483.10 Resident Rights	Ì		coordinator or designee on proper		<u> </u>
		rehensive Person-Centered			weighing techniques, obtaining,		
	Care Plans (F655) (F6	656), 42 CFR 483.25			documenting, and reporting of weight		
	Quality of Care (F684	) (F686), 42 CFR 483.35			changes to the Registered Dietician.		Ì
	Nursing Services (F72	25), and 42 CFR 483.45			d) On 9-13-21 the Dietary		
	Pharmacy Services (F	755); and to "E" at 42 CFR			Manager was educated by the Regiona		
	483.12 Freedom from	Abuse (F600), 42 CFR			CDM on diet order accuracy and provis	ion	
		e (F692), 42 CFR 483.70			of timely nutritional assessment to ensu	ıre	
-		(F837), 42 CFR 483.75			diet order accuracy.		
	Quality Assurance and						
	Improvement (F867),				e) On 11-22-21 the Regional		
	Infection Control (F88	u), wrille the facility	1		CDM educated the Dietary Manager an	d i	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		40000				6	₹
		185256	B. WING		<del></del>	09/	30/2021
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE  OO NURSING HOME LANE  IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	The findings include: Review of the facility' Assessment and Interevealed the multidisciprevent, monitor, and weight loss for the respolicy, nursing staff weights on admission for two weeks thereal weight changes of fivithe last weight assess obtaining the weight a confirmation. If nursing they would notify the staff would document review of the policy respond within twenty written notification and weight record by the follow individual weight reatment team would and determine if the refor significant weight changed in the significant weight loss in one more percent considered so (7.5) percent weight loss in six (6) or greater than ten (10)	eness of systemic changes activities.  It is policy titled "Weight reention," not dated, ciplinary team would strive to intervene for undesirable sidents. According to the rould measure resident in, the next day and weekly fiter. According to the policy, is (5) percent or more since sment, would result in again the next day for ing staff verified the weight, dietitian immediately and in the notification. Further evealed the dietitian would refour (24) hours of receipt of dietitian would review the unit fifteenth of the month to the trends over time. The dievaluate negative trends resident had met the criterial change. The policy defined inge as, a five (5) percent onth, greater than five (5) evere; seven and one-half red severe; ten (10) percent months was significant and percent considered severe.	{F 6	92}	dietary staff on facility policy regarding meal service times and the use of recipincluding recipes for those requiring fortified diets to ensure all meals meet inutritional needs of residents in accordance with established national guidelines to reflect religious, cultural a ethnic needs of the population.  h) By 11-22-21 the CDM educated the dietary manager and diets staff on obtaining food preferences, Dining RD, placing order by menus for facility, stocking snack/hydration carts, snacks and hydrations, appropriate scosizes and/or portion sizes. i) Starting 9-16-21 newly admitted/re-admitted resident food and beverage preferences will be obtained the dietary manager or designee within hours of admission and entered in DiningRD for listing on their tray cards. Food preference will be completed bi-annually and as needed for all residents. j) Starting 9-15-21 snacks a being offered daily morning and afternously the restorative or activity aides or designee to all residents. Intake will be documented in the electronic medical record.  Criteria 4: a) Starting 8-25-2021 the Dietician or designee will audit diet ordefrom PCC against orders entered in	nd ary oop 72	
	the interventions for u	y, the facility should base indesirable weight loss on of resident choices and tional needs of facility			DiningRD (diet software) to ensure accuracy monthly until substantial compliance is achieved b) Starting on 9/23/2021		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1''		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING				R 30/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	30/2021
DA DICIACI				;	200 NURSING HOME LANE		
PARKVIE	V POST-ACUTE AND RE	HABILITATION CENTER		1	PIKEVILLE, KY 41501		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	•	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLÉTION DATE
(F 692)	Continued From page	e 542	{F 6	92)			
	residents.		` `	,	Dietary Manager or designee will ensu	re	
					and audit meals leaving the kitchen an		
		t #65's medical record			reaching the units timely, audits will be		
	revealed the facility a				conducted for random meals monthly u		
		nosis that included Cerebral			substantial until substantial compliance	is	
	Infarction, Dysphagia	, Polyarthritis and			achieved		
	Paraplegia.				c) Starting 9-11-21 the		
	Review of Resident 6	5's Admission MDS			Dietary Manager or designee will time passing of meal trays to residents after		
		3/30/202,1 revealed the			arriving to the unit. All three meals will		i
	facility assessed the	•			observed monthly until substantial	DE .	
		-nine (179) pounds, and was			compliance is achieved.		
		two (2) staff with Activities of			d) Starting 9-13-21 MD		
		g eating. Further review			ordered snack intake will be audited by	, }	
		had no weight loss/gain or			Dietary Manager monthly until substan		
		ain history was unknown and			compliance is achieved.		
		rs. The MDS revealed			e) Beginning on 12/1/21	į	
	Resident #65 had cor	mplaints of difficulty or pain			Weights are reviewed in the Clinical		
	risk for malnutrition.	had malnutrition or was at			Meetings Monday ☐ Friday reviews ar	ıy	
	nsk for mainutition.				recommendations from the RD/MD for residents are addressed at that meetin	_	
	Review of Resident #	65's weight record revealed			Dietary Manager reports any nutrition	9.	
		esident's weight was one			concerns of residents with the group.		
		d seven tenths (142.7)			Minutes of the meetings are maintained	d in	
		s of thirty-six and six tenths			the DON s office. The Dietary Manage		
,	(36.6) pounds since a	admission to the facility on			conducts visits with resident to address		
	03/23/2021. Review				their preferences weekly and if issues	will	
		o documented evidence the			visit daily. Also, Starting on 9/23/21 the	e i	
į		nt #65 after the weight loss			Dietary Manager audits portion control		
	and no documented e				recipe followed, and forfeited foods.		
	addressed the weight	I IOSS.			Interviews with residents to ensure the	y	
į	Medical record rovies	v revealed Resident #65 was			are getting enough food and are not		
		spital on 04/08/2021 for			hungry is done and recorded on the preference audit form.		
	_	and was re-admitted to the			Audits will be reviewed monthly in QAF	)	
		with diagnoses that included			x3 months then quarterly until in	1	
		Acute Respiratory Failure,			substantial compliance.		
		ection. The record revealed			Substantial Compilatios.		
		ented evidence the facility			Criteria 5: Date of compliance:		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R <b>30/2021</b>
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<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 692}	Review of the Situation Assessment and Recommunication form, PM, revealed the Resideep tissue injury (DT Review of the medical #65 weighed one humbounds on 05/04/2021 tenths (7.7) pound we weight on 04/06/2021 Approximately one (1) initial weight loss, the #65. Review of a Nutrassessment, dated 05 resident's weight was calculated the resident and four tenths (5.4) pand twenty-four and sin sixty (60) days. Accassessment, Resident malnutrition related to recommended fortified day and a frozen cup documented evidence resident had a DTI and resident needed anyth. Interview with the RD, PM, revealed the facilinher of resident skin brishes stated she was un	upon readmission to the  an, Background, commendation (SBAR) dated 05/02/2021 at 5:29 ident #65 had developed a il) to the coccyx.  I record revealed Resident dred and thirty-five (135) I, another seven and seven ight loss from the previous  month after the resident's RD assessed Resident rition Data Collection i/06/2021, revealed the 135 pounds, and the RD it's weight was down five percent in thirty (30) days even tenths (24.7) percent cording to the RD's it #65 had severe weight loss. The RD if foods three (3) times a at dinner. There was no it the RD identified the d addressed whether the and for wound healing.  on 08/26/2021 at 12:16 ity had not been notifying eakdown and weight loss, haware that Resident #65	{F €	592}			
	resident on 05/06/202	when she assessed the  1. She stated had she e increased the resident's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		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	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	PROVIDER'S PLAN OF CORRECTIV X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE	
{F 692}	stated ideally she woo of new pressure ulcer Review of a change of Resident #65, dated (revealed the pressure coccyx was "worsening revealed the deep tisse unstageable pressure loss (death) in which the covered by slough (yeand/or eschar (tan, brown bed) that measured secentimeters (cm) long (9.7) cm wide.  Review of a Nutrition 05/18/2021 at 10:46 for weight was one hund (142.6) pounds, a sign (3) percent in seven (20.5) percent in nine revealed the RD was unstageable pressure Based on the progress receiving fortified food a frozen nutrition cupideal body weight (IBN forty-eight (148) poun recommendations.  Continued interview wat 12:16 PM, revealed #65's pressure ulcer wassessed the residen stated, had she know	ssure ulcer healing. She ald like to be notified weekly is.  If condition form for 15/11/2021 at 2:40 PM, a ulcer to the resident's ag". Continued review sue injury (DTI) was now an a ulcer (full thickness tissue the base of the ulcer was allow, tan, green or brown) rown, or black) in the wound ix and one-half (6.5) and nine and seven tenths  Progress Note, dated on PM, revealed Resident #65's red forty-two and six tenths and inficant weight loss of three (7) days, twenty and one-half try (90) days. Further review aware the resident had an a ulcer to the sacrum. It is note, the resident was districted the sacrum and at dinner. The resident's W) was one hundred districted the try of the was unaware Resident was worsening when she to no 05/18/2021. She in she would have erventions to address the	{F 6	92}			

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 <b>30/2021</b>
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 200 NURSING HOME LANE PIKEVILLE, KY 41501	IP CODE		0012021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BI TO THE APPROPRIA		(XS) COMPLETION DATE
{F 692}		ident #65's weight record weighed one hundred	{F 6	92}			
	resident had a twelve percent weight gain in sustained a fifteen an weight loss in ninety (revealed the resident' his/her needs; howev for malnutrition due to days, a pressure wou required a therapeutic	6/13/2021, revealed the and two tenths (12.2) In thirty (30) days and had done-half (15.5) percent (90) days. Further review is intake was greater than er, the resident was at risk to a weight loss in ninety (90)					
	05/28/2021 at 3:54 Pl had a "worsening wou a wound culture and I However, per the cha later called back and	nge of condition form, "MD decided to send resident to evaluation and treat for					
	05/28/2021. Review of Department (ED) nurs 05/28/2021 at 5:36 Pt a "large decubitus (prifiteen (15) cm by eight sloughing and underly had surrounding eryth."	admitted to the hospital on of the resident's Emergency					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	IPLE CONSTRUC			SURVEY
	ı	185256	B. WNG			l .	R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER			RESS, CITY, STATE, ZIP CODE G HOME LANE 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 ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	Resident #65 was "cli decubitus [pressure] u infection including cel developing abscess". Disease Consult note resident "underwent of per operative note, all removed and the exci Interview with Surgeo PM, revealed he debr pressure ulcer to Resi 05/30/2021. He state tissue in the wound ar down to the bone. He measured ten (10) cm depth prior to debride the area measured fiften (10) cm in width a Surgeon #1 stated, "N development/worsenii Further review of the I 05/28/2021 at 11:38 P (low albumin can indicat one and three tenth (g/dL) with normal ran (3.4) to five (5.0) g/dL, the resident's Total Pramount of albumin an "low" at five and six te range of six and four tenths (8.4) g/dL (low in severe malnutrition)	at 1 at 9:24 PM, revealed nically septic with large ulcer with associated fulitis and possible  According to an Infectious, dated 06/01/2021, the lebridement on 05/30/2021, inecrotic tissues were sion was down to the bone".  In #1, on 08/31/2021 at 1:30 ided the large stage four-(4) ident #65's sacrum on dithere was non-viable at atted the pressure ulcer in length by six (6) cm in ment, and post debridement iden (15) cm in length by nd was very extensive. Illutrition is a big key" in the large of pressure ulcers.  In \$1, on 08/31/2021 at 1:30 ided the large stage four-(4) ident #65's sacrum on dithere was non-viable at a stated the pressure ulcer in length by six (6) cm in ment, and post debridement iden (15) cm in length by indicate malnutrition) was "in the large of pressure ulcers.  In ospital record revealed, on the pressure ulcers.  In ospital record revealed, on the pressure ulcers.  In ospital record revealed on the pressure ulcers.	{F 6	92}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				२ 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	<u> </u>	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 APPROP			_	(X5) COMPLETION DATE
{F 692}	weighed one hundred (152.2) pounds on 06 and six tenths (150.6) one hundred forty-through pounds on 06/29/202 Review of a Nutrition 06/29/2021 at 9:52 Pland sustained a signipercent in less than than two tenths (20.2) ninety (90) days. The weight (IBW) was one pounds. Further revideveloped a Deep Tisand left heels and conductive for the progress note, the restortified foods three (3 current intake was incresident's protein near resident's protein near recommended adding breakfast and dinner for healing.  Continued review of Frecord revealed on 07 weighed one hundred (142.7) pounds.  Review of the resider dated 07/13/2021, resignificant weight loss (6.3) percent in thirty one-half (20.5) percentighty (180) days. The right heel, two (2)	esident. The resident d fifty-two and two tenths i/15/2021, one hundred fifty ) pounds on 06/22/2021 and ee and one tenth (143.1) 1.  Progress Note, dated M, revealed Resident #65 ficant weight loss of six (6) hirty (30) days and twenty percent weight loss in e resident's ideal body e hundred forty-eight (148) ew revealed the resident had esue Injury (DTI) to the right intinued to have a Stage IV the coccyx. According to the sident continued to receive B) times a day; however, the	{F €	592}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED
		185256	B. WING			R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	09/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIA	
{F 692}	foods three times a da at breakfast and dinner resident's intake great needs and no nutrition made.  Review of Resident ## resident was to receive fortified foods with med.  Observation of Resident ## (108/05/2021 at 7:50 PM resident received larg.)  Review of Resident ## (108/05/2021 at 7:50 PM resident received larg.)  Review of Resident ## (11) The resident was not vapproximately one (1) The resident weighed and two tenths (133.2 tenths (6.6) percent we (30) days. There was the RD assessed the documented evidence the resident's weight is revealed the resident one and four tenths (108/11/2021, a seven a percent loss in approx There was no docume assessed the resident ## (108/11/2021) at 2 resident's weight was and eight tenths (137.	e resident received fortified ay and large protein portions er. According to the RD, the tly exceeded the resident's nal recommendations were  65's tray card revealed the re large protein portions and eals.  ent #65 dinner tray, on M, revealed no evidence the e protein portions.  65's weight record revealed veighed again until month later on 08/06/2021.  one hundred thirty three  1) pounds, a six and six  eight loss in less than thirty on documented evidence resident and no e that the facility addressed oss. Continued review weighed one hundred thirty  31.4) pounds on and nine tenths (7.92) cimately five (5) weeks.  ented evidence the RD equity five (5) weeks.	{F 6	592)		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE	SURVEY
		185256	B. WING				R
NAME OF P	ROVIDER OR SUPPLIER	103230	D. WING			09/	30/2021
	W POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE TO 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)		COMPLETION DATE
(F 692)	continued to have a Done-(1) pressure ulcer to san unstageable press extremity. Review of resident had a desired tenths (4.6) pounds of and no recommendat.  Further review of Reservealed the resident weighed (132) pounds on 08/2 thirty-one and seven to 08/24/2021 and one intenths (131.4) pounds interview with the RD and 08/18/2021 at 10 not aware the facility of providing large protein. She stated if the facility is provided in the facility of the facility o	ress note, the resident OTI to right heel, a stage r to left heel, a stage four- sacrum, and had developed ure ulcer to left lower the note revealed the d weight gain of four and six ver the "past few weeks" ions were made.  ident #65's weight record continued to lose weight. one hundred thirty-two 3/2021, one hundred enths (131.7) pounds on aundred thirty-one and four is on 08/25/2021.  on 08/11/2021 at 4:10 PM c30 AM, revealed she was was not fortifying foods, nor in portions as recommended. by had fortified Resident d large protein portions as in-going significant weight this resident would have	{F 6	692}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE	SURVEY
							R
		185256	B. WING			09/	30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	2. Review of Resident revealed the facility at 10/07/2016 with diagr Unspecified Protein-C Dysphagia.  Review of Resident # (MDS) assessment do the facility assessed the facility assessed the facility assessed the facility assessed the resident had moderate MDS also revealed the dependent on staff for stated the resident we pounds and was at rist.  Review of Resident # the resident weighed on 02/02/2021.  Review of Resident # plan in place on 02/19 identified on 11/20/20 potential for weight complement of the resident # on 03/06/2021, the related eight tenths (86.8 pounds in thirty-two (3 was no documented eight policy.  Continued review of Resident # on 03/06/2021, the related eight tenths (86.8 pounds in thirty-two (3 was no documented eight policy.	ng of pressure ulcers. It #90's medical record dmitted the resident on noses including Dementia, calorie Malnutrition and It 90's Minimum Data Set ated 02/19/2021, revealed he resident to have a BIMS of fifteen (15), indicating the e cognitive impairment. The e resident was totally reating. The assessment eighed ninety-seven (97) sk for malnutrition. It is seven (97) sk for malnutrition.	(F 6	692}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. BUILDING		TIPLE CONSTRUCTION	(	X3) DATE COMP	SURVEY LETED		
		185256	B. WING_			F 09/:	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		0071	50,2021
(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 S  CROSS-REFERENCED TO THE A  DEFICIENCY)	SHOULD BE	E	COMPLETION DATE
{F 692}	revealed the RD note sustained an eight an weight loss in thirty (3 one-half (10.5) perceid (180) days. The docurecommended serving with meals, ice cream whole milk with meals Med Pass (nutritional twenty (120) milliliters. However, review of Radministration record through July 2021, readminister the resider House Supplement the fone hundred twent by the RD on 04/09/2 Continued review of Frevealed on 05/04/20 weight and weighed in (93.6) pounds. However documented evidence resident the next day weight was accurate a policy.  Review of Resident # on 06/08/2021, the resid	entation, dated 04/09/2021, d Resident #90 had d eight tenths (8.8) percent (0) days, and ten and in one hundred eighty mentation stated the RD g the resident fortified foods in with lunch and supper, is and administer the resident supplement) one hundred is (ml), three (3) time per day.  esident #90's medication is (MAR), dated April 2021 evealed staff continued to int ninety (90) ml of the larce (3) times a day, instead by (120) ml as recommended (120).  Resident #90's weight record (121), the resident had gained the larce was no enthe facility re-weighed the to ensure the increased as required by the facility's (120)'s weight record revealed sident's weight was tenths (84.7) pounds, and	{F 6	92}			
	eighty-two and one-harmonic Review of Resident #						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		DNSTRUCTION	(X3) DATE COMP	SURVEY PLETED
· <del></del>		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER	Ì	200	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, 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 692}	days, a twelve and ni weight loss in ninety (one-half (11.5) percer hundred eighty (180) documented the reside exceeds the resident weight". The RD recoresident's Med Pass to Review of Resident #Administration Record 2021, revealed the Madministered to the reday.  Review of Resident #on 06/29/2021, the reand three tenths (82.3) Review of RD documerevealed the RD documerevealed the RD documerevealed the RD documerevealed the RD maderecommendations.  Further review of Resident #07/08/2020 was eighty and two terms of Resident #07/27/2021, revealed foods at meals and iccomper meals.  Observations of Resident #07/27/2021, revealed foods at meals and iccomper meals.	cent weight loss in thirty (30) ne tenths (12.9) percent 90) days, and an eleven and nt weight loss in one days. However, the RD lent's intake "greatly needs yet continues to lose mmended increasing the o four (4) times per day.  90's Medication ds, for June 2021 and July ed Pass continued to be esident three (3) times per  90's weight record revealed sident weighed eight-two 10) pounds.  entation dated 07/07/2021, mented Resident #90 had enth (13.1) percent in ninety and seven tenths (11.7) undred eighty (180) days, de no new  ident #90's weight record 21, the resident's weight nths (80.2) pounds.	{F 6	92}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	IE.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BI APPROPRIA		(X5) COMPLETION DATE
{F 692}	Cream on either day.  Observation of staff w 08/05/2021, from 2:00 Resident #90 weigher (81.1) pounds. However documented evidence that the resident was Interview with the RD and 08/18/2021 at 10 facility had fortified Reservations are commended and precommended supple have prevented the oil loss that occurred for stated she assumed it recommendation the unless she was notified she did not conduct a ensure residents were recommendations. The RD routinely notify her if a weight loss, and the control that information was to came to the facility.  3. Review of Resident revealed the facility and 03/15/2021 with diagrangemented the residution hundred one and Review of Resident # orders, dated 03/15/2	reighing residents on DPM thru 5:00 PM, reveled deighty-one and one tenth over, there was no at the facility notified the RD continuing to lose weight.  In on 08/11/2021 at 4:10 PM:30 AM, revealed if the resident #90's foods as ovided the resident with the rements and snacks, it would in going significant weight this resident. The RD if she made a facility implemented it, and otherwise. The RD stated only type of monitoring to be getting the and made, such as meal as stated the facility did not a resident had experienced only way for her to obtain or run a report when she it #327's medical record dimitted the resident on noses including Dementia,	{F 6	992}			

	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 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		HOULD BE		(X5) COMPLETION DATE
{F 692}	Review of RD documents for Resident #327 review of Resident #327 review of Resident #327 review of Resident #328 review of Resident #328 requiring set up help of weighed two hundred Review of Resident #328 recommended addingto the resident complain swallowing, and was in requiring set up help of weighed two hundred Review of Resident #328 review of a RD evaluation review of a RD evaluation recommended addingto the resident's lunch Review of a RD documented to the RD documented to the RD documented to the resident's lunch Review of a RD documented to the resident's lunch Review of a RD documented to the resident's lunch Review of a RD documented to the resident's lunch Review of the report review of the report review of the report review of the report recommended referring physician for a medical review of a reduction of the report recommended referring physician for a medical review of the report recommended referring physician for a medical review of the report recommended referring physician for a medical review of the report recommended referring physician for a medical review of the report recommended referring physician for a medical review of the report recommended referring physician for a medical review of the report recommended referring physician for a medical review of the report recommended referring physician for a medical review of the report recommended referring physician for a medical review of the report recommended referring physician for a medical review of the recommended referring physician for a medical review of the recommended referring physician for a medical review of the report recommended referring physician for a medical review of the recommended referring physician for a medical review of the recommended referring physician for a medical review of the recommended referring physician for a medical review of the recommended referring physician for a medical review of the recommended referring physician for a medical review of the recommended referring physician for a medical review	entation, dated 03/17/2021, realed she recommended of foods with all meals, is a day and finger foods  327's Admission MDS 322/2021, revealed the resident to be severely. The assessment also stated ed of difficulty or pain with independent with meals only, and the resident and five (205) pounds.  327's baseline care plan.  1, revealed the plan failed to alus.  327's baseline care plan.  27 weighed one hundred enths (194.2) pounds, and he resident had sustained a troop to the resident had sustained a troop troop to the resident had sustained a troop tro	{F 6	592}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185256	B. WING			R 09/30/2021	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		, 037	0012021
(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 692}	loss. However, there evidence in the reside indicate the facility im recommendation and the staff notified the reweight loss or that a recompleted.  Review of RD documerevealed she evaluate 05/07/2021, because hundred eighty-two and 04/27/2021. The Rhad lost six (6) percent thirty (30) days and to percent of body weight days. However, the Recommendations, stawas likely adequate, I weight was stable sin Review of Resident # on 05/09/2021, reveathe resident was at risrelated to dementia a problems. The resident was weight. The interventiplan included assistin needed, RD consults and administer the resupplement as ordered Review of RD docume 06/06/2021, the RD ebecause the resident	seed to experience weight was no documented ent's medical record to plemented the no documented evidence esident's physician of the medication review was entation, dated 05/07/2021, ed Resident #327 on the resident weighed one not one-half (182.5) pounds &D documented the resident ent of body weight in the past en and eight tenths (10.8) and in the past ninety (90) D made no further enting the resident's intake occause the resident's ce the last review.  327's care plan, developed led the facility documented sk for impaired nutrition and chronic medical ent's care plan also stated dent had sustained weight estill above ideal body ons on the resident's care g the resident with meals as as needed, obtain weights, sident the House ed.	{F 6	592}			

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		<del></del>		R
NAME OF P	ROVIDER OR SUPPLIER	103230	D. 111110		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER			00 NURSING HOME LANE IKEVILLE, KY 41501		
(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 692}	and four tenths (11.4) However, the RD mad Resident #327.  Review of RD docume 07/07/2021, the RD e who weighed one hur tenths (179.9) pounds made no new recomm resident's weight had thirty (30) days.  Observation of Residemeal, on 07/27/2021 revealed the resident with the meal, per the Continued review of Frevealed the resident seventy (170) pounds a five and one-half (5, thirty (30) days, howe the RD re-evaluated to Observation of staff w facility on 08/05/2021 PM, revealed Resider hundred seventy and pounds.  Interview with the RD and 08/18/2021 at 10 opinion, if the facility is resident's diet orders resident would not has significant weight loss failure to provide fortif	ant weight loss of eleven percent in ninety (90) days. de no recommendations for entation revealed on valuated Resident #327, ndred seventy-nine and nine is on 07/06/2021. The RD nendations stating the remained stable in the past ent #327 during the lunch at approximately 2:00 PM, was not served ice cream RD recommendation.  Resident #327's record weighed one hundred on 08/03/2021, which was 5) percent weight loss in ver, there was no evidence he resident.  reighing residents in the from 2:00 PM until 5:00 nt #327 weighed one	{F 6	92}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B. WNG			R 09/30/2021	
	ROVIDER OR SUPPLIER  ** POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	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		ON SHOULD B	_	(X5) COMPLETION DATE
(F 692)	loss. The RD stated finformed her of Resident stated the only way stresident's weight loss she was at the facility she was not aware the sustained additional stressed of the sustained additional stressed of the sustained additional stressed of the facility and the sustained additional stressed of the facility and the sustained the sustaine	ident's continued weight acility staff had never ent #327's weight loss. She he was aware of the was to run a report when. Therefore, the RD stated at the resident had significant weight loss from 2021.  It #82's medical record dmitted the resident on hoses including Parkinson's Disease, Insomnia and Further review of the led the resident's weight -three and six tenths (153.6)  In an Admission orders, 2 was to receive a with thin liquids, and on cian ordered the house wided to the resident four (4) 07/27/2021 the physician betite stimulant) to be x (6) hours.	{F €	592}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NURSING HOME LANE PIKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	related to nutritional s Review of Resident # on 06/01/2021, the re forty-five and one tent and one-half (5.5) per thirty (30) days. Howe documented evidence #82 until 06/05/2021, admission and eighter resident sustained a v Review of the RD ass identified Resident #8 one-half (5.5) percent days, and a thirteen a percent loss in ninety recommended to add fortified foods to the R  Continued review of R revealed on 06/08/20 one hundred forty-thre pounds.  Review of Resident # developed on 06/17/2 identified the resident loss, and was at risk f Alzheimer's Disease a Interventions impleme included honoring the requests/preferences, make dietary changes needed, obtain weigh and report and signs/s the physician. The fac signs/symptoms as signs/sy	tatus was on the care plan.  82's weight record revealed sident weighed one hundred th (145.1) pounds, a five cent weight loss in less than ever, there was no at the RD evaluated Resident twenty-four (24) days after en (18) days after the veight loss.  essment, dated 06/05/2021, 2 had sustained a five and weight loss in thirty (30) and four tenths (13.4) (90) days. The RD a nighttime snack and Resident's diet.  Resident #82's weight record 21, the resident weighed ee and two tenths (143.2)  82's nutritional care plan, 021, revealed the facility had a potential for weight loss. ented on 06/17/2021,	{F 6	92}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R 30/2021
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	Ual	30/2021
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER			00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	and one-half (7.5) per months and a ten (10) (6) months.  Further review of Res the resident weighed one-half (142.5) poun hundred thirty-nine and on 07/20/2021, one had three tenths (137.3) per 132.9 pounds on 08/0 loss of 13.4% in the lawas no evidence the lawas no evidence the lawas no evidence the resident after 06/05/20 facility notified the resweight loss.  Observation of staff weight loss.  Observation of staff weight loss.  Observation of staff weight loss.  Interview with the RD and 08/18/2021 at 100 opinion, if the facility if foods as recommended with an adequate and would have prevented significant weight loss. She stated the othe resident's weight I when she was at the lastated she did not alw times, staff failed to er into the system, so a strigger. Therefore, the	ident #82's record revealed one hundred forty-two and ds on 07/13/2021, one and one tenth (139.1) pounds undred thirty-seven and ounds on 07/27/2021 and 03/3021, a significant weight ast 90 days. However, there RD re-evaluated the 021, and no evidence the ident's physician of the reighing residents on PM thru 5:00 PM, revealed d 140 pounds.  on 08/11/2021 at 4:10 PM 030 AM, revealed in her and fortified Resident #82's ed and provided the resident punt of food and snacks, it I the resident's on-going on The RD stated facility staff er of Resident #327's weight only way she was aware of coss, was to run a report facility. However, the RD cays run that report and at other the resident's weights	{F 6	92}			
	significant weight loss						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL <sup>*</sup> A. BUILDI		DISTRUCTION		SURVEY PLETED
		185256	B. WING			1	R
	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	1 09/	/30/2021
PARKVIE	N POST-ACUTE AND RE				NURSING HOME LANE EVILLE, 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)		COMPLETION DATE
{F 692}	Continued From page	: 560	{F 6	92}			
	revealed the facility a 03/11/2020 with diagr	t #330's medical record dmitted the resident on loses including Cerebral lellitus, Hemiplegia and					
	Review of Resident # May 2021, revealed the mechanical soft diet v	330's physician orders for ne resident was to receive a vith thin liquids.					
	facility assessed the r Interview for Mental S (4) out of fifteen (15), cognitively impaired, I and held residual food the assessment revea resident to require lim staff member at meals	330's Annual MDS 5/12/2021, revealed the esident to have a Brief status (BIMS) score of four indicating the resident was nad swallowing difficulties in mouth. Further review of alled the facility assessed the ited assistance of one (1) s. The assessment stated was two hundred thirty-nine					
	o5/12/2021, revealed potential weight conce the resident's diagnos the facility identified the body weight and was the resident had a fee nutrition. Interventions included RD consults and monitor/report and mainutrition to the physigns/symptoms of making the mainutrition of three (3) percent of body weight	at the resident was at risk for the resident was above ideal obese. The note indicates ding tube, not utilize for the initiated on the care plan as needed, obtain weights a signs/symptoms of the resident was reported and intrition to report included all pounds in a week, five (5) at in one month, seven and the of body weight in three (3)					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R /30/2021	
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		130/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE .	(X5) COMPLETION DATE	
{F 692}	(6) months. The care "Explain and reinforce importance of maintai Explain consequence obesity/malnutrition riresident being severe requiring staff assistant Review of Resident # revealed on 06/08/202 was two hundred thirt pounds. However, the evidence the RD eval 06/28/2021, twenty (2 sustained a ten and sweight loss in approxi Review of a RD assess revealed the RD docut lost ten and six tenths body weight in one humade no dietary record Continued review of R07/06/2021, revealed hundred fifteen and or Review of a nurse's not the third floor for an The note stated within floor staff were calling stating the resident". the writer went to the resident crying, and the resident crying.	percent of body weight in six plan also directed staff to a to (the resident) the ning the diet ordered. So of refusal, sk factors", despite the ly cognitively impaired and nice with meals.  330's weight record 21, the resident's weight een and six tenths (213.6) are was no documented uated the resident until 0) days after the resident ix tenths (10.6) percent mately thirty (30) days.  ssment, dated 06/28/2021, amented Resident #330 had a (10.6) percent of his/her undred eighty (180) days, but mmendations.  Resident 330's weight on the resident weighed two ne-half (215.5) pounds.  Oute, dated 07/18/2021 at a left took Resident #330 down in-person visit with spouse. The ten (10) minutes, the third up to the resident's floor, spouse was very upset. The se told staff "they were.  The nurse's note indicated third floor and found the	{F 6	992}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			1		<del></del>		R
		185256	B. WNG				30/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	30/2021
PARKVIEL	N POST-ACUTE AND RE	HARRISTATION CENTER		2	200 NURSING HOME LANE		
- TANKVIL		HABICIATION CENTER		F	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 PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED T DEFICIE		_	(XS) COMPLETION DATE
(F 692)	"visibly lost weight." resident says he/she in the resident says he/she in the resident spouse stated the resident has prior visits and the resident and lost weight. The the resident at home a left the resident at home a left the resident unables stated when the resident unables stated when the resident unables are a "gnawing mot resident was hungry, he/she realized during that the resident was asking the resident in gnawing motion on his reported asking the resident an his/her head. The spot that he/she had purches chips" on the way to the resident if he/she wan giving the food to the ate the chips and drar began to cry during the trying to arrange to calor finding another facito, because the resident #3	the stated the resident had The note further stated the was not hungry.  Int #330's spouse, on M, confirmed the spouse ent on 07/18/2021. The ident all of a sudden wanted as crying. The spouse of never acted that way on sident looked like he/she spouse reported caring for after the stroke, which had be to speak. The spouse ent was home, they had ate through actions and stated when the resident tion" on the arm it meant the The spouse stated when go the visit on 07/18/2021, crying, the spouse reported that was wrong. The spouse mediately began making a signer arm. The spouse endeated yes by shaking the facility and asked the steed it. The Spouse reported resident who immediately that he soda. The spouse interview and voiced are for the resident at home lifty to transfer the resident ent was "going hungry."  330's weight on 08/03/2021,	{F 6	692}			
		weighed two hundred and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
_		185256	B. WING				⋜ <b>30/2021</b>	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	001	0012021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BI E APPROPRIA		COMPLETION DATE	
{F 692}	weight loss since 07/6 was no documented of re-evaluated the resident didition, there was no notified Resident #33 resident had sustained the facility.  Observation of staff wo 08/05/2021, from 2:00 Resident #330 weight (210) pounds.  Interview with the RD and 08/18/2021 at 10 Resident #330 had so loss on 06/28/2021, wresident #330 had so loss on 06/28/2021, wresident, the resident above ideal body weight stated no intervention the RD stated facility of Resident #330's constated the only way stresident's weight loss she was at the facility she did not always runstaff failed to enter the system, so a weight lot Therefore, the RD state the resident had continued to the resident had continued to the resident had continued to the facility and 11/25/2011, and re-actification of 04/03/2018	ve and one-half (5.5) pound 06/2021. However, there evidence the RD lent after 06/28/2021. In the odocumented evidence staff 0's physician that the disignificant weight loss in veighing residents on 0 PM thru 5:00 PM, revealed ed two hundred and ten 0.0 PM thru 5:00 PM, revealed ed two hundred and ten 0.0 PM thru 5:00 PM, revealed ed two hundred and ten 0.0 PM thru 5:00 PM, revealed ed two hundred and ten 0.0 PM thru 5:00 PM, revealed ed two hundred and ten 0.0 PM thru 5:00 PM, revealed ed two hundred and ten 0.0 PM thru 5:00 PM, revealed ed two hundred and thrught statined a significant weight when she evaluated the still remained significantly ght, so therefore the RD swere warranted. However, staff had never informed her intinuing weight loss. She had never of the providence of the providen	{F 6	592}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
	185256	B. WING				R	
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REH	IABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501	<u>  09/</u>	30/2021	
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)					(XS) COMPLETION DATE	
the resident was cognit assessment also reveal independent with eating ninety-six (296) pounds physician ordered weight Review of Resident #35 the resident weighed to pounds on 04/04/2021, weighed in May 2021.  Review of Resident #35 plan, dated 06/17/2021 identified the resident volutrition related to recediet and the diagnosis of implemented on 06/17/honoring the resident's requests/preferences, weight and providing the ordered.  Review of Resident #35 the resident weighed to the vertical weighed to the resident weighed to the resident weighed to the resident weighed to the resident approximately one his Review of an RD assessible provides a representing a fourteent in approximately one his Review of an RD assessible provides a representing a fourteent in approximately one his Review of an RD assessible provides a representing a fourteent in approximately one his Review of an RD assessible provides a representing a fourteent in approximately one his Review of an RD assessible provides a representing a fourteent in approximately one his Review of an RD assessible provides a representing a fourteent in approximately one his Review of an RD assessible provides a representing a fourteent in approximately one his Review of an RD assessible provides a representation of the resident was a r	9's Quarterly MDS 01/2021 revealed the esident to have a BIMS t of fifteen (15), indicating tively intact. The aled the resident was g, weighed two hundred s, and was not on a pht loss plan.  9's weight record revealed wo hundred ninety (290) , and refused to be  9's comprehensive care , revealed the facility was at risk for impaired eiving a mechanical soft of Diabetes. Interventions (2021 included staff food monitoring the residents he resident with diet as  9's weight record revealed wo hundred fifty-three and unds on 06/22/2021, a (14) percent weight loss undred eighty (180) days.	(F €	992}				
revealed the RD recom resident's dietary prefer resident fortified foods a Further review of Resid	rences and serve the at meals.						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI	IPLE CONSTR	RUCTION	(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		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  ' 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 692}	Resident #39 weigher seven tenths (261.7) Interview with Resider 10:45 AM, revealed the available for residents same food several time the supper meal. Resident stated the fact and stated, "I get hunger light the supper meal and stated, "I get hunger light the supper meal and stated, "I get hunger light the supper meal and stated, "I get hunger light the supper	reighing residents on PM thru 5:00 PM, revealed of two hundred sixty-one and pounds.  Int #39, on 07/27/2021 at the facility had no snacks and the facility served the these a week, especially for ident #39 also stated, "You supper to eat anyway". The cility never passes snacks gry".  Int #39 and during the lunch at 1:20 PM, revealed the ads for lunch, and liked to be also for lunch, and liked to lunch but had never lunch. The resident reported the whole that had never stated, "It's always a forgot, or they're out of 9 also stated he/she had cereal, stating that was before admission into the ident #39 stated, "they won't er." The resident stated, ask me what I liked or are not gonna give it to me, eresident stated breakfast	{F 6	92}			
	was frequently cold ar until lunch. However,	nd he/she remains hungry the resident stated "but if I					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_				R
	ROVIDER OR SUPPLIER  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	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		OULD BE		(X5) COMPLETION DATE
{F 692}	make it myself." Resident refusing to allow staff  Interview with the RD, and 08/18/2021 at 10: #39's food preference resident would most lisignificant weight loss weight loss would have resident, but a sudder not desirable.  7. Review of Resident revealed the facility at 03/12/2021 with diagn Chronic Kidney Disea Reflux Disease, Hype and Femoral Neck Fratewiew of Resident #303/12/2021, revealed a two thousand (2000) Diabetes Association)  Review of a Dietary-Nassessment, complete PM, revealed Resident hundred ninety-nine a pounds and the resident to meet the resident's the assessment revealed fortified foods to the energy needs.  Review of Resident #3 assessment, dated 03	Il could eat that, I could dent #39 also denied ever to weigh him/her.  on 08/11/2021 at 4:10 PM 30 AM, revealed if Resident shad been honored, the kely not have experienced a The RD stated a gradual rebeen beneficial for the n significant weight loss was at #332's medical record dimitted the resident on loses including Diabetes, se, Gastro-Esophageal rension, Atrial Fibrillation, acture.  332's diet orders, dated the resident was to receive to calorie ADA (American and Renal Diet.  utrition Data Collection and Renal Diet.  utrition Data Collection and Renal Diet.  utrition Data Collection and Renal Diet.  st #332's weight was one and nine tenths (199.9) and interesident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident's meals to meet as a sale of the resident was	{F 6	92}			
	score of fourteen (14)	esident to have a BIMS out of fifteen (15),					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		SURVEY PLETED
		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		3012021
(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 692}	assessment revealed independent with eatin hundred (200) pounds. Review of Resident # revealed the resident eighty-two and six ten 04/05/2021.  Review of the Nutrition dated 04/11/2021, review of the Nutrition dated 04/11/2021, review of the food dinner, and a snack a revealed the resident eighty-four and nine to 05/04/2021.  Review of a Nutrition #332, dated 05/27/2021 had a seven and six to loss in ninety (900 day the note the resident's needs, yet (he/she) had a seven and six to loss in ninety (900 day the note the resident recondend the resident reconden	tion. Further review of the the resident was ng, and weighed two s.  332's weight record weighed one hundred of the (182.6) pounds on the Progress Note by the RD, realed Resident #332 had ercent weight loss in thirty liew revealed the resident's requate to meet the resident was les, large protein portions at the bedtime.  332's weight record weighed one hundred enths (184.9) pounds on the Progress Note for Resident enths (7.6) percent weight yes. However, according to a "current intake exceeds as remained weight stable".  RD evaluations revealed the not #332 on 06/29/2021 and eived two (2) bologna to and mayonnaise at lunch ident's request. However,	{F 69	32}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ı		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				3
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
DARWIEL	ALDOCT ACUTE AND DE				200 NURSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		HABILITATION CENTER			PIKEVILLE, KY 41501		
(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 B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}			{F 6	92	}		
!	documented "current the RD made no new	intake exceeds needs", so dietary recommendations.					
	revealed staff weigher 06/07/2021, 07/05/2021 However, staff failed to resident's electronic in the weights revealed lose weight, weighing and six tenths (183.6) hundred eighty-two ar pounds on 07/05/2022 seventy-nine and nine 08/03/2021.	21, and 08/03/2021. to enter the weights into the nedical record. Review of Resident #332 continued to one hundred eighty-three pounds on 06/07/2021, one nd nine tenths (182.9) 1 and one hundred etenths (179.9) pounds on					
		reighing residents on  PM thru 5:00 PM, revealed  ed one hundred and eighty			i		
	on 08/05/2021 at 7:28	ent #332's supper meal tray, BPM, revealed the resident sandwiches or large protein ray.			10)		
	11:00 AM, revealed the and the resident report admission. The reside supposed to get a boltray at lunch and supposed.	ogna sandwich on the meal per. However, the resident ot the sandwiches at lunch					:

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			i .	R /30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	•	200	REET ADDRESS, CITY, STATE, ZIP CODE  D NURSING HOME LANE  KEVILLE, KY 41501	1 03/	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	would usually state the bologna. In addition, if facility never had snack reported going to sleet stated staff would tell morning when the kitch and the stated staff would tell morning when the kitch and the stated the facility had been out for week and 08/18/2021 at 100 facility had fortified Relarge protein portions, two (2) bologna sandwand provided a nightly prevented the resident would be stated the resident would be stated to the resident was providing the she was ordered as the made. However, the resident. The RD stated facility was providing the she was ordered as the made. However, the resident. The RD stated facility she reviewed must physically observed.  8. Review of Resident revealed the facility and 10/12/2015, and re-additional reports.	e sandwich were, staff e kitchen was out of Resident #332 stated the cks especially at night and ep hungry. The resident me I have to wait till in the chen opens.  2, on 08/05/2021 at 5:20 ity was out of bologna, and cs.  on 08/11/2021 at 4:10 PM 30 AM, revealed if the esident #332's foods, added provided the resident with viches at lunch and supper, snack, it would have t's on-going significant in, the RD stated, "most all have gained weight". Ily looks at weights sident's electronic medical ving knowledge of a "weight she could only assume the he resident with the diet and the recommendations he RD stated she had esident's weight or diet with stated when she was at the ecords and weights, but did er or talk to residents.  #81's medical record dmitted the resident on mitted the resident on entia, Anemia, Anxiety and	{F 6	92}			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		185256	B. WNG				R /30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		200 NURSII	DRESS, CITY, STATE, ZIP CODE NG HOME LANE E, KY 41501	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	· 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	facility assessed the rescore of six (6) out of resident was cognitive of the MDS assessme required extensive as resident weighed one (117) pounds.  Review of Resident #plan, in effect on 05/1 resident had a history and poor nutritional in malnutrition.  Review of Resident #0 on 06/01/2021, the resident was tenths (10 Review of a RD assess completed on 06/05/2 sustained a six and or loss in thirty (30) days tenths (8.9) percent we days. Further review of the resident needs. stated the resident memalnutrition due to we stated Resident #81 we get fortified foods, whe with meals, and an ice The RD recommender cream cup and adding dinner.  Review of a Nutrition (10 of the Nutrition (10 of the Nutrition (11 of the Nutr	81's Quarterly MDS /18/2021, revealed the resident to have a BIMS fifteen (15), indicating the rely impaired. Further review ent revealed the resident sistance for eating, and the hundred and seventeen  81's comprehensive care 8/2021, revealed the of unplanned weight loss take and was at risk for  81's weight record revealed sident weighed one hundred 109.2) pounds.  ssment for Resident #81, 021, revealed the resident ne-half (6.5) percent weight and an eight and nine reight loss in ninety (90) of the assessment revealed intake was inadequate to The assessment further	{F €	92}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		2	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	seven tenths (108.7) and four tenths (9.4) p (90) days. However, the resident's weight was and implemented no resident's weight of the resident seven and one tenth (100 observation of staff w 108/05/2012, revealed hundred seven and nice of the resident of the received two (2) perceived two (2) perceived two (2) perceived two (2) perceived two (3) perceived two (4) perceived two (5) perceived two (6) perceived two (7) perceived two (8) perceived no sandwich such as the resident's weight of the resident's weight of the reweight of one hundred (107.1) pounds. In addresident's current nutrexceeded the resident and nutritional status.	was one hundred eight and pounds, representing a nine percent weight loss in ninety the RD also documented the stable for thirty (30) days, new recommendations.  81's weight on 08/03/2021, weighed one hundred (107.1) pounds.  reighing Resident #81, on Resident #81 weighed one ne tenths (107.9) pounds.  reighing Resident tray, on M, revealed the resident ent milk with the meal and tweight loss of eight and the weight loss of eight and the tent in ninety (90) days and (10.7) percent in less than 80) days. The note stated the index (BMI) was below the esident's age and body of seven and one tenth dition, the note stated the index (BMI) was below the esident's age and body of seven and one tenth dition, the note stated the itional intake greatly the RD, on 08/11/2021 at 10:30 AM, revealed	{F €	592)			
	resident's body mass normal limits for the reweight of one hundred (107.1) pounds. In addresident's current nutrexceeded the resident and nutritional status.  Further interview with 4:10 PM, and 08/18/20	index (BMI) was below esident's age and body diseven and one tenth dition, the note stated the itional intake greatly t's need to maintain weight the RD, on 08/11/2021 at					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING					E SURVEY PLETED
		185256	B. WING			0.0	R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	<u>.</u>	200	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501	08	<u>//30/20</u> 21
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO {EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 692}	was saying, "We have on to explain that if th what was ordered and documented correctly not be losing weight.	ed the resident needs, that e a problem". The RD went e resident was receiving d the resident's intake was r, then the resident would	{F 6	92}			
	08/26/2021 at 2:33 Pt notified the resident's weight loss. The prog resident's appetite wa resident required cuel further stated the calle	daughter of the resident's ress note stated the is improving, and the ing for meals. The note er told the daughter the RD sident and the resident					
:	Observations of the snack refrigerator and snack storage areas on the third floor, on 07/27/2021 at 11:30 AM, revealed no snacks, drinks or juices were available for the residents.  Observations of the snack refrigerator and snack storage areas on the fourth floor, on 07/27/2021						
	juices were available Observations of the si storage areas on the f	nack refrigerator and snack fifth floor, on 07/27/2021 at no snacks, drinks or juices			*		
	SRNA #1, and at 5:00 07/28/2021 at 5:10 PM the facility did not prov residents. In addition,	2021, at 4:40 PM, with PM with SRNA #2, and on M, with SRNA #4, revealed wide enough snacks for the the SRNAs stated they had hem they were hungry, but em.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		00	R 9/30/2021	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  200 NURSING HOME LANE  P!KEVILLE, KY 41501		13012021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	, , , , , , , , , , , , , , , , , , , ,	LD BE	(XII) COMPLETION DATE	
{F 692}	revealed the facility's hungry and stated it h problem at the facility, works from 6:00 PM L resident supper trays until 7:30 or 8:00 PM. staffed with only one stated with only one stated with only one stated all residents to get adequistated she assisted the best she could; however for approximately forty had to pass evening in Review of the menu for 08/05/2021, revealed received three (3) our mashed potatoes, and addition, the "Diet Rosindicated forty-two (42 foods, including Reside #332, #81, and #65.  Observation of the lunrevealed staff served in mashed potatoes and addition, when staff we protein to ensure it was functioning scale in the landition, there was designated as "fortifier revealed three (3) residence in the landition, there was designated as "fortifier revealed three (3) residence in the landition of the landition, there was designated as "fortifier revealed three (3) residence in the landition, there was designated as "fortifier revealed three (3) residence in the landition, there was designated as "fortifier revealed three (3) residence in the landition, there was designated as "fortifier revealed three (3) residence in the landition, there was designated as "fortifier revealed three (3) residence in the landition in the landition, there was designated as "fortifier revealed three (3) residence in the landition in the landiti	on 07/29/2021 at 9:30 PM, residents complain of being ad been an ongoing. RN #9 stated she routinely intil 6:00 AM, and at times, do not arrive on the floor. Per interview the facility SRNA to pass all the trays idents who required is impossible for the pate nutrition. The RN is aide with meal service the part of the pate nutrition. The RN is aide with meal service the part of the pate nutrition. The RN is aide with meal service the part of the pate nutrition. The RN is aide with meal on the residents, and she in the residents should have need cate of protein, 1/2 cup of the provided by the facility is residents required fortified lents #90, #327, #82, #39, which meal, on 08/05/2021, the residents 1/3 cup of 3/8 cup of vegetable. In as asked to weigh the is adequate, there was no is kitchen to weigh the meat, no food prepared and dir. Continued observation dents were supposed to get is including Residents #332 in other residents were is for the lunch meal.	{F 6	92)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	/30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		_	00 nursing home lane PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	observation and intender revealed the facility dilettuce, or other sandoln addition, observation the meal was schedul at approximately 12:0 not exit the kitchen under the meal was schedul at approximately 12:0 not exit the kitchen under the kitch	view with dietary staff d not have lunchmeat, wich ingredients available. ons revealed that although ed to be served to residents 0 PM, the last food tray did dil 2:45 PM.  2, on 08/05/2021 at 5:20 I worked full time at the ely one (1) year. Cook #2 or trained her or directed her lity residents. She stated bys a week and cooks all e days she works, and had or had instruction on how to e, Cook #2 stated she had wed fortified foods for the so stated she had never or training on scoop sizes or or serve residents. In ed she never knew she was eat or protein. She stated intly out of food items. The sidents continuously asked	{F €	92}	DEFICIENCY)		
:	longer." She stated the amount of food items a menu, and "definitely at the facility to provide s	ere was not an adequate purchased to fulfill the not enough" purchased at macks.					
		Aide (DA) #1, on I, revealed the facility was items that the residents					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	DA #1 also stated the lettuce, ice cream and on resident tray cards Interview with Dietary 08/18/2021 11:40 AM have a Dietary Managthe DM at a sister fact food orders for the fact conducted no monitor was involved in meeti to resident weight loss. Interview with the RD and 08/18/2021 at 10 been contracted to profer approximately one been provided a list o RD stated she ran her and formulated her overaluate. The RD state concerns in the facility identified concerns wiresidents, concerns the were not being implementation with most had discussed the occasions with the Ad facility had taken no a problems. The RD state and there was not aware stated not fortifying for scoop size to portion of stated not fortifying f	to fulfill dietary interventions.  facility rarely had bologna, d other food items that were  Manager (DM) #1, on , revealed the facility did not ger at this time, but she was illity and had placed some cility. The DM stated she ring of resident weights or ngs or discussions related s.  on 08/11/2021 at 4:10 PM 30 AM, revealed she had ovide services at the facility (1) year and had never f resident to evaluate. The r own reports in the system vn list of residents to sted she had many ongoing y. The RD stated she had th weight loss for the nat her recommendations mented, resident honored, and ursing staff. The RD stated e concerns on multiple ministrator; however, the	{F €	692}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	750		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
NAME OF PI	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		20	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 692}	recommended such a serving residents their to weight loss and made According to the RD, also frequently out of menu. The RD stated notified her that any of sustained a weight loss way she knew as mucrunning reports and in RD also stated she be resident's reviewed, if implemented her recording resident's snacks, the resident's snacks, the resident's snacks, the resident's would not have weight loss. The RD afacility had contracted never been invited or to discuss weight loss for facility residents. The valuate residents on the facility did not impour buy enough food to fe menus were followed, loss and malnutrition to the facility with the Ass Nursing/Interim Direct (ADON/IDON), on 08/revealed she had bee for approximately one the IDON position a fed Director of Nursing (Difacility. The ADON/IDO been at the facility, the	g supplements she had so ice cream, and not a preferences, could all lead all inutrition for the residents. The dietary department was food items to follow the nursing staff had never of the resident had a set. The RD stated the only ch as she did, was by exestigating on her own. The elieved for each of the the facility had ammendations, provided the majority, if not all the ave sustained significant also stated in the year the liner services, she had attended a nutrition meeting for any nutritional concerns the RD stated she could a daily basis, however, if lement recommendations, ed residents or ensure it would not prevent weight from occurring in the facility.  In the ADON at the facility (1) year, and was placed in the weeks ago when the ON) resigned from the DN stated since she had	{F 6	92}			
	there was no staff ava	ilable to participate. The					

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING	<u> </u>	_		R <b>30/2021</b>	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, S 200 NURSING HOME LAN PIKEVILLE, KY 41501	NE .		50/2521	
(X4) ID PREFIX TAG	(ÉACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRI	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 692}	worked as floor nurse ADON/IDON stated s weights in the facility, not conduct weekly N meetings since she had ADON/IDON stated s responsible to monito implementing RD reconstruction and the state of the time to follow-up on the facility and who were provided that to evaluate and was responsible to monito the facility and who were provided that to evaluate and was responsible to monito the facility had no unifured and the facility had no unifured in addition, the ADON conducted no monitor received meal trays tipulatable, that snacks that staff implemented and that staff were aboresidents requiring as timely. She stated, "I imponitor that".  Interview with the Adm 6:00 PM and on 08/18 she had been the facility did not have residents, that staff we portions, that nursing	er and the former DON s more often than not. The he had never monitored and stated the facility had utrition At Risk (NAR) ad been at the facility. The he was not sure who was r or ensure staff was commendations. The he RD sent her he DON, ADON and the r visits, but she did not have hem because she was a ADON/IDON stated she he RD with a list of residents hot sure who was r residents for weight loss in has responsible to notify the host weight. Per interview, he managers to track weights. I/IDON, stated she hing to ensure residents he were available and served, he RD recommendations, he to get meals passed and histstance were assisted hust don't have time to  hinistrator, on 08/11/2021 at histoly and having here not fortifying foods, that	{F 6	92}				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI	TIPLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY PLETED
		185256	B. WING_				R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD B IE APPROPRI		(X5) COMPLETION DATE
{F 692}	had no systems in pla weight loss or nutritio Administrator stated s the RD after she cond Administrator stated s information was in the read them. The Admin resident preferences honored at the facility planned on talking to on the resident's tray provide. The Adminis should be able to mal prevent weight loss w ordered. The Administrator working on getting the Administrator could need to the Administrator could need to the resident's tray provide. The Administrator working on getting the Administrator could need to the everything possible to loss.  **The facility alleged s implemented to remo effective 09/26/2021:  1). Braden Scale Asso on all residents by face and comprehensive for were completed on all The facility utilized the and comprehensive for review and update cal had pressure injuries	s were not being ministrator stated the facility ace to monitor resident and needs. The she received e-mails from duced visits. However, the she was not sure what am, because she had not nistrator acknowledged that could not always be and stated she had the RD about all the items cards that the facility did not trator stated that the RD ace recommendations to ith items the facility routinely trator confirmed the facility are meetings since she had or, but stated she was use established. The not voice any monitoring or sure the facility was doing a prevent resident weight the following was we Immediate Jeopardy  sessments were completed cility nurses on 08/28/2021 all body skin assessments I residents on 09/11/2021. The Braden Scale Assessment to re plans of residents who	{F 6	92)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(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 CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		SHOULD BE		(X5) COMPLETION DATE
{F 692}	them to the Medical D 09/17/2021.  3). Beginning 09/17/2 assessment and Brad be completed, and the developed within 48 h pressure ulcer or pote comprehensive care p 21 days of admission or potential pressure uinterventions to preve development or worse 4). Residents #45, #6 and #320 were bathed care and moisturizing and assisted with dresclothing. Clean linens residents' beds on 09/2 were evaluated by socious 5). All residents were interviewed to obtain a by the Director of Nurse by nursing staff to according plans and State Regis care plans by the Register of the completed on 09/2006. On 08/28/2021, the	staff assessed and a injuries, and staff arealments and reported director/Physician #1 by  021, upon admission a skin and scale assessment will be baseline care plan will be abours to include any ential for pressure ulcer. A colan will be developed within a to include pressure ulcers ulcers and include and pressure ulcers and include and pressure ulcers.  5, #308, #309, #311, #314 and including a shower, nail lotion applied post shower, assing in clean appropriate as were placed on the were placed on the many and shower/hygiene preferences under a shower and shower/hygiene preferences asing (DON) or designee. Edules were implemented commodate resident preferences for hygiene corporated into resident care astered Nurse Aide (SRNA) gional Nurse Consultant 19/13/2021.	{F 6	92}			
	recommendations for	esidents' diets and made meal changes or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R 09/3	0/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	0310	012021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE		(X5) COMPLETION DATE
(F 692)	any weight loss issue  7). All residents with the and Chronic Obstruct (COPD), Asthma and by licensed nurse and with no concerns were 08/13/2021.  8). The Regional Nurse with orders for glucos and orders were ame entry of glucose value Administration Record  9). The Regional Cert (CDM) observed the relunch and dinner on 0 were delivered on time  10). Direct Care staffing recruitment efforts with provided through age Direct care nursing stream of the unit at the staff won the unit at the staff won the unit at the staff Director of Nursing, Nadministrator or designation of the calling agencies qualified staff to see it and/or calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Narional Calling agencies qualified s	the diagnoses of Diabetes ive Pulmonary Disorder Pneumonia were assessed d/or Respiratory Therapist e identified completed  See reviewed all residents e monitoring by 07/30/2021 inded to include mandatory es on the Medication d (MAR).  Sified Dietary Manager meal service for breakfast, 19/11/2021, all three meals e.  Ing was increased through the additional staffing increased through the additional staffing increased through the additional staffing increased through the distribution of the instrator to ensure staffing or meet the acuity of the ill be validated as present to of each shift by the lursing Supervisor, ginee. Direct care nursing eplaced by calling other if they can fill the opening, es to see if they have expening. If direct care staffing the present is to see if they have expening. If direct care staffing the present is to see if they have expening. If direct care staffing the present is to see if they have expening. If direct care staffing the present is they can fill the opening.	{F 6	92}			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		185256	B. WNG				R <b>30/2021</b>
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, 200 NURSING HON PIKEVILLE, KY		, 55,	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	center will prioritize reachieved during emer required task including medication, no showe provided to incontiner that cannot turn self, rassist residents with not turn self, rassist residents have be meals are prepared at 12). On 08/11/2021, at #86 and #322, were reand physical forms of for Mental Status (BIN above and skin integris BIMS less than eight (Licensed Nurse, Residents had their Carevised, as necessary (MDS) Coordinator on residents were identificated by the mos contential interventions of the school of the mos contential interventions.	vels cannot be met, the sident care that can be gency staffing, prioritize g administration of crs- sponge baths, care at residents, turn residents meals served timely, and neal if needed.  creased dietary staffing forts and appropriate een achieved to ensure and delivered timely.  Il residents including #64, eassessed for psychosocial abuse with Brief Interview (B) score of eight (B) or ity reviews for residents with (B) were completed by dents with a diagnosis of are Plan reviewed and by the Minimum Data Set (D9/07/2021. No new ed as indicating any hysical harm.  These Consultant completed a sment on all residents by many through the many through the first of all the crisk residents were g station with a list of for nursing to reference.	{F 6	92}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		SURVEY
		185256	B. WNG			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	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BI	(X5) COMPLETION DATE
{F 692}	recommendations we recommendations by (DON) or designee or DON or designee, spot Medical Doctor (MD) and recommendations entered into the electric the tray card. The Reg Director of Nursing (Din electronic medical record and tray card rinformation on 09/17/2 15). Beginning 09/15/2 snacks to all residents afternoon by the resto aides, or designee. Sr physician will be docuaide, dietary aides and 16). The facility evalua 08/11/2021, located of for compliance with C implemented yellow a identified two (2) residexposed to positive rewas designated with electronic and those two this zone on 08/11/2021. The facility had the in the red zone on 08/11/2021. The facility had the in the red zone on 08/11/2021. Reside two completed quarantine completed quarantine	on assessment and RD re reviewed for the Director of Nursing to 09/17/2021. Further, the oke with the attending and validated the diet orders s. Recommendations were onic medical record and on gistered Dietician and ON), reviewed diet orders ecord to ensure both the effected accurate 2021. 2021, staff began offering daily in the morning and rative nurse aide, activity nacks ordered by a mented by the restorative d/or licensed nursing staff. ated the COVID-19 unit on in the 5th floor of the facility DC guidelines and ind red zones. The DON ents who had been sidents and a yellow zone erection of a plastic zip wall (2) residents were moved to 21.  ree (3) residents who were 11/2021 (Residents #327, dents #327, #328 and #329 entine per facility policy and	{F 6	92}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION		E SURVEY IPLETED
		185256	B. WING_		00	R 9/30/2021
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		73012021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
{F 692}	COVID-19 on 09/16/2	e 583 or testing were tested for 021. The facility did not s based on the employee	⟨F 6	592}		
	testing on 09/16/2021 tested for COVID-19 odid not identify any no	. All residents eligible were on 09/17/2021. The facility w positive cases.				
	placed in isolation zor droplet precautions w	s recommended for OVID-19 residents will be ne (red zone) and placed in ith use of personal				
	physician notification, plan revisions. The Donewly positive COVID isolation precautions I addition, any resident droplet precaution in if 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 will be testefacility by the Infection designee. All testing oposted to the employer common areas.	exposed will be placed in solation zone (yellow). The ysician notification, family blan revisions. The facility ocol will be twice weekly on tive 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 lates and times will be see page, time clock and				
	for signs and/or symp documented on the M Record (MAR). The fa	ns all residents once a shift toms of COVID-19 and edication Administration icility implemented nd/or symptoms on all				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R /30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	[09/	<u> 50/20</u> 21
(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 692}	Resident #326 and Rewere reviewed for usa administration times to 09/23/2021.  22). The facility stated their medication as or and implemented phanotification if any medication regarding the facility will abide to physician regarding the 123. The facility formuto 09/23/2021, with the find the facility with a three medications that required for cost authorization 124. New admissions the facility after normal weekends will have disentered into the electrous submitted to pharmacy integration. The facility fax transmittal as a be pharmacy integration electronic medical recommend of the facility will utilize the facility the physical substitution and/or new 25). The Regional Nutrians of the facility of the facility of the facility of the physical substitution and/or new 25.	sident #321, Resident #324, esident #351, medications age and appropriate by the physician on a lall residents will receive dered beginning 09/23/2021 rmacy and physician dication was unavailable, by new orders from the ne unavailable medication.  Ilated an agreement on acility's pharmacy to provide a (3) day supply of irres the facility's approval while pending cost review.  and re-admissions entering all business hours and on scharge orders submitted, onic medical record and by through pharmacy by implemented the use of lickup to the electronic by entering the order in the ord to receive medications. In a armacy will be notified, and the emergency medication is cian will be notified for	{F €	392			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R /30/2021
	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	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIA			(X5) COMPLETION DATE
{F 692}	verified all medication facility by 09/25/2021.  26). The facility conduperformance Improve 08/12/2021. The facility process, and a ensure compliance with Administrator over The QAPI committee Nursing, Administrator Services Director, Act Maintenance, Dietary Services.  27). The facility appoin Administrator on 09/1 current Administrator. Administrator will receipt administrator will receipt administrator will receipt administrative Team of the thirty-day oversigh Administrative Team of the administration has responsibility to direct communicate areas of the administration Administrative Team of the administration has responsibility to direct communicate areas of the Administration	ordered medications and s were available in the sected a Quality Assurance ment (QAPI) meeting on the ty reviewed education, udited implementation to the the AOC and all audits. It is sees the QAPI committee. Consists of the Director of the ty is consists of the Director of the ty is consists of the Director, Social invities, Clinical, Therapy, and Environmental section of the facility's Interimental section of the Regional Vice President or Operations and Regional lays. Upon completion of the Regional will audit the Administrator to I daily oversight is needed. It is direct oversight and the discipline, and the facility is concern and process of the Administrator to I daily oversight and the concern and process of the Concern and process of the Administrator to I daily oversight and the concern and process of the Concern and the Co	{F €	692			

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING		-		R
NAME OF PROVIDER OR S	UPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
DARKVIEW DOST ACI	ITE AND DE	HABILITATION CENTER			00 NURSING HOME LANE		
PARKVIEW POST-ACC	I E AND RE	HABILITATION CENTER		P	PIKEVILLE, KY 41501		
PREFIX (EAC				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Clinical Optionsultant options of the Rules and the following infection Costaff at the turn and recare, prepresidents welffective Pland neglection of the Rules and neglection of the Rules and recare, prepresidents welffective Pland neglection of the Rules appropriate QAPI community and recommendation of the Rules and neglection of the Rules appropriate QAPI community and reviewed a agendation of the Rules and recommendation of the Rules and recommendation of the Rules and	Is conducted with a conducted with a conducted of the survive Governing Regulation and control (CO) facility to reposition rear and disvith eating, tharmacy Soft effectivel e ADLS, armittee.  I will be a conducted of the conducted reviewed and the conducted reviewed reviewed and the conducted reviewed reviewed and the conducted reviewed reviewed reviewed reviewed review	and Regional Nurse and a conference call on antract company for a and the following: (1) the and general general general general and general general general and general general general and the following: (1) the and general general and general general and general general and and general general and presented the general and presented the reviews and revised the QAPI Plan and presented the reviews and presented the reviews and and presented the reviews and presented the reviews and presented the reviews and presented the reviews and presented the general and presented the reviews a	{F 6	92}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			,	R
NAME OF B	ROVIDER OR SUPPLIER	103230	D. 111110.	_		09/	30/2021
NAME OF F	KONDEK OK ZUPPLIEK				STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	W POST-ACUTE AND RE	HABILITATION CENTER			200 NURSING HOME LANE		
					PIKEVILLE, KY 41501		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTION	<del></del> -	(X5)
PREFIX TAG	(EACH DEFICIENCY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 692}	Continued From page	587	{F 6	192			
	business office, and a	dmission actions. The QAPI	' '		<b>'</b>		
	Committee and Medic	al Director approved the					
	standardized agenda	on 09/16/2021 to include,					
	but not limited to, the	topics presented during the					
	meeting.	topioo processing the					
	J						
	31). The Regional Dire	ector of Operations and				į	
	Vice President of Ope	rations met with the					
		N, and the Medical Director	İ				
	on 09/16/2021 regard						
		iding setting policy and					
		emented in the facility and					
	communicating inform	ation to other members of					
1	the Governing Body, [	During the meeting, the					
	QAPI processes, the r	need to participate regularly					
	in the QAPI process, t	he need to identify root					l i
	causes with the utiliza	tion of the five (5) why					
	approaches and, audi	ting systems per the QAPI	1				
	Calendar. The Admin						
	medical Director of fut	ure QAPI Committee					
	meetings.						
		will collect all monitoring					
	reports before each Q	API Committee meeting					
	beginning 09/15/2021	for review to ensure					
	compliance with the de	eficiencies cited during the					
		API Meetings were held on					- 1
		abatement and develop					
	interventions to remov	e the jeopardy. The facility					
	implemented QAPI me	eetings weekly, times four					
	(4) weeks, as needed,	and monthly. The					
	Administrator will forw		1				
	minutes to the Govern						
	including the Vice Pres						ľ
	Regional Vice Preside	nt of Operations, and the					
ł		ultant, to review the audit					J
	results. The QAPI com	nmittee will review the					i
	audits at the QAPI me		1				I
	review. The Administra	ator oversees the QAPI					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		CONSTRUCTION		SURVEY
		185256	B. WING			l .	R
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			5° 20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	Director of Nursing, A Director, Social Servic Clinical, Therapy, Mai Environmental Service	PI Committee consists of the dministrator, Medical ces Director, Activities, ntenance, Dietary and es.	{F €	92}			
	Administrator with res materials for QAPI, in QAPI Tool Kit, QAPI a guide to effectively im	cluding but not limited to the tagging and a resource plement the QAPI plan.  The Governing Body will upcoming year and					
	of QAPI Committee m (4) weeks and, as nee to ensure the quality of complies with the stan	will increase the frequency eetings to weekly for four eded effective 09/16/2021, if care is monitored and edard of care and and Federal requirements					
	35). All nursing staff w Director of Nursing, M designee on proper w obtaining, documentin changes to the Registe 09/17/2021.	DS Coordinator, or eighing techniques, g, and reporting weight					
	Manager on the provis assessment to ensure diet order accuracy, ar orders into the electroi CDM educated the Die resident diet orders int	in discrete the Dietary     ion of timely nutritional     diet order accuracy, on     ind on when to enter diet     inc medical record. The					

NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER  185256  B, WING  STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  200 NURSING HOME LANE			185256	B. WING		00		
			HABILITATION CENTER	22	200 NURSING HOME LANE		/30/2021	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	DBE	(X5) COMPLETION DATE	
witten communication to the dietary staff, including diet and texture. In the morning clinical meetings, staff will review diet orders from the previous day to ensure accuracy.  37). Therapy provided education to all nursing staff on turning and positioning range of motion, and transfer of resident from bed to chair and chair to bed beginning on 08/19/2021 and completed on 09/17/2021. The facility employed and assigned additional staff through recruitment and agency contracts to ensure adequate staff to turn and reposition all residents who cannot reposition themselves.  38). The Regional Director of Nursing educated all nursing staff on pressure ulcer prevention, including turning and repositioning, adequate hydration and nutrition, positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician, and RP of a new skin impairment by 09/17/2021. The facility nursing staff will call or email the Registered Dietitian, Physician, and Resident Representative of any new skin changes.  39). The DON or designee educated all staff on timely call light response. In addition, direct care staff, including nurses and certified nursing assistants, were provided education on providing timely hygiene per the resident's plan of care, timely tolieting, dressing residents in their choice of clean clothing, and timely delivery of meal trays. The DON or designee will educate any facility staff not working during education upon returning to work.	{F 692}	written communication including diet and text meetings, staff will resprevious day to ensur 37). Therapy provided staff on turning and pland transfer of reside chair to bed beginning completed on 09/17/2 and assigned addition and agency contracts turn and reposition all reposition themselves 38). The Regional Dirall nursing staff on preincluding turning and hydration and nutrition to complete and docu assessment, and how dietician, physician, a impairment by 09/17/3 staff will call or email to Physician, and Residenew skin changes.  39). The DON or desitimely call light resportatiff, including nurses assistants, were provitimely hygiene per the timely toileting, dressi of clean clothing, and trays. The DON or defacility staff not working returning to work.	n to 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 at to ensure adequate staff to I residents who cannot is.  rector of Nursing educated essure ulcer prevention, repositioning, adequate in, positioning devices, how ament a head-to-toe skin of to notify the registered and RP of a new skin 2021. The facility nursing the Registered Dietitian, ent Representative of any ignee educated all staff on the search certified nursing ided education on providing the resident's plan of care, ing residents in their choice timely delivery of meal signee will educate anying during education upon	{F 6	92}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY 200 NURSING HOME L. PIKEVILLE, KY 4150	ANE	<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	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 692)	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 Residents with a change of the consideration of the considerati	icensed nursing staff, the the Social Service Director, on entering new care plans dical record, including goals addition, the Regional lucated staff to update the ne electronic medical record terventions for any new skin during their shift.  piratory Therapist educated lentifying and assessing ge in respiratory status on n, on 08/12/2021, the DON lated all licensed nurses on stoms of locumentation of blood lecord, notification of the g physician orders. The g staff will not be allowed to leceived this education. The lical staff on documentation 8/19/2021 and 08/20/2021 lervices.  2021, the DON educated lection and lection and local party. In the lection of long and goals relevant to latery diagnosis within 48 leviewing and providing a lod/or the responsible party. In the long long in geducation and levork until they have	{F 6	92}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_				R 30/2021
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
{F 692}	call-off procedure for event a person needs dayshift, they are to n supervisor two hours. If staff needs to call of to notify their immediate before the start of the not have appropriate simmediate supervisor other qualified staff to off. If emergency staff Administrator and/or cassistance from staffir working will be in-served. All staff were process of identify reporting abuse, as wimplementing immediate wandering residents.  45). All nursing staff working, Macsignee on proper woobtaining, documenting changes to the Regist 09/17/2021. On 09/13 the Dietary Manager of timely nutritional assess accuracy. When staff electronic medical recorder will send the wridietary staff. The Diet order into the tray care	call off' procedure. The the facility included: in the to call out of work for otify their immediate before the start of the shift. If on the night shift, they are the supervisor four hours is shift. If the facility does staffing levels, the and/or designee will call replace the person calling fing is required, the lesignee will call for any companies. Staff not riced upon return to work.  In the facility does staffing levels, the and/or designee will call replace the person calling fing is required, the lesignee on 08/12/2021 on ing, preventing, and sell as identifying and ate interventions for  The educated by the DS Coordinator, or eighing techniques, g, 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 ary Manager will enter the e system. The facility will in the previous day in the	{F 6	92}			

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			ı	R /30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTI	ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
{F 692}	46). The Regional CD Manager on 09/13/20 regarding meal service recipes including reciping fortified diets to ensurantificational needs of restablished national goultural and ethnic needs of restablished national good prefere system, ordering food snack/hydration carts, procedures, appropriate portion sizes.  48). The Director of N of Nursing educated number of the procedurations for 09/17/2021.  49). All staff were provided national gould donning/doffing Person (PPE), yellow and red DON/designee educational goultural gould national goultural gould national goultural gould not not working. Dur 08/12/2021, the Covid handwashing policy, of the country of the procedurated all staff, inclined the procedurated all staff, inclined national goultural gould national gould	M educated the Dietary 21 on facility policy e times and the use of pes for those requiring e all meals meet the sidents in accordance with uidelines to reflect religious, eds of the population.  The Regional CDM with the dietary manager on ences, the facility's tray card based on menus, stocking snacks, and hydrations ate scoop sizes, and/or  ursing or Regional Director arses and the Dietary ass for entering, activating, the registered dietician's dietary orders on  wided re-education by the by 09/17/2021 on the elines, handwashing, nal Protective Equipment zones. In addition, the ted, licensed staff on or Covid-19 symptoms 1, the DON/designee uding contract staff, who ing the QAPI meeting on -19 policy, the lonning and doffing PPE, and monitoring residents	{F 6	692}			

	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY
	185256	B. WING_			R 9/30/2021
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILIT	ATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		510012021
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	LD BE	(X5) COMPLETION DATE
(F 692) Continued From page 593  50). Staff were provided re-ec 08/20/2021 by the DON, Reg Regional Nurse Consultant to symptom monitoring orders of admissions into the resident's 51). All licensed nursing staff educated on the five (5) rights administration, including right patient, right dose, right time, Regional DON/DON/designed licensed nursing staff working the process to follow when a available for administration as education included calling the medication, obtaining the medication delivery time, notion ordered medication will either outside of the ordered medicated education also included follow given by the MD, documenting and new orders from the MD medical record. All other licent will be provided training as so 52). On 09/25/2021, the DON Consultant educated all licents including new hires and/or aguse of the emergency medication to place for ensuring medication notifying the physician for new re-admitting residents, including after-hours.  53). The Interim Administrator on his contact information and Coordinator from 09/13/2021. In addition, education on staff	conal DON, or on all new so record.  Thave been so of medication is medication, right and right route. The electronic sordered. The electronic pharmacy to obtain anticipated for the wing new orders go the conversation, in the electronic is ed nursing staff, ency staff, on the stion kit, the system ons are in-house, or worders for new or ing on weekend and in educated all staff dorole as the Abuse through 09/17/2021.	{F 69	92}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	P.5		CONSTRUCTION		SURVEY
		185256	B. WING				R
NAME OF D	ROVIDER OR SUPPLIER	183230	B. WIII4G			09	/30/2021
	W POST-ACUTE AND RE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 692)	shift.  54). The facility will au head-to-toe skin asse through Friday, for thr 09/17/2021 to ensure weekly on each reside will notify the physicia Responsible Party of and those new interve place to prevent declir  55). Central supply au expiration date on 08/conducted weekly for weeks effective 09/17/three (3) months.  56). The Director of Ni Nursing (ADON), or Ni resident progress note effective 09/13/2021, 1 month. Staff will review Saturday and Sunday Supervisor conducted areas of skin impairmed plan implemented to in 57). Beginning on 09/1 leadership staff and/or rounding of residents a	dit weekly resident ssments daily, Monday ee (3) months effective they have been completed ent. In addition, the facility n, Registered Dietician, and any new skin impairment entions have been put in ne.  dited all lab supplies for the 28/2021. Audits will be all lab supplies for four (4) //2021 and then monthly for ursing, Assistant Director of ursing 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.	{F €	592}			
	shift daily for two (2) w residents each shift for twenty-five percent of	fly rounding on once each reeks, fifty percent of the rour (4) weeks, and residents each shift for four has two (2) shifts, 6:00 AM					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		CONSTRUCTION	(X3) DATE	SURVEY LETED
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	began visual monitoring response times, including lights are answered, a staff will conduct ten (leach shift for two (2) will light observations each shift observations and the facility reviewed a respiratory status for limplementation of any Plans were reviewed and a week for four times a	the facility's leadership staffing and timing of call light ding the length of time call across all shifts. Leadership (10) call light observations weeks and then five (5) call the shift for eight (8) weeks.  The DON and/or Designee biratory assessments and Assessment and Ass	{F 6	92}	DEFICIENCY)		
	morning meeting by th nursing designee.	dded to the care plan in the ne DON, ADON, and/or 19/2021, the MDS Nurse,					

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  W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	03/03/2021	_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		TION SHOULD BE THE APPROPRIAT		ı
{F 692}	care plans for comple with the resident and/variance or identified immediately. Audits withrough Friday for all a to the facility for four (admissions for a week then ten percent of adweeks.  63). On 09/11/2021, the designee began auditimeal trays to residents All three (3) meals will (3) units daily for two (all three (3) units daily (1) meal on all three (3) units daily (1) meal on all three (3) weeks.  64). On 08/15/2021, the began audits of staff's quiz of identification at with a change in respinsions/symptoms of hypithe facility's diabetic prochange in a resident's physician and following Leadership will quiz st shifts; ten (10) staff for staff a week for four (4) 65). On 08/13/2021, the gan monitoring all diresults Monday throug morning meeting. The any blood sugar result	e will monitor new missions to audit baseline tion, accuracy, and review or responsible party. Any concern was addressed fill be conducted Monday admissions/re-admissions (4) weeks, fifty percent of (5) for two (2) weeks, and Imissions weekly for four (4) the Dietary Manager and/or ing how long it took to pass after arriving at the unit. I be observed on all three (2) weeks, two (2) meals on for two (2) weeks, and one (3) units daily for four (4) the DON and/or Designee knowledge with a verbal assessment of residents ratory status, identifying perglycemia/hypoglycemia, rotocol, documenting a condition, notification of the g physician's orders. aff randomly across all rone (1) week and five (5) weeks.	{F 6	92)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG			SURVEY
		185256	B. WING				R
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, ST 200 NURSING HOME LANI PIKEVILLE, KY 41501	323	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	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	designee will complet diabetic residents acre (3) units to identify an signs and symptoms of hypoglycemia/hypergly resident was immediate staff. Any variance or addressed immediate one (1) week, then fiv (4) weeks.  66). On 08/13/2021, the designee implemented questionnaire on abust residents with wander the proper reporting of units. The employee completed for five (5) then three (3) times a and then weekly for foor identified concerns immediately.  67). Beginning on 08/Nursing and/or design resident's wandering radmission and quarter Set (MDS) assessment wandering will be discomorning meeting to reinterventions. Any variable in the sign of the staff of the sign of the	rs. Care plans will be d as needed. The DON or e a visual rounding on oss both shifts and all three y resident with apparent of lycemia to ensure the stely assessed by licensed identified concerns will be ly. Audits will be daily for e (5) times a week for four  the Administrator and/or d an employee se and identification of ing behavior to determine f 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 see will review each isk assessment upon rly with their Minimum Data out. Any resident identified as sussed in the clinical view and initiate new iance or identified concerns sediately. New interventions of the morning meeting by out, Assistant Director of resignee.	{F 6	92}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		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	, 30,	00/2021
(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 692}	Services Director or drandom interviews of of eight (8) or greater the facility and have n witnessed abuse. The review random weekly residents with a BIMS to ensure no injuries of 08/13/2021. Any varia will be addressed imm 69). On 08/25/2021, the conducted audits of reflectronic medical regime the diet/tray card so 70). Beginning on 08/25/2021, the conducted for randone (1) week, twice peand then weekly for outrays arrive at the unit assist in passing trays meal trays, and certifications in passing trays meal trays, and certifications arrive at the unit assist in passing trays meal trays, and certifications promptly. The 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 residents in an admitted/re-admitted residents and enter the services admission and enter the services admi	lesignee will perform residents with a BIMS score to ensure they feel safe in not been subject to or e DON or designee will y skin assessments for score of less than eight (8) of unknown origin beginning ance or identified concerns mediately.  The Registered Dietician esident diet orders from the cord against orders entered oftware to ensure accuracy.  23/2021, the Dietary and audit meals leaving the the units timely. Audits will flom meals twice daily for ter week for two (2) weeks, the (1) month. Once meal the management staff will to to ensure residents receive ed nursing assistants assist the Dietary Manager or the time it takes to pass meal or they arrive on the unit they arrive on the unit All three (3) meals will be the daily for two (2) weeks, the unit daily for two (2) on each unit daily for four (4)  ager or designee will review residents' food and	{F 6	592)			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		185256	B. WING			ľ	R
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER				S1 20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	09	<u>0/30/2021</u>
(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)	= \TE	COMPLETION DATE
	completed bi-annually residents. Physician-be audited by the Diet (1) week, weekly for frafter that for four (4) m 09/15/2021.  72). Daily COVID-19 saudited beginning on Resources (HR) Director, and weekend their shift. Audits will be through Friday for four Director, and weekend staff not screened will immediately on the CO by the HR Director. The ducated on the COVI Nurse, an infection cordoors will remain locked entry by staff and screentry.  73). Beginning on 09/1 designee will round se for eight (8) weeks, fiv. (4) weeks to audit infectifiering shifts and unit observation of handwall and zones; donning/doPPE; and mask compli	of food preferences will be and as needed for all ordered snack intakes will lary Manager daily for one our (4) weeks, and monthly nonths beginning screenings for staff will be 08/25/2021 by the Human stor against time clock reening before beginning be completed Monday (4) weeks by the HR ds audited on Mondays. Any be re-educated 0VID-19 Screening Policy be HR Director was ID-19 policy by the Regional introl preventionist. All entry ed. Visitors must be allowed ened by staff at the time of 17/2021, the DON and/or ven (7) times each week e (5) times weekly for four ction control compliance on s. Audits will include shing; isolation signage offing (putting on/taking off)	{F 6	92}			
	74). The DON, ADON, review all residents on pharmacy to ensure ar beginning 09/23/2021.	narcotics with the active script is on file					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		40000					R
NAME OF D	BOVIDED OD CUDOUES	185256	B. MNG			09	/30/2021
PARKVIE	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION	SHOULD BE	TE	(X5) COMPLETION DATE
į	expiration.  75). The Regional Nurand/or Director of Nurmedication pass obse 09/25/2021 on random jeopardy removed to eaccuracy of medicatio CMS Critical Element Administration to condobservation of twenty-  76). Beginning 09/25/2 Friday, the DON, ADO audit medication delive medications daily to eneeding a renewal have pharmacy. Audits will almmediate Jeopardy is 77). Beginning 09/11/2 and/or DON will be resourcing staff daily for feadequate staffing is marked. Beginning 09/11/2 Dietary Manager will be dietary staffing daily for adequate staffing.  79). Beginning 09/11/2 President of Operation	rse Consultant, Pharmacy, sing will conduct random reations effective in shifts daily until immediate ensure timeliness and ins. The facility utilized the Pathway for Medication fluct the medication pass five medications.  2021 Monday through in the ensure that all narcotics are been sent to the continue until the same removed.  2021, the Administrator enough in the ensure that all narcotics are been sent to the continue until the same removed.  2021, the Administrator enough in the ensure that all narcotics are been sent to the continue until the same removed.	{F 6	592}			
	09/23/2021 to monitor	Il be conducted beginning for residents' change of tion of need for "Stop and		i			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING			SURVEY
		185256	B. WNG				R /30/2021
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	<u>  US</u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B		(X5) COMPLETION DATE
{F 692}	81). Beginning 09/11/2 designee performed in BIMS score of eight (8 felt safe in the facility to or witnessed abuse concerns. Interviews we conducted of resident designees weekly untremoved.  **The State Survey agactions to remove the 09/26/2021 as alleged  1). Review of Head-to revealed staff assessed on 09/11/2021. A review revealed eight (8) resimplement in the resident's current pressure ulcer pressure injuries of two comprehensive care phessive injuries	andition) communication.  2021, the Administrator or interviews of residents with a street or greater to ensure they and had not been subjected at No residents had any will continue to be as by the Administrator or ill immediate jeopardy is supported the facility's limmediate Jeopardy on the skin assessments and the skin assessments dents (Residents #65, #27, #74, and #358) had as with a total number of enty (20). A review of the slans for Residents #65, #27, #74, and #358 the care plans to reflect pressure injuries. The review on 09/17/2021.  It can be care to skin assessments to reflect pressure injuries. The review on 09/17/2021.  It can be care to skin assessments to reflect pressure injuries. The review on 09/17/2021.	{F 6	992}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LTIPLE CONSTRUCTION		(X3) DATE	SURVEY PLETED
		185256	B. WNG		,		R
NAME OF P	ROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE,	710 0005	09/	30/2021
	W POST-ACUTE AND RE			200 NURSING HOME LANE PIKEVILLE, KY 41501	ZIF CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE ) TO THE APPROPRIA CIENCY)	E	(X5) COMPLETION DATE
	update the residents' Resident #65, #324, # and #358's care plans current pressure injuri with MDS Nurse #1 or revealed she updated reflect current pressur addition, she complete rounds on 09/15/2021 the Registered Dieticia DON, and the MDS Nurse #45, #14, #357, review revealed the In reviewed each resident's orders care plan, and implemed with the each resident on 08/25/202's tage four (4) pressured the Medical Desident on 08/25/202's tage four (4) pressured the Medical Desident on 08/25/202's tage four (4) pressured to the In Resident #65's wound 08/26/2021 at 9:00 AN wound measured, "13 12.3 cm width and 0.2 at 10 o'clock measurin 12 o'clock that measured No palpable bone, slot removed with wound continued to treat the rulcer with Aquacel Ag. evaluation completed of Resident #65 had six (4)	revealed the intilized the skin den Scale assessments to care plans. She stated that l45, #14, #357, #27, #74 is were updated to reflect es by 09/17/2021. Interview in 09/30/2021 at 1:39 PM all residents' care plans to re injuries by 09/17/2021. In red a review of walking with Therapy Personnel, red, the Medical Director, the rurse for Residents #65, #27, #74 and #358. A terdisciplinary Team In current skin breakdown, rented changes as needed. It #65's medical record Director assessed the If at 1:45 PM and noted a re ulcer on the sacrum; a In to the left and right heels; reft inner leg. Review of care note dated In, revealed the sacrum cm (centimeter) (length) by cm depth with undermining g 2 cm and undermining at res 1 cm, muscle exposed. In the facility resident's sacral pressure A review of a wound on 09/15/2021 revealed	{F €	592}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R	
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE		09/30/2021	
				PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	COMPLETION DATE	
	0.1 cm (depth), stage measuring 2.5 cm by stage two (2) to left high cm x less than 0.1 cm scapula measuring 1 cm. x less than 0.1 cm scapula measuring 1 cm. y 0.6 cm. and for measuring 12 cm by 1 Interventions in place heel protectors while i weekly documentation mattress to bed, nutrit turning/repositioning. (for the sacral pressure 10:21 AM revealed the by 11 cm by 0.3 cm wild drainage and 95 percent Resident #65 declined observation of other precord review revealed PM, Physician #1 dete weight loss and wound 09/28/2021, Resident in-house wound care in record revealed on 09/28/2021, completed 09/10/2021, completed 09/10/2021, completed 09/10/2021, and compon 09/10/2021, Resided 09/28/2021. Further rerevealed staff developed	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 , stage two (2) to left cm by 0.2 cm by less than 0 right heel measuring 0.6 ur (4) areas to the sacrum 1.6 cm by 0.4 cm. for the resident included in bed, diet as ordered, in of the wound, an air it ional supplements, and Observation of wound care is ulcer on 09/29/2021 at it is wound measured 13 cm th a scant amount of ient granulation tissue. It would not consent to the ressure areas. A medical id that on 09/21/2021 at 2:19 is immed the resident's diet were unavoidable. On #65's family declined visits. Further review of the (29/2021, staff notified the in the resident's wound he resident was diagnosed at Resident #355 on it a skin assessment on it a Braden Scale on letted a baseline care plan ent #355 was discharged on	{F 6				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	İ	185256	B. WNG			1	R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501	1 09	/30/2021
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)			COMPLETION DATE
{F 692}	4). Observation of Re. 1:48 PM, Resident #308 or Resident #309 on 09// Resident #311 on 09// Resident #314 on 09// Resident #314 on 09// Resident #320 on 09// Resident #320 on 09// Resident #320 on 09// Resident #320 on 09// Resident #320 on 09// Residents' beds. Intervigent to 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, #31 with no identified concerns reviews revealed Residents #309, #311, #314, and shower preference an obtained and included review of the resident' the comprehensive caplan, revealed staff up to reflect the resident's the Vice President of Concerns the Vice President of Concerns reviews revealed staff up to reflect the resident's the Vice President of Concerns reviews revealed staff up to reflect the resident's the Vice President of Concerns reviews revealed staff up to reflect the resident's the Vice President of Concerns reviews revealed staff up to reflect the resident's the Vice President of Concerns reviews revealed staff up to reflect the resident's the Vice President of Concerns reviews revealed staff up to reflect the resident's the Vice President of Concerns reviews revealed staff up to reflect the resident's the Vice President of Concerns reviews revealed staff up to reflect the resident's the Vice President of Concerns reviews revealed staff up to reflect the resident's the Vice President of Concerns reviews revealed staff up to reflect the resident's the Vice President of Concerns reviews revealed reviews revealed staff up to reflect the resident's the Vice President of Concerns reviews revealed reviews r	d the resident had an sment completed on cale on 09/28/2021, and a veloped on 09/28/2021.  sident #45 on 09/28/2021 at 5 on 09/28/2021 at 1:40 on 09/29/2021 at 11:10 AM, 29/2021 at 11:26 AM, 29/2021 at 11:52 AM, 29/2021 at 11:30 AM and 29/2021 at 11:30 AM and 29/2021 at 11:13 AM as appeared clean, linens were on the riews with the residents observations revealed no review of Progress Notes 5, #308, #309, #311, #314, e linterim Social Service on e residents on 09/15/2021 with resident hygiene.  D on 09/30/2021 at 2:23 PM red Residents #45, #65, 14, and #320 on 09/15/2021 cerns regarding hygiene.  idents during the initial tour 33 PM to 2:32 PM revealed . Interviews and record dents #45, #65, #308, if #320 each had their d hygiene preference	{F €	92)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			CONSTRUCTION		SURVEY
		185256	B. WING				R
	ROVIDER OR SUPPLIER  POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	was interviewed for shapreference, and the faresident's care plan. A interviews revealed the preference was obtains shower schedule revealed shower/hygiene preference was obtains shower schedule revealed shower/hygiene preference was obtains shower schedule revealed shower/hygiene preference was obtains shower schedule revealed she resident diets on 08/20 that she implemented recommendations for loss and/or wound head documentation revealed reviewed all residents. DON reviewed all diet Interview with the RDO revealed she complete and recommendations.  7). A review of facility ob/13/2021 revealed the with a diagnosis of Diasigns and symptoms of hyperglycemia and the intervention. Interview 09/30/2021 at 4:17 PM the residents and did reconcerns. Observation 09/28/2021 at 11:13 A 09/29/2021 at 11:13 A 09/29/2021 at 11:52 A signs/symptoms of hyperglycew of facility assigns/symptoms of facility assigns/symptoms of facility assigns/symptoms of facility assigns/symptoms of facility assigns/symptoms.	She stated each resident nower and hygiene cility updated each a review of resident eir shower/hygiene ned. A review of the facility's aled that the resident rences were honored.  Dietician on 09/30/2021 at began reviewing all 8/2021. She further stated new and/or additional residents to address weight aling. A review of the ned the Registered Dietician diets, and the Regional sand recommendations. On 09/30/2021 at 4:17 PM and the review of all diets on 09/30/2021 at 4:17 PM and the review of all diets on 09/30/2021 at 4:17 PM and the review of all diets on 09/30/2021 at 4:17 PM and the review of all diets on 15 per sidents were assessed for a flypoglycemia/ and the Regional DON on 16 revealed she assessed not identify immediate as of Resident #348 on 16 per sident #348 on 17 per sident #320 on 18 per sident #320 on 19 per sident #311 on 19 per s	⟨F €	592}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED	Ì
		185256	B. WNG			R	
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	09/30/2021	7
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BI HE APPROPRIA		1
{F 692}	assessed by Respirat with Respiratory Ther at 12:45 PM revealed with diagnoses of Chr Disorder (COPD), Ast 08/12/2021 with no id Observation of Reside 1:48 PM, Resident #43 revealed no respirator 8). Interview with the lon 09/30/2021 at 3:40 all resident's orders for g stated the facility ame include mandatory en MAR. Review of Resident's orders revealed each the glucose value on the glucose value on the glucose value on the glucose value on the glucose levels than 400.  9). A review of audits or evealed meals were with the Regional Cert (RCDM) on 09/28/202 09/30/2021 at 1:52 PM observed on 09/11/20 within five (5) to ten (1 scheduled times.  10). A review of the face of the glucose of the face of the glucose of the face of the glucose of the face of the glucose of the face of the glucose of the face of the glucose of the face of the glucose of the face of the glucose of the glu	chma 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. Sent #45 on 09/28/2021 at 1:40 stress.  Regional Nurse Consultant of PM revealed she reviewed agnosis of Diabetes and the lucose monitoring. She nded all resident orders to try of glucose values on the dent #3, #41, and #357's order required staff to enter the resident's MAR. Further ncerns with residents less than 60 and/or greater completed on 09/11/2021 delivered timely. Interview diffied Dietary Manager 1 at 2:26 PM, and 1 revealed lunch was 21 and arrived at the unit 0) minutes of the	{F 6	692}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION DING	•	(X3) DATE COMP	SURVEY LETED
		185256	B. WING				₹
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	E	<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	IX (EACH CORRECTIVE ACTION	SHOULD BI		(X5) COMPLETION DATE
{F 692}	6:00 AM.  A review of the staffing 09/30/2021 revealed to three (3) certified nursing from 6:00 AM to 6:00 staffing revealed one (2) certified nursing as 6:00 PM to 6:00 AM.  Observation of facility 1:20 PM to 5:30 PM; of to approximately 6:00 7:55 AM to 5:17 PM, robeing answered timely clean/well-groomed, substitution of the complete of the comple	each floor from 6:00 PM to  g for 09/29/2021 and two (2) licensed nurses, and sing assistants on each floor PM. Further review of (1) licensed nurse and two ssistants for each floor from  staffing on 09/28/2021 from on 09/29/2021 from 8:11 AM PM and 09/30/2021 from evealed call lights were y, residents appeared staff was offering and sh baths/showers, vas being conducted timely, vassed timely.  I on 09/29/2021 at 11:55 1 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 4 PM; LPN #10 on PM, LPN #11 on 09/30/2021 egistered Nurse Aide aide) #1 on 09/29/2021 at on 09/29/2021 at 3:23 PM; 21 at 3:29 PM; SRNA #19	{F 6	692}			

	OF DEFICIENCIES F 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	<u> </u>	21	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)		(X5) COMPLETION DATE
{F 692}	one (1) evening cook, day aides, and two (2) Observation of the kith PM reflected the staffi schedule. Interview w at 1:12 PM, and Dieta 2:10 PM revealed kitch and they were able to their shift.  12). A review of assess withdrawn, crying, or conducted for Resider 08/11/2021. No concereview of skin assessino identified concerns interviews conducted and 09/30/2021 revea with psychosocial and including observations and #322. Interview w 09/29/2021 at 11:54 A with abuse. Interview w 09/30/2021 at 1:39 PM a diagnosis of Demenreviewed and revised with the RDON on 09/revealed she complete 08/11/2021, for all resi of licensed nursing staidentified. A review of Social Service Directo	ffing schedule for 21, and 09/30/2021 nsisted of one (1) day cook, one (1) prep cook, two (2) evening aides. Chen on 09/28/2021 at 2:26 ng was accurate per the fith Cook #3 on 09/29/2021 ry Aide #3 on 09/30/2021 at then staffing had improved, complete their duties during other abuse symptoms was nts #64, #86, and #322 on rns were identified. A ments completed revealed on 09/28/2021, 1ed no identified concerns for Resident #322 on M revealed all residents with tia had their care plans as necessary. Interview 30/2021 at 4:17 PM ed skin assessments on dents, with the assistance	{F €	692}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE COMP	SURVEY
		18525 <del>6</del>	B. WNG				R <b>30/2021</b>
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200 N	ET ADDRESS, CITY, STATE, ZIP CODE IURSING HOME LANE VILLE, 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	wander, revealed all r wandering risk assess Review of the elopem each nursing station of binder on each floor the including a description interventions for each 14). Review of Reside and #332's medical reresidents had been will net review with the Reg 09/30/2021 at 3:53 Ph comprehensive nutritic Residents #39, #65, #Review of the medical completed a compreh assessment on 09/16/09/16/2021 for Reside Resident #81, 09/16/2021 for Reside Resident #81, 09/16/2021 for Reside recommendations madischarged. Interview Dietician on 09/30/202 resident had received assessment and revie by nursing staff. Furth and Regional DON rettray card were reviewed information.	esiments for residents that esidents had received a sment by 08/16/2021. ent/wandering binder at an 09/29/2021 revealed a nat contained information in, a photo and potential resident identified at risk.  ent #39, #65, #81, #90, #330 record revealed all of the eighed by 09/17/2021. pistered Dietician on in in in items from the intervention of the eighed she completed a conal assessment on items from the intervention of items from the item	{F €	92}			
	revealed snacks include	ding but not limited to					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				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				х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 692}	drinks were present, i juice. Observations or revealed snacks were Review of Resident #: Resident #14's record intake 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 09/29/2021 at 11:41 A 8/30/2021 at 10:36 AM or symptoms of COVII been discharged from 18). Review of facility staff working on 09/16 COVID-19 with no ider review of resident test 09/17/2021, revealed 19). Interview with MD at 1:39 PM, MDS Nurs PM, Maintenance Assi 2:56 PM, Therapy Maintenance Assi 2:56 PM, Therapy Maintenance Interview of the Interview of Interview of Interview of Interview MD at 1:39 PM, Housekeepin 09/30/2021 at 1:24 PM. Director (HR) on 09/30 Marketing Liaison on 0 Medical Records on 05	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 roiew with SRNA #19 on the revealed she was intation of snacks.  The facility's red zone and 2021 at 2:12 PM revealed in the zones contained no sents #327, #328 and #329 is were isolated per CDC in of Resident #328 on in the facility.  The facility is red zone and sents #327 had the facility.  The staff testing revealed all in the facility.  The facility is red zone and sents #327 had the facility.  The staff testing revealed all in the facility is staff testing revealed all in the facility.  The facility is red zone and sents #327 had the facility is staff testing revealed all in the facility is red zone on 09/30/2021 at 1:31 is the facility is staff the facility is an ager on 09/30/2021 at no 19/30/2021 at no 19/30/2021 at no 19/30/2021 at no 19/30/2021 at 10:48 AM, Senior 19/30/2021 at 10:48 AM, Senior 19/30/2021 at 10:55 AM,	{F 6	92}				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII	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			3372021
(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 692}	12:58 PM, RN #4/Wol 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #2 SRNA #22 on 09/29/2 #23 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 she was conducting to following CDC guidant tested revealed tested times weekly.  20). Review of Reside and #90's medical recresident had COVID-1 implemented. In additing resident's MAR reveal monitoring as ordered  21). Interview with the 09/30/2021 at 3:25 PM Resident #321, Reside and Resident #351's medical resi	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 In 09/30/2021 at 10:31 19/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 on 09/29/2021 In 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 M, Dietary Aide #3 on M, Former Activities 1988 ger #3 on 09/30/2021 at 1 facility is testing staff two 100/2021 at 3:10 PM revealed 100/2	{F 6	92)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	.77	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		185256	B. WING			R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, Z 200 NURSING HOME LANE PIKEVILLE, KY 41501	IP CODE	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)	ACTION SHOULD BE TO THE APPROPRIA	
{F 692}	identified concerns wi addition, observation floor on 09/30/2021 at identified concerns. In 09/29/2021 at 11:55 APM, N #4/Wound Card 2:54 PM, LPN #6 on CLPN #7 on 09/29/2021 09/30/2021 at 1:54 PM at 12:50 PM and LPN AM revealed no concernedications.  23. Interview with the Operations on 09/30/2Co-Owner/President of at 3:11 PM revealed be agreement that the phracility with a three-darrequiring cost review, pharmacy agreement requiring a cost review, the facility a minimum medication while being would communicate at guidance to the pharm Director of Operations the Vice President of Cisigned the agreement.  24). Interview with RN AM and 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 revealed they had received.	of on 3rd floor revealed no th missing medications. In of a narcotic count on 5th it 12:50 PM revealed no sterview with RN #1 on of and 09/30/2021 at 12:58 at Nurse on 09/30/2021 at 12:44 PM, it at 3:00 PM and of LPN #10 on 09/30/2021 at 10:31 at 10:00 PM and of Pharmacy on 09/30/2021 oth parties made a formal armacy will supply the y supply for medication of the pharmacy would send of a three-day supply of the greviewed. The facility my changes or continuance of Guardian Pharmacy and Operations of the facility which is the pharmacy of the facility my changes or continuance of Guardian Pharmacy and Operations of the facility which is the pharmacy of the facility which is the facility of Guardian Pharmacy and Operations of the facility #1 on 09/29/2021 at 11:55	{F €	592}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B. WNG				R
	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>	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 692}	they were aware that physician if the pharm medication to the facil 25). Interview with the on 09/30/2021 at 3:40 09/30/2021 at 4:17 PM completed of all reside and verified all medica facility by 09/25/2021. pass on 09/29/2021 a and 09/30/2021 at 8:0 concerns with missing 26). Review of a QAP the facility conducted with the Regional DOI Consultant, Human Records, the Houseke Supply, MDS Nurse # Therapy Manager, the the Administrator, the Dietary Manager, and administration team.  27). Interview with the Interview with the Interview with the Interview with the Interview with the current 09/30/2021 at 5:05 PM appointed the current 09/13/2021. Further in Operations revealed s Administrator with dail 09/10/2021.	a addition, they revealed the nurse would notify the pacy could not deliver a lity.  Regional Nurse Consultant PM, and Regional DON on M revealed an audit was ents' ordered medications ations were available in the Observation of medication to 4:35 PM on the third floor PM AM revealed no identified medications.  I signature sheet revealed a meeting on 08/12/2021 N, Regional Nurse esources, SSD #2, Medical reping Supervisor, Central 1, MDS Nurse #2, the endinssions Coordinator, Activities Director, the other members of the  Vice President of 2021 at 4:10 PM and rim Administrator on M revealed the facility Interim Administrator on the terview with the VP of the had provided the Interim	{F 6	92}			
	09/30/2021 at 3:40 PM	Interim Administrator on  1, the Medical Director on  1 and members of the QAPI					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
	ROVIDER OR SUPPLIER		<u>                                     </u>	S'	TREET ADDRESS, CITY, STATE, ZIP CODE DO NURSING HOME LANE IKEVILLE, 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	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	procedures for contact answering call lights, delivering meal trays and turning/reposition 09/15/2021.  29). Interview with the Operations on 09/30/2 Nurse Consultant on 6 the Med-Net Concept: 09/28/2021 at 3:00 PN conducted a conferent following: (1) the outce expectations and roles outlined in the Rules a determined a plan for communication/monitor and COVID-19 isolated facility to monitor/assereposition residents, prepare and distribute residents with eating, effective Pharmacy Seand neglect effectively appropriate ADLS, and QAPI committee.  30). Interview with the 09/30/2021 at 3:40 PN	the Regional Nurse 2021 at 3:40 PM, revealed sting staff for call-ins, ADL Care, serving and timely, incontinence care ing were reviewed on  2021 at 4:10 PM, Regional 2021 at 4:10 PM, Regional 209/30/2021 at 3:40 PM, and s Nurse Consultant on of revealed the facility ce call to review the comes of the survey, (2) s of the Governing Body as and Regulations, (3) the following coring tools: Infection Control con, enough staff at the cass residents, turn and covide incontinent care, emeals, and assist caring for pressure wounds, ervices, dealing with abuse of, sufficient staff, providing d providing a functioning  Interim Administrator on of, and Regional Nurse	{F 6	92}			
	reviewed and revised presented the reviews Committee during the facility developed a strail all topics were reviewed	and/or revision to the QAPI 09/16/2021 meeting. The andardized plan to ensure ed as needed at the QAPI cluded pressure ulcers,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		185256	B. WING			l	R /30/2021	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		03/	30/2021		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
{F 692}	usage, risk managements hospital re-admission management, social signievance, activities, recouncil concerns and discharges, census, signievance tray a work injuries, terminal medical leave of absence hires, medical repharmacy reports, resoffice, and admission Committee and Medic standardized agenda but not be limited to the meeting. Interview 09/30/2021 at 1:39 PM 09/30/2021 at 1:31 PM Manager on 09/28/20/20/20/2021 at 1:52 PM Director/Dietary Mana 1:30 PM, Medical Recomposition of Medical Recomposition of the Medical Recomposition	restraints, medication ent, infection control, the rate, rehabilitation services, concerns of resident council, and family or grievances, admissions, staff development, openings in, employee orientations, audit report, weight losses, stions, employees on family since or leave of absence, cord compliance review, storative nursing, business actions. The QAPI real Director approved the on 09/16/2021 to include the topics presented during with MDS Nurse #1 on M, Regional Certified Dietary 21 at 2:26 PM and M, Former Activities ger #3 on 09/30/2021 at sords on 09/29/2021 at 8:34 to Director (HR) on M, Therapy Manager on M, Housekeeping to 1021 at 1:24 PM, to 1031 (RT) #1 on 09/30/2021 at supply on 09/29/2021 at information was presented tield on 09/16/2021.  Vice President of to 2021 at 4:10 PM, the Interim to 2020 at 3:40 PM, DON #2	{F €	592}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		185256	B. WING_			1	R /30/2021
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE		30,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE
(F 692)	policy and procedures facility and communic members of the Governmenting, the QAPI proparticipate regularly in need to identify root of utilization of the "5 which systems per the QAPI 32). Interview with the 09/30/2021 at 3:40 PI monitoring reports be and reviewed the data QAPI attendance she conducted meetings of and 09/30/2021. Interview of Operations on 09/30 Regional Nurse Conserving body, and of forwarded to them.  33). Interview with the Operations on 09/30/2021 at 3:40 PI revealed the governing body would be ducation regarding 034). Interview with the 09/30/2021 at 3:40 PI at 3:4	erning Body including setting is to be implemented in the sating information to other string Body. During the occesses, the need to in the QAPI process, the sauses of system problems, by approach and auditing I Calendar were reviewed.  Interim Administrator on M revealed he collected all fore each QAPI meeting a for compliance. A review of ets revealed the facility on 09/16/2021, 09/23/2021, view with the Vice President of 2021 at 4:10 PM and cultant on 09/30/2021 at 3:40 re members of the QAPI meetings had been at the vice President of 2021 at 4:10 PM and the cultant on 09/30/2021 at 3:40 reming body provided the ources and education of the interviews revealed the limeet quarterly for the iew with the Interim 0/2021 at 3:40 PM revealed with resources and other interviews and collected and paper.  Interim Administrator on of revealed QAPI meetings by effective 09/16/2021 to	{F 6	92}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER	-I	200 (	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501	09/	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 692}	complied with the star compliance. Further in President of Operatio PM, Regional Nurse (3:40 PM, MDS Nurse PM, MDS Nurse PM, MDS Nurse PM, MDS Nurse PM, MDS Nurse PM, MDS Nurse PM, PM, Former Activities #3 on 09/30/2021 at 1:0 n 09/29/2021 at 8:34 Director (HR) on 09/3 Therapy Manager on Housekeeping Super PM, Respiratory Therat 12:45 PM and Cent 2:40 PM revealed the weekly QAPI meeting and 09/23/2021. In ad Medical Director/Phys 3:25 PM revealed he QAPI meetings on 09/5 Further interview with 09/30/2021 at 3:40 PM meeting had been correview of the facility Q sheet reflected the ab identified concerns.  35). Interview with RN AM and 09/30/2021 at 12:4 09/29/2021 at 3:00 PM, LPN #10 on 09/30/2021 at 09/29/2021 at 3:40 PM PM, LPN #10 on 09/30/2021 at 09/29/2021 at 3:40 PM 09/29/2021 at 3:40 PM 09/29/2021 at 3:23 PM 09/29/2021 at 3:23 PM 09/29/2021 at 3:23 PM 09/29/2021 at 3:23 PM	ndard of care and interview with the Vice ins on 09/30/2021 at 4:10 Consultant on 09/30/2021 at #1 on 09/30/2021 at 1:39 in 09/30/2021 at 1:31 PM, etary Manager on M and 09/30/2021 at 1:52 Director/Dietary Manager 1:30 PM, Medical Records AM, Human Resource 0/2021 at 10:48 AM, 09/30/2021 at 1:18 PM, visor on 09/30/2021 at 1:18 PM, visor on 09/30/2021 at 1:24 apist (RT) #1 on 09/30/2021 at y had participated in the seconducted on 09/16/2021 at y had participated in the seconducted on 09/16/2021 at participated in the weekly 1/16/2021 and 09/23/2021. At the Interim Administrator on M revealed the weekly QAPI inducted on 09/30/2021. A the Interim Administrator on M revealed the weekly QAPI inducted on 09/30/2021. A the Interim Administrator on M revealed the weekly QAPI inducted on 09/30/2021. A the Interim Administrator on M revealed the weekly QAPI inducted on 09/30/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 4 PM, LPN #7 on M and 09/30/2021 at 1:54 and 09/30/2021 at 1:54 and 09/30/2021 at 1:54 and 09/30/2021 at 1:54 and 09/30/2021 at 1:54 and 09/30/2021 at 1:54 and 09/30/2021 at 1:550 PM, LPN 10:31 AM, SRNA #1 on	{F €	92}				

(F 692)  Continued From page 618  SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:07 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021. Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician.  36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and timely nutritional assessments to ensure diet order accuracy. When staff enter diet orders into the electronic medical record, the nurse entering the order sends written communication to the dietary staff, which includes diet and texture. She further revealed that she entered the order into	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 692)  Continued From page 618  SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021 in Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician  (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician.  36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and timely nutritional assessments to ensure diet order accuracy. When staff enter diet orders into the electronic medical record, the nurse entering the order sends written communication to the dietary staff, which includes diet and texture. She further revealed that she entered the order into		185256	185256 B. WIN	G	
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 692)  Continued From page 618  SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021. Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician.  36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30  PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and timely nutritional assessments to ensure diet order sends written communication to the dietary staff, which includes diet and texture. She further revealed that she entered the order into				200 NURSING HOME LANE	1 09/30/2021
SRNA#21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021. Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician.  36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and timely nutritional assessments to ensure diet order accuracy. When staff enter diet orders into the electronic medical record, the nurse entering the order sends written communication to the dietary staff, which includes diet and texture. She further revealed that she entered the order into	PREFIX (EACH DEFIC	HENCY MUST BE PRECEDED BY FULL	DEFICIENCY MUST BE PRECEDED BY FULL PRI	EFIX (EACH CORRECTIVE ACTION SHOULD AG CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
orders. She stated that all diet orders from the previous day would be reviewed in the clinical meeting. Interview with the Regional CDM on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she completed education with Former Activities Director/Dietary Manager #3. In addition, she stated that she had been on site to provide additional assistance during the transition to her new role.  37). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6	SRNA #21 on 09 on 09/29/2021 at 4: education on 09/staff revealed the weighing resident reporting the weighing resident reporting the weighing resident reporting the weight of the weighing resident reporting weight of the weig	3:17 PM and SRNA #23 on 10 PM revealed they received 17/2021. Interview with nursing by verbalized understanding of 1s, obtaining, documenting, and 1st to the Registered Dietician 1st Regional DON on 09/30/2021 led staff was provided with 17/2021 on proper weighing 1st, documenting, and 1st changes to the Registered Dietician 1st changes to the Registered 1st changes 1s	on 09/29/2021 at 3:04 PM, SRNA #22 21 at 3:17 PM and SRNA #23 on at 4:10 PM revealed they received n 09/17/2021. Interview with nursing at they verbalized understanding of sidents, obtaining, documenting, and a weights to the Registered Dietician iew with Regional DON on 09/30/2021 revealed staff was provided with n 09/17/2021 on proper weighing obtaining, documenting, and eight changes to the Registered  w with Former Activities Director and any Manager on 09/30/2021 at 1:30 d she received education on by the Regional Certified Dietary DM) on diet order accuracy and onal assessments to ensure diet acy. When staff enter diet orders into ac medical record, the nurse entering ands written communication to the which includes diet and texture. She aled that she entered the order into al system to reflect the resident's diet stated that all diet orders from the y would be reviewed in the clinical erview with the Regional CDM on at 2:26 PM and 09/30/2021 at 1:52 at she completed education with wities Director/Dietary Manager #3. In a stated that she had been on site to tional assistance during the transition pole.  w with RN #1 on 09/29/2021 at 11:55 ab/2021 at 12:58 PM, RN #4/Wound	692}	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG			(3) DATE SURVEY COMPLETED	
		185256	B. WING	<u> </u>			R 30/2021	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			<u>0</u> 3/	3012021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		(X5) COMPLETION DATE	
{F 692}	PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PM 09/29/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2021 at 4:10 PM education on turning/r motion and transferring chair and from chair to turning, positioning, at on 09/29/2021 at 10:2 revealed no identified Therapy Manager on revealed she provided beginning on 08/19/20 turning/repositioning, transferring a resident 38). Interview with RN AM and 09/30/2021 at 3:40 PM, LPN #10 on 09/30/00 09/30/2021 at 109/29/2021 at 3:40 PM, LPN #10 on 09/30/2021 at 09/29/2021 at 3:29 PM, SRNA #11 SRNA #21 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PM education on pressure turning and reposition nutrition, Positioning of	M and 09/30/2021 at 1:54 30/2021 at 12:50 PM, LPN 10:31 AM, SRNA#1 on M, SRNA#11 on M SRNA#7 on 09/29/2021 9 on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA#22 PM and SRNA#23 on M, revealed they received repositioning, range of reg residents from bed to bed. Observations of and wound care with RN#11 11 AM for Resident #65 10 concerns. Interview with the 12 AM for Resident #65 12 concerns. Interview with the 13 taff with education 13 taff with education 14 from bed. 15 tail on 09/29/2021 at 11:55 16 tail on 09/29/2021 at 11:55 17 tail on 09/29/2021 at 11:54 18 PM, LPN #7 on 18 and 09/30/2021 at 1:54 18 PM, LPN #7 on 18 and 09/30/2021 at 1:54 18 PM, LPN #7 on 19 and 09/30/2021 at 1:54 18 PM, LPN #7 on 19 and 09/30/2021 at 1:54 18 PM, LPN #7 on 19 and 09/30/2021 at 1:54 19 AM, SRNA#1 on	{F 6	92}				

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				30/2024
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		2	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 692}	RP of a new skin impore email the Registers and the resident's repchanges. Interview with Consultant on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/3 revealed they educate prevention including the adequate hydration and devices, how to comphead-to-toe skin asset the registered dieticianew skin impairment, impairment, the nurse Registered Dietitian for MD, and resident's res	registered dietician, MD and airment. The nurse will call ad Dietitian, the physician, resentative with any th Regional Nurse 2021 at 3:40 PM and the 30/2021 at 4:17 PM and staff on pressure ulcer urning/repositioning, and nutrition, Positioning alete and document a ssment, and how to notify any physician and RP of a With any change to skin a will call or email the per new recommendations, presentative.  25 Nurse #1 on 09/30/2021 at 1:31 airstant #1 on 09/30/2021 at 1:31 airstant #1 on 09/30/2021 at 1:31 airstant #1 on 09/30/2021 at 1:31 airstant #1 on 09/30/2021 at 10:48 AM, Senior 09/30/2021 at 10:48 AM, Senior 09/30/2021 at 10:48 AM, Senior 09/30/2021 at 2:40 PM, Cook 1:12 PM, Dietary Aide #3 on M, Former Activities ager #3 on 09/30/2021 at 1:55 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	{F €	692}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	I		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B, WING				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	03/	50/2021
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 692) (F 695) SS=D	09/30/2021 at 10:31 at 3:40 PM, SR Respiratory/Tracheos CFR(s): 483.25(i)  § 483.25(i) Respirato tracheostomy care ar The facility must ensurated respiratory car care and tracheal succare, consistent with practice, the compret	AM, SRNA #1 on 09/29/2021 storny Care and Suctioning ry care, including nd tracheal suctioning, ure that a resident who e, including tracheostomy ctioning, is provided such professional standards of nensive person-centered nts' goals and preferences,	{F €				11/30/21
	by: Based on interview a determined the facility care for one (1) of fifty residents (Resident # required a bilevel post (BiPAP) machine (a r non-invasive ventilativadded oxygen, under  Resident #323 was a 07/06/2021 with a dia Failure and required to when sleeping. The sephysician orders for the	323), a resident that sitive airway pressure nachine that provides on via a mask, usually with positive pressure).  dmitted by the facility on agnosis of Acute Respiratory the use of a BiPAP machine facility failed to obtain he machine and set up a ent's use until 07/14/2021,			F 695 Respiratory/Tracheostomy Car and Suctioning  Criteria 1: Resident #323 no longer resides at the facility.  Criteria 2: An audit was conducted by DON/ADON/RT or designee on 10/1/21 for all residents admitted within the last days to determine if admitting information indicated the need for a BiPAP/CPAP machine while sleeping. Any residents requiring this equipment had review to verify orders were in place, and the equipment in use.  Criteria 3: a) Inservice education was provided by the DON/Respiratory	y I 30 on	

	OF DEFICIENCIES 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  V POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 695}	(ADON)/Interim Direct 08/11/2021 at 12:05 Finot have a policy regard She stated the facility to supply and maintain machines and had magacility for use. She signer physician's order.  Review of Resident #revealed the resident on 07/06/2021 with di Metabolic Encephalog Failure, Autistic Disordiabetes, Dysphagia, Review of the Admiss (MDS) Assessment, on Resident #323 was raccontinued review of the resident was coded to mechanical ventilator resident in the facility.  However, further reviewed in the facility.  However, further reviewed in a physician's on until 07/14/2021. Reviewed 12/14/2021. Reviewed 13/14/2021. Reviewed 13/14/202	istant Director of Nursing for of Nursing (DON), on PM, revealed the facility did arding BiPAP machines.  used a respiratory company in residents' BiPAP achines available at the stated they should be utilized  323's medical record was admitted by the facility agnoses that included bothy, Acute Respiratory der, Sepsis, Type 2 Pneumonia and Aphasia.  ion Minimum Data Set lated 07/13/2021, revealed rely/never understood.  The MDS revealed the putilize a non-invasive (BiPAP/CPAP) while a sew of Resident #323's ed the facility failed to order for the BiPAP machine view of the Physicians order, realed Resident #323's ealed Resident #323's for the Physicians order, realed Resident #323's BiPAP in Machine William (MAR) revealed there was noce Resident #323's BiPAP	{F €	695}	Therapist for all licensed nursing staff a Admission Review Team beginning 11/24/21 on BiPAP/CPAP machine use including but not limited to: verifying orders upon admission; notifying the respiratory therapist for any needed assistance/set-up; ensuring BIPAP/CPA equipment is put in place on admission for immediate use.  b) The admissions coordina was educated by the DON or designee 11/24/2021 on the need to review pre-admission information to identify residents that will need BiPAP/CPAP equipment and will notify the unit of the need to prepare for the admission order and arrangements to put this equipment into use upon admission.  Criteria 4: The DON/ ADON or designee will review all new admissions/readmission beginning 11-1-2021 weekly x 4 weeks then mont x 2months to determine that all indicate equipment, including BiPAP/CPAP machines, were ordered and implement upon admission.  Audits will be reviewed monthly in QAP x3 months then quarterly until in substantial compliance.  Criteria 5: Date of compliance: 11/30/2021	AP tor on rs t	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		185256	B. WING_				R <b>30/2021</b> □
	ROVIDER OR SUPPLIER  **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  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG		HOULD BE		(X5) COMPLETION DATE
{F 695}	08/02/2021 at 8:50 Al nursing staff at the fac 07/11/2021, that Resist to be worn at night. Swore BiPAP well at he further revealed she for wearing BiPAP contributes a contribute on 07/07/2021 and on 07/07/2021 at a case of the did recall the resided on 07/07/2021 and on 07/08/2021, 07/17/2021 and on 07/08/2021, 07/17/2021 and on 07/08/2021, 07/12/2021 and on 07/08/2021, 07/12/2021 at a case on 07/08/2021, 07/09/2021 at a case on 07/08/2021 at 4:16 working on 07/06/2022 admitted to the facility aware Resident #323	ant #323's family member, on M, revealed she notified the cility, approximately dent #323 required a BiPAP is stated Resident #323 are with no problems. She celt Resident #323 not buted to the ne resident.  Registered Nurse Aide 8/2021 at 6:28 AM, revealed it where Resident #323 1, 07/08/2021, 07/13/2021, 21 and 07/18/2021, and she lent #323 wearing BiPAP is 16, on 07/28/2021 at 8:00 ked night shift and provided 3 on 07/07/2021, 21, 07/13/2021 and multiple is resident leaving the never observed Resident MAP.  Ref. on 07/28/2021 at 9:54 ided care for Resident #323 iz 021, 07/10/2021 and the la BiPAP that night. He less, (exact date unknown), ent wearing BiPAP at night.  Ref. of Practical Nurse (LPN) #3, PM, revealed she was 1 when Resident #323 was 1 when Resident #323 was	{F 6	95)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
	185256	B. WNG_			1	R /30/2021
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REF	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		1 03	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
got a BiPAP machine f 07/06/2021; however, machine because they machine settings for R she reported to the one orders were needed fo resident's BiPAP. How facility did not place the 07/14/2021, when Res identified no setting ord Interview with LPN #8, revealed she was not r needed orders for his/r resident should have h he/she required one fo revealed not wearing a negative impact on bre  Interview with Register 07/29/2021 at 9:17 PM did not wear his/her Bil admission. She stated resident required a Bip unable to obtain a phys machine settings. She was not obtained until ( Nursing/Assistant Direct obtained an order on 0 the resident should have BiPAP prior to 07/14/20 BiPAP could have a ne breathing.  Interview with RN #6, of and 3:45 PM, confirmer Resident #323 a BiPAF	egistered Nurse (RN) #6 from facility stock on they did not set up the did not have an order for resident #323. She stated coming nurse, LPN #8, that or the settings for the evever, LPN #3 stated the re resident on BiPAP until spiratory Therapist (RT) #1 ders had been obtained.  on 07/28/2021 at 9:29 PM, notified Resident #323 her BiPAP. She stated the read orders for the BiPAP if or breathing. She further read BiPAP could have reathing.  red Nurse (RN) #9, on l, revealed Resident #323 PAP for several nights after of the family notified her the PAP; however, she was sician's order for BiPAP restated a physician's order the Interim Director of ctor of Nursing (ADON) 7/14/2021. RN #9 stated we had an order for the D21 because not wearing	{F 6	95}			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B, WNG		R	
NAME OF P	ROVIDER OR SUPPLIER	100200	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/30/2021	
		HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
{F 695}	machine and treatme 07/14/2021, the Resp came to the unit to de required respiratory e she notified RT #1 ab however, the RT did not the equipment. R she identified the resinights without the BiF Resident #323 should 07/14/2021. She stat have potential negative Interview with Respiration of the facility and was unot have settings for 07/14/2021 at 8:28 Al the facility and was unot have settings for 07/14/2021. She stat resident's room on 07 not wearing BiPAP ar resident had a machin Interview with Emergo 08/03/2021 at 10:47 presented to the Eme	ne settings for the resident's not was not initiated. On siratory Therapist (RT) #1 etermine any residents who equipment. RN #6 stated out Resident #323; not have a physician order N #6 revealed at that time, dent had went several PAP machine. She stated thave had the BiPAP before ted not wearing BiPAP could be impacts on breathing.  Actory Therapist (RT) #1, on M, revealed she was new to naware Resident #323 did his/her BiPAP machine until ted she entered the P/14/2021 and resident was not did not notice whether the ne in the room.  Bency Room Physician #1, on PAM, revealed Resident #323 ergency Department (ED) on g stridor. He stated his revealed the resident had an in.  Sistant Director of Nursing thor of Nursing (ADON), on PAM, revealed she was aware with obtaining Resident evealed she was unable to was obtained, however, she	(F 69	5)		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			l	R 09/30/2021	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		00 NURSING HOME LANE		30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
{F 695} {F 697} SS=G	6:00 PM, revealed sh since June 2021, and systems to monitor to respiratory care as repain Management CFR(s): 483.25(k)  §483.25(k) Pain Mana The facility must ensure provided to residents consistent with profess	BiPAP could result in status.  ninistrator on 08/11/2021 at e had been at the facility had not developed any ensure resident's received quired.  agement.  agement that pain management is who require such services, sional standards of practice, erson-centered care plan,	{F 6				11/30/21	
	by: Based on observation and review of the facility management was profifty-seven (57) sampl #326) who required suprofessional standard comprehensive perso the resident's goals at Observations and recresident #326 completis/her head and back PM on 08/05/2021 (apbefore staff administer)	r failed to ensure pain vided for one (1) of ed residents (Resident uch services consistent with s of practice, the n-centered care plan, and nd preferences. ord review revealed ained of severe pain in x, from 10:01 AM until 5:15 proximately 7.25 hours) red the resident pain the resident's prescribed			F 697 Pain Management  Criteria 1: Resident #326 was discharged from the facility on 9-3-2021  Criteria 2: a) On 11/22/2021 all residents were audited to ensure they receive their pain medication as ordered Residents noted to be outside parameter or with any medication not available to administered as ordered had he pharmacy and MD/NP made aware.  Criteria 3  a) Beginning 11/24/2021 all licensed nursing staff have been re-educated on:	d. ers		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		CONSTRUCTION	(X3) DATE SURV COMPLETED		
		185256	B. WING			R 09/30/2021		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	097.	30/2021	
NAME OF FROVIDER ON SUFFLIER				_	00 NURSING HOME LANE			
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				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 CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		_	(X5) COMPLETION DATE	
{F 697}	Assessment and Mar 2020, revealed the parawas based on a facility appropriate assessment based on professional comprehensive care professional comprehensive care professional comprehensive care professional comprehensive care professional condition and review of Resident # revealed the facility and Friday 07/30/2021, which was assessment of the facility assessment of th	inued From page 627 findings include:  aw of the facility's policy titled, "Pain ssment and Management", dated March revealed the pain management program based on a facility-wide commitment to popriate assessment and treatment of pain, don professional standards of practice, the prehensive care plan, and the resident's ease. Further review revealed the facility ed "pain management" as the process of fating the resident's pain based on his or her all condition and established treatment goals.  Bew of Resident #326's medical record alled the facility admitted the resident on by 07/30/2021, with diagnoses that included addomyolysis, Respiratory Failure with pression Fractures.  Bew of Resident #326's Minimum Data Set as assessment dated 08/06/2021, revealed acility assessed the resident to have a Brief wiew for Mental Status (BIMS) score of nine indicating the resident was moderately itively impaired.  Bew of Resident #326's care plan revealed the care developed for the resident as of 5/2021, was the resident's Baseline Care, which had been initiated on admission (six prior). The Base Line Care Plan did not		697}	"The 5 rights of medication administration including right amedication, patient, dose, time, and row The process to follow when a medication is not available to be given ordered, which includes check the eto determine if the medication is availa in the e-kit; if not available in the e-kit of the pharmacy to obtain the medication and the anticipated medication delivery time, notify the MD/NP that an ordered medication will either be omitted or give outside of the ordered medication time follow new orders given by the MD/NP document the conversation and new orders from the MD/NP in PCC.  "The process to obtain a narcotic the is not available from the e-kit includes obtain an order for the narcotic, fill out pharmacy form for removal of narcotics from the e-kit. Fax a copy of the form the pharmacy. Call the pharmacy and requal a code. Enter the code into the box and remove the narcotic.  Licensed nursing staff not working will educated on their next scheduled shift. Education will be added to new hire orientation.  All new admissions, re-admissions that include weekend and after normal business hours discharge orders are submitted to pharmacy medications are entered into PCC and submitted to pharmacy through pharmal integration, if medications are not	cation ight  , time, and route. v when a le to be given as check the e-kit lation is available le in the e-kit call line medication cation delivery at an ordered omitted or given edication time, by the MD/NP, on and new in PCC. In a narcotic that le-kit includes- larcotic, fill out the leal of narcotics of the form to lineacy and request to the box and t working will be cheduled shift, on new hire  lons, le weekend and lurs discharge charmacy		
	dated 07/30/2021, re-	326's Physician's Orders vealed the only ordered pain sident was Oxycodone			received in a timely manner the pharm is notified, as well as use of the E-kit. I emergency would arise for needed medication while awaiting on pharmac	fan		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
					,	R	
		185256	B. WNG		09/	09/30/2021	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  200 NURSING HOME LANE  PIKEVILLE, KY 41501				
(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 CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE	
{F 697}	mouth every six (6) he moderate/severe pair 07/31/2021.  Review of the Nurse's 10:01 AM, revealed Recomplaining of head a pain as an eight (8) owith one (1) representen (10) representing further review of the medication was availate resident. The note stapharmacy and request delivery of the medication was interested by the medication and interested he/she was "he waiting on pain medicated he/she had been in part an eight (8) on the passent was a recomplete to the pain. However, none documented as being resident.  Interview with License on 08/05/2021 at 11:1 #326 did not have any facility and they were from pharmacy. She #326 was not her resident resident.	cocet) to be administered by cours as needed for a. The order start date was a Notes dated 08/05/2021 at desident #326 was and back pain, and rated the cut of ten (10) on a pain scale ting minimal discomfort and severe pain. However, note revealed no pain able to administer to the cuted staff notified the cuted a "STAT" (urgent) ation.  In the resident was cation. The resident voiced ain "all morning" and rated it in scale.  326's admission Medication at (MAR) revealed the was on the MAR to be at (6) hours, as needed, for of the medication was	⟨F 69	the MD is notified for substitution an new orders. License nursing staff no working will be educated on the nex scheduled to work. Education will be added to the new licensed nurse orientation. A post test will be administered and will be graded to validate competency.  b) On 9-23-21 the Co-owner/President of ETPS Pharm has agreed to providing a 3-day sup meds that require a cost authorization be sent to the facility while pending review  Criteria 4: a) Starting 9.25. random med pass audits on random using the CMS medication administry observation form, will be conducted Regional Nurse Consultant, Pharma Director of Nursing or designee were 4 weeks and monthly until substantial compliance is achieved. Audits will be reviewed monthly in QAPI x3 month quarterly until in substantial compliance b) Starting 11/24/2021 5 random residents with a BIMS of 8 c greater will be interviewed to ensure medication is administered as reques 5 random residents with a BIMS of 7 less will be visually assessed for observable s/s of pain; such as facial grimacing, crying, restlessness, etc. visual indicators of pain are observe MD/NP will be made aware for new orders. Audits will be weekly x 4 weethen monthly until substantial compliance achieved. Audits will be reviewed monthly in QAPI x3 months then guesting the province of	acy poly of n will cost  21, 5 shifts ation py the cy, kly x al e s then nce r pain sted, or I If d the ek and ance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185256	B, WNG			R	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER				20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	<u>j 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 PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		-	(X5) COMPLETION DATE
(F 697)	PROVIDER OR SUPPLIER  W POST-ACUTE AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		{F 6	97}	until in substantial compliance. Criteria 5: Date of compliance: 11/30/2021		