	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		JCTION	(X3) DATE SURVEY COMPLETED			
		185256	B. WING			1	R /30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		1 03/	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 697}	revealed she was not that the facility had a medications available ever trained her or to medications.  Observation of the fa administration pass or revealed RN #5 admi Percocet tablet from Resident #326 continuan eight (8).  Interview with Pharm PM revealed the pharmany record of receiving #326's Percocet. However, the facility for Reside Representative states Emergency Kit at the Percocet. However, the nurse requesting to submit certain resimpharmacy. Subsequently the facility and withdraw that specific Interview with RN #16 revealed it had been prescription refills for when the facility administrations.	on 08/05/2021 at 5:00 PM, aware, prior to this incident, amergency kit with a She stated no one had lid her about the emergency cility's medication on 08/05/2021 at 5:15 PM, mistered Resident #326 a the facility's emergency kit, used to rate his/her pain at acist #1, on 07/28/2021 4:05 rmacy was unable to find ag the request for Resident wever, the pharmacy was unable to find ag the request for Resident wever, the pharmacy was unable to find ag the request for Resident wever, the pharmacy was unable to find ag the request for Resident wever, the pharmacy was unable to find ag the request for Resident wever, the pharmacy was unable to find ag the request for Resident wever, the pharmacy was unable to find a facility, which contained the representative stated that the medication was required dent information to the ntly, the pharmacy would a electronic code to dose of medication.  On 08/25/2021 at 4:28 PM, more difficult lately to get narcotics. The RN stated itted a resident on a t may not have any or only	{F 6	97}			
	narcotic medications	equently they did not have available. RN #10 stated it em for residents not to get					

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 09/30/2021		
-	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	<u> </u>	20	REET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501	03/	30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
{F 697}	know specifically why medication at the faci Interview with RN #1 revealed she often hat the pharmacy multiple prescription or a refill The nurse stated resi days without medication arrival of the medication arrival of the medication the know why Reside not available.  Interview with Certification 08/05/2021 at 1:00 often run out of narco stated residents must the facility could obtain the facility could obtain the facility could obtain the facility. However, he station and not have madministration. Contine staff to follow admission to the staff to follow admission medicate care to resistated he had ordered	ly. However, RN #10 did not Resident #326 did not have lity.  on 08/05/2021 at 1:55 PM, do to notify Physician #1 and extimes to obtain a for narcotic medications, dents "often" go multiple on while waiting for a refill eation. RN #1 stated she did not #326's medications were  d Medication Aide (CMA) #1  PM revealed residents tic medications. CMA #1  go without medication until not a refill.  an #1 on 08/04/2021 at 1:05  21 at 1:26 PM, revealed here a problems with obtaining ions for residents at the stated he was not aware that several days without pain ician also stated it was not ent to be in pain for several predications available for sued interview revealed here to be available to residents at a facility and he expected on orders and implement didents. The Physician didents. The Physician didents is to the facility and here facility did not have it	{F 6	97}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		185256	B. WING_			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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETION DATE
{F 697}	(ADON)/Interim Direct 08/27/2021 at 12:00 finot have a back-up ply was aware that reside without narcotic pain medications not being ADON/IDON stated P there was an issue winot being available for interview revealed shy (Resident #326) didn'the facility. In addition she was unaware that of the facility's emerged However, the ADON/ICONDUCTED ADON/ICONDUCTED ADON/IDON stated the facility had medications. She stated the facility had medications. She stated the facility had medications. She stated the facility had medications at the padon/IDON stated she resident #326 was well acceptable standard of the facility seven the ADON/IDON stated she reproximately seven the ADON/IDON stated she resident with Administration of the facility. So PM, revealed she orders would be followould be available for admission to facility. So reviewed new admission to facility. So reviewed	sistant Director of Nursing stor of Nursing (IDON) on PM, revealed the facility did harmacy. She stated she ents were going several days medications due to gravailable. The Physician #1 was aware that ith narcotic pain medications in administration. Continued the had "no idea why thave pain medication" at the harmacy medication kits. IDON, stated the nurses were not aware ency medication kits. IDON, stated she had never gring in the facility regarding the nikts. The ADON/IDON no system in place to track sted the facility had not problem was yet. The he was not aware that ithout pain medication and pain on 08/05/2021, for hours and fifteen minutes, ed that a resident being in medication was not an of practice.	{F 65	97)		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B, WING				₹ 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 SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
(F 697)	Continued From page stated that it was not wait several hours be medication.	acceptable for residents to	{F €	97}			
(F 725) SS=D	the appropriate comp provide nursing and resident safety and at practicable physical, it well-being of each resident assessments and considering the resident assessments and considering the rediagnoses of the faciliaccordance with the fat §483.70(e).  §483.35(a)(1) The faciliaccordance with the fat §483.70(e).  §483.35(a)(1) The faciliaccordance with the fat §483.70(e).  §483.35(a)(1) The faciliaccordance of personnel on nursing care to all resident care plans: (i) Except when waive this section, licensed (ii) Other nursing personial to the section of this section of this section of this section of this section each tour of this REQUIREMENT by:	Staff.  e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care umber, acuity and ity's resident population in acility assessment required sidents in accordance with ed under paragraph (e) of nurses; and connel, including but not when waived under section, the facility must nurse to serve as a charge	{F 7	(25)	F 725 Sufficient Nursing Staff		12/30/21
		policy, and review of the			7 720 Summeric Nursing Stati		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	100204	0. 11110		TOTAL PROPERT AND ATTAL TO ATTAL	09/	30/2021
				ľ	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	N POST-ACUTE AND RE	HABILITATION CENTER			00 NURSING HOME LANE		
			ر		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 CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
{F 725}	5) Continued From page 634		{F 7	'25}			
	facility's assessment.	it was determined the		,	Criteria 1: a) Resident #311, #45.		
	facility failed to ensure		Ì		#314, #65, #308, #320, and #309 was		
		ursing and related services			provided a shower with nail care and		
	to maintain the highes	st practicable physical,			moisturizing lotion applied post shower		
	mental, and psychoso	ocial well-being for seven (7)			assisted with dressing in clean	*	
	of fifty-seven (57) san	npled residents (Residents			appropriate clothing, clean linens place	d	
	#321, #65, #320, #30	8, #314, #311 and #3).			on bed on 9/11/21,	_	
					b) Resident #65 was seen b	ıy	
	Review of Resident #				the wound care physician on 8/25/21. A		
	revealed the resident				pressure injuries were assessed and		
		red staff to monitor the			measured, and current treatments were		
	resident's blood gluco	se. However, interviews			evaluated and reported to the primary		
	with stair revealed du	e to the lack of staff it was			care physician by 9/17/21.		
	difficult to monitor the		1		c) The residents were		ĺ
		poglycemia/hyperglycemia ). On 07/18/2021, Resident	1		evaluated by social services on 9/15/21		
		(2) episodes of critically			d) Resident #321 no longer		
	low blood glucose lev	els requiring staff to			resides at the facility.		
	intervene and adminis	ster emergency treatment.			E) Resident #3 was interviewed to ensure food is hot, meals	_ :	
į	However, due to the f	acility's lack of available			are timely, call lights are answered	5	
i	staff the resident's lev	el of monitoring was not			showers are given and he feels staffing	ie	
		2021, at approximately			adequate.	15	
	12:30 AM, staff found	Resident #321	}		avaquata.		
		ritically low blood glucose			Criteria 2: a) All residents were		
	level. The facility trans	sferred the resident to the			interviewed to obtain shower/hygiene		
	hospital where he/she				preferences by DON or designee and n	ew	
	hospital admitted Res	ident #321 to the Intensive			schedules implemented by nursing staf	f.	
	Care Unit (ICU) with o	liagnoses of Hypoxemia			All residents were offered a shower at t	his	
		sustain life), Pneumonia			time. All resident requests for shower		
		phalopathy, and Acute			were honored. Resident preferences fo	- 1	
		econdary to prolonged			days and type of hygiene were obtained		
	Hypoglycemia (low blo				and entered into resident care plan and CNA Kardex by Regional Nurse.		
	Review of Resident #				b) Resident meal service for		
		was at risk for pressure			breakfast, lunch and dinner was observ	ed	
		ssistance of staff for turning,			on 9/11/21 all three meals were delivere		l
	repositioning, and inco	ontinent care. Interviews			on time,		
		re was not enough staff to					
	turn and reposition res	sidents, including Resident			Criteria 3: a) Direct Care staffing has		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF R	ROVIDER OR SUPPLIER	103230			09/30/2021
	W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
{F 725}	#65. The resident de pressure ulcer to the infected and required 05/08/2021. Accordir record, the pressure is (removal of dead and bone. The facility rethe facility on 06/09/2 developed four (4) ad 08/26/2021, the wourthe wound had blackerythema, fever, num consistent with the rehaving infrequent post in addition, observation survey revealed resident had the same days and (1) resident Additionally, interview resident family membanswer call lights time toileting timely, resides scheduled showers; a late and the food was staffing.  The facility's failure to available to provide nor is likely to cause se impairment or death to Jeopardy was identified determined to exist of 483.10 Resident Right Freedom from Abuse Comprehensive Pers (F655) (F656) 42 CFF (F684) (F686) (F692)	sacrum that became hospitalization on ing to the resident's hospital ulcer required debridement infected tissue) down to the admitted Resident #65 iditional pressure ulcers. On id care clinic documented ened tissue, blistering, bness and swelling sident being bed ridden and sition changes.  ons conducted during the lents' hair was oily, one (1) e clothes on for three (3) had body odor. Is with staff, residents, and ers revealed staff did not ely, did not assist with ents were not receiving and, residents' meals were is cold, due to insufficient of ensure sufficient staff was aursing services has caused	{F 725}	been increased through recruitment efforts with additional staffing provided through agency and travel contracts.  b) Direct care nursing staff schedules for the next day will be reviewed daily by the Director of Nursi and the Administrator to ensure staffin levels are adequate to meet the acuity the residents. The staff will be validate as present on the unit at the start of easiff by the Director of Nursing, Nursin Supervisor, Administrator, or designee Direct care nursing staff call offs will b replaced by calling other qualified staff see if they can fill the opening, and/or calling agencies to see if they have qualified staff to fill the opening. If direcare staff cannot be replaced the Director of Nursing, Assistant Director of Nursing or member of the nursing management team will fill the shift. Nurse management team was educated on 11/1/2021.  c). The process for determining staffing needs involves a baseline review of 1) the assessments and plan of care of each resident, 2) the MDS assessments, 3) the required standard of care per diagnosis of each resident, and 4) number of medication and treatments ordered for each resid Staffing per direct care hours per patie day is measured daily and evaluated the DON and/or designee to ensure residents needs have been met.  Beginning 12/22/2021 adjustments for additional staffing are done to ensure resident needs are met in the clinical meeting where re-admissions, new physician orders and change of conditional staffing are done to ensure resident needs are met in the clinical meeting where re-admissions, new physician orders and change of conditional staffing are done to ensure resident needs are met in the clinical meeting where re-admissions, new physician orders and change of conditional staffing are done to ensure resident needs are met in the clinical meeting where re-admissions, new physician orders and change of conditional staffing are done to ensure resident needs are met in the clinical meeting where re-admissions, new physician orders and change of co	ng g g of ed ach g e f to  ct ctor ng it ent ent by

	OF DEFICIENCIES F CORRECTION	I IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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		185256	B. WNG_			l .	R 130/3004	
NAME OF P	ROVIDER OR SUPPLIER		<del>'</del>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021	
PARKVIE	W POST-ACUTE AND RE	HARII ITATION CENTER	200 NURSING HOME LANE		O NURSING HOME LANE			
				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	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E KTE	(X5) COMPLETION DATE	
{F 725}	was received on 09/02/removal of the Immed 09/02/2021. However verified based on obstand review of the facil Additional Immediate 42 CFR 483.35 Nursin 483.70 Administration 483.75 Quality Assural Improvement (F867). The Immediate Jeopard Immediat	acility was notified of on 08/11/2021.  ion of Compliance (AOC) 3/2021, which alleged liate Jeopardy on r, the AOC could not be ervations, staff interviews, lity's documentation.  Jeopardy was identified at an one of the facility was notified of dy on 09/10/2021. The stance and Performance of the facility was notified of dy on 09/10/2021. The stance of the facility was notified of dy on 09/10/2021. The stance of the facility was notified of dy on 09/10/2021. The stance of the facility was notified of dy on 09/10/2021. The stance of the facility was notified of dy on 09/10/2021. The stance of the facility was notified of dy on 09/10/2021. The stance of the facility was notified of dy on 09/10/2021. The stance of the facility was notified of dy on 09/10/2021. The stance of the facility was notified at the facility was	{F 73	25}	are reviewed to determine if there is an increase in clinical complexity that need a staffing level to be changed.  d) All staff were education beginning on 9/13/2021 on the call off procedure which includes in the event a person needs to call out of work for dayshift they are to notify their immedia supervisor two hours prior to the start of the shift. In the event a person needs to call off on night shift they are to notify the immediate supervisor four hours prior to the start of their shift. If appropriate staffing levels are not met the immediat supervisor and/or designee will call othe qualified staff to potentially replace the person calling off. In the event emerger staffing is required the administrator and/or designee will call for assistance from staffing companies. Staff not working will be in-serviced upon return work. New hires will be educated during new hire orientation.  e) Dietary staffing has been increase through recruitment efforts and appropriate staffing levels has been achieved to prepare meals and ensure timely meal delivery. Dietary Manager and Administrator began reviewing dietary staffing on 9/13/2021 weekly x four weet then monthly x 2 months to ensure adequate staffing is maintained. f) All staff were educated on timely call light response. Direct care start to include nurses and certified nursing assistants were educated on providing	ds  atte f o neir o eer ncy to sed		
	and quality assurance	ness of systemic changes activities.			hygiene per resident plan of care, timely toileting/hygiene and ensuring residents are dressed in clean clothing of resident	.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			SURVEY PLETED
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	185256	B. WING			09	/30/2021
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  200 NURSING HOME LANE  PIKEVILLE, KY 41501			
PREFIX (EACH DEFICIENCY I			ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
revised October 2017, provide sufficient numb skills/competency neces services for all resident resident care plans and policy stated licensed in assistants would be available for a service of the "Facility of determined based on resident's plan of care.  Review of the "Facility of dated 08/18/2017, reveight (8) to nine (9) lice to fifteen (15) State Regassistants (SRNA), and staff in a twenty-four (2-facility met resident need interview with the Admin 6:00 PM, revealed the fifthe building was to have (4) SRNAs on each floor AM-7:00 PM) and two (5-aides for night shift (7:00 Review of the mealtime facility scheduled break 12:00 PM and the even 1. Review of Resident is revealed the facility admin 07/16/2021, with diagnor Diabetes Mellitus, and I	policy titled "Staffing," last revealed the facility would be so of staff with the essary to provide care and is in accordance with difficulty assessment. The nurses and nursing allable twenty-four (24) grumbers would be esidents' needs and each esidents' needs and four end four day to ensure the eds.  Inistrator, on 08/11/2021 at facility's goal for staffing in ele two (2) nurses and four end for day shift (7:00 ele two (2) nurses and three (3) ele two (2) nurses and three (3) ele two (3) electron end four end for the fast at 7:00 AM, lunch at ing meal at 5:00 PM.	{F 7	725}	choice and timely delivery of meal trays g) Dietary staff were educated meal service times. All education provid by DON or designee and completed on 9/14/21 staff not working or new hires who be educated.  Criteria 4: a) Visual rounding of reside to assess for hygiene, toileting/incontinence/ resident repositioning to be completed by leadership staff/designee, Beginning 9/11/21 25 % of residents will be audite weekly x 4 weeks then monthly x 2 months.  b) Visual monitoring and timi of call light response times, including the length of time call lights are answered, who be completed by leadership staff across all shifts: Beginning 9/11/21 ten (10) callight observations weekly x 4 weeks the monthly x 2 months  c) Dietary manager or designer to time passing of meal trays to resident after arriving to the unit. Beginning 9/11/21 all three meals will be randomly observed on each unit weekly x 4 weeks then monthly x 2 months. Audits will be reviewed monthly in QAPI x3 months the quarterly until in substantial compliance d) Beginning 12/11/21 the DO and/or designee began visual audits of resident noted to be in need of assistant with turning and positioning. Random Audits will be conduct weekly to include one resident per floor per shift to ensuraturing and repositioning is done. e) Beginning 11/24/2021 The	on ded vill nts d ng e will sill ne ets , s en . N ce	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	'	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R	
NAME OF P	ROVIDER OR SUPPLIER		1 -1 -11110 -			09/	30/2021	
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PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER	200 NUR		200 NURSING HOME LANE			
				F	PIKEVILLE, KY 41501			
(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 725}	Data Set (MDS) assess revealed the facility as a Brief Interview for M of thirteen (13) out of resident was cognitive Review of the Physicia 07/16/2021, revealed Resident #321 for sign hypoglycemia (low block hyperglycemia (high bounded on the resident's the resident's blood sure Review of Resident's the resident's blood sure Review of Nursing No 3:20 PM, revealed Rewas sixty-seven (67) of (mg/dL). The note staresident's breakfast traind Licensed Practical a repeat glucose level documented as one himg/dL. Interview with #6 on 07/27/2021 at 4	ssment, dated 07/19/2021, ssessed the resident to have lental Status (BIMS) score fifteen (15), indicating the ely intact.  an's Orders, dated an order for staff to monitor as and symptoms of cod sugar) and elood sugar) every shift.  321's baseline care plan, realed the facility did not a diabetes and/or monitoring ugar.  tes, dated 07/18/2021 at sident #321's blood glucose milligrams per deciliter at staff delivered the lay (exact time unknown) all Nurse (LPN) #6 obtained after breakfast which was undred thirty-nine (139)  Licensed Practical Nurse	{F 7	25}		ind i d		
	obtained a blood glucd #321, which was sixty- deciliter (mg/dL). How documented evidence	ose reading for Resident -seven (67) milligrams per vever, there was no LPN #6 continued to				i e	:	
	glucose levels for the	condition or obtain further resident.						
	revealed the resident a Department (ED) on 0	ecord for Resident #321, arrived at the Emergency 7/19/2021, at 1:36 AM, nable to follow commands.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R	
NAME OF D	ROVIDER OR SUPPLIER	165230	D. WING	_		09	30/2021	
NAME OF P	ROVIDER OR SUPPLIER			١	STREET ADDRESS, CITY, STATE, ZIP CODE			
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		4	200 NURSING HOME LANE			
				1	PIKEVILLE, KY 41501			
(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 APPROPRI			COMPLETION DATE	
{F 725}	Continued From page 639  The resident required intubation and was admitted to the Intensive Care Unit (ICU) with diagnoses of hypoxemia (not enough oxygen to		{F 7	'25)		80		
	sustain life), Pneumor Encephalopathy, and secondary to prolonge	nia, Acute Metabolic acute respiratory failure, ed hypoglycemia.						
	08/02/2021 at 5:30 PM the facility for a sched 10:45 AM. She stated	nt #321's Daughter, on M, revealed she arrived at fuled visit on 07/18/2021 at Resident #321 told her						
	(67) mg/dL that morni stated that she left the 3:00 PM that day and	ad dropped to sixty-seven ng. However, the daughter e facility at approximately no staff member obtained						
·	the resident's blood gl She stated Resident # his/her lunch meat wh							
	daughter visited Resid	nt #321's Spouse, on M, revealed his/her her dent #321 on 07/18/2021. e daughter reported that the						
	resident's glucose was facility smelled of uring and washcloths were	s low that morning, the e and the resident's blanket soiled from the resident's						
		he/she had talked to telephone numerous times						
	he/she could tell his/he low because of the wa							
	had still not re-checke 4:00 PM, since that me							
	spouse stated at appro 07/18/2021, was the la	ne facility at 10:45 AM. The oximately 4:00 PM on ast time he/she spoke to be resident reported ringing						

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_				20/2024	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, 2 200 NURSING HOME LANE PIKEVILLE, KY 41501	ZIP CODE	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 B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			- 1	(X5) COMPLETION DATE	
{F 725}	Interview with State R (SRNA) #1, on 07/27/08/03/2021 at 3:19 Pt working on 07/18/202 and remembered Resbeing low that mornin stated she did not che until sometime after luresident non-responsishe and one other SR on day shift for the encaring for approximate stated that lunch had the floor that day and PM when she found to stated it was difficult to multiple times during not enough staff to do resident was able to reprobably checked on could let you know if sign of the resident's condition of 18/2021 at 11:3 recall Resident #321 hypoglycemic episode on 07/18/2021 (exact SRNA #1 summonsed and she found the resistated she obtained to mg/dL". The LPN starecollection, she had	staff answered the light.  Registered Nursing Assistant (2021 at 4:40 PM, and on M, revealed she was at from 7:00 AM to 7:00 PM, sident #321's blood glucose g. However, the SRNA eck on the resident again unch, when she found the live. SRNA#1 stated that RNA were the only SRNAs attre floor that day, and was ely 40 residents. SRNA#1 been very late arriving to it was probably after 4:00 he resident. SRNA#1 to check on residents the shift because there was be that. The SRNA stated if a ring the call light, staff them less, because they something was wrong. Immediately notified LPN #6 ition.  Bed Practical Nurse (LPN) #6, 80 AM, revealed she did having another enduring the late afternoon time unknown). She stated did her to the resident's room, sident unresponsive. LPN #6 the resident's blood glucose was around forty (40)	{F 7	(25)				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		20	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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	LPN #6 stated she go from the other end of administered Resider Glucagon (hormone is critically low blood glu LPN #6 stated the resconsciousness and it meal, so she gave the eat before the supper Resident #321's med documented evidence resident's hypoglycen resident's blood glucowas no documented the resident's condition the remainder of her difficult to care for all documentation.  Review of Resident #07/19/2021 at 12:23 // the resident unrespondocumentation stated blood glucose and it will the facility subseque	resident since that time.  It Registered Nurse (RN) #1  Ithe unit to assist her and  It #321 an injection of  Injection used to treat a  Illucose) and oral glucose.	{F 7	25}			
	PM, revealed she wo 07/18/2021 until 6:00 assigned to care for F stated she and the nu the floor to care for a residents. The SRNA resident was fine. Sh	#4, on 07/28/2021 at 7:35 rked from 6:00 PM on AM on 07/19/2021, and was Resident #321. SRNA #4 arse were the only staff on oproximately forty (40) A stated at 8:45 PM, the are stated she did not check SRNA #4 stated she was xt round, when the					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER	A. BUILD	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
185256	B. WING			R	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		/30/2021	
DARWIEN DOCT AGUTE AND DEUADN IN-TON COMPA	:	200 NURSING HOME LANE	5	1	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		PIKEVILLE, KY 41501			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 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 725] Continued From page 642  Iaboratory technician arrived on the floor and found Resident #321 unresponsive. Continued interview with SRNA #4 revealed she had received in report that the resident's glucose levels had been low that day. However, the SRNA stated there was no way for her to check on the residents more frequently, when she was the only SRNA on the floor.  Interview with the Laboratory Technician (LT) #1, on 08/02/2021 at 4:45 PM, revealed she arrived at Resident #321's unit, on 07/19/2021 at approximately 12:15 AM, and found Resident #321 unresponsive.  Interview with RN #7, on 07/28/2021 from 7:00 PM until 07/19/2021 at 7:00 AM. RN #7 stated she received in shift report that Resident #321's blood glucose levels had been low during the day The RN stated sometime between 7:30 PM and 8:00 PM, Resident #321 rang the call light and reported he/she thought his/her blood sugar was low. The nurse stated she checked the resident's blood glucose level, and it was one hundred and six (106) mg/dL. However, RN #7 stated she failed to document the blood glucose. RN #7 stated that she and one SRNA were the only staff that worked the floor that night, and she was busy and probably forgot to document. She stated she took the resident some peanut butter and crackers, and the resident stated he/she "just felt funny". RN #7 stated at approximately 9:00 PM, she returned to check on the resident. The nurse stated Resident #321 had not eaten the peanut butter and crackers, so she offered the resident pudding or juice, but the resident's glucose.		25}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		Oc.	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		70012021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
{F 725}	on 07/19/2021, the laid on the floor, and soor Resident #321 was unwhen she entered Refresident was unrespoimmediately tell the relow because the resident stated she checked thand it was thirty-two (because it was only sworked the entire floor other floors to assist I 2. Review of Resider revealed the facility a 03/24/2021 and re-ad 04/29/2021 with diagrifundarction, Dysphagia Obstructive Pulmonal Review of Resident 6 Data Set (MDS) asserevealed the resident two (2) staff with Active review revealed the resident two (2) staff with Active review revealed the MDS Resident #65 was not program.  Review of a Braden Sore Risk form, dated Resident #65 was at to being chair fast and Continued review of Frecord revealed no defined the record revealed of the record record revealed	t approximately 12:15 AM boratory technician arrived after discovered that boratory technician arrived after discovered that bresponsive. She stated sident #321's room, the nsive, and she could esident's blood glucose was lent was clammy. RN #7 be resident's blood glucose, 32) mg/dL. RN #7 stated the and (1) SRNA that br., she called for staff from ther and call the physician.  at #65's medical record dimitted the resident on broses that included Cerebral br., Polyarthritis, Chronic br. Disease and Paraplegia.  5's Admission Minimum brossment, dated 03/30/2021, brities of Daily Living. Further besident was at risk for d on a formal assessment. broad dated 03/30/2021, broad on a turning/repositioning broad on a turning/repositioning broad of the pressure of 103/23/2021, revealed brisk for pressure ulcers due	(F 7	725}			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R <b>30/202</b> 1	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, 200 NURSING HOME LA PIKEVILLE, KY 41501	NE		30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORE	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)	_	(X5) COMPLETION DATE	
{F 725}	05/02/2021 at 10:35 / had developed a dee maroon localized are: blood-filled blister due soft tissue from press coccyx.  Interview with License on 08/25/2021 at 4:00 the deep tissue injury coccyx/sacrum area of the LPN stated she did to being "overwhelmenot enough staff.  Review of a Change of 05/11/2021 at 2:40 Pl pressure ulcer to the measured six and one long and nine and secontinued review of Frecord, including Weethe resident's pressur Review of a Change of 05/28/2021 at 3:54 Pl had a "worsening worphysician sent the resident's pressur Review of a Change of 05/28/2021 at 3:54 Pl had a "worsening worphysician sent the resident's pressur Review of a Change of 05/28/2021 at 3:54 Pl had a "worsening worphysician sent the resident at "worsening worphysician sent the resident at the resident with State F (SRNA) #4, on 08/26, Resident #65's pressur about a month and no She stated she knew "looked bad and sme	of Condition form, dated AM, revealed Resident #65 p tissue injury (a purple or a of discolored intact skin or a to damage of underlying ure and/or shear) to the ed Practical Nurse (LPN) #4, 0 PM, revealed she identified to Resident #65's on 05/02/2021. However, id not measure the area due and with her workload due to of Condition form, on M, revealed the resident's coccyx was "worsening" and e-half (6.5) centimeters (cm) wen tenths (9.7) cm wide. Resident #65's medical ackly skin checks, revealed are ulcer continued to decline. Of Condition form, dated M, revealed Resident #65 und". The form stated the sident to the Emergency unation and treatment.	{F 7	25}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_		,	R 19/30/2021	
	ROVIDER OR SUPPLIER  V POST-ACUTE AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u> </u>	13/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 725}	stated she was unable hours, because she care for, SRNA #4 sturn and reposition ras much as needed, staff.  Review of Resident revealed the hospita 05/28/2021, and diagonal clinically Septic with Associated Infection possible developing	pe 645 Irmed and repositioned, but ble to do so every two (2) had forty other residents to tated staff were not able to esidents with pressure areas due to not having enough  #65's hospital record I admitted the resident on gnosed the resident as being a Pressure Wound and including Cellulitis and Abscess. According to the ulcer "smells like dead	{F 72	25}			
	for Resident #65, rewith a large necrotic sacrum. The operatic extremely extensive amount of fat necros as necrotic tissue". read, "Debrided all of level of the bone".  Interview with Surge PM, who debrided R revealed he was not or diagnosis that corpressure ulcer. He sereposition and improto pressure ulcers and Further review of facility re-admitted R 06/09/2021. Per the	tive report, dated 05/30/2021, vealed the resident presented appearing area on his/her ve report stated, "It was down to the base large sis was encountered as well. The operative report further levitalized tissue down to the son #1, on 08/31/2021 at 1:30 resident #65's wound, aware of any terminal illness attributed to the resident's stated failure to turn and oper nutrition could contribute and progression of wounds.					

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		TPLE CO	(X3) DATE SURVEY COMPLETED		
		185256	B. WNG				R 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	, 33,	3072021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	06/23/2021, and a de heel on 06/26/2021.  Review of Wound Car Resident #65, dated (resident's wounds we resident being bed rid infrequent position chrevealed the sacrum value the facility's last 07/05/2021, and mea: (15.5) cm (length) by one and eight tenth (15.5) cm (length) by on	ew pressure areas to e I (1) to the left heel on ep tissue injury to the right  re Office Visit notes for 07/29/2021, revealed the re consistent with the den, friction, rubbing and anges. The note further wound had increased in size assessment, on sured fifteen and one-half fifteen (15) cm (width) and .8) cm (depth).  re Weekly Skin Check 8/12/2021 at 11:52 AM, 5 had developed a new back of the left, lower leg e resident developed a new eft hip.  are note for Resident #65, 1:00 AM, revealed the ng in the resident's wounds he resident being "bed"	{F 7	25}			
	PM, revealed she cou	ld not perform rounds and heck/change residents,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				੨ <b>30/2021</b>
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	•	20	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 037	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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 725)	there was only one (1 assistants to care for stated when they wentook four (4) hours to Interview with SRNA AM, SRNA #12 on 07, LPN #2 on 07/28/202 facility did not have erreposition residents etc. Interview with Registe 08/27/2021 at 9:55 AM been able to turn and two (2) hours, includir they were so short stated they were so short stated the SRNAs have rounds every two (2) Interview with RN #7, and 08/24/2021 at 3:4 not enough staff to turn as required. She furth assessments were received they do not always cowas not enough staff. Interview with Registe Care Nurse, on 08/25, she could not take care appropriately, because more than she worked because of short staff.	5, every two (2) hours when or two (2) nursing 40 residents. The SRNA is short staffed it sometimes complete just one round.  #14 on 07/28/2021 at 11:43 /28/2021 at 6:08 AM, and 1 at 6:52 AM, revealed the nough staff to turn and every two (2) hours.  #red Nurse (RN) #3, on M, revealed staff had not reposition residents every ag Resident #65, because affed. She stated, "It is dishe had worked by herself ow with approximately forty of to her care. She further we told her they cannot do nours. She stated she with a DON.  on 08/01/2021 at 11:40 AM 99 PM, revealed, there was an and reposition residents her revealed skin quired weekly; however, implete them because there  ared Nurse (RN) #4/Wound /2021 at 8:30 PM, revealed se she had to work the floor is as the wound nurse	{F 7	[25]			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		185256	B. WNG_				R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u>_</u>		<u> </u>
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
{F 725}	was not monitoring the physically could not a Interview with the Adv. Nurse (APRN) #1, who Care Clinic on 08/27/2 Resident #65's pressed bony prominence. He appear to be able to the Continued interview roto wait more than two repositioned, it could interview with Physici 08/27/2021 at 1:18 Pf. Resident #65 had a proposition with the pressed stated he was not away turn and reposition reduce to decreased stated the was not away turn and reposition reduced to decreased stated and reducer could develop a was not turned and recare not provided for a care not provided for the care not prov	wounds as required, she e wounds and she ssess them all.  vanced Practice Registered to worked at the Wound 2021 at 3:14 PM, revealed ture ulcer developed over a e stated the resident did not turn and reposition self. evealed if resident #65 had (2) hours to be cause wound decline.  an #1/Medical Director, on M, revealed he was aware ressure ulcer to his/her ware the resident had sure ulcers. He further are staff were not able to sidents every two (2) hours fing. He stated a pressure ind/or decline if a resident repositioned, or incontinence more than two (2) hours.  at #320's medical record dmitted the resident on hoses including Hemiplegia	{F 7	25}			

	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  N POST-ACUTE AND RE	HABILITATION CENTER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			COMPLETION DATE
{F 725}	Continued From page 649		{F :	725}		-	
	11:20 AM, revealed the black jogging pants a Observation on 07/28 the resident was wea 07/27/2021. Observation?29/2021 at 9:15 Al continued to wear the 07/272021 and 07/28 observation revealed noticeable when close resident's hair had an Interview with Reside 9:00 AM, revealed the ask staff to change hi #320 stated, "I usually three (3) times before resident denied gettin scheduled, stating, the here".  Interview with the DO 9:50 PM, revealed the record for Resident #320 stated the record for Resident #34. Review of Resident #350 PM, revealed the record for Resident #350 PM, revealed the record for Resident #350 PM, revealed the facility at 11/29/2019 with diagrof Coordination and A Review of Resident #350 PM, revealed the facility assessment, dated 00 facility assessed the rescore of twelve (12) of the resident was cognitive to the r	aring the same clothes as on the resident as an unpleasant odor was a to the resident and the oily appearance.  In #320, on 07/28/2021 at a resident frequently had to sher clothes. Resident and the resident frequently had to sher clothes. Resident as a hower twice weekly as a shower twice weekly as a shower twice weekly as a sere was "not enough help to shower as a shower twice weekly as a facility had no shower as a shower twice weekly as a facility had no shower as a shower as a shower twice weekly as a facility had no shower as a shower twice weekly as a facility had no shower as a shower					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 725}	11:10 AM, revealed th	ent #308, on 07/27/2021 at the resident was in his/her Continued observation	{F 7	725)	}			
	revealed the resident' uncombed.	s hair was oily and						
	Interview with Resident #308, on 07/27/2021 at 11:10 AM, revealed staff had not assisted him/her with a bath in nine (9) days. The resident stated, "For about a year it's been hard to get anyone to help you around here." Resident #308 stated meals were late and the food was "cold and not worth eating most of the time". Resident #308 stated it took up to an hour for staff to answer a call light. The resident reported complaining to everyone about not enough help and not being							
:	had been done to corr Interview with the DOI	N/IDON, on 08/18/2021 at			A			
		t #314's medical record					:	
:		Imitted the resident on oses that included Lack of				ļ		
	facility assessed the rescore of ten (10) out or resident was moderate	730/2021, revealed the esident to have a BIMS fifteen (15), indicating the ely cognitively impaired. Resident #314 to require						
	Interview with Resider 12:50 PM, revealed th	nt #314, on 07/27/2021 at e resident reported he/she						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185256	B. WING_			I	R 30/2021	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	EHABILITATION CENTER		200 NU	TADDRESS, CITY, STATE, ZIP CODE IRSING HOME LANE VILLE, KY 41501	1 03/	30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			_	(X5) COMPLETION DATE			
{F 725}	admission to the facility despecially at night.  Interview with the DO 9:50 PM, reveled the record for Resident #6. Review of Resident #6. Review with Resident #6. The revealed the facility twenty-1. The review with the DO 9:50 PM, reveled the record for Resident #6. Review of Resident #6. Review	e (1) bath each week since lity. Continued interview lid not have enough help  ON/IDON, on 08/18/2021 at facility had no shower sal4.  Int #311's medical record admitted the resident on moses that included facility had no shower salf to have a BIMS of fifteen (15), indicating the gnitive impairment. Resident ance of one (1) staff member sing.  Int #311, on 07/27/2021 at he resident reported he/she sale showers since admission three (23) days go. Resident by didn't have enough had stopped using the call mission, because "no one  ON/IDON on 08/18/2021 at facility had no shower sal1.  Int #3's medical record admitted the resident on	{F 7	25}				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	6	185256	B. WING				R 30/2021
NAME OF PI	ROVIDER OR SUPPLIER		'	S	TREET ADDRESS, CITY, STATE, ZIP CODE	U3/	3012021
DADKVIEV	W BOST ACUTE AND DE	HABILITATION CENTER		2	00 NURSING HOME LANE		
TARRET	TOST-ACUTE AND RE	HABILIATION CENTER		Р	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	Continued From page	652	{F 7	'25}	la.		i
	facility assessed their score of fifteen (15) of the resident was cognof the MDS revealed to assistance with dress assistance with toileting linterview with Reside 10:00 AM, revealed the attended resident countated every meeting residents always voice meals served late, can showers not given, and provide care. However, "Nothing has been do as considered with the arrived on the unit at thours later than scheen on the cart. Further of was the only staff pass PM until 2:04 PM. St. 2:16 PM.  Observation of the test of the pureed meat was Fahrenheit, potatoes Fahrenheit, degrees Fahrenheit awas sixty (60) degrees with the content of the test of the pureed gegrees Fahrenheit awas sixty (60) degrees	7/22/2021, revealed the resident to have a BIMS' aut of fifteen (15), indicating shitively intact. Further review the resident required ing and extensive and personal hygiene.  Int #3, on 07/28/2021 at the resident routinely sincil meetings. The resident he/she attended the ed concerns over cold food, and not enough staff to er, the resident stated, and."  705/2021 of the lunch meal first fourth floor meal cart 1:59 PM (approximately two duled) with twenty (20) trays beservation revealed RN #8 asing meal trays from 1:59 aff passed the last tray at st tray food temperatures, on imately 2:16 PM, revealed ninety (90) degrees ninety-two (92) degrees areen beans ninety (90) pureed bread eighty (80) and cold chocolate pudding is Fahrenheit.					
	Observation on 08/05	/2021 revealed the second					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B. WING	<u> </u>			R <b>30/202</b> 1
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	031	0012021
(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 725}	fourth floor meal cart PM (approximately 2 than scheduled) with Observation revealed was passing trays. S resident tray at 2:35 f Observation of the se food temperatures, or approximately 2:35 P steak with gravy was degrees Fahrenheit, hundred twelve (112) mashed potatoes one degrees Fahrenheit, (fifty-eight (58) degree hundred eight (108 dechocolate pudding was Fahrenheit.  Interview with State F (SRNA) #16, on 07/2 the facility was short The SRNA stated the SRNAs for night shift had only been one (1 for forty (40) residents service was always to PM before the kitched The SRNA stated the could pass trays and some of which required interview with Registe 07/29/2021 at 9:30 P confirmed the facility stated there should be on the fifth floor for the	arrived on the unit at 2:10 hours and 10 minutes later fifteen (15) trays. I only one (1) staff person staff delivered the last PM.  cond meal cart test tray n 08/05/2021 at M, revealed chicken fried one hundred and four (104) whole kernel corn one degrees Fahrenheit, hundred twenty-four (124) two (2) percent milk was as Fahrenheit, coffee one degrees Fahrenheit and cold as sixty-eight (68) degrees  Registered Nurse Aide 7/2021 at 8:10 PM, revealed staffed especially at night, re should be three (3) However, for months there SRNA scheduled to care s. SRNA #16 stated meal ate and at times, it was 8:00 in delivered trays to the floor, re was no way one (1) staff assist forty (40) residents, ed total feeding.	{F 7	(25)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		2, ,,,,,,,		TREET ADDRESS SITV STATE TO ASSE	09	/30/2021	
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE	
{F 725}	she had reported staff ADON/IDON and the occasions. RN #9 also resident call light come complaints, but she had recalled an incident wago. RN #9 stated the to provide 1:1 supervited However, RN #9 stated Administrator that the residents on the floor were the only staff on and that level of residents on the floor were the only staff on and that level of residents on the floor were the only staff on and that level of residents on the floor were the only staff on and that level of residents on the floor to ensure the Interview with the Ass Nursing/Interim Direct (ADON/IDON), on 08/revealed she had worked approximately one (1) been inadequately stated she had worked more than she had be administrative nursing stated she had worked (7) nights on the floor stated she was aware getting showers, not gare, not being turned receiving appropriate the lack of staff. The wayare that meals were	standard of Services of Servic	{F 7	25}				

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  V POST-ACUTE AND RE			S1 20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	USI	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 725}	food cart did not arrive 8:00 PM in the evening and assist residents in (1) SRNA and the number medications at that time the country in the Adri 6:00 PM, revealed shours a staffed and did nurse aides. The Adri "good ratio" was ten (1) assistant, and that was facility. The Administration (2) nurses and fool floor for day shift (7:00 nurses and three (3) a PM-7:00 AM). However, the facility had not measure she had been a Administrator stated so only one (1) SRNA are care to approximately because the facility with the Administrator state those staffing number facility. The Administri in and was unable to cover the shift resulting the Administrator state those staffing number facility. The Administrator the Administrator the Administrator there was an inadequation for them. The Administrator state was aware that of were routinely caring patients, she denied it were not receiving she	N/IDON stated when the e on the floor until 7:00 or ag, it was difficult to serve because there was only one ses were administering an eand could not help.  Ininistrator, on 08/11/2021 at e was aware the facility was not have enough nurses or ministrator stated optimally a 10) residents per nursing as the goal for staffing in the ator stated there should be ur (4) nurse aides on each 0 AM-7:00 PM) and two (2) aides for night shift (7:00 over, the Administrator stated et those staffing numbers to the facility. The she was aware there was and one (1) nurse providing forty (40) residents as short staffed. However, ed the facility had not met as since she had been at the ator stated when staff called come, there was no one to	{F 7	25}			

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		185256	B. WNG	-			R /30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	effective 09/26/2021:  1). Braden Scale Asson all residents by fact and comprehensive for were completed on all The facility utilized the and comprehensive for review and update cat had pressure injuries  2). The wound care pleasured all pressure evaluated all current to the Medical Diagrams. Beginning 09/17/2021.  3). Beginning 09/17/2021.  3). Beginning 09/17/2021.  3). Beginning 09/17/2021.  2) Beginning 09/17/2021.  3) Beginning 09/17/2021.  3) Beginning 09/17/2021.  3) Beginning 09/17/2021.	che following was we Immediate Jeopardy  essments were completed cility nurses on 08/28/2021 all body skin assessments. I residents on 09/11/2021. The Braden Scale Assessment to be plans of residents who be open of the plans of the pl	{F 7	725)			
	4). Residents #45, #6: and #320 were bathed care and moisturizing and assisted with dres clothing. Clean linens residents' beds on 09/	ening of pressure ulcers.  5, #308, #309, #311, #314  d including a shower, nail lotion applied post shower, saing in clean appropriate as were placed on the /11/2021. The residents cial services on 09/15/2021.					

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		185256	B. WING				R
	ROVIDER OR SUPPLIER  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 725}	by the Director of Nur New bath/shower sch by nursing staff to acc preference. Resident were obtained and inceplans and State Regist care plans by the Regist care plans by the Register ecompleted on 05 care plans by the recommendations for supplements to prome any weight loss issues care plans with the control of the plans of	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 2/13/2021.  Re Registered Dietitian (RD) esidents' diets and made meal changes or one healing and to address s.  The diagnoses of Diabetes ive Pulmonary Disorder Pneumonia were assessed lor Respiratory Therapist is identified completed.  Re reviewed all residents is monitoring by 07/30/2021 anded to include mandatory is on the Medication of (MAR).	{F 7	725)			
	recruitment efforts wit	ng was increased through					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE COMP	SURVEY LETED
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	,	185256	B. MNG			09/	30/2021
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		21	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IMMARY STATEMENT OF DEFICIENCIES  DEFICIENCY MUST BE PRECEDED BY FULL  ATORY OR LSC IDENTIFYING INFORMATION)  DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		(X5) COMPLETION DATE			
{F 725}	day will be reviewed of Nursing and the Adm levels are adequate to residents. The staff won the unit at the starf pricetor of Nursing, Madministrator or design staff call offs will be requalified staff to see it and/or calling agencial qualified staff to fill the cannot be replaced the Assistant Director of nursing management appropriate staffing lecenter will prioritize reachieved during emerequired task including medication, no showed provided to incontine that cannot turn self, assist residents with through recruitment estaffing levels have be meals are prepared at 12). On 08/11/2021, at 486 and 4322, were and physical forms of for Mental Status (Blig above and skin integral BIMS less than eight Licensed Nurse. Respendital had their Crevised, as necessary	raff schedules for the next daily by the Director of inistrator to ensure staffing or meet the acuity of the rill be validated as present to feach shift by the dursing Supervisor, gnee. Direct care nursing eplaced by calling other of they can fill the opening esto see if they have ele opening. If direct care staffine Director of Nursing, Nursing, or member of the exteam will fill the shift. If exels cannot be met, the esident care that can be regency staffing, prioritize and administration of ers-sponge baths, care not residents, turn residents meals served timely, and meal if needed.	{F 7	(25)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
(F 725)	wandering risk asses. 08/16/2021. All reside at risk for wandering lupdated by the MDS identified active wand placed at each nursing potential interventions.  14). Residents #39, # #332 were weighed be Registered Dietician (comprehensive nutritive recommendations were commendations by (DON) or designee of DON or designee, specified into the election of the tray card. The Redirector of Nursing (Din electronic medical record and tray card information on 09/17/15). Beginning 09/15/15, snacks to all resident afternoon by the restraides, or designee. Sphysician will be docuated, dietary aides and 16). The facility evaluations.	ied as indicating any onlysical harm.  It see Consultant completed a sment on all residents by ents who were identified as had care plans reviewed and Coordinator. A list of all ler risk residents were g station with a list of s for nursing to reference.  If s, #81, #90, #330 and by 09/17/2021. The (RD) completed a sion assessment and RD are reviewed for the Director of Nursing to 09/17/2021. Further, the oke with the attending and validated the diet orders s. Recommendations were ronic medical record and on gistered Dietician and DON), reviewed diet orders record to ensure both the reflected accurate 2021.  If 2021, staff began offering is daily in the morning and corative nurse aide, activity macks ordered by a umented by the restorative id/or licensed nursing staff.	{F 72	25}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/S IDENTIFICAT	TON MUMPED	MULTIPLE UILDING	CONSTRUCTION	(X3) DATE COMP	SURVEY
	185256 B. W	1NG			R
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION	CENTER	20	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501	09/	30/2021
(X4) ID SUMMARY STATEMENT OF DEFI PREFIX (EACH DEFICIENCY MUST BE PRECE TAG REGULATORY OR LSC IDENTIFYING I	DED BY FULL P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
implemented yellow and red zones. identified two (2) residents who had exposed to positive residents and a was designated with erection of a pl barrier and those two (2) residents v this zone on 08/11/2021.  17). The facility had three (3) resider in the red zone on 08/11/2021(Resider) and #328 and #329). Residents #327, #3 have completed quarantine per faciliphysician orders. Residents #311 arrompleted quarantine per COVID-19 physician's order. Residents #311 arrompleted quarantine per COVID-19 on 09/16/2021. The facilitidentify any new cases based on the testing on 09/16/2021. All residents tested for COVID-19 on 09/17/2021. did not identify any new positive cas 19). The facility was conducting ong surveillance testing as recommende COVID-19. Positive COVID-19 residents in isolation zone (red zone) and droplet precautions with use of personal placed in isolation zone (red zone) and droplet precautions. The DON or designer newly positive COVID-19 residents to isolation precautions have been initial addition, any resident exposed will be droplet precaution in isolation zone (facility will provide physician notification and care plan revisions. employee testing protocol will be twit designated days effective 08/16/202	The DON been yellow zone astic zip wall vere moved to  Ints who were dents #327, 328 and #329 ity policy and and #314 policy and and #314 were  Itested for ty did not e employee eligible were The facility es.  In provide tion and care e will review o ensure ated. In e placed in tyellow). The tion, family The facility ce weekly on	{F 725}			

	E SURVEY MPLETED					
		185256	B. WNG_			R 9/30/2021
	ROVIDER OR SUPPLIER  **POST-ACUTE AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 725}	days. If the employer not allow the employer not allow the employer negative COVID-19 employee will be test facility by the Infection designee. All testing posted to the employee common areas.  20). The facility scree for signs and/or symmodocumented on the Record (MAR). The monitoring for signs residents on 09/17/2  21). Resident #9, Resident #326 and I were reviewed for usuadministration times 09/23/2021.  22). The facility state their medication as and implemented phrotification if any medication if any medication regarding  23). The facility will abide physician regarding  23). The facility with the the facility with a thromedications that regarding the facility with a thromedications that regarding states and the facility after normal the facility after nor	st be tested on designated te is not tested, the facility will yee to work without a current test. During testing, the sted prior to entering the on Prevention Nurse or dates and times will be yee page, time clock and  ens all residents once a shift uptoms of COVID-19 and Medication Administration facility implemented and/or symptoms on all 2021.  esident #321, Resident #324, Resident #351, medications sage and appropriate by the physician on  ed all residents will receive ordered beginning 09/23/2021 farmacy and physician edication was unavailable. The by new orders from the the unavailable medication.  facility's pharmacy to provide	{F 72	5}		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		185256	B. WNG		_		R 30/2021
	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, ST 200 NURSING HOME LANE PIKEVILLE, KY 41501			OUTSUS !
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	submitted to pharmace integration. The facility fax transmittal as a bat pharmacy integration electronic medical recoll fithe facility does not timely manner the phat the facility will utilize the facility manner the physical substitution and/or nervices.  25). The Regional Nur Nursing, and licensed audit of all residents of verified all medication facility by 09/25/2021.  26). The facility conduperformance Improve 08/12/2021. The facility process, and a ensure compliance with The Administrator over The QAPI committee Nursing, Administrator over The QAPI committee Nursing, Administrator on 09/13 current Administrator. Administrator on 09/13 current Administrator will received and process of Capital Director of Capital Services of Capital Director of Capital Services of Capital Director of Capital Services of Ca	ronic medical record and by through pharmacy ty implemented the use of ackup to the electronic by entering the order in the cord to receive medications. The receive medications in a sarmacy will be notified, and the emergency medication rises and medication is scian will be notified for worders.  The Consultant, Director of a nursing staff completed an ordered medications and is were available in the second of the entering on the entering of	{F 7	25}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	determine if continued The administration has responsibility to direct communicate areas of improvement.  28). The Administration QAPI Committee revice contact person for call Activities of Daily Living timeliness of meal traturning and reposition.  29). The Vice Preside Clinical Operations are Consultants conducted 09/15/2021 with a core consultation to review outcomes of the survey roles of the Governing Rules and Regulation the following communifiection Control (CO staff at the facility to inturn and reposition recare, prepare and dis residents with eating, effective Pharmacy Sand neglect effectively appropriate ADLS, and QAPI committee.  30). The Administrato Consultant reviewed a beginning 09/16/2021 and/or revisions to the the 09/16/2021 meetic	will audit the Administrator to did aily oversight is needed. Its direct oversight and it, discipline, and if concern and process or, Medical Director, and ewed procedures for a lil-ins, answering call lights, ang (ADL) Care, serving, and ys incontinence care and ining on 09/15/2021.	{F 7	725}			

195256 R WING	R 09/30/2021	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	30/2021	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
(F 725) Continued From page 664 reviewed as needed at the CAPI meetings. The agenda included reviewing pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, hospital readmission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns, grievances, admissions, discharges, census, staff development, vacant positions, employee orientation, dietary variances, tray audit report, weight loss, work injuries, terminations, employees on family medical leave, a leave of absence, new hires, medical record compiliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include, but not limited to, the topics presented during the meeting.  31). The Regional Director of Operations and Vice President of Operations mut with the Administrator, the DON, and the Medical Director on 09/16/2021 regarding the duties of the Governing Body, including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body, including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body, including setting policy and procedures and, auditing systems per the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes with the utilization of the five (5) why approaches and, auditing systems per the QAPI Calendar. The Administrator will collect all monitoring reports before each QAPI Committee meeting.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI		E CONSTRUCTION		SURVEY
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	ROVIDER OR SUPPLIER  **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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
{F 725}	09/10/2021 survey. Q 09/16/2021 to discuss interventions to removimplemented QAPI m (4) weeks, as needed Administrator will forw minutes to the Govern including the Vice Preside Regional Vice Preside Regional Nurse Consiresults. The QAPI on audits at the QAPI mereview. The Administrator of Nursing, Addirector, Social Service Clinical, Therapy, Mail Environmental Service 33). The Governing Be Administrator with resematerials for QAPI, and guide to effectively impleginning 09/16/2021 meet quarterly for the reevaluate for frequentally. The Administrator of QAPI Committee m (4) weeks and, as need to ensure the quality ocomplies with the standard policy of the standard policy with the standard policy with the standard policy of the standard policy with the standard policy policy with the standard policy policy policy with the standard policy poli	for review to ensure eficiencies cited during the API Meetings were held on a abatement and develop by the jeopardy. The facility eetings weekly, times four and monthly. The facility eating sold members, sident of Operations, and the facility enting Body members, sident of Operations, and the facility entitles will review the audit for eview the audit for eview the entings. Committee for eator oversees the QAPI of Committee consists of the diministrator, Medical eas Director, Activities, intenance, Dietary and eas.  Following but not limited to the ta Glance, and a resource plement the QAPI plan. The Governing Body will upcoming year and cy after one (1) year.  Find increase the frequency eetings to weekly for four ded effective 09/16/2021, if care is monitored and dard of care and and Federal requirements	{F 7	25}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		185256	B. WNG			1	R
NAME OF P	ROVIDER OR SUPPLIER		1 1 1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
	W POST-ACUTE AND RE				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 725}	Director of Nursing, M designee on proper w obtaining, documentir changes to the Regist 09/17/2021.  36). On 09/13/2021, to Dietary Manager (CDI Manager on the provisus assessment to ensure diet order accuracy, a orders into the electron CDM educated the Diresident diet orders in the nurse enters the ownitten communication including diet and text meetings, staff will reversious day to ensure 37). Therapy provided staff on turning and position and transfer of resider chair to bed beginning completed on 09/17/2 and assigned addition and agency contracts turn and reposition all reposition themselves  38). The Regional Direction and agency contracts turn and reposition all reposition themselves  38). The Regional Direction and agency contracts turn and reposition all reposition themselves	IDS Coordinator, or reighing techniques, and, and reporting weight tered Dietician by  the Regional Certified M) educated the Dietary sion of timely nutritional ediet order accuracy, on and on when to enter diet unic medical record. The etary Manager to enter to the tray care system. If order, the nurse will send a an to the dietary staff, ture. In the morning clinical view diet orders from the eaccuracy.  I education to all nursing obstitioning range of motion, and from bed to chair and gon 08/19/2021 and 021. The facility employed hal staff through recruitment to ensure adequate staff to residents who cannot become a control of Nursing educated assure ulcer prevention, repositioning, adequate an positioning devices, how ment a head-to-toe skin to notify the registered	{F 7	25}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		SURVEY PLETED
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		.D BE	COMPLETION DATE
{F 725}	new skin changes.  39). The DON or desitimely call light responsitif, 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.  40). On 08/31/2021, 70 Nursing educated all If 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 Resulcensed nurses on it residents with a change of the condition of the electronic meand intervention. In Director of Nursing edexisting care plan in the with new goals and in impairments identified 41). The facility's Resulcensed nurses on it residents with a change in condition, do and/or designee education designee education of the protocol, docton the medical rephysician and following facility licensed nursing work until they have residents with the place.	gnee educated all staff on ase. In addition, direct care and certified nursing ded education on providing a resident's plan of care, and resident's plan of care, and residents in their choice timely delivery of meal signee will educate any and during education upon the Regional Director of icensed nursing staff, the the Social Service Director, on entering new care plans addition, the Regional functional during their shift.  Privatory Therapist educated terretions for any new skin and during their shift.  Privatory Therapist educated tentifying and assessing a in respiratory status on a no 08/12/2021, the DON ated all licensed nurses on a stoms of ycemia, the facility's	{F 7	25}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	- 1	IPLE CONSTRUCT	TON		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				₹ 30/2021	
	F PROVIDER OR SUPPLIER  VIEW POST-ACUTE AND REHABILITATION CENTER  SUMMARY STATEMENT OF DESICIENCIES			STREET ADDRE		[	<u> </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 ACH CORRECTIVE ACTION SHOULD B DSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 725}	during mandatory in-s  42). Beginning 08/12/ licensed nurses on co Plan with intervention diabetes and a respirat hours of admission, re copy to the resident a Licensed nursing staff education was notified will not be allowed to received this educatio  43). Beginning 08/12/ staff on the facility's "c 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 immediat before the start of the not have appropriate immediate supervisor other qualified staff to off. If emergency staff Administrator and/or c assistance from staffin working will be in-sen  44). All staff were pro-	services.  2021, the DON educated impleting a baseline Care is and goals relevant to atory diagnosis within 48 eviewing and providing a ind/or the responsible party. If not working during dief of ongoing education and work until they have in.  2021, the DON educated all call off" procedure. The ithe facility included: in the ito call out of work for otify their immediate before the start of the shift. If on the night shift, they are ste supervisor four hours in shift. If the facility does is staffing levels, the and/or designee will call replace the person calling fing is required, the designee will call for ing companies. Staff not viced upon return to work.  Vided re-education by the designee on 08/12/2021 on ing, preventing, and ell as identifying and ate interventions for	{F 7	25}				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION 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		2	TREET ADDRESS, CITY, STATE, ZIP CODE TOO NURSING HOME LANE PIKEVILLE, KY 41501	05/	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	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 Die order into the tray car review diet orders from clinical meeting to ensure the content of the tray car review diet orders from clinical meeting to ensure the content of th	in in its continuity of the side of the population.  In its continuity of the side of the population.  In its continuity of the side of the population.  In its continuity of the side of the population.  In the Regional CDM with the dietary manager on the side of the population.  In the Regional CDM with the dietary manager on the side of the population.  In the Regional CDM with the dietary manager on the side of the population.  In the Regional CDM with the dietary manager on the side of the population.  In the Regional CDM with the dietary manager on the side of the population.  In the Regional CDM with the dietary manager on the side of the population.  In the Regional CDM with the dietary manager on the side of the populations are scoop sizes, and/or the side of the populations are scoop sizes, and/or the pietary the side of the p	{F 7	(25)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING	<u> </u>			R /30/2021
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP ( 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	1 00,	332021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B THE APPROPRIA		COMPLETION DATE
{F 725}	DON and/or designed COVID-19 policy/guid donning/doffing Perso (PPE), yellow and red DON/designee educated monitoring residents fibeginning. 08/12/202 educated all staff, includer end working. Dur 08/12/2021, the Covid handwashing policy, ored and yellow zones, for signs/symptoms or reviewed.  50). Staff were provid 08/20/2021 by the DORegional Nurse Consistymptom monitoring of admissions into the residucated on the five (administration, includication, included patient, right dose, rig Regional DON/DON/olicensed nursing staff the process to follow available for administreducation included cathe medication, obtain medication delivery time ordered medication woutside of the ordered education also included given by the MD, docuand new orders from the control of the ordered education also included given by the MD, docuand new orders from the control of the ordered education also included given by the MD, docuand new orders from the control of the ordered education also included given by the MD, docuand new orders from the control of the ordered education also included given by the MD, docuand new orders from the control of the ordered education also included given by the MD, document of the ordered education also included given by the MD, document of the ordered education also included given by the MD, document of the ordered education also included given by the MD, document of the ordered education also included given by the MD, document of the ordered education also included given by the MD, document of the ordered education also included given by the MD, document of the ordered education also included given by the MD, document of the ordered education also included given by the MD, document of the ordered education also included given by the MD, document of the ordered education also included given by the MD, document of the ordered education also included given by the MD.	vided re-education by the by 09/17/2021 on the lelines, handwashing, onal Protective Equipment I zones. In addition, the ted, licensed staff on for Covid-19 symptoms 11, the DON/designee luding contract staff, who ring the QAPI meeting on Id-19 policy, the donning and doffing PPE, and monitoring residents of the Covid-19 were  ed re-education on DN, Regional DON, or cultant to enter COVID-19 porders on all new resident's record.  Ing staff have been 15) rights of medication on gright medication, right that 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 ting the anticipated	{F 7	725}			

	OF DEFICIENCIES 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	EHABILITATION CENTER		200 NURSI	DRESS, CITY, STATE, ZIP CODE NG HOME LANE E, KY 41501	1 031	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	52). On 09/25/2021, Consultant educated including new hires a use of the emergency in place for ensuring notifying the physicia re-admitting resident after-hours.  53). The Interim Admon his contact inform Coordinator from 09/In addition, education who to notify if unablishift.  54). The facility will a head-to-toe skin asset through Friday, for the 09/17/2021 to ensure weekly on each reside will notify the physicial Responsible Party of and those new interviplace to prevent decided to prevent decided to the property of the conducted weekly for weeks effective 09/1 three (3) months.  56). The Director of Mursing (ADON), or resident progress no effective 09/13/2021.	the DON /Regional Nurse all licensed nursing staff, and/or agency staff, on the y medication kit, the system medications are in-house, or in for new orders for new or s, including on weekend and attinistrator educated all staff attion and role as the Abuse 13/2021 through 09/17/2021. In on staffing schedules and it to work their scheduled audit weekly resident essments daily, Monday aree (3) months effective they have been completed alent. In addition, the facility an, Registered Dietician, and if any new skin impairment rentions have been put in	{F 7	25}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION UILDING			(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 CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	<u> </u>	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		ON SHOULD B		(X5) COMPLETION DATE	
{F 725}	Supervisor conducted areas of skin impairm plan implemented to it 57). Beginning on 09/leadership staff and/or rounding of residents incontinence, and res residents will be visual shift daily for two (2) visual residents each shift for twenty-five percent of (4) weeks. The facility to 6:00 PM and 6:00 It began visual monitoring response times, including that are answered, a staff will conduct ten each shift for two (2) light observations each shift for two (2) light observations each shift for two (2) the gan monitoring response times in respiration Background Recommendation (SE acute change in respiratory status for implementation of any Plans were reviewed Audits will be daily for times a week for four 60). The MDS Nurse,	on Monday. The Nursing and audits to ensure any new ent identified had a care include new interventions.  11/2021, the facility's or designee began visual assessing hygiene, toileting, ident repositioning. All ally rounding on once each weeks, fifty percent of the perfour (4) weeks, and residents each shift for four visual has two (2) shifts, 6:00 AM PM to 6:00 AM.  The facility's leadership staffing and timing of call light ding the length of time call 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 piratory assessments and Assessment and Assessment and BAR) communications for ratory status Monday clinical morning meeting, any acute change in Physician notification and viphysician order. Care and updated as needed.	{F 7	25}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING			·	R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	_	200 N	ET ADDRESS, CITY, STATE, ZIP CODE URSING HOME LANE VILLE, KY 41501	001	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 725)	baseline Care Plan w 61). All residents adm days with a diagnosis Obstructive Pulmonal Asthma, or current Pr Care Plan reviewed a the MDS Nurse(s) an interventions will be a morning meeting by th nursing designee. 62). Beginning on 08/ DON, and/or Designe admissions and re-ad care plans for comple with the resident and/ variance or identified immediately. Audits w through Friday for all to the facility for four of admissions for a weethen ten percent of ac weeks. 63). On 09/11/2021, the designee began audit meal trays to resident All three (3) units daily (1) meal on all three ( weeks. 64). On 08/15/2021, the gan audits of staff's	admissions and ure staff completed the ithin 48 hours of admission.  Thitted within the last thirty of Diabetes, Chronic by Disease (COPD), neumonia had their baseline and updated as needed by dor designee. New added to the care plan in the the DON, ADON, and/or	{F 7	25}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	E	09/30/2021
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	
(F 725)	signs/symptoms of hy the facility's diabetic p change in a resident's physician and followin Leadership will quiz shifts; ten (10) staff for staff a week for four (4) staff a week for four (4) began monitoring all coresults Monday through morning meeting. The any blood sugar result range for MD notification any Physician's Order reviewed and updated designee will complete diabetic residents acre (3) units to identify any signs and symptoms of hypoglycemia/hypergl resident was immediated one (1) week, then five (4) weeks.  66). On 08/13/2021, the designee implemented questionnaire on abust residents with wander the proper reporting of units. The employee a completed for five (5) then three (3) times a	perglycemia/hypoglycemia, protocol, documenting a condition, notification of the graphysician's orders. taff randomly across all rone (1) week and five (5) 4) weeks.  The DON and/or Designee documented blood sugar graph Friday in the clinical and implementation of s. Care plans will be a visual rounding on the avisual rounding on the earth of the protocoment of the protoc	{F 7	725}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	50	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/-	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG		SHOULD BE	TE	(X5) COMPLETION DATE
{F 725}	Nursing and/or design resident's wandering admission and quarte Set (MDS) assessmer wandering will be discomposed in the Director of Nursing Nursing, or nursing design interventions. Any variation of eight (8) or greater the facility and have now itnessed abuse. The review random weekly residents with a BIMS to ensure no injuries of 08/13/2021. Any variation will be addressed immediate the diet/tray card so facility and have now itnessed abuse. The review random weekly residents with a BIMS to ensure no injuries of 08/13/2021. Any variation will be addressed immediated audits of reflectronic medical recommediated audits of reflectronic medical recommediated audits of reflectronic medical recommediated in the diet/tray card so facility and the normal reaching be conducted for randome (1) week, twice per and then weekly for outrays arrive at the unit	13/2021, the Director of nee will review each risk assessment upon riy with their Minimum Data nt. Any resident identified as cussed in the clinical eview and initiate new riance or identified concerns nediately. New interventions in the morning meeting by g, Assistant Director of resignee.  13/2021, the Social resignee will perform residents with a BIMS score to ensure they feel safe in not been subject to or a DON or designee will y skin assessments for a score of less than eight (8) of unknown origin beginning rece or identified concerns nediately.  The Registered Dietician resident diet orders from the resident diet orders entered of tware to ensure accuracy.	{F 7	725}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1, ,	IPLE CONS	·	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		200 NUF	ADDRESS, CITY, STATE, ZIP CODE RSING HOME LANE LLE, 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 725)	residents promptly. To designee will audit the trays to residents after beginning 09/11/2021 observed on each unit two (2) meals on each weeks, one (1) meal of weeks.  71). The dietary mana admitted/re-admitted beverage preferences admission and enter to system for listing on the completed bi-annually residents. Physician-be audited by the Die (1) week, weekly for fafter that for four (4) rog/15/2021.  72). Daily COVID-19 audited beginning on Resources (HR) Direct punches to ensure so their shift. Audits will be through Friday for four Director, and weeken staff not screened will immediately on the Coving punches an infection condoors will remain lock doors will remain lock.	ed nursing assistants assist The Dietary Manager or the time it takes to pass meal or they arrive on the unit . 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 y and as needed for all ordered snack intakes will tary Manager daily for one our (4) weeks, and monthly months beginning  screenings for staff will be 08/25/2021 by the Human ctor against time clock reening before beginning be completed Monday or (4) weeks by the HR ds audited on Mondays. Any l be re-educated OVID-19 Screening Policy	{F 7	25}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE COMP	SURVEY
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-	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER	<i>5. W</i> <sub>1</sub> (0)	200	REET ADDRESS, CITY, STATE, ZIP CODE  NURSING HOME LANE	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	designee will round s for eight (8) weeks, fi (4) weeks to audit infi differing shifts and un observation of handw and zones; donning/o PPE; and mask comp identified concerns w by the auditor.  74). The DON, ADON review all residents o pharmacy to ensure a beginning 09/23/202 physician within two expiration.  75). The Regional Nu and/or Director of Nu medication pass obso 09/25/2021 on rando jeopardy removed to accuracy of medication CMS Critical Element Administration to com observation of twenty  76). Beginning 09/25 Friday, the DON, ADO audit medication delim medications daily to e needing a renewal ha pharmacy. Audits will Immediate Jeopardy  77). Beginning 09/11 and/or DON will be re-	/17/2021, the DON and/or even (7) times each week ve (5) times weekly for four ection control compliance on aits. Audits will include vashing; isolation signage doffing (putting on/taking off) obliance. Any variance or ill be addressed immediately  N, and/or Designee will narcotics with the an active script is on file Staff will notify the (2) days of the prescription's arse Consultant, Pharmacy, rsing will conduct random ervations effective m shifts daily until immediate ensure timeliness and ons. The facility utilized the transparent passivations.  //2021 Monday through ON, and/or Designee will very tickets against ordered ensure that all narcotics are been sent to the continue until the	{F 7	225}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501	, 05	3012021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	Dietary Manager will I dietary staffing daily for adequate staffing.  79). Beginning 09/11/President of Operation monitor and audit the days to ensure complements of the days to ensure condition and identified Watch" (change of condition and identified watch "Change of the days of the da	naintained.  2021, the Administrator and be responsible for reviewing or four (4) weeks to maintain  2021, the Divisional Vice instant and/or designee will Administrator daily for 30 iance.  Will be conducted beginning infor residents' change of ration of need for "Stop and indition) communication.  2021, the Administrator or interviews of residents with a 33 or greater to ensure they and had not been subjected in No residents had any will continue to be is by the Administrator or ill immediate jeopardy is gency validated the facility's Immediate Jeopardy on I by:  -Toe Skin Assessments and all residents in the facility ew of the skin assessments dents (Residents #65, #27, #74, and #358) had is with a total number of	{F 7	725}			
		enty (20). A review of the plans for Residents #65,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	<u> </u>	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 725}	the resident's current facility completed the A review of the facility revealed staff assess pressure ulcers with t with the Regional DO revealed she complet assessment on all resident revealed that t (20) total pressure injusted facility completed assessments on all resident revealed that the Continued interviews Interdisciplinary Team assessments and Braupdate the residents' Resident #65, #324, # and #358's care plans current pressure injusted with MDS Nurse #1 or revealed she updated reflect current pressure addition, she complet rounds on 09/15/2021 the Registered Dietici DON, and the MDS New 1824, #45, #14, #357 review revealed the Irreviewed each resident's orders care plan, and implem 2). Review of Resider revealed the Medical resident on 08/25/202	d the care plans to reflect pressure injuries. The review on 09/17/2021.  I'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 Braden Scale and the facility identified twenty the Braden Scale and the Braden Scale and the Braden Scale and the sidents on 08/28/2021.  I revealed the and the stated that the Braden Scale and the stated that the stated the stated the stated that the stated that the Braden Scale and the stated that the Braden Scale and the stated that the stated that the stated the stated that the stated that the stated that the stated the stated that t	{F 7	725}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		SURVEY
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 03	3972021
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{F 725}	and a skin tear to the Resident #65's wound 08/26/2021 at 9:00 Al wound measured, "13 12.3 cm width and 0.2 at 10 o'clock measurin 12 o'clock that measured with wound continued to treat the ulcer with Aquacel Ag evaluation completed Resident #65 had six including a stage two measuring 1.2 cm (let 0.1 cm (depth), stage measuring 2.5 cm by stage two (2) to left hicm x less than 0.1 cm scapula measuring 1 0.1 cm, unstageable tom by 0.6 cm. and fo measuring 12 cm by Interventions in place heel protectors while weekly documentation mattress to bed, nutrifurning/repositioning, for the sacral pressuring 12 cm by 0.3 cm with the desired the sacral pressuring 11 cm by 0.3 cm with the desired the sacral pressuring 12 cm by 11 cm by 0.3 cm with the desired the sacral pressuring 12 cm by 11 cm by 0.3 cm with the sacral pressuring 12 cm by 11 cm by 0.3 cm with the sacral pressuring 12 cm by 11 cm by 0.3 cm with the sacral pressuring 12 cm by 11 cm by 0.3 cm with the sacral pressuring 12 cm by 11 cm by 0.3 cm with the sacral pressuring 12 cm by 12 cm by 13 cm with the sacral pressuring 14 cm by 15 cm with the sacral pressuring 15 cm with the sacral pressuring 16 declined observation of other precord review reveale PM, Physician #1 determined the sacral pressuring 15 declined observation of other precord review reveale PM, Physician #1 determined the sacral pressuring 15 declined observation of other precord review reveale PM, Physician #1 determined the sacral pressuring 15 declined observation of other precord review revealed PM, Physician #1 determined the sacral pressuring 15 declined observation of other precord review revealed PM, Physician #1 determined the sacral pressuring 15 declined observation of other precord review revealed PM, Physician #1 determined the sacral pressuring 15 declined observation of other precord review revealed PM, Physician #1 determined the sacral pressuring 15 declined observation of other precord review revealed PM.	left inner leg. Review of dicare note dated M, revealed the sacrum of cm (centimeter) (length) by com depth with undermining at these 1 cm, muscle exposed. Sugh is present, partially cleanser." The facility resident's sacral pressure. A review of a wound on 09/15/2021 revealed (6) pressure ulcers, (2) to the left superior calfungth) by 1.4 cm (width) by one (1) to the right hip 2 cm by less than 0.1 cm, p measuring 1.2 cm by 0.8 d, stage two (2) to left cm by 0.2 cm by less than or right heel measuring 0.6 ur (4) areas to the sacrum 11.6 cm by 0.4 cm, for the resident included in bed, diet as ordered, in of the wound, an air tional supplements, and Observation of wound care in ulcer on 09/29/2021 at ewound measured 13 cm iith a scant amount of ent granulation tissue. It would not consent to the pressure areas. A medical dithat on 09/21/2021 at 2:19 ermined the resident's ds were unavoidable. On	{F 7	25}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
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NAME OF PI	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE
(F 725)	25) Continued From page 681 in-house wound care visits. Further review of the record revealed on 09/29/2021, staff notified the physician of the decline in the resident's wound		{F 7	'25}			
	with no new orders. T with Failure to Thrive.	he resident was diagnosed					
	09/10/2021, complete 09/10/2021, and compon 09/10/2021. Resid 09/25/2021 and re-ad 09/28/2021. Further rerevealed staff develop plan on 09/21/2021. A re-admission revealed admission skin assess 09/28/2021, Braden S baseline care plan developed. A composition of Resident #308 or Resident #309 on 09/2 Resident #311 on 09/2	and a skin assessment on and 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 at the resident had an esment completed on scale on 09/28/2021, and a eveloped on 09/28/2021.  Sident #45 on 09/28/2021 at 5 on 09/28/2021 at 11:10 AM, 29/2021 at 11:26 AM, 29/2021 at 11:52 AM,					
	Resident #320 on 09// revealed the residents well-kempt, and clean residents' beds. Interveduring the time of the identified concerns. A for Residents #45, #6/ and #320) revealed th Director interviewed th and had no concerns Interview with the ISS revealed she interview	s appeared clean, I linens were on the riews with the residents observations revealed no review of Progress Notes 5, #308, #309, #311, #314, se Interim Social Service ne residents on 09/15/2021					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HABILITATION CENTER	1	STREET ADDRESS, CITY 200 NURSING HOME L	ANE	09/30	0/2021	
			_	PIKEVILLE, KY 415	01 			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 725}	5). Observation of reson 09/28/2021 from 1 no identified concerns reviews revealed Res #309, #311, #314, and shower preference are 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 stippreference, and the faresident's care plan. A interviews revealed the preference was obtain shower schedule revealed shower/hygiene preference with the instance of the commendations for loss and/or wound he documentation reveal reviewed all residents DON reviewed all diet Interview with the RDG revealed she complete	cerns regarding hygiene.  idents during the initial tour :33 PM to 2:32 PM revealed is. Interviews and record idents #45, #65, #308, d #320 each had their id hygiene preference if on their care plan. A is medical record, including are plan and SRNA care odated each resident's plan is preference. Interview with Operations on 09/30/2021 is assisted with obtaining She stated each resident hower and hygiene icility updated each a review of resident iteir shower/hygiene ited. A review of the facility's italed that the resident rences were honored.  Dietician on 09/30/2021 at it began reviewing all 8/2021. She further stated inew and/or additional residents to address weight aling. A review of the ed the Registered Dietician ' diets, and the Regional is and recommendations. O on 09/30/2021 at 4:17 PM ed the review of all diets	{F 7	25)	DEFICIENCY			
		assessments completed by hirty-nine (39) residents						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		03/30/2021		
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{F 725}	signs and symptoms hyperglycemia and the intervention. Interview 09/30/2021 at 4:17 Please the residents and did concerns. Observation 09/28/2021 at 1:36 Please 1	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 AM, and Resident #311 on AM revealed no visible register with a completed on fifty (50) residents with a Obstructive Pulmonary thma and Pneumonia were tory Therapist #1. Interview rapist (RT) #1 on 09/30/2021 Is he assessed all residents ronic Obstructive Pulmonary thma, and pneumonia lentified concerns. ent #45 on 09/28/2021 at 1:40 3 on 09/28/2021 at 2:03 PM.	{F 7.	25}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.  (X2) MULTIPLE CONSTRUCTION  A, BUILDING			(X3) DATE COMP	SURVEY	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER	<u> </u>	2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	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 (scheduled times.  10). A review of the fa 09/28/2021 from 6:00 two (2) licensed nurse assistants were schedulity. A review of the one (1) licensed nurse nursing assistants for 6:00 AM.  A review of the staffin 09/30/2021 revealed three (3) certified nurse from 6:00 AM to 6:00 staffing revealed one (2) certified nursing as 6:00 PM to 6:00 AM.  Observation of facility 1:20 PM to 5:30 PM; to approximately 6:00 7:55 AM to 5:17 PM, being answered timel clean/well-groomed, sassisting residents witurning/repositioning and meal trays were passive to the control of the control of the clean well-groomed, sassisting residents witurning/repositioning and meal trays were passive the control of the control of the clean well-groomed, sassisting residents witurning/repositioning and meal trays were passive the control of the control of the clean well-groomed, sassisting residents witurning/repositioning and meal trays were passive the control of the control of the clean well-groomed, sassisting residents witurning/repositioning and meal trays were passive the clean well-groomed the clean well-groomed the clean well-groomed the clean well-groomed and meal trays were passive the clean well-groomed the c	completed on 09/11/2021 delivered timely. Interview tified Dietary Manager 21 at 2:26 PM, and M revealed lunch was i21 and arrived at the unit 10) minutes of the  acility's staffing for AM to 6:00 PM revealed as and three (3) nursing duled for each floor of the acility's staffing revealed as and two (2) certified and two (2) certified ach 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 a staffing on 09/28/2021 from an on 09/29/2021 from 8:11 AM and 09/30/2021 from arevealed call lights were y, residents appeared staff was offering and th baths/showers, was being conducted timely, bassed timely.  1 on 09/29/2021 at 11:55	{F 7	725)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CHY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		94/2021
(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 CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 725)	LPN (Licensed Practicat 12:44 PM; LPN #7 and 09/30/2021 at 12:50 F at 10:31 AM; State Re (SRNA/certified nurse 3:40 PM; SRNA #11 SRNA #7 on 09/29/2021 at 4:10 09/29/2021 at 3:04 PM at 3:17 PM and SRNA PM, revealed staffing staff member revealed duties as assigned.  11). Review of the sta 09/28/2021, 09/29/202 revealed each day coone (1) evening cook, day aides, and two (2 Observation of the kith PM reflected the staffischedule. Interview wat 1:12 PM, and Dieta 2:10 PM revealed kitcand they were able to their shift.  12). A review of assess withdrawn, crying, or conducted for Resided 08/11/2021. No concerview of skin assessino identified concerns interviews conducted and 09/30/2021 reveal with psychosocial and	e on 09/30/2021 at 2:54 PM; cal Nurse) #6 on 09/30/2021 on 09/29/2021 at 3:00 PM 64 PM; LPN #10 on PM, LPN #11 on 09/30/2021 agistered Nurse Aide et aide) #1 on 09/29/2021 at on 09/29/2021 at 3:23 PM; SRNA #19 on PM; SRNA #21 on PM; SRNA #22 on 09/29/2021 at 4:10 had improved, and each did they had time to perform filling schedule for 21, and 09/30/2021 at 2:26 ing was accurate per the ith Cook #3 on 09/29/2021 at did no 09/28/2021 at did no identified. A ments completed revealed is Observation and on 09/28/2021, olded no identified concerns	{F 7:	25)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND MORO		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
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{F 725}	with abuse. Interview 09/30/2021 at 1:39 Pl a diagnosis of Demer reviewed and revised with the RDON on 09 revealed she complet 08/11/2021, for all res of licensed nursing stridentified. A review of Social Service Director BIMS score of eight (8 identified concerns.  13). A review of assess wander, revealed all revandering risk assess Review of the elopement each nursing station of binder on each floor thincluding a description interventions for each 14). Review of Reside and #332's medical reresidents had been with the Reg 09/30/2021 at 3:53 Pl comprehensive nutritic Residents #39, #65, #Review of the medical completed a comprehension 09/16/2021 for Reside Resident #81, 09/16/2021 for Reside Resident #81, 09/16/2021 for Resident #8	with Resident #322 on M revealed no concerns with MDS Nurse #1 on M revealed all residents with the tital had their care plans as necessary. Interview /30/2021 at 4:17 PM ed skin assessments on idents, with the assistance aff. No concerns were audits completed by the or (SSD) for residents with a matter and the sidents had received a sment by 08/16/2021. The entity wandering binder at an at contained information in a photo and potential resident identified at risk.  The first #39, #65, #81, #90, #330 record revealed all of the eighed by 09/17/2021. Sistered Dietician on M revealed she completed a contained information of the eighed by 09/17/2021. Sistered Dietician on M revealed she completed a contained information of the eighed by 09/17/2021. Sistered Dietician on M revealed she completed a contained information of the eighed by 09/17/2021. Sistered Dietician on M revealed she completed a contained in the matter and mat	{F 7	25}				

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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STAT 200 NURSING HOME LANE PIKEVILLE, KY 41501	TE, ZIP 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	X (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRI FICIENCY)		
{F 725}	Nurse Consultant on Regional DON on 09/DON #2 on 09/30/202 resident had received assessment and revie by nursing staff. Furth and Regional DON retray card were review information.  15). Observation of that 2:22 PM, the fourth PM and the fifth floor revealed snacks included the state of snacks were Review of Resident # Resident #14's recordinate of snacks. Interested the snacks were Review of Resident # 14's recordinate of snacks. Interested on document 16). Observation of the yellow 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 AN or symptoms of COVI been discharged from	21 at 3:53 PM, the Regional 09/30/2021 at 3:40 PM, the 30/2021 at 4:17 PM and 21 at 3:20 PM revealed each a comprehensive nutritional ew of the recommendations are interview with the RD vealed both the record and ed to reflect accurate  The third floor on 09/28/2021 at 2:00 on 09/28/2021 at 2:06 PM ding but not limited to crackers, cookies and including soda, milk, and in 09/29/2021 at 10:30 AM are being passed on third floor. 331, Resident #65 and revealed documented review with SRNA #19 on and revealed she was intation of snacks.  The zones contained no sents #327, #328 and #329 on and Resident #328 on and Resident #329 on and revealed no obvious signs D-19. Resident #327 had	{F 7	(25)			

	OF DEFICIENCIES CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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{F 725}	COVID-19 with no idereview of resident tes 09/17/2021, revealed 19). Interview with MI at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 Pl Director (HR) on 09/3 Marketing Liaison on Medical Records on Central Supply on 09 on 09/29/2021 at 11:5 12:58 PM, RN #4/W0 09/30/2021 at 2:54 Pl 12:44 PM, LPN #7 on 09/30/2021 at 1:54 Pl at 12:50 PM, LPN #1 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 09/29/2021 at 3:29 Pl at 4:10 PM, SRNA #2 SRNA #22 on 09/29/2 #23 on 09/29/2021 at 1:12 Pl 09/30/2021 at 1:12 Pl 09/30/2021 at 1:12 Pl 09/30/2021 at 2:10 Pl Director/Dietary Mana 1:30 PM revealed the (2) times weekly. Interested revealed tested times weekly.	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 inager on 09/30/2021 at inager on 09/30/2021 at ing Supervisor on M, Human Resource 0/2021 at 10:48 AM, Senior 09/30/2021 at 10:55 AM, 09/29/2021 at 8:34 AM, /29/2021 at 2:40 PM, RN #1 55 AM and 09/30/2021 at und Care Nurse on M, LPN #6 on 09/30/2021 at 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 at 10:31 con 09/30/2021 at 10:31 con 09/30/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 on 09/29/2021 at 3:04 PM, cook #3 on M, Dietary Aide #3 on M, Dietary Aide #3 on	{F 7	725)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			30/2021
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{F 725}	resident had COVID-implemented. In addit resident's MAR reveal monitoring as ordered 21). Interview with the 09/30/2021 at 3:25 PN Resident #321, Resident #321, Resident #351's infor usage and appropriate physician on 09/29/2021 at 4:35 PN 09/30/2021 at 4:35 PN 09/30/2021 at 8:09 AN identified concerns with addition, observation of floor on 09/30/2021 at 11:55 APM, N #4/Wound Card 2:54 PM, LPN #6 on 0 LPN #7 on 09/29/202: 09/30/2021 at 1:54 PM at 12:50 PM and LPN AM revealed in concerned ications.  23. Interview with the Operations on 09/30/2021 at 3:11 PM revealed be agreement that the physician cost review. Pharmacy agreement requiring a cost review.	cord revealed that each 19 monitoring orders ion, review of each led staff was completing the 18 by the physician.  2 Medical Director on M revealed Resident #9, ent #324, Resident #326 medications were reviewed riate administration times by 3/2021.  medication pass on M on 3rd floor and M on 3rd floor revealed no th missing medications. In of a narcotic count on 5th the 12:50 PM revealed no therview with RN #1 on therview with RN #1 on M and 09/30/2021 at 12:58 a Nurse on 09/30/2021 at 19/30/2021 at 12:44 PM, 1 at 3:00 PM and M, LPN #10 on 09/30/2021 #11 on 09/30/2021 #11 on 09/30/2021 at 10:31 arns with unavailable  Vice President of	{F 7	725}			

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{F 725}	would communicate a guidance to the pharm Director of Operations the Vice President of signed the agreement 24). Interview with RN AM and 09/30/2021 at 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 revealed they had recaware of the process from the pharmacy. In they were aware that physician if the pharm medication to the facility were with the on 09/30/2021 at 3:40 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 at 8:00 concerns with missing 26). Review of a QAP the facility conducted with the Regional DOI Consultant, Human Riccords, the Houseke Supply, MDS Nurse #Therapy Manager, the	g reviewed. The facility my changes or continuance macy within 72 hours. The sof Guardian Pharmacy and Operations of the facility st.  I #1 on 09/29/2021 at 11:55 t 12:58 PM, RN #4 on M, LPN #6 on 09/30/2021 at 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 I on 09/30/2021 at 10:31 AM eived education and was for obtaining medications addition, they revealed the nurse would notify the facty could not deliver a sity.  Regional Nurse Consultant PM, and Regional DON on M revealed an audit was ents' ordered medications ations were available in the Observation of medication t 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 eeping Supervisor, Central	{F 7.	25}				
	Dietary Manager, and	other members of the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE			2	TREET ADDRESS, CITY, STATE, ZIP CODE  00 NURSING HOME LANE  IKEVILLE, KY 41501	1 09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	appointed the current 09/13/2021. Further i Operations revealed Administrator with da 09/10/2021.  28). Interview with the 09/30/2021 at 3:40 P 09/30/2021 at 3:25 P committee, including Consultant on 09/30/procedures for containswering call lights, delivering meal trays and turning/reposition 09/15/2021.  29). Interview with the Operations on 09/30/Nurse Consultant on the Med-Net Concep 09/28/2021 at 3:00 P conducted a conferent following: (1) the outdexpectations and role outlined in the Rules determined a plan for communication/monitand COVID-19 isolatifacility to monitor/ass reposition residents, prepare and distribut	e Vice President of 2021 at 4:10 PM and arim Administrator on M revealed the facility Interim Administrator on nterview with the VP of she had provided the Interim ily oversight since  e Interim Administrator on M, the Medical Director on M and members of the QAPI the Regional Nurse 2021 at 3:40 PM, revealed cting staff for call-ins, ADL Care, serving and timely, incontinence care ning were reviewed on  e Vice President of 2021 at 4:10 PM, Regional 09/30/2021 at 3:40 PM, and ts Nurse Consultant on M revealed the facility nce call to review the comes of the survey, (2) as of the Governing Body as and Regulations, (3) r the following toring tools: Infection Control ion, enough staff at the less residents, turn and provide incontinent care,	{F 7	725}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE	V POST-ACUTE AND RE	HABILITATION CENTER			DO NURSING HOME LANE IKEVILLE, 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 TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIA			(X5) COMPLETION DATE
{F 725}	and neglect effectively appropriate ADLS, and QAPI committee.  30). Interview with the o9/30/2021 at 3:40 PI Consultant on 09/30/2 reviewed and revised presented the reviews Committee during the facility developed a stall topics were review meetings. The plan in Foley catheters, entercontractures, physical usage, risk management, social significance, activities, in council concerns and discharges, census, is by department/position dietary variance tray a work injuries, terminal medical leave of absence whires, 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 PI 09/30/2021 at 1:52 PI Director/Dietary Manager on 09/28/20 09/30/2021 at 1:52 PI Director/Dietary Manager on Manager	ervices, dealing with abuse y, sufficient staff, providing d providing a functioning.  Interim Administrator on M, and Regional Nurse 2021 at 3:40 PM revealed the QAPI Plan and and/or revision to the QAPI 09/16/2021 meeting. The andardized plan to ensure ed as needed at the QAPI cluded pressure ulcers, ral feeding tubes, I 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, tions, employees on family ence or leave of absence, cord compliance review, storative nursing, business actions. The QAPI cal Director approved the on 09/16/2021 to include the topics presented during with MDS Nurse #1 on M, MDS Nurse #2 on M, Regional Certified Dietary 21 at 2:26 PM and	{F 7	25}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI IDENTIFICATION NUMBER A. BUILDING		ULTIPLE CONSTRUCTION  LDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R 09/30/2021		
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	,			
(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 CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE		(x5) COMPLETION DATE	
{F 725}	09/30/2021 at 1:18 PI Supervisor on 09/30/2 Respiratory Therapist 12:45 PM and Centra 2:40 PM, revealed the at the QAPI meeting I 31). Interview with the Operations on 09/30/202 at 3:20 Director on 09/30/202 meeting was conduct the duties of the Gove policy and procedures facility and communic members of the Gove meeting, the QAPI proparticipate regularly in need to identify root outilization of the "5 wh systems per the QAPI attendance she conducted meetings of and 09/30/2021. Interview of Operations on 09/3 Regional Nurse Cons PM revealed they were	e Director (HR) on AM, Therapy Manager on M, Housekeeping 2021 at 1:24 PM, (RT) #1 on 09/30/2021 at 1 Supply on 09/29/2021 at 2 information was presented peld on 09/16/2021.  e Vice President of 2021 at 3:40 PM, the Interim 0/2021 at 3:40 PM, DON #2 0 PM, and the Medical at 3:25 PM revealed a 2ed on 09/16/2021 regarding 2 to be implemented in the ating information to other string Body including setting as to be implemented in the ating information to other string Body. During the coesses, the need to a the QAPI process, the auses of system problems, my 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 2016/2021, 09/23/2021, view with the Vice President 20/2021 at 4:10 PM and 2014 that on 09/30/2021 at 3:40 the members of the 2016 the collecting and the collecting and the collection of the 2016 the collecting at 2016 the collection of the 2016 the collection of the 2016 the collection of the 2017 the collection of the 2018 the co	{F 7	25}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	037	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
(F 725)	Regional Nurse Cons PM revealed the gove Administrator with resmaterial for QAPI. Further administrator on 09/3 he had been provided education regarding 034). Interview with the 09/30/2021 at 3:40 Pl were conducted week ensure the quality of complied with the star compliance. Further in President of Operation PM, Regional Nurse PM, MDS Nurse PM, Former Activities #3 on 09/30/2021 at 2:26 PPM, Former Activities #3 on 09/30/2021 at 3:40 PM, Respiratory Therapy Manager on Housekeeping Super PM, Respiratory Therat 12:45 PM and Center 2:40 PM revealed the weekly QAPI meeting and 09/23/2021. In activities PM revealed the QAPI meetings on 09 Further interview with	2021 at 4:10 PM and the ultant on 09/30/2021 at 3:40 erning body provided the cources and education of the interviews revealed the dimeet quarterly for the riew with the Interim 0/2021 at 3:40 PM revealed I with resources and DAPI.  Interim Administrator on M revealed QAPI meetings by effective 09/16/2021 to care is monitored and enterview with the Vice on 09/30/2021 at 4:10 Consultant on 09/30/2021 at 1:39 on 09/30/2021 at 1:39 on 09/30/2021 at 1:31 PM, setary Manager on M and 09/30/2021 at 1:52 Director/Dietary Manager I:30 PM, Medical Records I AM, Human Resource	{F 725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER		S'	TREET ADDRESS, CITY, STATE, ZIP CODE  ON NURSING HOME LANE  PIKEVILLE, KY 41501	[09 <i>i</i>	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 725)	meeting had been correview of the facility C sheet reflected the abidentified concerns.  35). Interview with RN AM and 09/30/2021 at 12:4 09/29/2021 at 3:00 PN PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PN 09/29/2021 at 3:23 PN at 3:29 PM, SRNA #1! SRNA #21 on 09/29/20 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PN education on 09/17/20 staff revealed they verweighing residents, of reporting the weights (RD). Interview with Rat 4:17 PM revealed seducation on 09/17/20 techniques, obtaining, reporting weight change porting weight porting weigh	anducted on 09/30/2021. A DAPI meeting attendance dove interviews with no  I #1 on 09/29/2021 at 11:55 It 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 I PM, LPN #7 on M and 09/30/2021 at 1:54 B0/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on M, SRNA #11 on M SRNA #11 on M SRNA #7 on 09/29/2021 I on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA #22 I PM and SRNA #23 on M revealed they received 021. Interview with nursing I rebalized understanding of Dataining, documenting, and to the Registered Dietician egional DON on 09/30/2021 Itaff was provided with 021 on proper weighing documenting, and ges to the Registered  I mer Activities Director and ger on 09/30/2021 at 1:30 ived education on gional Certified Dietary	{F 7	25}				

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021	
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	CH 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)		(X.) COMPLETION DATE
further revealed is the tray of corders. Since previous of meeting, if the tray of the tra	ard system in a stated the day would be interview with a 2:26 Piled she conclivities Directly with a stated the distinguishes stated the distinguishes are on 09/30/2021 at 12:41 at 3:00 Piled 1 at 3:23 Pile	she entered the order into to reflect the resident's diet at all diet orders from the e reviewed in the clinical th the Regional CDM on M and 09/30/2021 at 1:52 apleted education with ctor/Dietary Manager #3. In that she had been on site to sistance during the transition N #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound (2021 at 2:54 PM, LPN #6 44 PM, LPN #7 on M and 09/30/2021 at 1:54 30/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on M, SRNA #11 on M, SRNA #11 on M, SRNA #11 on M, SRNA #22 or PM and SRNA #23 on M, revealed they received repositioning, range of the gresidents from bed to o bed. Observations of and wound care with RN #11 21 AM for Resident #65 I concerns. Interview with the 09/30/2021 at 1:18 PM d staff with education 021 regarding range of motion, and	{F 7	725}			

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021		
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		200 1	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501	00/1	0072021	
(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 725}	on 09/30/2021 at 12:4 09/29/2021 at 3:00 Pt PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 Pt 09/29/2021 at 3:40 Pt 09/29/2021 at 3:23 Pt at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2 on 09/29/2021 at 4:10 Pt education on pressure turning and reposition nutrition, Positioning of and document a head and how to notify the RP of a new skin impore email the Registere and the resident's rep changes. Interview wit Consultant on 09/30/2 Regional DON on 09/30	2021 at 2:54 PM, LPN #6 44 PM, LPN #7 on M and 09/30/2021 at 1:54 80/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on M, SRNA #1 on M, SRNA #1 on M, SRNA #1 on M, SRNA #22 7 PM and SRNA #23 on M revealed they received a ulcer prevention including ing, adequate hydration and devices, how to complete l-to-toe skin assessment, 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 lete and document a ssment, and how to notify m, physician and RP of a With any change to skin a will call or email the or new recommendations, presentative.  DS Nurse #1 on 09/30/2021 at nager on 09/30/2021 at	{F 7	25)				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER					09/30/2021	
THAT OF FE	TOVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZID COD CODE 200 NURSING HOME LANE		
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(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF COF CORRECTION		(X5)
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{F 725}	Continued From p	page 698	{F 7	725	5}		
	Director (HR) on (	09/30/2021 at 10:48 AM, Senior					
	Marketing Liaison	on 09/30/2021 at 10:55 AM,					
	Medical Records	on 09/29/2021 at 8:34 AM,					
	Central Supply on	09/29/2021 at 2:40 PM, Cook					
		at 1:12 PM, Dietary Aide #3 on					
		0 PM, Former Activities					
	Director/Dietary M	lanager #3 on 09/30/2021 at					
		they received education on					]
		sponse. In addition, interviews					
		29/2021 at 11:55 AM and					
		58 PM, RN #4/Wound Care					
11.1		021 at 2:54 PM, LPN #6 on					[
		44 PM, LPN #7 on 09/29/2021					
		9/30/2021 at 1:54 PM, LPN #10					
		12:50 PM, LPN #11 on					
		31 AM, SRNA #1 on 09/29/2021 A #11 on 09/29/2021 at 3:23 PM					
		9/2021 at 3:29 PM, SRNA #19					
		4:10 PM, SRNA #21 on					
		4 PM, SRNA #22 on 09/29/2021					
		RNA #23 on 09/29/2021 at 4:10					
		received education on timely					
		, providing timely hygiene per					
		are, timely toileting, ensuring					
		nts in their choice of clean					
		y delivery of meal trays. Further					
		ok #3 on 09/29/2021 at 1:12 PM					
		09/30/2021 at 2:10 PM, and					
		Director/Dietary Manager #3 on					
	09/30/2021 at 1:30	PM revealed they received					
	education on mea						
		MDS Nurse #1 on 09/30/2021			ł		
	at 1:39 PM, MDS	Nurse #2 on 09/30/2021 at 1:31					
		29/2021 at 11:55 AM and					
		58 PM, RN #4/Wound Care					
		021 at 2:54 PM, LPN #6 on					
		44 PM, LPN #7 on 09/29/2021					
	at 3:00 PM and 09	9/30/2021 at 1:54 PM, LPN #10					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	100200	D. VV,IVO_	STREET ADDRESS CITY, STATE, ZIP CODE	09/30/	2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / 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) OMPLETION DATE
(F 725)	education on ensuring entered into the electrobservation of RN #1 revealed the nurse was knowledge of the educoncerns.  41). Interview with RN AM and 09/30/2021 at 2:4 09/29/2021 at 3:00 PN PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PN 09/29/2021 at 3:23 PN at 3:29 PM, SRNA #1! SRNA #21 on 09/29/2 on 09/29/2021 at 4:10 PN education on identificaresidents with a change on identifying signs/sy hyperglycemia/hypogl protocol, documental medical record, notific following physician or revealed they received documentation of glucon 09/30/2021 at 12:4 09/29/2021 at 13:00 PN AM and 09/30/2021 at 12:4 09/29/2021 at 3:00 PN	Mrevealed they received one care plans were conic medical record. On 09/29/2021 at 11:55 AM as able to demonstrate cation with no identified  ##1 on 09/29/2021 at 11:55 tt 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 0/2021 at 12:50 PM, LPN 10:31 AM, SRNA#1 on M, SRNA#22 PM and SRNA#23 on M revealed they received ation and assessment of the in respiratory status and imptoms of the physician and ders. In addition, interviews dieducation on tose levels.  ##1 on 09/29/2021 at 11:55 th 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6	{F 7:	25}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	<u></u>	185256	B. WNG			09/	30/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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***********	ITTOOT-MODILE AND INC	TIABLETATION CENTER		ı	PIKEVILLE, KY 41501		
(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 725}	#11 on 09/30/2021 at 09/29/2021 at 3:40 Pl	10:31 AM, SRNA#1 on	{F 7	'25)			
	SRNA #21 on 09/29/2 on 09/29/2021 at 3:17 09/29/2021 at 4:10 Pi education on complet with interventions and	ng a copy to the					
	at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 Pl Director (HR) on 09/3 Marketing Liaison on Medical Records on 0 Central Supply on 09/0 on 09/29/2021 at 11:5 12:58 PM, RN #4/W0 09/30/2021 at 2:54 Pl 12:44 PM, LPN #7 on 09/30/2021 at 1:54 Pl at 12:50 PM, LPN #1 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 09/29/2021 at 3:29 Pl 09/29/2021 at 3:04 PM, SRNA #2 and SRNA #23 on 09/29/2021 at 09/30/2021 at 2:10 Pl 9/30/2021 at 2:10 Pl	M, Human Resource 60/2021 at 10:48 AM, Senior 09/30/2021 at 10:55 AM, 09/29/2021 at 8:34 AM, //29/2021 at 2:40 PM, RN #1 65 AM and 09/30/2021 at und Care Nurse on M, LPN #6 on 09/30/2021 at 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 1 on 09/30/2021 at 10:31 29/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 Aide on M, SRNA #21 on 09/29/2021 1:2 on 09/29/2021 at 3:17 PM //29/2021 at 4:10 PM, Cook 1:12 PM, Dietary Aide #3 on					3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R 09/30/2021	
	DER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PRE#I; TAG	· ·	SHOULD BE	(X5) COMPLETION DATE	
1:3 pro abo im  45 AM Ca on 09 PM LP the tec rep Dic Ma ha an en are nu co die orc clii Fri  46 09 ed tim for nu esi cul 47	coess of identifying use as well as iden mediate intervention. Interview with RN and 09/30/2021 at 12:4/29/2021 at 3:00 PN LPN #10 on 09/30/2020 at 12:4/29/2021 at 3:00 PN LPN #10 on 09/30/2020 at 12:4/29/2021 at 3:00 PN manager on 09/30/2020 at 12:4/29/2021 at 3:00 PN midues, obtaining corting of weight characteristic of the edician. In addition, anager on 09/30/2021 at coeput into the electrorise entering the order acceptation of the edical meeting, which and texture. She ders from the previous meeting, which day, to ensure acceptation on facility press and the use of restablished national gettural, and ethnic necessity. Interview with the latest and texture with the standard provision of facility press and the use of restablished national gettural, and ethnic necessity. Interview with the complex provision of the standard provision of the standard provision of facility press and the use of restablished national gettural, and ethnic necessity. Interview with the complex provision with the standard provision of the standard provision of the standard provision of the previous provision of the	y were educated on the preventing, and reporting tifying and implementing as for wandering residents.  I #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 and 09/30/2021 at 1:54 0/2021 at 12:50 PM and 21 at 10:31 AM revealed on on proper weighing, documenting, and anges to the Registered an interview with the Dietary 21 at 1:30 PM revealed she on on diet order accuracy y nutritional assessment to uracy. When the diet orders onic medical record, the diet will send a written dietary staff that will include further revealed all diet ous day are reviewed in the hoccurs Monday through	{F 7	25}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	10000			TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		21	00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	tray card system, ordersnack/hydration pass, and/or portion sizes, scarts and snacks and 48). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/on 09/30/2021 at 12:4	g food preference, facility er placement for meals, , appropriate scoop sizes stocking snack/hydration hydrations.  I #1 on 09/29/2021 at 11:55 t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 I4 PM, LPN #7 on	{F 7	725}			
	PM, LPN #10 on 09/3 #11 on 09/30/2021 at Activities Director/Die 09/30/2021 at 1:30 Pt education on the prod	of revealed they received ress for entering, activating, the registered dietician's					
	09/30/2021 at 5:05 PN 3:20 PM, Interview wi 09/30/2021 at 1:39 PN 09/30/2021 at 1:31 PN on 09/30/2021 at 1:56 09/30/2021 at 1:18 PN Supervisor on 09/30/2 Resource Director (HI AM, Senior Marketing 10:55 AM, Medical Re 8:34 AM, Central Sup PM, RN #1 on 09/29/09/30/2021 at 12:58 PN wise on 09/30/2021 at 12:44 Pat 3:00 PM and 09/30 on 09/30/2021 at 12:50 09/30/2021 at 10:31 AM	M, MDS Nurse #2 on M, Maintenance Assistant #1 FPM, Therapy Manager on M, Housekeeping 2021 at 1:24 PM, Human R) on 09/30/2021 at 10:48 Liaison on 09/30/2021 at ecords on 09/29/2021 at 2:40 2021 at 11:55 AM and PM, RN #4/Wound Care at 2:54 PM, LPN #6 on PM, LPN #7 on 09/29/2021 //2021 at 1:54 PM, LPN #10					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_				₹
NAME OF PI	ROVIDER OR SUPPLIER			_	TREET ADDRESS SITE AT THE SECOND	09/	30/2021
					STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		_			
					PIKEVILLE, KY 41501	<u> </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)		(X5) COMPLETION DATE
{F 725}	on 09/29/2021 at 4:10 09/29/2021 at 3:04 PN at 3:17 PM and SRNAPM, Cook #3 on 09/29 Aide #3 on 09/30/202 Activities Director/Die 09/30/2021 at 1:30 PN received education or policy/guidelines, ham Personal Protective E red zones. Observation and yellow zone on 09 revealed no identified were in the red or yelloconducted on 09/28/2 09/30/2021 revealed in the COVID-19 policy/gdonning/doffing Perso (PPE), or the yellow/received education on 09/30/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/2021 received educymptom monitoring of admissions. A review #355 on 09/10/2021 recovID-19 symptom in resident orders. Resident #355 revealed COVID-19 symptom in Resident Res	221 at 3:29 PM, SRNA #19 D PM, SRNA #21 on W, SRNA #22 on 09/29/2021 A #23 on 09/29/2021 at 4:10 B/2021 at 1:12 PM, Dietary 1 at 2:10 PM, Former tary Manager #3 on W revealed they had in the COVID-19 dwashing, donning/doffing equipment (PPE), yellow and on of the red facility zone B/28/2021 at 2:12 PM concerns. No residents ow zones. Observations 021, 09/29/2021, and in identified concerns with equidelines, handwashing, and Protective Equipment B/2021 at 2:54 PM, LPN COPM and 09/30/2021 at 11:55 B/2021 at 12:54 PM, LPN COPM and 09/30/2021 at 10/30/2021 at 12:50 PM, COPM and 09/30/2021 at 10/30/2021 at 10/31 AM revealed decation entering COVID-19 orders on all new of newly admitted Resident everaled the resident had an onitoring entered in the lent #355 was discharged-admitted to the facility on of re-admission for ed the resident had a nonitoring entered in the	{F 7	25}			
	09/28/2021. A review Resident #355 reveale COVID-19 symptom n	of re-admission for ed the resident had a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1''		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R 09/30/2021	
	ROVIDER OR SUPPLIER V 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)	1	(X5) COMPLETION DATE
{F 725}	monitoring orders imp 51). Interview with RN AM, and 09/30/2021 at Care Nurse on 09/30/20 #7 on 09/29/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/20 they had received edi of medication administ medication, right patin and right route. In ad on the process to folly not available for admicalling the pharmacy obtaining the anticipa notifying the physicia would either be omitte ordered medication ti included following ner physician, documenti new orders from the frecord.  52). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/20 #7 on 09/29/2021 at 1:54 PM, LPN #10 or LPN #11 on 09/30/20 they had received ed emergency medication floor three (3) on 09/2 four (4) on 09/29/2020	5, and #90's medical h resident had COVID-19 blemented.  N #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound /2021 at 2:54 PM, LPN 121 at 12:44 PM, LPN (LPN) 13:00 PM and 09/30/2021 at 10:09/30/2021 at 12:50 PM, 121 at 10:31 AM revealed ucation on the five (5) rights stration including right ent, right dose, right time, lidition, they were educated ow when a medication was inistration, which included to obtain the medication, lited medication delivery time, in if an ordered medication ed or given outside of the me. The education also	{F 7	25}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	PLE CONSTRUCTION  G		(X3) DATE COMP	SURVEY LETED
		185256	B. WNG_				R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CIT 200 NURSING HOME I PIKEVILLE, KY 415	LANE	03/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION PRECTIVE ACTION SHOULD BI ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	with an emergency m LPN (LPN) #9 on 09/3 she was a new hire to received education remedication kit.  53). Interview with DC PM, MDS Nurse #1 on MDS Nurse #2 on 09/2 Maintenance Assistar PM, Therapy Manage Housekeeping Supen PM, Human Resource 09/30/2021 at 10:48 / Liaison on 09/30/202: Records on 09/29/2025 Supply on 09/29/2027 Supply on 09/29/2027 O9/29/2021 at 11:55 / PM, RN #4/Wound Citize PM, LPN (LPN) #7 or 09/30/2021 at 1:54 PM, LPN (LPN) #7 or 09/30/2021 at 1:54 PM, 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 09/29/2021 at were educated on the contact information at Coordinator. Observa 09/28/2021, 09/29/2020 revealed signage pos Administrator's contact Abuse Coordinator positions.	ation room was equipped edication kit. Interview with 30/2021 at 2:27 PM revealed to the facility and had garding the emergency on 9/30/2021 at 3:20 on 09/30/2021 at 1:39 PM, 9/30/2021 at 1:31 PM, 10 on 09/30/2021 at 1:18 PM, 10 on 09/30/2021 at 1:18 PM, 10 on 09/30/2021 at 1:24 on 09/30/2021 at 1:24 on 09/30/2021 at 1:25 on 09/30/2021 at 1:25 on 09/30/2021 at 1:25 on 09/30/2021 at 12:58 on 09/30/2021 at 12:58 on 09/30/2021 at 12:58 on 09/30/2021 at 12:58 on 09/30/2021 at 12:44 on 09/30/2021 at 12:44 on 09/30/2021 at 10:31 on 09/30/2021 at 10:31 on 09/30/2021 at 10:31 on 09/30/2021 at 3:40 PM, SRNA #7 on M, SRNA #19 on 09/29/2021 on 09/29/2021 at 3:04 PM, 10 PM revealed they on 121, and 09/30/2021	{F 7	55}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF FI	ROVIDER OR SUPPLIER	103230	D. 111110			09/:	30/2021
	W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  200 NURSING HOME LANE  PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		(X5) COMPLETION DATE
{F 725}	no identified concerns #27 skin and wound a at 10:20 AM revealed review of the medical #324, #45, #14, #357 revealed the weekly v completed with physic notifications. Interview 09/30/2021 at 3:53 Pl of new and/or worsen reviewed the resident with Medical Director revealed that he was worsening skin impair interventions to preverevealed that he partiand discussed ongoir residents. Interview won 09/30/2021 at 5:05 team discussed all au including new and/or and interventions imp 55). Interview with Ce at 2:40 PM revealed sall laboratory supplies revealed that the aud for four (4) weeks and months. A review of a Observation of floor the (5) supplies and reviewed identified concerns.  56). Interview with the 09/30/2021 at 4:17 Pl 09/30/2021 at 3:20 Pl were audited during residentified during residenti	kin assessments revealed is. Observation of Resident assessment on 09/30/2021 no identified concerns. A record for Resident #65, #27, #74, and #358 yound assessments cian and responsible party with the Dietician on M revealed she was notified ing pressure ulcers and is as indicated. Interview on 09/30/2021 at 3:25 PM notified of new and/or ments and new and decline. He further cipated in QAPI meetings in audits and care of with the Interim Administrator is PM revealed the QAPI indits in QAPI meetings, worsening pressure injuries alemented.  Sentral Supply on 09/29/2021 is on 08/28/2021. She further its were conducted weekly it then monthly for three (3) audits revealed no concerns. Indicate the audits revealed no expected the audits revealed the audits revealed the audits revealed the au	{F 7	725}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WNG		84.0	1	R 30/2021
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER	1	2	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-RÉFÉRENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	the area of concern. no identified concerns 57). Interview with the on 09/30/2021 at 10:3 completed visual roun hygiene, toileting, inc repositioning in additi Review of audits reve nails, clothes, body o dry, toileted as reque hair clean and combe clean, call light within applicable and turned 58). Interview with the Operations on 09/30/ Senior Marketing Liai AM revealed they par monitoring, and moni times including the le unanswered. Intervie activated more than f addressed with the st revealed they were c and different shifts.  59). Interview with the 4:17 PM revealed shir respiratory assessme communication Mono clinical meeting. She assessed to ensure t respiratory status and completed had physic implementation of ph Resident #315 SBAR	A review of audits revealed s. A revealed he noting of residents assessing ontinence, and resident on to other leadership staff, ealed staff were auditing dor, incontinent clean and sted or every two (2) hours, ed, sheets and blankets reach, facial hair shaved if and repositioned.  A Vice President of 2021 at 4:10 PM and the son on 09/30/2021 at 10:55 rticipated in visual toring call light response ngth of time call lights go ws revealed any call ive (5) minutes were taff. A review of audits ompleted on different units are completed audits of	{F 7	725}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRU		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_			R 09/30/2021	
	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		200 NURSI	DRESS, CITY, STATE, ZIP CODE NG HOME LANE E, 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 725}	physician notification, plans updated as indirevealed no identified 60). Review of Residual admitted on 09/10/20 had a baseline care programmer of the first of t	2021 revealed assessment, interventions, and care cated. A review of audits I concerns.  Lent #355, who the facility 21, revealed the resident plan developed on the facility were for the facility on the facility of	{F 7	25}			

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE : COMPL	
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	IDER OR SUPPLIER	HABILITATION CENTER	Ti .	2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	1 00/1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(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
the reduction of the contract	evealed they include ate, baseline care pledivered to resident and education as need evealed no identified ates as indicated.  3). Review of the aund/or CDM revealed with no identified ated with no identified at a consultant on the property of the verbal at aff members were designing on 8/15/20 at a consultant on the verbal of the	dew of the audits completed do resident name, admission an completion, care plan and/or responsible party, aded. A review of the audits concern with completion dits completed by the DM they were completed as ed concerns. Interview with a Dietary Manager on M and 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 1:70 m, DON 3:20 PM, and MDS Nurse #2	{F 7	725}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 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	Œ		50/2021
(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		(XS) COMPLETION DATE
{F 725}	on 09/29/2021 at 11:5 12:58 PM, RN #4/Wo 09/30/2021 at 2:54 Pl 09/30/2021 at 12:44 Pl participated in verbal 65). Interview with the 09/30/2021 at 4:17 Pl audits of documented Monday through Frida She further revealed less than 60 and/or g staff were expected to Responsible Party, at follow physician order stated she identified of 08/12/2021 to have a and one (1) on 09/20 glucose level of 465 v evidence the licensed process. She provide and LPN #5. A Reviet further concerns. A R RN #2 and LPN #5 re the facility process. 66). Review of verbal was verbally asked si when to report, signs and wandering interv verbal quizzes reveal quizzed daily for one 08/19/2021 with no ic review revealed verb three (3) times a wee 08/21/2021 to 09/02/c concerns. A review of	ders. Interviews with RN #1 55 AM and 09/30/2021 at und Care Nurse on M, LPN (LPN) #6 on PM, revealed they quizzes with facility staff.  Regional DON on M revealed she completed I blood glucose levels ay in the clinical meeting. that with any blood sugar reater than 40, the facility o notify the physician, and Registered Dietician and rs. The Regional DON one (1) resident on blood glucose level of 430 //2021 to have a blood	{F 7	25}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		O) DATE SURVEY COMPLETED	
		185256	B. WING		09/30	0/2021	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	, 5516		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 725}	09/03/2021 to 09/24/concerns. Interview of Consultant on 09/30/09/30/2021 at 4:17 P 09/30/2021 at 1:39 P the completion of verinterview revealed the verbally quizzed on the tool (signs and sympreport, signs and 09/30/2021 at 1:54 P 11:55 AM and 09/30/2021 at 1:54 P 11:55 AM and 09/30/2021 at 10:48 Assistant #1 on 09/30/2021	weeks from the week of 2021 with no identified with the Regional Nurse 2021 at 3:40 PM, RDON on M, and MDS Nurse #1 on M revealed each assisted in bal staff quizzes. Further at each staff member was the areas listed on the audit toms of abuse, when to aptoms of wandering and cons), and any need for leted immediately with each SRNA #11 on 09/29/2021 at #6 on 09/30/2021 at 12:44 on 09/29/2021 at 2:54 PM, RN #1 on 09/29/2021 at 2:2021 at 12:58 PM, RN #1 on 09/30/2021 at 2:54 PM, 09/29/2021 at 2:40 PM, on 09/30/2021 at 1:18 PM, on 09/30/2021 at 1:18 PM, on 09/30/2021 at 1:24 or Director (HR) on AM and Maintenance 0/2021 at 2:56 PM revealed verbal quizzes regarding rt, wandering and wandering sement completed on ont #355 was discharged on dmitted to the facility on	{F 725				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DATE COMPI	SURVEY LETED
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	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	1 05/1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREFII TAG	· I '	N SHOULD BI		(X5) COMPLETION DATE
{F 725}	Nurse #1 on 09/30/20 MDS staff will schedul assessments to ensur Regional Nurse Cons PM and DON #2 on 0 revealed all-new adm in the morning clinical appropriate assessment wandering risk assess Further interviews revidentified as at risk for discussed during this interventions implement 68). Review of interview with a BIMS score of identified concerns. Of interviews were initial (10) resident interview weeks then five (5) re Interview with ISSD of and MDS Nurse #1 or revealed they were as with residents with no of audits initiated on 0 random weekly skin a with a BIMS score of there are no injuries of no identified concerns. Nurse Consultant on DON #2 on 09/30/20 were completing auditidentified concerns. Of assessment on 09/30 9:23 AM and on 09/3	ng. Interview with MDS 121 at 1:39 PM revealed that le wandering risk re completion. Interview with re completed to ensure rents, including the realed that residents re wandering would be recited.  rews performed for residents realed that revealed no rented.  rews performed for residents realed on 08/13/2021 with ten revs completed for four (4) residents for eight (8) weeks. residents for eight (8) weeks. residents for review of residents for residents residents residents for residents residents for residents r	{F 7	725}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		185256	B, WNG_			R	
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		9/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 725}	09/30/2021 at 3:53 P audits on 08/25/2021 electronic medical re in the diet/tray card s Review of Resident # 09/29/2021 at 12:04 on 09/29/2021 at 1:30 P Manager on 09/28/2021 at 1:30 P Manager on 09/28/2021 at 1:52 P performed as including breakfast a PM, and dinner at 5:09/28/2021 at 5:03 P had been served on 10 on 09/29/2021 lunch at the third floor at 12:16 iffth floor at 12:34 PM 71). Review of Resid 09/29/2021 at 1:204 on 09/29/2021 at 12: tray card on 09/29/2021 tray card on 09/29/2021 at 12: tray card on 09/29/2021 tray card on 09/29/2021 tray card on 09/29/2021 tray card on 09/29/2021 at 12: tray card on 09/29/2021 tray	e Registered Dietician on M revealed she started of resident diet orders from cords against orders entered oftware to ensure accuracy. 4308's tray card on PM, Resident #39's tray card 06 PM, and Resident #334 021 at 12:30 PM revealed ordered by the physician. A aled audits were conducted eeks.  letted audits revealed random wice daily for one (1) week 1. Starting 08/30/2021, observed two (2) times per ks and then weekly from 1) month. Interview with ector/Dietary Manager #3 on M, Regional Certified Dietary 021 at 2:26 PM, and M revealed audits were ed. Further interviews were served as scheduled, t 7:00 AM, lunch at 12:00 00 PM. Observation on M revealed the evening meal the third floor. Observation meal revealed meals arrived oproximately 12:16 PM, the PM and 12:24 PM, and the	{F 7:	25}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
	185256	B. WNG_		1	₹ 30/2021
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
Manager on 09/30/2 would be responsible beverage preference admission and enter system. A review of a were audited daily for 09/15/2021 to 09/21/2 audits revealed snace beginning on 09/22/2 Regional Certified Di 09/28/2021 at 2:26 F PM revealed she aud not identified any con- 72). Interview with the (HR) on 09/30/2021 completed audits for time clock punches. concerns. Observatio 09/28/2021, 09/29/20 revealed no concern  73). Interview with th on 09/30/2021 at 3:4 at 4:17 PM, DON #2 and Interim Infection 09/30/2021 at 3:10 F being conducted with handwashing, isolatin donning/doffing PPE variance or identified immediately. A review were conducted beging shifts and units.  74). Interview with th on 09/30/2021 at 3:4	derview with the Dietary 221 at 1:30 PM revealed she a for obtaining food and as within seventy-two hours of ing the preferences into the audits revealed snack intakes ar one (1) week from 2021. Further review of the acks were audited weekly 2021. Interview with the actary Manager on 2M and 09/30/2021 at 1:52 dited snack intake and had acerns.  The Human Resource Director at 10:48 AM revealed she daily staff screening against She revealed no identified an of entry doors on 21, and 09/30/2021 as.  The Regional Nurse Consultant O PM, RDON on 09/30/2021 on 09/30/2021 at 3:20 PM, Control Nurse on M revealed audits were	{F 72	25)		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL <sup>*</sup> A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING	_			R /30/2021
•	ROVIDER OR SUPPLIER  POST-ACUTE AND RE	HABILITATION CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		130/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
(F 725) (F 755) SS=D	beginning 09/23/2021 no identified concerns 11:55 AM and 09/30/20 (LPN) #6 on 09/30/20 #7 on 09/29/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/202 concerns with obtaining Pharmacy Srycs/Proc CFR(s): 483.45(a)(b)( §483.45 Pharmacy Set The facility must providrugs and biologicals them under an agreen §483.70(g). The facility personnel to administe permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accura dispensing, and admir biologicals) to meet the	n narcotics with the nat an active script is on file. A review of audits revealed in RN #1 on 09/29/2021 at 2021 at 12:58 PM, LPN 21 at 12:44 PM, LPN (LPN) 2:00 PM and 09/30/2021 at 09/30/2021 at 12:50 PM, 21 at 10:31 AM revealed no not see the description of the revealed in the provided in the general supervision of the general supervision of the general supervision of the section, receiving, aistering of all drugs and the needs of each resident.	{F 7				11/30/21
	§483.45(b) Service Co must employ or obtain pharmacist who-	nsultation. The facility the services of a licensed					
	§483.45(b)(1) Provides aspects of the provision the facility.	s consultation on all n of pharmacy services in	:				
	§483.45(b)(2) Establis receipt and disposition	hes a system of records of of all controlled drugs in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(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 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	03/30/2021	
(X4) ID PREFIX TAG			ID PREFI TAG	PROVIDER'S PLAN O ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN			
{F 755}		ible an accurate ines that drug records are in ount of all controlled drugs	{F 7	55}			
	by: Based on observation and review of the facility pharmaceutical service (5) of fifty-seven (57) (Resident #321, Resident #39, and Resfailed to acquire and a medications to meet the Resident #351, Resident #351, Resident #351, Resident #351, Resident #361, Re	railed to provide tes to meet the needs of five sampled residents dent #326, Resident #351, ident #324). The facility administer prescribed he needs of Resident #326, ent #9 and Resident #324.  admitted Resident #321 on iagnoses of Urosepsis and cer with Physician's Orders c to treat the Urosepsis. ed the facility to "cost tion before it could be the facility failed to address I Resident #321 did not		#324 had a medication re on 09-23-21 to validate if medications should continvalidate appropriate admib here with the op-24-2021 to validate if continvalidate appropriated admit validate appropriated admit imes.  c) Resident #33 discharged from the facility discharged from the facility continuation of the	#9, and Residence by the Mordered and to nistration time and to mordered and to ninistration 21 was by on 7-19-202 and to medication of the medication of th	ent D	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE DO 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 PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 755}	the needs of each resilikely to cause serious death to a resident. In identified, on 08/11/20 exist on 03/06/2021, a Rights (F580), 42 CFI Abuse (F600), 42 CFI Abuse (F600), 42 CFI Abuse (F600), 42 CFI Abuse (F692), 42 CFR 483.4 (F755) and 42 CFR 483.4 (F755) and 42 CFR 483.4 (F880). The facility was Jeopardy on 08/11/20 An acceptable Allegat was received on 09/02 removal of the Immed 09/02/2021. However verified based on obsand review of facility of Immediate Jeopardy (483.35 Nursing Service Administration (F835) Quality Assurance and Improvement (F867). The Immediate Jeopardy in A second acceptable was received on 09/20 removal of the Immediate Jeopardy in A second acceptable was received on 09/20 removal of the Immediate Jeopardy in The Statt determined the Immedi	sident, has caused or is injury, harm, impairment or inmediate Jeopardy was 021, and was determined to at 42 CFR 483.10 Resident R 483.12 Freedom from R 483.12 Comprehensive Plans (F655), (F656), 42 of Care (F684) (F686) Pharmacy Services R 183.80 Infection Control R 183.70 Infection Compliance Infection Control R 183.70 Infection Compliance I	{F 7	55}	was available. The pharmacy and MD were notified of any medication not available to be administered as ordered and new orders received from the MD was be followed.  b)On9.27.21  DON/ADON/Designee reviewed all residents on narcotics with the pharmat to ensure that an active script is on file. Any renewals needed; the MD was be notified and a new script was obtained.  Criteria 3: a) Beginning 11/22/2021 all licensed nursing staff have been re-educated on:  "The 5 rights of medication administration including right II medication, patient, dose, time, and rou!" The process to follow when a medication is not available to be given a ordered, which includes II check the e-to determine if the medication is available in the e-kit; if not available in the e-kit can 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 this not available from the e-kit includesobtain an order for the narcotic, fill out the pharmacy form for removal of narcotics from the e-kit. Fax a copy of the form to pharmacy. Call the pharmacy and required a code. Enter the code into the box and remove the narcotic.	vill Ey ste. as kit ble all	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER	<u>.l.</u>	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 755}	Pharmacy Services (f. 483.12 Freedom from 483.25 Quality of Car Administration (F835) Quality Assurance an Improvement (F867), Infection Control (F88 monitors the effective and quality assurance. The findings include:  Review of the facility's Pharmacy Requiremerevealed regular and services were available prescription and nonposervices, and related Further review revealed Further review revealed perform routine and tilliand emergency pharmacy addition, the pharmacy determining the approdispensing and admirrand biologicals to medication in a sealed container in a timely in Review of the facility's Ordering and Receiving as revised on 01/2021 pharmacy services were	25), and 42 CFR 483.45 F755); and to "E" at 42 CFR Abuse (F600), 42 CFR e (F692), 42 CFR 483.70 (F837), 42 CFR 483.75 d Performance and 42 CFR 483.80 (0), while the facility ness of systemic changes e activities.  Spolicy titled, "Provider ents", revised 01/2021, reliable pharmaceutical le to provide residents with rescription medications, equipment and supplies, ed the provider agreed to mely pharmacy services, nacy services twenty-four even (7) days a week. In, by would assist the facility in opriate acquisition, receipt, distration of all medications et the medication needs of ely dispense prescriptions orescriber orders, and d replenish emergency d and properly labeled manner.  Spolicy titled, "Medication ng from Pharmacy," dated revealed emergency ere available on a 24-hour emergency medications by	{F 7	755}	Licensed nursing staff not working will I educated on their next scheduled shift. Education will be added to new hire orientation.  b) On 9-24-21 the Co-owner/President of ETPS Pharmach has agreed to providing a 3-day supply meds that require a cost authorization to be sent to the facility while pending cost review.  Criteria 4: Beginning 11/24/2021 5 random residents medication orders will be audited by the DON and/or designed ensure medication is available as order in the medication cart. If medication is ravailable as ordered the pharmacy, MD/NP will be notified for new orders. Taudit will be weekly x 4 weeks then monthly until substantial compliance is achieved Audits will be reviewed month in QAPI x3 months then quarterly until i substantial compliance.  Criteria 5: Date of compliance 11/30/2021	y of so st	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
(F 755)	provider pharmacy. T supplies emergency remergency drugs, and substances, and prodiguantities, in the emergency pharmacy pharmacy pharmacy nurses stations and/ophysician on call 24/7 were posted at the numedication storage revealed the pharmacy "stat" medications accargement, and if avairement, an	by special order from the he provider pharmacy medications including tibiotics, controlled fucts for infusion in limited regulations. Further review for (facsimile) numbers for a services were posted at the redication storage rooms, and telephone numbers for services stations and/or forms. Continued review for supplied emergency or cording to the pharmacy filable, should be obtained with until the provider fine appropriate medications.  Is policy titled, "Administering for revised on 04/2019 were administered in a safe is prescribed. Further review for were administered in criber orders, including any find medications were fine (1) hour of their fine so otherwise specified, such fals.  In #321's medical record dimitted the resident on forces of Urosepis, Diabetes and Bladder Cancer.	{F 758	5}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
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PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		PIKEVILLE, KY 41501			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	I ID	_	PROVIDER'S PLAN OF CORRECTION	DRRECTION	
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP		_	(X5) COMPLETION DATE
{F 755}	Continued From page 720		{F 7	'55	<b>&gt;</b>		
	of thirteen (13), indica cognitively intact.	ting the resident was	,	,			
	record revealed the fa	al on 07/20/2021 related to					
	Review of Resident #321's admission Physician's Orders, dated 07/16/2021, revealed an order for the staff to administer Fosfomycin Thromethamine (antibiotic) by mouth every Saturday to treat the resident's diagnosis of		:				
	Urosepsis. Staff was t	o administer the medication starting on 07/17/2021 and					
	revealed the Fosformy medication was due a but was not administe was not available. Fu	I (MAR), dated 07/17/2021,					
	on 07/27/2021 at 4:10 contacted the pharma attempt to obtain Resi However, the pharma required cost approvathey could send it to the she notified Physician not available and aske substitute antibiotic. H	cy on 07/17/2021 in an dent # 321's medication. cy stated the antibiotic I from the facility before the facility. She further stated #1 that the medication was the diffusion of the could order a conduction of the could not substitute the esident needed the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	100200	0. 11110	_		09/	30/2021
					STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER			200 NURSING HOME LANE		
<u> </u>					PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 755}	Continued From page	721	(F 7	'55)			
{F 755}	notified the Director on Nursing (DON/IDON) approval. However, with the next of medication was still not according to LPN #6, identified the medication for the resident's continuous with the Admonth of the resident's continuous admission continuous admission medication prior to the resident's each medication was admission coordinated issues with cost approbeen at the facility has admission date and the resident the resident of the resident's each medication was admission coordinated issues with cost approbeen at the facility has admission date and the resident the resident of the res	f Nursing/Interim Director of of the need for a cost when she provided care for day, on 07/18/2021, the ot available for the resident, someone should have for required a cost approval admission to the facility.  Inission Coordinator, on the facility of the resident from the hospital, the coordinator met with the ger for the referral, and she is needs, bed availability, of staff faxed the resident's orders to the pharmacy admission and the cost of reviewed. According to the facility, she had not had any size is the facility of the cost of reviewed of a resident's expected of the resident expected of the resident expected of the resident expected of the resident	{F 7	755)			
	4:05 PM, revealed the Resident #321's medi- 6:57 PM. She stated the medication to the	rcist #1 on 07/28/2021 at pharmacy received cation list on 07/16/2021 at the pharmacy had not sent facility because they were from the ADON/IDON. She					
	further stated any med non-formulary, expens insurance, required a facility prior to delivery	dication, which was sive, or not approved by cost approval from the shated the pharmacy they attempted to reach the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		Г	STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	30/2021
					200 NURSING HOME LANE		
PARKVIEV	N POST-ACUTE AND RE	HABILITATION CENTER			PIKEVILLE, KY 41501		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		1000 kg
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(F 755)	Continued From page	722	{F 7	'55	3)		
	Resident #321's antib	iotic on 07/16/2021 at 11:25	Ι,				
		d-up with an email to the					
	ADON/IDON, request						ļ
	Interview with Physici	an #1, on 08/04/2021 at					
	1:05 PM, revealed ne	expected medications to be upon admission to the					
		orders to be followed to					
		re to residents. He stated	1				
		notifying him that Resident					
		rosepsis was not available					
	to administer on 07/17	7/2021. Physician #1 stated					
	he told the nurse the r						
1	medication and he did	i not change the order.					i i
		ecall the facility making him					İ
		321's antibiotic did not					
	the medication was no	on on 07/18/2021, nor that ever administered to the					
	resident.	ever administered to the					
			-				
	Interview with the ADO	DN/IDON, on 08/11/2021 at					
		nat when the facility received					
		Admission Coordinator					
		ensure the facility could					
		eds. The ADON/IDON the					
		tor should have already					
	handled any cost appr	rovals during the s. She further stated she					
		iying her that Resident 321's					
		needed a cost approval. The					
	ADON/IDON stated st						
		ent or given to the resident.					
	Interview with the Adn	ninistrator, on 08/10/2021 at					
	1:50 PM, revealed the						
		the facility could meet their					
	needs prior to admissi					1	
		w admission orders and					
	medications to be ava	ilable for the resident prior					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	09/	50/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
{F 755}	not aware Resident # available following his cost approval issue. Coordinator should he related to cost approvarrival to the facility.  2. Record review reversesident #9 on 11/01/included Multiple Scleand Dementia.  Review of Resident # assessment, dated 06 facility assessed their cognitively impaired.  Review of Resident # Plan, dated 07/09/202 was at risk for decline Disabilities and Muscimaintain the highest lefurther review reveals potential for alteration for pain related to Muscimuscle spasms with a as comfortable as posincluded administering as ordered, notifying the pain, and if the pain in Review of Resident #10/13/2020, revealed resident Gabapentin bedaily and Norco by modizepam by mouth the beginning on 06/17/20	cility. She stated she was 321's antibiotic was not after admission due to a She stated the Admissions are resolved any issue ral prior to Resident #321's ealed the facility admitted /2013 with diagnoses that crosis, Muscular Dystrophy, 9's Annual MDS 5/09/2021, revealed the esident to be severely esident to be severely esident to Intellectual ular Dystrophy with a goal to evel of comfort possible, and Resident #9 had the in comfort and was at risk scular Dystrophy and a goal to keep the resident spible. Interventions go the resident's medications the physician of new onset medication was ineffective.  9's Physician's Orders dated staff were to administer the by mouth three (3) times daily, and three (3) times daily, and three (3) times daily, and three (3) times daily	{F 7	55}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021	
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER	_	2	200 NURSING HOME LANE PIKEVILLE, KY 41501			
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{F 755}	thru 08/04/2021, reve 06/24/2021, and 07/2 administer Resident # times daily as prescrit medication was not an 08/02/2021, 08/03/202 facility failed to admin Gabapentin three (3) the medication had not Further review of the I 08/03/2021 the facility Resident #9's Norco p times daily as prescrit the medication was not Interview with Registe 08/05/2021 at 1:00 PN been out of Gabapent days. She stated she and Physician #1 multi pharmacy had not del 08/04/2021. RN #1 stamedications sometime stated often had to no pharmacy multiple timor refill for narcotics for nurses notified the phythere were three (3) dremaining, but often remedication for several or arrival of the medicalinterview with Certified Interview with Certified	and agitation.  9's MAR, from 06/23/2021 aled on 06/23/2021, 7/2021, the facility failed to 9's Diazepam three (3) bed and documented the vailable from pharmacy. On 21 and 08/04/2021, the ister Resident #9's times daily and documented by arrived from pharmacy. MAR revealed, on valso failed to administer vain medication two (2) bed and staff documented by in from pharmacy.  And Revealed Resident #9 had in medication for several had notified the pharmacy tiple times, but the invered the medication until ated obtaining refills on valous to obtain a prescription valous to	{F 7	(55)				
	#9 had been out of Ga	EDU PM, revealed Resident abapentin for several days, RN #1. CMA #1 stated she						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		200	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501	<u>  U</u> 9	/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 755}	3. Review of Resident revealed the facility at 07/30/2021 with diagra Respiratory Failure with Myocardial Infarction.  Review of Resident # assessment, dated 08 facility assessed their Interview for Mental Stindicating the resident impaired.  Review of Resident # Plan, dated 08/12/202 was care planned for interventions included as ordered.  Review of Resident # dated 07/31/2021, rev (pain medication) to be every six (6) hours as moderate/severe pain 07/31/2021.  Review of Electronic Maccord (E-Mar), dated Resident #326 receives mg (milligram), one (1 and back pain at 5:14 hours after requesting voicing severe pain to Review of a Nursing Maccord American Review of Americ	ication was unavailable.  It #326's medical record dmitted the resident on noses of Rhabdomyolysis, ith Hypercapnia and  326's Admission MDS  306/2021, revealed the esident to have a Brief status score of nine (9), it was moderately cognitively  326 Comprehensive Care  21, revealed the resident pain management and ladministering medications  326's Physician's Orders, realed an order for Percocet e administered by mouth needed for with a start date of  Medication Administration of 08/05/2021, revealed ed Percocet Tablet 5-325  ) tablet by mouth for head PM, approximately six (6) pain medication and	{F 7	755}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		- 1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, S 200 NURSING HOME LAN PIKEVILLE, KY 41501	NE	1 09	/30/2021
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			(X5) COMPLETION DATE
{F 755}	revealed no pain med resident, and staff red delivery of the medical Observation of Resid 11:09 AM, revealed tholding his/her head. #326, on 08/05/2021 resident stated he/she was waiting on pain restated he/she had be rated his/her pain as scale.  Interview with License on 08/05/2021 at 11: #326 did not have pa awaiting the medicatistated RN #8 was the resident.  Interview with RN #8, revealed Resident #3 and they were attempt from the pharmacy. Interview with Reside 1:42 PM, revealed he his/her pain medicatio "My head is still killing Interview with RN #8, revealed she had not with any medication for nothing in the building needed something for	pain scale. Further review dication was available for the quested a "STAT" (now) ation.  ent #326 on 08/05/2021, at the resident was lying in bed Interview with Resident at 11:09 AM, revealed the e was "hurting all over" and medication. The resident en in pain "all morning" and an eight (8) on the pain  ed Practical Nurse (LPN) #4, 11 AM, revealed Resident in medication and they were on from pharmacy. LPN #4 enurse assigned to the  on 08/05/2021 at 11:57 AM, 26 had no pain medication of the RN stated she was ency medication kit.  nt #326, on 08/05/2021 at /she had not yet received on. Resident #326 stated,	{F 7	55}			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09	/30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOULD PROPRIES (EACH CORRECTIVE ACTION SHOULD PROPRIES (EACH CORRECTION CO			(X5) COMPLETION DATE	
(F 755)	medication any soone Interview with Resider 4:45 PM, revealed the received any pain mer pain. Interview with RN #8, revealed, she had spot they had instructed he emergency medication Resident #326's pain of Observation of a medication Resident #326 a Percemergency kit. Interview with Physicia 1:26 PM, revealed he issues with obtaining r for residents at the face physician stated he waincluding Resident #32 pain medications. Interview with ADON/I 12:00 PM, revealed sh were going several da medications due to me available. The ADON/I no designated back-up medications. Interview with Adminis 1:50 PM, revealed the	ant #326, on 08/05/2021 at a resident still had not dication and was still in on 08/05/2021 at 4:47 PM, when to the pharmacy and are on the facility's in kit and how to obtain medication from the kit.  Cation pass, on 08/05/2021 RN #5 administered ocet tablet from the are #1, on 08/27/2021 at was aware there were nearcotic pain medications sility. However, the as unaware residents 26, were going days without DON, on 08/27/2021 at the was aware residents are without narcotic pain edications not being DON stated the facility had to pharmacy to supply trator, on 08/10/2021 at facility reviewed new the facility could meet their	{F 7	755}			
	stated she expected re	esidents' medications to be		į			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE  NURSING HOME LANE  KEVILLE, KY 41501	09	30/2021
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 755}	available and adminis Administrator stated s #326's pain medicatio following admission.  4. Record review reve Resident #351 on 10/ included Diffuse Traul Hypertension, and Qu Review of Resident # assessment, dated 05 facility assessed the r score of three (3), ind severely cognitively in Review of Resident # Care Plan, dated 09/0 #351 had potential for to pain due to muscle due to a motor vehicle revealed the goal for r comfortable as possib administer medication physician of new onse physician if pain medi Review of the Physici #351 dated 10/06/202 Oxycodone-Acetamin mouth every eight (8) intracranial injury with Review of Resident # thru 08/06/2021, reve administer Resident # prescribed on 04/01/2 08/02/2021, 08/03/20	stered as ordered. The she was not aware Resident on was not available saled the facility admitted (28/2002 with diagnoses that matic Brain Injury, Judriplegia.  351's Quarterly MDS (5/26/2021 revealed the resident to have a BIMS dicating the resident was inpaired.  351's the Comprehensive (24/2020, revealed Resident or alteration in comfort related is passms and chronic pain a accident. Further review the resident was to be as oble with interventions to his as ordered, notify set of pain, and notify the feation was ineffective.  (20), revealed an order for complem (pain medication) by hours, prescribed for sout loss of consciousness.  (351's MAR from 04/01/2021 aled the facility failed to (351's Oxycodone tablet as (2021, 04/02/2021, 04/02/2021).	{F 7	755}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		09/	30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
{F 755}	Interview with Certified (CMT) #1, on 08/05/26 Resident #351 had be several days. The CM and documented their She stated sometimes available to administe and the nurse would in pharmacy. She further out of narcotic medical or the facility did not he available to administe. Interview with RN #1, revealed she often had the pharmacy multiple prescription or refill for The RN stated the nur and pharmacy when the maining of medication would go multiple days awaiting a refill or arrivational formulation of the RN stated the nur and pharmacy when the maining of medication would go multiple days awaiting a refill or arrivational formulation of the RN stated the nur and pharmacy when the maining of medication would go multiple days awaiting a refill or arrivation of the second formulation of the second formulation of the resident #324 on 03/2 including Quadriplegia Reflux Disease (GERG Syndrome.  Review of Resident #3 assessment, dated 07 facility assessed the rescore of fourteen (14), cognitively intact.	cation was not available ninister to the resident.  d Medication Technician 021 at 1:00 PM, revealed sen without Oxycodone for IT stated she notified RN #1 medication was unavailable, as medications were not r and she notified the nurse, notify the physician and the r stated residents often run ation when waiting for a refill leave the medication r.  on 08/05/2021 at 1:55 PM, d to notify Physician #1 and the times to obtain a r narcotics for a resident. The notified the physician has an often residents as without medication while wall of the medication.  aled the facility admitted 24/2021 with diagnoses and Gastro-Esophageal D), and Chronic Pain	{F 7	755}			

STATEMENT OF DEFICIENCIES (X1) PI AND PLAN OF CORRECTION ID	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
	185256	B. WNG				R
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABIL	ITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u>  09</u>	9/30/2021
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDER	BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	E ATE	COMPLETION DATE
F 755) Continued From page 730 Plan, dated 06/18/2021, rev had chronic pain with a goal complications or discomfort. revealed interventions included resident medications as orderesident management as needed.  Review of Resident #324's a Orders, dated 03/24/2021, refeated in three (3) times of three (3) times daily. Furthered in three (3) times and day revealed an order for Fentan patch applied/changed every hours.  Review of Resident #324's Nos/26/2021 the facility failed Resident #324's Sertraline, Legabapentin, and Baclofen as facility documented the medical available to administer to the Additionally, on 03/29/2021, 06/05/2021, 06/06/2021 and facility failed to administer the Clonazepam and documented was not available from pharm facility failed to administer Resident from 07/02/2021-07 failed to change the resident 07/09/2021 and 07/12/2021. both the Baclofen and Fental not available from pharmacy.  Interview with Certified Medical 08/05/2021 at 1:00 PM, reveal	I to remain free of Further review ded administering the ered and pain  admitting Physician evealed Resident line HCI daily, mes daily, daily, and Baclofen er review of Physician 021, an order for or and on 07/03/2021, myl via transdermal by seventy-two (72)  MAR revealed that on to administer Lactulose, s ordered. The ications were not er resident. 06/04/2021, 06/07/2021, the er resident's ed the medication macy. Further, the esident #324's 7/03/2021 and staff 's Fentanyl patch on Staff documented myl medications were . cation Aide #1, on	{F 7	755)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		09/30/2021	
	N POST-ACUTE AND RE			200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG				IX (EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	She stated she notifier called the physician are interview revealed the residents' narcotic me waiting on a refill or the medication available to when medications were administer she notified called the physician are stated the facility random edications and the repain medications and the repain medicine for sever refill.  Interview with RN #10, revealed it had been more prescription refills for more when there was a three medication remaining; physician and the pharpharmacy's "cut off time orders for prescriptions not fill anything received next day. In addition, if admitted a resident on resident's medications RN #10 stated there were sidents not getting nastated staff could remove mergency kit on the flefor the medication needed was was different. RN #10 smedication from the emedication from the	available to administer.  If the nurse, and the nurse and the pharmacy. Further facility often ran out of dications when they were ey did not have the coadminister. She stated for not available to if the nurse, and the nurse and pharmacy. She further but of residents' narcotic residents had to go without for all days while waiting for a  for 08/25/2021 at 4:28 PM, for edifficult to get farcotics. The RN stated for (3) day supply of for the nurse would notify the formacy. RN #10 stated the for was 4:00 PM until the for was 4:00 PM until the for #10 stated if the facility for the weekend, none of the formight be available, for frequent issues with for arcotic refills on time. She for the was an order for there was an order for there was an order for the pharmacy along for the pharmacy along	(F 7				
	pharmacist would call the relay an electronic code	he nurse at the facility and					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 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 PREFI TAG	IX (EACH CORRECTIVE A	ACTION SHOULD BE TO THE APPROPRIA	(X5) COMPLETION DATE	
	emergency kit, and obstated she was unsure the emergency kits to available. RN #10 stat training on the emerge "figured it out".  Interview with RN #7, revealed there were is being available to resimedication was not avacheck the emergency physician if the medication urse should call the predication was not avarefill. If the medication nurse should call the predication was not avarefill. If the medication region was not avarefill. If the medication was not avarefill. If the medication for the resident. The state pharmacy. RN #7 furtheresponsible to pull the medication's container seventy-two (72) hours for the resident. The state pharmacy to obtain the pharmacy the pharmacy to obtain the pharmacy to obtain the pharmacy the ph	stain the narcotic. RN #10 show the facility maintained ensure medications were sed she had never received ency kit, stating she just  on 08/24/2021 at 4:28 PM, sues with medications not dents. She stated if a railable, the nurse should kit first and call the ation was not in the kit. She medication needed, then sharmacy to find out if the ailable due to needing a did require a refill, the shysician and get an order nedication from the facility's medication arrived from the stated the nurse was sticker from the when there was so of medication remaining aff then faxed the sticker to a refill of the medication. available, because the refill, they would contact and she notified the medication. RN #7 stated to the emergency kit, the sician's order to the epharmacy would call and to open the box.	{F 7	755}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	_  09	9/30/2021	
(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	
	would notify the physicanter the medication is medication record (EMelectronically authorized medication. She further specific process in play were refilled, but if any the facility or the residemedication, the facility stated there have been and having to resend imedications because them, only to later find not see them.  Interview with Physician 1:05 PM, revealed here available to residents in facility and expected sorders and implement immediately.  Continued interview with medications for resident here were issues with medications for resident here were incompleted the facility when the resident's surface down to a ten (10) day stated he was not awas several days without printerview with Physician aware there were issue pain medications for released the facility and several days without printerview with Physician aware there were issue pain medications for released the facility and several days without printerview with Physician aware there were issue pain medications for released to the physician medications for the p	dication refill, facility staff cian's office, and she would not the electronic MAR) for Physician #1 to a the pharmacy to refill the er stated the office had no ce to ensure medications nedication did not arrive to ent was completely out of a would call the office. She in issues with the pharmacy prescriptions for they said they did not have out they had them and did expected medications to be upon admission to the taff to follow the admission care to residents  the physician #1, on the physician into at the facility. He stated by send him a refill request poply of medications. Continued in #1, revealed he was supply. The physician re residents were going an medications. Continued in #1, revealed he was es with obtaining narcotic sidents at the facility.  In stated he was unaware everal days without pain the stated residents in the s	{F 7	(55)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE		U. VIIIVO	STR	REET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
	<del></del>			PIK	KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 755)	Continued From page treated as soon as po		{F 7	55}			
	12:00 PM, revealed sl notify the physician will pain medication was of supply. The ADON/ID not have a designated obtain residents' medi was aware residents without narcotic pain in medications not being was not acceptable. S aware there was an is medications getting to interview reviewed that and pharmacy in adva ADON/IDON stated it	cations. She stated she vere going several days nedications due to available and stated this he stated Physician #1 was sue with narcotic pain the facility timely. Further at staff notified the physician nce for refills. The was not standard practice the in pain for several hours					
	1:50 PM, revealed she medications to be filled administered as order reviewed new admissic could meet their needs Administrator stated it residents to wait sever medication.  **The facility alleged the implemented to remove effective 09/26/2021:  1). Braden Scale Assesson all residents by facility and sever medication.	d, available and ed. She stated the facility ons to ensure the facility prior to admission. The was not acceptable for all hours for pain					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	<del>-</del>	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R	
PARKVIE	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STAT  200 NURSING HOME LANE  PIKEVILLE, KY 41501	E, ZIP CODE	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	X (EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)	E ATE	(X5) COMPLETION DATE
(F 755)	were completed on all The facility utilized the and comprehensive for review and update cathad pressure injuries.  2). The wound care placed to a sure of the sure	residents on 09/11/2021. Braden Scale Assessment all body skin assessment to re plans of residents who by 09/17/2021.  In prician evaluated Resident taff assessed and a injuries, and staff reatments and reported irector/Physician #1 by  D21, upon admission a skin en Scale assessment will be baseline care plan will be ours to include any nitial for pressure ulcer. A clan will be developed within to include pressure ulcers and include the pressure ulcers.  S, #308, #309, #311, #314  I including a shower, nail lotion applied post shower, using in clean appropriate were placed on the 11/2021. The residents it is a services on 09/15/2021.  Differed a shower and services were implemented ended to the pressure ulcer.	{F 7	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	U	0/30/2021	
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER			O NURSING HOME LANE			
(X4) ID	SUMMARY ST	TEMENT OF DEFICIENCIES		PI	KEVILLE, KY 41501			
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP		E TE	COMPLETION DATE	
	care plans by the Reg were completed on 09  6). On 08/28/2021, the began reviewing all re recommendations for supplements to promo any weight loss issues  7). All residents with the and Chronic Obstructive (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 amentary of glucose values Administration Record  9). The Regional Certiff (CDM) observed the munch and dinner on 09 were delivered on time  10). Direct Care staffing recruitment efforts with provided through agentary will be reviewed day will be reviewed day will be reviewed day Nursing and the Admin levels are adequate to residents. The staff will on the unit at the start of	stered Nurse Aide (SRNA) pional Nurse Consultant 2/13/2021.  Registered Dietitian (RD) residents' diets and made meal changes or the healing and to address s.  Re diagnoses of Diabetes we Pulmonary Disorder Pneumonia were assessed /or Respiratory Therapist reidentified completed  Re reviewed all residents remonitoring by 07/30/2021 reded to include mandatory real service for breakfast, 2/11/2021, all three meals real service for breakfast, real service for the next real service for the next real service for the next real by the Director of restrator to ensure staffing meet the acuity of the reach shift by the	{F 7	755}	DEFICIENCY)			
	Director of Nursing, Nu Administrator or design	ising Supervisor, iee. Direct care nursing						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	103250	B. WNG			09/30/2021	
	W POST-ACUTE AND RE			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 PREFI TAG		OULD BE	COMPLETION DATE	
	qualified staff to see if and/or calling agencie qualified staff to fill the cannot be replaced the Assistant Director of Nursing management appropriate staffing le center will prioritize reachieved during emerrequired task including medication, no showe provided to incontinent that cannot turn self, in assist residents with in through recruitment ef staffing levels have be meals are prepared and their Calledone and skin integrif BIMS less than eight (Licensed Nurse, Residents were identified psychosocial and/or phenomenate in the Regional Nurse, Regional Re	eplaced by calling other if they can fill the opening, set to see if they have a opening. If directcare staff be Director of Nursing, sursing, or member of the team will fill the shift. If vels cannot be met, the sident care that can be gency staffing, prioritize g administration of rs- sponge baths, care at residents, turn residents neals served timely, and neal if needed.  creased dietary staffing iforts and appropriate sen achieved to ensure and delivered timely.  If residents including #64, seassessed for psychosocial abuse with Brief Interview IS) score of eight (8) or ty reviews for residents with 8) were completed by then swith a diagnosis of are Plan reviewed and by the Minimum Data Set 09/07/2021. No new ed as indicating any mysical harm.  see Consultant completed a ment on all residents by its who were identified as and care plans reviewed and	{F 7	755}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	0.00		E CONSTRUCTION		SURVEY
		185256	B. WING		<u></u>		R
NAME OF P	ROVIDER OR SUPPLIER	100230	0. 11,110	_		09/	30/2021
TACKING OF P	NOVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER			200 NURSING HOME LANE		
		THE STATE OF THE S			PIKEVILLE, KY 41501		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	al		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 755}	Continued From page	738	{F 7	755			
	identified active wand		1 1, ,	, 55,			l i
	placed at each nursing						
	protection interventions	g station with a list of					
	potential interventions	for nursing to reference.					
	1/1\ Decidents #20 #/	65, #81, #90, #330 and					
	#332 were weighed by	00, #61, #90, #330 and					
	Posistored Distinger	y 09/17/2021. The	1				
	Registered Dietician (	RU) completed a					
	recommendations wer	on assessment and RD					
ı			-				
	(DOM) as desires as	the Director of Nursing					
	DON and asignee on	09/17/2021. Further, the	1				ĺ
	DON or designee, spo	oke with the attending					
	Medical Doctor (MD) 8	and validated the diet orders					
		s. Recommendations were			1		
		onic medical record and on					
	the tray card. The Reg	gistered Dietician and					
	Director of Nursing (D	ON), reviewed diet orders					
1	in electronic medical re	ecord to ensure both the					
	record and tray card re	eflected accurate					·
	information on 09/17/2	2021.					
	15). Beginning 09/15/2	2021, staff began offering					
i	snacks to all residents	daily in the morning and					
	afternoon by the sector	rative nurse aide, activity					I
	aides, or designee. Sn	rauve riurse alue, activity					ĺ
	physician will be decor	montal by the anatomic					
	bulyarcian will be docal	mented by the restorative					
	aide, dietary aides and	d/or licensed nursing staff.					
	16). The facility evalua	ited the COVID-19 unit on					
	08/11/2021 Incated or	the 5th floor of the facility					
	for compliance with CI	C quidelines and					
	implemented vallous or	nd red zones. The DON					
	identified has (2) resid	nu reu zones. The DON					
	identified two (2) reside	cidente end e velt-					
	exposed to positive res	sidents and a yellow zone					
	was designated with e	rection of a plastic zip wall					
	parner and those two (	2) residents were moved to					Į
	this zone on 08/11/202	!1.					
	17). The facility had the	ree (3) residents who were					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	_
		185256	B. WING			R	
PARKVIE	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, 200 NURSING HOME LANE PIKEVILLE, KY 41501	ZIP CODE	09/30/2021	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIA CIENCY)	E COMPLETION DATE	
,	#328 and #329). Resi have completed quara physician orders. Res completed quarantine physician's order. Res no longer in isolation.  18). All staff eligible for COVID-19 on 09/16/201 identify any new cases testing on 09/16/2021, tested for COVID-19 or did not identify any new 19). The facility was consurveillance testing as COVID-19. Positive Coplaced in isolation zon droplet precautions with protective equipment, physician notification, plan revisions. The DO newly positive COVID-isolation precautions in addition, any resident of droplet precaution in is facility will provide phy notification and care plemployee testing protective all staff must to days. If the employee is	antine per facility policy and idents #327, #328 and #329 antine per facility policy and idents #311 and #314 per COVID-19 policy and idents #311 and #314 were are testing were tested for D21. The facility did not a based on the employee all residents eligible were in 09/17/2021. The facility with positive cases.  Anducting ongoing recommended for DVID-19 residents will be expected for eligible were in the use of personal and placed in the use of personal and care in the provide family notification and care in the provide in the provide in the provide in the placed in olation zone (yellow). The sician notification, family an revisions. The facility is an revisions. The facility is to work without a current is to work without a current is to uning testing, the provide and times will be in the provide or in the provide or in the provide or in the provide or in the facility will be the provide or in the facility will be the provide or in	{F 7	'55}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		185256	B. WNG	<u>;                                    </u>		F	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/3	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTION SH	HOULD BE	E	(X5) COMPLETION DATE
	for signs and/or symp documented on the M Record (MAR). The famonitoring for signs a residents on 09/17/20 21). Resident #9, Res Resident #326 and Rewere reviewed for usa administration times b 09/23/2021.  22). The facility stated their medication as ordand implemented phannotification if any medication in the facility after normal weekends will have disentered into the electrosubmitted to pharmacy integration. The facility fax transmittal as a bac pharmacy integration is electronic medical recoll if the facility does not refer to the facility does not refer	ns all residents once a shift toms of COVID-19 and edication Administration acility implemented and/or symptoms on all 21.  ident #321, Resident #324, esident #351, medications age and appropriate by the physician on  all residents will receive dered beginning 09/23/2021 amacy and physician ication was unavailable, by new orders from the e unavailable medication.  ated an agreement on acility's pharmacy to provide (3) day supply of a the facility's approval while pending cost review.  and re-admissions entering I business hours and on scharge orders submitted, onic medical record and a through pharmacy implemented the use of	{F 7	755}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ECONSTRUCTION	(X3) DATE	SURVEY PLETED
		185256	B. WNG			l .	R
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
PARKVIEV	W POST-ACUTE AND RE	HABILITATION CENTER		2	100 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		E NTE	(X5) COMPLETION DATE
	kit. If an emergency as unavailable, the physis substitution and/or new 25). The Regional Nur Nursing, and licensed audit of all residents' of verified all medications facility by 09/25/2021.  26). The facility condurer Performance Improves 08/12/2021. The facility process, and as ensure compliance with The Administrator ove The QAPI committee of Nursing, Administrator Services Director, Actification Maintenance, Dietary is Services.  27). The facility appoint Administrator on 09/13 current Administrator. Administrator will receiguidance from the Reg Regional Director of Of Clinical Nurse for 30 dithe thirty-day oversight Administrative Team will receive the substitution of the	the emergency medication rises and medication is cian will be notified for worders.  The Consultant, Director of nursing staff completed an ordered medications and is were available in the sected a Quality Assurance ment (QAPI) meeting on the reviewed education, audited implementation to the the AOC and all audits. The resest the QAPI committee. Consists of the Director of the Medical Director, Social vities, Clinical, Therapy, and Environmental the daily oversight and gional Vice President or perations and Regional ays. Upon completion of the Regional will audit the Administrator to daily oversight is needed. Significant or the direct oversight and discipline, and concern and process	{F 7	755}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LTIPLE CONSTRUCTION DING		(X3) DATE SU COMPLE	RVEY
		185256	B. WING			R	
PARKVIE	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZI 200 NURSING HOME LANE PIKEVILLE, KY 41501	IP CODE	09/30	<u>/2021</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETION DATE
{F 755}	QAPI Committee revier contact person for cal Activities of Daily Livir timeliness of meal tray turning and reposition  29). The Vice Preside Clinical Operations and Consultants conducte 09/15/2021 with a conconsultation to review outcomes of the surveroles of the Governing Rules and Regulations the following communitate following communitate following communitate following communitate to Control (CON staff at the facility to murn and reposition rescare, prepare and distresidents with eating, deflective Pharmacy Seand neglect effectively appropriate ADLS, and QAPI committee.  30). The Administrator Consultant reviewed a beginning 09/16/2021 and/or revisions to the the 09/16/2021 meetin standardized plan to en reviewed as needed at agenda included review catheters, enteral feed physical restraints, memanagement, infection readmission rate, rehall	ewed procedures for a l-ins, answering call lights, ag (ADL) Care, serving, and as incontinence care and and on 09/15/2021.  Int of Operations, Director of d Regional Nurse d a conference call on tract company for a the following: (1) the y; (2) expectations and Body as outlined in the s; (3) determined a plan for fication/monitoring tools: and Plan light services, residents, and assist caring for pressure wounds, arvices, dealing with abuse by, sufficient staff, providing d providing a functioning  and Regional Nurse and revised the QAPI Plan and presented the reviews QAPI Committee during g. The facility developed a ansure all topics were the QAPI meetings. The wing pressure ulcers, Foley and the providing tubes, contractures, dication usage, risk control, hospital bilitation management, ans of grievance, activities,	{F 7	755}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION			SURVEY PLETED
		185256	B. WNG			I	R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u></u>	<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		SHOULD BE	E VTE	(X5) COMPLETION DATE
	development, vacant orientation, dietary var weight loss, work injuremployees on family rabsence, new hires, moreview, pharmacy repubusiness office, and a Committee and Medicatandardized agendate but not limited to, the fameeting.  31). The Regional Direvice President of Operation of Operat	ns, discharges, census, staff positions, employee riances, tray audit report, ries, terminations, medical leave, a leave of medical record compliance orts, restorative nursing, dmission actions. The QAPI al Director approved the on 09/16/2021 to include, topics presented during the ector of Operations and rations met with the N, and the Medical Director ng the duties of the ding setting policy and emented in the facility and ation to other members of During the meeting, the need to identify root tion of the five (5) why ing systems per the QAPI strator will notify the ure QAPI Committee  will collect all monitoring API Committee meeting for review to ensure efficiencies cited during the API Meetings were held on abatement and develop et the jeopardy. The facility etings weekly, times four and monthly. The	{F 7	'55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		185256	B. WNG		· · · · · · · · · · · · · · · · · · ·		R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			S 2	TREET ADDRESS, CITY, STATE, ZIP CODE  OO NURSING HOME LANE  PIKEVILLE, KY 41501	09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 755)	Regional Nurse Cons results. The QAPI cor audits at the QAPI mereview. The Administr Committee. The QAP Director of Nursing, A Director, Social Service Clinical, Therapy, Mai Environmental Service 33). The Governing Bardeninistrator with resmaterials for QAPI, in QAPI Tool Kit, QAPI a guide to effectively imbeginning 09/16/2021 meet quarterly for the reevaluate for frequentally as the compliance with State is demonstrated.  35). All nursing staff w Director of Nursing, Midesignee on proper we obtaining, documenting changes to the Registe 09/17/2021.	ning Body members, esident of Operations, and the ultant, to review the audit mmittee will review the setings. Committee for ator oversees the QAPI PI Committee consists of the dministrator, Medical ces Director, Activities, internance, Dietary and ess.  Ody will provide the facility's ources and education cluding but not limited to the at a Glance, and a resource plement the QAPI plan. The Governing Body will upcoming year and cy after one (1) year.  Twill increase the frequency eetings to weekly for four eded effective 09/16/2021, of care is monitored and dard of care and and Federal requirements  The Governing weight ered Dietician by	{F 7	'55}			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING			ATE SURVEY OMPLETED	
		185256	B. WING			R		
PARKVIE	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIF 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	09/3	0/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE AC	CTION SHOULD BE D THE APPROPRIA	TE	(X5) COMPLETION DATE	
	Manager on the provisassessment to ensure diet order accuracy, a orders into the electro CDM educated the Dietresident diet orders into the nurse enters the ownitten communication including diet and text meetings, staff will rev previous day to ensure 37). Therapy provided staff on turning and poand transfer of resident chair to bed beginning completed on 09/17/20 and assigned additional and agency contracts for turn and reposition all reposition themselves.  38). The Regional Direction all nursing staff on presincluding turning and rehydration and nutrition, to complete and document assessment, and how dietician, physician, an impairment by 09/17/20 staff will call or email the Physician, and Residernew skin changes.	sion of timely nutritional diet order accuracy, on and on when to enter diet nic medical record. The etary Manager to enter to the tray care system. If order, the nurse will send a to the dietary staff, ure. In the morning clinical iew diet orders from the etacuracy.  education to all nursing sitioning range of motion, at from bed to chair and on 08/19/2021 and 021. The facility employed at staff through recruitment to ensure adequate staff to residents who cannot corrector of Nursing educated source ulcer prevention, expositioning, adequate positioning devices, how ment a head-to-toe skin to notify the registered of RP of a new skin 021. The facility nursing the Registered Dietitian, at Representative of any mee educated all staff on the ln addition, direct care and certified nursing the deducation on providing and education and education on providing and education and education on providing and education and educati	{F 7	755}				

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	4	LTIPLE CONSTRUCTION		(X3) DATI	C. 0936-039   E SURVEY PLETED
		185256	B. WING				R
PARKVIE	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	ſΈ	(X5) COMPLETION DATE
	of clean clothing, and trays. The DON or defacility staff not working returning to work.  40). On 08/31/2021, Thursing educated all lift Registered Dietician, the and the MDS Nurses of into the electronic mediand interventions. In a Director of Nursing edexisting care plan in the with new goals and intimpairments identified.  41). The facility's Resplacensed nurses on idensified with a change 08/12/2021. In additionand/or designee education in the medical resplayments in th	ing residents in their choice timely delivery of meal signee will educate any g during education upon the Regional Director of idensed nursing staff, the he Social Service Director, on entering new care plans dical record, including goals addition, the Regional ucated staff to update the re electronic medical record erventions for any new skin during their shift.  Directory Therapist educated entifying and assessing e in respiratory status on on, on 08/12/2021, the DON attend all licensed nurses on toms of remia, the facility's menting a resident's promentation of blood ecord, notification of the graphysician orders. The graff will not be allowed to ceived this education. The call staff on documentation /19/2021 and 08/20/2021 ervices.	{F 7	755}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	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			00/20/21
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	PREFIX TAG		HOULD BE		(X5) COMPLETION DATE
{F 755}	Licensed nursing staff education was notified will not be allowed to received this educatio 43). Beginning 08/12/2	nd/or the responsible party. Toot working during I of ongoing education and work until they have	{F 7	55}			
	call-off procedure for the event a person needs dayshift, they are to not supervisor two hours of the staff needs to call of the tonotify their immediate before the start of their not have appropriate simmediate supervisor other qualified staff to	he facility included: in the to call out of work for colify their immediate pefore the start of the shift. If on the night shift, they are te supervisor four hours or shift. If the facility does staffing levels, the and/or designee will call replace the person calling					
	working will be in-serv 44). All staff were prov	ring is required, the lesignee will call for leg companies. Staff not liced upon return to work.  rided re-education by the lesignee on 08/12/2021 on					
	the process of identify reporting abuse, as we implementing immedia wandering residents.	ing, preventing, and ell as identifying and ate interventions for	:			i	
	changes to the Registr 09/17/2021. On 09/13/ the Dietary Manager of timely nutritional assess	DS Coordinator, or eighing techniques, g, and reporting weight					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 000	TIPLE CONSTRUCTION			SURVEY
		185256	B. WNG				R /30/2021
	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DDE	1 09	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
	order will send the wridietary staff. The Diet order into the tray care review diet orders from clinical meeting to ensist 46). The Regional CD Manager on 09/13/202 regarding meal service recipes including recipe fortified diets to ensure nutritional needs of reseatablished national groultural and ethnic needs of the established national groundlets of the established national groundlets and properties and process of the process and/or implementing the recommendations for confidence of the established national groundlets and process and/or implementing the recommendations for confidence of the established national groundlets and process and proces	and, the nurse entering the litten communication to the lary Manager will enter the encystem. The facility will in the previous day in the sure accuracy.  Meducated the Dietary 21 on facility policy in the same and the use of loss for those requiring it is all meals meet the sidents in accordance with suidelines to reflect religious, and of the population.  The Regional CDM with the dietary manager on inces, the facility's tray card based on menus, stocking snacks, and hydrations the scoop sizes, and/or arising or Regional Director curses and the Dietary is for entering, activating, the registered dietician's dietary orders on ided re-education by the by 09/17/2021 on the selines, handwashing, and Protective Equipment zones. In addition, the lead, licensed staff on or Covid-19 symptoms	{F 7	'55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED
		185256	B. WING				R
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
	W POST-ACUTE AND RE			20	NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  ( 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)	E JE	(X5) COMPLETION DATE
{F 755}	were not working. Dur 08/12/2021, the Covid handwashing policy, or red and yellow zones, for signs/symptoms of reviewed.  50). Staff were provide 08/20/2021 by the DO Regional Nurse Const symptom monitoring of admissions into the result of the five (stadministration, including patient, right dose, right Regional DON/DON/d licensed nursing staff of the process to follow wavailable for administration delivery time ordered medication obtains medication delivery time ordered medication with outside of the ordered education also include given by the MD, document of the medical record. All oth will be provided training the provided trai	uding contract staff, who ing the QAPI meeting on I-19 policy, the forming and doffing PPE, and monitoring residents if the Covid-19 were  ed re-education on N, Regional DON, or ultant to enter COVID-19 orders on all new sident's record.  In g staff have been 50 rights of medication ing right medication, right meticated all working on 09/23/2021 on when a medication was not ation as ordered. The ling the pharmacy to obtain ing the anticipated ine, notify the MD if an II either be omitted or given medication time. The d following new orders menting the conversation,	{F 7	555}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	- 1	CONSTRUCTION		SURVEY PLETED	
		185256	B. WNG				R
	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		S'	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	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)	TE	COMPLETION DATE
	after-hours.  53). The Interim Admi on his contact informa Coordinator from 09/1 In addition, education who to notify if unable shift.  54). The facility will authead-to-toe skin asset through Friday, for through Friday, for through Friday for through Friday, for through Friday for each reside will notify the physicial Responsible Party of and those new interve place to prevent declines for the decimal state of the decimal st	nistrator educated all staff ation and role as the Abuse 3/2021 through 09/17/2021. On staffing schedules and to work their scheduled adit weekly resident assments daily, Monday ee (3) months effective they have been completed and any new skin impairment and all lab supplies for the 28/2021. Audits will be all lab supplies for four (4) (2021 and then monthly for aursing Assistant Director of aursing Supervisor will audit as for daily four (4) weeks then weekly for one (1) and a care and and a care are according to the staff and a care according to the staff and the staff an	{F 7	555}			
	leadership staff and/or	designee began visual assessing hygiene, toileting,					

	TATEMENT OF DEFICIENCIES  ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING			1	R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	)DE	09.	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE 1E APPROPRIA	E VTE	(X5) COMPLETION DATE
	residents will be visual shift daily for two (2) visual residents each shift for twenty-five percent of (4) weeks. The facility to 6:00 PM and 6:00 F 58). On 09/11/2021, the began visual monitoring response times, including that are answered, a staff will conduct ten (each shift for two (2) wight observations each 59). On 08/13/2021, the began monitoring response times are situation Background and Recommendation (SB, acute change in respiratory friday in the control of the facility reviewed a respiratory status for Primplementation of any Plans were reviewed and Audits will be daily for times a week for four (60). The MDS Nurse, It began audits on 09/15, completion for all new in re-admissions to ensure baseline Care Plan with 61). All residents admit days with a diagnosis of Obstructive Pulmonary	ident repositioning. All ally rounding on once each weeks, fifty percent of the ar four (4) weeks, and residents each shift for four has two (2) shifts, 6:00 AM PM to 6:00 AM.  The facility's leadership staff and and timing of call light ling the length of time call cross all shifts. Leadership and timing of call light ling the length of time call cross all shifts. Leadership and communications weeks and then five (5) call and shift for eight (8) weeks.  The DON and/or Designee alternative status Monday and and and and by sician notification and physician notification and physician order. Care and updated as needed. The property of the property of the staff completed the hin 48 hours of admission.  The property of the staff completed the hin 48 hours of admission.  The property of the staff completed the hin 48 hours of admission.	{F 7	55)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING		<del></del>		R	
NAME OF P	ROVIDER OR SUPPLIER	103238	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021	
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER			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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
(F 755)	the MDS Nurse(s) and interventions will be a morning meeting by the nursing designee.  62). Beginning on 08/DON, and/or Designe admissions and re-addissions and re-addissions and re-addisterior comple with the resident and/variance or identified immediately. Audits withough Friday for all ato the facility for four (admissions for a week then ten percent of adweeks.  63). On 09/11/2021, the designee began audit meal trays to resident All three (3) meals will (3) units daily for two all three (3) units daily for two all three (3) units daily	and updated as needed by d/or designee. New dded to the care plan in the he DON, ADON, and/or	{F :	355}				
	began audits of staff's quiz of identification a with a change in respi signs/symptoms of hy the facility's diabetic p change in a resident's physician and followin Leadership will quiz st	aff randomly across all rone (1) week and five (5)						

AND PLAN OF COI	EFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	-	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R	
	DER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021	
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
65) beg res mo any ran any rev des dial (3) sign hyperesistaf add one (4) feet and or id imm 67). Nurs resid adm Set (4) want feet and or id imm	gan monitoring all doubts Monday through rules Monday through residents or of the second of t	the DON and/or Designee occumented blood sugar h Friday in the clinical DON/designee will review is outside of the normal on and implementation of its. Care plans will be as needed. The DON or its a visual rounding on its both shifts and all three is resident with apparent of its cemia to ensure the elely assessed by licensed dentified concerns will be its. Audits will be daily for (5) times a week for four its earn and/or an employee is and identification of its behavior to determine abuse across all shifts and uestionnaire will be taff daily for one (1) week, week for two (2) weeks, its faily for one (1) week, week for two (2) weeks, its faily for one (3) weeks, its faily for one (4) weeks. Any variance will be addressed	{F 7				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
	185256		>		R	
NAME OF PROVIDER OR SUPPLIER	165256	B. WING_	<del></del>	09	/30/2021	
PARKVIEW POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPRIES  DEFICIENCY)	BE	(X5) COMPLETION DATE	
will be addressed immail be care planned in the Director of Nursing Nursing, or nursing de 68). Beginning on 08/ Services Director or de random interviews of of eight (8) or greater the facility and have not witnessed abuse. The review random weekly residents with a BIMS to ensure no injuries of 08/13/2021. Any variate will be addressed immail be conducted for rand one (1) week, twice per and then weekly for or trays arrive at the unit, assist in passing trays meal trays, and certificate residents promptly. The designee will audit the trays to residents after beginning 09/11/2021. observed on each unit two (2) meals on each	inance or identified concerns hediately. New interventions in the morning meeting by g. Assistant Director of esignee.  13/2021, the Social esignee will perform residents with a BIMS score to ensure they feel safe in ot been subject to or a DON or designee will y skin assessments for score of less than eight (8) of unknown origin beginning ince or identified concerns hediately.  The Registered Dietician esident diet orders from the ord against orders entered offware to ensure accuracy.  23/2021, the Dietary and audit meals leaving the the units timely. Audits will om meals twice daily for the week for two (2) weeks, the (1) month. Once meal a management staff will to ensure residents receive and nursing assistants assist the Dietary Manager or time it takes to pass meal they arrive on the unit.  All three (3) meals will be daily for two (2) weeks,	{F 7	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B. WING	_		l .	R	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09	0/30/2021	
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	admitted/re-admitted in beverage preferences admission and enter it system for listing on the 109/16/2021. Review of completed bi-annually residents. Physician-residents. Physician-residents. Physician-residents. Physician-residents. Physician-residents. Physician-residents. Physician-residents. Physician-residents for four (4) m 09/15/2021.  72). Daily COVID-19 standited beginning on Resources (HR) Direct punches to ensure scribeir shift. Audits will be through Friday for four Director, and weekends staff not screened will immediately on the CO by the HR Director. The ducated on the COVI Nurse, an infection condoors will remain locked entry by staff and screentry.  73). Beginning on 09/1 designee will round serior eight (8) weeks, five (4) weeks to audit infection ghifts and unit observation of handwards.	residents' food and swithin 72 hours of hem into the diet/tray card heir tray cards beginning of food preferences will be and as needed for all bridered snack intakes will ary Manager daily for one bur (4) weeks, and monthly nonths beginning screenings for staff will be 28/25/2021 by the Human for against time clock deening before beginning se completed Monday (4) weeks by the HR las audited on Mondays. Any be re-educated 2VID-19 Screening Policy se HR Director was D-19 policy by the Regional introl preventionist. All entry ed. Visitors must be allowed ened by staff at the time of 27/2021, the DON and/or ven (7) times each week et (5) times weekly for four ction control compliance on s. Audits will include shing; isolation signage offing (putting on/taking off)	{F 7	'55}				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE			20	REET ADDRESS, CITY, STATE ZIP CODE  NURSING HOME LANE  KEVILLE, KY 41501	09/	/30/2021
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{F 755}	by the auditor.  74). The DON, ADON review all residents or pharmacy to ensure a beginning 09/23/2021 physician within two (2 expiration.  75). The Regional Nurand/or Director of Nurmedication pass obse 09/25/2021 on randon jeopardy removed to eaccuracy of medication CMS Critical Element Administration to concobservation of twenty-  76). Beginning 09/25/2 Friday, the DON, ADO audit medications daily to eneeding a renewal have pharmacy. Audits will almmediate Jeopardy is 77). Beginning 09/11/2 and/or DON will be resursing staff daily for fadequate staffing is m  78). Beginning 09/11/2 Dietary Manager will be dietary staffing daily for adequate staffing.	Il be addressed immediately  I, and/or Designee will In narcotics with the In active script is on file I. Staff will notify the I. Staff will noti	{F 7	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	Œ	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG		N SHOULD BE APPROPRIA	TE	(X5) COMPLETION DATE
	monitor and audit the days to ensure compliance of the days to ensure compliance of consultation and identification and identif	Administrator daily for 30 ance.  will be conducted beginning for residents' change of ation of need for "Stop and addition) communication.  2021, the Administrator or aterviews of residents with a ) or greater to ensure they and had not been subjected. No residents had any will continue to be a by the Administrator or atmediate jeopardy is  ency validated the facility's lammediate Jeopardy on by:  Toe Skin Assessments at all residents in the facility when of the skin assessments lents (Residents #65, #27, #74, and #358) had a with a total number of tenty (20). A review of the ans for Residents #65, #27, #74, and #358 the care plans to reflect ressure injuries. The	{F 7:	55}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501		<u>  09</u> /	30/2021
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	E JTE	(X5) COMPLETION DATE
revealed she complet assessment on all res further revealed that t (20) total pressure injust the facility completed assessments on all rescontinued interviews Interdisciplinary Team assessments and Braupdate the residents'd Resident #65, #324, # and #358's care plans current pressure injurity with MDS Nurse #1 or revealed she updated reflect current pressure addition, she complete rounds on 09/15/2021 the Registered Dieticiation, and the MDS Nurse #324, #45, #14, #357, review revealed the In reviewed each resident's orders care plan, and implem 2). Review of Resident revealed the Medical Dresident on 08/25/2021 Stage four (4) pressure deep tissue injury (DTI and a skin tear to the lates of the lat	N on 09/30/2021 at 4:17 PM ed head-to-toe skin sidents on 09/11/2021. She he facility identified twenty uries. She further stated that the Braden Scale sidents on 08/28/2021. revealed the utilized the skin den Scale assessments to care plans. She stated that the beautilized the skin den Scale assessments to care plans. She stated that the states of t	{F 7	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DDE	09/30/2021	
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	removed with wound a continued to treat the ulcer with Aquacel Age evaluation completed Resident #65 had six including a stage two measuring 1.2 cm (ler 0.1 cm (depth), stage measuring 2.5 cm by 3 stage two (2) to left hip cm x less than 0.1 cm scapula measuring 1 co.1 cm, unstageable to cm by 0.6 cm. and for measuring 12 cm by 1 Interventions in place theel protectors while in weekly documentation mattress to bed, nutriti turning/repositioning. Of or the sacral pressure 10:21 AM revealed the by 11 cm by 0.3 cm with drainage and 95 perce Resident #65 declined observation of other precord review revealed PM, Physician #1 determined to the weight loss and wound 09/28/2021, Resident #65 in-house wound care verecord revealed on 09/2 physician of the declined	rugh is present, partially cleanser." The facility resident's sacral pressure. A review of a wound on 09/15/2021 revealed (6) pressure ulcers, (2) to the left superior calford (2) to the left superior calford (3) to the right hip (2) cm by 1.4 cm (width) by one (1) to the right hip (2) cm by less than 0.1 cm, or measuring 1.2 cm by 0.8 to stage two (2) to left cm by 0.2 cm by less than to right heel measuring 0.6 cm (4) areas to the sacrum 1.6 cm by 0.4 cm. for the resident included in bed, diet as ordered, of the wound, an air onal supplements, and Observation of wound care ulcer on 09/29/2021 at the wound measured 13 cm that a scant amount of ant granulation tissue. would not consent to the resure areas. A medical that on 09/21/2021 at 2:19 rmined the resident's swere unavoidable. On (65's family declined isits. Further review of the 29/2021, staff notified the erinthe resident's wound eresident was diagnosed.	{F 7	755)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	185256	B. WING			09.	/30/2021	
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	on 09/10/2021. Reside 09/25/2021 and re-adi 09/28/2021. Further rerevealed staff develop plan on 09/21/2021. A re-admission revealed admission skin assess 09/28/2021, Braden S baseline care plan development of the state of the	d a Braden Scale on bleted a baseline care plan ent #355 was discharged on mitted to the facility on eview of the medical record ed the comprehensive care a review of Resident #355's I the resident had an ament completed on cale on 09/28/2021, and a //eloped on 09/28/2021 sident #45 on 09/28/2021 at 5 on 09/28/2021 at 1:40 109/29/2021 at 11:10 AM, 29/2021 at 11:52 AM, 29/2021 at 11:52 AM, 29/2021 at 11:30 AM and 29/2021 at 11:13 AM appeared clean, linens were on the lews with the residents observations revealed no review of Progress Notes is, #308, #309, #311, #314, el Interim Social Service e residents on 09/15/2021 with resident hygiene. 0 on 09/30/2021 at 2:23 PM ed Residents #45, #65, 4, and #320 on 09/15/2021 erns regarding hygiene. dents during the initial tour 33 PM to 2:32 PM revealed Interviews and record dents #45, #65, #308, #320 each had their	{F 7	755}				

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	review of the resident' the comprehensive caplan, revealed staff up to reflect the resident' the Vice President of at 4:10 PM revealed's resident preferences. was interviewed for ship preference, and the faresident's care plan. A interviews revealed the preference was obtain shower schedule reveshower/hygiene preference was obtain shower schedule revesled she resident diets on 08/28 that she implemented recommendations for revealed all residents' DON reviewed all diets Interview with the RDC revealed she complete and recommendations  7). A review of facility a 08/13/2021 revealed the with a diagnosis of Dia signs and symptoms or hyperglycemia and the intervention. Interview	s medical record, including re plan and SRNA care dated each resident's plan is preference. Interview with Operations on 09/30/2021 he assisted with obtaining She stated each resident lower and hygiene cility updated each review of resident eir shower/hygiene ed. A review of the facility's aled that the resident ences were honored.  Dietician on 09/30/2021 at began reviewing all 8/2021. She further stated new and/or additional residents to address weight ling. A review of the ed the Registered Dietician diets, and the Regional stand recommendations.  On 09/30/2021 at 4:17 PM diether the review of all diets ences were assessed for fiving hypoglycemia/ need for immediate with the Regional DON on revealed she assessed of dentify immediate so five Resident #348 on	{F 7	755}				

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	o9/29/2021 at 11:52 A signs/symptoms of hy A review of facility ass 08/12/2021 revealed f diagnosis of Chronic C Disorder (COPD), Asti assessed by Respirate with Respiratory Thera at 12:45 PM revealed with diagnoses of Chronic COPD), Asti O8/12/2021 with no ide Observation of Resident #65 PM, and Resident #65 PM, and Resident #43 revealed no respiratory.  8). Interview with the Fon 09/30/2021 at 3:40 all residents with a diagnesident's orders for glistated the facility amer include mandatory entitled m	aM, and Resident #311 on a M revealed no visible poglycemia/hyperglycemia.  Ressments completed on a postructive Pulmonary and Pneumonia were pory Therapist #1. Interview apist (RT) #1 on 09/30/2021 she assessed all residents poinc Obstructive Pulmonary and, and pneumonia entified concerns.  Int #45 on 09/28/2021 at 50 on 09/28/2021 at 2:03 PM. And a prevealed she reviewed gnosis of Diabetes and the pucose monitoring. She anded all resident orders to any of glucose values on the ent #3, #41, and #357's proder required staff to enter the resident's MAR. Further anders with residents ess than 60 and/or greater properties of Diabetes and the completed on 09/11/2021 elivered timely. Interview fied Dietary Manager at 2:26 PM, and revealed lunch was 1 and arrived at the unit	{F 7	755}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	two (2) licensed nurse assistants were sched facility. A review of the one (1) licensed nurse nursing assistants for 6:00 AM.  A review of the staffing 09/30/2021 revealed to three (3) certified nursi from 6:00 AM to 6:00 F staffing revealed one (2) certified nursing as 6:00 PM to 6:00 AM.  Observation of facility: 1:20 PM to 5:30 PM; or to approximately 6:00 F 7:55 AM to 5:17 PM, rebeing answered timely clean/well-groomed, st assisting residents with turning/repositioning wand meal trays were particularly with the control of	cility's staffing for AM to 6:00 PM revealed is and three (3) nursing luled for each floor of the efacility's staffing revealed each floor from 6:00 PM to grow of the each floor from 6:00 PM to grow of the each floor from 6:00 PM to grow of the each floor from 6:00 PM to grow of the each floor from each floor PM. Further review of the each floor from each floor each floor from ea	{F 7	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		_
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	on 09/29/2021 at 4:10 09/29/2021 at 3:04 PM at 3:17 PM and SRNA PM, revealed staffing staff member revealed duties as assigned.  11). Review of the staf 09/28/2021, 09/29/202 revealed each day cor one (1) evening cook, day aides, and two (2) Observation of the kito PM reflected the staffir schedule. Interview wit at 1:12 PM, and Dietar 2:10 PM revealed kitch and they were able to a their shift.  12). A review of assess withdrawn, crying, or o conducted for Residen 08/11/2021. No concer review of skin assessm no identified concerns. interviews conducted o and 09/30/2021 reveale with psychosocial and/a including observations and #322. Interview wit 09/29/2021 at 11:54 AM with abuse. Interview w	21 at 3:29 PM; SRNA #19 PM; SRNA #21 on A; SRNA #22 on 09/29/2021 A; #23 on 09/29/2021 at 4:10 had improved, and each I they had time to perform  Ifing schedule for 21, and 09/30/2021 hisisted of one (1) day cook, one (1) prep cook, two (2) evening aides. Hen on 09/28/2021 at 2:26 hig was accurate per the th Cook #3 on 09/29/2021 by Aide #3 on 09/30/2021 at hen staffing had improved, complete their duties during  Isinents for being ther abuse symptoms was ts #64, #86, and #322 on his were identified. A hents completed revealed Observation and n 09/28/2021, 09/29/2021, ed no identified concerns or physical abuse, of Residents #64, #86, h Resident #322 on A revealed no concerns with MDS Nurse #1 on revealed all residents with a had their care plans s necessary. Interview 0/2021 at 4:17 PM	{F 7	55}				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCT	TION	(X3) DAT	E SURVEY PLETED	
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	08/11/2021, for all res of licensed nursing statidentified. A review of Social Service Director BIMS score of eight (8 identified concerns.  13). A review of assess wander, revealed all rewandering risk assess Review of the elopemeeach nursing station obinder on each floor thincluding a description interventions for each 14). Review of Resideand #332's medical reresidents had been wellnterview with the Reg 09/30/2021 at 3:53 PM comprehensive nutrition Residents #39, #65, #8 Review of the medical completed a compreheassessment on 09/16/2021 for Resident Resident #81, 09/16/2021 for Resident Resident Polymer Resident Polymer Resident Olymer Consultant on 09/30/2021 for Resident Polymer Regional DON on 09/3 DON #2 on 09/30/2021 resident had received assessment and review by nursing staff. Further	idents, with the assistance off. No concerns were audits completed by the residents with a strain or above revealed no sments for residents that esidents had received a ment by 08/16/2021. The strain of the sident identified at risk. The sident ide	{F 7	55}				
	and regional DOM 160	ealed both the record and						

AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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	at 2:22 PM, the fourth PM and the fifth floor of revealed snacks include oatmeal pies, goldfish drinks were present, in juice. Observations on revealed snacks were Review of Resident #3 Resident #14's record intake of snacks. Inter 09/29/2021 at 4:10 PM educated on documen 16). Observation of the yellow zone on 09/28/2 no identified concerns. residents.  17). Review of Resider revealed the residents guidance. Observation 09/29/2021 at 11:41 Al 8/30/2021 at 10:36 AM or symptoms of COVID been discharged from the staff working on 09/16/COVID-19 with no iden review of resident testin 09/17/2021, revealed no 19). Interview with MDS at 1:39 PM, MDS Nursea	et third floor on 09/28/2021 floor on 09/28/2021 at 2:00 on 09/28/2021 at 2:06 PM ding but not limited to crackers, cookies and ncluding soda, milk, and 1 09/29/2021 at 10:30 AM being passed on third floor. 131, Resident #65 and revealed documented view with SRNA #19 on I revealed she was tation of snacks.  2 facility's red zone and 2021 at 2:12 PM revealed The zones contained no  1 st #327, #328 and #329 were isolated per CDC of Resident #328 on M and Resident #329 on revealed no obvious signs 1-19. Resident #327 had the facility.  1 staff testing revealed all 2021 were tested for tified new cases. Further ng for COVID-19 on	{F 7.	55}				

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	1:18 PM, Housekeepi 09/30/2021 at 1:24 PM Director (HR) on 09/30 Marketing Liaison on 0 Medical Records on 0 Central Supply on 09/30 on 09/29/2021 at 11:5 12:58 PM, RN #4/Wot 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 3:09/29/2021 at 3:29 PM at 4:10 PM, SRNA #21 SRNA #22 on 09/29/2021 at 3:09/29/2021 at 1:12 PM 09/30/2021 at 1:12 PM 09/30/2021 at 1:12 PM 09/30/2021 at 1:12 PM 09/30/2021 at 2:10 PM Director/Dietary Manage 1:30 PM revealed the 10 (2) times weekly. Intended the 10 (2) times weekly.	nager on 09/30/2021 at ng Supervisor on M, Human Resource 0/2021 at 10:48 AM, Senior 09/30/2021 at 10:55 AM, 9/29/2021 at 8:34 AM, 29/29/2021 at 2:40 PM, RN #1 5 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 on 09/30/2021 at 10:31 9/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 on 09/29/2021 at 3:17 PM and SRNA 4:10 PM, Cook #3 on I, Dietary Aide #3 on I, Dietary Aide #3 on I, Former Activities ger #3 on 09/30/2021 at facility is testing staff two view with Interim Infection 0/2021 at 3:10 PM revealed sting two (2) times weekly be. Review of facility staff is being conducted two (2) at #329, #328, #311, #65 and revealed that each 9 monitoring orders on, review of each ed staff was completing the by the physician.	{F 7	55}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STAT 200 NURSING HOME LANE PIKEVILLE, KY 41501	E, ZIP CODE	1 09	<del>//30/2021</del>
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	and Resident #351's r for usage and appropithe physician on 09/2:  22). Observation of a 09/29/2021 at 4:35 PM 09/30/2021 at 8:09 AM identified concerns with addition, observation of floor on 09/30/2021 at identified concerns. In 09/29/2021 at 11:55 A PM, N #4/Vound Care 2:54 PM, LPN #6 on 0 LPN #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 NO perations on 09/30/2 Co-Owner/President of a 3:11 PM revealed be agreement that the phase facility with a three-day requiring cost review. If pharmacy agreement is requiring a cost review the facility a minimum of medication while being would communicate ar guidance to the pharma Director of Operations the Vice President of Cosigned the agreement.	ent #324, Resident #326 medications were reviewed riate administration times by 3/2021.  medication pass on M on 3rd floor and M on 3rd floor revealed no th missing medications. In of a narcotic count on 5th 12:50 PM revealed no terview with RN #1 on M and 09/30/2021 at 12:58 e Nurse on 09/30/2021 at 9/30/2021 at 12:44 PM, at 3:00 PM and f, LPN #10 on 09/30/2021 #11 on 09/30/2021 at 10:31 rms with unavailable  Vice President of 021 at 4:10 PM and f Pharmacy on 09/30/2021 oth parties made a formal armacy will supply the v supply for medication Review of the facility's revealed for any medication the pharmacy would send of a three-day supply of the	{F 7	55}			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	Ē	09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION	SHOULD BE	TE	(XS) COMPLETION DATE
	12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 revealed they had recaware of the process from the pharmacy. In they were aware that if physician if the pharm medication to the facility by 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 at and 09/30/2021 at 8:09 concerns with missing 26). Review of a QAPI the facility conducted a with the Regional DON Consultant, Human Re Records, the Houseke Supply, MDS Nurse #1 Therapy Manager, the the Administrator, the Dietary Manager, and administration team.	t 12:58 PM, RN #4 on M, LPN #6 on 09/30/2021 at 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 on 09/30/2021 at 10:31 AM eived education and was for obtaining medications addition, they revealed the nurse would notify the accy could not deliver a ty.  Regional Nurse Consultant PM, and Regional DON on the revealed an audit was ents' ordered medications tions were available in the Observation of medication 4:35 PM on the third floor PAM revealed no identified medications.  signature sheet revealed a meeting on 08/12/2021 If, Regional Nurse esources, SSD #2, Medical eping Supervisor, Central ping Supervisor the other members of	{F 7	755}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09	9/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE	
	Administrator with dai 09/10/2021.  28). Interview with the 09/30/2021 at 3:40 PN 09/30/2021 at 3:25 PN committee, including the Consultant on 09/30/2 procedures for contact answering call lights, and turning/reposition on 09/15/2021.  29). Interview with the Operations on 09/30/2 Nurse Consultant on 09/30/2	Interim Administrator on M, the Medical Director on M and members of the QAPI the Regional Nurse 1021 at 3:40 PM, revealed ting staff for call-ins, ADL Care, serving and imely, incontinence care ing were reviewed on 1021 at 4:10 PM, Regional 19/30/2021 at 3:40 PM, and is Nurse Consultant on 11 revealed the facility the call to review the 10 pm so of the Survey, (2) to of the Governing Body as 11 nd Regulations, (3) the following 12 ring tools: Infection Control 13 revealed the staff at the 15 residents, turn and 15 rovide incontinent care,	{F 7	(55)				
[1	09/30/2021 at 3:40 PM	Interim Administrator on , and Regional Nurse 121 at 3:40 PM revealed						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
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PARKVIE	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	<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		TION SHOULD BE THE APPROPRIA	ŧ vīE	(X5) COMPLETION DATE
	Committee during the facility developed a stall topics were review meetings. The plan in Foley catheters, enter contractures, physical usage, risk managem hospital re-admission management, social s grievance, activities, rouncil concerns and/discharges, census, s by department/position dietary variance tray a work injuries, terminat medical leave of absenew hires, medical recipharmacy reports, resoffice, and admission accommittee 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 09/28/202 09/30/2021 at 1:32 PM Director/Dietary Manager on 09/28/202 09/30/2021 at 1:34 PM O9/30/2021 at 1:38 PM O9/30/2021 at 1:38 PM Supervisor on 09/30/2021 Respiratory Therapist 12:45 PM and Central	the QAPI Plan and and/or revision to the QAPI 09/16/2021 meeting. The andardized plan to ensure ed as needed at the QAPI cluded pressure ulcers, ral feeding tubes, restraints, medication ent, infection control, the rate, rehabilitation services, concerns of esident council, and family or grievances, admissions, taff development, openings in, employee orientations, audit report, weight losses, ions, employees on family ince or leave of absence, cord compliance review, torative nursing, business actions. The QAPI al Director approved the pro 09/16/2021 to include e topics presented during with MDS Nurse #1 on 1, Regional Certified Dietary 11 at 2:26 PM and 1, Former Activities ger #3 on 09/30/2021 at on 09/29/2021 at 1:24 PM, (RT) #1 on 09/30/2021 at Supply on 09/29/2021 at information was presented	{F 7	'55}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	E	<u>  09/</u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
{F 755}	Administrator on 09/3 on 09/30/2021 at 3:20 Director on 09/30/2022 meeting was conduct the duties of the Gove policy and procedures facility and communic members of the Gove meeting, 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 Phi monitoring reports being and reviewed the data QAPI attendance she conducted meetings of and 09/30/2021. Interview of Operations on 09/30/2021. Interview with the Operations on 09/30/2021. Interview with the Operations on 09/30/2021. Interview with the Operations on 09/30/2021. Regional Nurse Const PM revealed they were governing body, and Construction on 09/30/2021. Regional Nurse Const PM revealed the gove Administrator with resemble of the province of the governing body would upcoming year. Interview in the province of the province of the governing body would upcoming year. Interview in the province of the governing body would upcoming year. Interview in the province of the governing body would upcoming year. Interview in the governing body would upcoming year. Interview in the governing body would upcoming year.	e Vice President of 2021 at 4:10 PM, the Interim 0/2021 at 3:40 PM, DON #2 0 PM, and the Medical 21 at 3:25 PM revealed a ed on 09/16/2021 regarding erning Body including setting is to be implemented in the rating information to other erning Body. During the pocesses, the need to in the QAPI process, the auses 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 0/2021 at 4:10 PM and cultant on 09/30/2021 at 3:40 re members of the DAPI meetings had been  Vice President of 2021 at 4:10 PM and the cultant on 09/30/2021 at 3:40 rning body provided the ources and education ther interviews revealed the meet quarterly for the	{F 7	55}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
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{F 755}	09/30/2021 at 3:40 PN were conducted week ensure the quality of complied with the star compliance. Further in President of Operation PM, Regional Nurse C3:40 PM, MDS Nurse PM, Former Activities PM, Former Activities #3 on 09/30/2021 at 1 on 09/29/2021 at 8:34 Director (HR) on 09/30/2021 at 10 nusekeeping Superv PM, Respiratory Therat 12:45 PM and Cent 2:40 PM revealed they weekly QAPI meeting and 09/23/2021. In ad Medical Director/Phys 3:25 PM revealed he published PM revealed he published PM revealed he published	with resources and DAPI.  Interim Administrator on M revealed QAPI meetings by effective 09/16/2021 to care is monitored and oddard of care and offerview with the Vice on 09/30/2021 at 4:10 consultant on 09/30/2021 at 1:39 of 09/30/2021 at 1:31 PM, offerview Manager on M and 09/30/2021 at 1:52 Director/Dietary Manager on M and 09/30/2021 at 1:52 Director/Dietary Manager on M and 09/30/2021 at 1:18 PM, offerview Manager on 09/30/2021 at 1:18 PM, offerview Man	{F 75	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	109/	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	1-1-1-1	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
{F 755}	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 3:23 PM at 3:29 PM, SRNA #15 SRNA #21 on 09/29/2 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PM education on 09/17/20 staff revealed they ver weighing residents, of reporting the weights of (RD). Interview with R at 4:17 PM revealed s education on 09/17/20 techniques, obtaining, reporting weight chang Dietician.  36). Interview with For current Dietary Manag PM revealed she rece 09/13/2021 by the Reg Manager (CDM) on die timely nutritional asses order accuracy. When the electronic medical the order sends writter dietary staff, which inc further revealed that si the tray card system to orders. She stated tha previous day would be meeting. Interview with 09/28/2021 at 2:26 PM PM revealed she comp	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 021. Interview with nursing realized understanding of otaining, documenting, and to the Registered Dietician regional DON on 09/30/2021 taff was provided with 121 on proper weighing documenting, and ges to the Registered  Immer Activities Director and rer on 09/30/2021 at 1:30 red education on gional Certified Dietary et order accuracy and saments to ensure diet staff enter diet orders into record, the nurse entering in communication to the fludes diet and texture. She whe entered the order into or reflect the resident's diet at all diet orders from the reviewed in the clinical of the Regional CDM on and 09/30/2021 at 1:52	{F 7	55}			

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABI	ILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	1 09/	30/2021	
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
(F 755) Continued From page 775 addition, she stated that she provide additional assistant to her new role.  37). Interview with RN #1 (AM and 09/30/2021 at 12::4 PM 09/29/2021 at 3:00 PM and PM, LPN #10 on 09/30/202 #11 on 09/30/2021 at 3:40 PM, S 09/29/2021 at 3:23 PM SR at 3:29 PM, SRNA #19 on SRNA #21 on 09/29/2021 on 09/29/2021 at 4:10 PM, refeducation on turning/reposition and transferring residair and from chair to be durning, positioning, and won 09/29/2021 at 10:21 AM revealed no identified condition on the chair and from chair to be durning, positioning, and won 09/29/2021 at 10:21 AM revealed she provided staff beginning on 08/19/2021 in turning/repositioning, range transferring a resident from 38). Interview with RN #1 (AM and 09/30/2021 at 12:44 PM 09/29/2021 at 3:00 PM and PM, LPN #10 on 09/30/2021 at 10:3: 09/29/2021 at 3:23 PM SR at 3:29 PM, SRNA #19 on	the had been on site to ince during the transition on 09/29/2021 at 11:55 is 8 PM, RN #4/Wound 1 at 2:54 PM, LPN #6 in M, LPN #7 on ind 09/30/2021 at 1:54 in December 2021 at 12:50 PM, LPN in December 2021 at 12:50 PM, LPN in December 2021 at 2:50 PM, LPN in December 2021 at 2:50 PM, LPN in December 2021 at 4:10 PM, at 3:04 PM, SRNA #22 in December 2021 at 4:10 PM, at 3:04 PM, SRNA #22 in December 2021 at 4:10 PM, at 3:04 PM, SRNA #22 in December 2021 at 4:10 PM, at 3:04 PM, SRNA #22 in December 2021 at 4:10 PM, at 3:04 PM, srna #11 in December 2021 at 1:18 PM in Section 2021 at 1:18 PM in Section 2021 at 1:155 in December 2021 at 1:155 in December 2021 at 1:54 PM, LPN #6 in December 2021 at 1:50 PM, LPN #6 in December 2021 at 1:50 PM, LPN in Decemb	{F 7	755}				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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PARKVIE	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZII  200 NURSING HOME LANE  PIKEVILLE, KY 41501	P CODE	09/30/2021	
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	SRNA #21 on 09/29/2 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PN education on pressure turning and reposition nutrition, Positioning cand document a head and how to notify the rRP of a new skin impaor email the Registere and the resident's reproduced the resident's reproduced they educate prevention including to adequate hydration and devices, how to complished-to-toe skin assess the registered dieticiar new skin impairment, the nurse Registered Dietitian fo MD, and resident's reproduced they educate prevention including to adequate hydration and devices, how to complished-to-toe skin assess the registered dieticiar new skin impairment, the nurse Registered Dietitian fo MD, and resident's reproduced they with MD at 1:39 PM, MDS Nurse PM, Maintenance Assi 2:56 PM, Therapy Mart 1:18 PM, Housekeepin 09/30/2021 at 1:24 PM Director (HR) on 09/30 Marketing Liaison on 0 Medical Records on 09/29/2021 at 1:09/30/2021 at 2:10 PM	2021 at 3:04 PM, SRNA #22 2 PM and SRNA #23 on 2 revealed they received 3 ulcer prevention including 3 ing, adequate hydration and 3 fevices, how to complete 3 fevices, how to complete 4 fevices, how to complete 5 fevices, how to complete 6 fevices, how to assessment, 6 fevices, how to and 6 fevices, how to and 6 fevices, how to and 6 fevices, how to assessment, 6 fevices, how to complete 6 fevices, how to complete 6 fevices, how to assessment, 6 fevic	{F 7	755}			

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	E OF PROVIDER OR SUPPLIER  KVIEW POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	)DE	09	/30/2021
PRE	EFIX   (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		<del></del>		E NTE	(X5) COMPLETION DATE
{F ·	with RN #1 on 09/29// 09/30/2021 at 12:58 F Nurse on 09/30/2021 09/30/2021 at 12:44 F at 3:00 PM and 09/30 on 09/30/2021 at 12:59 09/30/2021 at 10:31 A at 3:40 PM, SRNA #1 SRNA #7 on 09/29/20 on 09/29/2021 at 4:10 09/29/2021 at 3:04 PM at 3:17 PM and SRNA PM, revealed they rec call light response, pro resident plan of care, is staff dress residents in clothing and timely del interview with Cook #3 Dietary Aide #3 on 09/ Former Activities Direc 09/30/2021 at 1:30 PM education on meal ser 40). Interview with MD at 1:39 PM, MDS Nurs PM, RN #1 on 09/29/2 09/30/2021 at 12:58 P Nurse on 09/30/2021 at 09/30/2021 at 12:44 P at 3:00 PM and 09/30// on 09/30/2021 at 10:31 Al education on ensuring entered into the electro	nse. In addition, interviews 2021 at 11:55 AM and PM, RN #4/Wound Care at 2:54 PM, LPN #6 on PM, LPN #7 on 09/29/2021 /2021 at 1:54 PM, LPN #10 in PM, LPN #11 on PM, LPN #11 on PM, SRNA #1 on 09/29/2021 at 3:23 PM 21 at 3:29 PM, SRNA #19 in PM, SRNA #21 on PM, SRNA #21 on PM, SRNA #22 on 09/29/2021 at 4:10 elived education on timely eviding timely hygiene per timely toileting, ensuring in their choice of clean livery of meal trays. Further is on 09/29/2021 at 1:12 PM, 30/2021 at 2:10 PM, and attor/Dietary Manager #3 on it revealed they received vice times.  S Nurse #1 on 09/30/2021 at 1:31 in perceived vice times.  S Nurse #1 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 at 1:54 PM, LPN #10 in PM, LPN #11 on PM revealed they received new care plans were an ic medical record. In 09/29/2021 at 11:55 AM is able to demonstrate	{F 7				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09	9/30/2021	
(X4) ID PREFIX TAG			ID PREFI TAG		8E	(X5) COMPLETION DATE	
{F 755}	Continued From page 41). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30// on 09/30/2021 at 12:4 09/29/2021 at 3:00 PN PM, LPN #10 on 09/36 #11 on 09/30/2021 at 09/29/2021 at 3:40 PN 09/29/2021 at 3:40 PN 09/29/2021 at 3:23 PN at 3:29 PM, SRNA #15 SRNA #21 on 09/29/20 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PN education on identificate residents with a change on identifying signs/sy hyperglycemia/hypoglyprotocol, documentate medical record, notificate following physician orderevealed they received documentation of gluce 42). Interview with RN	#1 on 09/29/2021 at 11:55 t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 4 PM, LPN #7 on M and 09/30/2021 at 1:54 0/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on M SRNA #11 on M SRNA #7 on 09/29/2021 0 on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA #22 PM and SRNA #23 on I revealed they received tion and assessment of the in respiratory status and mptoms of y/cemia, facility diabetic resident change in ion of blood sugar in the ation of the physician and lers. In addition, interviews I education on	{F 7	DEFICIENCY)	NATE	DATE	
	Care Nurse on 09/30/2 on 09/30/2021 at 12:44 09/29/2021 at 3:00 PM PM, LPN #10 on 09/30 #11 on 09/30/2021 at 1 09/29/2021 at 3:40 PM 09/29/2021 at 3:23 PM at 3:29 PM, SRNA #19 SRNA #21 on 09/29/20 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PM	021 at 2:54 PM, LPN #6 4 PM, LPN #7 on 1 and 09/30/2021 at 1:54 1/2021 at 12:50 PM, LPN 0:31 AM, SRNA #1 on , SRNA #11 on SRNA #7 on 09/29/2021 on 09/29/2021 at 4:10 PM, 1/21 at 3:04 PM, SRNA #22					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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PARKVIE	ROVIDER OR SUPPLIER  W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	0	9/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	(	DBE	COMPLETION DATE
	within forty-eight hours reviewing and providir resident/responsible p  44). Interview with MD at 1:39 PM, MDS Nurs PM, Maintenance Assi 2:56 PM, Therapy Mar 1:18 PM, Housekeepir 09/30/2021 at 1:24 PM Director (HR) on 09/30 Marketing Liaison on 0 Medical Records on 09/29/2021 at 11:55 12:58 PM, RN #4/Wou 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 AM, SRNA #1 on 09/29/2021 at 3:29 PM 09/29/2021 at 3:29 PM 09/29/2021 at 4:10 PM at 3:04 PM, SRNA #22 and SRNA #23 on 09/29/2021 at 1:09/30/2021 at 2:10 PM Director/Dietary Manag 1:30 PM revealed they process of identifying, abuse as well as identifimmediate interventions 45). Interview with RN #	goals relevant to the and a respiratory diagnosis of admission, and a g a copy to the arty.  S Nurse #1 on 09/30/2021 at 1:31 stant #1 on 09/30/2021 at 1:31 stant #1 on 09/30/2021 at 1:39 supervisor on I, Human Resource 1/2021 at 10:48 AM, Senior 1/2021 at 10:55 AM, 1/202021 at 10:55 AM, 1/202021 at 10:50 AM, Senior 1/202021 at 3:40 PM, Cook 1/202021 at	{F 7	755}		
	Care Nurse on 09/30/20	021 at 2:54 PM, LPN #6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	185256	B. WNG				R
NAME OF PROVIDER OR SUPPLIER	103236	B. WING			09	/30/2021
PARKVIEW POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP COI 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE .		
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CO IX (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	E TE	(X5) COMPLETION DATE
PM, LPN #10 on 09/30/202 they received education techniques, obtaining, reporting of weight characteristic techniques, and received education and provision of timely ensure diet order accurate put into the electronurse entering the orders from the previous clinical meeting, which Friday, to ensure accurate accurate the techniques and the use of refortified diets to ensure nutritional needs of resestablished national gualitural, and ethnic needs the techniques with the 09/30/2021 at 1:30 PM education on obtaining tray card system, order snack/hydration pass, and/or portion sizes, starts and snacks and he	A PM, LPN #7 on M and 09/30/2021 at 1:54 0/2021 at 12:50 PM and 21 at 10:31 AM revealed on on proper weighing documenting, and anges to the Registered an interview with the Dietary 21 at 1:30 PM revealed she on on diet order accuracy or nutritional assessment to uracy. When the diet orders onic medical record, the fer will send a written dietary staff that will include further revealed all diet us day are reviewed in the cocurs Monday through eracy.  Dietary Manager on M revealed she received olicy regarding meal service ecipes, including recipes for eall meals meet the sidents in accordance with uidelines to reflect religious, eds of the population.  Dietary Manager on I revealed she received of food preference, facility or placement for meals, appropriate scoop sizes tocking snack/hydration	{F 7	'55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			l .	R
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS GITT OTHER THE	09	30/2021
DADIONE	*/ DOOT A DUTT A 117 TO				STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE		
FARAVIE	W POST-ACUTE AND RE	HABILITATION CENTER			PIKEVILLE, KY 41501		
(X4) ID		ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	COMPLETION DATE
{F 755}	Continued From page	781	{F 7	'55	3		
	Care Nurse on 09/30/	2021 at 2:54 PM, LPN #6			<b>'</b>		
	on 09/30/2021 at 12:4	4 PM, LPN #7 on					
	09/29/2021 at 3:00 PN	M and 09/30/2021 at 1:54					
	PM, LPN #10 on 09/3	0/2021 at 12:50 PM, LPN					
	#11 on 09/30/2021 at						
	Activities Director/Diet	lary Manager #3 on					
	education on the proc	If revealed they received ess for entering, activating,					
	and/or implementing to	he registered dietician's					
	recommendations for	dietary orders					
	49). Interview with the	Interim Administrator on					
	09/30/2021 at 5:05 PN	/i, DON #2 on 09/30/2021 at					
	3:20 PM, Interview wit	h MDS Nurse #1 on	i				- 1
	09/30/2021 at 1:39 PN	/I, MDS Nurse #2 on					
	09/30/2021 at 1:31 PN	//, Maintenance Assistant #1					ľ
	09/30/2021 at 1:18 PM	PM, Therapy Manager on				İ	
	Supervisor on 09/30/2	021 at 1:24 PM, Human					- 1
	Resource Director (HF	R) on 09/30/2021 at 10:48	İ				- 1
	AM, Senior Marketing	Liaison on 09/30/2021 at					ŀ
	10:55 AM, Medical Re	cords on 09/29/2021 at					- 1
	8:34 AM, Central Supp	oly on 09/29/2021 at 2:40					- 1
	PM, RN #1 on 09/29/2	2021 at 11:55 AM and					
	09/30/2021 at 12:58 P	M, RN #4/Wound Care					ĺ
	Nurse on 09/30/2021 a	at 2:54 PM, LPN #6 on					
	09/30/2021 at 12:44 P	M, LPN #7 on 09/29/2021					- 1
		2021 at 1:54 PM, LPN #10					
	on 09/30/2021 at 12:50	M, SRNA #1 on 09/29/2021					ĺ
	at 3:40 PM SRNA #1	1 on 09/29/2021 at 3:23 PM					
		21 at 3:29 PM, SRNA #19					
	on 09/29/2021 at 4:10	PM, SRNA#21 on					
		I, SRNA #22 on 09/29/2021					
		#23 on 09/29/2021 at 4:10					
	PM, Cook #3 on 09/29	/2021 at 1:12 PM, Dietary					
	Aide #3 on 09/30/2021	at 2:10 PM, Former					
	Activities Director/Dieta	ary Manager #3 on					
	09/30/2021 at 1:30 PM	revealed they had					

	DER/SUPPLIER/CLIA ICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED	
	185256	B. WING					R	
NAME OF PROVIDER OR SUPPLIER	100200	D. 111110	0.777.			09	/30/2021	
PARKVIEW POST-ACUTE AND REHABILITATI			200 NURSI	DDRESS, CITY, STATE, ING HOME LANE I.E, KY 41501	ZIP CODE			
(X4) ID SUMMARY STATEMENT OF I PREFIX (EACH DEFICIENCY MUST BE PF TAG REGULATORY OR LSC IDENTIFYI	RECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIA IENCY)	E ITE	(X5) COMPLETION DATE	
received education on the COVI policy/guidelines, handwashing, Personal Protective Equipment (red zones. Observation of the re and yellow zone on 09/28/2021 a revealed no identified concerns. were in the red or yellow zones. conducted on 09/28/2021, 09/29 09/30/2021 revealed no identifier the COVID-19 policy/guidelines, donning/doffing Personal Protect (PPE), or the yellow/red zones.  50). Interview with RN #1 on 09/3 AM, and 09/30/2021 at 12:58 PN Care Nurse on 09/30/2021 at 12:54 (LPN) #6 on 09/30/2021 at 3:00 PM and 1:54 PM, LPN #10 on 09/30/2021 LPN #11 on 09/30/2021 at 10:31 they had received education ente symptom monitoring orders on all admissions. A review of newly ac #355 on 09/10/2021 revealed the COVID-19 symptom monitoring eresident orders. Resident #355 won 09/25/2021 and re-admitted to 09/28/2021. A review of re-admited to 09/28/2021 at 2:50 PM review of re-admited to 09/28/2021 at 2:50 PM review of re-admited to 09/28/2021 at 2:50 PM review of re-admited to 09/28/2021 at 2:50 PM review of	donning/doffing (PPE), yellow and d facility zone at 2:12 PM No residents Observations /2021, and d concerns with handwashing, tive Equipment  29/2021 at 11:55 1, RN #4/Wound 64 PM, LPN PM, LPN (LPN) d 09/30/2021 at 1 at 12:50 PM, AM revealed ering COVID-19 If new denitted Resident eresident had entered in the vas discharged to the facility on esion for lent had a entered in the view of Resident s medical ad COVID-19  29/2021 at 11:55 I, RN #4/Wound 4 PM, LPN	{F 7	55}					

		(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			STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	Ē	<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		SHOULD BI		(X5) COMPLETION DATE
(F 755)	1:54 PM, LPN #10 on LPN #11 on 09/30/20; they had received edu of medication, right paties and right route. In ad on the process to folk not available for admit calling the pharmacy obtaining the anticipal notifying the physiciar would either be omitted ordered medication the included following new physician, documenting new orders from the Arrecord.  52). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/(LPN) #6 on 09/30/2021 at Care Nurse on 09/30/(LPN) #6 on 09/30/2021 at 31:54 PM, LPN #10 on LPN #11 on 09/30/2021 they had received educemergency medication floor three (3) on 09/29/2021 at 2 medication administra with an emergency multiple medication remedication remedication kit.	2:00 PM and 09/30/2021 at 09/30/2021 at 12:50 PM, 21 at 10:31 AM revealed acation on the five (5) rights stration including right ent, right dose, right time, dition, they were educated by when a medication was instration, which included to obtain the medication, led medication delivery time, at if an ordered medication also worders given by the me. The education also worders given by the mg the conversation, and and and in the electronic medical at 2:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN (LPN) 1:00 PM and 09/30/2021 at 09/30/2021 at 12:50 PM, 21 at 10:31 AM revealed acation on the use of the matic (e-kit). Observation of 19/2021 at 3:10 PM, floor at 2:57 PM, and floor five 2:50 PM revealed edication kit. Interview with 19/2021 at 2:27 PM revealed	{F 7	55)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		185256	B. WING				R
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	09	30/2021
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER		200 N	IURSING HOME LANE VILLE, 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 PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
{F 755}	MDS Nurse #2 on 09/ Maintenance Assistan PM, Therapy Manage Housekeeping Super PM, Human Resource 09/30/2021 at 10:48 A Liaison on 09/30/2021 Records on 09/29/2021 09/29/2021 at 11:55 A PM, RN #4/Wound Ca 2:54 PM, LPN (LPN) #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #2: SRNA #22 on 09/29/20 #23 on 09/29/2021 at were educated on the contact information an Coordinator. Observat 09/28/2021, 09/29/202 revealed signage post Administrator's contact Abuse Coordinator pos 54). Review of audits it weekly head-to-toe ski no identified concerns. #27 skin and wound at at 10:20 AM revealed review of the medical r #324, #45, #14, #357, revealed the weekly we	n 09/30/2021 at 1:39 PM, 30/2021 at 1:31 PM, tt #1 on 09/30/2021 at 2:56 on 09/30/2021 at 1:18 PM, risor on 09/30/2021 at 1:24 e Director (HR) on M, Senior Marketing at 10:55 AM, Medical at 2:40 PM, RN #1 on M and 09/30/2021 at 12:58 are Nurse on 09/30/2021 at 12:44 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 on 09/30/2021 at 10:31 99/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 on 09/29/2021 at 3:04 PM, D21 at 3:17 PM and SRNA 4:10 PM revealed they Interim Administrator's d role as Abuse ion of the facility on 21, and 09/30/2021 ed with the Interim tinformation and title of sted throughout the facility.	{F 7	55}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B, WING		i	1	R /30/2021
PARKVIEV	ROVIDER OR SUPPLIER  N POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	E	03	3072021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFI TAG		N SHOULD BE	TE	(X5) COMPLETION DATE
	notifications. Interview 09/30/2021 at 3:53 PN of new and/or worseni reviewed the residents with Medical Director revealed that he was a worsening skin impaininterventions to prever revealed that he particuland discussed ongoing residents. Interview with on 09/30/2021 at 5:05 team discussed all audincluding new and/or vand interventions implementations implementations. Interview with Cerat 2:40 PM revealed stall laboratory supplies revealed that the audit for four (4) weeks and months. A review of au Observation of floor th (5) supplies and review identified concerns.  56). Interview with the 09/30/2021 at 4:17 PM 09/30/2021 at 3:20 PM were audited during mensure all new areas of been care planned with the area of concern. A no identified concerns.	with the Dietician on M revealed she was notified ing pressure ulcers and is as indicated. Interview on 09/30/2021 at 3:25 PM notified of new and/or ments and new int decline. He further cipated in QAPI meetings in gaudits and care of the Interim Administrator PM revealed the QAPI dits in QAPI meetings, vorsening pressure injuries emented.  Intral Supply on 09/29/2021 the completed the audits of on 08/28/2021. She further is were conducted weekly then monthly for three (3) audits revealed no concerns. Interest (3), four (4), and five of the audits revealed no interventions to address review of audits revealed.	{F 7	755}			
	on 09/30/2021 at 10:55 completed visual round hygiene, toileting, inco	ling of residents assessing					

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 PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE 200 NURSING HOME LANE PIKEVILLE, KY 41501	TE, ZIP CODE	09/	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	( (EACH CORRECT CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 755}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		{F 7	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED  R	
		185256	B. WNG				
NAME OF PROVIDER OR SUPPLIER  PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
(F 755)	09/25/2021 and re-adi 09/28/2021. Further re for Resident #355 rev. comprehensive care p (11) days after admiss re-admission for Resident had a baselin 09/28/2021. Interview 09/30/2021 at 1:39 PM 09/30/2021 at 1:31 PM admissions and re-additional reviewed during meeting Monday throus completion. 61). Review of the additional revealed newladmission MDS Nurse #1 on 09/3 revealed newladmission being updated as need 62). Interview with MD at 1:39 PM revealed ne plans were being audit completion, accuracy, was conducted with the responsible party withi admission/re-admissio revealed the audits we through Friday. A revier revealed they included date, baseline care pla delivered to resident at and education as need	#355 was discharged on mitted to the facility on eview of the medical record ealed staff completed the olan on 09/21/2021 (elevention). A review of dent #355 revealed the ecare plan developed on with MDS Nurse #1 on and MDS Nurse #2 on and revealed all new missions to the facility were the morning clinical eigh Friday to ensure missions for the last thirty -08/16/2021 revealed no ecare plans. Interview with 30/2021 at 1:39 PM on baseline care plans were ded in morning meetings.  S Nurse #1 on 09/30/2021 ew admission baseline care ted Monday-Friday for and to ensure a review e resident and/or n 48 hours of n. Further interviews	{F 7	55}			