| 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 | | | ę | STREET ADDRESS, CITY, STATE, ZIP CODE | 031. | 30/2021 |
| DA DIO (IE) | U DOOT 40UTS 4ND DE | | | 2 | 200 NURSING HOME LANE | | |
| PARKVIE | V POST-ACUTE AND RE | HABILITATION CENTER | | F | 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 755} | and/or CDM revealed stated with no identification the Regional Certified 09/28/2021 at 2:26 Pl PM, and Dietary Maniti:30 PM revealed trayensure they arrived of timely. 64). Review of verbal staff members were obeginning on 8/15/20/2 education. Further revealed five (5) staff four (4) weeks from 0 on 09/13/2021 with no review of the verbal question. | dits completed by the DM I they were completed as ed concerns. Interview with I Dietary Manager on M and 09/30/2021 at 1:52 ager #3 on 09/30/2021 at ys were audited for to n the unit and were passed quizzes revealed ten (10) quizzed for one (1) week 21 with no needed view of verbal quizzes members were quizzed for 8/22/2021 and completed o identified concerns. A quiz revealed staff was | {F 7 | 55} | | | |
| | Consultant on 09/30// Regional DON on 09/ #2 on 09/30/2021 at 3:30 on 09/30/2021 at 1:31 performed verbal quiz assessment of reside respiratory status, ide hyperglycemia/hypog protocol, documenting condition, notification following physician or on 09/29/2021 at 11:512:58 PM, RN #4/W0 09/30/2021 at 2:54 Pl 09/30/2021 at 12:44 F | and SBAR/physician with the Regional Nurse 2021 at 3:40 PM, the /30/2021 at 4:17 PM, DON 3:20 PM, and MDS Nurse #2 1 PM revealed they zzes for identification and nts with a change in entifying signs/symptoms of lycemia, facility diabetic g a change in a resident's of the physician and rders. Interviews with RN #1 55 AM and 09/30/2021 at end Care Nurse on M, LPN (LPN) #6 on PM, revealed they quizzes with facility staff. | | | | | |

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | | OMB N | <u>IO. 0938-0391</u> |
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| AND PLAN O | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | | LE CONSTRUCTION | | TE SURVEY MPLETED |
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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 | | 1 0 | 9/30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | ıx | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | SHOULD BE | |
| | audits of documented Monday through Frida She further revealed tiless than 60 and/or gr staff were expected to Responsible Party, an follow physician orders stated she identified or 08/12/2021 to have a land one (1) on 09/20/2 glucose level of 465 w evidence the licensed process. She provided and LPN #5. A Review further concerns. A ReRN #2 and LPN #5 recthe facility process. 66). Review of verbal swas verbally asked sig when to report, signs a and wandering interververbal quizzes revealed quizzed daily for one (108/19/2021 with no idea review revealed verbal three (3) times a week 08/21/2021 to 09/02/20 concerns. A review of verbal quizzes were per week for four (4) we 09/03/2021 to 09/24/20 concerns. Interview with Consultant on 09/30/2021 at 4:17 PM, 09/30/2021 at 1:39 PM the completion of verbal | A revealed she completed blood glucose levels y in the clinical meeting. hat with any blood sugar eater than 40, the facility notify the physician, d Registered Dietician and s. The Regional DON ne (1) resident on blood glucose level of 430 2021 to have a blood ith no documented nurse followed the facility education to both RN #2 of audits revealed no view of education regarding that ff quizzes revealed staff ns and symptoms of abuse nd symptoms of wandering notions. A review of the dive (5) staff were verbally (1) week from 08/13/2021 to notified concerns. Further quizzes were conducted for two (2) weeks from 21 with no identified erbal quizzes revealed e conducted one (1) time eeks from the week of 21 with no identified in the Regional Nurse 21 at 3:40 PM, RDON on and MDS Nurse #1 on revealed each assisted in | {F 7 | 755} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF 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 | 1 | STF 200 | REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501 | 09 | /30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRI | | | (X5) COMPLETION DATE |
| | tool (signs and symptoreport, signs and symptoreport, symptoreport, signs and symptoreport, symp | e areas listed on the audit ons of abuse, when to ptoms of wandering and ns), and any need for eted immediately with each 6RNA #11 on 09/29/2021 at #6 on 09/30/2021 at 12:44 09/29/2021 at 3:00 PM and M, RN #1 on 09/29/2021 at 021 at 12:58 PM, RN e on 09/30/2021 at 2:54 PM, 9/29/2021 at 8:34 AM, 29/2021 at 2:40 PM, 09/30/2021 at 1:18 PM, isor on 09/30/2021 at 1:24 Director (HR) on M and Maintenance 12021 at 2:56 PM revealed roal quizzes regarding wandering and wandering wandering and wandering 1555 was discharged on nitted to the facility on of re-admission for d the resident had an isk assessment completed sident was not identified to 15 at 1:39 PM revealed that the wandering risk as completion. Interview with litant on 09/30/2021 at 3:40 1/30/2021 at 3:20 PM reveled as sidens would be reviewed | {F 7 | (55) | | | |

| 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 | | 20 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501 | 0 | <u>9/30/2021 </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION; | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | E | (X5) COMPLETION DATE | |
| | appropriate assessme wandering risk assess Further interviews revidentified as at risk for discussed during this interventions implemed 68). Review of interview with a BIMS score of 8 identified concerns. Conterviews were initiated (10) resident interview weeks then five (5) resident interview with ISSD or and MDS Nurse #1 on revealed they were as with residents with no of audits initiated on 0 random weekly skin as with a BIMS score of letter are no injuries of no identified concerns. Nurse Consultant on 0 DON #2 on 09/30/202 were completing audits identified concerns. Old assessment on 09/30/9:23 AM and on 09/30/9/2021 at 3:53 PM audits on 08/25/2021 celectronic medical recoin the diet/tray card sof Review of Resident #3 09/29/2021 at 12:04 PI | ents, including the ament, had been completed. ealed that residents wandering would be meeting and appropriate nted. Ews performed for residents or greater revealed no onlinued review revealed ed on 08/13/2021 with ten s completed for four (4) sidents for eight (8) weeks. 109/30/2021 at 2:23 PM, 109/30/2021 at 1:39 PM sisting in completing audits concerns identified. Review 63/13/2021 for review of sessments for residents ess than eight (8) to ensure in unknown origin revealed linterview with Regional 19/30/2021 at 3:40 PM, and 1 at 3:20 PM revealed they is as indicated with no operation of skin 2021 of Resident #45 at 2021 at 10:20 AM of all no concerns with injuries Registered Dietician on revealed she started of resident diet orders from ords against orders entered tware to ensure accuracy. | {F 7 | 755} | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | LTIPLE CONSTRUCTION DING | . | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WNG | _ | I | R | |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501 | ODE | <u> 09</u> | /30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y 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) | | E ATE | (X5) COMPLETION DATE |
| | diets were served as a review of audits reveal weekly for four (4) were review of audits reveal weekly for four (4) were review of complete meals were audited the beginning 08/23/2021 random meals were of week for two (2) week 09/13/2021 for one (1) Former Activities Direct 09/30/2021 at 1:30 PM Manager on 09/28/2020 09/30/2021 at 1:52 PM performed as indicated revealed that meals wincluding breakfast at PM, and dinner at 5:00 09/28/2021 at 5:03 PM had been served on the on 09/29/2021 lunch in at the third floor at appround fourth floor at 12:34 PM in the fifth floor at 12:34 PM in the fifth floor at 12:34 PM in the fifth floor at 12:04 PM on 09/29/2021 at 12: | 21 at 12:30 PM revealed ordered by the physician. A aled audits were conducted eks. 22 at 23 at 23 at 24 at 25 at | {F 7 | | | | |
| | were audited daily for o | one (1) week from 021. Further review of the | | | | | |

| 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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| PARKVIE | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | | | STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | <u> 0</u> 9/: | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD BE | E TE | (X5) COMPLETION DATE |
| | beginning on 09/22/26 Regional Certified Die 09/28/2021 at 2:26 PM PM revealed she audi not identified any cond 72). Interview with the (HR) on 09/30/2021 at completed audits for d time clock punches. S concerns. Observation 09/28/2021, 09/29/202 revealed no concerns. 73). Interview with the on 09/30/2021 at 3:40 at 4:17 PM, DON #2 o and Interim Infection C 09/30/2021 at 3:10 PM being conducted with o handwashing, isolation donning/doffing PPE, r variance or identified o immediately. A review were conducted begins shifts and units. 74). Interview with the on 09/30/2021 at 3:40 responsible in addition review all residents on pharmacy to ensure the beginning 09/23/2021. no identified concerns. 11:55 AM and 09/30/202 #7 on 09/29/2021 at 3:6 | s were audited weekly 121. Interview with the tary Manager on If and 09/30/2021 at 1:52 ted snack intake and had terns. Human Resource Director 10:48 AM revealed she aily staff screening against the revealed no identified of entry doors on 11, and 09/30/2021 Regional Nurse Consultant PM, RDON on 09/30/2021 In 09/30/2021 at 3:20 PM, control Nurse on I revealed audits were observations of signage and zones, mask compliance. Any oncems will be addressed of the audits revealed they ning 09/17/2021 on random Regional Nurse Consultant PM revealed she was to other members to narcotics with the at an active script is on file A review of audits revealed RN #1 on 09/29/2021 at | {F 7 | '55} | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCT | (X3) DA | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | R | | |
| NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER | | | HABILITATION CENTER | · | STREET ADDRE 200 NURSING PIKEVILLE, K | | 1 0 | 9/30/2021 |
| | (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | ID PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY) | | 36 | COMPLETION DATE |
| | | concerns with obtaining and/or receiving medication pass on the third floor and 09/3 revealed no identified a medications. In additionarcotic count on the final 12:50 PM revealed no 12:50 PM revealed no 12:50 PM revealed no 15:50 PM revealed from 15:5 | g scripts for medications cations timely. Observation 09/29/2021 at 4:35 PM on 60/2021 at 8:09 AM concerns with missing n, observation of the fifth floor on 09/30/2021 at identified concerns. Regional Nurse Consultant PM revealed she was ting random medication inning 09/25/2021. She natified any concerns with edications or narcotic dits revealed the facility Medicare Services Critical dedication Administration to a pass observation of a A review of audits twenty-five medications on their review of medication dhat medication erved on random shifts, 00 PM and 6:00 PM to revealed medication ing reviewed in clinical gh Friday against ordered of the audit revealed no other medication of the medica | {F 7 | 55} | | | |

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | | OMB N | <u>O. 0938-039</u> | 1 |
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| AND PLAN O | AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. BUILD | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | | A. BOILD | 1140 | | LOW | | |
| | | 185256 | B. WING | | | | R | i |
| NAME OF F | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 09 | 30/2021 | _ |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | | 200 NURSING HOME LANE | | | |
| | | | | F | PIKEVILLE, KY 41501 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E NTE | (X5) COMPLETION DATE | |
| | Continued From page Consultant on 09/30/2 09/30/2021 at 4:17 PM 09/30/2021 at 3:20 PM being audited daily be ensure adequate staffireview of the audits re concerns. 78). Interview with the 09/30/2021 at 5:05 PM on 09/30/2021 at 1:30 being monitored daily is staffing. A review of the identified concerns. 79). Interview with the Operations on 09/30/20 Administrator on 09/30/20 Administrator on 09/30/20 Administrator on 09/30/20 identified concerns. 80). Interview with the 3 on 09/30/2021 at 10:55 completed observations identified, staff would or An audit review revealed change of conditions no facility staff. 81). Review of interview 09/25/2021 for residents or greater revealed no in | 795 7021 at 3:40 PM, RDON on M, and the DON on M revealed staffing was ginning 09/11/2021, to ing was maintained. A vealed no identified Interim Administrator on M, and the Dietary Manager PM revealed staffing was to ensure adequate a audits revealed no Vice President of D21 at 4:10 PM and Interim //2021 at 5:05 PM revealed conducted daily from f the audits revealed no Senior Marketing Liaison in AM revealed he is on different shifts to resident condition. Further change in condition was complete a stop and watch, and no concerns with the out being addressed by Vs performed on is with a BIMS score of 8 identified concerns. A | {F 7 | | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | | |
| ; | review of the questionnanterviews revealed resi everyone treating you w | dents were asked: Is rell? Do you feel safe | | | | | | |
| | ere? Do you have any | concerns? Interview with | | | | | | |

| AND PLAN C | EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL A. BUILDI | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| L | | 185256 | B. WING | | | R |
| PARKVIEW POST-ACUTE AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | <u> </u> | 09/30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI. TAG | | SHOULD BE | COMPLETION DATE |
| {F 755} {F 802} \$S=F | the Medical Records: AM revealed she com residents on 09/25/20 identified no concerns Sufficient Dietary Sup CFR(s): 483.60(a)(3)(§483.60(a) Staffing The facility must empl appropriate competen out the functions of the taking into considerati- individual plans of care and diagnoses of the fi- in accordance with the required at §483.70(e) §483.60(a)(3) Support The facility must provice personnel to safely an- functions of the food a §483.60(b) A member Services staff must par interdisciplinary team a (2)(ii). This REQUIREMENT by: | Staff on 09/29/2021 at 8:34 upleted the interviews with 21, and she stated she is port Personnel b) oy sufficient staff with the cies and skills sets to carry e food and nutrition service, on resident assessments, e and the number, acuity facility's resident population e facility assessment is staff. de sufficient support d effectively carry out the nd nutrition service. of the Food and Nutrition ricipate on the as required in § 483.21(b) is not met as evidenced | {F 8 | DEFICIENCY) 55} | | 12/30/21 |
| | and review of the facility determined the facility staff with the appropria sets to carry out the fur nutrition service. | failed to employ sufficient te competencies and skills actions of the food and | | F 802 Sufficient Dietary Supp Personnel Criteria 1: All residents with recommendations from register dietician/ regional dietician and/ for fortified foods received these their meal trays as determined to | red /or MD/ NF e item on by | |
| | Observation of the residual of | dents' meal, on and dinner revealed dietary | | observation on November 17th meal ticket and visual comparis | of the | |

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI | TIPI | E CONSTRUCTION | OMB NO. 0938-0391 | | |
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| AND PLAN O | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | | | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS OFFI CO. | 05 | 9/30/2021 | |
| DADIONE | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | | 200 NURSING HOME LANE | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | ' | PIKEVILLE, KY 41501 | | | |
| PREFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | IX . | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E NTE | COMPLETION DATE | |
| (SOZ) | Continued From page 797 staff failed to serve fortified foods (foods with an increased content of essential nutrients that have been added to improve nutritional content) as recommended by the Registered Dietitian (RD) for forty-two (42) of forty-two (42) residents out of one-hundred thirteen (113) residents, which received fortified foods. Staff interviews revealed they had not been educated on how to fortify foods. During the lunch meal on 08/05/2021, dietary staff failed to utilize the correct scoop size when plating the food; and, failed to weigh the protein portion of the meal to ensure the correct serving size. | | {F 8 | 102} | ticket to the prepared meal tray by the Regional Director of Dietary Services Criteria 2: a) All residents with recommendations from registered dietician/ regional dietician and/or MD/ for fortified foods received these item of their meal tray on 11/22/2021. The regional director of dietary services reviewed the registered dieticians recommendation for fortified food, compared those recommendation to the meal tray ticket to ensure they matched and then observed the lunch meal tray line to ensure each ticket that had fortific | n ed | | |
| | In addition, resident moserved late due to insukitchen. | eals were consistently fficient staffing in the | | | food listed received the fortified food on tray. | ! | | |
| | The findings include: | | | | Criteria 3: Inservice education was provided for the dietary staff by the Regional Director of Dietary Services on 11/22/2021 on the preparation and servi | 1 | | |
| | revealed staff would pro nourishing, palatable, verthe resident's daily nutro needs, with preference into consideration. The would be provided with the scheduled mealtime | t revised October 2017, povide residents with a vell-balanced diet that met itional/special dietary s of each resident taken policy also stated meals in forty-five (45) minutes of | | | of fortified foods in accordance with the resident meal tray tickets to include scot size. The RD also in-serviced correct serving of protein. On 8/23/21 a new Dietary Manager was hired as part of the corrective actions that were taken. Criteria 4: Starting 11/22/2021 Dietary Manager/Dietary Consultant/Designee w complete tray preparation observations fall three meals weekly x 4 weeks and the | op e vill | | |
| Review of the facility's policy titled, "Portion Control," undated, revealed portion size was determined by the nutritional needs of the residents, and portion sizes must be served according to the facility's menu and staff should weigh or measure ingredients as applicable. | | | | monthly x 2 months to determine that fortified foods are prepared and served in accordance with resident orders/tray cards. Monitoring began 9/1/21 of late meals, ensuring the correct scoop size during plating of food, and ensure the correct protein serving. Two meals were | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (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 | <u> 0:</u> | 9/30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E *TE | (X5) COMPLETION DATE |
| | Servers guidance utilial undated, revealed a # cup, #8 scoop was equal to 1/ Interview with the Adm 6:00 PM, revealed the related to fortified food residents that were as foods should be provide interventions the phys Dietician (RD) had detended to maintain the 1. Review of the menu 08/05/2021, revealed to served their meal of chemenu revealed the residency of the menu should be utilized when served and a four (4) or green beans or other work provided to the residency of the, "Diet Rofacility indicated forty-the assessed to need fortiff meals, to assist in ensurement. Observations of the transervice, on 08/05/2021 were serving beef fritte green beans, mashed | a Scoops/Ladles and Portion zed in the facility's kitchen, 10 scoop was equal to 3/8 ual to ½ cup and a #12 3 cup. Ininistrator, on 08/11/2021 at facility had no policy is. However, she stated sessed to require fortified ded them, as well as any ician and/or the Registered ermined the resident eir nutritional status. If or the lunch meal on the residents were being noice. Further review of the idents should receive three for the lunch meal. If a #8 (1/2 cup) scoop in mashed potatoes were bunce- {1/2 cup} serving of the egetables should be stated. Dester' provided by the wo (42) residents had been ited foods with all three facility in the residents with gravy, corn or potatoes, chocolate ther observations of the riffied foods had been ited foods had bee | {F 8 | 302} | visual audited beginning 8/23/21by DO or designee until 9/6/21. Beginning 9/11/21 all three meals are audited by Dietary Manager. Audits will be reviewed monthly in QAP x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 12/30/2021 | | |

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (70) 1414 | | 3977 | OWR I | <u>IO. 0938-0391</u> |
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| AND PLAN O | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDI | NG | TRUCTION | (X3) DATE SURVEY COMPLETED | |
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| NAME OF P | PROVIDER OR SUPPLIER | | | STOCET | ADDRESS, CITY, STATE, ZIP CODE | 0 | 9/30/2021 |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | 200 NUR | ISING HOME LANE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ae. | COMPLETION DATE |
| | Further observations of Cook #2 used a #10 s residents mashed pota cup) to serve the reside for the lunch meal. Coothe protein (meat) porthowever, the kitchen havever, the kitchen havever the scale was a manuscalibrated at zero (0). Further observations of the kitchen havever the scale was a manuscalibrated at zero (0). Further observations of o8/05/2021, and review Roster revealed dietained at tray cards to expressed the preferences were honounterview with Cook #2 PM, revealed she had never facility for approximatel employment, the cook strained or directed to for also stated she had never facility, to provide any of foods and she had never for the residents. Per the rained on scoop sizes of appropriate portions. Have have the second of the utilization of the resident she utilization with the cook stated of the residents. Per the rained on scoop sizes of appropriate portions. Have have the second of the utilization of the resident she utilization with the cook stated of the provide and she had never for the residents. Per the rained on scoop sizes of appropriate portions. Have the second of the utilization of the utili | of the tray line revealed accop (3/8 cup) to serve the atoes and a #12 scoop (1/3 fents corn or green beans ook #2 was asked to weightion of the lunch meal; had no functioning scale. Ichen scale available for 021 at approximately 3:00 e was metal, dusty with led and rusty in discretions revealed at scale and was visibly not of the facility's "Diet by staff failed to review ensure their food ored. In on 08/05/2021 at 5:20 worked full-time at the lay one (1) year. During her stated she had not been writing residents' food. She wer seen a recipe at the lirections on how to fortify ear prepared fortified foods the cook, she had been to provide residents with lowever, the cook at the wrong scoop sizes. | {F 8 | 02} | DEFICIENCY) | | |
| | during the lunch meal. esidents should have n | The cook stated the eceived larger portions of | | | | | |

| STATEMENT | OF DEFICIENCIES | (X1) BEOMOGRACION ISSUELLA | | _ | | OMB N | <u>IO. 0938-0391</u> |
|--------------------------|---|--|-------------------|------|---|-------------------------------|----------------------------|
| | F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILD | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 185256 | B. WNG | | | | R |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | 1 09 | 9/30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | ıx | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERÊNCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | the facility had not trai weigh meat/protein or ensure residents rece acknowledged she did should" during the tray because there was no would be even more of the tray of the facility's indicated breakfast was served at 12:00 PM was served at 5:00 PM Observations of the tray carts hadn't exited to go to the third floor. revealed the last tray capproximately 2:45 PM which went to the 5th floops of three (3) tray cakitchen to be served to PM. Continued observed. | vegetables. Per the cook, ined her or directed her to any other food items to ive adequate portions. She do not review tray cards "like I y line for resident meals of "enough of us and meals off schedule." if "2, on 08/05/2021 at 12:00 at the was serving lunch to be residents (113). mealtime schedule as served at 7:00 AM, lunch and the evening meal off. ay line for the lunch meal on even though the meal time the lunch meal time to PM, the first of three (3) at the kitchen until 1:30 PM. Further observation the cart exited the kitchen at at (almost 3 hours late) alloor residents. by line for the supper meal and even though the supper to be served at 5:00 PM, by line until 6:15 PM. The rist did not leave the the residents until 6:50 ration revealed the last cart until 8:00 PM (three hours ents on the 5th floor. | {F & | 802} | | | |

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | | OWR M | <u>O. 0938-0391</u> |
|------------------------|----------------------------|---|-------------|------|---|-------------------------------|---------------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILD | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 185256 | B. WING | | | | R |
| NAME OF P | ROVIDER OR SUPPLIER | | | Т | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 09 | 0/30/2021 |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | : | 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | T 15 | _ | | | |
| PREFIX TAG | (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | COMPLETION DATE |
| {F 802} | Continued From page | 801 | {F & | የበ2ነ | , | | |
| | department had been | short staffed for months, | , , | , | '] | | |
| | meals were always lat | te and there was not | | | | | |
| | adequate time to revie | ew tray cards to ensure | 1 | | | | 1 1 |
| | residents' preferences | were honored because | | | | | 1 |
| | there should be three | (3) dietary aides, but staff | | | | | 1 1 |
| | had worked with only t | two (2) for months. | | | | | |
| | Interview with DA #2 | on 08/17/2021 at 2:15 PM, | | | | | |
| | revealed the dietary de | epartment was short staffed | | | | | l i |
| | and they should be wo | orking with three (3) dietary | | | | | . 1 |
| | aides. However they | had worked with only two | - | | | | 1 1 |
| | (2) aides for approxima | ately one (1) year. | | | | | |
| | Interview with Cook #2 | 2, on 08/05/2021 at 5:20 | | | | | |
| | PM, revealed she had | worked full-time at the | | | | | 1 1 |
|] | facility for approximate | ly one (1) year. She stated | | | | | |
| | she worked five (5) day | ys a week and cooked all | | | | |] |
| | three (3) meals on the | days she worked. She | | | | | |
| | stated she had works t | this way for months due to | | | | | [|
| | snon statting. She also | stated she worked "a lot" | | | | 1 | 1 1 |
| | or overtime and had ap | proximately 15-20 hours of | | | | | |
| 1 | ovenime during the las | it pay period. She stated | 1 | | | | j l |
| | the meal services were | late because they were | | | | | 1 |
| | short staffed in the kitch | nen. Per the cook, the | | | | | |
| | short one (4) distant | Manager and they were | | | | | |
| | short one (1) dietary air | de and had been for | | | | | |
| | on time, "impossible " (| getting meals to residents | | | | | |
| | on time, "impossible." S | one acknowledged she | | | | | |
| | tray line for resident me | ards "like I should" during | | | | | |
| | enough of us and most | eals "because there is not s would be even more off | | | | | |
| | schedule." | a would be even more off | | | | | |
| | Interview with Dietary N | Manager (DM) #2 on | | | | | |
| | 08/17/2021 at 3:00 PM | , revealed she was | | | | - 1 | |
| | employed at another fa | cility the company owned, | | | | 1 | |
| | and had been asked ap | pproximately three (3) | | | | | |
| | weeks ago, to come pro | ovide assistance/oversight | | | | | |
| | and retrain dietary staff | on dietary processes, | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL | TIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|--------------------------|---|---|---------------------|--|--------------|------------------|--|--|
| | | DENTIFICATION NUMBER: | A. BUILDI | NG | | COMPLETED | | |
| | | 185256 | B. WING | | | R | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DE | 09/30/2021 | | |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | 1 | ON SHOULD BE | COMPLETION DATE | | |
| | been identified in the she had visited the facility she been trained/directed residents and there we guide staff on preparir stated she had initiate however, due to short had worked more han provided guidance on before the meal time, a residents' food to them interview revealed she the facility, and meals to inadequate staffing Interview with the RD, and on 08/18/2021 at had been contracted to facility for approximate stated meals were alw Interview with the Assi (ADON)/Interim Directed 08/18/2021 at 9:50 PM meals were consistent difficult for staff and residents. She stated the fithe floor until 7:00 PM Interview with the Adm 6:00 PM, revealed she cold food complaints at late to the residents. Since the state of the residents. | ad no DM and concerns had kitchen. The DM stated cility approximately three (3) e DM, when she initially identified that staff had not to fortify foods for the ere no recipes available to ag fortified foods. The DM d training with staff; staffing in the kitchen she ds on with staff and prepping certain food items to assist in getting the non time. Continued a observed meal services at were consistently late, due of dietary aides. on 08/11/2021 at 4:10 PM 10:30 AM, revealed she oprovide services at the ely one (1) year. The RD ways served late. stant Director of Nursing or of Nursing, on I, revealed she was aware | {F 8 | | | | | |
| i | in the kitchen. Howeve | r, the kitchen had worked nly three (3) staff since | | | | | | |

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | | OWB V | <u>10. 0938-0391</u> |
|--------------------------|---|---|-------------------|-------|--|-------|----------------------|
| AND PLAN O | FCORRECTION | IDENTIFICATION NUMBER | A. BUILD | | DISTRUCTION | | TE SURVEY MPLETED |
| | | 185256 | B. WING | | | | R |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | 200 1 | EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501 | 0: | 9/30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | STEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | COMPLETION DATE |
| | she had been Adminis stated she was aware in the kitchen to ensur she was "working on i Menus Meet Resident CFR(s): 483.60(c)(1)-6 §483.60(c) (1) Meet the residents in accordance guidelines.; §483.60(c)(2) Be prepared \$483.60(c)(3) Be follow \$483.60(c)(4) Reflect, reasonable efforts, the ethnic needs of the resinput received from resignuts; §483.60(c)(5) Be upda §483.60(c)(6) Be review dietitian or other clinical professional for nutrition | strator at the facility. She that was not enough staff the meals were timely, and t." Nds/Prep in Adv/Followed (7) Inutritional adequacy. Inutritional needs of the with established national ared in advance; wed; based on a facility's religious, cultural and dident population, as well as sidents and resident ted periodically; wed by the facility's ally qualified nutrition and adequacy; and this paragraph should be esident's right to make | {F 8 | | DEPICIENCY | | 12/30/21 |
| | This REQUIREMENT i | s not met as evidenced | | | | | |

| STATEMENT AND PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I | TIPLE CONSTRUCTION NG | (X3) DATE | SURVEY |
|-------------------------|--|---|---------------|--|--|----------------------------|
| | | | A. BOILDI | | | R |
| NAME OF S | 50.455 | 185256 | B. WING | | | /30/2021 |
| | W POST-ACUTE AND RE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 30/2021 |
| PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | DRE | (X5) COMPLETION DATE |
| | and review of the facility were followed for one one hundred nine (109 meal tray. Observation of the tray 06/15/2021, revealed to green beans with smathem, pinto beans with ham in them, fried pota white cake with marsh menu for the lunch me residents were to recepinto beans, buttered cand cornbread. The findings include: Review of the facility's Substitutions and Alter the food substitute wou usual and ordinary food. Review of the facility's Nutrition Services," last revealed staff would pronourishing, palatable, with resident's daily nutrineeds, with preference into consideration. 1. Review of the menu 06/15/2021, revealed revea | n, interview, record review, ity's policies, it was failed to ensure menus hundred eight (108) out of presidents who received a line for the lunch meal on the residents were served li pieces of country ham in a small pieces of country had on 06/15/2021, revealed ity a country ham slice, carrots, Texas sheet cake, carrots, Texas sheet cake, carrots, it is a consistent with the dittems. policy titled, "Food and the revised October 2017, ovide residents with a vell-balanced diet that met itional/special dietary is of each resident taken. | {F 86 | F 803 Menus Meet Resident Needs/Prep in Adv/Followed Criteria 1: Residents are served maccordance with the scheduled mer determined by tray preparation observations completed by the Regi Director of Dietary Services on 11-17-2021. Criteria 2: All residents have the poto be affected by this cited deficienc resident's meal trays were audited to ensure menus were followed on 11-17-2021. All residents' meals folk the menu. Criteria 3: The Dietary Consultant provided in-service education for the Dietary Manager, facility cooks, and dietary staff by reviewing the current scheduled facility menus to clarify he each item was to be served in accorwith the menu as completed on 11-22-2021 Criteria 4: Starting 11-22-2021 the Dietary Manager/Dietary Consultant/Designe complete tray preparation observation determine that meals are prepared a served in accordance with the sched menus. All three meals will be observedly x 4week then monthly x 2more Beginning 12/20/2021 5 random resident will be interviewed to ensure food is served timely, food temperature appropriate, and if they receive snacl meals are served timely, substitutes and the served in accordance with the sched menus are served timely, substitutes are served timely. | tential y. All bowed bietary ee will ns to nd uled yed nths. n that re is | |

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | | OMB N | <u> 10. 0938-039</u> | 1 |
|---------------|---------------------------|--|-------------------|------------|--|----------|-------------------------------|---|
| AND PLAN O | FCORRECTION | IDENTIFICATION NUMBER | A. BUILD | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | 18525 6 | B. WING | | | | R | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 0 | 9/30/2021 | _ |
| DARWIE | N DOOT A CALE | | | | | | | |
| LARKAIE | W POST-ACUTE AND RE | HABILITATION CENTER | | | 200 NURSING HOME LANE | | | |
| (X4) ID | SUMMARY CT | TEMPLE OF PERIOD | | <u>_</u> ' | PIKEVILLE, KY 41501 | | | |
| PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | E NTE | (X5) COMPLETION DATE | |
| {F 803} | Continued From page | 805 | , re . | 0031 | | _ | | |
| | | y line for the lunch meal | {F 8 | 03} | | | | |
| | service, on 06/15/202 | 1 at 1:14 PM, revealed the | | | available and preferences are met. | | | 1 |
| | residents were served | green beans with small | | | Interviews will be conducted weekly x 4 | 1 | | ı |
| | pieces of country ham | in them, pinto beans with | | | weeks then monthly x 2 months. | | | 1 |
| | small pieces of country | v ham in them, fried notate | | | Audits will be reviewed monthly in QAP | | | ı |
| | cnunks, cornbread, an | d white cake with | | | x3 months then quarterly until in | ı | | ١ |
| | marshmallows in it. | | 1 | | substantial compliance | | 1 | Ī |
| | Group intension and | 1 1 20 4 15 | 1 | | | | | |
| | (Residents #3 #16 #3 | cted with six (6) residents | 1 | | Criteria 5: Date of compliance: | | | |
| | 06/16/2021 at 10:13 A | 88, #51, #92, and #96), on | | | 12/30/2021 | | | ł |
| | meal on 06/15/2021 w | as not good. The residents | | | | | | l |
| - 1 | stated they did not like | both green beans and | | - 1 | | | | l |
| | pinto beans served tog | ether. The residents stated | | - 1 | | | | ۱ |
| | they rarely got cake wi | th icing. The residents also | | | | | 1 | ı |
| İ | revealed menus were i | rarely followed. | | | | | | |
| | Observation and interv | iew with Resident #27, on | | | | | | |
|] | eating club crackers as | , revealed the resident was | | | | | | l |
| | not know what was on | nd stated that he/she did the menu for lunch that | | | | | | l |
| | day. The resident state | ed sometimes they asked | | | | | | ı |
| | for the alternate and so | metimes they got it, but | ļ | | | | | ı |
| | usually they did not. Ti | he resident laughed and | | | | | | ı |
| T I | stated that they asked t | for the alternate when the | | - | | | | |
| İ | facility served mystery | meat. | | | | | | |
| | Interview with Resident | #307, on 06/16/2021 at | | | | | | |
| | 1:16 PM, revealed the r | esident lying in bed with a | | | | | | |
| | tray from lunch on the c | overbed table. The | | | | | | |
| 1 | resident stated, "I would | not feed a dog what they | | | | | | |
| | give me". The resident | had a soda and peanut | | | | | | |
| ļ i | butter crackers beside f | nis/her lunch tray. | | | | | | |
| | nterview with Resident | #57. on 06/16/2021 at | | | | ı | | |
| 1. | 10:25 AM, revealed the | food was "horrible". Per | | | | | | |
| į į | nterview, the milk was t | warm and the meat was | | | | | | |
| t | oo tough. The resident | further stated that he/she | | | | | | |
| v | vould go hungry if it we | re not for food brought in | | | | | | |

| STATEMENT | OF DEFICIENCIES | (V4) 000 (000 (000 (000 (000 (000 (000 (00 | | _ | | OWR M | <u>0. 0938-0391</u> |
|--------------------------|--|--|----------------------|-----|---|-------|---------------------|
| | CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | ONSTRUCTION | | E SURVEY PLETED |
| | | 185256 | B. WNG | | | 0.0 | R |
| NAME OF P | ROVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | 05 | /30/2021 |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | | NURSING HOME LANE | | |
| | | | | PIK | EVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | COMPLETION DATE |
| {F 803} | Continued From page from the outside. Interview with Cook # PM, revealed she cook carrots because she I Cook stated she did in ham so the Dietary Michop the country ham The Cook stated she with made white cake with Texas sheet cake. The worked at the facility for Interview conducted with Manager (DM), on 06/2 revealed she had quit stated she had told the ham in both the green because there was no DM stated she was resensuring there was enfood on the menu. The reported to the Register could not prepare the Interview conducted wat 4:18 PM, revealed sfacility was not following approved. The RD states. | e 806 1, on 06/16/2021 at 2:00 oked green beans instead of iked them herself. The ot have enough country anager had instructed her to up and put it in the beans, did not have chocolate cake e cake mix, so she had marshmallows instead of a Cook stated she had only or four (4) weeks. with the former Dietary 16/2021 at 1:30 PM, on 06/15/2021. The DM a Cook to put the country beans and the pinto beans it enough country ham. The sponsible for ordering and ough food to prepare the a DM revealed she had not ered Dietician (RD) that she menu as directed. | {F 8 | _ | CROSS-REFERENCED TO THE APPROPR | IATE | |
| | staff not following the rassured by the DM the corrected. The RD stafe could cause malnutrition health concerns. The Frequired to notify her a menu and they had no | menu and had been situation had been ted not following the menus on, weight loss, and other | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MUL | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--------------|--|---------------------------------|-------------------------------|----------------------------|
| | | 185256 | B. WNG | | | | R |
| NAME OF P | PROVIDER OR SUPPLIER | | | 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) | NTEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIA | E NTE | (X5) COMPLETION DATE |
| {F 803} | have no authority ove | r her. " | {F 8 | 03} | | | |
| {F 804} SS=E | 06/19/2021 at 1:30 PM been the Administrator weeks. The Administrator with both the RD and aware of the problems Administrator stated of the kitchen and found food to be prepared for Administrator stated is and had purchased the Administrator stated it realized the DM was not needed to prepare the kitchen. Nutritive Value/Appear CFR(s): 483.60(d)(1)(2) §483.60(d) Food and continue to Each resident receives §483.60(d)(1) Food proconserve nutritive values §483.60(d)(2) Food an attractive, and at a safe temperature. This REQUIREMENT by: Based on observation policy review, it was deto provide food at palatemperatures for the exand the lunch meal on | n 06/14/2021, she went into the DM had not ordered the or 06/15/2021. The he went to the grocery store eneeded food. The was not until then that she tot ordering what was meals needed in the or ordering what was meals needed in the or ordering what was meals needed in the or ordering what was meals needed in the or ordering what was meals needed in the or ordering what was meals needed in the or ordering what was meals needed in the ordering ordering or orde | {F 80 | F 804 Nutritive Value/App Palatable/Prefer Temp. Criteria 1: Resident # 332 resides at the facility. Residence received her evening meal | no longer dent # 39 | | 11/30/21 |

| NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER (C4) ID PREFIX REMARKY OR IS DEMINIFING INFORMATION PREFIX REGISTRATORY OR IS DEMINIFING INFORMATION PREFIX RATE OF DEFICIENCY MAST BE PRECEDED BY FILL REGISTRATORY OR IS DEMINIFING INFORMATION PARK THAT DEPOSITION OF THE PREFIX RATE OF DEFICIENCY MAST BE PRECEDED BY FILL REGISTRATORY OR IS DEMINIFING INFORMATION PARK THAT DEPOSITION OF THE PREFIX RATE OF DEPOSITION SHOULD BE CHOSEN FROM THAT DEPOSITION ON THE PREFIX RATE OF DEPOSITION FOR THAT DEPOSITION OF THE PREFIX RATE OF DEPOSITION FOR THAT DEPOSITION OF THE PREFIX RATE OF DEPOSITION FOR THAT DEPOSITION OF THE PREFIX RATE OF DEPOSITION FOR THAT DEPOSITION OF THE PREFIX RATE OF DEPOSITION FOR THAT DEPOSITION OF THE PREFIX RATE OF DEPOSITION FOR THAT DEPOSITION OF THE PREFIX RATE OF DEPOSITION FOR THAT DEPOSITION OF THE PREFIX RATE OF DEPOSITION FOR THAT THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF THE PREFIX RATE OF THE PREFIX RATE OF DEPOSITION FOR THE PREFIX RATE OF THE PREFIX RA | | OF DEFICIENCIES F CORRECTION | I IDENTIFICATION NUMBER I | | | E CONSTRUCTION | (X3) DATE SURVEY | | |
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| NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER CAND Continued From page 808 Characteristics Characte | | | I I I I I I I I I I I I I I I I I I I | A. BUILD | ING. | | СОМ | COMPLETED | |
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| PARKVIEW POST-ACUTE AND REHABILITATION CENTER 230 NURSING HOME LANE PIKEVILLE, NY 41501 | NAME OF P | ROVIDER OR SUPPLIER | | | - | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> Us</u> | 9/30/2021 | |
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| Interview with the Acting Dietary Manager (DM), on 06/16/2021 at 6:05 PM, revealed cold foods should be less than forty-one (41) degrees. The DM stated she did random tray checks to ensure the food taste good and was at the appropriate temperature. The DM stated she was only helping out because the former DM quit on 06/15/2021. The DM stated she worked at another facility owned by the company and was only filling in. temperatures changing to outside the acceptable parameters. The dietary staff were provided in-service education by the dietary manager/dietary consultant on the process for stocking snacks in the nourishment room on 11/1/2021. Criteria 4: Beginning on 11/24/2021 The Dietary Manager/Dietary Consultant/Designee will complete weekly random tray pass audits until substantial | | coleslaw at sixty (60) o | legrees Fahrenheit which | | | meal trays in a timely manner to preven | ıt | i [| |
| Interview with the Acting Dietary Manager (DM), on 06/16/2021 at 6:05 PM, revealed cold foods should be less than forty-one (41) degrees. The DM stated she did random tray checks to ensure the food taste good and was at the appropriate temperature. The DM stated she was only helping out because the former DM quit on 06/15/2021. The DM stated she worked at another facility owned by the company and was only filling in. acceptable parameters. The dietary staff were provided in-service education by the dietary manager/dietary consultant on the process for stocking snacks in the nourishment room on 11/1/2021. Criteria 4: Beginning on 11/24/2021 The Dietary Manager/Dietary Consultant/Designee will complete weekly random tray pass audits until substantial | | was cool, but tasted bl | and. | | İ | temperatures changing to outside the | | | |
| were provided in-service education by the dietary manager/dietary consultant on the process for stocking snacks in the process for stocking snacks in the nourishment room on 11/1/2021. The DM stated she was at the appropriate temperature. The DM stated she was only helping out because the former DM quit on 06/15/2021. The DM stated she worked at another facility owned by the company and was only filling in. were provided in-service education by the dietary manager/dietary consultant on the process for stocking snacks in the nourishment room on 11/1/2021. Criteria 4: Beginning on 11/24/2021 The Dietary Manager/Dietary Consultant/Designee will complete weekly random tray pass audits until substantial | | Intonious with the A-V | Distance Administration of the Control of the Contr | | | acceptable parameters. The dietary sta- | ff | | |
| should be less than forty-one (41) degrees. The DM stated she did random tray checks to ensure the food taste good and was at the appropriate temperature. The DM stated she was only helping out because the former DM quit on 06/15/2021. The DM stated she worked at another facility owned by the company and was only filling in. dietary manager/dietary consultant on the process for stocking snacks in the nourishment room on 11/1/2021. Criteria 4: Beginning on 11/24/2021 The Dietary Manager/Dietary Consultant/Designee will complete weekly random tray pass audits until substantial | | on 06/16/2024 - Leice | ng Dietary Manager (DM), | | | were provided in-service education by the | he | | |
| DM stated she did random tray checks to ensure the food taste good and was at the appropriate temperature. The DM stated she was only helping out because the former DM quit on 06/15/2021. The DM stated she worked at another facility owned by the company and was only filling in. The DM stated she worked at another facility consultant/Designee will complete weekly random tray pass audits until substantial compliance to determine that mosts are | | should be less than for | rivi, revealed cold foods | | ł | dietary manager/dietary consultant on the | ne | | |
| the food taste good and was at the appropriate temperature. The DM stated she was only helping out because the former DM quit on 06/15/2021. The DM stated she worked at another facility owned by the company and was only filling in. Criteria 4: Beginning on 11/24/2021 The Dietary Manager/Dietary Consultant/Designee will complete weekly random tray pass audits until substantial | | DM stated she did res- | dom tray abodus to account | | | process for stocking snacks in the | | | |
| temperature. The DM stated she was only helping out because the former DM quit on 06/15/2021. The DM stated she worked at another facility owned by the company and was only filling in. Criteria 4: Beginning on 11/24/2021 The Dietary Manager/Dietary Consultant/Designee will complete weekly random tray pass audits until substantial | | the food taste good an | dum day checks to ensure | | | nourishment room on 11/1/2021. | | | |
| out because the former DM quit on 06/15/2021. The DM stated she worked at another facility owned by the company and was only filling in. Dietary Manager/Dietary Consultant/Designee will complete weekly random tray pass audits until substantial | | temperature. The DM | stated she was only boloine | | | Called Al D. V. I. | | | |
| The DM stated she worked at another facility owned by the company and was only filling in. Consultant/Designee will complete weekly random tray pass audits until substantial | | out because the forme | r DM quit on 06/15/2021 | | | | ; | | |
| owned by the company and was only filling in. random tray pass audits until substantial compliance to determine that meals are | | The DM stated she wo | rked at another facility | | | | | | |
| compliance to determine that mode are | | owned by the company | and was only filling in | | | consultant/besignee will complete weel | kly | | |
| | | , := ==::, | , and the very many mi. | | | compliance to determine that me. | 1 | | |
| Observation on 08/05/2021 revealed the first prepared and served in accordance with | | Observation on 08/05/2 | 2021 revealed the first | | | prepared and conted in accordance in | | | |
| fourth floor lunch meal cart arrived on the unit at the scheduled menus and required | | fourth floor lunch meal | cart arrived on the unit at | | | the scheduled menus and constant | ' | | |
| 1:59 PM with twenty (20) trays on the cart. | | 1:59 PM with twenty (2 | 0) trays on the cart. | | | temperature parameters to include all | | | |

| STATEMENT AND PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|---------------------|---|-------------------------------|
| | | 185256 | B. WING_ | | R |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | 09/30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION | RE COMPLETION |
| | Further observation re (RN) #8 was the only from 1:59 PM until 2:0 Observation of the last from the cart on 08/05 Regional Dietitian reve on the test tray were: degrees Fahrenheit (Fidegrees Figureed greed grees Figureed breand chocolate pudding Interview with the Reg 08/05/2021 at 2:16 PM should be at or below and hot foods should be and thirty-five (135) detemperatures of the for in acceptable parameted on the companion of the test of the companion of the test 08/05/2021 at 2:35 PM. Observation of the test 08/05/2021 at 2:35 PM. | evealed Registered Nurse staff passing meal trays 4 PM. It tray (test tray) passed /2021 at 2:16 PM, with the saled the food temperatures oursed meat at ninety (90)), potatoes ninety-two (92) en beans ninety (90) ad eighty (80) degrees F, sixty (60) degrees F, sixty (60) degrees F, sixty (60) degrees F, sonal Dietitian, on I, revealed that cold foods forty-one (41) degrees F, se at or above one hundred grees F. She stated the od on the test tray were not ears. 2021 revealed the second cart arrived on the unit at 5) trays. Observation traff person was passing e last tray passed was tray delivered, on , revealed food s: chicken fried steak with four (104) degrees F, nundred twelve (112) | (F 86 | three meals, one tray per floor for each meal per observation. Beginning on 11/24/2021 the dietary manager/ dieta consultant/ designee will complete a weekly audit that nourishment rooms all three floors are stocked daily until substantial compliance. Beginning 11/4/2021 residents will be asked in earesident council meeting if they are be served their meals utilizing regular dishware. The Activity Director/Designee will not the Dietary Manager for follow up of an residents who report they are not beinserved meals on regular dishware. Auwill be monthly x 3 months. Audits will reviewed at QAPI monthly x3 months at then quarterly until in substantial compliance. Criteria 5: Date of compliance: 11/30/2 | ry on ach ing fy dits be and |

| AND PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ILTIPLE CONSTRUCTION DING | | (3) DATE SURVEY COMPLETED |
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| L | | 185256 | B. WNG | 4 | | R |
| NAME OF F | PROVIDER OR SUPPLIER | | | 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 | TIX (EACH CORRECTIVE ACTION SI | HOULD BE | (X5) COMPLETION DATE |
| | Interview with Resider 1:20 PM, revealed her in the past year" beca always late and the form of the past year beca always late and the form of the past year beca always late and the form of the past year. The Residents on informed her they were had failed to supply so about a year. The Resident informed the Administr complaints and request department to send up for the residents; howe yet." Interview with State Residents; howe yet." Interview with State Residents informed the Administr complaints and request department to send up for the residents; howe yet." Interview with State Residents in the SRNA stated therefor night shift; however worked short staffed with almost forty (40) reside service was always late 8:00 PM before the traysthat require assistance | int, #332 on 07/27/2021 at the food was always cold. Int #39, on 08/17/2021 at the food was always cold. Int #39, on 08/17/2021 at the facility's food was cold. Int #39, on 08/17/2021 at the facility's food was cold. Int #39, on 08/17/2021 at the facility was cold. Int #39, on 08/17/2021 at the facility was cold. Int #39, on 08/17/2021 at the facility was cold. Int #39, on 08/17/2021 at 10:00 AM, the floor frequently was cold. Int #39, on 08/17/2021 at 10:00 AM, the floor frequently was cold. Int #39, on 08/17/2021 at 10:00 AM, the floor frequently was cold. Int #39, on 08/17/2021 at 10:00 AM, the floor frequently was cold. Int #39, on 08/17/2021 at 10:00 AM, the floor frequently was cold. Int #39, on 08/17/2021 at 10:00 AM, the floor frequently was cold. Int #39, on 08/17/2021 at 10:00 AM, the floor frequently was cold. Int #39, on 08/17/2021 at 10:00 AM, the floor floor frequently was cold. Int #39, on 08/17/2021 at 10:00 AM, the floor | {F 8 | 804} | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | l . | R |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | <u> 09</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 APPROPRIA DEFICIENCY) | E ATE | (X5) COMPLETION DATE |
| | should be one-hundre when it reaches the recoffee should be served degrees F and milk be to forty (40) degrees F Interview conducted w (RD), on 06/18/2021 a completed a test tray of stated she had not had temperature, but food RD stated cold food st (41) degrees Fahrenhipalatability concerns of and malnutrition. Interview with the Assi (ADON)/Interim Direct 08/18/2021 at 9:50 PN at the facility for approache facility had been in nurses and aides during she was aware resider food. However, she st could with the number ADON stated she was were consistently late, staff and residents during stated when the food of floor until 7:00 PM or 8 was difficult to serve are because there was onlinurses were busy admiduring that time and no completed timely. Per | M, revealed all hot foods and, forty degrees (140) Fesident. She also stated and at one hundred (120) a served between thirty-six served between thirty-six served. With the Registered Dietician at 4:18 PM, revealed she conce a month. The RD and a concern with had very little taste. The mould be served at forty one eit or less. The RD stated could lead to weight loss stant Director of Nursing (DON), on the revealed she had worked eximately one (1) year and adequately staffed with a stated and staff did the best they of staff at the facility. The also aware meal times which made it difficult for any the evening meal. She art did not come to the concern medications at everything could be the ADON/IDON, she is to be delivered timely | {F & | 804} | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | | ATE SURVEY | |
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| | PROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS. CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | (| <u>09/30/2021</u> | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETION DATE | |
| | 6:00 PM, revealed she short staffed, there we nurse aides. She stat nurses and four (4) nu day shift (7:00 AM-7:0 and three (3) aides for PM-7:00 AM). However the facility had not me since she had been at interview with the Admaware of residents' comeals were served lat stated there should be least four (4) other stated there should be least four (4) other stated there was not ensure meals were time on it." Resident Allergies, Pre CFR(s): 483.60(d)(4)(5) §483.60(d) Food and come should be leach resident receives should be leach resident receives should be least four (4) other stated there was not ensure meals were time on it." Resident Allergies, Pre CFR(s): 483.60(d)(4) Food the later resident receives should be leach receives should be leach receives should be leach receives should be leach receives should be leach receives should be leach receives should be leach receives should be leach receives should be leach receives should be leach receives should be leach receives should be leach receives should be leach receives should be leach rece | ninistrator, on 08/11/2021 at a was aware the facility was ere not enough nurses and ed there should be two (2) are aides on each floor for 10 PM) and two (2) nurses the night shift (7:00 ere, the Administrator stated at those staffing numbers the facility. Continued hinistrator revealed she was lid food complaints and e to the residents. She a Dietary Manager and at aff in the kitchen; however, d with no manager and only he had been the cility. She stated she was nough staff in the kitchen to hely, and was she "working eferences, Substitutes 5). Arink and the facility provides— at accommodates resident and preferences; ag options of similar ents who choose not to eat | {F 80 | | | 12/30/21 | |

| STATEMENT OF DEFICIENCIES | | (X1) PROVIDER/SUPPLIER/CLIA | | | | OMB NO. 0938-0391 | | |
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| AND PLAN O | FCORRECTION | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | SURVEY PLETED | |
| | | 185256 | B. WNG | | | R | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 09 | /30/2021 | |
| DA DIZIATE | | | | | | | | |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | | 200 NURSING HOME LANE | | | |
| (M.A. 10) | | | | PIKEVILLE, KY 41501 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT 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 APPROPRIA DEFICIENCY) | E NTE | (X5) COMPLETION DATE | |
| | review, it was determinensure one hundred a hundred nine (109) restrays were offered apportant and addition, the food served. In addition, the food served accommon intolerance, and prefer (57) sampled residents #332) who were serve 08/05/2021. Also, Restrained and the food served accommon intolerance, and prefer (57) sampled residents #332) who were serve 08/05/2021. Also, Restrained free milk, howether lactose free milk; howether lactose free milk of interviews revealed the of the milk. The findings include: Review of the facility's Substitutions and Alter revealed staff should eneeds were met and reallergies, dislikes or who food were served a sultivalue. According to the preference would be fonutritionally/medically pacceptance, and food pould be placed on the serving line. Review of the facility's Nutrition Services," last | n, interview, and record ned the facility failed to and eight (108) out of one sidents who received meal realing options (substitutes or nutritive value when the eat food that was initially efacility failed to ensure dated residents' allergies, rences for (3) of fifty-seven is (Resident #350, #39 and id food from the kitchen on sident #350 was to receive ever, the facility was out of in 08/05/2021 and staff is facility was frequently out policy titled, "Menu natives" (not dated), insure residents' nutritional esidents with known to expressed a refusal of ostitute of similar nutritive is policy, the resident's illowed to the extent cossible to encourage food oreference information is tray card for use on the policy titled, "Food and the revised October 2017. | (F 8 | 06} | F 806 Resident Allergies, Preferences Substitutes Criteria 1: a) Residents #350, #39, ar #332 are served food which accommodates their allergies, intolerant and preferences. Resident #332 is served lactose free milk as requested. b) Substitutes are available each meal as options for residents when they choose not to eat food that was initially served. Criteria 2: a) On 11/17/21 the regional director of dietary services printed each resident meal tray card and interviewed current residents with a BIMS greater than 8 to determine that their meal tray cards accurately identify their allergies, intolerances, and preferences. Resident with a BIMS less than an 8 have had the allegies, intolerances and preferences reviewed with nursing. After interview were complete the tray card system was updated to reflect any preference changes. b) The Dietary Consultant and Dietary Manager have developed an always available menu for all threes mer for the residents to choose from when they choose not to eat food that was initially served. Criteria 3: The Regional Direcotor of | nd nce, red for n nan | | |
| | revealed staff would pro nourishing, palatable, w the resident's daily nutr | ovide residents with a vell-balanced diet that met | | | Dietary Service/Dietary Manager or designee has provided in-service education for the dietary staff on: 11/22/2021 on the always available men the need to follow the resident meal trav | u | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
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| | | | A. BUILDIN | 4G | COMPLETED | | |
| | | 185256 | B. WING_ | | | R 09/30/2021 | |
| PARKVIEW POST-ACUTE AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX | 200 PH | REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) | | (X5) COMPLETION |
| | REGULATORY OR L | | TAG | | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| | into consideration. 1. Review of the ment 06/15/2021, revealed country ham slice, pin Texas sheet cake, and not serving what was alternate menu was list. Observation of the traservice, on 06/15/202 residents were served pieces of country ham pieces of country ham chunks, cornbread, and marshmallows in it. Group interview condu (Resident #3, #16, #38 06/16/2021 at 10:13 A meal on 06/15/2021 with residents stated than alternate menu if the served to them. Interview with Cook #1 PM, revealed she was prepare an alternate more prepared one. Interview with the prev (DM), on 06/16/2021 at had quit on 06/15/2021 not directed the Cook to menu but, she (the DM menu was required. The know why she did not a serving with the previous prepared on the cook to menu was required. The know why she did not a serving with the previous prepared on the cook to menu was required. The know why she did not a serving with the previous prepared on the cook to menu was required. The know why she did not a serving with the previous prepared on the cook to menu was required. The know why she did not a serving with the previous prepared on the cook to menu was required. The know why she did not a serving with the previous prepared on the cook to menu was required. The know why she did not a serving with the previous prepared the cook to menu was required. The know why she did not a serving with the previous prepared the cook to menu was required. The know why she did not a serving was required. | u for the lunch meal, on residents were to receive a sto beans, buttered carrots, d cornbread. In addition to listed on the menu, no sted or prepared. y line for the lunch meal 1 at 1:14 PM, revealed the 1 green beans with small 1 in them, fried potato 1 in them, fried potato 1 in them, fried potato 1 in them, fried potato 1 in them, as not good. In addition, ey were not provided with 1 in them, as not good. In addition, ey were not good. In addition, ey were not good. In addition, ey were not good. In addition, ey were not good. In addition, ey were not good. In addition, ey were not good. In addition, ey were not good. In addition, ey were not good. | {F 80 | | card for resident allergies, intolerances and preferences Criteria 4: Beginning on 11/22/2021 the regional director of Dietary Services/Dietary Consultant/Designee of complete meal service observations on three meals weekly X 4 weeks, then monthly x 2 months to determine that meals are prepared and served in accordance with the resident listed allergies, intolerances and preferences. Audits will be reviewed monthly in QAP x3 months then quarterly until in substantial compliance. Random residents are interviewed to ensure preferences beginning 12/6/21. 12/20/2021 5 random resident wibe interviewed to ensure that food is served timely, food temperature is appropriate, and if they receive snacks, meals are served timely, substitutes are available and preferences are met. Interviews will be conducted weekly x 4 weeks then monthly x 2 months. Criteria 5: Date of compliance: 12/30/20 | will all | |

| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | · F | LTIPLE CONSTRUCTION DING | | 3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | R | |
| PARKVIE | ROVIDER OR SUPPLIER **POST-ACUTE AND RE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | <u> </u> | 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 | IX (EACH CORRECTIVE ACTION | SHOULD BE | COMPLETION DATE | |
| | Interview with the Reg 06/18/2021 at 4:18 PM the facility was not follow the facility was not followed the facility was not followed the facility was not followed the facility was not followed the facility was not followed the facility was not followed the facility was not followed the facility of the facility of the facility with the DM but her." Interview with the Admitistrator at the facility with the Administrator at the facility of the | istered Dietitian (RD), on for revealed she was aware owing the menus and was be menus. The RD stated oken with the DM regarding of following the menu and ative menu. The RD stated er the situation had been ted not providing an at who refused what was almutrition, weight loss, and The RD stated, "I work to I have no authority over inistrator, on 06/19/2021 at had only been the cility for two (2) weeks. The le had identified on that no alternative menus served. She stated she had D and the DM, but had not e problems in the kitchen. If that on 06/14/2021, kitchen she found that the er food to be prepared for inistrator stated she did not that the DM was not died to prepare the meals ine/tray cards and further icated one (1) resident | {F 8 | 806} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|--|----------------------|------|---|-------------------------------|----------------------------|
| | | 405070 | | | _ | R | |
| NAME OF D | ROVIDER OR SUPPLIER | 185256 | B. WNG | _ | | 09/30/2021 | |
| | PARKVIEW POST-ACUTE AND REHABILITATION CENTER | | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | 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 APPROPRIA DEFICIENCY) | E NTE | (X5) COMPLETION DATE |
| | service, on 08/05/202 were serving beef fritte green beans, mashed pudding and a roll. Colunch meal service revent have lactose free reindicated on the dietar Interview with Dietary 08/17/2021 at 5:30 PM enough food purchase food preferences. The "always" out of multiple wanted and it had bee to work at the facility, a According to the DA, lapreference, "it was an milk was rarely available. Interview with Certified 08/05/2021 at 2:45 PM the kitchen and requestion to the floor for Reswas unavailable. She see Administrator and the More for the resident. Interview with Dietary More facility on three (3) differences on the stated resident. | ay line for the lunch meal 1 at 1:15 PM, revealed staff ers with gravy, corn or potatoes, chocolate ontinued observation of the realed Resident #350 did milk on his/her tray as y tray card. Aide (DA) #1, on 1, revealed there was not ed and available to honor e aide stated the facility was e items the residents in this way since she started a few months ago. actose free milk wasn't a eed," however lactose free elle for the resident. Medication Aide #1, on I, revealed she contacted sted lactose free milk be sident #350 and was told it stated she contacted the citchen sent a supplement Manager (DM) #2, on , revealed she visited the erent occasions, and the lactose free milk on each esidents that required d have that available at all | {F 8 | (06) | | | |
| ; | 3. Review of Resident | #332's medical record | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI | TIPLI | E CONSTRUCTION | (X3) DATE SURVEY | | |
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| ANDFEAROR | CORRECTION | IDENTIFICATION NUMBER | 1 | A. BUILDING | | | PLETED |
| | | 185256 | B. WING | | | | R |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 09 | 9/30/2021 |
| PARKVIE | W POST-ACUTE AND RE | HARII ITATION CENTER | | | 200 NURSING HOME LANE | | |
| | | | | F | PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | E ATE | (X5) COMPLETION DATE |
| | O3/12/2021 with diagn 2 Diabetes, Chronic K Gastro-esophageal Re and Unspecified Atrial Review of Resident #3 assessment, dated 06 facility assessed the re Interview for Mental St fourteen (14) out of fift cognition. Further review as independent with hundred eighty-four (1 Review of Resident #3 06/16/2021, revealed at the resident's therapeut to provide the resident and to offer substitution indicated. Review of Resident #3 diet, dated 06/16/2021 to receive a no added thin liquids consistency protein with meals. Review of Resident 33. Collection assessment at 5:39 PM, revealed the was inadequate to mee Further review revealed add fortified foods with resident's energy need stated the resident's ide hundred and ninety (19 usual body weight was | dmitted the resident on closes, which included Type idney Disease, efflux Disease, Hypertension Fibrillation. 32's Quarterly MDS /19/2021, revealed the esident to have a Brief latus (BIMS) score of een (15), indicating intact ew revealed the resident eating and weighed one 84) pounds. 32's plan of care, dated a focused area related to utic diet with interventions with his/her ordered diet ins as requested or 32's physician ordered , revealed the resident was salt diet, regular texture, y, with one (1) ounce extra 2's Dietary-Nutrition Data , completed on 03/16/2021 he resident's current intake ent the resident's needs. It is a recommendation to meals to better meet the salt body weight was one loo pounds; however, the | {F & | 806} | | | |
| | (201) pounds. | | 1 | | | | |

| <u> </u> | (X3) DATE SURVEY COMPLETED | | |
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| 185256 B.WNG | R | | |
| NAME OF PROVIDER OR SUPPLIER 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 (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | |
| Review of Resident #332's Nutrition Progress Note, dated 04/11/2021 at 2:26 PM, revealed the resident had a nine (9) percent weight loss in thirty days. Further review revealed the resident's current intake was inadequate to meet the resident's needs. The Progress Notes stated the resident's needs. The Progress Notes stated the resident's needs. The Progress Notes stated the resident's needs. The Progress Notes stated the resident's activate in the resident's activate in the resident's diet to a regular diet, add large protein portions at dinner and add a snack at bedtime. Interview with Resident #332, on 07/27/2021 at 11:00 AM, revealed the food was always cold,. Further interview revealed the resident had lost weight and he/she was supposed to get a bologna sandwich on his/her tray for furnch and dinner. However, the facility did not send the sandwiches. The resident stated that he/she had requested bologna sandwiches and the facility stated they were out of bologna, Resident #332 stated they were out of bologna, Resident #332 stated they were out of bologna, Resident #332 stated the facility never had snacks, especially at night when he/she was hungry. The resident stated that staff tell him/her that he/she must wait until morning when the kitchen opens. Observation of Resident #332's tray, on 08/05/2021 at 7:28 PM, revealed the resident did not have a bologna sandwich or a large protein portion. Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed the facility was out of bologna, ice cream, lettuce, lactose free milk, tomato juice and have been out of those items for weeks at a time. The cook also stated the dieatray department should prepare and send out snacks for residents, especially those that have or have the potential to experience weight loss. However, | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | ONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|----------------------|--|---|-------------------------------|----------------------------|
| | | 185256 | B. WING | B. WING | | R | |
| | NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER | | | STR 200 | REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501 | 09 | 3/30/2021 |
| (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 CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | E ITE | (X5) COMPLETION DATE |
| | six months or longer." an adequate amount of fulfill the menu, and do purchased at the facilithose that needed and stated she had information multiple occasions of the requests/preferences of the requests/preferences of the requests/preferences of the residents' part of the residents' part of the resident of the resident of the resident of the resident to have a BIM of fifteen (15), and was independent with meal indicated it was unknown experienced a significate to the MDS the resident of the MDS the resident of the resi | She stated there was not of food items purchased to efinitely not enough ty to provide snacks to display wanted them. She also ed the Administrator on the residents' which were included on the he Administrator failed to rehased and available to references/requests. It #39's medical record limited the resident on oses which included Type 2 19's Quarterly MDS, dated the facility assessed the S score of fifteen (15) out is interviewable, was and the assessment which included the facility assessed the stand the facility three (253) 19's comprehensive care for revealed the facility was at risk for impaired siving a mechanical soft of Diabetes. Interventions (2021 included staff) | {F & | 06} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | | A. BUILD | ING_ | | R | | |
| | | 185256 | B. WING | | | | | |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | 1 0 | 9/30/2021 | |
| (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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE | |
| {F 806} | Continued From page Further review of Res | ident #39's weight record | ⟨F 8 | 306} | | | | |
| | to allow staff to obtain Observation of staff w | eighing Resident #39, on the resident weighed two | | | | | | |
| | Registered Dietician (I revealed he/she weigh (294) pounds on 01/04 three (253) pounds on identified was a twelve percent significant wei hundred eighty (180) of | ned two hundred ninety-four 4/2021 and two hundred fifty 06/22/2021, which the RD e and eight tenths (12.8) ight loss in the past one days. Recommendations is/her dietary preferences | | | | | | |
| | 1:20 PM, revealed the for lunch, and he/she I cereal). However, a si to the resident for lunch resident stated he/she the past year" because always late and the for stated even though he for lunch "a long time a received a salad. The asked staff in the past, received salads and he different excuse, they feltuce." Resident #39 requested Fruit Loops | had "lost a lot of weight in a the facility's food was od was cold. Resident #39 /she had requested salads ago" he/she had never resident stated he/she had why he/she never e/she stated, "It's always a forgot, or they're out of a stated he/she had also cereal, as that was his/her | | | | | | |
| | favorite cereal before a | edmission into the facility. 9 stated "They won't give | | | | | | |

| Apraro R | | |
|---|-----------------|--|
| 185256 B. WNG | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PARKVIEW POST-ACUTE AND REHABILITATION CENTER PIKEVILLE, KY 41501 | 0/2021 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE | |
| (F 806) Continued From page 821 me that here either." He/she also stated, "Why would someone ask me what I liked or wanted to eat, if they're not gonna give it to me, makes no sense." According to the resident, breakfast was frequently cold and sometimes the resident was hungry until funch. Resident #39 stated, if I could get me cereal I could eat that, I could make it myself." 5. Review of the tray line/tray cards for the noon meal on 08/05/2021, revealed three (3) residents had requested bologna sandwiches for funch and dinner, and three (3) other residents had requested salads for the funch meal. However, the facility was out of bologna and lettuce, and no other sandwiches or substitutes were provided to the residents. Review of the diet roster also indicated two (2) residents preferred Fruit Loops cereal for breakfast; however, there was no Fruit Loops in the facility. Observations of the cold cereal available in the facility at 4:30 PM on 08/05/2021 revealed there was one (1), nine (9) ounce bag of unsweetened corn flakes available for the residents. Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full-time at the facility for approximately one (1) year. She stated the facility was frequently out of food items. The cook stated two (2) residents continuously asked for Fruit Loops cereal for breakfast. However, the Administrator refused to order the food items timely, or at all, to meet the residents 'nutritional request and needs. She also stated she had informed the Administrator on multiple occasions of the residents request and needs. She also stated she had informed the Administrator on multiple occasions of the residents request of the food items. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 185256 | B. WNG | | | R | | |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | <u> 09</u> | 9/30/2021 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | , | | | D BE COMPLETION | | |
| | purchased and availal preferences/request. Interview with Dietary 08/17/2021 at 5:30 PN enough food purchase food preferences. The lettuce, ice cream and was out of, more than residents. Interview with the RD, and 08/18/2021 at 10: been contracted to prefer approximately one she had identified continued to the residents. Per intercommendations not at all, and resident chonored. The RD state been discussed on mu Administrator. However to correct the problem. Informed of residents that even though the A informed of residents that required lactose from that required lactose from the state of the s | ensure the foods were ble to honor the residents' Aide (DA) #1, on fl, revealed there wasn't ed and available to honor e aide also stated bologna, other food items the facility it was available for the on 08/11/2021 at 4:10 PM 30 AM, revealed she had evide services at the facility (1) year. The RD stated cerns with weight loss for erview, concerns of her being addressed timely or bice/preference not ed these concerns had eltiple occasions with the er, nothing had been done. Further interview revealed diministrator had been that had ongoing requests juice, bologna and one (1) ee milk, those items eilable for the residents. The product interventions implemented, if Resident #39's significant | {F & | 806} | | | | |
| | DM at another facility a and placed some food | M, revealed she was the nd had assisted the facility | | | | | | |

| STATEMENT OF DEFICIENCIES | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | | OMB NO. 0938-0391 | |
|---------------------------|---|---|----------------------------|-----|--|-------------------------------|--------------------|---|
| AND PLAN O | F CORRECTION | IDENTIFICATION NUMBER | | | | (X3) DATE SURVEY COMPLETED | | |
| | | 100 | A, BUILD | ING | | COMPLETED | | |
| | | 185256 | B. WNG | | | R | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | _ | | 0: | 9/30/2021 | |
| = . = | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | | 200 NURSING HOME LANE | | | |
| (X4) ID | SUMMARY ET | ATCHENT OF PETITION | | _ | PIKEVILLE, KY 41501 | | | |
| PREFIX (EACH DEFICIENC | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFI | lx. | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B | | (X5) | _ |
| IAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION DATE | |
| | | | | | DEFICIENCY) | | | |
| {F 806} | Continued From page | . 022 | | | | | | ٦ |
| () | | | {F 8 | 106 | } | | | |
| | stated showers and an | ers for the facility. She also | 1 | | | | 1 | |
| | weren't being honored | vare resident preferences | | | | | | |
| | always followed at the | facility. The DM stated, if | | | | | 1 | |
| | residents requested/no | referred specific food/drink | | | | | 1 | ľ |
| | items or a certain cere | eal "we buy it," because we | | | | | | 1 |
| | are "required to." The | DM stated if the menu was | | | | | | |
| | not followed, weights v | were not monitored. RD | 1 | | | | | - |
| | recommendations wer | e not implemented and | | | | | | 1 |
| | resident preferences was not honored that could lead to further weight loss, resident decline and | | | | | | | 1 |
| | | | | | | | | 1 |
| | "lots of other problems | s" for the residents. | | | 1: | | | ı |
| | Interview with the Adm | ninistrator, on 08/11/2021 at | | | | | | ۱ |
| | 6:00 PM and 08/18/20 | 21 at 3:30 PM, revealed | | | | | 1 | ı |
| | she acknowledged res | idents had requested Fruit | | | | | | ١ |
| | Loops cereal on multip | ple occasions. She stated, | | | | | | l |
| | "We only offer two kind | ds of cereal here. Corn | | | | | | 1 |
| | Flakes and Cheerios". | She stated she planned | | | | | | ı |
| ļ | on talking to the "RD a | bout all the stuff that's on | | | | |] | ۱ |
| 1 | these tray cards." The | Administrator declined to | | | | | | |
| | further discuss the nee | ed to talk with the RD | | | | | | ı |
| İ | related to honoring the | residents' preference and | j | | | | 1 | ľ |
| | here " However she a | offer two kinds of cereal | | | | | | ۱ |
| | requirement to honor th | cknowledged the facility's | | | | | 1 | l |
| - | Dreferences and also s | tated, " as long as I feel" | | | | | | l |
| | those preferences "are | within reason." According | | | | | | |
|] | to the Administrator, sh | e as well as a DM from | | | | | | ı |
| - 1 | another facility placed t | the facility's food orders. | | | | 1 | | l |
| ĺ | The Administrator state | ed she had been notified of | | | | | | |
| | various things the kitch | en had been out of and | | | | ļ | | |
| 1 | she felt like she provide | ed everything staff had | | | | | | |
| | requested for the reside | ents. | | | | | | |
| (F 809) | Frequency of Meals/Sn | acks at Bedtime | {F 80 | 9} | | | 12/30/21 | |
| SS=E | CFR(s): 483.60(f)(1)-(3 |) | | | | | 12/30/21 | |
| | §483.60(f) Frequency o | if hteel- | | | | | | |
| | 3-00.00(i) Frequency 0 | ii ivieals | | | | | | |
| MEMS TESTING ON D | | | | | | | | |

| STATEMENT (AND PLAN OF | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1 | | DNSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | R | |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501 | 09/30/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| {F 809} | facility must provide a regular times compar the community or in a needs, preferences, regular to the community or in a needs, preferences, regular to the community or in a needs, preferences, regular to the community of the co | sident must receive and the at least three meals daily, at able to normal mealtimes in accordance with resident equests, and plan of care. The stantial evening meal and g day, except when a served at bedtime, up to 16 and the following day if a resident neal span. The provided to residents in traditional times or outside received times, consistent with | {F 8 | 09} | | | |
| | by: Based on observation and review of the facility resident received mean comparable to normal community or in accommunity failed to ensure each als at regular times mealtimes in the rdance with the residents' equests, and facility policy. failed to provide nourishing snacks for residents who raditional times or outside vice times, consistent with | | E C C C C C C C C C C C C C C C C C C C | F 809 Frequency of Meals/Snacks at Bedtime Criteria 1: a) Test tray results completed on 10/27/21 indicate that meals are served a timely manner at palatable and safe emperatures for all resident floor/units. On 11/2/2021 resident unit/floor nourishment storage areas were verified by Dietary Manager as being stocked we macks/drinks for staff to access when offering residents these items between regular mealtimes. Criteria 2: a) Test tray results completed on 10/27/21 indicate that meals are | b) | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | | 10. 0938-0391 | |
|---|---------------------------|---|----------------|-----|--|---------------|---|
| AND PLAN O | F CORRECTION | IDENTIFICATION NUMBER: | A, BUILDI | | | | TE SURVEY |
| | | *** | 11,00.201 | | | | 127 |
| | | 185256 | B. WING | | | | R |
| NAME OF P | ROVIDER OR SUPPLIER | | 1011110 | _ | | 0: | 9/30/2021 |
| | | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | 1 | | 0 NURSING HOME LANE | | |
| (X4) ID | SUMMARY CT | | , _ | P | KEVILLE, KY 41501 | | |
| PREFIX | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | PREFI | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | E | COMPLETION DATE |
| | | | | | DEFICIENCY) | | J PAIL |
| | | | | | | | |
| {F 809} | Continued From page | 825 | {F 8 | neı | | | |
| | and resident interview | s revealed residents | , " | 1 | | | |
| | frequently did not rece | eive snacks and, meals | 1 | | served in a timely manner at palatable | | |
| | were later than schedi | uled for most meals. | | | and safe temperatures for all resident | | |
| | | | | - 1 | floor/units. b) Starting 9-15-21 snacks a | ге | |
| | The findings include: | | | | being offered daily morning and afterno by the restorative or activity aides or | on | 1 |
| | 20. | | | - 1 | designee to all residents. Intake will be | | 1 1 |
| | Review of the facility's | policy titled, "Food and | | | documented on snacks in the electronic | | 1 1 |
| | Nutrition Services" las | t revised October 2017 | | - | medical record. | • | 1 |
| | revealed staff would pr | rovide residents with a | | - 1 | Criteria 3: By 9-15-21 the CDM educate | vel. | 1 1 |
| | nourishing, palatable, | well-balanced diet that met | | | the dietary manager on obtaining food | .u | 1 1 |
| | the resident's daily nut | ritional/special dietary | | | preferences, Dining RD, placing order b | iv. | 1 1 |
| | needs, with preference | es of each resident taken | | | menus for facility, stocking | , | |
| | into consideration. The | policy also stated meals | | - 1 | snack/hydration carts, snacks and | | 1 |
| | would be provided with | nin forty-five (45) minutes of | | - 1 | hydrations, appropriate scoop sizes | | |
| | the scheduled mealtim | e. The policy stated | | | and/or portion sizes. Beginning on | | |
| | reasonable efforts wou | | | | 11/24/2021 Nursing staff will be educate | ed . | 1 [|
| | nourishing spacks she | t choices/preferences and | | | on when to provide snacks, what to do it | f | 1 |
| | nourishing snacks sho | uid be available to | | | snacks are not available and where to | | 1 |
| | nolicy residents could | (24) hours a day. Per the request snacks as desired | } | - 1 | document snack intake. Beginning | | 1 1 |
| 1 | of stacks could be ech | request snacks as desired reduled between meals to | | | 11/24/2021 dietary staff will be educated | i | |
| | accommodate the resid | dent's typical eating | | | by the Dietary Manager on assuring | | 1 1 |
| | patterns. | cent a typical eating | | | snacks are stocked daily. The CDM also |) | 1 1 |
| | | | ĺ | | in-serviced staff ensuring meals are | | |
| | 1. Observation of the 3 | 3rd floor refrigerator and | | | serviced timely on 11/24/21 | | |
| | snack storage on 07/27 | 7/2021 at 11:30 AM | | | Criteria 4: a) Beginning on 11/24/2021 | | |
| | revealed no snacks or | drinks were available for | | - 1 | The Dietary Manager/Dietary | | |
| 1 | residents on the unit. T | he refrigerator contained | | 1 | Consultant/Designee will complete week | dy | |
| | five (5) cartons of expir | ed milk dated 07/25/2021 | | | random tray pass audits until substantial | j | [[|
| [| and one (1) half gallon | of expired buttermilk dated | | | compliance to determine that meals are | | |
| - 1 | 07/21/2021. Additional | observation revealed two | | | prepared and served in accordance with the scheduled menus and required | | |
| 1 | (2) pudding cups labele | ed for medication pass. No | | | temperature parameters to include all | ľ | |
| | additional snacks were | observed on the unit/floor. | | | three meals, one tray per floor for each | | |
| | | | | | meal per observation. Beginning on | | |
| | Observation of the 5th | floor refrigerator and | | | 11/24/2021 the dietary manager/ dietary | | |
| | snack storage on 07/27 | 7/2021 at 12:05 PM | | | consultant/ designee will complete a | | |
| | revealed no snacks or o | drinks were available for | | | weekly audit that nourishment rooms on | | |
| | residents on the floor. T | he refrigerator contained | | | all three floors are stocked daily until | | |
| | three (3) cartons of exp | ired milk dated | | | substantial compliance. b) Beginning | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1 | | CONSTRUCTION | (X3) DATE | SURVEY PLETED |
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| | | 185256 | B. WNG | | | | R |
| NAME OF P | ROVIDER OR SUPPLIER | 103250 | B. WING | _ | | 09 | /30/2021 |
| | W POST-ACUTE AND RE | HABILITATION CENTER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| | (2) of which were und 07/27/2021. No addition the floor. Observation of the 4th on 07/27/2021 at 11:3 Additional observation and snack storage on revealed the refrigerat of milk and one (1) cas nacks available. Interview with Resider 10:45 AM, revealed no residents and the saminghts a week. The resort provide him/her with ungry. Interview with Resider 11:00 AM, revealed with ungry snacks were not provide him/her with ungry snacks were not provide him/her with ungry. Interview with Resider 11:00 AM, revealed with facility being out of the facility being out of the facility and staff had in was available. Resident #3 requested "a snack of one occasion since he facility, and staff had in was available to give he stated he/she would had discharged and "go ho | container of expired 07/07/2021. Further four (4) pudding cups, two ated, and two (2) dated onal snacks were observed on floor resident refrigerator 0 AM revealed no snacks. of the 5th floor refrigerator 08/05/2021 at 1:50 PM for contained one (1) carton of med pass with no on t#39, on 07/27/2021 at 0 snacks were available for 0 fe food was served multiple of sident stated the facility did of the snacks when he/she was on t#3, on 07/27/2021 at 0 nen he/she would get of always available due to 0 fe snacks a lot of the time. On t#332, at 11:00 AM on on t#332, at 11:00 AM on on t#308 on 07/27/2021 at 0 acks were not always 0 acks were not | {F 8 | 09} | 11/24/2021 The Dietary Manager/Dieta Consultant/Designee will review physic prescribed snack intake documentation monthly X 2 to determine that residents are being offered snacks in accordance with the facility protocol. Beginning on 11/4/2021 residents are interviewed in monthly resident council meeting on whether they are receiving snacks and meals in a timely manner and if meal/snack proportions are enough Audits will be reviewed monthly in QAP x3 months then quarterly until in substantial compliance. b) Starting on 9/23/2021 Dietary Managor designee will ensure and audit meals leaving the kitchen and reaching the untimely, audits will be conducted for random meals monthly until substantial until substantial compliance is achieved c) Starting 9-11-21 the Dietary Manager or designee will time passing of meal trays to residents after arriving to the unit. All three meals will observed monthly until substantial compliance is achieved. Audits will be reviewed monthly in QAP x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 12/30/20 | ian i i i i i i i i i i i i i i i i i i | |

PRINTED: 01/31/2023 FORM APPROVED

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI | TJPI | E CONSTRUCTION | | <u>J. 0938-0391</u> |
|---------------|---|--|-------------|------|--|----|----------------------------|
| AND PLAN O | F CORRECTION | IDENTIFICATION NUMBER | A. BUILD | | | | E SURVEY PLETED |
| | | | | | | | R |
| NAME OF D | ROVIDER OR SUPPLIER | 185256 | B, WING | _ | | 09 | /30/2021 |
| | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | | 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID. | _ | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX TAG | (EACH DEFICIENC) REGULATORY OR L | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 809} | Continued From page stated, "I have to stay choice." | 827 here for now, I have no | {F 8 | 309} | | | |
| | 11:30 AM, and Reside revealed snacks were night when they were something to eat. Acc informed them they we morning when dietary would be able to get s Observations and inte on 07/27/2021 at 11:4 items, which included crackers and snack ca | not available, especially at hungry and requested ording to the residents, staff ould have to wait until the staff arrived before they omething to eat. Inview with Resident #343 5 AM, revealed various food microwaveable soups, sikes were observed at the | | | | | |
| | were always late, food not been available to r Resident #343 stated, to keep so I don't go h for me I would have st long time ago." | ne resident stated the meals was cold and snacks had esidents "for a long time." "My sister brings me food ungry, if she didn't do that arved to death in here a | | | | | |
| İ | 07/27/2021 at 4:40 PM enough snacks for the times. The SRNA state staff had to call the kitte the unit/floor. In additi "When residents say the | egistered Nurse Aide #1, on I, revealed there were not residents and no juice at ed if juice was available, then to get it delivered to on, the SRNA stated, ney are hungry there are inpletely out of snacks." | | | | | |
| | PM, revealed when res hungry there were not the residents on the un | many snacks available for lit. She stated there were e for residents and it was | | | | | |

| | 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 | | | 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 CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | | (X5) COMPLETION DATE |
| | PM, revealed staff wa snacks to give to the roften the kitchen only and two (2) bowls of pnearly forty (40) reside stated Administration and the kitchen staff senough snacks availal facility was out of juice residents were being s (2) to three nights out staff often bought snact o give to the residents available for them whe linterview with Certified #1, on 08/05/2021 at 1 facility did not have snresidents. She stated snacks. CMA #1 state would buy the resident their own money when were hungry. Interview with Register 07/28/2021 at 10:00 A her floor frequently informatic many many many many many many many many | #4, on 07/28/2021 at 7:35 s not provided enough residents on the floor and sent two (2) sandwiches bineapple to the floor with ents on the unit. She further was aware of the situation, aid they did not have ble. SRNA #4 stated the efor a while and the served cold sandwiches two of the week. She stated cks out of their own pocket is due to not having any en they were hungry. If Medication Aide (CMA) If 30 PM, revealed the tacks available for usually there were noted that she and other staff its snacks and drinks with in they told them that they ared Nurse #6, on M, revealed residents on formed her they were they had failed to supply or "about a year." The RN view and stated, the food willing they are and provide snacks to suldn't have any." RN #6 | {F 8 | | | | |
| | also stated that she, as had informed the Admi complaints and reques | s well as other co-workers, inistrator of the residents' sted she direct the dietary nacks to have available for | | | | | |

| AND PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WNG | | | | R |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | | | 20 | TREET ADDRESS, CITY, STATE, ZIP CODE TO 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 SCIDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E NTE | (XS) COMPLETION DATE |
| {F 809} | the residents. However, " Interview with RN #9, revealed the residents hungry to staff and stafor so long and its pitin informed the Administ complaints. The RN shift, and no access of food for the residents stated she had purchas food/snacks from her into the facility for staft the RN, she bought the food/snacks to provide stated "someone told and she then informed wouldn't allow me to k made me take it back. Interview with State R (SRNA) #19, on 08/17 she was also a restoral She stated the facility provided/prepared by which was given to face AM, 2:00 PM and at not there has not been share interview with SRNA # AM, revealed there was She further revealed the snacks unless the dithem to the unit. Interview with SRNA # Interview with S | on 07/29/2021 at 9:30 PM, so complained of being ated, "That's been going on ful." The RN stated she had rator of the residents' stated she worked the night or no one here to ask for when "I am here." She ased \$84.00 worth of personal funds and brought of to keep on her floor. Per se snack so staff would have at to the residents; however the Administrator I did that if me it was illegal and eep the food here, she home." Registered Nurse Aide (72021 at 1:50 PM, revealed ative aide at the facility. "use to have snacks" the dietary department, cility residents daily at 10:00 ight. However, she stated acks available/provided to | {F & | 809} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DATE | SURVEY PLETED |
|--------------------------|--|---|----------------------|-----|--|-----------|----------------------------|
| | | 185256 | B. WNG | | | | R |
| NAME OF P | ROVIDER OR SUPPLIER | 163236 | D. WING | | TREET ADDRESS SIDE STATE BY | 09 | /30/2021 |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | 20 | REET ADDRESS, CITY, STATE, ZIP CODE O NURSING HOME LANE (KEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | E TE | (X5) COMPLETION DATE |
| {F 809} | bring up four (4) to fiventire unit and staff hat the snacks. She state are hungry but the stakitchen to get any additional uniterview with Dietary | the dietary department will e (5) sandwiches for the ave to determine who gets s that residents state they iff cannot get into the litional food. Aide (DA) #1, on | {F 8 | 09} | | | |
| | at 2:15 PM revealed the cream, tomato juice, labologna "constantly." (2) residents request the second secon | The aides also stated two ruit loop cereal, which is s, "all the time"; however, s not purchased and ents, even though the n informed on multiple | | | | | |
| | PM, revealed she had facility for approximate also stated the dietary and send out snacks f those that have or hav experience weight lose sent out snacks in six stated there is not an a items purchased to ful not enough purchased snacks to those that ne | s; however, "we haven't months or longer." She adequate amount of food fill the menu, and definitely at the facility to provide eed and want them. | | | | | |
| | and had been asked a weeks ago, to come po and retrain dietary staf | I, revealed she was acility the company owns, | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1 | TIPLE CONSTRUCTION | | (X3) DATE | SURVEY PLETED |
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| | | 185256 | B. WNG | | | | R |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501 | ODE | 09 | /30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) | ION SHOULD BE HE APPROPRIA | | (X5) COMPLETION DATE |
| | facility approximately time the facility had be tomato juice, lactose other things she was stated resident prefer facility and stated two loop cereal, as well as personally went throu and made a list of neathe nutritional needs/pwere met in the facility the Administrator. Ho informed the DM, she items and the residen She also stated since assistance to the facility grocery store on two (purchased food items own pocket, because purchase what the resident's weren't gett look of the facility that we will be also she had purchase what the resident's weren't gett look of 200 PM and 08/18/20 she had been the facility of 200 PM and 08/18/20 she had been the facility of 200 PM and 08/18/20 she had been the facility of 200 PM and 108/18/20 she had been the facility of 200 PM and 108/18/20 she had been the facility of 200 PM and 208/18/20 she had been the facility of 200 PM and 208/18/20 she had been the facility of 200 PM and 208/18/20 she had been the facility of 200 PM and 208/18/20 she had been the facility of 200 PM and 208/18/20 she had been the facility of 200 PM and 208/18/20 she had been the facility of 200 PM and 208/18/20 she had been the facility of 200 PM and 208/18/20 she had been the facility of 200 PM and 208/18/20 she had been the facility of 200 PM and 208/18/20 she had been the facility of 200 PM and 208/18/20 she had been the facility of 200 PM and 200 P | kitchen. She has visited the three (3) times, and each een out of ice cream, free milk and bologna and unable to recall. She also ence was not honored at the (2) residents request fruit is other items and she had gh the residents tray cards eded food items to ensure preferences of the residents to ensure preferences of the residents to ensure the Administrator "wasn't buying all those its could eat what was here." she had been providing ity, she had went to the 2) separate occasions and for the residents, out of her the Administrator refused to sidents needed to eat/drink. Chased items on her own, alk out of here knowing ing what they needed." Ininistrator, on 08/11/2021 at 121 at 3:30 PM, revealed lity Administrator since was not aware snacks were the also acknowledged | {F 8 | 309) | | | |

| STATEMENT | OF DEFICIENCIES | (VI) DEGUIDED ISHIPP ISHIP | T | | | OIMB M | <u>0. 0938-0391</u> |
|--------------------------|---|--|-------------------|------|--|--------|----------------------------|
| | CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILD | | E CONSTRUCTION | | E SURVEY PLETED |
| | | 185256 | B. WING | | | | R |
| NAME OF P | ROVIDER OR SUPPLIER | | | _ | STOCKT ADDRESS AND | 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 | (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 I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | E | (X5) COMPLETION DATE |
| | to honor the resident's stated "as long as I fe within reason." Accor she as well as a DM fithe food orders for the been notified of various been out of and stated everything staff had receively thing cility in the service of the facility in the service of the menu for 08/05/2021, revealed the residents in Observations of the transport of the transport of the service on 08/05/2021 were serving beef fritted green beans, mashed pudding and a roll. Observations of the luneven though the meal 12:00 PM the first of the exited the kitchen until floor, and the last tray approximately 2:45 PM which went to the 5th free received the facility in Review of the facility in the staff | the detection of the lunch meal of the lunch meal of the evening meal of choice. The lunch meal of the residents were being meal of choice. The lunch meal of the residents were being meal of choice. The lunch meal of the residents were being meal of choice. The lunch meal of the residents were being meal of choice. The lunch meal of the lunch meal of the residents were being meal of choice. The lunch meal of the lunch meal of the residents were being meal of choice. The lunch meal of the lunch meal of the lunch meal at 1:15 PM, revealed staff fers with gravy, corn or potatoes, chocolate The lunch meal also revealed time was scheduled for the lunch meal at 1:30 PM to go to the third cart exited the kitchen at a lance of the lunch late) loor residents. | {F 8 | 809) | | | |
| | conducted of tray line to 08/05/2021, revealed to | for the supper meal on he facility was serving a | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING_ | | | | R 30/2024 |
| | ROVIDER OR SUPPLIER W 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 MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI TAG | | HOULD BE | | (X5) COMPLETION DATE |
| {F 809} | salad and two (2) goo Continued observation supper meal was sche PM, staff was not obsected. The first of left the kitchen to be section in the first of left the kitchen to be section in the first of left the kitchen to be section in the first of left the kitchen to be section in the first of left the kitchen to be section in the first of left the kitchen to be section in the first of left the kitchen to be section in the first of left the kitchen to be section in the first of left the kitchen to be section in the first of left the kitchen to be section in the first of left the kitchen the left the kitchen the left the kitchen the left the kitchen the left the | wich, tater tots, three bean ey butter cookies. In sevealed even though the eduled to be served at 5:00 erved to start tray line until three (3) tray carts had not erved to the residents until cart had not left the kitchen ours late) going to the our. 221 with Resident #332 at ent #308 at 11:10 AM never provided to the fulled time in the facility. 221 with Resident #45 at ent #309 at 11:40 AM, always served late in the enterprise at 11:40 AM, always served late in the enterprise at 11:40 AM, always served late in the enterprise at 11:40 AM, always served late in the enterprise at 11:40 AM, always served late in the enterprise at 11:40 AM, always served late in the enterprise at 11:40 AM, always late and was enterprise at 11:40 PM, revealed taffed, "especially at night." one was always late and was enterprise at 11:40 PM, revealed taffed, "especially at night." one was always late and was enterprise at 11:40 PM, revealed taffed, "especially at night." one was always late and was enterprise at 11:40 PM, revealed taffed, "especially at night." one was always late and was enterprise at 11:40 PM, revealed taffed, "especially at night." one was always late and was enterprise trays were delivered a stated, "There's no way trays and feed the assistance and do it right." onts frequently complain of cold before they're getting | {F 8 | 09} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | ECONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | l . | R /30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501 | 1 | 73072021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| {F 809} | Continued From page Interview with LPN #2 | 834 c, on 07/28/2021 at 6:52 AM, were often late. She stated at | {F 8 | 09} | | | \$ B |
| | times it has been 8:00 | PM before the supper the unit. She stated late ving residents their | | | | | |
| | PM, revealed she prin She stated the supper | #16, on 07/28/2021 at 8:00 narily worked floor five (5). r trays would come out to 00 PM and there was not hem timely. | | | | | |
| ; | Interview with SRNA # PM, revealed meal tra at 8:00 PM. | #18, on 07/28/2021 at 9:54 ys came to the unit at times | | | | | |
| | revealed meal trays w times it has been 8:00 trays have made it to t | on 08/01/2021 at 11:40 AM, ere often late. She stated at PM before the supper the unit. She stated it sidents their medications | | | | | |
| | revealed residents on informed her they were had failed to supply sn "about a year." The R | e "hungry" and the facility lacks on the floors for N became tearful in he food that came from the | | | | | |
| | revealed she worked to sometimes supper tray floor until 7:30 PM - 8:0 most of the time, there | on 07/29/2021 at 9:30 PM, he 6 PM-6 AM shift and ys were not delivered to her 00 PM. The RN stated was only one (1) aide to he residents, which makes | | | | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | FIPLE CONSTRUCTION NG | | ATE SURVEY DMPLETED |
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| | | 185256 | B. WNG | | | R |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RI | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 09/30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | COMPLETION DATE |
| {F 809} | meal service like that assisted the aide will could; however, state approximately 40 res medication administr "have to have their make to have their make to have their make to have their make works five (5) dathree (3) meals on the for months due to she also stated she work had approximately 15 the last pay period. Swere late because the kitchen. Per the cool manager and were she had been for months to residents on time, acknowledged she de "like I should" during because there is not would be even more stated the facility was items. She also stated bologna, ice cream, let tomato juice and have weeks at a time. Interview with the RD and 08/18/2021 at 10 been contracted to programmeals are always ser | residents to have a good I." The RN stated she in meal service the best she ed she was the only nurse to idents, and that was also a ation time and the residents redicines too." I. On 08/05/2021 at 5:20 I. On 08/05/2021 at 5:20 I. On 08/05/2021 at 5:20 I. On 08/05/2021 at 5:20 I. On one of the stated I. On one of the stated I. On one of the stated I. On one of the stated I. On one of the stated I. On one of the stated I. On one of the stated I. On one of the stated I. On one of the stated I. On one of the stated I. On one of the stated I. On one of the stated I. On one of the stated I. On | {F 8 | 09} | | |
| | residents. | ed to provide snacks to the | | | | 1 |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1 | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------|---|-------------------------------|----------------------------|
| | | 185256 | B, WING | | 1 | R |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | 09 | //30/2021 |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| (F 809) | (ADON)/Interim Direct 08/18/2021 at 9:50 PM at the facility for approach the facility had been in nurses and aides since ADON stated she was were consistently late staff and residents durated when the food floor until 7 PM-8 PM difficult to serve and a there was only one (1) | istant Director of Nursing tor of Nursing, on M, revealed she had worked eximately one (1) year and nadequately staffed with e during that time. The salso aware that meal times, which made it difficult for ring the evening meal. She cart did not come to the in the evening, it was ssist residents because aide. She stated nurses ng medications during that | {F 8 | 09} | | |
| (F 812) SS=F | 6:00 PM, revealed she short staffed, with not aides. The Administration of residents' cold food were served late to the there should be a Diet four (4) other staff in the kitchen had worked withree (3) staff since shat the facility. She stated not enough staff in the were timely, and was " | ore/Prepare/Serve-Sanitary) requirements. | {F 8· | 12} | | 11/30/21 |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|--|---|--------------------------------------|-------------------------------|--|
| | | 185256 | B. WNG | | | | R | |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | 20 | REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE KEVILLE, KY 41501 | 09/ | 30/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | PREFIX (EACH CORRECTIVE ACTION SHO | | | (X5) COMPLETION DATE | |
| (F 812) | approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regulatives from using places, subject to consider growing and food (iii) This provision doe from consuming food from consuming food from consuming food standards for food set and from consuming food standards for food set and from consuming food standards for food set and from consuming food standards for food set and from consuming food standards for food set and from consuming food standards for food set and from consuming food set and from consuming food set and from consuming food set and from consuming food set and from consuming food set and from consuming food was observed and from consuming food was observed and from consuming food was observed and from consuming food was observed and from consuming food was observed and from consuming food was observed and from consuming food was observed and from consuming food was observed and from consuming food was observed and from consuming food was observed and from consuming food food from consuming food from | ed satisfactory by federal, ies. cood items obtained directly subject to applicable State ulations. Is not prohibit or prevent roduce grown in facility compliance with applicable dhandling practices. Is not preclude residents is not procured by the facility. In prepare, distribute and ince with professional rivice safety. It is not met as evidenced in, interview, and facility determined the facility failed food under sanitary in of the lunch tray line on uncovered cake was sent all trays to the units. In the line of the deep oil was observed to be dark | {F 8 | 112} | F 812 Food Procurement, Store/Prepare/Serve □ Sanitary Criteria 1: a) All food items are properly covered when sent out on the resident meal trays to the units. b) The deep fry was emptied and deep cleaned inside a out. c) All resident unit/floor refrigerator have been cleaned with all expired food/drink items thrown away and replaced as indicated. Criteria 2: All residents have the potent to be affected by this cited deficiency. € 10/27/2021 the kitchen was inspected, and all food items were covered, the defryer was clean inside and out and resident/unit floor refrigerators were cleand had no expired items. Criteria 3: The Dietary Consultant/Dieta | er and rs tial On eep | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | R | |
| NAME OF P | ROVIDER OR SUPPLIER | 100200 | | STREET ADDRESS OFFI OTHER NO | 09/30/2021 | |
| PARKVIE\ | W POST-ACUTE AND RE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DÉFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| {F 812} | staff would maintain the sanitation of the dining areas through complia comprehensive cleans. Review of the facility's and Palatability", undawould prepare food in Interview with the Adm 1:50 PM revealed the policy/process in placestored in the refrigeration resident use were. 1. Observation of the service on 06/15/2021 was observed to place resident meal trays arounits/floors. In additioninches of dried food winside of the deep fryer oil was obsin need of changing. Review of the facility's the deep fryer oil was observed to place resident meal trays arounits/floors. In additioninches of dried food winside of the deep fryer oil was obsin need of changing. Review of the facility's the deep fryer was not schedule. Interview with Cook #PM, revealed she kep kitchen to cut off the dinside of the deep fryer only worked at the facility only worked at the facility is stated she had only clime since she had worked. | e food and nutrition services the cleanliness and groom and food service ance with a written, ing schedule. Is policy titled, "Food: Quality ated, revealed the Cook a sanitary manner. Ininistrator on 08/10/2021 at facility had no e to ensure foods/fluids tors, which were available safe for consumption. It at 1:14 PM, revealed staff e uncovered cake on ad send them to the en, approximately two (2) has observed around the er which was being used to so for the lunch meal. The erved to be dark brown and a daily cleaning log, revealed to listed on the cleaning | {F 812 | Manager have in-serviced the dietary son: checking for expired foods, the neet to properly cover all food sent out on the resident meal trays to the units; the neet to follow the established cleaning schedule to include cleaning for the defryer; and the schedule for checking of resident unit/floor refrigerators to maint food/drink that is within date range, as completed on 11/01/21 Criteria 4: The dietary sanitation compliance tool for the monitoring of dietary sanitation will be utilized Weekly 4 weeks then monthly x 2 months beginning on 11/22/2021 under the supervision of the Dietary Manager/Dietary Consultant/ or Design These audits will include monitoring of trays before leaving dietary to ensure the are properly covered, and ensuring the deep fryer is cleaned per cleaning schedule. Unit/floor refrigerators are currently being monitored daily beginning on 11/1/2021. Audits will be reviewed monthly in QAPI x3 months then quarter until in substantial compliance. Criteria 5: Date of compliance: 11/30/20 | d ee ed ep the ain / x ee. ney | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER: | | 1, , | TIPLE CONSTRUCTION ING | | (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) | ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | LD BE | (X5) COMPLETION DATE |
| {F 812} | stated she was also us have been covered presidents. Interview with the Die 06/16/2021 at 1:30 PM 06/15/2021. The DM stated cleaned after every us been covered. The DM should have been on Interview with the Reg 06/18/2021 at 4:18 PM the deep fryer once in was dirty. The RD stated prior to leaving the kitt residents. The RD stated it should have. Interview conducted wo 06/19/2021 at 1:30 PM been the Administrato weeks. She stated the covered previously when The Administrators the Administrator stated the RD and the Daware of the problems 06/15/2021. 2 Observation of the snack storage on 07/2 revealed the refrigeral | er every use. The Cook naware the cake should for to sending it out to the stary Manager (DM), on M, revealed she had quit on stated she had trained the lathe deep fryer should be se and the cake should have M stated the deep fryer the cleaning scheduled. Spistered Dietitian (RD), on M, revealed she had cleaned at the past month because it ted cake should be covered chen and being delivered to ted she was not aware the not list the deep fryer and with the Administrator, on M, revealed she had only or at the facility for two (2) at deep fryer had been then she was in the kitchen. The deals had spoken with DM and had not been made as in the kitchen, until strated of the contained five (5) at dated 07/25/2021 and one | {F 8 | 312} | | |

| STATEMENT OF AND PLAN OF CO | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1 | TIPLE CONSTRUCTION | 1 | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | R 09/30/2021 | |
| | POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | <u>'</u> | 03/00/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES 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) | | | |
| In to complete the | enack storage on 07/2 evealed the refrigeral cartons of expired mill container of expired the 17/07/2021. Further of 18/07/2021. Further of 18/07/2021. Further of 18/07/2021 at 2:15 PM 18/17/2021 at | a floor refrigerator and 27/2021 at 12:05 PM for contained three (3) k dated 07/25/2021 and one nickened dairy dated bservation revealed four (4) of which were undated, and 021. Aide (DA) #2, on M and DA #1 on 08/17/2021 neither aide had been tock or monitor food/fluids ated on all three (3) floors a date and safe for resident whinistrator, on 08/10/2021 at d/fluids that were available fon should be in date and e also stated she was not sible to monitor food/fluid rigerators on the units. | {F 8 | | | 12/30/21 | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULT | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|-------------------|-------------------------------|---|-----------------------|-----|---|----------------------------|--------------------|
| | | | | | | | R |
| | | 185256 | B. WNG_ | | | | 30/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| PARKVIEV | V POST-ACUTE AND RE | HARII ITATION CENTER | 200 NURSING HOME LANE | | 0 NURSING HOME LANE | | |
| | | | | Pil | KEVILLE, KY 41501 | | |
| (X4) ID PREFIX | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| (F 835) | Continued From page | 841 | {F 83 | 35} | | | |
| | Based on interview, r | ecord review, and review of | ' | | F 835 Administration | | |
| | the Administrator's an | d the Director of Nursing | | | | | |
| | (DON) Job Description | n, the facility failed to be | | | Criteria 1: An acceptable Allegation of | | |
| | | nner that enabled effective | | | Compliance (AOC) was received on | | |
| | | attain and maintain the | ŀ | l | 09/03/2021, which alleged removal of the | he | |
| | highest practicable ph | ysical, mental and | | | Immediate Jeopardy on 09/02/2021 on | | |
| | psychosocial well-beir | ng for each resident, and to | | | (F580, F600, F655, F656, F684, F686, | | |
| | ensure quality care ar | nd services were provided | | | F692, F755, F880). However, the AOC | | |
| | | the residents (Refer to | | | could not be verified based on | | |
| | | 56, F657, F684, F686, | İ | | observations, staff interviews, and review | ew | |
| | F692, F725, F744, F7 | 55, F867 and F880). | | | of facility documentation. Additional | | |
| | Depend and an and at | | | | Immediate Jeopardy was identified for | | |
| - | | aff interviews revealed the | | | (F725, F835, F837, F867). The facility | | |
| | | systems in place to ensure | | | was notified of the Immediate Jeopardy | ' | |
| | addressed timels feile | hanges in condition were | | | on 09/10/2021. | | |
| | fron from abuse: faile | ed to ensure residents were | | | An acceptable allegation of compliance | | |
| | | d to ensure baseline and plans were developed and | | | was received on 09/25/2021, which | | İ |
| | implemented: failed to | ensure resident care was | | | alleged removal of the Immediate | | |
| | delivered in accordant | ensure resident care was | | | Jeopardy on 9/26/2021. The State Surv | ey | |
| | | failed to ensure residents | | | Agency determined the Immediate | | i |
| | received care to preve | | | | Jeopardy was removed as alleged during | ng | |
| | healing for pressure s | | | | a revisit conducted on 09/28-30/2021, | _ | |
| | | acceptable parameters of | | | which lowered the scope and severity to | ן ספ | ļ |
| | nutritional status and/ | or body weight; and failed to | | | for all tags, while the facility monitors the | e | |
| | ensure the facility had | adequate numbers of | | | effectiveness of systemic changes and | | |
| | | staff. Staff interviews | | | quality assurance activities. Criteria 2: Effective 9/13/21 an Interim | | |
| | revealed the Administr | rator was aware of the | | | administrator replaced current | | i |
| | | no action to correct the | | | administrator. Interim administrator | | - 1 |
| | failures, and condition | | | | received daily oversight and guidance | | I |
| | | | | | from the Regional Vice President and/o | , | ľ |
| | The facility's failure to | be administered in a | | | Regional Director of Operations and | • | |
| | manner that enabled e | effective use of its | | | Regional Clinical Nurse for 30 days. At | the | |
| | resources to attain and | d maintain the highest | | | end of this time the administrator was | | |
| | practicable physical, n | nental and psychosocial | | | evaluated by Regional Administrative | | |
| | well-being for each res | sident, and to ensure quality | | | Team and determined to continue daily | | |
| | care and services were | e provided that met the | | | oversight as needed. On October 1st, | | 1 |
| | needs of the residents | , has caused or is likely to | | | 2021, a permanent Administrator was | | |
| | cause serious injury, h | narm, impairment or death | | | placed in the facility and monitored for t | he | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | | ONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | ļ | R |
| | | 185256 | B. WNG_ | | | 09/ | 30/2021 |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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 835) | exist on 03/06/2021, Rights (F580), 42 CF Abuse (F600), 42 CF Person-Centered Car CFR 483.25 Quality of (F692), 42 CFR 483.4 (F755) and 42 CFR 4 (F880). The facility was received on 09/07 removal of the Immediate Jeopardy of facility of Immediate Jeopardy (F867). The Immediate Jeopardy of Jeopard of Jeopardy of Jeopard of Jeopardy of Jeopard of Jeopardy of Jeopard Office Jeopard Office Jeopard Office Jeopard Office Je | diate Jeopardy was 121, and was determined to at 42 CFR 483.10 Resident R 483.12 Freedom from R 483.12 Comprehensive Plans (F655) (F656), 42 of Care (F684) (F686) Pharmacy Services 83.80 Infection Control as notified of Immediate 121. Ition of Compliance (AOC) 3/2021, which alleged liate Jeopardy on r, the AOC could not be ervations, staff interviews, documentation. Additional was identified at 42 CFR (F837), 42 CFR 483.70 (F837), 42 CFR 483.75 d Performance The facility was notified of rdy on 09/10/2021. The is ongoing. allegation of compliance 5/2021, which alleged liate Jeopardy on the Survey Agency diate Jeopardy was uring a revisit conducted on lowered the scope and R 483.10 Resident Rights rehensive Person-Centered | {F 8: | | following 30 days by the Regional Vice President and/or Regional Director of Operations and Regional Clinical Nurse On 10/1/21 the Divisional Vice Preside and/or the Regional Director of Operations educated the new Administrator on the IJs, other tags, and the submitted AOC/POC. Administration has direct oversight and responsibility of direct, discipline, and communicate are of concern and process improvement. Criteria 3: Beginning 9-13-21 through 9-17-21 the interim administrator educated all staff on his contact information and role as the abuse coordinator. Also, at the same time all staff were in-service on staffing schedules, and who to notify when unate work. Any staff missing in-services or receive the education when they return work. Other education provided was reviewed by the QAPI Committee lister below and provided for staff. On 9/16/2021 the Administrator, Medic Director, and QAPI Committee have reviewed procedures for who to call if unable to work, Answering Call Lights, ADL Care, Serving Meal Tray Timely, incontinence care, turning and repositioning, the four PIs, Abuse Prevention Program, Care plans, and Infection Control. Criteria 4: Beginning on 09-13-2021, the interim administrator started monitoring daily, weekly, and monthly audits for F580, F650, F681, F686, F692, F755, F880, F725, F835, F837, F867. The Administrator will monitor all for F580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. The Administrator will monitor all f580. T | e. nt d n o o o o o as ble will o o al | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | - | | s | TREET ADDRESS, CITY, STATE, ZIP CODE | 09/ | 30/2021 |
| | | | | | 00 NURSING HOME LANE | | |
| PARKVIEV | V POST-ACUTE AND RE | HABILITATION CENTER | | | PIKEVILLE, KY 41501 | | |
| 07.41.10 | SUBMARY PT | ATCHENT OF DECIDIONALES | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREF | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | _ | (X5) COMPLETION DATE |
| (F 835) | Continued From page 843 | | {F 835 | | | - | |
| | 483.12 Freedom from | Abuse (F600), 42 CFR | ` | • | audits on a weekly and/or until substan | tial | |
| | 483.25 Quality of Car | e (F692), 42 CFR 483.70 | | | compliance is met and monthly thereaf | | |
| | | (F837), 42 CFR 483.75 | | | as recommended by the QAPI committ | | |
| | Quality Assurance an | | | | Any findings that were not within | | |
| | Improvement (F867), | and 42 CFR 483.80 | | | regulations and addressed immediate | | |
| | Infection Control (F88 | 30), while the facility | | | and/or not reported immediately will res | sult | |
| | | ness of systemic changes | | | in disciplinary action in accordance with | | |
| | and quality assurance | e activities. | | | facility policy and procedures that can | | |
| | | | | | result in termination. All findings and | | |
| | The findings include: | | | | progress will be presented to QAPI | | |
| İ | D- 1- 70 04 1 | | | | Committee consisting of at a minimum | of: | |
| | | istrators Manual" dated May | | | Administrator, Medical Director, Director | r | |
| | 2021 revealed the fac | | | | of Nursing, Dietary Manager, Social | | |
| | | residents and their family strive to create a homelike | | | Service Director, and two other staff | | |
| | | ne needs of the residents | | | members to update progress and/or | | |
| | were of utmost import | tance. The manual also | | | findings to determine recommendations | S OF | |
| | | red dynamic services and | | | feedback to continue current plan in | اما | |
| | | of each resident would be | | | place. When the 11/01/21oversight end the Corporate oversite was provided by | ea, | |
| | evaluated and service | | | | the RDO and a Regional Clinical Nurse | | |
| | accordingly. Accordin | | | | Consultant every day. The Divisional | | |
| | | ry purpose was to direct the | | | President oversight is reviewing audits | | |
| | | of the facility in accordance | İ | | ensure they are done and any actions | | |
| | with current federal, s | state and local standards, | | | needed have been done. When | | |
| | | tions that govern nursing | | | Divisional Vice President is not on site | the | |
| | | highest degree of quality | 1 | | RDO will be on-site to ensure audits an | e | |
| | | all times to the residents. | | | done and any actions needed have bee | en | |
| | | s required to make daily | | | done. | | 1 |
| | | and evaluate the overall | | | | İ | |
| | | /equipment, evaluate care | | | Criteria 5: Date of compliance: | | |
| | provided to the reside | | | | 12/30/2021 | | |
| | _ | ection. The manual also | | | | | |
| | stated the Administrat | | | | | | |
| | developing and maint | | | | | | ĺ |
| | practice which cover- | nd professional standards of the operation of the facility. | | | | | |
| | practice which govern | i the operation of the facility. | | | | | |
| | Further review reveale | ed the Administrator's daily | | | | | |
| | duties included ensuri | ing the Interdisciplinary | | | | | |

| | OF DEFICIENCIES CORRECTION | IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | 1 | ₹ 30/2021 | |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | • | 20 | REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501 | 007 | 0012021 | |
| (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 APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE | |
| (F 835) | which included dining assistance was provice Administrator's weekly residents, which had a reviewing weight and facility residents. More included ensuring followed consultant reports, when and to ensure QAPI in monthly as required. Administrator would rewould coordinate all in and would ensure corevents to State and F. Administrator should be residents and ensure residents were met. Administrator should daily and that nourish residents. 1. Review of Incident #82's ongoing behavioresident-to-resident a 05/18/2021, Resident #322 causing a skin to Resident #82 grabbed would not let go. On held Resident #82's wandered into his/her On 07/15/2021, Resident #82's with a shoe causing a resident's upper arm. #82 hit Resident #86 on was afraid when he/si | were occurring; ag; observe facility systems, and ensure personal ded to the residents. The y duties included monitoring dentified problems, and pressure ulcer reports for nithly Administrator duties ow up had occurred for nich included dietary reports; neetings were conducted The manual also stated the eview all incident reports, nvestigations in the facility, npliance for reporting of all ederal agencies. The isten to and know their the individual needs of the According to the manual, the ensure menus were posted ments were offered to the Reports revealed Resident ors resulted in buse incidents. On #82 grabbed Resident ear. On 06/04/2021, d Resident #64's wrist and 06/30/2021, Resident #317 wrist because Resident #82 room and would not leave. lent #82 hit Resident #86 | {F 8 | 35} | | | | |

| STATEMENT OF AND PLAN OF C | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1'' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | R 09/30/2021 | |
| | OVIDER OR SUPPLIER POST-ACUTE AND RE | HABILITATION CENTER | | ; | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | 1 03/ | 50/2021 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | IX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| | Interview with the Adribitor PM, revealed ships a provided the resident #82 with the Adribitor PM, revealed the residents of the facilitian and required staff to reglucose. Review of Resident #82 with the resident for the facilitian and required staff to reglucose. Review of Resident #82 with the revealed the resident and required staff to reglucose. Review of Rotes dated 07/18/20 approximately 7:30 All #321's blood glucose per deciliter) (less that blood glucose result). Interview with LPN #62 AM, revealed she care 07/18/2021. She staft hypoglycemic episode 7:30 AM as noted in the second episode was less that the found the resident glucose level "around Continued review of Feather with the position of the resident glucose level "around Continued review of Feather with the position of Feather with the resident glucose level "around Continued review of Feather with the position of Feather with the resident glucose level "around Continued review of Feather with the position of Feather with | ninistrator, on 08/11/2021 at a was the Abuse aware Resident #86 was 2. She stated she was also vandered into other gering resident-to-resident vever, there was no trator had taken any action om abuse. Ly's mealtime schedule as served at 7:00 AM, lunch PM and the evening meal M. 321's medical record had a diagnosis of Diabetes nonitor the resident's blood desident #321's Nursing 21 at 3:20 PM, revealed at M on 07/18/2021, Resident was 67 mg/dL (milligrams in 70 is considered a low 6, on 07/30/2021 at 11:30 and for Resident #321 on and the resident had two (2) as, once at approximately the nursing notes. The ate afternoon on the unknown). She stated at unresponsive, with a blood | {F 8 | 335) | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WNG | | | ľ | R |
| | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | 0.9 | /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 TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | | (X5) COMPLETION DATE |
| | The resident's docume was 32 mg/dL. Staff a raise the resident's bloresident remained unexperienced labored by of the Nursing Notes of the Nursing Notes of the Nursing Notes of Emergency Medical Signal Resident #321 to the Mospital record revealed diagnosed with hypoxesustain life), Pneumon Encephalopathy, and secondary to prolonge sugar). Interview with Administ 1:50 PM, revealed the monitor to ensure residenceiving basic and coresident's blood glucos acceptable parameters system to ensure resident system to ensure resident were identified/address. Administrator further side two (2) nurses and at night. 3. Record review revealed the resident #65 on 03/23 ulcers. Continued reviews Resident #65's was at and required assistance repositioning, and incofacility failed to turn an On 05/02/2021, Reside tissue injury to the coordinate in the resident properties of the resident | responsive and clammy. ented blood glucose and it dministered medication to bod glucose; however, the responsive and breathing. Continued review evealed at 1:00 AM, ervices (EMS) transported hospital. Review of the ed the resident was emia (not enough oxygen to hia, Acute Metabolic faculte respiratory failure, hid hypoglycemia (low blood trator, on 08/10/2021 at facility had no system to dents with Diabetes were ensistent care to ensure the se levels remained within as and did not have a fient changes in condition sed timely. The tated there should always two (2) aides on fifth floor aled the facility admitted hi/2021 without pressure ew of the record revealed risk for pressure ulcers he of staff for turning and antinent care. However, the d reposition the resident. ent #65 developed a deep cyx. The facility failed to | {F 8 | 135) | | | |
| | assess the pressure ul | cer (measurements, | | | | | |

| STATEMENT AND PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY | |
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| | | 405050 | | | | R | |
| NAME OF C | ROVIDER OR SUPPLIER | 185256 | B. WNG | | | 09/30/2021 | |
| PARKVIE | PARKVIEW POST-ACUTE AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501 | Ε | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX (EACH CORRECTIVE ACTION | SHOULD BE | E COMPLETION DATE | |
| | the facility also failed had worsened. On 05 was transferred to the (ED) due to worsening Resident #65 was adr to the sacral pressure and was, "clinically se [pressure] ulcer with a including cellulitis and Resident #65 underwed 05/30/2021, when all removed the "excision Resident #65 was real However, the facility creposition Resident #65 weekly skin and/or pre Resident #65 develope ulcers: a Stage I (one) 06/23/2021; a DTI (deheel on 06/26/2021; and, two (ulcers to the back of the 08/12/2021; and, two (ulcers to the left hip or review revealed a wou assessed Resident #6: 08/26/2021 at 9:00 AN wound had worsened. Interview with SRNA #PM, SRNA #1 on 8/5/2 on 08/27/2021 at 3:00 PM enough staff to turn an provide incontinence of SRNA #10 stated the A | e, odor, etc.). Subsequently, to identify the pressure ulcer 5/28/2021, Resident #65 Emergency Department of the pressure ulcer. Initial to the hospital related ulcer that had worsened ptic with large decubitis ssociated infection possible abscess." International to the facility. In the pressure was was down to the bone. In the pressure ulcer assessments. In the facility on tinued to fail to turn and fist and, failed to conduct the same ulcer assessments. In the facility of the left heel on t | {F 8 | 835} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | E CONSTRUCTION | (X3) DATE | SURVEY |
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| | | 185256 | B. WING | | | | R |
| NAME OF P | ROVIDER OR SUPPLIER | |] | _ | STREET ADDRESS, CITY, STATE, ZIP CODE | 09/ | 30/2021 |
| PARKVIE | N POST-ACUTE AND RE | HABILITATION CENTER | | 2 | 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE | |
| (F 835) | Continued From page | 848 | (F8 | 35} | | | 300 |
| (1- 835) | hours turns and reposichanges in" and "they anything". SRNA #11 one (1) or two (2) nurs over 40 residents and every two (2) to three "It can't be done by or Interview with the Adm 6:00 PM, revealed she staffing daily. She stawas not enough staff related services to ma practicable physical, nwell-being for resident still admitting new resithough she knew the staffed to meet the resident care with professional stand the facility operated with professional stand monitor the care deliverable facility. She also state any oversight meeting weekly or monthly Quisince she became the to ensure care plans wimplemented and care pressure sores and at professional standards. | iditions and checks and don't help us with stated there were usually se aides to provide care for residents were only turned (3) hours. SRNA #4 stated, he person". Ininistrator on 08/11/2021 at exast required to review atted she was aware there to provide nursing and aintain the highest mental, and psychosocial as; however, stated she was idents at the facility, even facility was not adequately sident's needs. The axas also responsible to axas provided in accordance dards of practice and that aithin the regulatory according to the had no systems in place to dered to residents in the dishe had not conducted as, which included daily, ality Assurance meetings. Administrator (June 2021), were developed and a delivered to residents with risk for pressure sores met | {F 8 | 35} | | | |
| | and review of the men 08/05/2021, revealed | u for the lunch meal on the residents should have ces of protein, 1/2 cup of | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED |
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| NAME OF S | 2011050 00 01101110 | 185256 | B. WING | | | 09/30/2021 |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | OULD BE | |
| | residents 1/3 cup of recup of vegetable. In a asked to weigh the provided by the facility residents required for Residents #90, #327, #65. However, there was an designated as "fortifier revealed three (3) resistant with meal and #81, and three (3) supposed to get salad including Resident #3: observation and intervevealed the facility dilettuce, or other sandy In addition, observation the meal due to be seapproximately 12:00 Fexit the kitchen until 2 Review of Resident #82, Fexion #332, a records revealed each significant weight loss failure to have a systemonitor resident weight to notify the Registere resident sustained weight loss, failed to have a systemonitor recommendation weight loss, failed to have a systemonitor resident weight to notify the Registere resident sustained weight loss, failed to have a systemonitor recommendation weight loss, failed to have a systemonitor resident weight to notify the Registere resident sustained weight loss, failed to have a systemonitor recommendation weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss, failed to have a system for the resident sustained weight loss. | as revealed staff served the mashed potatoes and 3/8 ddition, when staff was obein to ensure it was no functioning scale in the meat. The "Diet Roster" y indicated forty-two (42) lified foods, including #82, #39, #332, #81, and was no food prepared and d". Continued observation idents were supposed to get is including Residents #332 other residents were is for the lunch meal so the food that although riew with dietary staff d not have lunchmeat, wich ingredients available. The serve aled that although riew do to residents at PM, the last food tray did not in the food tray did not in the food tray did not in the resident #81's medical in of the residents sustained as a result of the facility's mic procedure in place to int loss. The facility failed to see according to policy, failed do Dietitian (RD) when a light loss, failed to provide ons to prevent further informer served adequate. | ⟨F 8 | 335} | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
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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 | U3/ | 50/2021 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFIX (EACH CORRECTIVE ACTION SHOULD | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | _ | (X5) COMPLETION DATE |
| (F 835) | and 08/18/2021 at 10 been contracted to propose for approximately one been provided a list of weight loss or because pressure ulcer. The froncerns with weight concerns that her received being implemented, mot honored, and constaff. The RD stated concerns on multiple Administrator. However, had taken no action to RD stated meals were not enough food purce the residents. The RI staff did not know how been approximately a | on 08/11/2021 at 4:10 PM :30 AM, revealed she had ovide services at the facility (1) year and had never of resident to evaluate for see the resident had a RD stated she had identified loss for the residents, commendations were not esident choice/preference numerication with nursing she had discussed the occasions with the er, she stated the facility of correct the problems. The e always late and there was hased to provide snacks to D stated she was not aware | {F 8 | :35} | | | |
| | not fortifying foods, no size to portion out res provide snacks, not we supplying supplement such as ice cream, ar preferences, could all malnutrition for the re | ot utilizing the correct scoop sidents servings, failing to reighing protein portions, not ts she had recommended and not serving residents their I lead to weight loss and | | | | | |
| | 6:00 PM and on 08/10 she had been the faci 06/07/2021. The Adm had no systems in pla weight loss or nutritio facility "was working of The Administrator corconducted NAR (Nutri | B/2021 at 3:30 PM, revealed lility's Administrator since sinistrator stated the facility ace to monitor resident nal needs, but stated the on getting one in place". Ifirmed the facility had not itional at Risk) meetings ne Administrator, but stated | | | | | |

| 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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| | | 185256 | B, WNG_ | | | l . | R 30/2021 |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | 20 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501 | j u <i>si</i> . | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 835} | The Administrator coor tracking she did to doing everything possive weight loss. Further is Administrator revealed department was "a most enough kitchen sign provided timely and wavailable to ensure maddition, the Administic preferences were not were not available for was "working" on a plin the facility. **The facility alleged implemented to remove ffective 09/26/2021: 1). Braden Scale Asson all residents by fact and comprehensive for were completed on a The facility utilized the and comprehensive for the facility utilized the and pressure injuries. 2). The wound care put #65 on 08/25/2021. Sign measured all pressure evaluated all current them to the Medical E09/17/2021. 3). Beginning 09/17/2 assessment and Braden in the material street in the material section. | getting those established. Juld not voice any monitoring ensure the facility was sible to prevent resident interview with the dishe was aware the dietary ess". She stated there was raff to ensure meals were was aware food was not renus were followed. In trator was aware food met/followed and snacks residents and stated she can to correct the problems the following was we Immediate Jeopardy essments were completed cility nurses on 08/28/2021 residents on 09/11/2021. The Braden Scale Assessment will body skin assessment to be plans of residents who by 09/17/2021. They will be a subject to the problem of the plans of residents who by 09/17/2021. They will be a subject to the problem of the plans | {F 8 | 35} | | | |
| | be completed, and th | e baseline care plan will be | 1 | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LTIPLE CONSTRUCTION | | (X3) DATE S | |
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| | | 185256 | B. WING | | | R | |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | | 5.71110 | STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501 | ODE | 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 | | ION SHOULD BI HE APPROPRIA | | (X5) COMPLETION DATE |
| 1 | comprehensive care page 21 days of admission or potential pressure interventions to preve development or worse. 4). Residents #45, #6, and #320 were bather care and moisturizing and assisted with drest clothing. Clean linens residents' beds on 09, were evaluated by soc. 5). All residents were interviewed to obtain a by the Director of Nurshew bath/shower schiby nursing staff to accorderence. Resident were obtained and incoplans and State Regis care plans by the Regis care plans b | cours to include any ential for pressure ulcer. A colan will be developed within to include pressure ulcers ulcers and include nt pressure ulcer ening of pressure ulcers. 5, #308, #309, #311, #314 di including a shower, nail lotion applied post shower, asing in clean appropriate were placed on the 11/2021. The residents cial services on 09/15/2021. offered a shower and shower/hygiene preferences sing (DON) or designee, edules were implemented commodate resident care tered Nurse Aide (SRNA) ional Nurse Consultant 1/13/2021. Registered Dietitian (RD) sidents' diets and made meal changes or te healing and to address or te healing and to address or Respiratory Therapist | {F 8 | 335} | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMPI | |
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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 | | 30,202 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 835} | 8). The Regional Nurswith orders for glucos and orders were ame entry of glucose value Administration Record 9). The Regional Cert (CDM) observed the runch and dinner on 0 were delivered on tim 10). Direct Care staffi recruitment efforts wit provided through age Direct care nursing st day will be reviewed on the unit at the start Director of Nursing, N Administrator or designatified staff to see if | se reviewed all residents se monitoring by 07/30/2021 anded to include mandatory es on the Medication d (MAR). Itified Dietary Manager meal service for breakfast, 19/11/2021, all three meals sec. Ing was increased through the additional staffing ency and travel contracts. Italif schedules for the next daily by the Director of inistrator to ensure staffing on meet the acuity of the rill be validated as present to of each shift by the lursing Supervisor, gnee. Direct care nursing eplaced by calling other of they can fill the opening, | {F 8 | | DEFICIENCY) | VTE . | DATE |
| | cannot be replaced the Assistant Director of Norsing management appropriate staffing lecenter will prioritize reachieved during emer required task including medication, no showed provided to incontiner | e opening. If direct care staff ne Director of Nursing, Nursing, or member of the team will fill the shift. If evels cannot be met, the esident care that can be rgency staffing, prioritize g administration of ers- sponge baths, care nt residents, turn residents meals served timely, and | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | - 1 | TIPLE CONSTRUCTION | , | (X3) DATE SURVEY COMPLETED | |
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| NAME OF REQUIRED OR OTHER TER | 103236 | B. WING | | | 09/ | 30/2021 |
| PARKVIEW POST-ACUTE AND | | | STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE P!KEVILLE, KY 41501 | CODE | | |
| PREFIX (EACH DEFICIE) | 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 APPROP | | E ATE | (X5) COMPLETION DATE |
| through recruitment staffing levels have meals are prepared 12). On 08/11/2021 #86 and #322, were and physical forms for Mental Status (E above and skin inte BIMS less than eight Licensed Nurse. Re Dementia had their revised, as necessa (MDS) Coordinator residents were ident psychosocial and/or 13). The Regional N wandering risk asse 08/16/2021. All residents for wandering updated by the MDS identified active war placed at each nurs potential interventio 14). Residents #39, #332 were weighed Registered Dieticiar comprehensive nutrecommendations were commendations be (DON) or designee, s Medical Doctor (MD and recommendation entered into the election of the signer in the staff in the signer in | increased dietary staffing efforts and appropriate been achieved to ensure and delivered timely. all residents including #64, reassessed for psychosocial of abuse with Brief Interview IMS) score of eight (8) or grity reviews for residents with at (8) were completed by sidents with a diagnosis of Care Plan reviewed and my by the Minimum Data Set on 09/07/2021. No new lified as indicating any physical harm. Surse Consultant completed a ssment on all residents by dents who were identified as a had care plans reviewed and 6 Coordinator. A list of all der risk residents were my station with a list of all for nursing to reference. #65, #81, #90, #330 and by 09/17/2021. The (RD) completed a tion assessment and RD | {F & | 335} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 185256 | B. WNG_ | <u> </u> | | R 9/30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 3/30/2021 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | (EXPLOSIVE OUT OU | | |
| {F 835} | in electronic medical record and tray card rinformation on 09/17/. 15). Beginning 09/15/. snacks to all residents afternoon by the restoraides, or designee. Suphysician will be docuaide, dietary aides and 16). The facility evalue 08/11/2021, located of for compliance with Complemented yellow a identified two (2) residexposed to positive rewas designated with a barrier and those two this zone on 08/11/2017). The facility had the in the red zone on 08/11/2017). The facility had the inthe red zone on 08/11/2017. | cON), reviewed diet orders record to ensure both the reflected accurate 2021. 2021, staff began offering additionally in the morning and practive nurse aide, activity macks ordered by a mented by the restorative d/or licensed nursing staff. ated the COVID-19 unit on the 5th floor of the facility DC guidelines and and red zones. The DON dents who had been residents and a yellow zone erection of a plastic zip wall (2) residents were moved to 21. Aree (3) residents who were concern the facility policy and didents #327, #328 and #329 antine per facility policy and didents #311 and #314 were concern the facility did not a sased on the employee. All residents eligible were on 09/17/2021. The facility were positive cases. | {F 8 | 35) | | |

| A. BUILDING COMPLETED A. BUILDING R R R R R R R R | |
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| U9/30/2021 | |
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| STALL ADDRESS, CIT STALE, ZIP COLE | |
| PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE | |
| PIKEVILLE, KY 41501 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE DEFICIENCY) | |
| (F 835) Continued From page 856 surveillance testing as recommended for COVID-19. Positive COVID-19 residents will be placed in isolation zone (red zone) and placed in droplet precautions with use of personal protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review newly positive COVID-19 residents to ensure isolation precautions have been initiated. In addition, any resident exposed will be placed in droplet precaution in isolation zone (yellow). The facility will provide physician notification, family notification and care plan revisions. The facility employee testing protocol will be twice weekly on designated days effective 08/16/2021. The facility requires all staff must be tested on designated days. If the employee is not tested, the facility will not allow the employee to work without a current negative COVID-19 test. During testing, the employee will be tested prior to entering the facility by the Infection Prevention Nurse or designee. All testing dates and times will be posted to the employee page, time clock and common areas. 20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021. 21). Resident #3, Resident #321, Resident #324, Resident #363 and Resident #351, medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION | | (X3) DATE | |
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| | ROVIDER OR SUPPLIER **POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIF 200 NURSING HOME LANE PIKEVILLE, KY 41501 | CODE | 1 007 | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | CTION SHOULD B THE APPROPRIA | É NTE | (X5) COMPLETION DATE |
| {F 835} | and implemented phanotification if any med The facility will abide physician regarding the 23). The facility formut 09/23/2021, with the facility with a three medications that required for cost authorization 24). New admissions the facility after normal weekends will have dientered into the electronic medical received integration. The facility fax transmittal as a bapharmacy integration electronic medical received in the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility of all residents of 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 | dered beginning 09/23/2021 armacy and physician lication was unavailable, by new orders from the ne unavailable medication. lated an agreement on facility's pharmacy to provide to (3) day supply of ires the facility's approval while pending cost review. and re-admissions entering to business hours and on ischarge orders submitted, conic medical record and to through pharmacy ty implemented the use of tackup to the electronic by entering the order in the tord to receive medications. The emergency medication rises and medication is cian will be notified for tw orders. The Consultant, Director of mursing staff completed an ordered medications and to were available in the | {F 8 | 35) | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l . | | DNSTRUCTION | (X3) DATE | SURVEY |
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| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | 200 | EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501 | 09/ | 30/2021 |
| (X4) ID PREFIX TAG | | | PREFIX (EACH CORRECTIVE ACTION SHOULD | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 835} | The QAPI committee Nursing, Administrato Services Director, Act Maintenance, Dietary Services. 27). The facility appoinadministrator on 09/1 current Administrator. | ersees the QAPI committee. consists of the Director of r, Medical Director, Social ivities, Clinical, Therapy, and Environmental nted an Interim 3/2021 to replace the The facility's Interim | {F 8 | 35} | | | |
| | guidance from the Re Regional Director of C Clinical Nurse for 30 of the thirty-day oversigh Administrative Team v | vill audit the Administrator to I daily oversight is needed. s direct oversight and , discipline, and | | | | | |
| | QAPI Committee revie contact person for call Activities of Daily Livir | l-ins, answering call lights, ng (ADL) Care, serving, and /s incontinence care and | | | | | |
| | Clinical Operations an Consultants conducte 09/15/2021 with a con consultation to review outcomes of the surve roles of the Governing Rules and Regulations the following commun | d a conference call on tract company for a | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | C | X3) DATE S COMPLI | |
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| | | 185256 | B, WNG_ | | | R | |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 09/3 | 0/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | E | (X5) COMPLETION DATE |
| (F 835) | turn and reposition recare, prepare and dis residents with eating, effective Pharmacy S and 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 meeting standardized plan to be reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda included reviewed as needed a agenda feet council, and grievances, admission development, vacant orientation, dietary value weight loss, work injuremployees on family review, pharmacy repusiness office, and a Committee and Medic standardized agenda but not limited to, the meeting. | nonitor/assess residents, sidents, provide incontinent tribute meals, and assist caring for pressure wounds, ervices, dealing with abuse y, sufficient staff, providing of providing a functioning of providing a functioning of and Regional Nurse and revised the QAPI Plan and presented the reviews a QAPI Committee during ang. The facility developed a rensure all topics were at the QAPI meetings. The rewing pressure ulcers, Foley ding tubes, contractures, redication usage, risk an control, hospital abilitation management, rens of grievance, activities, family council concerns, as, 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 and Director approved the on 09/16/2021 to include, topics presented during the | {F 8: | 35} | | | |
| | Vice President of Ope | ector of Operations and rations met with the N, and the Medical Director | | | | | |

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WNG | | | | R 30/2024 |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 091 | 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 835} | procedures to be imple communicating inform the Governing Body. I QAPI processes, the in the QAPI processes, the in the QAPI processes, the in the QAPI processes, the in the QAPI processes, the in the QAPI processes, the in the QAPI processes, the in the QAPI processes with the utilization approaches and, audit Calendar. The Adminimedical Director of furmeetings. 32). The Administrator reports before each Question of poly 15/2021 compliance with the director of poly 16/2021 to discuss interventions to remove implemented QAPI method (4) weeks, as needed Administrator will forward including the Vice Preside Regional Vice Preside Regional Vice Preside Regional Vice Preside Regional Nurse Consideration and the QAPI method (5) and the QAPI consults at the QAPI consults. The QAPI consults at the QAPI method (5) and the QAPI method (6) and | ling the duties of the uding setting policy and lemented in the facility and nation to other members of During the meeting, the need to participate regularly the need to identify root ation of the five (5) why iting systems per the QAPI histrator will notify the ture QAPI Committee It will collect all monitoring the ture QAPI Committee meeting for review to ensure deficiencies cited during the API Meetings were held on a abatement and develop by the jeopardy. The facility eetings weekly, times four and monthly. The ward all QAPI Meeting hing Body members, esident of Operations, and the ultant, to review the audit mmittee will review the eetings. Committee for a ator oversees the QAPI Committee consists of the dministrator, Medical ces Director, Activities, intenance, Dietary and es. | {F 8 | 335} | | | |
| | | cluding but not limited to the | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 185256 | B. WNG_ | <u> </u> | 00 | R 0/30/2021 | |
| | 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 COME (FACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| (F 835) | QAPI Tool Kit, QAPI a guide to effectively imbeginning 09/16/2021 meet quarterly for the reevaluate for frequer 34). The Administrate of QAPI Committee in (4) weeks and, as net to ensure the quality complies with the star compliance with State is demonstrated. 35). All nursing staff v Director of Nursing, indesignee on proper wobtaining, documenting changes to the Regis 09/17/2021. 36). On 09/13/2021, t Dietary Manager (CD Manager on the proviassessment to ensure diet order accuracy, a orders into the electron CDM educated the Direction of the nurse enters the communication including diet and tex meetings, staff will reprevious day to ensure 37). Therapy provided staff on turning and p | at a Glance, and a resource replement the QAPI plan. The Governing Body will a upcoming year and recy after one (1) year. The will increase the frequency rectings to weekly for four eded effective 09/16/2021, of care is monitored and redard of care and requirements. The will increase the frequency rectings to weekly for four eded effective 09/16/2021, of care is monitored and redard of care and requirements. The were educated by the recting techniques, recting the techniques, recting and reporting weight rected Dictician by The Regional Certified Mile educated the Dictary sion of timely nutritional edict order accuracy, on and on when to enter dict onic medical record. The feetary Manager to enter the tray care system. If order, the nurse will send a in to the dictary staff, ture. In the morning clinical view dict orders from the re accuracy. If education to all nursing ositioning range of motion, | {F 8: | 35} | | | |
| | chair to bed beginning | nt from bed to chair and g on 08/19/2021 and | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION AND MORE | | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING_ | | | R 09/30/2021 | |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RI | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 373072021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | COMPLETION DATE | |
| {F 835} | and assigned addition and agency contract turn and reposition a reposition themselved. 38). The Regional Diall nursing staff on princluding turning and hydration and nutrition to complete and doctorous assessment, and howedietician, physician, impairment by 09/17 staff will call or email Physician, and Resionew skin changes. 39). The DON or destimely call light responsatiff, including nurse assistants, were provimely hygiene per thimely toileting, dress of clean clothing, and trays. The DON or deadlity staff not work returning to work. 40). On 08/31/2021, Nursing educated all Registered Dietician, and the MDS Nurses into the electronic meand interventions. In Director of Nursing existing care plan in | 2021. The facility employed anal staff through recruitment is to ensure adequate staff to all residents who cannot is. Irrector of Nursing educated ressure ulcer prevention, if repositioning, adequate on, positioning devices, how the urment a head-to-toe skin who to notify the registered and RP of a new skin (2021. The facility nursing if the Registered Dietitian, ident Representative of any signee educated all staff on onse. In addition, direct care is and certified nursing vided education on providing the resident's plan of care, sing residents in their choice in dimely delivery of meal esignee will educate any ing during education upon The Regional Director of allicensed nursing staff, the interest the social Service Director, is on entering new care plans edical record, including goals in addition, the Regional educated staff to update the the electronic medical record interventions for any new skin | {F 8 | 35} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER A. BUILDIN | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 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 | | 1 03 | 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 CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | | | (Xf) COMPLETION DATE |
| {F 835} | Licensed nurses on ic residents with a change 08/12/2021. In additionand/or designee eduction didentifying signs/symphyperglycemia/hypoglidiabetic protocol, doctorange in condition, or sugar in the medical rights physician and following facility licensed nursing work until they have redowned and they have redowned and they have redowned and they have redowned and they have redowned and they have redowned and they have redowned and they have redowned and they have redowned and they have redowned and they have redowned the | piratory Therapist educated dentifying and assessing ge in respiratory status on an, on 08/12/2021, the DON cated all licensed nurses on otoms of lycemia, the facility's umenting a resident's documentation of blood ecord, notification of the ag physician orders. The ag staff will not be allowed to eceived this education. The pical staff on documentation 8/19/2021 and 08/20/2021 ervices. 2021, the DON educated ampleting a baseline Care is and goals relevant to atory diagnosis within 48 eviewing and providing a not/or the responsible party. If not working during di of ongoing education and work until they have in. | {F 8 | 35} | | | |
| | staff on the facility's "c call-off procedure for the event a person needs dayshift, they are to no supervisor two hours if staff needs to call of to notify their immedia | otify their immediate before the start of the shift. If on the night shift, they are tle supervisor four hours Ir shift. If the facility does | | : | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | R 09/30/2021 | |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501 | 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 835} | other qualified staff to off. If emergency sta Administrator and/or assistance from staffi working will be in-sent 44). All staff were pro Administrator and/or the process of identify reporting abuse, as wimplementing immedi wandering residents. 45). All nursing staff will Director of Nursing, Masignee on proper wobtaining, documenting changes to the Regis 09/17/2021. On 09/13 the Dietary Manager timely nutritional asses accuracy. When staff electronic medical recorder will send the windietary staff. The Dietary staff. The Dietary diet orders froclinical meeting to en 46). The Regional CD Manager on 09/13/20 regarding meal service recipes including recifortified diets to ensuruntritional needs of reestablished national established na | rand/or designee will call replace the person calling ffing is required, the designee will call for ng companies. Staff not viced upon return to work. vided re-education by the designee on 08/12/2021 on ving, preventing, and rell as identifying and ate interventions for vere educated by the fDS Coordinator, or reighing techniques, ng, and reporting weight tered Dietician by 8/2021, the CDM educated on diet order accuracy and ressment to ensure diet order enters diet orders into the cord, the nurse entering the itten communication to the re system. The facility will m the previous day in the sure accuracy. DM educated the Dietary retimes and the use of res for those requiring | (F 8 | 335} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | R /30/2021 | |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 10012021 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PROVIDER'S PLAN OF CORRI IX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| {F 835} | obtaining food prefere system, ordering food snack/hydration carts procedures, appropria portion sizes. 48). The Director of Nof Nursing educated Manager on the procedure implementing recommendations for 09/17/2021. 49). All staff were proposition of the procedure implementing recommendations for 09/17/2021. 49). All staff were proposition of the procedure implementing recommendations for 09/17/2021. 49). All staff were proposition of the procedure implementing residents in the proposition of the procedure implementation of the procedure implementation of the provide and yellow zones for signs/symptoms or reviewed. 50). Staff were provide 08/20/2021 by the DORegional Nurse Consistency into the procedure into the provide admissions into the procedure into the procedure into the provide admissions into the procedure into the provided into the | with the dietary manager on ences, the facility's tray card it based on menus, stocking it, snacks, and hydrations are scoop sizes, and/or hursing or Regional Director nurses and the Dietary east for entering, activating, the registered dietician's dietary orders on wided re-education by the elegines, handwashing, and Protective Equipment discones. In addition, the sted, licensed staff on for Covid-19 symptoms 21, the DON/designee duding contract staff, who ring the QAPI meeting on di-19 policy, the donning and doffing PPE, and monitoring residents of the Covid-19 were | {F 8 | 335) | | | |

| 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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| | | 185256 | B. WING_ | | | R 09/30/2021 | |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | 20 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501 | 1 031. | 3072021 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | - | (X5) COMPLETION DATE |
| {F 835} | patient, right dose, rig Regional DON/DON/ licensed nursing staff the process to follow available for administ education included ca the medication, obtain medication delivery ti ordered medication wo outside of the ordered education also includ given by the MD, doc and new orders from medical record. All of will be provided traini 52). On 09/25/2021, to Consultant educated including new hires a use of the emergency in place for ensuring notifying the physicia re-admitting residents after-hours. 53). The Interim Adm on his contact inform Coordinator from 09/ In addition, education who to notify if unable shift. 54). The facility will a head-to-toe skin asset through Friday, for the 09/17/2021 to ensure weekly on each reside | ing right medication, right the time, and right route. The designee educated all working on 09/23/2021 on when a medication was not ration as ordered. The alling the pharmacy to obtain ning the anticipated me, notify the MD if an will either be omitted or given domedication time. The ed following new orders sumenting the conversation, the MD in the electronic ther licensed nursing staffing as scheduled for shifts. The DON /Regional Nurse all licensed nursing staff, and/or agency staff, on the y medication kit, the system medications are in-house, or an for new orders for new or s, including on weekend and sinistrator educated all staff ation and role as the Abuse 13/2021 through 09/17/2021. In on staffing schedules and e to work their scheduled | {F 8 | 35} | | | |

| | DER/SUPPLIER/CLIA FICATION NUMBER: | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITAT | ION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | | 00.0012.021 | |
| (X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE P REGULATORY OR LSC IDENTIFY | RECEDED BY FULL | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | | | (X5) COMPLETION DATE | |
| (F 835) Continued From page 867 Responsible Party of any new s and those new interventions have place to prevent decline. 55). Central supply audited all latexpiration date on 08/28/2021. Aconducted weekly for all lab supweeks effective 09/17/2021 and three (3) months. 56). The Director of Nursing, As Nursing (ADON), or Nursing Suresident progress notes for daily effective 09/13/2021, then week month. Staff will review Progres Saturday and Sunday on Monda Supervisor conducted audits to areas of skin impairment identificially plan implemented to include new 57). Beginning on 09/11/2021, the leadership staff and/or designed rounding of residents assessing incontinence, and resident reporesidents will be visually rounding shift daily for two (2) weeks, fifty residents each shift for four (4) weeks. The facility has two (10 6:00 PM and 6:00 PM to 6:00 FM to 6:00 PM and 6:00 PM to 6:00 FM are answered, across all staff will conduct ten (10) call lig each shift for two (2) weeks and light observations each shift for | ab supplies for the Audits will be uplies for four (4) I then monthly for sistant Director of pervisor will audit or four (4) weeks ly for one (1) so notes for ay. The Nursing ensure any new ed had a care or interventions. The facility's began visual hygiene, toileting, sitioning. All ag on once each or percent of the weeks, and each shift for four (2) shifts, 6:00 AM AM. The leadership staffing of call light angth of time call shifts. Leadership ht observations then five (5) call | {F 8: | 35} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | IPLE CONSTRUCTION | | (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 | | 13012021 | |
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| {F 835} | began monitoring res Situation Background Recommendation (SI acute change in resp through Friday in the The facility reviewed respiratory status for implementation of an Plans were reviewed Audits will be daily fo times a week for four 60). The MDS Nurse began audits on 09/1 completion for all nev re-admissions to ens baseline Care Plan w 61). All residents adm days with a diagnosis Obstructive Pulmona Asthma, or current P Care Plan reviewed a the MDS Nurse(s) an interventions will be a morning meeting by nursing designee. 62). Beginning on 08 DON, and/or Designe admissions and re-ac care plans for comple with the resident and variance or identified immediately. Audits of through Friday for all to the facility for four | the DON and/or Designee piratory assessments and I Assessment and I Assessment and I Assessment and I Assessment and I Assessment and I Assessment and I Assessment and I Assessment and I Assessment and I Assessment and I Assessment and I Assessment and I Assessment and I Assessment and I Assessment I As | {F 8 | 35} | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 185256 | B. WNG | | | 09/ | 30/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | , | |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | 2 | 200 NURSING HOME LANE | | |
| | | THE PROPERTY OF THE PROPERTY O | | ı | 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 CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | | _ | (X5) COMPLETION DATE |
| (F 835) | Continued From page 869 then ten percent of admissions weekly for four (4) weeks. | | {F 83 | | | | |
| | | | , | • | | | |
| | designee began audit meal trays to resident All three (3) meals wil (3) units daily for two all three (3) units daily (1) meal on all three (weeks. 64). On 08/15/2021, the began audits of staff's quiz of identification a with a change in respisigns/symptoms of hy the facility's diabetic penange in a resident's physician and followin Leadership will quiz si | the Dietary Manager and/or ing how long it took to pass is after arriving at the unit. If the observed on all three (2) weeks, two (2) meals on or for two (2) weeks, and one (3) units daily for four (4) The DON and/or Designee is knowledge with a verbal and assessment of residents irratory status, identifying operglycemia/hypoglycemia, protocol, documenting a condition, notification of the long physician's orders. It affects the condition of the long physician's orders. | | | | | |
| | began monitoring all of results Monday through morning meeting. The any blood sugar result range for MD notificat any Physician's Order reviewed and updated designee will completed in the compl | he DON and/or Designee documented blood sugar gh Friday in the clinical DON/designee will review its outside of the normal ion and implementation of its. Care plans will be if as needed. The DON or e a visual rounding on coss both shifts and all three by resident with apparent of | | | | | |

| 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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| | | 185256 | B. WING | | | 09/ | 30/2021 |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 200 NURSING HOME LANE | | |
| (X4) ID PREFIX TAG | IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| (F 835) | addressed immediate one (1) week, then fiv (4) weeks. 66). On 08/13/2021, the designee implemente questionnaire on abust residents with wander the proper reporting of units. The employee completed for five (5) then three (3) times a and then weekly for foor identified concerns immediately. 67). Beginning on 08/Nursing and/or design resident's wandering admission and quarte Set (MDS) assessme wandering will be discomorning meeting to resinterventions. Any var will be addressed immediately will be care planned in the Director of Nursing. Nursing, or nursing design on 08/Services Director or design on 08/Service | ly. Audits will be daily for the (5) times a week for four the Administrator and/or do an employee see and identification of the staff daily for one (1) week, week for two (2) weeks, week for two (2) weeks, but (4) weeks. Any variance will be addressed to the a | {F 8 | 335) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE | SURVEY PLETED |
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| | | 185256 | B. WNG | | · · · · · · · · · · · · · · · · · · · | | R |
| NAME OF P | ROVIDER OR SUPPLIER | 103230 | D. WIIVG | | | 09 | /30/2021 |
| | W POST-ACUTE AND RE | HABILITATION CENTER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| | conducted audits of re- electronic medical rec- in the diet/tray card so 70). Beginning on 08/3 Manager will ensure a kitchen and reaching to 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 certifier residents promptly. The designee will audit the trays to residents after beginning 09/11/2021. observed on each unit two (2) meals on each weeks, one (1) meal of weeks. 71). The dietary mana- admitted/re-admitted re beverage preferences admission and enter the system for listing on the 09/16/2021. Review of completed bi-annually residents. Physician-of be audited by the Dieta (1) week, weekly for for after that for four (4) m 09/15/2021. | the Registered Dietician esident diet orders from the cord against orders entered oftware to ensure accuracy. 23/2021, the Dietary and audit meals leaving the the units timely. Audits will om meals twice daily for er week for two (2) weeks, the (1) month. Once meal and amanagement staff will to ensure residents receive ed nursing assistants assist the Dietary Manager or time it takes to pass meal they arrive on the unit. All three (3) meals will be adaily for two (2) weeks, unit daily for two (2) n each unit daily for four (4) ger or designee will review esidents' food and within 72 hours of them into the diet/tray card eir tray cards beginning if food preferences will be and as needed for all ordered snack intakes will any Manager daily for one tur (4) weeks, and monthly tonths beginning | {F 8 | 35} | DEPICIENCY | | |
| | 72). Daily COVID-19 s | creenings for staff will be | | | | | |

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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MUL | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
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| NAME OF P | ROVIDER OR SUPPLIER | 103230 | B. WING | _ | TDEET ADDRESS OF THE STATE OF T | 09 | /30/2021 |
| | W POST-ACUTE AND RE | HABILITATION CENTER | | 2 | 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | E TE | (X5) COMPLETION DATE |
| | Resources (HR) Direct punches to ensure so their shift. Audits will through Friday for four Director, and weekend staff not screened will immediately on the CO by the HR Director. The ducated on the COV Nurse, an infection co doors will remain locked entry by staff and screentry. 73). Beginning on 09/1 designee will round sefor eight (8) weeks, fiv (4) weeks to audit infediffering shifts and unit observation of handward zones; donning/do PPE; and mask complidentified concerns will by the auditor. 74). The DON, ADON, review all residents on pharmacy to ensure and beginning 09/23/2021. physician within two (2) expiration. 75). The Regional Nurse and/or Director of Nurse medication pass obser 09/25/2021 on random jeopardy removed to expiration. | ctor against time clock reening before beginning be completed Monday r (4) weeks by the HR ds audited on Mondays. Any be re-educated DVID-19 Screening Policy he HR Director was ID-19 policy by the Regional introl preventionist. All entry led. Visitors must be allowed lened by staff at the time of leven (7) times each week e (5) times weekly for four ction control compliance on its. Audits will include leshing, isolation signage offing (putting on/taking off) iance. Any variance or I be addressed immediately and/or Designee will narcotics with the in active script is on file. Staff will notify the chays of the prescription's less Consultant, Pharmacy, sing will conduct random vations effective is shifts daily until immediate. | {F 8 | 35} | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | TIPLE CONST | | (X3) DA | ATE SURVEY DMPLETED |
|--------------------------|---|---|-------------------|-------------|--|---------|----------------------------|
| | | 185256 | B. WING | | | | R |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | 200 NUR | ADDRESS, CITY, STATE ZIP CODE ISING HOME LANE LLE, KY 41501 | | 09/30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | × | PROVIDER'S PLAN OF CORRECTII (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY) | DBE | (X5) COMPLETION DATE |
| | CMS Critical Element Administration to condobservation of twenty- 76). Beginning 09/25// Friday, the DON, ADC audit medication deliving medications daily to eneeding a renewal harpharmacy. Audits will Immediate Jeopardy is 77). Beginning 09/11/2 and/or DON will be resulted in the staffing is marked audit staffing is marked audit staffing. 78). Beginning 09/11/2 Dietary Manager will be dietary staffing daily for adequate staffing. 79). Beginning 09/11/2 President of Operation monitor and audit the Adays to ensure compliance was to ensure compliance was to ensure compliance was to ensure of condition and identification. BIMS score of eight (8) felt safe in the facility at the or witnessed abuse. | Pathway for Medication fluct the medication pass five medications. 2021 Monday through the particles against ordered insure that all narcotics are been sent to the continue until the seremoved. 2021, the Administrator approached for monitoring our (4) weeks to ensure aintained. 2021, the Administrator and the responsible for reviewing are four (4) weeks to maintain the maintained. 2021, the Divisional Vice is and/or designee will administrator daily for 30 ance. If be conducted beginning for residents' change of the | {F 8 | 35} | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|--------------------|----------------|---|----------|----------------------------|
| | | 185256 | B. WNG | | _ | | R |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | 1 09 | /30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | E ATE | (X5) COMPLETION DATE |
| | designees weekly unt removed. **The State Survey agactions to remove the 09/26/2021 as alleged. 1). Review of Head-to revealed staff assessed on 09/11/2021. A review of the design to revealed eight (8) resign to revealed eight (8) resign to revealed eight (8) resign to revealed eight (8) resign to revealed eight (8) resign to revealed eight (8) resign to revealed eight (9) revealed staff updated the resident's current pressure injuries of two comprehensive care pressure independent of the resident's current pressure ulcers with the revealed staff assesses pressure ulcers with the with the Regional DON revealed she completed assessment on all resign the facility completed that the (20) total pressure injurities on the residents on all resident revealed that the residents of the residents of the residents of the residents of the residents of the residents of the residents of the residents of the residents of the resident residents of the resident residents of the resident residents of the resident residents of the resident residents of the resident residents of the resident residents of the resident residents of the resident resident residents of the resident residents of the resident residents of the resident residents of the resident residents of the residents of the residents of the resident residents of the resident residents of the residen | gency validated the facility's Immediate Jeopardy on I by: -Toe Skin Assessments ed all residents in the facility ew of the skin assessments dents (Residents #65, #27, #74, and #358) had s with a total number of enty (20). A review of the class for Residents #65, #27, #74, and #358 I the care plans to reflect coressure injuries. The review on 09/17/2021. Its census on 08/28/2021 at all residents at risk for the Braden Scale. Interview N on 09/30/2021 at 4:17 PM and head-to-toe skin dents on 09/11/2021. She he facility identified twenty ries. She further stated that the Braden Scale sidents on 08/28/2021. evealed the utilized the skin den Scale assessments to eare plans. She stated that 45, #14, #357, #27, #74 were updated to reflect es by 09/17/2021. Interview | {F 8 | 335} | | | |
| | with MDS Nurse #1 on | 09/30/2021 at 1:39 PM all residents' care plans to | | | | | |

| STATEMENT OF DEFI | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A, BUILDI | | | (X3) DATE | SURVEY PLETED |
|---|--|--|-----------------------|---|--|-----------|----------------------------|
| | | 185256 | D 11010 | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | R |
| NAME OF PROVIDE | D OD CUIDDUICO | 183236 | B. WING | | | 09 | /30/2021 |
| NAME OF PROVIDE | K OK SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PARKVIEW POS | T-ACUTE AND RE | HABILITATION CENTER | | 2 | 00 NURSING HOME LANE | | |
| | | | | F | PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR | | E TE | (X5) COMPLETION DATE |
| reflect addition round the R DON, #324, review review each care part of the R P P P P P P P P P P P P P P P P P P | ion, she completed on 09/15/2021 degistered Dieticia, and the MDS N., #45, #14, #357, we revealed the Inwed resident's orders plan, and implemented the Medical I dent on 08/25/202 defour (4) pressuratissue injury (DT a skin tear to the I dent #65's wound 1/2021 at 9:00 ANd measured, "13 cm width and 0.2 o'clock measuring clock that measuring lipable bone, slow with Aquacel Ag. ation completed of the ent #65 had six (injuring 1.2 cm (lend) (depth), stage of the ent #65 had six (injuring 2.5 cm by 2 two (2) to left hip ess than 0.1 cm, I a measuring 1 cm, unstageable to 0.6 cm, and four on 10 | re injuries by 09/17/2021. In ed a review of walking with Therapy Personnel, an, the Medical Director, the urse for Residents #65, #27, #74 and #358. A sterdisciplinary Team and the changes as needed. It #65's medical record Director assessed the 1 at 1:45 PM and noted a e ulcer on the sacrum; a l) to the left and right heels; eft inner leg. Review of | {F 8 | 335} | | | |

| STATEMENT AND PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | - 1 | LTIPLE CONSTRUCTION DING | | (X3) DATE S | |
|--------------------------|---|--|--------------------|--|----------------------------------|-------------|----------------------------|
| | | 185256 | B, WING | | | R | |
| PARKVIE | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | | | STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501 | CODE | 09/3 | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | IX (EACH CORRECTIVE AC | CTION SHOULD BE THE APPROPRIA | TE | (X5) COMPLETION DATE |
| | Interventions in place heel protectors while is weekly documentation mattress to bed, nutrit turning/repositioning. for the sacral pressure 10:21 AM revealed the by 11 cm by 0.3 cm widrainage and 95 perce Resident #65 declined observation of other precord review revealed PM, Physician #1 dete weight loss and wound 09/28/2021, Resident in-house wound care vecord revealed on 09, physician of the declin with no new orders. The with Failure to Thrive. 3). The facility admitted 09/10/2021, completed 09/10/2021, completed 09/10/2021, and compon 09/10/2021, and compon 09/10/2021, and re-admission fevealed staff developed plan on 09/21/2021. A re-admission revealed admission skin assess 09/28/2021, Braden Schaseline care plan dev. | for the resident included in bed, diet as ordered, in of the wound, an air ional supplements, and Observation of wound care is ulcer on 09/29/2021 at it wound measured 13 cm iith a scant amount of ent granulation tissue. If would not consent to the ressure areas. A medical id that on 09/21/2021 at 2:19 ermined the resident's its were unavoidable. On #65's family declined visits. Further review of the (29/2021, staff notified the in the resident's wound he resident was diagnosed of Resident #355 on it a skin assessment on the late of a baseline care plan with #355 was discharged on intendity on view of the medical record and the comprehensive care review of Resident #355's the resident had an intendical record and the completed on cale on 09/28/2021, and a eloped on 09/28/2021 at 1:40 09/29/2021 at 1:40 09/29/2021 at 1:10 AM. | {F 8 | 335) | | | |

| FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION INFORMATION INFORMAT | (X3) DATE SURVEY COMPLETED | |
|--|-------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 835) Continued From page 877 Resident #311 on 09/29/2021 at 11:52 AM, | | |
| PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE PIKEVILLE, KY 41501 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 835) Continued From page 877 Resident #311 on 09/29/2021 at 11:52 AM, | 30/2021 | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 835) Continued From page 877 Resident #311 on 09/29/2021 at 11:52 AM, | | |
| Resident #311 on 09/29/2021 at 11:52 AM, | (X5) COMPLETION DATE | |
| Resident #320 on 09/29/2021 at 11:30 AM and Resident #320 on 09/29/2021 at 11:13 AM revealed the residents appeared clean, well-kempt, and clean linens were on the residents' beds. Interviews with the residents during the time of the observations revealed no identified concerns. A review of Progress Notes for Residents #45, #65, #308, #309, #311, #314, and #320) revealed the Interim Social Service Director interviewed the residents on 09/15/2021 and had no concerns with resident hygiene. Interview with the ISSD on 09/30/2021 at 2:23 PM revealed she interviewed Residents #45, #65, #58, #65, #308, #309, #311, #314, and #320 on 09/15/2021 with no identified concerns regarding hygiene. 5). Observation of residents during the initial tour on 09/28/2021 from 1:33 PM to 2:32 PM revealed no identified concerns. Interviews and record reviews revealed Residents #45, #65, #308, #309, #311, #314, and #320 each had their shower preference and hygiene preference obtained and included on their care plan. A review of the resident's medical record, including the comprehensive care plan and SRNA care plan, revealed staff updated each resident's plan to reflect the resident's preference. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM revealed she assisted with obtaining resident preferences. She stated each resident was interviewed for shower and hygiene preference preference, and the facility updated each resident interviews revealed their shower/hygiene preference was obtained. A review of the facility's shower schedule revealed that the resident interviews revealed their shower/hygiene preference. | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|------------------------|------|---|-------------------------------|----------------------------|
| | | 185256 | B. WNG | | | | 20/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | 30/2021 |
| PARKVIEV | N POST-ACUTE AND RE | HARII ITATION CENTER | | 2 | 200 NURSING HOME LANE | | |
| | | TABLETATION CENTER | | F | PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| (F 835) | 3:53 PM revealed she resident diets on 08/2 that she implemented recommendations for loss and/or wound he documentation reveal reviewed all residents DON reviewed all diet Interview with the RD revealed she complet and recommendations 7). A review of facility 08/13/2021 revealed with a diagnosis of Dissigns and symptoms of hyperglycemia and thintervention. Interview 09/30/2021 at 4:17 PN the residents and did concerns. Observation 09/28/2021 at 11:36 PN 09/29/2021 at 11:36 PN 09/29/2021 at 11:32 PN 09/29/2021 at 11:32 PN 09/29/2021 revealed idiagnosis of Chronic Obsorder (COPD), Ast assessed by Respirat with Respiratory Therat 12:45 PM revealed with diagnoses of Chronicorder (COPD), Ast 08/12/2021 with no identification of the complex of the post of t | Dietician on 09/30/2021 at a began reviewing all 8/2021. She further stated new and/or additional residents to address weight aling. A review of the ed the Registered Dietician diets, and the Regional and recommendations. O on 09/30/2021 at 4:17 PM ed the review of all diets s. assessments completed by thirty-nine (39) residents abetes were assessed for of hypoglycemia/ e need for immediate with the Regional DON on M revealed she assessed not identify immediate ns of Resident #348 on M, Resident #320 on M, and Resident #311 on M revealed no visible poglycemia/hyperglycemia. sessments completed on fifty (50) residents with a Dbstructive Pulmonary than and Pneumonia were ory Therapist #1. Interview apist (RT) #1 on 09/30/2021 she assessed all residents onic Obstructive Pulmonary than, and pneumonia | {F 8 | :35} | | | |
| | | 5 on 09/28/2021 at 1:40 | | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUL [*] A. BUILDI | | (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 | , | |
| (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 835) | Revealed no respirator 8). Interview with the on 09/30/2021 at 3:40 all residents with a diaresident's orders for gestated the facility ame include mandatory en MAR. Review of Resiorders revealed each the glucose value on review revealed no containing glucose levels than 400. 9). A review of audits revealed meals were with the Regional Cer (RCDM) on 09/28/2020 09/30/2021 at 1:52 Plobserved on 09/11/20 within five (5) to ten (1) scheduled times. 10). A review of the face of the f | Regional Nurse Consultant PM revealed she reviewed agnosis of Diabetes and the lucose monitoring. She ended all resident orders to try of glucose values on the dent #3, #41, and #357's order required staff to enter the resident's MAR. Further uncerns with residents less than 60 and/or greater completed on 09/11/2021 delivered timely. Interview tified Dietary Manager at at 2:26 PM, and M revealed lunch was 21 and arrived at the unit lo) minutes of the estacility's staffing for AM to 6:00 PM revealed as and three (3) nursing duled for each floor of the estacility's staffing revealed as and two (2) certified each floor from 6:00 PM to | {F 8 | 35} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|---|--|--------------|-------------------|----------------------------|
| | | 185256 | B. WNG | | | | ₹ 30/2021 |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | | , 037 | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | 1 | ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY) | | | (X5) COMPLETION DATE |
| {F 835} | 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 vand meal trays were platerviews with RN #AM and on 09/30/202 #4/Wound Care Nurse LPN (Licensed Practicat 12:44 PM; LPN #7 and 09/30/2021 at 12:50 Fat 10:31 AM; State Re (SRNA/certified nurse 3:40 PM; SRNA #11 SRNA #7 on 09/29/20 on 09/29/2021 at 4:10 09/29/2021 at 3:04 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 co one (1) evening cook, day aides, and two (2 Observation of the kit PM reflected the staffing reflected reflect | ssistants for each floor from staffing on 09/28/2021 from on 09/29/2021 from 8:11 AM PM and 09/30/2021 from revealed 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 1 at 12:58 PM; RN e on 09/30/2021 at 2:54 PM; cal Nurse) #6 on 09/30/2021 on 09/29/2021 at 3:00 PM 64 PM; LPN #10 on PM, LPN #11 on 09/30/2021 egistered Nurse Aide e aide) #1 on 09/29/2021 at on 09/29/2021 at 3:23 PM; bi21 at 3:29 PM; SRNA #19 0 PM; SRNA #21 on M; SRNA #21 on M; SRNA #22 on 09/29/2021 A #23 on 09/29/2021 at 4:10 had improved, and each d they had time to perform offing schedule for 21, and 09/30/2021 nsisted of one (1) day cook, one (1) prep cook, two (2) | {F 8 | 35} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|-----|----------------------|-------------------------------|----------------------------|
| | | 185256 | B. WNG | | | | R /30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 00 NURSING HOME LANE | | - |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | | | | (X5) COMPLETION DATE |
| {F 835} | 2:10 PM revealed kitch and they were able to their shift. 12). A review of assess withdrawn, crying, or conducted for Resider 08/11/2021. No concereview of skin assessing interviews conducted and 09/30/2021 reveated and 09/30/2021 reveated and 322. Interview would with psychosocial and including observations and #322. Interview would with abuse. Interview would with abuse. Interview ould with abuse. Interview ould with abuse. Interview ould with the RDON on ould with the RDON on ould with the RDON on ould be of licensed nursing stational service. BIMS score of eight (a 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 the including a description. | ary Aide #3 on 09/30/2021 at then staffing had improved, complete their duties during saments for being other abuse symptoms was not #64, #86, and #322 on erns were identified. A ments completed revealed is. Observation and on 09/28/2021, 09/29/2021, aled no identified concerns alor physical abuse, is of Residents #64, #86, with Resident #322 on alw revealed no concerns with MDS Nurse #1 on and revealed all residents with attal 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 sign or above revealed no assments for residents that esidents had received a | {F 8 | 35} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|---|-------------------------------|--|
| | | 185256 | B. WING_ | | | R 19/30/2021 | |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 3/30/2021 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHO | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| {F 835} | and #332's medical residents had been will the residents had been will the residents with the Re 09/30/2021 at 3:53 P comprehensive nutritions of the medical completed a comprehensive nutrition of the medical completed a comprehensive of the medical completed a comprehensive of the medical completed accompleted assessment on 09/16/2021 for Resident #81, 09/16/09/16/2021 for Resident medical recommendations madischarged. Interview Dietician on 09/30/20 Nurse Consultant on Regional DON on 09/20/20 resident had received assessment and review by nursing staff. Furth and Regional DON retray card were review information. | ent #39, #65, #81, #90, #330 ecord revealed all of the reighed by 09/17/2021. gistered Dietician on M revealed she completed a ional assessment on #81, #90, #330 and #332. al record revealed the RD nensive nutritional i/2021 for Resident #39, ent #65, 09/16/2021 for 2021 for Resident #90 and ent #330 with no dietary ade. Resident #332 was with the Registered 21 at 3:53 PM, the Regional 09/30/2021 at 4:17 PM and 21 at 3:20 PM revealed each I a comprehensive nutritional ew of the recommendations ner interview with the RD evealed both the record and red to reflect accurate | {F 8: | 35} | | | |
| | at 2.22 PM, the fourth PM and the fifth floor revealed snacks inclu- oatmeal pies, goldfish drinks were present, juice. Observations or revealed snacks were Review of Resident # Resident #14's record | | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING | | | X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---|-----|---|------------------------------|----------------------------|
| | | 185256 | B. WNG | | | | R |
| NAME OF 5 | | 183256 | B. WING_ | _ | | 09/ | 30/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PARKVIEV | V POST-ACUTE AND RE | HABILITATION CENTER | | . 2 | 200 NURSING HOME LANE | | |
| <u> </u> | | | | F | PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 835} | Continued From page | e 883 | (F 8 | 35} | | | |
| | yellow zone on 09/28/ | ne facility's red zone and /2021 at 2:12 PM revealed s. The zones contained no | | | | | |
| | revealed the residents guidance. Observation 09/29/2021 at 11:41 A 8/30/2021 at 10:36 Af | ents #327, #328 and #329 s were isolated per CDC n of Resident #328 on M and Resident #329 on M revealed no obvious signs D-19. Resident #327 had n the facility. | | | | į | |
| | staff working on 09/16 COVID-19 with no ide review of resident test 09/17/2021, revealed 19). Interview with MD at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 PM | no new cases. OS Nurse #1 on 09/30/2021 se #2 on 09/30/2021 at 1:31 sistant #1 on 09/30/2021 at mager on 09/30/2021 at ng Supervisor on M, Human Resource | | | | | |
| | Director (HR) on 09/3 Marketing Liaison on Medical Records on 0 Central Supply on 09/ on 09/29/2021 at 11:5 12:58 PM, RN #4/Wor 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at | 0/2021 at 10:48 AM, Senior 09/30/2021 at 10:55 AM, 19/29/2021 at 8:34 AM, 1/29/2021 at 2:40 PM, RN #1 1/55 AM and 09/30/2021 at 1/55 AM and 09/30/2021 at 1/55 AM and 09/30/2021 at 1/55 AM and 09/30/2021 at 1/55 AM and 09/30/2021 at 1/55 AM and 09/30/2021 at 1/55 AM and 09/30/2021 at 1/56 AM and 09/30/2021 at 1/57 AM and 1/57 AM | | | | | |

| 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 | | | R | |
| NAME OF D | ROVIDER OR SUPPLIER | 100200 | 1 2, 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 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | (EACH CORRECTIVE ACTION SI | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| (F 835) | at 4:10 PM, SRNA #2 SRNA #22 on 09/29/2 #23 on 09/29/2021 at 09/29/2021 at 1:12 Pl 09/30/2021 at 2:10 Pl Director/Dietary Mana 1:30 PM revealed the (2) times weekly. Inte Control Nurse on 09/3 she was conducting to following CDC guidar tested revealed tested times weekly. 20). Review of Reside and #90's medical recresident had COVID-implemented. In additive resident so ordered 21). Interview with the 09/30/2021 at 3:25 Pl Resident #321, Resident #321, Resident #321, Resident #351's for usage and approp the physician on 09/2 22). Observation of a 09/29/2021 at 4:35 Pl 09/30/2021 at 8:09 Al identified concerns we addition, observation floor on 09/30/2021 at identified concerns. In 09/29/2021 at 11:55 / PM, N #4/Wound Car | 2021 at 3:17 PM and SRNA 4:10 PM, Cook #3 on M, Dietary Aide #3 on M, Former Activities ager #3 on 09/30/2021 at a facility is testing staff two rview with Interim Infection 30/2021 at 3:10 PM revealed esting two (2) times weekly ace. Review of facility staff d is being conducted two (2) ent #329, #328, #311, #65 cord revealed that each 19 monitoring orders tion, review of each alled staff was completing the d by the physician. e Medical Director on M revealed Resident #9, lent #324, Resident #326 medications were reviewed rriate administration times by 3/2021. medication pass on M on 3rd floor and M on 3rd floor revealed no ith missing medications. In of a narcotic count on 5th t 12:50 PM revealed no atterview with RN #1 on AM and 09/30/2021 at 12:58 te Nurse on 09/30/2021 at 09/30/2021 at 12:44 PM, | ⟨F 8: | 35} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1 1 | MULTIPLE CONSTRUCTION JUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | R 09/30/2021 | | |
| | ROVIDER OR SUPPLIER POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 1 031 | 30/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | · · | TION SHOULD B | | (X5) COMPLETION DATE | |
| {F 835} | at 12:50 PM and LPN AM revealed no conc medications. 23. Interview with the Operations on 09/30/Co-Owner/President at 3:11 PM revealed I agreement that the pl facility with a three-darequiring cost review, pharmacy agreement requiring a cost review the facility a minimum medication while beir would communicate aguidance to the pharm Director of Operation the Vice President of signed the agreement 24). Interview with RI AM and 09/30/2021 at 2:54 P 12:44 PM, LPN #7 or 09/30/2021 at 1:54 P at 12:50 PM, LPN #1 revealed they had recaware of the process from the pharmacy. In they were aware that physician if the pharm medication to the fact 25). Interview with the on 09/30/2021 at 3:40 09/30/2021 at 4:17 P | M, LPN #10 on 09/30/2021 I #11 on 09/30/2021 at 10:31 erns with unavailable Vice President of 2021 at 4:10 PM and of Pharmacy on 09/30/2021 both parties made a formal harmacy will supply the ay supply for medication Review of the facility's a revealed for any medication with pharmacy would send of a three-day supply of the ag reviewed. The facility any changes or continuance macy within 72 hours. The s of Guardian Pharmacy and Operations of the facility t. N #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4 on M, LPN #6 on 09/30/2021 at n 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 1 on 09/30/2021 at 10:31 AM ceived education and was for obtaining medications n addition, they revealed the nurse would notify the nacy could not deliver a | {F 8 | 35} | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDI | TIPLE CONSTRUCTION NG | (X: | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | - | R | |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | <u> </u> | 09/30/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | 1 | SHOULD BE | (X5) COMPLETION DATE | |
| {F 835} | facility by 09/25/2021 pass on 09/29/2021 and 09/30/2021 at 8:3 concerns with missin 26). Review of a QAF the facility conducted with the Regional DC Consultant, Human F Records, the Housek Supply, MDS Nurse of Therapy Manager, the Administrator, the Dietary Manager, and administration team. 27). Interview with the Operations on 09/30/Interview with the Introp/30/2021 at 5:05 P appointed the curren 09/13/2021. Further of 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 | ations were available in the . Observation of medication at 4:35 PM on the third floor . OP AM revealed no identified g medications. PI signature sheet revealed a meeting on 08/12/2021 PN, Regional Nurse Resources, SSD #2, Medical Reeping Supervisor, Central #1, MDS Nurse #2, the Red Admissions Coordinator, Red Activities Director, the dother members of the revealed the facility to Interim Administrator on M revealed the facility to Interim Administrator on the members of the lad provided the Interim . Mand 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 | ⟨F 8 | 335) | | | |

| 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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| | ! | | 71. 551.251 | | | | R |
| | | 185256 | B. WNG | | | | 30/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | DRESS, CITY, STATE, ZIP CODE | | |
| PARKVIEV | V POST-ACUTE AND RE | HABILITATION CENTER | | | NG HOME LANE | | |
| | | | | PIKEVILLI | E, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 835} | Nurse Consultant on the Med-Net Concept 09/28/2021 at 3:00 Ph conducted a conferent following: (1) the outcexpectations and role outlined in the Rules a determined a plan for communication/monitoriand COVID-19 isolating facility to monitor/asse reposition residents, prepare and distribute residents with eating, effective Pharmacy Scand neglect effectively appropriate ADLS, an QAPI committee. 30). Interview with the 09/30/2021 at 3:40 Ph Consultant on 09/30/2 reviewed and revised presented the reviews Committee during the facility developed a stall topics were review meetings. The plan in Foley catheters, enter contractures, physical usage, risk managem hospital re-admission management, social significance, activities, ricouncil concerns and/discharges, census, siby department/positio | 2021 at 4:10 PM, Regional 09/30/2021 at 3:40 PM, and s Nurse Consultant on M revealed the facility are call to review the omes of the survey, (2) s of the Governing Body as and Regulations, (3) the following oring tools: Infection Control on, enough staff at the ess residents, turn and provide incontinent care, a meals, and assist caring for pressure wounds, ervices, dealing with abuse by, sufficient staff, providing diproviding a functioning and providing a functioning and providing a functioning and/or revision to the QAPI 09/16/2021 meeting. The andardized plan to ensure eed as needed at the QAPI cluded pressure ulcers, and feeding tubes, are restraints, medication ent, infection control, the rate, rehabilitation services, concerns of resident council, and family or or grievances, admissions, staff development, openings n, employee orientations, | {F 8 | 35} | | | |
| | dietary variance tray a | audit report, weight losses, | ļ | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | R 09/30/2021 | |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | 200 | REET ADDRESS, CITY, STATE, ZIP CODE D NURSING HOME LANE KEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | 1 | ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | | | (XS) COMPLETION DATE |
| (F 835) | medical leave of absence hires, medical repharmacy reports, resoffice, and admission Committee and Medic standardized agenda but not be limited to the meeting. Interview 09/30/2021 at 1:39 Pl 09/30/2021 at 1:39 Pl 09/30/2021 at 1:52 Pl Director/Dietary Mana 1:30 PM, Medical Rec AM, Human Resource 09/30/2021 at 1:18 Pl Supervisor on 09/30/2021 at 1:18 Pl Supervisor on 09/30/2021 at 1:18 Pl Supervisor on 09/30/2021 at 1:45 PM and Centra 2:40 PM, revealed the at the QAPI meeting least the QAPI meeting least the QAPI meeting least the duties of the Government of the G | tions, employees on family ence or leave of absence, cord compliance review, storative nursing, business actions. The QAPI cal Director approved the on 09/16/2021 to include the topics presented during with MDS Nurse #1 on M, MDS Nurse #2 on M, Regional Certified Dietary 21 at 2:26 PM and M, Former Activities to the cords on 09/29/2021 at 8:34 to Director (HR) on M, Therapy Manager on M, Housekeeping 2021 at 1:24 PM, (RT) #1 on 09/30/2021 at 1 supply on 09/29/2021 at 1 information was presented the led on 09/16/2021. 1 Vice President of 2021 at 3:40 PM, DON #2 or PM, and the Medical 1 at 3:25 PM revealed a end on 09/16/2021 regarding the leave of | (F 8 | 35} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | |
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| | | | | | | R | |
| | | 185256 | 185256 B. WING | | | 09/30/2021 | |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE P!KEVILLE, KY 41501 | JDE JDDE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | | ON SHOULD B HE APPROPRIA | 4.44 | |
| (F 835) | | | {F 8 | 335} | | | |
| | 09/30/2021 at 3:40 Pl monitoring reports be and reviewed the data QAPI attendance she conducted meetings of and 09/30/2021. Inter of Operations on 09/3 Regional Nurse Cons PM revealed they we governing body, and forwarded to them. 33). Interview with the Operations on 09/30/ Regional Nurse Cons PM revealed the gove Administrator with res material for QAPI. Fu | QAPI meetings had been e Vice President of 2021 at 4:10 PM and the cultant on 09/30/2021 at 3:40 erning body provided the sources and education rther interviews revealed the | | | | | |
| | upcoming year. Inten Administrator on 09/3 he had been provided education regarding 0 34). Interview with the 09/30/2021 at 3:40 P were conducted weel ensure the quality of complied with the sta compliance. Further i President of Operation PM, Regional Nurse 3:40 PM, MDS Nurse PM, MDS Nurse #2 of Regional Certified Dii 09/28/2021 at 2:26 P | d with resources and QAPI. In the Interim Administrator on M revealed QAPI meetings kly effective 09/16/2021 to care is monitored and interview with the Vice ons 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, | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--|-----|---|-------------------------------|----------------------------|--|
| | | 185256 | B. WNG | | | F | | |
| NAME OF PE | ROVIDER OR SUPPLIER | 103230 | | _ | TREET ADDRESS, CITY, STATE, ZIP CODE | 09/3 | 30/2021 | |
| THANKE OF F | OVIDER OR SOFFEIER | | | | 00 NURSING HOME LANE | | | |
| PARKVIEV | V POST-ACUTE AND RE | HABILITATION CENTER | | | PIKEVILLE, KY 41501 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| {F 835} | on 09/29/2021 at 8:3- Director (HR) on 09/3 Therapy Manager on Housekeeping Super PM, Respiratory Therat 12:45 PM and Cere 2:40 PM revealed the weekly QAPI meeting and 09/23/2021. In an Medical Director/Phy 3:25 PM revealed he QAPI meetings on 05 Further interview with 09/30/2021 at 3:40 P meeting had been conceive of the facility (10 sheet reflected the allidentified concerns. 35). Interview with RI AM and 09/30/2021 at 3:40 P meeting had been conceived of the facility (10 sheet reflected the allidentified concerns. 35). Interview with RI AM and 09/30/2021 at 3:09/29/2021 at 3:40 P meeting had been conceived of the facility (10 sheet reflected the allidentified concerns. 35). Interview with RI AM and 09/30/2021 at 3:50 PM, LPN #10 on 09/30/2021 at 3:29 PM, SRNA #10 on 09/29/2021 at 3:23 PM, SRNA #21 on 09/29/2021 at 3:109/29/2021 at 4:10 Pmeeting the weighing residents, coreporting the weights (RD). Interview with the second process of the second process of the weighting residents, coreporting the weights (RD). Interview with the second process of the second | 1:30 PM, Medical Records 4 AM, Human Resource 80/2021 at 10:48 AM, 09/30/2021 at 1:18 PM, visor on 09/30/2021 at 1:24 rapist (RT) #1 on 09/30/2021 at ey had participated in the gs conducted on 09/16/2021 ddition, an interview with the sician #1 on 09/30/2021 at participated in the weekly 0/16/2021 and 09/23/2021. In the Interim Administrator on M revealed the weekly QAPI anducted on 09/30/2021. A QAPI meeting attendance bove interviews with no N #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 1/2021 at 2:54 PM, LPN #6 44 PM, LPN #7 on 1/2021 at 2:54 PM, LPN #6 44 PM, LPN #7 on 1/2021 at 12:50 PM, LPN 1/2021 at 12:50 PM, LPN 1/2021 at 3:04 PM, SRNA#1 on 1/2021 at 3:04 PM, SRNA#22 7 PM and SRNA #23 on 1/2021 interview with nursing erbalized understanding of obtaining, documenting, and is to the Registered Dietician Regional DON on 09/30/2021 | {F 8 | 35} | | | | |
| | at 4:17 PM revealed | staff was provided with | | | | | 1 | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | RUCTION | (X3) DATE SURVEY COMPLETED | |
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| | _ | 185256 | B. WING | | | R 09/30/2021 | |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | 200 NURS | DDRESS, CITY, STATE, ZIP CODE SING HOME LANE LE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | _ | (X5) COMPLETION DATE |
| {F 835} | techniques, obtaining reporting weight chan Dietician. 36). Interview with Fo current Dietary Manager PM revealed she rece 09/13/2021 by the Re Manager (CDM) on ditimely nutritional asset order accuracy. When the electronic medical the order sends writted dietary staff, which infurther revealed that sthe tray card system to orders. She stated the previous day would be meeting. Interview with 09/28/2021 at 2:26 PP PM revealed she comformer Activities Direaddition, she stated the provide additional asset to her new role. 37). Interview with RNAM and 09/30/2021 at 12:409/29/2021 at 3:00 PP PM, LPN #10 on 09/30/2021 at 09/29/2021 at 3:40 PP 09/29/2021 at 3:23 PP 09/29/2021 at 3:23 PP 09/29/2021 at 3:23 PP | oz1 on proper weighing documenting, and ges to the Registered ormer Activities Director and ger on 09/30/2021 at 1:30 elived education on gional Certified Dietary let order accuracy and essments to ensure diet in staff enter diet orders into it record, the nurse entering en communication to the cludes diet and texture. She she entered the order into to reflect the resident's diet at all diet orders from the enviewed in the clinical entered the Regional CDM on Mand 09/30/2021 at 1:52 expleted education with ctor/Dietary Manager #3. In that she had been on site to elistance during the transition of th | (F 8 | 35} | | | |
| | SRNA #21 on 09/29/2 | 9 on 09/29/2021 at 4:10 PM, 2021 at 3:04 PM, SRNA #22 7 PM and SRNA #23 on | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | COMPLETED | | | | |
|--|--|---|-------------------|------|--|-------|----------------------------|
| | | 185256 | B. WING | | | 1 | K 30/2021 |
| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501 | , 551 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE . | (X5) COMPLETION DATE |
| (F 835) | education on turning, motion and transferrichair and from chair turning, positioning, a on 09/29/2021 at 10: revealed no identified. Therapy Manager on revealed she provide beginning on 08/19/2 turning/repositioning, transferring a resider. 38). Interview with R AM and 09/30/2021 at 2:09/29/2021 at 3:00 FPM, LPN #10 on 09/411 on 09/30/2021 at 09/29/2021 at 3:40 FO/29/2021 at 3:40 FO/29/2021 at 3:40 FO/29/2021 at 3:40 FO/29/2021 at 3:40 FO/29/2021 at 3:40 FO/29/2021 at 3:40 FO/29/2021 at 3:40 FO/29/2021 at 3:40 FO/29/2021 at 3:40 FO/29/2021 at 3:40 FO/29/2021 at 3:40 FO/29/2021 at 4:40 FO/29/202 | M, revealed they received frepositioning, range of ang residents from bed to to bed. Observations of and wound care with RN #11 21 AM for Resident #65 d concerns. Interview with the a 09/30/2021 at 1:18 PM and staff with education 2021 regarding and and from bed. N #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 20/2021 at 2:54 PM, LPN #6 and 09/30/2021 at 1:54 /30/2021 at 12:50 PM, LPN and 09/30/2021 at 1:54 /30/2021 at 12:50 PM, LPN and 10:31 AM, SRNA#1 on PM, SRNA#11 on PM SRNA#11 on PM SRNA#11 on PM SRNA#20 at 3:04 PM, SRNA#22 at 7 PM and SRNA#23 on PM revealed they received are ulcer prevention including aning, adequate hydration and a devices, how to complete ad-to-toe skin assessment, a registered dietician, MD and pairment. The nurse will call red Dietitian, the physician, appresentative with any | {F { | 335} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 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 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFIX (EACH CORRECTIVE ACTION SHO | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 835} | devices, how to comphead-to-toe skin asset the registered dieticianew skin impairment. Impairment, the nurse Registered Dietitian for MD, and resident's reasonable and resident's reasonable and resident's reasonable and resident's reasonable and resident's reasonable and resident's reasonable and resident's reasonable and resident's reasonable and resident's reasonable and resident's reasonable and resident's reasonable and resident's reasonable and resident and reside | and nutrition, Positioning selete and document a syment, and how to notify n, physician and RP of a With any change to skin e will call or email the or new recommendations, presentative. OS Nurse #1 on 09/30/2021 at 1:31 sistant #1 on 09/30/2021 at 1:31 sistant #1 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, Cook I:12 PM, Dietary Aide #3 on M, Former Activities ager #3 on 09/30/2021 at by received education on inse. 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 at 1:54 PM, LPN #10 so PM, LPN #11 on OP/29/2021 at 3:23 PM, SRNA #1 on 09/29/2021 at 3:29 PM, SRNA #19 | {F 8 | 35} | | | |

| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULT A. BUILDII | FIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
|--------------------------|--|--|-------------------------|--|-----------------------------------|----------------------------|
| | | 185256 | B. WING_ | | , | R 9/30/2021 |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| {F 835} | clothing and timely dinterview with Cook # Dietary Aide #3 on 05 Former Activities Dire 09/30/2021 at 1:30 P education on meal set 40). Interview with M at 1:39 PM, MDS Nu PM, RN #1 on 09/29/09/30/2021 at 12:58 Nurse on 09/30/2021 at 12:44 at 3:00 PM and 09/3 on 09/30/2021 at 12:09/30/2021 at 10:31 education on ensuring entered into the elect Observation of RN # revealed the nurse with knowledge of the ediconcerns. 41). Interview with R AM and 09/30/2021 at 12:09/29/2021 at 3:00 FPM, LPN #10 on 09/30/2021 at 09/29/2021 at 3:40 FPM, LPN #10 on 09/30/2021 at 3:29 PM, SRNA #21 on 09/29/2021 at 3:09/29/2021 at 4:10 FPM, BRNA #21 on 09/29/2021 at 3:09/29/2021 at 4:10 FPM, BRNA #21 on 09/29/2021 at 3:09/29/2021 at 4:10 FPM/29/2021 at 4:10 FP | in their choice of clean elivery of meal trays. Further elivery of meal trays. Further elivery of meal trays. Further elivery of meal trays. Further elivery of meal trays. Further elivery of meal trays. Further elivery of meal trays. Further elivery of meal trays on the elivery of meal trays on the elivery of meal trays. DS Nurse #1 on 09/30/2021 at 1:31 (2021 at 11:55 AM and PM, RN #4/Wound Care elivery of trays of the elivery of trays of the elivery of trays of the elivery of th | {F 8 | 335} | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | ATE SURVEY OMPLETED |
|--------------------------|---|--|--|---|-----------|----------------------------|
| | | 185256 | B. WING_ | | | R 09/30/2021 |
| | ROVIDER OR SUPPLIER | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 5310012021 |
| (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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| (F 835) | on identifying signs/hyperglycemia/hypo protocol, documentic condition, documenting medical record, notifical following physician or revealed they received documentation of gli 42). Interview with FAM and 09/30/2021 Care Nurse on 09/3 on 09/30/2021 at 12 09/29/2021 at 3:00 PM, LPN #10 on 09 #11 on 09/30/2021 at 3:29 PM, SRNA #21 on 09/29/2021 at 3:29 PM, SRNA #21 on 09/29/2021 at 3:09/29/2021 at 4:10 education on complication on complication on complication with interventions and diagnosis of diabeted within forty-eight hor reviewing and provices ident/responsible 44). Interview with his at 1:39 PM, MDS N PM, Maintenance A 2:56 PM, Therapy M 1:18 PM, Housekee 09/30/2021 at 1:24 Director (HR) on 09 Marketing Liaison of Medical Records or Medical Records of | symptoms of glycemia, facility diabetic ingresident change in ation of blood sugar in the fication of the physician and orders. In addition, interviews red education on ucose levels. IN #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 0/2021 at 2:54 PM, LPN #6 at 10:31 AM, SRNA #1 on PM and 09/30/2021 at 1:54 //30/2021 at 12:50 PM, LPN at 10:31 AM, SRNA #1 on PM, SRNA #7 on 09/29/2021 at 10:31 AM, SRNA #23 on PM, revealed they received eting a baseline Care Plan and goals relevant to the es and a respiratory diagnosis urs of admission, and ding a copy to the exparty. MDS Nurse #1 on 09/30/2021 at 1:31 assistant #1 on 09/30/2021 at Manager on 09/30/2021 at Man | {F 8: | 35} | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | | |
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| | | 185256 | B. WNG | | | R 09/30/2021 | | |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501 | CODE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | | |
| {F 835} | 12:58 PM, RN #4/Wo 09/30/2021 at 2:54 P 12:44 PM, LPN #7 or 09/30/2021 at 1:54 P at 12:50 PM, LPN #1 AM, SRNA #1 on 09/#11 on 09/29/2021 at 09/29/2021 at 4:10 P at 3:04 PM, SRNA #2 and SRNA #23 on 09/#3 on 09/29/2021 at 09/30/2021 at 2:10 P Director/Dietary Man 1:30 PM revealed the process of identifyin abuse as well as idea immediate intervention 45). Interview with R AM and 09/30/2021 Care Nurse on 09/30/2021 at 12:09/29/2021 at 3:00 P PM, LPN #10 on 09/30/201 they received educatechniques, obtaining reporting of weight of Dietician. In addition Manager on 09/30/2021 had received educaten and provision of time ensure diet order ac are put into the election of the communication to the communi | 255 AM and 09/30/2021 at bound Care Nurse on M, LPN #6 on 09/30/2021 at 1 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 1 1 on 09/30/2021 at 10:31 (29/2021 at 3:40 PM, SRNA t 3:23 PM SRNA #7 on M, SRNA #19 Aide on M, SRNA #21 on 09/29/2021 22 on 09/29/2021 at 3:17 PM (29/2021 at 4:10 PM, Cook 1:12 PM, Dietary Aide #3 on PM, Former Activities ager #3 on 09/30/2021 at 2:54 PM, LPN #6 (24 PM, LPN #7 on PM and 09/30/2021 at 1:54 (30/2021 at 12:50 PM and 021 at 10:31 AM revealed tion on proper weighing | {F 8 | 335} | | | | |

| | MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A, BUILD | | E CONSTRUCTION | COMPLETED R | | |
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| | | 185256 | B. WNG | | | | 0/2021 | |
| | ROVIDER OR SUPPLIER | OVIDER OR SUPPLIER POST-ACUTE AND REHABILITATION 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 PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| {F 835} | clinical meeting, whi Friday, to ensure ac 46). Interview with the 109/30/2021 at 1:30 education on facility times and the use of fortified diets to ensurtitional needs of established national cultural, and ethnic 47). Interview with the 109/30/2021 at 1:30 education on obtain tray card system, of snack/hydration parand/or portion sizes carts and snacks at 48). Interview with 1 AM and 09/30/2021 care Nurse on 09/30/2021 at 1:09/29/2021 at 3:00 PM, LPN #10 on 09/30/2021 Activities Director/D 09/30/2021 at 1:30 education on the pland/or implementing recommendations 49). Interview with 49). Interview with 49). Interview with 49). | rious day are reviewed in the ich occurs Monday through curacy. The Dietary Manager on PM revealed she received policy regarding meal service of recipes, including recipes for the including recipes for the residents in accordance with a guidelines to reflect religious, needs of the population. The Dietary Manager on PM revealed she received in food preference, facility of the properties of the population. The Dietary Manager on PM revealed she received in food preference, facility of the properties of the population. The Dietary Manager on PM revealed she received in food preference, facility of the properties of the population. The Dietary Manager on PM revealed she received at 11:55 per population. The Dietary Manager #3 on PM revealed they received rocess for entering, activating, ing the registered dietician's for dietary orders. | {F | 835 | | | | |
| | 3:20 PM, Interview 09/30/2021 at 1:39 | PM, DON #2 on 09/30/2021 at with MDS Nurse #1 on PM, MDS Nurse #2 on PM, Maintenance Assistant #1 | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER A. BUILDING | | | CONSTRUCTION | COMPL | (X3) DATE SURVEY COMPLETED | | |
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| | | 185256 | B. WING | | <u> </u> | | 30/2021 | | |
| | ROVIDER OR SUPPLIER | 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 LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE | | |
| (F 835) | 09/30/2021 at 1:18 P Supervisor on 09/30/Resource Director (HAM, Senior Marketin: 10:55 AM, Medical R 8:34 AM, Central Supervisor on 09/30/2021 at 12:58 Nurse on 09/30/2021 at 12:44 at 3:00 PM and 09/3 on 09/30/2021 at 12:44 at 3:00 PM and 09/3 on 09/30/2021 at 10:31 at 3:40 PM, SRNA#SRNA#7 on 09/29/20 on 09/29/2021 at 4:109/29/2021 at 3:04 fat 3:17 PM and SRN PM, Cook #3 on 09/30/202 Activities Director/Di 09/30/2021 at 1:30 freceived education opolicy/guidelines, har Personal Protective red zones. Observatiand yellow zone on revealed no identified were in the red or yellow zone on revealed on 09/28 09/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective red zones. Observatiand yellow zone on revealed no identified were in the red or yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective red zones. Observatiand yellow zone on revealed no identified were in the red or yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revealed the COVID-19 policy donning/doffing Personal Protective yellow 209/30/2021 revea | 6 PM, Therapy Manager on M, Housekeeping (2021 at 1:24 PM, Human IR) on 09/30/2021 at 10:48 g Liaison on 09/30/2021 at tecords on 09/29/2021 at 2:40 pply on 09/29/2021 at 2:40 pply on 09/29/2021 at 2:40 pply on 09/29/2021 at 2:40 pply on 09/29/2021 at 2:54 PM, LPN #6 on PM, RN #4/Wound Care I at 2:54 PM, LPN #6 on PM, LPN #7 on 09/29/2021 0/2021 at 1:54 PM, LPN #10 0:50 PM, LPN #11 on AM, SRNA #1 on 09/29/2021 at 3:23 PM 0:021 at 3:29 PM, SRNA #19 0:0 PM, SRNA #21 on PM, SRNA #22 on 09/29/2021 at 4:10 pp. SRNA #22 on 09/29/2021 at 2:10 PM, Former etary Manager #3 on PM revealed they had on the COVID-19 andwashing, donning/doffing Equipment (PPE), yellow and then of the red facility zone 09/28/2021 at 2:12 PM and concerns. No residents ellow zones. Observations /2021, 09/29/2021, and did no identified concerns with y/guidelines, handwashing, sonal Protective Equipment | {F 8 | 335) | | | | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | (X2) MULTI | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING_ | | | R /30/2021 | |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RI | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | | |
| (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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETION DATE | |
| {F 835} | (LPN) #6 on 09/30/2 #7 on 09/29/2021 at 1:54 PM, LPN #10 o LPN #11 on 09/30/20 they had received ec symptom monitoring admissions. A review #355 on 09/10/2021 COVID-19 symptom resident orders. Res on 09/25/2021 and r 09/28/2021. A review Resident #355 revec COVID-19 symptom resident orders. In a #329, #328, #311, # records revealed ea monitoring orders in 51). Interview with F AM, and 09/30/2021 Care Nurse on 09/30/2 (LPN) #6 on 09/30/2 #7 on 09/29/2021 at 1:54 PM, LPN #10 o LPN #11 on 09/30/2 they had received e of medication admir medication, right pa and right route. In a on the process to fo not available for adr calling the pharmac obtaining the anticip notifying the physici would either be omi ordered medication included following n | 021 at 12:44 PM, LPN (LPN) 3:00 PM and 09/30/2021 at n 09/30/2021 at 12:50 PM, 021 at 10:31 AM revealed ducation entering COVID-19 orders on all new v of newly admitted Resident revealed the resident had monitoring entered in the ident #355 was discharged e-admitted to the facility on v of re-admission for aled the resident had a monitoring entered in the ddition, a review of Resident 65, and #90's medical ch resident had COVID-19 | {F 83 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 185256 | B. WING | | | | R 09/30/2021 | |
| NAME OF PR | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 037. | 3012021 | |
| | | | | | 200 NURSING HOME LANE | | | |
| PARKVIEV | N POST-ACUTE AND RE | HABILITATION CENTER | | ı | PIKEVILLE, KY 41501 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| (F 835) | Continued From page new orders from the N | 900 MD in the electronic medical | {F 8 | 335] | } | | | |
| | record. 52). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/2021 at 3 (LPN) #6 on 09/30/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/20 they had received ediemergency medication floor three (3) on 09/2 four (4) on 09/29/202 (5) on 09/29/2021 at medication administrawith an emergency mLPN (LPN) #9 on 09/2 she was a new hire to received education remedication kit. 53). Interview with DO PM, MDS Nurse #1 on MDS Nurse #2 on 09 Maintenance Assistan PM, Therapy Manage Housekeeping Super PM, Human Resourc 09/30/2021 at 10:48 A Liaison on 09/30/202 Records on 09/29/20 | N #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound (2021 at 2:54 PM, LPN (21 at 12:44 PM, LPN (LPN) (23:00 PM and 09/30/2021 at (29/30/2021 at 12:50 PM, (21 at 10:31 AM revealed (22:10 at 10:31 AM revealed (22:10 at 10:31 AM revealed (23:10 PM, floor (23:10 P | | | | | | |
| | 09/29/2021 at 11:55 A PM, RN #4/Wound C 2:54 PM, LPN (LPN) PM, LPN (LPN) #7 or 09/30/2021 at 1:54 P | AM and 09/30/2021 at 12:58 are Nurse on 09/30/2021 at #6 on 09/30/2021 at 12:44 n 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 1 on 09/30/2021 at 10:31 | | | | | | |

| 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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| | | 185256 | B. WNG | MNG | | R 09/30/2021 | |
| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | 200 1 | EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501 | US/. | 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 835} | #11 on 09/29/2021 at 09/29/2021 at 3:29 Pl 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, 09/29/20 revealed signage pos Administrator's conta Abuse Coordinator pt 54). Review of audits weekly head-to-toe sino identified concern #27 skin and wound at 10:20 AM revealed review of the medical #324, #45, #14, #357 revealed the weekly completed with physinotifications. Interview 09/30/2021 at 3:53 P of new and/or worser reviewed that he was worsening skin impai interventions to preverevealed that he part and discussed ongoir residents. Interview won 09/30/2021 at 5:0 team discussed all at | 29/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 on 09/29/2021 11 on 09/29/2021 at 3:04 PM, 2021 at 3:17 PM and SRNA 4:10 PM revealed they 12 Interim Administrator's 13 and 09/30/2021 14 and 09/30/2021 15 and 09/30/2021 16 and 09/30/2021 16 and 09/30/2021 17 and 09/30/2021 18 assessments revealed 18 assessment on 09/30/2021 19 and operation of Resident 19 assessment on 09/30/2021 19 and operation of Resident 19 assessment on 09/30/2021 10 and operation of Resident 10 assessment on 09/30/2021 11 and operation of Resident 12 assessment on 09/30/2021 13 and operation on the second for Resident #65, 17 and #358 18 and assessments 19 and assessments 10 and assessments 10 and assessments 10 and assessments 11 and assessments 12 and assessments 13 and assessments 14 and assessments 15 and assessments 16 and assessments 17 and #358 18 and assessments 18 and assessments 19 and assessments 19 and assessments 10 and assessments 10 and assessments 11 and assessments 12 and assessments 13 and assessments 14 and assessments 15 and assessments 16 and assessments 17 and assessments 18 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 10 and assessments 10 and assessments 11 and assessments 12 and assessments 13 and assessments 14 and assessments 15 and assessments 16 and assessments 17 and assessments 18 and assessments 18 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 19 and assessments 10 and | {F 8 | 35} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | A. BUILD | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 200 NURSING HOME LANE | 1 0370 | | |
| (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 835) | 55). Interview with Ce at 2:40 PM revealed all laboratory supplies revealed that the aud for four (4) weeks and months. A review of a Observation of floor to (5) supplies and review identified concerns. 56). Interview with the 09/30/2021 at 4:17 P 09/30/2021 at 3:20 P were audited during rensure all new areas been care planned with the area of concerns no identified concerns for identified concerns (57). Interview with the on 09/30/2021 at 10:200 completed visual rour hygiene, toileting, increpositioning in addit Review of audits revenalls, clothes, body of dry, toileted as requentiar clean and combe clean, call light within applicable and turned (58). Interview with the Operations on 09/30. Senior Marketing Lia AM revealed they parmonitoring, and mon | entral Supply on 09/29/2021 she completed the audits of son 08/28/2021. She further its were conducted weekly did then monthly for three (3) audits revealed no concerns. hree (3), four (4), and five ew of the audits revealed no expected in the audits revealed no expected in the audits revealed no expected in the audits revealed no expected in the audits revealed no expected in the audits revealed no expected in the audits revealed in the interventions to address and review of audits revealed in the interventions to address and review of audits revealed in the interventions to address and interventions assessing continence, and resident into other leadership staff. It is also to other leadership staff. It is | {F 8 | 335} | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULT A. BUILDI | | (X3) DATE SURVEY COMPLETED | | | |
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| | | 185256 | B. WING | | | R 09/30/2021 | | |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | 20 | REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | L. | (X5) COMPLETION DATE | |
| {F 835} | Continued From pag addressed with the s revealed they were and different shifts. 59). Interview with the 4:17 PM revealed sh respiratory assessm communication Mon clinical meeting. She assessed to ensure respiratory status an completed had phys implementation of pl Resident #315 SBAI #324 SBAR completed on 08/15. physician notification plans updated as increvealed no identifies 60). Review of Residentitted on 09/10/2 had a baseline care | taff. A review of audits completed on different units are RDON on 09/30/2021 at the completed audits of the ends and SBAR day through Friday in the end further revealed that she that any acute change in d/or SBAR assessments ician notification and/or hysician orders. Review of R completed on 09/26/2021, and #326 (2021 revealed assessment, in, interventions, and care dicated. A review of audits d concerns. Ident #355, who the facility 021, revealed the resident plan developed on | {F 8 | 35} | | | | |
| | 09/25/2021 and re-a 09/28/2021. Further for Resident #355 rd comprehensive care (11) days after admi re-admission for Re resident had a base 09/28/2021. Intervie 09/30/2021 at 1:39 09/30/2021 at 1:31 admissions and re-a being reviewed duri | nt #355 was discharged on admitted to the facility on review of the medical record evealed staff completed the e plan on 09/21/2021 (eleven ission). A review of sident #355 revealed the line care plan developed on ew with MDS Nurse #1 on PM and MDS Nurse #2 on PM revealed all new admissions to the facility were ng the morning clinical rough Friday to ensure | | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 185256 | B. WNG | | <u> </u> | | R 30/2021 |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | 21 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE !KEVILLE, KY 41501 | 1 031 | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| (F 835) | days from 07/16/2021 concerns with baselin MDS Nurse #1 on 09/ revealed new/admissibeing updated as need 62). Interview with MI at 1:39 PM revealed replans were being audicompletion, accuracy was conducted with the responsible party with admission/re-admission/re-admission/re-admission-revealed the audits with through Friday. A reviewealed they include date, baseline care pladelivered to resident and education as need revealed no identified dates as indicated. 63). Review of the audicated with no identified the Regional Certified 09/28/2021 at 2:26 Pland, and Dietary Mand 1:30 PM revealed trayensure they arrived of timely. 64). Review of verbal staff members were concerned to the provided of the concerned to | missions for the last thirty 1-08/16/2021 revealed no the care plans. Interview with 1/30/2021 at 1:39 PM 1/30/2021 at 1:39 PM 1/30/2021 at 1:39 PM 1/30/2021 at 1:39 PM 1/30/2021 1/30/30/2021 1/30/30/2021 1/30/30/30/30/30/30/30/30/30/30/30/30/30/ | {F 8 | 35} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | IPLE CONSTRUCTION | | (X3) DATE | SURVEY |
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| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, 200 NURSING HOM PIKEVILLE, KY 4 | | 1 09/ | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH | OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 835} | review of the verbal q quizzed on respiratory hypo/hyperglycemia, notification. Interview Consultant on 09/30/2 Regional DON on 09/30/2021 at 3 on 09/30/2021 at 3 on 09/30/2021 at 131 performed verbal quiz assessment of reside respiratory status, ide hyperglycemia/hypog protocol, documenting condition, notification following physician or on 09/29/2021 at 11:512:58 PM, RN #4/Wo 09/30/2021 at 2:54 Pl 09/30/2021 at 12:44 F participated in verbal 65). Interview with the 09/30/2021 at 4:17 Pl audits of documented Monday through Frida She further revealed to Responsible Party, ar follow physician order stated she identified of 08/12/2021 to have a and one (1) on 09/20/glucose level of 465 we vidence the licensed process. She provided and LPN #5. A Review and LP | o identified concerns. A uiz revealed staff was y status, and SBAR/physician with the Regional Nurse 2021 at 3:40 PM, the 30/2021 at 4:17 PM, DON 2:20 PM, and MDS Nurse #2 I PM revealed they zes for identification and nts with a change in ntifying signs/symptoms of lycemia, facility diabetic g a change in a resident's of the physician and ders. Interviews with RN #1 is AM and 09/30/2021 at und Care Nurse on M, LPN (LPN) #6 on PM, revealed they quizzes with facility staff. Regional DON on M revealed she completed blood glucose levels by in the clinical meeting, hat with any blood sugar reater than 40, the facility o notify the physician, and Registered Dietician and s. The Regional DON one (1) resident on blood glucose level of 430 2021 to have a blood | {F 8 | 35} | | | |

| 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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| | | 185256 | B. WNG | | | | R | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | 09/ | 30/2021 | |
| | W POST-ACUTE AND RE | HABILITATION CENTER | | 20 | DO NURSING HOME LANE IKEVILLE, KY 41501 | | | |
| (X4) ID PREFIX TAG | | | | ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | | | COMPLETION DATE | |
| {F 835} | the facility process. 66). Review of verbal was verbally asked signs and wandering interverbal quizzes revealed quizzed daily for one to 08/19/2021 with no iddreview revealed verbal three (3) times a weel 08/21/2021 to 09/02/2 concerns. A review of that verbal quizzes were per week for four (4) who 09/03/2021 to 09/24/2 concerns. Interview who was completed to complete the completion of verbinterview revealed that verbally quizzed on the tool (signs and symptom wandering intervention education was completed to was completed to the complete of the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verball of the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom wandering intervention education was completed to the verbally quizzed on the tool (signs and symptom w | staff quizzes revealed staff gns and symptoms of abuse and symptoms of wandering entions. A review of the ed five (5) staff were verbally (1) week from 08/13/2021 to entified concerns. Further all quizzes were conducted a for two (2) weeks from 021 with no identified verbal quizzes revealed ere conducted one (1) time veeks from the week of 021 with no identified ith the Regional Nurse 021 at 3:40 PM, RDON on M, and MDS Nurse #1 on M revealed each assisted in val staff quizzes. Further at each staff member was be a reas listed on the audit coms of abuse, when to proms of wandering and ans), and any need for eled immediately with each as RNA #11 on 09/29/2021 at 66 on 09/30/2021 at 12:44 09/29/2021 at 3:00 PM and M, RN #1 on 09/29/2021 at 021 at 12:58 PM, RN e on 09/30/2021 at 2:54 PM, 9/29/2021 at 2:40 PM, 09/30/2021 at 1:18 PM, isor on 09/30/2021 at 1:24 | ⟨F 8 | 335} | | | | |

| STATEMENT OF DEFICIENCIES (X: | | (X1) PROVIDER/SUPPLIER/CLIA | (20) 1111 | TIOL C. | 0.0410774107404 | | |
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| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | 1 | | CONSTRUCTION | (X3) DATE | SURVEY |
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| NAME OF P | ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | 1 09/ | 30/2021 |
| DA DIO IICI | | | | | 0 NURSING HOME LANE | | |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | Pi: | KEVILLE, KY 41501 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | _ | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| (F 835) | Continued From | . 007 | | | | | |
| (1 000) | , F-3. | | {F 8 | 35} | | | |
| | 09/30/2021 at 10:48 / | AM and Maintenance N/2021 at 2:56 PM revealed | | | | | |
| | | erbal quizzes regarding | 1 | | | |] |
| | | t, wandering and wandering | | | | | |
| | interventions. | r, wandering and wandering | | | | | |
| | | | | | | | l i |
| | 67). Review of Reside | ent #355 on 09/10/2021 | | ľ | | | |
| | revealed the resident | | | } | | | |
| | wandering risk assess | sment completed on | | | | | |
| | | #355 was discharged on | | - 1 | | | |
| | | mitted to the facility on | | | | | |
| | 09/28/2021. A review | of re-admission for ed the resident had an | | | | | |
| | | risk assessment completed | | | | | |
| | on 09/28/2021. The re | esident was not identified to | | | | | |
| | | ng. Interview with MDS | | | | | |
| | | 21 at 1:39 PM revealed that | | ŀ | | | |
| - | MDS staff will schedu | | | | | | |
| | | re completion. Interview with | | | | | |
| | | ultant on 09/30/2021 at 3:40 | | | | | |
| | PM and DON #2 on 0 | | | | | | |
| | | issions would be reviewed | | | | | |
| | in the morning clinical appropriate assessme | | | | | | |
| | | sment, had been completed. | | | | | |
| | Further interviews rev | ealed that residents | | | | | |
| | identified as at risk for | | | | | | |
| | | meeting and appropriate | | | | | |
| | interventions impleme | ented. | | ŀ | | | |
| | 68) Review of intents | ews performed for residents | | | | | |
| | | 8 or greater revealed no | | | | | |
| | | ontinued review revealed | | | | | |
| | | ed on 08/13/2021 with ten | | | | | |
| | | s completed for four (4) | | | | | |
| | | sidents for eight (8) weeks. | | | | | |
| | Interview with ISSD or | n 09/30/2021 at 2:23 PM, | | | | | |
| | | 1 09/30/2021 at 1:39 PM | | | | | |
| | revealed they were as | sisting in completing audits | | | | | |

| 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 | 163256 | B. WII4G | | <u> </u> | 09/30/20 | 21 |
| | W POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501 | DDE | | |
| (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 APPROPRIED TO THE APP | | ON SHOULD B | Е СОМ | (X5) PLÉTION DATE |
| (F 835) | of audits initiated on 0 random weekly skin a with a BIMS score of 1 there are no injuries of no identified concerns. Nurse Consultant on 0 DON #2 on 09/30/202 were completing auditidentified concerns. Of assessment on 09/30, 9:23 AM and on 09/30, 9:23 AM and on 09/30, Resident # 27 revealed of unknown origin. 69). Interview with the 09/30/2021 at 3:53 PM audits on 08/25/2021 electronic medical recipion the diet/tray card so Review of Resident #3 (09/29/2021 at 12:04 Fon 09/29/2021 at 12:04 Former Activities Direct 09/30/2021 for one (1) Former Activities Direct 09/30/2021 at 1:30 PM Manager on 09/28/202 | concerns identified. Review 08/13/2021 for review of sesesments for residents less than eight (8) to ensure of unknown origin revealed in Interview with Regional 09/30/2021 at 3:40 PM, and 21 at 3:20 PM revealed they are as indicated with no observation of skin 1/2021 of Resident #45 at 0/2021 at 10:20 AM of and no concerns with injuries are Registered Dietician on 1/2021 at 10:20 AM of and no concerns with injuries are resident diet orders from ords against orders entered of resident diet orders from ords against orders entered offware to ensure accuracy. 308's tray card on 1/2021 at 12:30 PM revealed ordered by the physician. A 1/2021 at 12:30 PM revealed ordered by the physician. A 1/2021 at 12:30 PM revealed random 1/2021 at 1/2021 at 1/2021, beerved two (2) times per a sand then weekly from 1/2021 at 1/2026 PM, and 1/2021 at 1/2021 at 1/2026 PM, and 1/20 | ⟨F 8 | 335) | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MUL A. BUILD | | ONSTRUCTION | (X3) DATE | SURVEY PLETED |
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| NAME OF P | ROVIDER OR SUPPLIER | 05250 | J D. VIIIVG | CTD | | 09/ | 30/2021 |
| | N POST-ACUTE AND RE | HABILITATION CENTER | | 200 | EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIAT | | | COMPLETION DATE |
| {F 835} | including breakfast at PM, and dinner at 5:00 09/28/2021 at 5:03 PM had been served on the on 09/29/2021 lunch at the third floor at 12:16 PM fifth floor at 12:34 PM 71). Review of Reside 09/29/2021 at 12:04 PM on 09/29/2021 at 12:04 PM on 09/29/2021 at 12:04 PM anager on 09/29/2020 meals honored reside likes and dislikes. Interview of an auditory of the period of the control of the period of the control of | vere served as scheduled, 7:00 AM, lunch at 12:00 0 PM. Observation on M revealed the evening meal me third floor. Observation meal revealed meals arrived proximately 12:16 PM, the M and 12:24 PM, and the and 12:49 PM. ent #308's tray card on PM, Resident #39's tray card of PM, and Resident #334's 21 at 12:30 PM revealed the ent preferences, including erview with the Dietary 21 at 1:30 PM revealed she for obtaining food and within seventy-two hours of eg the preferences into the sudits revealed snack intakes one (1) week from eg 1. Further review of the s were audited weekly el 21. Interview with the etary Manager on M and 09/30/2021 at 1:52 ted snack intake and had cerns. Human Resource Director t 10:48 AM revealed she laily staff screening against the revealed no identified of entry doors on 21, and 09/30/2021 | {F & | 335} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MUL' A. BUILDI | TIPLE CONSTRUCTION NG | | (X3) DATE COMP | SURVEY |
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| | ROVIDER OR SUPPLIER **POST-ACUTE AND RE | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501 | , ZIP CODE | | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD B HE APPROPRIA | | (XS) COMPLETION DATE |
| (F 835) | at 4:17 PM, DON #2 of and Interim Infection (09/30/2021 at 3:10 Pl being conducted with handwashing, isolation donning/doffing PPE, variance or identified immediately. A review were conducted beginshifts and units. 74). Interview with the on 09/30/2021 at 3:40 responsible in addition review all residents on pharmacy to ensure the beginning 09/23/2021 no identified concerns 11:55 AM and 09/30/20 (LPN) #6 on 09/30/20 #7 on 09/29/2021 at 3:54 PM, LPN #10 on LPN #11 on 09/30/202 concerns with obtaining and/or receiving mediation pass on the third floor and 09/30/20 medications. In additionarcotic count on the 12:50 PM revealed no 12:50 PM revealed no 12:50 PM revealed no 13:40 responsible for complepass observations begitated she had not ideastions begitated she had not ideastions. | PM, RDON on 09/30/2021 on 09/30/2021 at 3:20 PM, Control Nurse on of revealed audits were observations of in signage and zones, mask compliance. Any concerns will be addressed of the audits revealed they ining 09/17/2021 on random Regional Nurse Consultant PM revealed she was in to other members to in narcotics with the mat an active script is on file i. A review of audits revealed is. RN #1 on 09/29/2021 at i. 2021 at 12:58 PM, LPN 21 at 12:44 PM, LPN (LPN) i. 200 PM and 09/30/2021 at i. 209/30/2021 at 12:50 PM, i. 21 at 10:31 AM revealed no ing scripts for medications cations timely. Observation i. 09/29/2021 at 8:09 AM concerns with missing on, observation of the lifth floor on 09/30/2021 at | {F 8 | 335} | | | |

| (F 835) Continued From page 911 counts. A review of audits revealed the facility utilized the Centers for Medicare Services Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications a review of audits revealed a minimum of twenty-five medications were observed daily from 09/25/2021 with no identified concerns. Further review of medication observations revealed that medication administration was observed on random shifts, including 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 76). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM. The DON on 09/30/2021 at 3:40 PM. The DON on 09/30/2021 at 3:00 PM revealed medication delivery tickets were being reviewed in clinical meetings Monday through Friday against ordered medications. A review of the audit revealed no identified concerns. 77). Interview with the Interim Administrator on 09/30/2021 at 3:05 PM, Regional Nurse Consultant on 09/30/2021 at 3:20 PM revealed staffing was being audited daily beginning 09/11/2021, to | | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER | | 1 | TPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| MAKE OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 835) Continued From page 911 counts. A review of audits revealed the facility utilized the Centers for Medicare Services Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications were observed daily from 09/25/2021 with no identified concerns. Further review of medications administration was observed and insistration was observed and insistration was observed in and 6:00 PM to 6:00 AM. 76). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM. The DON on 09/30/2021 at 3:20 PM revealed medication delivery tickets were being reviewed in clinical meetings Monday through Friday against ordered medications. A review of the audit revealed no identified concerns. 77). Interview with the Interim Administrator on 09/30/2021 at 3:50 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, Repons Nurse Consultant on 09/30/2021 at 3:40 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, Repons Nurse Consultant on 09/30/2021 at 3:40 PM, Repons Nurse Consultant on 09/30/2021 at 3:40 PM, ROON on 09/30/2021 at 3:40 PM, ROON on 09/30/2021 at 3:40 PM, ROON on 09/30/2021 at 3:40 PM, ROON on 09/30/2021 at 3:40 PM, ROON on 09/30/2021 at 3:40 PM, ROON on 09/30/2021 at 3:40 PM, ROON on 09/30/2021 at 3:40 PM, ROON on 09/30/2021 at 3:40 PM, ROON on 09/30/2021 at 3:40 PM, ROON on 09/30/2021 at 3:40 PM, ROON on 09/30/2021 at | | | 185256 | B. WNG | | | | |
| CX4 ID SUMMARY STATEMENT OF DEFICIENCIES DIRECTOR PRECIDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DIRECTOR PRECIDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DIRECTOR CROSS-REFERENCED TO THE APPROPRIATE DATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DIRECTOR CROSS-REFERENCED TO THE APPROPRIATE DATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DIRECTOR CROSS-REFERENCED TO THE APPROPRIATE DATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TAG REGULATORY OR LSC IDENTIFYING INFORMATION DIRECTOR DEFICIENCY TAG REGULATORY OR LSC IDENTIFYING INFORMATION DEFICIENCY TAG REGULATORY OR LSC IDENTIFYING INFORMATION DEFICIENCY TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFYING INFORMATION TAG RECULATORY OR LSC IDENTIFY TAG RECULATORY OR LSC IDENTIFY TAG RECULATORY OR LSC IDENTIFY TAG RECULATORY OR LSC IDENTIFY TAG RECULATORY OR LSC IDENTIFY TAG RECULATORY OR LSC IDENTIFY TAG RECULATORY OR LSC IDENTIFY TAG RECULATORY OR LSC IDENTIFY TAG RECULATORY OR LSC IDENTIFY TAG RECULATORY OR LSC IDENTITY TAG RECULATORY OR LSC IDENTIT | NAME OF P | ROVIDER OR SUPPLIER | | D. VIII.O. | | STATE, ZIP CODE | 09/ | 30/2021 |
| REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CONTINUED TO THE APPROPRIATE DEFICIENCY PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CONTINUED | PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | | | | |
| counts. A review of audits revealed the facility utilized the Centers for Medicare Services Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. A review of audits revealed a minimum of twenty-five medications were observed daily from 99/25/2021 with no identified concerns. Further review of medication observations revealed that medication administration was observed on random shifts, including 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 76). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM. The DON on 09/30/2021 at 3:20 PM revealed medication delivery tickets were being reviewed in clinical meetings Monday through Friday against ordered medications. A review of the audit revealed no identified concerns. 77). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 3:20 PM revealed staffing was being audited daily beginning 09/11/2021, to | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP | | ECTIVE ACTION SHOULD BI | E ATE | COMPLETION |
| ensure adequate staffing was maintained. A review of the audits revealed no identified concerns. 78). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, and the Dietary Manager on 09/30/2021 at 1:30 PM revealed staffing was being monitored daily to ensure adequate staffing. A review of the audits revealed no identified concerns. 79). Interview with the Vice President of | | counts. A review of au utilized the Centers for Element Pathway for a conduct the medication twenty-five medication revealed a minimum of were observed daily fridentified concerns. Frobservations revealed administration was obincluding 6:00 AM to 6:00 AM. 76). Interview with the on 09/30/2021 at 3:40 09/30/2021 at 3:20 PM delivery tickets were be meetings Monday thromadications. A review identified concerns. 77). Interview with the 09/30/2021 at 5:05 PM Consultant on 09/30/2021 at 3:20 PM being audited daily beensure adequate staffireview of the audits reconcerns. 78). Interview with the 09/30/2021 at 5:05 PM on 09/30/2021 at 5:05 PM on 09/30/2021 at 1:30 being monitored daily staffing. A review of the identified concerns. | adits revealed the facility or Medicare Services Critical Medication Administration to an pass observation of the Areview of audits of twenty-five medications from 09/25/2021 with no urther review of medication of that medication at that medication asserved on random shifts, 6:00 PM and 6:00 PM to a Regional Nurse Consultant of PM. The DON on an areviewed in clinical and Friday against ordered of the audit revealed no and the audit revealed no and the DON on and revealed staffing was ginning 09/11/2021, to and the DON on and the DON on and the DON on and the DON on and the DON on and the DON on and the DON on and the DON on and the DON on and the DON on and the DON on and the DON on and the Dietary Manager PM revealed staffing was to ensure adequate e audits revealed no | {F 8 | 35} | | | |

| 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. WING | _ | | | R /30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | , 05 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX (EACH CORRECTIVE ACTION SHOULD | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 835} | Administrator on 09/3 daily audits had been 09/11/2021. A review identified concerns. | 2021 at 4:10 PM and Interim 0/2021 at 5:05 PM revealed | {F8 | 135 | } | | |
| | on 09/30/2021 at 10:5 completed observatio identify any change in interviews revealed if identified, staff would An audit review revea | | | | | | |
| | or greater revealed no review of the question interviews revealed re everyone treating you here? Do you have ar the Medical Records & AM revealed she com | nts with a BIMS score of 8 or identified concerns. A phaire completed during esidents were asked: Is well? Do you feel safe by concerns? Interview with Staff on 09/29/2021 at 8:34 pleted the interviews with 21, and she stated she in identified to the interviews with its stated she in identified to the interviews with its stated she in identified to the interviews with its stated she in identified to the interviews with its stated she in identified to the interviews with its stated she in identified to the interviews with its stated she in identified to the identif | {F 8 | 337 | | | 12/30/21 |
| | body, or designated p governing body, that i establishing and imple the management and | body. ility must have a governing ersons functioning as a s legally responsible for ementing policies regarding operation of the facility; and verning body appoints the | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WNG_ | | | | R |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | | | S 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501 | <u> 09/</u> | 30/2021 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 837} | required; (ii) Responsible for mand (iii) Reports to and is governing body. This REQUIREMENT by: | ate, where licensing is anagement of the facility; accountable to the is not met as evidenced | {F 8 | 37} | | | |
| | The Governing Body failed to ensure facility policies were developed and implemented regarding management and operation of the facility. The Governing Body failed to ensure compliance with 42 CFR 483.80 Infection Control during survey visits on 07/14/2020, 09/24/2020, 11/13/2020, and 12/10/2020. Immediate Jeopardy (IJ) was identified on 11/20/2020 and determined to exist on 11/17/2020, at 42 CFR 483.80 Infection Control, F-880 at a S/S of an "L" due to the facility's failure to prevent the spread of COVID-19. Immediate Jeopardy (IJ) was identified 11/25/2020 and determined to exist on 11/09/2020, in the area of 42 CFR 483.12 Freedom from Abuse, F-600 related to failure to protect Resident #21 from abuse. The facility submitted a Plan of Correction and achieved compliance effective 01/20/2021. However, the Governing Body failed to ensure the facility had an active Quality Assurance Performance Improvement program to ensure compliance was maintained. Immediate Jeopardy was identified again on 08/11/2021, at | | | | Criteria 1: An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of tl Immediate Jeopardy on 09/02/2021 on (F580, F600, F655, F656, F684, F686, F692, F755, F880). However, the AOC could not be verified based on observations, staff interviews, and revie of facility documentation. Additional Immediate Jeopardy was identified for (F725, F835, F837, F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. An acceptable allegation of compliance was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 9/26/2021. The State Surv Agency determined the Immediate Jeopardy was removed as alleged durir a revisit conducted on 09/28-30/2021, which lowered the scope and severity to for all tags, while the facility monitors the effectiveness of systemic changes and quality assurance activities. | ew ey ng o D | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | | X3) DATE SURVEY COMPLETED | |
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| NAME OF PROVIDER OR SUPPLIER | | | 61 | TOUT ADDRESS AND ASSESSMENT OF THE PARTY OF | 09/ | 30/2021 | |
| PARKVIEW POST-ACUTE AND REI | HABILITATION CENTER | | 20 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501 | | | |
| PREFIX (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| facility failed to isolate positive for COVID-19 residents. Two (2) residents. Two (2) residents. Two (2) resident #86 (who was 12/12/2020 survey) from The Governing Body for were enough staff at the residents, turn and regincontinent care, preparand assist residents where developed and in management and ope ensure compliance and free from abuse has caserious injury, harm, in resident. Immediate J. 08/11/2021, and was considered to 3/06/2021, at 42 CFF (F580), 42 CFR 483.11 (F600), 42 CFR 483.11 (F600), 42 CFR 483.11 (F692), 42 CFR 483.41 (F755) and 42 CFR 48 (F880). The facility was Jeopardy on 08/11/2021. An acceptable Allegatic was received on 09/03 removal of the Immedial 09/02/2021. However, verified based on obses and review of facility displays the service of facility of the limited | from Abuse, F-600. The residents who were to prevent spread to other sidents died due to he facility failed to protect as Resident #21 on the facility to monitor/assess position residents, provide are and distribute meals, with eating. If a failure to ensure policies implemented regarding ration of the facility to do do ensure residents were aused or is likely to cause impairment or death to a deepardy was identified, on a determined to exist on the facility to do the facility to do ensure residents were aused or is likely to cause in a facility to determined to exist on the facility to determined to exist on the facility to determined to exist on the facility to determined to exist on the facility for the facility to determined to exist on the facility for the facility to determined to exist on the facility for the facility to determined to exist on the facility for the facil | {F 8 | 337} | Criteria 2: On 9 /15/2021 a conference call was held with Med-Net Concepts the Vice President of Operations, Director Clinical Operations, Regional Nurse Consultants to review the following: 1) to outcomes of the Survey, 2) expectation and roles of the Governing Body as outlined in the Rules and Regulations, determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents provide incontinent care, prepare and distribute meals, and assist residents we eating, caring for pressure wounds, effective Pharmacy Services, dealing wabuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee The governing body replaced Administrator with an Interim Administrator was placed on 10-01-202 and he was presented the education proto assuming the role of administrator. Criteria 3: The Regional Director of Operations and VP of Operations met with Administrator, the DON, and the Medical Directors on 9/16/21 regarding the duties of the Governing Body includes the Governing Body includes the Governing Body includes the Governing Body. Also reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes, the need to identify Root Cause reviewed the QAPI/QAA processes. | ne of the s 3) on with the thing the s | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER IDENTIFICA | | (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, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 1 09/ | /30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD) | | | (x5) COMPLETION DATE |
| (F 837) | Administration (F835) Quality Assurance an Improvement (F867). the Immediate Jeopar Immediate Jeopardy i A second acceptable was received on 09/2 removal of the Immediate Jeopardy if 09/26/2021. The State determined the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Compounded for the Immediate Jeopardy in 19/26/2021, which severity to "D" 42 CFF (F580), 483.12 Co | ces (F725), 42 CFR 483.70 (F837), 42 CFR 483.75 d Performance The facility was notified of dy on 09/10/2021. The songoing. allegation of compliance 5/2021, which alleged liate Jeopardy on e Survey Agency diate Jeopardy was uring a revisit conducted on lowered the scope and R 483.10 Resident Rights rehensive Person-Centered 656), 42 CFR 483.25 (F686), 42 CFR 483.35 (F686), 42 CFR 483.45 (F55); and to "E" at 42 CFR Abuse (F600), 42 CFR 483.70 (F837), 42 CFR 483.75 d Performance and 42 CFR 483.80 (In the Regional Nurse of systemic changes activities. | {F 8. | 37} | (we will use the 5 whys) and auditing systems per the QAPI Calendar. Effect 12/3/21the Governing Body approved to have a member of the Governing Body team on site every day until the Immedi Jeopardy is removed. Members consist of Vice President of Operations, Region Vice President of Operations, and region nurse consultants. Members of the governing body will review weekly the grievance log and the interviews with residents to ensure they feel safe to ensure any new grievances are addressed. Criteria 4: Beginning on 09-13-2021, the interim administrator started monitoring daily, weekly, and monthly audits for F580, F600, F655, F656, F684, F686, F692, F755, F880, F725, F835, F837, a F867. The Administrator will monitor all audits on a weekly and/or until substant compliance is met and monthly thereafted as recommended by the QAPI committed Any findings that were not within regulations and addressed immediated and/or not reported immediately will resin disciplinary action in accordance with facility policy and procedures that can result in termination. All findings and progress will be presented to QAPI Committee consisting of at a minimum of Administrator, Medical Director, Director of Nursing, Dietary Manager, Social Service Director, and two other staff members to update progress and/or findings to determine recommendations feedback to continue current plan in place. | o iate t nal nal nal nal nal nal nal nal nal nal | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | ECONSTRUCTION | | SURVEY |
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| | | 185256 | B. WING | | | 09/ | 30/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PARKVIF | W POST-ACUTE AND RE | HARII ITATION CENTER | | 2 | 00 NURSING HOME LANE | | |
| | | | | PIKEVILLE, KY 41501 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE | |
| {F 837} | Continued From page | 916 | {F 8 | 37) | | | |
| | Review of Statements survey visits on 07/14 11/13/2020, and 12/10 was found to be out of 483.80 Infection Contenters for Medicare (CMS) and the Cente Prevention (CDC) recoprepare for COVID-15 Review of the SOD in abbreviated survey con Agency on 12/12/2020 Jeopardy (IJ) was idedetermined to exist or 483.80 Infection Contenter 42 CFR 483.21 Care F-657 at a S/S of an " | of Deficiencies (SOD) for /2020, 09/24/2020, 09/24/2020, 0/2020, revealed the facility of compliance with 42 CFR rol regulations for the and Medicaid Services are for Disease Control and commended practices to 0. itial comments for an empleted by the State 0, revealed Immediate ntified on 11/20/2020 and 11/17/2020, at 42 CFR rol, F-880 at a S/S of an "L", Plan Timing and Revision, L", and 42 CFR 483.70 at a S/S of an "L". The | | | The Administrator will forward all QAPI Meeting minutes to the members of the Governing Body including the Vice President of Operations, Regional Vice President of Operations, and regional nurse consultant for review of all audits results. QAPI committee meetings have been monthly and as of 12/11/21 the QAPI meetings are weekly until DVO approves any changes. A governing body representative was onsite daily since 9-10-21 and remained through the removal of the immediate jeopardy; and attended the facility QAF meetings. Site visits will be weekly and until substantial compliance. The Governing Body will meet quarterly review findings from systematic audits. | e e s ve d d | |
| | the facility failed to ful implement their COV! Infection Control (IC) Department's (HD) replace IC/isolation sign were under precaution adequate personal pro (PPE)/supplies were at to ensure staff wore the guidelines and policie housekeeping, laundrinursing were observe to prevent cross contaup for COVID-19 positives in their control of the staff was a contauted to the staff was a contauted to prevent cross contauted to p | tion and interviews revealed by and consistently D-19 Action Plan (AP), policies and the Health commendations; failed to age on residents' door that as; failed to ensure otective equipment available for use; and failed the PPE according to s. Facility staff from | | | Compliance Date 12/30/2021 | | |

| 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 DE | ROVIDER OR SUPPLIER | 100200 | 15, ,,,,,, | 7 | | 09/30/20 | |
| TATALL OF FE | NOVIDEN ON SUFFEIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PARKVIEV | V POST-ACUTE AND RE | HABILITATION CENTER | | 2 | 200 NURSING HOME LANE | | |
| | | | | F | PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 837} | prevent the spread of facility's failure to follo Policies, CMS/CDC g recommendations, re- exposed to COVID-19 facility identified one (| nfection control practices to COVID-19. Due to the w their COVID-19 AP, IC | {F & | 337} | | | |
| | for COVID-19 on 10/1 On 10/22/2020, ten (1 identified to be positiv 10/24/2020 through 1 tested positive for CO | 7/2020 and 10/28/2020. 0) additional residents were e for COVID-19. From 1/13/2020 sixty-eight (68) VID-19 and there was a ent deaths. Six additional | | | | | |
| | 07/22/2021, the facilit of staff and residents 07/24/2021, two staff COVID-19 at an outport Although, the facility was positive, interviews with no attempt by the facility residents were expose effort to isolate the respread of the virus. In to immediately test residents were not test (4) days after the staff During the 07/28/2022 #314 and Resident #3 COVID-19. However, revealed the facility diprevent the spread of others. Interviews with | vas aware the staff tested th staff revealed there was lity to determine what ed to the infected staff in an sidents to prevent further a addition, the facility failed sidents for COVID-19 per the known exposure. ity testing, revealed sted until 07/28/2021, four f members were positive. I resident testing, Resident | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 185256 | B. WING | | | | R 30/2021 |
| PARKVIEW POST-ACUTE AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | HABILITATION CENTER | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | 1 03/ | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| (F 837) | wander the hallways of Observation and intermade no attempts to 08/05/2021, eight day positive, when a plast over the resident's do Further, continued revealed staff were roon 07/30/2021. However was not tested prior to on 07/30/2021 from 6 07/31/2021. During h 12:00 AM on 07/31/20 feeling sick while carrishe reported her symptonducted a rapid CO positive. From 07/28/2021 throadditional three (3) recovided the barrier being Resident #325, who recovided the hallway hallway adjacent to CResident #325 was no 08/08/2021, Resident COVID-19. On 08/09 developed respiratory transferred to the emethospitalized. Resident distress, had a decline of the positives, had a decline of the material stress, had a decline of the material stress, had a decline of the material stress, had a decline of the material stress, had a decline of the material stress. | ly, the resident continued to without a mask. views revealed the facility isolate the residents until its after the residents tested ic zip barrier was placed orway. View of facility testing utinely tested for COVID-19 ever, SRNA #13 stated she is starting her scheduled shift is 00 PM through 6:00 AM on er shift, at approximately 021, she stated she started ing for residents. She stated ploms to the nurse who invID-19 test, which was ugh 08/05/2021, an isidents tested positive for ing placed on 08/05/2021, esided across the hall from isidents, was observed is and sitting in a chair in the interest of the interest | {F 8 | :37} | | | |

| 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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| | | 185256 | B. WNG | | | | R 20/2024 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | 21 | TREET ADDRESS, CITY, STATE, ZIP CODE DO NURSING HOME LANE IKEVILLE, KY 41501 |]091 | 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 837} | tested positive for CO was hospitalized on 0 08/15/2021 at the hos Resident #329 had al COVID-19. Immediate Jeopardy of 08/11/2021, and was CFR 483.80 Infection was notified of the Im 08/11/2021. Further review of the additional IJ and Subsider (SQC) was identified determined to exist of 42 CFR 483.25 Qualified Accident Hazards/Sup 42 CFR 483.21 Comp Centered Care Plans, Comprehensive Care 42 CFR 483.70, Admit a "L". The facility was 11/25/2020. Additional IJ and Sub (SQC) was also identified determined to exist of 42 CFR 483.12 Free from Abuse at a and Implement Abuse F-608, Reporting Rea Crime at a S/S of a "J Violations at a S/S of a "J Violations at a S/S of a "J Violations at a S/S of a "J | sident (Resident #327) IVID-19 on 08/07/2021 and 8/14/2021, and expired on spital. Resident #82 and so been hospitalized due to was identified, on determined to exist at 42 Control (F880). The facility mediate Jeopardy on 12/12/2020 SOD revealed standard Quality of Care on 11/25/2020 and on 11/06/2020, in the areas of by of Care, F-689, Free from pervision at a S/S of a "J", prehensive Resident pervision at a S/S of a "J", and inistration F-835, at a S/S of a notified of the IJ on standard Quality of Care iffed on 11/25/2020 and 11/09/2020, in the areas of dom from Abuse, F-600, S/S of a "J", F-607, Develop a Policy at a S/S of a "J", sonable Suspicion of a "J", F-610, Investigation of I", F-609, Reporting Alleged a "J", F-610, Investigation of I", and 42 CFR 483.70, at a S/S of a "L". The | {F 8 | 337} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 185256 | B. WING | | | | R |
| NAME OF PI | ROVIDER OR SUPPLIER | | | _ | STREET ADDRESS, CITY, STATE, ZIP CODE | 09/ | 30/2021 |
| | | | | | 200 NURSING HOME LANE | | |
| PARKVIEV | N POST-ACUTE AND RE | HABILITATION CENTER | | | PIKEVILLE, KY 41501 | | |
| W41 ID | SHIMMOVET | ATEMENT OF DEFICIENCIES | | | | | |
| (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) | | (XS) COMPLETION DATE |
| {F 837} | Continued From page Continued review of the | he 12/12/2020 SOD, | {F 8 | 337} | | | |
| | | 183.10 Resident Rights, | | | | | |
| | | ls, at a S/S of a "D" and | | | | | |
| | | Change, at a S/S of a "G"; ity of Care, F-697, Pain | | | es. | | |
| | | S of a "G"; and 42 CFR | | | | | |
| | | trition Services, F-804. | | | | | |
| | | ble/Preferred Temperature, | | | | | |
| | at a S/S of a "D". Total | | | | | | |
| | According to the 12/1: | 2/2021 SOD, the facility | | | | | |
| | | lent #21 (Resident #86 in | | | | , | |
| | | y) from abuse and failed to | - | | | | |
| | implement the facility' | s policy related to reporting, | | | | | |
| | | gating allegations of abuse. | | | | | |
| | | cility transferred Resident | | | | | |
| | | an evaluation related to | | | | | |
| Ì | | review of the Emergency | | | | | |
| | | ated 11/09/2020, revealed | | | | | |
| | | sulted by a staff member at | | | | | |
| | | ent was diagnosed with a | | | | | |
| | #21, he/she stated that | ring interview with Resident | | | | | |
| | | N) #5 brutalized him/her: | | | | | |
| | | nis/her arm; and hit him/her | | | | | |
| | with a phone on his/h | | | | | | l |
| | - | ne of the interview revealed | | | | | |
| | | nt's right hand/thumb/wrist | | | | | |
| | | #19 and SRNA #20 stated | | | | | |
| | | ney found Resident #21 on | | | | | |
| | | cility crying and scared. The | [| | | | |
| | | ident reported to them that | | | | | |
| | | /her hand, twisted his/her | | | | | |
| | | vith the phone. SRNA #19 | | | | | |
| | | the resident's right thumb | | | | | |
| | | len. Further staff interviews | | | | | |
| | observed RN #5 being | aled that on 11/09/2020, they g aggressive towards | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--------------------|---|------------------------------|-------------------------------|----------------------------|
| | | 185256 | B. WNG | | | | 30/2024 |
| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501 | DDE | <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 | | ON SHOULD BE HE APPROPRIA | | (X5) COMPLETION DATE |
| {F 837} | "shot", and yelling at a SRNA #19 and SRNA facility's policy related report this to anyone. The remainder of the second 11/10/2020. Interview 11/17/2020 revealed in Resident #21's allega was the first time he wallegation. However, in Director of Nursing (Director of Nursing (Director of Nursing (Director of Nursing (Director of Nursing (Director of Nursing (Director of Nursing (Director of Nursing (Director of Nursing (Director of Nursing (Director of Nursing (Director of Nursing (Director) and the hospital for stated she did not review on the Not seallegation of assault. Review of Resident #12/12/2021 survey) mor/13/2021 at 11:15 A State Police because in his/her room and we however, review of the had Dementia and so record, the RN information been exposing him others. The RN also of the Police Resident #4 exaggerate." Further review of Resident report at approximately 5:50 wandered into Reside | ning the resident with a he resident. However, #20 failed to follow the to abuse and failed to RN #5 continued to work shift and worked again on with the Administrator on the was not aware of tion of abuse. He stated this was hearing of the interview with Interim | {F 8 | 337) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL | | NSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|--------------------|--------|--|-------------------------------|----------------------------|
| | 185256 | B. WNG | | | | R |
| NAME OF PROVIDER OR SUPPLIER | | | STREE | ET ADDRESS, CITY, STATE, ZIP CODE | 09/ | 30/2021 |
| PARKVIEW POST-ACUTE AND RE | HABILITATION CENTER | | 200 NI | URSING HOME LANE VILLE, KY 41501 | | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| personal alarm proviounknown) and threw to Documentation also in been implemented to wandering into his/he resident "frequently to report indicated the in Resident #82 was absolved because he/she threw he/she entered the restaken to prevent furth would encourage Resident stated Resident of the facility was not try resident did not know resident stated Resident of the resident stated Resident of the resident facility. The resident facility. The resident incidents to facility state here is helping me". I had even contacted the actions had been take The resident also stated down here" (to the opkeep Resident #82 av Resident #82 continuer room. Resident #86 she/she was lying in been tered his/her room exposed him/herself to the resident's shoe and the resident's shoe | desident #86 pressed his/her feed by the facility (exact date water on Resident #82. Indicated a stop sign had prevent residents from a room; however, the lakes it down." The incident investigation determined used by Resident #86 water on him/her when esident's room and steps for abuse was that the facility sident #86 to keep his/her sident #86, on 07/27/2021 at M, revealed he/she felt like wing to help him/her, and the rowhat else to do. The ent #82 entered his/her and then "asked me how I dent, Resident #82 had to the resident numerous #82's admission to the stated he/she reported the laft; however, stated, "No one Resident #86 stated he/she he Police, but again, no en to protect the resident, led he/she was "moved posite end of the hall) to way from him/her; however, ed to come in/out of his/her stated on 07/15/2021, ed and Resident #82 | {F 8 | 37} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--------------------|--|--|-------|-------------------------------|--|
| | | 185256 | B. WING | | | 1 | R | |
| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | 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 LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECT CROSS-REFERENC | LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY) | | (X5) COMPLETION DATE | |
| (F 837) | room, and reported; It been taken to protect abuse from Resident Immediate Jeopardy 08/11/2021, and was 42 CFR 483.12 Freed The facility was notified Jeopardy on 08/11/2021. Interview with the Reson 08/30/2021, at 3:33 the RVP at the facility member of the Governing Body mee he became the RVP. who the RVP was prenot sure how the facility and services were protected to the result of clinical meeting. However, the RVP, he had not for clinical meetings. It there were not enough and reposition resident stated he hoped with could get all the tasks done. The RVP state looking for staff, but he looking recently. Further interview with brought to his attention more money for food, | to get him/her out of his/her lowever, no actions had the resident from further #82. was identified, on determined to exist again at dom from Abuse (F600). Led of the Immediate 121. gional Vice President (RVP) 100 PM revealed he had been for 90 days, and was a ming Body. He stated a ting had not been held since He stated he did not know eviously. He stated he was sity monitored to ensure care poided to residents, except | (F 8 | 337} | | | | |
| | | attention and it had not hould have been notified. | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | IPLE CONSTRUCTION | (X: | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|---|--------|-------------------------------|--|
| <u></u> - | | 185256 | B. WING_ | | | R 09/30/2021 | |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND F | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | |
| {F 837} | if he had known abordeviancies from Decone told him anythin monitoring from the stated he had heard Immediate Jeopard know the specifics. **The facility alleger implemented to remeffective 09/26/202. 1). Braden Scale As on all residents by fand comprehensive were completed on The facility utilized that and comprehensive review and update of had pressure injuries. 2). The wound care #65 on 08/25/2021, measured all current them to the Medical 09/17/2021. 3). Beginning 09/17 assessment and Brabe completed, and the developed within 48 pressure ulcer or procomprehensive care 21 days of admission potential pressure interventions to previous pressure interventions to previous face on the developed within 48 pressure ulcer or procomprehensive care 21 days of admission potential pressure interventions to previous preventions to previous preventions to pr | atted it "would have been ideal" but the Infection Control cember 2020; however, no no about any ongoing QAPI December 2020 survey. He is the facility had been cited for any in the past, but he did not the following was cove Immediate Jeopardy it: It is sessments were completed acility nurses on 08/28/2021 full body skin assessments all residents on 09/11/2021. The Braden Scale Assessment full body skin assessment to care plans of residents who as by 09/17/2021. Physician evaluated Resident Staff assessed and are injuries, and staff the treatments and reported Director/Physician #1 by 1/2021, upon admission a skin adden Scale assessment will the baseline care plan will be a hours to include any otential for pressure ulcer. A explan will be developed within an to include pressure ulcers are ulcers and include | (F 8 | 37} | | | |

| | | IDENTIFICATION NUMBER | | PLE CONSTRUCTION G | 1, , | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|---|----------|-------------------------------|--|
| | | 185256 | B. WING_ | | | R 09/30/2021 | |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 03/30/2021 | |
| (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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| (F 837) | and #320 were bather care and moisturizing and assisted with dreclothing. Clean linear residents' beds on 09 were evaluated by so 5). All residents were interviewed to obtain by the Director of Nur New bath/shower sch by nursing staff to accepte frence. Resident were obtained and implans and State Register plans by the Register plans by the Register plans by the Register completed on 0.6). On 08/28/2021, the began reviewing all recommendations for supplements to promany weight loss issue 7). All residents with 0 and Chronic Obstruct (COPD), Asthma and by licensed nurse and with no concerns were 08/13/2021. | is, #308, #309, #311, #314 d including a shower, nail lotion applied post shower, ssing in clean appropriate s were placed on the //1/2021. The residents cial services on 09/15/2021. offered a shower and shower/hygiene preferences rsing (DON) or designee. redules were implemented commodate resident preferences for hygiene corporated into resident care stered Nurse Aide (SRNA) gional Nurse Consultant 9/13/2021. e Registered Dietitian (RD) residents' diets and made meal changes or ote healing and to address s. the diagnoses of Diabetes ive Pulmonary Disorder Pneumonia were assessed d/or Respiratory Therapist e identified completed se reviewed all residents re monitoring by 07/30/2021 anded to include mandatory | {F 83 | 77} | | | |
| | Administration Recor | d (MAR). | į | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|--|---------------------------------|-------------------------------|----------------------------|
| | | 185256 | B. WNG_ | | | | R 30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP C 200 NURSING HOME LANE PIKEVILLE, KY 41501 | ODE | 1 00 | 50/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | | TION SHOULD BI THE APPROPRIA | _ | (X5) COMPLETION DATE |
| {F 837} | (CDM) observed the lunch and dinner on (were delivered on time 10). Direct Care staff recruitment efforts with provided through age Direct care nursing stag will be reviewed Nursing and the Admilevels are adequate the residents. The staff won the unit at the star Director of Nursing, Nadministrator or designatified staff to see and/or calling agencial qualified staff to see and/or calling agencial qualified staff to fill the cannot be replaced the Assistant Director of nursing management appropriate staffing leventer will prioritize reachieved during emerequired task including medication, no showed provided to incontine that cannot turn self, assist residents with 11). The facility has in through recruitment estaffing levels have be meals are prepared as 12). On 08/11/2021, as | tified Dietary Manager meal service for breakfast, D9/11/2021, all three meals ite. Ing was increased through th additional staffing ency and travel contracts. Italiant schedules for the next daily by the Director of inistrator to ensure staffing o meet the acuity of the rill be validated as present t of each shift by the dursing Supervisor, gnee. Direct care nursing eplaced by calling other of they can fill the opening, les to see if they have the opening. If direct care staff the Director of Nursing, Nursing, or member of the read will fill the shift. If evels cannot be met, the esident care that can be regency staffing, prioritize the gradministration of the staff of t | {F 8 | 37} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | | SURVEY |
|--------------------------|--|--|--------------------|--|---|----------|--------------------|
| | | 185256 | B. WING | | | | R /30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | | | STREET ADDRESS, CIT 200 NURSING HOME I PIKEVILLE, KY 415 | LANE | <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 | (EACH CO | DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| {F 837} | and physical forms of for Mental Status (BIM above and skin integr BIMS less than eight Licensed Nurse. Resi Dementia had their Cirevised, as necessary (MDS) Coordinator or residents were identifipsychosocial and/or physical physical physical and physical | abuse with Brief Interview AS) score of eight (8) or ity reviews for residents with (8) were completed by dents with a diagnosis of are Plan reviewed and by the Minimum Data Set 09/07/2021. No new ied as indicating any hysical harm. Asse Consultant completed a sment on all residents by ints who were identified as had care plans reviewed and Coordinator. A list of all er risk residents were g station with a list of for nursing to reference. AS, #81, #90, #330 and by 09/17/2021. The RD) completed a on assessment and RD re reviewed for the Director of Nursing 109/17/2021. Further, the oke with the attending and validated the diet orders and Recommendations were onic medical record and on gistered Dietician and ON), reviewed diet orders ecord to ensure both the effected accurate | {F 8 | 37) | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1 | | 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 | 031 | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| {F 837} | aides, or designee. S physician will be docu aide, dietary aides an 16). The facility evalu 08/11/2021, located of for compliance with C implemented yellow a identified two (2) resid exposed to positive re was designated with o barrier and those two this zone on 08/11/20 17). The facility had the in the red zone on 08, #328 and #329). Resi have completed quara physician orders. Resi completed quarantine physician's order. Resi no longer in isolation. 18). All staff eligible for COVID-19 on 09/16/2 identify any new case testing on 09/16/2021 tested for COVID-19 of did not identify any new 19). The facility was of surveillance testing as COVID-19. Positive Co placed in isolation zon droplet precautions w protective equipment, physician notification, | prative nurse aide, activity nacks ordered by a urnented by the restorative id/or licensed nursing staff. ated the COVID-19 unit on in the 5th floor of the facility idented in the 5th floor of the facility idented in the 5th floor of the facility idented in the 5th floor of the facility idented in the 5th floor of the facility idented in the 5th floor of the facility idents who had been esidents and a yellow zone erection of a plastic zip wall (2) residents were moved to idented idents were idented in the facility idented idents #327, #328 and #329 antine per facility policy and idents #311 and #314 idented idents #311 and #314 idented idents #311 and #314 were idented in the facility idented in the facility idented in the facility idented in idented in identification in the facility idented in identification in the facility idented in identification in the facility idented in identification in the facility idented in identification in the facility idented in identification in the facility identification id | {F 8 | 37} | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. | 1 | X2) MULTIPLE CONSTRUCTION A BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--------------------|---------------------------------------|---|-----|-------------------------------|--|
| | | 185256 | B. WING | | | | R 30/2021 | |
| | ROVIDER OR SUPPLIER W POST-ACUTE AND RE | HABILITATION CENTER | , | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | U3/ | 50/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| (F 837) | isolation precautions addition, any resident droplet precaution in ifacility will provide phynotification and care pemployee testing prot designated days effect requires all staff must days. If the employee not allow the employee not allow the employee negative COVID-19 to employee will be testefacility by the Infection designee. All testing oposted to the employer common areas. 20). The facility scree for signs and/or symptocumented on the MRecord (MAR). The famonitoring for signs a residents on 09/17/20 21). Resident #9, Res Resident #326 and Rewere reviewed for use administration times be 09/23/2021. 22). The facility stated their medication as or and implemented phanotification if any med The facility will abide physician regarding the | chave been initiated. In exposed will be placed in solation zone (yellow). The yellow in the placed in solation zone (yellow). The yellow in the yellow in yellow in the y | {F 8 | 37} | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--|---|---|-------------------------------|----------------------------|
| | | 185256 | B. WING | | | | R 20/2024 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | L | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501 | <u>u 9</u> | 30/2021 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE |
| {F 837} | the facility with a three medications that required for cost authorization. 24). New admissions the facility after normal weekends will have dientered into the electric submitted to pharmaci integration. The facility fax transmittal as a bapharmacy integration electronic medical recility does not timely manner the phathe facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility manner the phathe facility manner the phathe facility manner the phathe facility manner the phathe facility manner the phathe facility will utilize the facility manner the phathe facility in the facility of all residents of audit of all residents of 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 will the Administrator over the QAPI committee. Nursing, Administrator. | racility's pharmacy to provide e (3) day supply of ires the facility's approval while pending cost review. and re-admissions entering al business hours and on ischarge orders submitted, ronic medical record and by through pharmacy ty implemented the use of ackup to the electronic by entering the order in the cord to receive medications. receive medications in a armacy will be notified, and the emergency medication rises and medication is ician will be notified for w orders. ree Consultant, Director of a nursing staff completed an ordered medications and s were available in the acted a Quality Assurance ment (QAPI) meeting on ty reviewed education, udited implementation to th the AOC and all audits. trees the QAPI committee. consists of the Director of r, Medical Director, Social ivities, Clinical, Therapy, | {F 8 | 337} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--|--|-------|-------------------------------|--|
| | | 185256 | B. WING_ | | | R | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE ZIP CODE | 1 09/ | /30/2021 | |
| PARKVIE | W POST-ACUTE AND RE | HABILITATION CENTER | | 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD | BE | (X5) COMPLETION DATE | |
| {F 837} | guidance from the Re Regional Director of C Clinical Nurse for 30 of the thirty-day oversigh Administrative Team of determine if continued The administration has responsibility to direct communicate areas of improvement. 28). The Administration QAPI Committee revisionated person for cal Activities of Daily Living timeliness of meal trait turning and reposition. 29). The Vice Preside Clinical Operations are Consultants conducted O9/15/2021 with a conconsultation to review outcomes of the survey roles of the Governing Rules and Regulation the following community for the following com | nted an Interim 3/2021 to replace the The facility's Interim eive daily oversight and gional Vice President or Operations and Regional days. Upon completion of nt, the Regional will audit the Administrator to d daily oversight is needed. Is direct oversight and f concern and process or, Medical Director, and ewed procedures for a I-ins, answering call lights, ng (ADL) Care, serving, and ys incontinence care and ing on 09/15/2021. ont of Operations, Director of nd Regional Nurse d a conference call on outract company for a | {F 8: | 37} | | | |

| 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 P | ROVIDER OR SUPPLIER | 100200 | | | TOUR ADDRESS OF STATE OF SOME | 09/ | 30/2021 |
| | N POST-ACUTE AND RE | HABILITATION CENTER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | _ | (X5) COMPLETION DATE |
| (F 837) | beginning 09/16/2021 and/or revisions to the the 09/16/2021 meetic standardized plan to e reviewed as needed a agenda included revie catheters, enteral feet physical restraints, me management, infectio readmission rate, reh social services, conce resident council, and grievances, admission development, vacant orientation, dietary va weight loss, work injuit employees on family in absence, new hires, in review, pharmacy rep business office, and a Committee and Medic standardized agenda but not limited to, the meeting. 31). The Regional Dir Vice President of Ope Administrator, the DO on 09/16/2021 regard Governing Body, inclu procedures to be impl communicating inform the Governing Body. I QAPI processes, the | r and Regional Nurse and revised the QAPI Plan and presented the reviews e QAPI Committee during ng. The facility developed a ensure all topics were at the QAPI meetings. The ewing pressure ulcers, Foley ding tubes, contractures, edication usage, risk in control, hospital abilitation management, erns of grievance, activities, family council concerns, is, discharges, census, staff positions, employee riances, tray audit report, ries, terminations, medical leave, a leave of medical record compliance orts, restorative nursing, idmission actions. The QAPI and Director approved the on 09/16/2021 to include, topics presented during the ector of Operations and trations met with the N, and the Medical Director | {F 8 | 37} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DATE COMP | SURVEY |
|--------------------------|---|---|----------------------|------|--|-------------------|----------------------------|
| | | 185256 | B. WNG | | | | R /30/2021 |
| PARKVIE | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES / 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 837} | causes with the utiliza approaches and, audi Calendar. The Admin medical Director of ful meetings. 32). The Administrator reports before each Q beginning 09/15/2021 compliance with the d 09/10/2021 survey. Q 09/16/2021 to discuss interventions to removimplemented QAPI me (4) weeks, as needed Administrator will forw minutes to the Governincluding the Vice Pre Regional Vice Preside Regional Nurse Constresults. The QAPI consudits at the QAPI mereview. The Administrator of Nursing, Addinical, Therapy, Main Environmental Service (2) The Governing Be Administrator with resemblements for QAPI, incomplements of QAPI, incomplements of QAPI, incomplements of the reevaluate for frequents. | tion of the five (5) why ting systems per the QAPI istrator will notify the sure QAPI Committee If will collect all monitoring API Committee meeting for review to ensure efficiencies cited during the API Meetings were held on abatement and develop te the jeopardy. The facility eetings weekly, times four and monthly. The and all QAPI Meeting ting Body members, sident of Operations, and the altant, to review the audit mmittee will review the etings. Committee for altor oversees the QAPI I Committee consists of the dministrator, Medical tes Director, Activities, menance, Dietary and tes. Dody will provide the facility's purces and education cluding but not limited to the that a Glance, and a resource tolement the QAPI plan The Governing Body will upcoming year and | {F 8 | 337} | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL' A. BUILDI | | CONSTRUCTION | (X3) DATE COMP | SURVEY |
|--------------------------|--|--|------------------------|--|---|-------------------|----------------------------|
| | | 185256 | B. WING | | | 1 | R |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE ON NURSING HOME LANE PIKEVILLE, KY 41501 | <u> </u> | 30/2021 |
| (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | | (X5) COMPLETION DATE |
| {F 837} | (4) weeks and, as neto ensure the quality complies with the state compliance with State is demonstrated. 35). All nursing staff via Director of Nursing, Nu | neetings to weekly for four eded effective 09/16/2021, of care is monitored and indard of care and e and Federal requirements overe educated by the MDS Coordinator, or reighing techniques, ing, 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 onic medical record. The fetary Manager to enter sto the tray care system. If order, the nurse will send a into the dietary staff, ture. In the morning clinical view diet orders from the re accuracy. If education to all nursing ositioning range of motion, and from bed to chair and gon 08/19/2021 and 1021. The facility employed and staff through recruitment to ensure adequate staff to residents who cannot is. | {F 8 | 337} | | | |
| | 38). The Regional Dir | ector of Nursing educated | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. | 1 ' ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--------------------|------|--|-------------------------------|----------------------------|
| | | 405756 | | | | | ₹ |
| | | 185256 | B. WING | | | 09/ | 30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE DO NURSING HOME LANE IKEVILLE, KY 41501 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| (F 837) | including turning and hydration and nutritio to complete and docuassessment, and how dietician, physician, a impairment by 09/17/staff will call or email Physician, and Residnew skin changes. 39). The DON or destimely call light respostaff, including nurses assistants, were provimely hygiene per the timely toileting, dress of clean clothing, and trays. The DON or defacility staff not working turning to work. 40). On 08/31/2021, Nursing educated all Registered Dietician, and the MDS Nurses into the electronic meand interventions. In Director of Nursing educated and interventions. In Director of Nursing educated and interventions and interventions. In Director of Nursing educated and interventions and interventions and interventions. In Director of Nursing educated and interventions and interventions and interventions. In Director of Nursing educated and interventions and interventions and interventions. In Director of Nursing educated and interventions and interventions and interventions and interventions. In Director of Nursing educated and interventions and interventions and interventions. In Director of Nursing educated and interventions and interventions. In Director of Nursing educated and interventions. In Director of Nursing educated and interventions. In Director of Nursing educated and interventions. In Director of Nursing educated and interventions. In Director of Nursing educated and interventions. In Director of Nursing educated and interventions. In Director of Nursing educated and interventions. | essure ulcer prevention, repositioning, adequate n, positioning devices, how ament a head-to-toe skin v to notify the registered and RP of a new skin 2021. The facility nursing the Registered Dietitian, ent Representative of any ignee educated all staff on nse. In addition, direct care is and certified nursing ided education on providing e resident's plan of care, ing residents in their choice I timely delivery of meal esignee will educate any ng during education upon The Regional Director of licensed nursing staff, the the Social Service Director, on entering new care plans edical record, including goals addition, the Regional ducated staff to update the the electronic medical record interventions for any new skin during their shift. | {F 8 | 337} | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | |
|--------------------------|---|---|---------------------|--|-----------------|------|
| | | 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 / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLE | TION |
| (F 837) | sugar in the medical rephysician and following facility licensed nursing work until they have report of the facility licensed nursing mandatory insections of glucose levels on ordering mandatory insections. Beginning 08/12/2 licensed nurses on complan with intervention diabetes and a respiration of admission, recopy to the resident a Licensed nursing staff education was notified will not be allowed to received this education. 43). Beginning 08/12/2 staff on the facility's "or call-off procedure for the event a person needs dayshift, they are to not supervisor two hours. If staff needs to call of the notify their immediate before the start of their not have appropriate simmediate supervisor other qualified staff to off. If emergency staff Administrator and/or cassistance from staffir | lycemia, the facility's sumenting a resident's sumenting a resident's sumenting a resident's sumenting a resident's sumenting a resident's sumenting a rediction of the graphysician orders. The graphysician orders. The graphysician orders. The graphysician orders. The graphysician orders. The graphysician orders and staff on documentation 8/19/2021 and 08/20/2021 ervices. 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 it of ongoing education and work until they have in. 2021, the DON educated all call off' procedure. The she facility included: in the to call out of work for other the start of the shift. If on the night shift, they are stee supervisor four hours in shift. If the facility does staffing levels, the and/or designee will call replace the person calling fing is required, the | {F 83 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | | E 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 | 1 03 | JUIZUZ 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| (F 837) | Administrator and/or the process of identify reporting abuse, as wimplementing immedi wandering residents. 45). All nursing staff vibration of Nursing, Manages on proper wobtaining, documenting changes to the Regist 09/17/2021. On 09/13 the Dietary Manager of timely nutritional assess accuracy. When staff electronic medical recorder will send the windietary staff. The Dietary staff. The Dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary staff. The Dietary dietary dietary staff. The Dietary dietary staff. The Dietary diet | vided re-education by the designee on 08/12/2021 on ving, preventing, and vell as identifying and rate interventions for vere educated by the IDS Coordinator, or veighing techniques, and reporting weight tered Dietician by 8/2021, the CDM educated on diet order accuracy and resement to ensure diet order enters diet orders into the cord, the nurse entering the litten communication to the tary Manager will enter the e system. The facility will me the previous day in the sure accuracy. IM educated the Dietary 21 on facility policy be times and the use of ones for those requiring reall meals meet the residents in accordance with puidelines to reflect religious, eds of the population. | {F 8 | 3337] | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. | ` ' | | CONSTRUCTION | | SURVEY |
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| _ | | 185256 | B. WNG | | | | R /30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501 | 1 031 | 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) | | COMPLETION DATE |
| {F 837} | Continued From page | 938 | {F 8 | 37} | | | |
| | of Nursing educated r Manager on the proce and/or implementing to recommendations for 09/17/2021. | • | | | | | |
| | DON and/or designed COVID-19 policy/guid donning/doffing Perso (PPE), yellow and red DON/designee educa monitoring residents f beginning. 08/12/202 educated all staff, includer not working. Dur 08/12/2021, the Covid handwashing policy, of the Covid handwashing policy, of the COVID Policy (PPE). | anal Protective Equipment I zones. In addition, the ted, licensed staff on or Covid-19 symptoms 1, the DON/designee luding contract staff, who ring the QAPI meeting on I-19 policy, the donning and doffing PPE, and monitoring residents | | | | | |
| | 50). Staff were provid 08/20/2021 by the DC Regional Nurse Cons symptom monitoring of admissions into the re | N, Regional DON, or ultant to enter COVID-19 orders on all new | | | | | |
| | administration, including patient, right dose, right d | 5) rights of medication ng right medication, right ht time, and right route. The lesignee educated all working on 09/23/2021 on when a medication was not | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION | _ | SURVEY |
|--------------------------|---|--|--------------------|--|-------------|----------------------------|
| | | 185256 | B. WING | | | R 30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501 |)E | 30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BI | (X5) COMPLETION DATE |
| {F 837} | ordered medication woutside of the ordered education also include given by the MD, doct and new orders from medical record. All off will be provided training the provided training the provided training the provided training the provided training the emergency in place for ensuring motifying the physician re-admitting residents after-hours. 53). The Interim Admit on his contact information coordinator from 09/1 In addition, education who to notify if unable shift. 54). The facility will authorise through Friday, for the 09/17/2021 to ensure weekly on each reside will notify the physician Responsible Party of a and those new interversidation in the province to prevent decline the doctors and those new interversidation and those new interversidation in the province to prevent decline the doctors and those new interversidation. | ning the anticipated me, notify the MD if an ill either be omitted or given a medication time. The ed following new orders umenting the conversation, the MD in the electronic mer licensed nursing staffing as scheduled for shifts. The DON /Regional Nurse all licensed nursing staffind as scheduled for shifts. The DON /Regional Nurse all licensed nursing staffind or agency staffing the medication kit, the system medications are in-house, or a for new orders for new or including on weekend and mistrator educated all staffintion and role as the Abuse 3/2021 through 09/17/2021. On staffing schedules and to work their scheduled with the weekly resident assements daily, Monday ee (3) months effective they have been completed ent. In addition, the facility in, Registered Dietician, and any new skin impairment entions have been put in the control of the con | {F8 | 337) | | |
| | expiration date on 08/ | dited all lab supplies for the 28/2021. Audits will be all lab supplies for four (4) | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | - 1 | TIPLE CONSTRUCTION ING | | (X3) DATE COMP | SURVEY |
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| | | 185256 | B. WING | | | | R 30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501 | = | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD B | | COMPLETION DATE |
| {F 837} | three (3) months. 56). The Director of N Nursing (ADON), or N resident progress note effective 09/13/2021, month. Staff will review Saturday and Sunday Supervisor conducted areas of skin impairmed plan implemented to in 57). Beginning on 09/leadership staff and/orounding of residents incontinence, and residents will be visual shift daily for two (2) we 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 the saff will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will conduct ten (each shift for two (2) weeks will be will conduct ten (each shift for two (2) weeks will be | ursing, Assistant Director of fursing Supervisor will audit es for daily four (4) weeks then weekly for one (1) w Progress notes for on Monday. The Nursing audits to ensure any new ent identified had a care include new interventions. 11/2021, the facility's r designee began visual assessing hygiene, toileting, ident repositioning. All ally rounding on once each weeks, fifty percent of the r four (4) weeks, and residents each shift for four has two (2) shifts, 6:00 AM | {F 8 | 337) | | | |
| | began monitoring resp Situation Background Recommendation (SB acute change in respir | AR) communications for ratory status Monday clinical morning meeting. | | · S | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1, , | TIPLE CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|--------------------|--|-----------|-------------------|----------------------------|
| | | 185256 | B. WNG | | | | 30/2024 |
| | ROVIDER OR SUPPLIER V POST-ACUTE AND RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 | | 09/ | <u>30/2021</u> |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD BE | | (X5) COMPLETION DATE |
| {F 837} | implementation of any Plans were reviewed Audits will be daily for times a week for four 60). The MDS Nurse, began audits on 09/15 completion for all new re-admissions to ensubaseline Care Plan w 61). All residents admidays with a diagnosis Obstructive Pulmonar Asthma, or current Procare Plan reviewed at the MDS Nurse(s) an interventions will be a morning meeting by thousing designee. 62). Beginning on 08/DON, and/or Designe admissions and re-adcare plans for complewith the resident and/variance or identified immediately. Audits withrough Friday for all to the facility for four eadmissions for a weethen ten percent of adweeks. 63). On 09/11/2021, to designee began audit meal trays to resident | Physician notification and physician order. Care and updated as needed. Tone (1) week, then five (5) (4) weeks. DON, and/or Designee 5/2021 of baseline care plan parameters and the staff completed the sithin 48 hours of admission. Ditted within the last thirty of Diabetes, Chronic by Disease (COPD), heumonia had their baseline and updated as needed by dor designee. New dided to the care plan in the he DON, ADON, and/or | {F 8 | 837} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | TIPLE NG _ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------|--|--|-------------------------------|----------------------------|
| | | 185256 | B. WING | | <u> </u> | | R 30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | 20 | TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501 | 03/ | 30/2021 |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE PROPRIES | | | (X5) COMPLETION DATE |
| {F 837} | all three (3) units daily (1) meal on all three (weeks. 64). On 08/15/2021, the began audits of staff's quiz of identification a with a change in respondings/symptoms of hythe facility's diabetic period change in a resident's physician and following Leadership will quiz shifts; ten (10) staff for staff a week for four (continuous form) and the results Monday throug morning meeting. The any blood sugar results morning meeting. The any blood sugar results any Physician's Order reviewed and updated designee will complet diabetic residents acrossing and symptoms of hypoglycemia/hyperginesident was immediated staff. Any variance or addressed immediate one (1) week, then five (4) weeks. | (2) weeks, two (2) meals on of for two (2) weeks, and one 3) units daily for four (4) the DON and/or Designee is knowledge with a verbal and assessment of residents irratory status, identifying perglycemia/hypoglycemia, protocol, documenting a condition, notification of the ag physician's orders. It is that the test of the test | {F 8 | 37) | | | |
| | questionnaire on abus | d an employee se and identification of | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|---|------|---|-----|----------------------------|
| | | 185256 | B. WNG | | | | R 30/2021 |
| | ROVIDER OR SUPPLIER N POST-ACUTE AND RE | HABILITATION CENTER | | 20 | TREET ADDRESS, CITY, STATE, ZIP CODE DO NURSING HOME LANE IKEVILLE, KY 41501 | 007 | 00/2021 |
| (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 837} | the proper reporting of units. The employee completed for five (5) then three (3) times a and then weekly for for identified concerns immediately. 67). Beginning on 08, Nursing and/or design resident's wandering admission and quarted Set (MDS) assessme wandering will be dismorning meeting to reinterventions. Any varied by the Director of Nursing, or nursing described by the facility and have review random weekly residents with a BIMS to ensure no injuries (08/13/2021, Any varied will be addressed immediated by the facility of the polytopic of the facility and have review random weekly residents with a BIMS to ensure no injuries (08/13/2021, Any varied will be addressed immediated audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of reelectronic medical reconstructed audits of recon | ring behavior to determine of abuse across all shifts and questionnaire will be staff daily for one (1) week, week for two (2) weeks, our (4) weeks. Any variance will be addressed 713/2021, the Director of nee will review each risk assessment upon with their Minimum Data out. Any resident identified as cussed in the clinical eview and initiate new riance or identified concerns nediately. New interventions on the morning meeting by gg, Assistant Director of esignee. 713/2021, the Social designee will perform residents with a BIMS score to ensure they feel safe in not been subject to or e DON or designee will y skin assessments for 6 score of less than eight (8) of unknown origin beginning ance or identified concerns | {F 8 | 337} | | | |