STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ULTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
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{F 837}	kitchen and reaching be conducted for rand one (1) week, twice prand then weekly for outrays arrive at the unit assist in passing trays meal trays, and certification residents promptly. To designee will audit the trays to residents afte beginning 09/11/2021 observed on each unit two (2) meals on each weeks, one (1) meal of weeks. 71). The dietary mana admitted/re-admitted beverage preferences admission and enter the system for listing on the completed bi-annually residents. Physician-be audited by the Dietary and the completed by the Dietary trays and the completed by the Dietary and the completed by the Dietary trays and the completed by the Dietary and the complete by the complete by the complete by the Dietary and the complete by the	23/2021, the Dietary and audit meals leaving the the units timely. Audits will formeals twice daily for er week for two (2) weeks, ne (1) month. Once meal and a management staff will are to ensure residents receive ed nursing assistants assist the Dietary Manager or entime it takes to pass meal are they arrive on the unit. All three (3) meals will be the daily for two (2) weeks, a unit daily for two (2) on each unit daily for four (4) and are tray cards beginning of food preferences will be a rand as needed for all ordered snack intakes will tary Manager daily for one our (4) weeks, and monthly	{F 8	337}				
	audited beginning on Resources (HR) Direct punches to ensure so their shift. Audits will through Friday for four	reening before beginning be completed Monday r (4) weeks by the HR ds audited on Mondays. Any						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BI		(X5) COMPLETION DATE
{F 837}	by the HR Director. To educated on the COV Nurse, an infection co doors will remain lock entry by staff and screentry. 73). Beginning on 09/	OVID-19 Screening Policy	{F8	337}			
	for eight (8) weeks, fiv (4) weeks to audit infe differing shifts and uni observation of handw. and zones; donning/d PPE; and mask comp	live (5) times each week ve (5) times weekly for four ection control compliance on its. Audits will include ashing; isolation signage loffing (putting on/taking off) liance. Any variance or ill be addressed immediately					
	review all residents or pharmacy to ensure a beginning 09/23/2021	in active script is on file					
	and/or Director of Nur medication pass obse 09/25/2021 on randon jeopardy removed to e accuracy of medicatio CMS Critical Element Administration to cond observation of twenty-	n shifts daily until immediate ensure timeliness and one. The facility utilized the Pathway for Medication duct the medication series.					
	Friday, the DON, ADO	2021 Monday through DN, and/or Designee will ery tickets against ordered					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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{F 837}	needing a renewal hapharmacy. Audits will Immediate Jeopardy i 77). Beginning 09/11/2 and/or DON will be renursing staff daily for adequate staffing is m. 78). Beginning 09/11/2 Dietary Manager will the dietary staffing daily for adequate staffing. 79). Beginning 09/11/2 President of Operation monitor and audit the days to ensure complete was to ensure complete was to ensure complete was to ensure of condition and identific Watch" (change of consumer of eight (and the facility to or witnessed abuse concerns. Interviews we conducted of resident designees weekly untermoved.	nsure that all narcotics we been sent to the continue until the s removed. 2021, the Administrator sponsible for monitoring four (4) weeks to ensure naintained. 2021, the Administrator and be responsible for reviewing for four (4) weeks to maintain for four (5) weeks to maintain for four (6) weeks to maintain for four (7) weeks to maintain for four (8) weeks to maintain for four (9) weeks for four four four four four four four	{F 83	37}		

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DA DKWEN	V DOST ACUTE AND DE	HABILITATION CENTER	200 NURSING HOME LANE		00 NURSING HOME LANE		
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(F 837)	. 3		{F 8	337}			
	1). Review of Head-to	-Toe Skin Assessments	l				
		ed all residents in the facility	!			ļ	
	on 09/11/2021. A revi	ew of the skin assessments	1				
		idents (Residents #65,				į	ļ
		, #27, #74, and #358) had					
		rs with a total number of				1	
		venty (20). A review of the				-	
		plans for Residents #65,					
	#324, #45, #14, #357	, #27, #74, and #358 d the care plans to reflect					
	the resident's current pressure injuries. The facility completed the review on 09/17/2021.						
	identy completed the	10104 011 03/17/2021.					
	A review of the facility	r's census on 08/28/2021					
		ed all residents at risk for					
	pressure ulcers with t	he Braden Scale. Interview					i
		N on 09/30/2021 at 4:17 PM					
	revealed she complet						
		sidents on 09/11/2021. She					
		the facility identified twenty					
		uries. She further stated that					
	the facility completed						
	Continued interviews	esidents on 08/28/2021.					
	Interdisciplinary Team						
	• -	aden Scale assessments to					
		care plans. She stated that					
		#45, #14, #357, #27, #74					
		s were updated to reflect					
		ies by 09/17/2021. Interview					
	with MDS Nurse #1 o	n 09/30/2021 at 1:39 PM					
	revealed she updated	f all residents' care plans to					
		re injuries by 09/17/2021. In					
		ed a review of walking					
		1 with Therapy Personnel,					
		ian, the Medical Director, the					
		lurse for Residents #65,					
ı		, #27, #74 and #358. A	1				
	review revealed the li	nterdisciplinary Team				}	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		E CONSTRUCTION	(X3) DATE	SURVEY
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{F 837}	Continued From page 948 reviewed each resident's orders, current skin breakdown, care plan, and implemented changes as needed.		{F 8	137)			
					:		
	revealed the Medical resident on 08/25/202 Stage four (4) pressur deep tissue injury (DT and a skin tear to the Resident #65's wound 08/26/2021 at 9:00 Al wound measured, "13 12.3 cm width and 0.2 at 10 o'clock measurin 12 o'clock that measur No palpable bone, sloremoved with wound continued to treat the ulcer with Aquacel Ag evaluation completed Resident #65 had six including a stage two measuring 1.2 cm (ler 0.1 cm (depth), stage measuring 2.5 cm by stage two (2) to left hi cm x less than 0.1 cm	at 1:45 PM and noted a re ulcer on the sacrum; a re ulcer on the sacrum; a religion to the left and right heels; left inner leg. Review of a care note dated of the sacrum of the composition of the composition of the left sacrum of the composition of the left sacrum of the left sacrum of the left sacrum of the left superior calford on 09/15/2021 revealed of the left superior calford on the l					
	0.1 cm, unstageable to cm by 0.6 cm. and for measuring 12 cm by 1 Interventions in place heel protectors while is weekly documentation mattress to bed, nutrit turning/repositioning. for the sacral pressure	for the resident included n bed, diet as ordered,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		00 NURSING HOME LANE		
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{F 837}	drainage and 95 perc Resident #65 decliner observation of other precord review revealed PM, Physician #1 det weight loss and wound 09/28/2021, Resident in-house wound care record revealed on 05 physician of the declin with no new orders. T with Failure to Thrive. 3). The facility admitte 09/10/2021, complete 09/10/2021, complete 09/10/2021, and com on 09/10/2021. Resid 09/25/2021 and re-ad 09/28/2021. Further revealed staff develop plan on 09/21/2021. Are-admission revealed admission skin asses 09/28/2021, Braden State of the plan on 09/21/2021. Are-admission revealed admission skin asses 09/28/2021, Braden State of the plan on 09/21/2021. Are-admission revealed admission skin asses 09/28/2021, Braden State of the plan on 09/21/2021. Are-admission revealed admission skin asses 09/28/2021, Braden State of the plan on 09/21/2021. Are-admission revealed admission skin asses 09/28/2021, Braden State of the plan on 09/21/2021. Are-admission of Resident #309 on 09/28/2021, Braden State of the resident #309 on 09/28/2021, Braden State of the resident well-kempt, and clear residents' beds. Intentional plan of the resident well-kempt, and clear residents' beds. Intentional plan of the resident well-kempt, and clear residents' beds. Intentional plan of the resident well-kempt, and clear residents' beds. Intentional plan of the resident well-kempt, and clear residents' beds. Intentional plan of the resident well-kempt, and clear residents' beds. Intentional plan of the resident well-kempt, and clear residents' beds. Intentional plan of the resident well-kempt, and clear	ith a scant amount of ent granulation tissue. It would not consent to the pressure areas. A medical of that on 09/21/2021 at 2:19 ermined the resident's discovered wisits. Further review of the 0/29/2021, staff notified the ne in the resident's wound the resident was diagnosed as a kin assessment on the discovered a baseline care plan ent #355 was discharged on eview of the medical record to the comprehensive care a review of Resident #355's differ the resident had an esment completed on 09/28/2021, and a veloped on 09/28/2021, and a veloped on 09/28/2021 at 1:40 m 09/29/2021 at 11:10 AM, 29/2021 at 11:26 AM, 29/2021 at 11:52 AM, 29/2021 at 11:30 AM and 29/2021 at 11:13 AM is appeared clean,	⟨F E	337}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE COMP	SURVEY PLETED
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{F 837}	for Residents #45, #6 and #320) revealed the Director interviewed the and had no concerns Interview with the ISS revealed she interview #308, #309, #311, #3 with no identified concerns reviews revealed Rese #309, #311, #314, and shower preference and obtained and included review of the resident the comprehensive caplan, revealed staff up to reflect the resident the Vice President of at 4:10 PM revealed seriolated preference, and the faresident's care plan. A interviews revealed the preference was obtain shower schedule revealed shower/hygiene preferenc	review of Progress Notes 5, #308, #309, #311, #314, the Interim Social Service the residents on 09/15/2021 with resident hygiene. 5D on 09/30/2021 at 2:23 PM wed Residents #45, #65, 14, and #320 on 09/15/2021 cerns regarding hygiene. Sidents during the initial tour 33 PM to 2:32 PM revealed 5. Interviews and record idents #45, #65, #308, d #320 each had their ad hygiene preference d on their care plan. A 's medical record, including are plan and SRNA care odated each resident's plan s preference. Interview with Operations on 09/30/2021 she assisted with obtaining She stated each resident nower and hygiene acility updated each A review of resident their shower/hygiene ned. A review of the facility's ealed that the resident rences were honored. Dietician on 09/30/2021 at the began reviewing all 8/2021. She further stated new and/or additional residents to address weight	{F 8	137)			

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(F 837)	Continued From page 951		{F 8	37)			
	DON reviewed all die Interview with the RD	s' diets, and the Regional ts and recommendations. O on 09/30/2021 at 4:17 PM led the review of all diets s.		·			
	08/13/2021 revealed with a diagnosis of Di signs and symptoms hyperglycemia and thintervention. Interview 09/30/2021 at 4:17 Pl the residents and did concerns. Observatio 09/28/2021 at 1:36 Pl 09/29/2021 at 11:13 / 09/29/2021 at 11:52 /	te need for immediate of with the Regional DON on M revealed she assessed not identify immediate ons of Resident #348 on M, Resident #320 on AM, and Resident #311 on AM revealed no visible					
	A review of facility as: 08/12/2021 revealed diagnosis of Chronic Disorder (COPD), As assessed by Respiral with Respiratory Ther at 12:45 PM revealed with diagnoses of Chi Disorder (COPD), As 08/12/2021 with no id Observation of Resid 1:48 PM, Resident #6 PM, and Resident #4 revealed no respirato 8). Interview with the	ent #45 on 09/28/2021 at 65 on 09/28/2021 at 1:40 3 on 09/28/2021 at 2:03 PM, ry distress. Regional Nurse Consultant					
	all residents with a di	DPM revealed she reviewed agnosis of Diabetes and the glucose monitoring. She					

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(F 837)	include mandatory en MAR. Review of Resi orders revealed each the glucose value on review revealed no co having glucose levels than 400. 9). A review of audits revealed meals were with the Regional Cer (RCDM) on 09/28/202 09/30/2021 at 1:52 Pl observed on 09/11/20 within five (5) to ten (1) scheduled times. 10). A review of the face of th	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 oncerns with residents less than 60 and/or greater completed on 09/11/2021 delivered timely. Interview tified Dietary Manager 21 at 2:26 PM, and M revealed lunch was 121 and arrived at the unit 10) minutes of the estandard for each floor of the afacility's staffing revealed estand two (2) certified each floor from 6:00 PM to	{F 8	37}			
	MAR. Review of Resionders 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 09/28/202 09/30/2021 at 1:52 Pt observed on 09/11/20 within five (5) to ten (1) scheduled times. 10). A review of the face of	dent #3, #41, and #357's order required staff to enter the resident's MAR. Further oncerns with residents less than 60 and/or greater completed on 09/11/2021 delivered timely. Interview tified Dietary Manager 21 at 2:26 PM, and W revealed lunch was 121 and arrived at the unit 10) minutes of the acility's staffing for AM to 6:00 PM revealed as and three (3) nursing duled for each floor of the a facility's staffing revealed and two (2) certified and two (2) certified and two (2) licensed nurses, and sing assistants on each floor PM. Further review of (1) licensed nurse and two assistants for each floor from a staffing on 09/28/2021 from on 09/29/2021 from 8:11 AM					

NAME OF PROVIDER OR SUPPLIER 185256 B, WING STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED	
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME	(X5) COMPLETION DATE	
Continued From page 953 being answered timely, residents appeared clean/well-groomed, staff was offering and assisting residents with baths/showers, lurring/repositioning was being conducted timely, and meal trays were passed timely. Interviews with RN #1 on 09/29/2021 at 11:55 AM and on 09/30/2021 at 12:58 PM; RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM; LPN (Licensed Practical Nurse) #6 on 09/30/2021 at 12:44 PM; LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM; LPN #10 on 09/30/2021 at 1:54 PM; LPN #10 on 09/30/2021 at 10:31 AM; State Registered Nurse Aide (SRNA/certified nurse aide) #1 on 09/29/2021 at 3:32 PM; SRNA #7 on 09/29/2021 at 3:32 PM; SRNA #11 on 09/29/2021 at 3:32 PM; SRNA #11 on 09/29/2021 at 3:32 PM; SRNA #21 on 09/29/2021 at 3:04 PM; SRNA #21 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 4:30 PM; SRNA #22 on 09/29/2021 at 4:10 PM; SRNA #23 on 09/29/2021 at 4:10 PM; SRNA #23 on 09/29/2021 at 4:10 PM; srevealed staffing had improved, and each staff member revealed they had time to perform duties as assigned. 11). Review of the staffing schedule for 09/28/2021, and 09/30/2021 revealed each day consisted of one (1) day cook, one (1) prep cook, live (2) day aides, and two (2) evening aides. Observation of the kitchen on 09/28/2021 at 2:26 PM reflected the staffing was accurate per the schedule. Interview with Cook #3 on 09/29/2021 at 2:10 PM revealed kitchen staffing had improved, and they were able to complete their duties during their shift. 12). A review of assessments for being withdrawn, crying, or other abuse symptoms was		

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{F 837}	08/11/2021. No concereview of skin assess no identified concerns interviews conducted and 09/30/2021 revea with psychosocial and including observation and #322. Interview v09/29/2021 at 11:54 /with abuse. Interview 09/30/2021 at 1:39 Pl a diagnosis of Demer reviewed and revised with the RDON on 09 revealed she complet 08/11/2021, for all resof licensed nursing stidentified. A review of Social Service Director BIMS score of eight (identified concerns. 13). A review of assess wander, revealed all revandering risk assess Review of the elopemeach nursing station of binder on each floor translations interventions for each 14). Review of Reside and #332's medical residents had been winterview with the Residents had been winterview with the Residents of the eloparation of the eloparation intervention with the Residents had been winterview with the Residents had been winterview with the Residents nursities and 1553 Pl comprehensive nutrities.	erns were identified. A ments completed revealed s. Observation and on 09/28/2021, 09/29/2021, aled no identified concerns d/or physical abuse, s of Residents #64, #86, with Resident #322 on AM revealed no concerns with MDS Nurse #1 on M revealed all residents with htia had their care plans as necessary. Interview /30/2021 at 4:17 PM ded skin assessments on sidents, with the assistance aff. No concerns were faudits completed by the or (SSD) for residents with a 8) or above revealed no ssments for residents that residents had received a sment by 08/16/2021. hent/wandering binder at on 09/29/2021 revealed a hat contained information n, a photo and potential or resident identified at risk. ent #39, #65, #81, #90, #330 decord revealed all of the reighed by 09/17/2021. gistered Dietician on M revealed she completed a	{F 8	337}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I '	X2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
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{F 837}	completed a compreh assessment on 09/16/2021 for Reside Resident #81, 09/16/209/16/2021 for Reside recommendations madischarged. Interview Dietician on 09/30/2020 Nurse Consultant on 09/30/2020 Regional DON on 09/DON #2 on 09/30/2020 resident had received assessment and review by nursing staff. Furth and Regional DON retray card were review information. 15). Observation of that 2:22 PM, the fourth PM and the fifth floor revealed snacks incluoatmeal pies, goldfish drinks were present, in juice. Observations or revealed snacks were Review of Resident #14's record intake of snacks. Interview of PM and the fifth floor revealed snacks were Review of Resident #14's record intake of snacks. Interview of PM and the fifth floor revealed snacks were Review of Resident #14's record intake of snacks. Interview of PM and the fifth floor revealed snacks were Review of Resident #14's record intake of snacks. Interview of PM and the fifth floor revealed on document floor of the pedicated on document floor of the pedicated on document floor of the pedicated on floor of the pedicated	I record revealed the RD ensive nutritional /2021 for Resident #39, ent #65, 09/16/2021 for 2021 for Resident #90 and ent #330 with no dietary de. Resident #332 was with the Registered 21 at 3:53 PM, the Regional 09/30/2021 at 3:40 PM, the 30/2021 at 4:17 PM and 21 at 3:20 PM revealed each a comprehensive nutritional ew of the recommendations are interview with the RD vealed both the record and ed to reflect accurate e third floor on 09/28/2021 floor on 09/28/2021 at 2:00 on 09/28/2021 at 2:06 PM ding but not limited to crackers, cookies and noluding soda, milk, and noly29/2021 at 10:30 AM being passed on third floor. 331, Resident #65 and revealed documented view with SRNA #19 on M revealed she was	{F 8	37}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	=	, 037	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	_	(XS) COMPLETION DATE
{F 837}	guidance. Observatio 09/29/2021 at 11:41 / 8/30/2021 at 10:36 Al or symptoms of COVI been discharged from 18). Review of facility staff working on 09/16 COVID-19 with no idereview of resident tes 09/17/2021, revealed 19). Interview with MI at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 PI Director (HR) on 09/3 Marketing Liaison on Medical Records on Central Supply on 09/0 on 09/29/2021 at 11:58 PM, RN #4/V/0 09/30/2021 at 2:54 PI 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PI at 12:50 PM, LPN #1 AM, SRNA #1 on 09/29/2021 at 09/29/2021 at 3:29 PI at 4:10 PM, SRNA #2 SRNA #22 on 09/29/2021 at 09/29/2021 at 1:12 PI 09/30/2021 at 2:10 PI Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PI Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PI Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PI Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PI Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PI Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PI Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PI Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and 19/29/2021 at 2:10 PM Director/Dietary Management of Covincia PM and	s were isolated per CDC n of Resident #328 on M and Resident #329 on M revealed no obvious signs ID-19. Resident #327 had n the facility. staff testing revealed all 6/2021 were tested for entified new cases. Further ting for COVID-19 on no new cases. DS Nurse #1 on 09/30/2021 at isistant #1 on 09/30/2021 at isistant #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, 19/29/2021 at 2:40 PM, RN #1 155 AM and 09/30/2021 at und Care Nurse on M, LPN #6 on 09/30/2021 at 1 on 09/30/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 I on 09/30/2021 at 10:31 29/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 on 09/29/2021 I on 09/29/2021 at 3:04 PM, 1021 at 3:17 PM and SRNA 4:10 PM, Cook #3 on M, Dietary Aide #3 on	(F 8.	37}			

STATEMENT OF DEFICIENT AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG			SURVEY
		185256	B, WNG				R
NAME OF PROVIDER OF PARKVIEW POST-A		HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/	/30/2021
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		(X5) COMPLETION DATE
(2) times Control she was following tested re times with times wit	Nurse on 09/3 conducting to g CDC guidan evealed tested eekly. The view of Reside of the conduction of	exiew with Interim Infection 30/2021 at 3:10 PM revealed esting two (2) times weekly ince. Review of facility staff d is being conducted two (2) ent #329, #328, #311, #65 cord revealed that each 19 monitoring orders ion, review of each led staff was completing the 1 by the physician. Medical Director on M revealed Resident #9, ent #324, Resident #326 medications were reviewed riate administration times by	(F 8	37)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		SURVEY
		185256	B. WNG				R /30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 03/	50/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 837}	at 3:11 PM revealed to agreement that the plot facility with a three-darequiring cost review, pharmacy agreement requiring a cost review the facility a minimum medication while being would communicate a guidance to the pharm Director of Operations the Vice President of signed the agreement 24). Interview with RN AM and 09/30/2021 at 2:54 Pl 12:44 PM, LPN #7 on 09/30/2021 at 1:54 Pl at 12:50 PM, LPN #1 revealed they had recaware of the process from the pharmacy. In they were aware that physician if the pharm medication to the facility by 09/30/2021 at 3:40 09/30/2021 at 4:17 Pl completed of all residiand verified all medicacility by 09/25/2021 and 09/30/2021 at 8:0 concerns with missing	of Pharmacy on 09/30/2021 coth parties made a formal narmacy will supply the ay supply for medication. Review of the facility's revealed for any medication with the pharmacy would send of a three-day supply of the greviewed. The facility any changes or continuance macy within 72 hours. The sof Guardian Pharmacy and Operations of the facility the sof Guardian Pharmacy and Operations of the facility the sof Guardian Pharmacy and Operations of the facility the sof Guardian Pharmacy and Operations of the facility the sof Guardian Pharmacy and Operations of the facility the sof Guardian Pharmacy and Operations of the facility the sof Guardian Pharmacy and Operations of the facility the sof Guardian Pharmacy and Operation of Soft Pharmacy and Operation of Soft Pharmacy and Operations of the soft Pharmacy Consultant of Pharmacy could not deliver a lity. The Regional Nurse Consultant of Pharmacy ordered medications are available in the conservation of medication of the third floor of Pharmacy Pharmacy Pharmacy Operation of Marcy and Pharmacy Operation of Marcy and Regional Don on the third floor of Pharmacy Pharmacy Operation of Marcy and	{F &	337}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
{F 837}	with the Regional DO Consultant, Human R Records, the Houseke Supply, MDS Nurse # Therapy Manager, the the Administrator, the Dietary Manager, and administration team. 27). Interview with the Operations on 09/30/201 at 5:05 Pl appointed the current 09/30/2021 at 5:05 Pl appointed the current 09/13/2021. Further in Operations revealed s Administrator with dai 09/10/2021. 28). Interview with the 09/30/2021 at 3:25 Pl committee, including the Consultant on 09/30/2021 at 3:25 Pl committee, including the Consultant on 09/30/2021. 29). Interview with the Operations on 09/30/2021. 29). Interview with the Operations on 09/30/2021.	a meeting on 08/12/2021 N, Regional Nurse esources, SSD #2, Medical eeping Supervisor, Central 1, MDS Nurse #2, the e Admissions Coordinator, e Activities Director, the 1 other members of the 2021 at 4:10 PM and erim Administrator on M revealed the facility Interim Administrator on therview with the VP of she had provided the Interim ly oversight since e Interim Administrator on M, the Medical Director on M and members of the QAPI the Regional Nurse 2021 at 3:40 PM, revealed cting staff for call-ins, ADL Care, serving and timely, incontinence care ing were reviewed on e Vice President of 2021 at 4:10 PM, Regional 20/30/2021 at 3:40 PM, and s Nurse Consultant on M revealed the facility	{F 8	37}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
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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	IDE	<u>j 09/</u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF		ON SHOULD BI		(X5) COMPLETION DATE
{F 837}	outlined in the Rules a determined a plan for communication/moniti- and COVID-19 isolatic facility to monitor/asse reposition residents, p prepare and distribute residents with eating, effective Pharmacy Sc and neglect effectively appropriate ADLS, an QAPI committee. 30). Interview with the 09/30/2021 at 3:40 PM Consultant on 09/30/2 reviewed and revised presented the reviews Committee during the facility developed a st all topics were reviews meetings. The plan in Foley catheters, enter contractures, physical usage, risk manageme hospital re-admission management, social s grievance, activities, re council concerns and/ discharges, census, s by department/position dietary variance tray a work injuries, terminat medical leave of abse new hires, medical re pharmacy reports, res office, and admission a Committee and Medic	the following pring 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 of a sufficient staff, providing of providing a functioning. Interim Administrator on of the QAPI plan and the QAPI Plan and the QAPI Plan and the QAPI plan to ensure ed as needed at the QAPI cluded pressure ulcers, all feeding tubes, restraints, medication ent, infection control, the rate, rehabilitation ervices, concerns of esident council, and family or grievances, admissions, that development, openings on, employee orientations, udit report, weight losses, ions, employees on family ince or leave of absence, cord compliance review, torative nursing, business	{F 8	B37}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			3012021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		(X5) COMPLETION DATE
{F 837}	but not be limited to the the meeting. Interview 09/30/2021 at 1:39 Pt 09/30/2021 at 1:31 Pt Manager on 09/28/20 09/30/2021 at 1:52 Pt Director/Dietary Mana 1:30 PM, Medical Rec AM, Human Resource 09/30/2021 at 10:48 A 09/30/2021 at 1:18 Pt Supervisor on 09/30/2 Respiratory Therapist 12:45 PM and Central 2:40 PM, revealed the at the QAPI meeting the Operations on 09/30/2 Administrator on 09/30/2 Director on 09/30/202 meeting was conducted the duties of the Gove policy and procedures facility and communic members of the Gove meeting, the QAPI proparticipate regularly in need to identify root outilization of the "5 which systems per the QAPI 32). Interview with the 09/30/2021 at 3:40 Pt monitoring reports befand reviewed the data QAPI attendance sheet	with MDS Nurse #1 on M, MDS Nurse #2 on M, Regional Certified Dietary 21 at 2:26 PM and M, Former Activities ager #3 on 09/30/2021 at 3:34 a 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 sinformation was presented held on 09/16/2021. E. Vice President of 2021 at 3:40 PM, DON #2 PM, and the Medical 1 at 3:25 PM revealed a ged on 09/16/2021 regarding arning Body including setting to be implemented in the ating information to other rining Body. During the	{F 8	337}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	09	30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		20	DO NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 837}	of Operations on 09/3 Regional Nurse Cons PM revealed they wer governing body, and of forwarded to them. 33). Interview with the Operations on 09/30/2 Regional Nurse Cons PM revealed the gove Administrator with res material for QAPI. Fur governing body would upcoming year. Interv	view with the Vice President 0/2021 at 4:10 PM and ultant on 09/30/2021 at 3:40 re members of the QAPI meetings had been 2021 at 4:10 PM and the ultant on 09/30/2021 at 3:40 rning body provided the ources and education ther interviews revealed the meet quarterly for the iew with the Interim 0/2021 at 3:40 PM revealed with resources and	{F &	37}			
	09/30/2021 at 3:40 PM were conducted week ensure the quality of complied with the star compliance. Further in President of Operation PM, Regional Nurse C3:40 PM, MDS Nurse PM, MDS Nurse #2 on Regional Certified Die 09/28/2021 at 2:26 PM PM, Former Activities #3 on 09/30/2021 at 1 on 09/29/2021 at 8:34 Director (HR) on 09/30 Therapy Manager on thousekeeping Superv PM, Respiratory Therapy Manager on PM, Respiratory Thera	ndard of care and interview with the Vice ins on 09/30/2021 at 4:10 Consultant on 09/30/2021 at #1 on 09/30/2021 at 1:39 in 09/30/2021 at 1:31 PM, tary Manager on If and 09/30/2021 at 1:52 Director/Dietary Manager :30 PM, Medical Records AM, Human Resource					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING				₹ 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	COMPLETION DATE
{F 837}	weekly QAPI meeting and 09/23/2021. In ad Medical Director/Phys 3:25 PM revealed he QAPI meetings on 09 Further interview with 09/30/2021 at 3:40 Pmeeting had been conview of the facility 0 sheet reflected the abidentified concerns. 35). Interview with RNAM and 09/30/2021 at 3:40 Pmeeting had been concerns. 35). Interview with RNAM and 09/30/2021 at 12:409/29/2021 at 3:00 Pmm LPN #10 on 09/30/2021 at 09/29/2021 at 3:40 Pmm Minus P	y had participated in the is conducted on 09/16/2021 idition, an interview with the sician #1 on 09/30/2021 at participated in the weekly /16/2021 and 09/23/2021. It is interimed the weekly QAPI inducted on 09/30/2021. A DAPI meeting attendance bove interviews with no over interviews with no with the interimed the weekly QAPI inducted on 09/30/2021. A DAPI meeting attendance bove interviews with no over interview interview interview interview interview interview over interview with nursing of over interview with nursing interview with nursing interview interview with nur	{F 8	337)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	136		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING				₹ 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	- 1	(X5) COMPLETION DATE
{F 837}	Manager (CDM) on ditimely nutritional asset order accuracy. When the electronic medical the order sends writted dietary staff, which industries the tray card system to orders. She stated that so the tray card system to orders. She stated that previous day would be meeting. Interview with 09/28/2021 at 2:26 Pt PM revealed she comported from the composition of the compositi	eived education on gional Certified Dietary iet order accuracy and essments to ensure diet in staff enter diet orders into I record, the nurse entering in communication to the cludes diet and texture. She she entered the order into io reflect the resident's diet at all diet orders from the erviewed in the clinical in the Regional CDM on M and 09/30/2021 at 1:52 inpleted education with ctor/Dietary Manager #3. In that she had been on site to isistance during the transition I #1 on 09/29/2021 at 11:55 it 12:58 PM, RN #4/Vound 2021 at 2:54 PM, LPN #6 if PM, LPN #7 on M and 09/30/2021 at 1:54 30/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on	{F 8	337}			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		3) DATE SURVEY COMPLETED	
		185256	B. WNG			F 09/3	R 30/2021	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,0		
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER			00 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 837}	revealed she provide beginning on 08/19/2 turning/repositioning, transferring a resider 38). Interview with RI AM and 09/30/2021 at 2: 09/29/2021 at 3:00 PM, LPN #10 on 09/#11 on 09/30/2021 at 3:40 PO/29/2021 at 3:40 PO/29/2021 at 3:40 PO/29/2021 at 3:29 PM, SRNA #SRNA #21 on 09/29/00 on 09/29/2021 at 3:10 Peducation on pressulturning and reposition nutrition, Positioning and document a hea and how to notify the RP of a new skin impor email the Register and the resident's rechanges. Interview wo Consultant on 09/30. Regional DON on 09/20/201 revealed they educa prevention including adequate hydration indevices, how to comhead-to-toe skin assithe registered dieticinew skin impairment	d staff with education d staff with education does not regarding range of motion, and at from bed. N #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound d/2021 at 2:54 PM, LPN #6 44 PM, LPN #7 on d and 09/30/2021 at 1:54 d/30/2021 at 12:50 PM, LPN d 10:31 AM, SRNA#1 on dM, SRNA#11 on dM, SRNA#11 on dM, SRNA#11 on dM SRNA#22 de on 09/29/2021 at 4:10 PM, does not be detected they received dre ulcer prevention including ning, adequate hydration and devices, how to complete d-to-toe skin assessment, de registered dietician, MD and doesirment. The nurse will call dred Dietitian, the physician, presentative with any	{F 8	337)				
	Registered Dietitian	for new recommendations,						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	SURVEY LETED
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		185256	B. WNG	_		09/	30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
(F 837)	at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 Pl Director (HR) on 09/3 Marketing Liaison on Medical Records on 0 Central Supply on 09/#3 on 09/29/2021 at 109/30/2021 at 2:10 Pl Director/Dietary Mana 1:30 PM revealed the timely call light respor with RN #1 on 09/29/20/2021 at 12:58 P Nurse on 09/30/2021 at 12:58 P Nurse on 09/30/2021 at 12:44 Pa 3:00 PM and 09/30 on 09/30/2021 at 12:44 Pa 3:00 PM and 09/30 on 09/30/2021 at 10:31 PM at 3:17 PM and SRNA PM, revealed they recall light response, proresident plan of care, staff dress residents in clothing and timely de interview with Cook #3 Dietary Aide #3 on 09	DS 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 0:48 AM, Senior 09/30/2021 at 10:48 AM, Senior 09/30/2021 at 10:55 AM, 19/29/2021 at 2:40 PM, Cook 1:12 PM, Dietary Aide #3 on M, Former Activities ager #3 on 09/30/2021 at 12:40 PM, Cook 1:12 PM, Dietary Aide #3 on M, Former Activities ager #3 on 09/30/2021 at 12:55 AM and 12:55 AM and 13:55 AM and 14:55 AM and 15:54 PM, LPN #6 on 15:54 PM, LPN #6 on 16:54 PM, LPN #10 in 16:55 PM, SRNA #1 on 09/29/2021 it 16:55 PM, SRNA #1 on 09/29/2021 it 16:55 PM, SRNA #19 in 16:55 PM, SRNA #21 on 16:55 PM, SRNA #21 on 16:55 PM, SRNA #22 on 09/29/2021 it 16:55 PM, SRNA #21 on 16:55 PM, SRNA #22 on 09/29/2021 it 16:55 PM, SRNA #21 on 16:55 PM, SRNA #22 on 09/29/2021 it 16:55 PM, SRNA #21 on 16:55 PM, SRNA #22 on 09/29/2021 it 16:55 PM, SRNA #21 on 16:55 PM, SRNA #22 on 09/29/2021 it 16:55 PM, SRNA #21 on 16:55 PM, SRNA #22 on 09/29/2021 it 16:55 PM, SRNA #21 on 16:55 PM, SRNA #22 on 09/29/2021 it 16:55 PM, SRNA #23 on	{F 8	337}			
		A revealed they received					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY
		185256	B. WING_			R 20/2024
	ROVIDER OR SUPPLIER POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ÐBE	(X5) COMPLETION DATE
{F 837}	at 1:39 PM, MDS Nur PM, RN #1 on 09/29/2 09/30/2021 at 12:58 F Nurse on 09/30/2021 09/30/2021 at 12:44 F at 3:00 PM and 09/30 on 09/30/2021 at 12:5 09/30/2021 at 10:31 A education on ensuring entered into the electr Observation of RN #1 revealed the nurse was	OS Nurse #1 on 09/30/2021 se #2 on 09/30/2021 at 1:31 2021 at 11:55 AM and PM, RN #4/Wound Care at 2:54 PM, LPN #6 on PM, LPN #7 on 09/29/2021 /2021 at 1:54 PM, LPN #10 60 PM, LPN #11 on M revealed they received g new care plans were	{F 8	37)		
	AM and 09/30/2021 at Care Nurse on 09/30/2021 at 12:4 09/29/2021 at 3:00 PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PM 09/29/2021 at 3:29 PM, SRNA #15 SRNA #21 on 09/29/2 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PM education on identificates idents with a change on identifying signs/sy hyperglycemia/hypogl protocol, documentate medical record, notificates at 12:20 PM 12:	M and 09/30/2021 at 1:54 0/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on M, SRNA #11 on M SRNA #7 on 09/29/2021 9 on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA #22 7 PM and SRNA #23 on M revealed they received ation and assessment of ge in respiratory status and mptoms of ycemia, facility diabetic g resident change in tion of blood sugar in the tation of the physician and ders. In addition, interviews				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WNG				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO			COMPLETION DATE
{F 837}	AM and 09/30/2021 at Care Nurse on 09/30/on 09/30/2021 at 12:4 09/29/2021 at 3:00 PI PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PI 09/29/2021 at 3:40 PI 09/29/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PI education on complet with interventions and diagnosis of diabetes within forty-eight hour reviewing and providing resident/responsible put 44). Interview with ME at 1:39 PM, MDS Nur PM, Maintenance Assessible 1:18 PM, Housekeepi 09/30/2021 at 1:24 PM Director (HR) on 09/3 Marketing Liaison on Medical Records on 00 Central Supply on 09/0 on 09/29/2021 at 1:54 PM 12:58 PM, RN #4/Wor 09/30/2021 at 1:54 PM at 12:50 PM, LPN #1	##1 on 09/29/2021 at 11:55 ##1 on 09/29/2021 at 11:55 ##1 12:58 PM, RN #4/Wound ##2021 at 2:54 PM, LPN #6 ##4 PM, LPN #7 on ## and 09/30/2021 at 1:54 ##0/2021 at 12:50 PM, LPN ##10:31 AM, SRNA #1 on ##M SRNA #11 on ### SRNA #11 on ### SRNA #7 on 09/29/2021 ##9 on 09/29/2021 at 4:10 PM, ##021 at 3:04 PM, SRNA #22 ### and SRNA #23 on ###, revealed they received ing a baseline Care Plan ### goals relevant to the and a respiratory diagnosis is of admission, and ing a copy to the party. ### OS Nurse #1 on 09/30/2021 ### se #2 on 09/30/2021 at 1:31 ### isistant #1 on 09/30/2021 at 1:31 ### inager on 09/30/2021 at 1:31 ### inager on 09/30/2021 at 1:35 ### inager on 09/30/2021 at 1:36 ### inager on 09/30/2021 at 1:37 ### in	{F &	337}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMP	SURVEY
		405350				1	R
		185256	B. WING			09/	30/2021
NAME OF PI	ROVIDER OR SUPPLIER			ı	STREET ADDRESS, CITY, STATE, ZIP CODE		-
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		THE LATION OF LEVE			PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
(F 837)	11-5-		{F 8	337	77)		
		3:23 PM SRNA #7 on					
	09/29/2021 at 3:29 PN	W, SRNA #19 Alde on M, SRNA #21 on 09/29/2021					
i		2 on 09/29/2021 at 3:17 PM					
		/29/2021 at 4:10 PM, Cook					
		1:12 PM, Dietary Aide #3 on					
	09/30/2021 at 2:10 PM						
		ager #3 on 09/30/2021 at					
		y were educated on the					
		, preventing, and reporting	1				
		tifying and implementing	!				
	immediate intervention	ns for wandering residents.					
		#1 on 09/29/2021 at 11:55					
		t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6					l i
	on 09/30/2021 at 12:4						
		M and 09/30/2021 at 1:54					
		0/2021 at 12:50 PM and					
		21 at 10:31 AM revealed					
	they received education						
	techniques, obtaining,						
		anges to the Registered					
	Dietician. In addition,	an interview with the Dietary					
	Manager on 09/30/203	21 at 1:30 PM revealed she					
		on on diet order accuracy					
		y nutritional assessment to					
		uracy. When the diet orders					
		onic medical record, the					
	nurse entering the ord						
		dietary staff that will include					
		further revealed all diet ous day are reviewed in the					
		ous day are reviewed in the occurs Monday through					
	Friday, to ensure accu						
	aay, to ensure door	naoy.					
	46). Interview with the	Dietary Manager on					
		Virevealed she received					
		olicy regarding meal service			N.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE COMP	SURVEY
		185256	B. WNG			1	R 30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	, 557	50/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
{F 837}	times and the use of refortified diets to ensur nutritional needs of reestablished national gcultural, and ethnic needs of reestablished national gcultural gcultu	ecipes, including recipes for e all meals meet the sidents in accordance with uidelines to reflect religious, eds of the population. Dietary Manager on of revealed she received g food preference, facility er placement for meals, appropriate scoop sizes stocking snack/hydration hydrations. H10 n 09/29/2021 at 11:55 t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 4 PM, LPN #7 on of and 09/30/2021 at 1:54 00/2021 at 12:50 PM, LPN 10:31 AM and Former tary Manager #3 on of revealed they received ess for entering, activating, he registered dietician's dietary orders. Interim Administrator on of the MDS Nurse #1 on of MMS Nurse #2 on of MMS Nurse #2 on of MMS Nurse #2 on of MMS Manager on of MMS Therapy Manager on	{F 8	37}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		NSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING				R
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200 N	ET ADDRESS, CITY, STATE, ZIP CODE IURSING HOME LANE EVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{F 837}	09/30/2021 at 12:58 f Nurse on 09/30/2021 09/30/2021 at 12:44 f at 3:00 PM and 09/30 on 09/30/2021 at 12:5 09/30/2021 at 10:31 / at 3:40 PM, SRNA #' SRNA #7 on 09/29/20 on 09/29/2021 at 4:10 09/29/2021 at 3:04 Pl at 3:17 PM and SRN/ PM, Cook #3 on 09/2 Aide #3 on 09/30/202 Activities Director/Die 09/30/2021 at 1:30 Pl received education or policy/guidelines, han Personal Protective E red zones. Observationand yellow zone on 0' revealed no identified were in the red or yell conducted on 09/28/2 09/30/2021 revealed in the COVID-19 policy/ donning/doffing Perso (PPE), or the yellow/r	/2021 at 11:55 AM and PM, RN #4/Wound Care at 2:54 PM, LPN #6 on PM, LPN #7 on 09/29/2021 //2021 at 1:54 PM, LPN #10 FM, SRNA #1 on 09/29/2021 fm, SRNA #1 on 09/29/2021 fm, SRNA #21 on M, SRNA #21 on M, SRNA #21 on M, SRNA #22 on 09/29/2021 fm, SRNA #21 on M, SRNA #23 on 09/29/2021 fm, SRNA #21 on M, SRNA #19 OP/2021 at 2:12 PM, Dietary I at 2:10 PM, Former I tary Manager #3 on M revealed they had on the COVID-19 I dwashing, donning/doffing iquipment (PPE), yellow and on of the red facility zone 19/28/2021 at 2:12 PM Concerns. No residents I was cones. Observations I concerns with I guidelines, handwashing, I on 109/29/2021, and I on identified concerns with I guidelines, handwashing, I on 109/29/2021 at 11:55	(F 8	37}			
	Care Nurse on 09/30/ (LPN) #6 on 09/30/20 #7 on 09/29/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/20 they had received edi symptom monitoring of	at 12:58 PM, RN #4/Wound (2021 at 2:54 PM, LPN (21 at 12:44 PM, LPN (LPN) (3:00 PM and 09/30/2021 at (09/30/2021 at 12:50 PM, (21 at 10:31 AM revealed (ucation entering COVID-19 (orders on all new (of newly admitted Resident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10.5		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING			ŀ	30/2024
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u> </u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 837}	COVID-19 symptom resident orders. Resident orders. Resident 09/28/2021 and re 09/28/2021. A review Resident #355 reveal COVID-19 symptom resident orders. In ad #329, #328, #311, #6 records revealed each monitoring orders imp 51). Interview with RN AM, and 09/30/2021 at 31:54 PM, LPN #10 on LPN #11 on 09/30/2021 at 31:54 PM, LPN #10 on LPN #11 on 09/30/2021 they had received edd of medication, right patie and right route. In ad on the process to follow the pharmacy is obtaining the anticipal notifying the pharmacy is obtaining the anticipal notifying the physician would either be omitted ordered medication the included following new physician, documenting new orders from the Marcord.	evealed the resident had monitoring entered in the dent #355 was discharged -admitted to the facility on of re-admission for ed the resident had a monitoring entered in the dition, a review of Resident 5, and #90's medical n resident had COVID-19 elemented. If #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN (LPN) 2:00 PM and 09/30/2021 at 09/30/2021 at 10:31 AM revealed acation on the five (5) rights ent, right dose, right time, dition, they were educated by when a medication was nistration, which included to obtain the medication, and medication delivery time, of an ordered medication also worders given by the gent the electronic medical at 11:55 at 11:55.	{F 8	337}			
	AM and 09/30/2021 a Care Nurse on 09/30/	t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN 21 at 12:44 PM, LPN (LPN)					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		185256	B. WING_				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 200 NURSING HOME LANE PIKEVILLE, KY 41501	ЭE	03,1	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 837}	1:54 PM, LPN #10 on LPN #11 on 09/30/202 they had received educemergency medication floor three (3) on 09/22 four (4) on 09/29/2021 at 2 medication administration with an emergency m LPN (LPN) #9 on 09/3 she was a new hire to received education remedication kit. 53). Interview with DC PM, MDS Nurse #1 or MDS Nurse #2 on 09/Maintenance Assistan PM, Therapy Manage Housekeeping Supen PM, Human Resource 09/30/2021 at 10:48 A Liaison on 09/30/2021 Records on 09/29/2021 Cog/29/2021 at 11:55 APM, LPN (LPN) FPM, LPN (LPN) FPM, LPN (LPN) FPM, LPN (LPN) FPM, LPN (LPN) #11 AM, SRNA #1 on 09/29/2021 at 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #2 SRNA #22 on 09/29/2021 at #23 on 09/29/2	2:00 PM and 09/30/2021 at 09/30/2021 at 12:50 PM, 21 at 10:31 AM revealed acation on the use of the n kit (e-kit). Observation of 9/2021 at 3:10 PM, floor 1 at 2:57 PM, and floor five 2:50 PM revealed each tion room was equipped edication kit. Interview with 80/2021 at 2:27 PM revealed at the facility and had garding the emergency 20 N #2 on 09/30/2021 at 1:39 PM, 30/2021 at 1:31 PM, 30/2021 at 1:31 PM, 30/2021 at 1:31 PM, 30/2021 at 1:34 PM, 30/2021 at 1:24 EDirector (HR) on 30/30/2021 at 1:24 EDirector (HR) on 30/30/2021 at 12:58 are Nurse on 09/30/2021 at 12:58 are Nurse on 09/30/2021 at 12:44 09/29/2021 at 3:00 PM and 30/20221 at 3:00 PM and 30/20221 at 3:40 PM, SRNA	(F 8.	37}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3		SURVEY LETED
		185256	B. WNG_			7 190	R 30/2021
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		0311	JUI 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)	JLD BE		(X5) COMPLETION DATE
(F 837)	Abuse Coordinator policy is a completed with physic notifications. Interview 09/30/2021 at 3:53 Ph of new and/or worsening skin impair interventions to preverevealed that he particand discussed ongoin residents. Interview on 09/30/2021 at 5:05 team discussed all aurincluding new and/or wand interventions implements. Interview on 09/30/2021 at 5:05 team discussed all aurincluding new and/or wand interventions implements. Interview with Ce at 2:40 PM revealed sall laboratory supplies revealed that the audit for four (4) weeks and months. A review of air serview of air ser	nd role as Abuse tion of the facility on 21, and 09/30/2021 ted with the Interim et information and title of sted throughout the facility. beginning 09/17/2021 of ein assessments revealed b. Observation of Resident essessment on 09/30/2021 eno identified concerns. A record for Resident #65, #27, #74, and #358 round assessments eian and responsible party with the Dietician on M revealed she was notified eing pressure ulcers and es as indicated. Interview eno 09/30/2021 at 3:25 PM enotified of new and/or ments and new ent decline. He further cipated in QAPI meetings g audits and care of eith the Interim Administrator ept revealed the QAPI dits in QAPI meetings, worsening pressure injuries	(F 8:	37)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		S 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROVIDENCY)			(x5) COMPLETION DATE
{F 837}	identified concerns. 56). Interview with the 09/30/2021 at 4:17 Pt 09/30/2021 at 3:20 Pt were audited during nensure all new areas been care planned withe area of concern. Ano identified concerns 57). Interview with the on 09/30/2021 at 10:5 completed visual roun hygiene, toileting, incorepositioning in additional Review of audits revenails, clothes, body or dry, toileted as requeshair clean and combe clean, call light within applicable and turned 58). Interview with the Operations on 09/30/2 Senior Marketing Liais AM revealed they part monitoring, and monit times including the ler unanswered. Interview activated more than finaddressed with the starevealed they were coand different shifts.	Regional DON on M, and DON #2 on M revealed progress notes norning clinical meetings to of skin impairment had the interventions to address A review of audits revealed is. Senior Marketing Liaison is AM revealed he interventions to address a review of audits revealed is. Senior Marketing Liaison is AM revealed he interventions to address in the interventions to address in the interventions of audits assessing in the intervention of the inte	{F 8	337}			

			(X3) DATE COMP	SURVEY LETED			
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 APPROPR DEFICIENCY)			(X5) COMPLETION DATE
{F 837}	clinical meeting. She assessed to ensure the respiratory status and completed had physici implementation of phy Resident #315 SBAR #324 SBAR complete completed on 08/15/2 physician notification, plans updated as indirevealed no identified 60). Review of Reside admitted on 09/10/202 had a baseline care p 09/10/2021. Resident 09/25/2021 and re-ad 09/28/2021. Further refor Resident #355 rev comprehensive care p (11) days after admission for Resident had a baselin 09/28/2021. Interview 09/30/2021 at 1:39 Ph 09/30/2021 at 1:31 Ph admissions and re-ad being reviewed during meeting Monday throucompletion. 61). Review of the add days from 07/16/2021 concerns with baselin MDS Nurse #1 on 09/ revealed new/admissions.	ay through Friday in the further revealed that she hat any acute change in /or SBAR assessments ian notification and/or visician orders. Review of completed on 09/26/2021, d on 09/27/2021, and #326 021 revealed assessment, interventions, and care cated. A review of audits concerns. Int #355, who the facility 21, revealed the resident lan developed on #355 was discharged on mitted to the facility on eview of the medical record ealed staff completed the plan on 09/21/2021 (elevention). A review of dent #355 revealed the recare plan developed on with MDS Nurse #1 on M and MDS Nurse #2 on M revealed all new missions to the facility were of the morning clinical uph Friday to ensure	{F 8	37}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B, WING				R 30/2024
	ROVIDER OR SUPPLIER POST-ACUTE AND RE	HABILITATION CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		_	(X5) COMPLETION DATE
{F 837}	at 1:39 PM revealed of plans were being aud completion, accuracy was conducted with the responsible party with admission/re-admission/r	DS Nurse #1 on 09/30/2021 new admission baseline care ited Monday-Friday for , and to ensure a review ne resident and/or nin 48 hours of on. Further interviews ere conducted Monday iew of the audits completed d resident name, admission an completion, care plan and/or responsible party, ided. A review of the audits concern with completion dits completed by the DM they were completed as ed concerns. Interview with I Dietary Manager on M and 09/30/2021 at 1:52 ager #3 on 09/30/2021 at ys were audited for to in the unit and were passed quizzes revealed ten (10) uizzed for one (1) week 21 with no needed yiew of verbal quizzes members were quizzed for 8/22/2021 and completed or identified concerns. A uiz revealed staff was y status, and SBAR/physician with the Regional Nurse	{F 8	337)			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER	<u> </u>	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 837}	on 09/30/2021 at 1:31 performed verbal quiz assessment of reside respiratory status, ide hyperglycemia/hypog protocol, documenting condition, notification following physician or on 09/29/2021 at 11:512:58 PM, RN #4/Wo 09/30/2021 at 2:54 Pt 09/30/2021 at 12:44 F participated in verbal 65). Interview with the 09/30/2021 at 4:17 Pt audits of documented Monday through Frida She further revealed to less than 60 and/or gr staff were expected to Responsible Party, ar follow physician order stated she identified to 08/12/2021 to have a and one (1) on 09/20/glucose level of 465 we evidence the licensed process. She provider and LPN #5. A Review further concerns. A Re RN #2 and LPN #5 re the facility process.	B:20 PM, and MDS Nurse #2 I PM revealed they rzes for identification and ints with a change in shiftying signs/symptoms of lycemia, facility diabetic g a change in a resident's of the physician and ders. Interviews with RN #1 i5 AM and 09/30/2021 at und Care Nurse on M, LPN (LPN) #6 on PM, revealed they quizzes with facility staff. Regional DON on M revealed she completed blood glucose levels ay in the clinical meeting. that with any blood sugar reater than 40, the facility onotify the physician, and Registered Dietician and rs. The Regional DON one (1) resident on blood glucose level of 430 incompleted in urse followed the facility deducation to both RN #2 w of audits revealed no eview of education revealed ceived education regarding staff quizzes revealed staff gns and symptoms of abuse	{F 8	337}			
		and symptoms of wandering entions. A review of the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING				R 30/2021
NAME OF P	ROVIDER OR SUPPLIER		'	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 051	0012021
PARKVIE	V POST-ACUTE AND RE	HABILITATION CENTER			NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		_	(X5) COMPLÉTION DATE
{F 837}	quizzed daily for one 08/19/2021 with no id review revealed verbathree (3) times a wee 08/21/2021 to 09/02/2 concerns. A review of that verbal quizzes with the everbal quizzes with the everbal quizzes with the everbal quizzes with the everbal to 09/30/2021 to 09/24/2 concerns. Interview with the everbal to 09/30/2021 at 1:39 Plothe completion of verification of verification of the everbally quizzed on the everbally everbal	ed five (5) staff were verbally (1) week from 08/13/2021 to entified concerns. Further all quizzes were conducted by for two (2) weeks from 2021 with no identified in the verbal quizzes revealed are conducted one (1) time weeks from the week of 2021 with no identified with the Regional Nurse 2021 at 3:40 PM, RDON on M, and MDS Nurse #1 on M revealed each assisted in a staff quizzes. Further at each staff member was at eareas listed on the audit oms of abuse, when to ptoms of wandering and ans), and any need for attend immediately with each SRNA #11 on 09/29/2021 at 2:44 to 09/29/2021 at 3:00 PM and M, RN #1 on 09/29/2021 at 2:54 PM, 20/29/2021 at 2:54 PM, 20/29/2021 at 2:40 PM, 20/29/2021 at 1:18 PM, visor on 09/30/2021 at 1:24 at Director (HR) on	{F 8	337}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	PLE CONSTRUCTION IG	1 '	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR	SUPPLIER	<u> </u>	T	STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	/30/2021	
PARKVIEW POST-AC	UTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	COMPLETION DATE	
revealed of wandering 09/10/202 09/25/202 09/28/202 Resident admission on 09/28/, be at risk Nurse #1 MDS staff assessme Regional PM and Drevealed a in the more appropriate wandering Further in identified discussed intervention with a BIM identified interviews (10) reside weeks the Interview and MDS revealed to with reside of audits in random we with a BIM there are no identified.	g risk assess 21. Resident 21. A review #355 reveal a wandering 2021. The re for wandering 2021. The re for wandering con 09/30/20 f will schedu ents to ensur Nurse Cons ON #2 on 0 all-new adm ming clinical te assessme g risk assess terviews rev as at risk for d during this ons impleme ew of interview en five (5) re with ISSD o Nurse #1 or they were as ents with no nitiated on 0 eekly skin a MS score of l no injuries of ed concerns ed concerns	had an admission sment completed on #355 was discharged on mitted to the facility on of re-admission for ed the resident had an risk assessment completed esident was not identified to ng. Interview with MDS 21 at 1:39 PM revealed that le wandering risk re completion. Interview with ultant on 09/30/2021 at 3:40 9/30/2021 at 3:20 PM issions would be reviewed meeting to ensure ents, including the sment, had been completed. ealed that residents r wandering would be meeting and appropriate	{F 83	37)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		09/30/2021	
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1.7.	HOULD BE	COMPLETION DATE	
{F 837}	were completing audi identified concerns. Of assessment on 09/30 9:23 AM and on 09/31 Resident # 27 revealed of unknown origin. 69). Interview with the 09/30/2021 at 3:53 Plaudits on 08/25/2021 electronic medical regin the diet/tray card serview of Resident # 09/29/2021 at 12:04 on 09/29/2021 at 12:04 on 09/29/2021 at 12:04 fray card on 09/28/2021 at 1:30 Plauding breakfast at PM, and dinner at 5:09/28/2021 at 5:03 Plaud been served on 09/29/2021 lunch	21 at 3:20 PM revealed they its as indicated with no observation of skin b/2021 of Resident #45 at 0/2021 at 10:20 AM of ed no concerns with injuries e Registered Dietician on M revealed she started of resident diet orders from cords against orders entered oftware to ensure accuracy. 308's tray card on PM, Resident #39's tray card on PM, and Resident #334 (21 at 12:30 PM revealed ordered by the physician. A aled audits were conducted eeks. eted audits revealed random wice daily for one (1) week 1. Starting 08/30/2021, observed two (2) times per ks and then weekly from 1) month. Interview with ector/Dietary Manager #3 on M, Regional Certified Dietary 121 at 2:26 PM, and M revealed audits were	{F 8	37)			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER	J	20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	09/	30/2021
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(F 837)	fifth floor at 12:34 PM 71). Review of Reside 09/29/2021 at 12:04 For 09/29/2021 at 12:04 For 09/29/2021 at 12:04 For 09/29/2021 at 12:05 Itray card on 09/29/20 meals honored reside likes and dislikes. Interview of a were audited daily for 09/15/2021 to 09/21/2 audits revealed snack beginning on 09/22/20 Regional Certified Die 09/28/2021 at 2:26 PI PM revealed she aud not identified any con 72). Interview with the (HR) on 09/30/2021 at completed audits for 09/28/2021, 09/29/20 revealed no concerns. Observation 09/28/2021, 09/29/20 revealed no concerns. 73). Interview with the on 09/30/2021 at 3:40 at 4:17 PM, DON #2 of and Interim Infection 09/30/2021 at 3:10 PI being conducted with handwashing, isolation.	M and 12:24 PM, and the and 12:49 PM. ent #308's tray card on PM, Resident #39's tray card 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 the preferences into the udits revealed snack intakes one (1) week from 12:21. Further review of the sewere audited weekly 12:21. Interview with the etary Manager on PM and 09/30/2021 at 1:52 at 10:48 AM revealed she daily staff screening against the revealed no identified of entry doors on 12:41, and 09/30/2021 at 3:20 PM, Control Nurse on PM, RDON on 09/30/2021 on 09/30/2021 at 3:20 PM, Control Nurse on PM, Con	{F 8	37)			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE DO NURSING HOME LANE IKEVILLE, KY 41501		
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{F 837}	immediately. A review were conducted begin 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 09/30/2021 at 1:54 PM, LPN #10 on LPN #11 on 09/30/20 concerns with obtaining and/or receiving medication pass on the third floor and 09/20 revealed no identified medications. In additinarcotic count on the 12:50 PM revealed no 12:50 PM revealed no 12:50 PM revealed no 13:44 responsible for complements and residents not having counts. A review of a utilized the Centers for Element Pathway for conduct the medication revealed a minimum	concerns will be addressed of the audits revealed they noting 09/17/2021 on random a Regional Nurse Consultant DPM revealed she was not oother members to nother members to nother members to nother script is on file 1. A review of audits revealed so. RN #1 on 09/29/2021 at 2021 at 12:58 PM, LPN 021 at 12:44 PM, LPN (LPN) 3:00 PM and 09/30/2021 at 10:9/30/2021 at 10:31 AM revealed noting scripts for medications ications timely. Observation in 09/29/2021 at 4:35 PM on	{F 8	337}			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER	<u> </u>	2	TREET ADDRESS, CITY, STATE, ZIP CODE 100 NURSING HOME LANE PIKEVILLE, KY 41501	1 09	/30/2021
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{F 837}	observations revealed administration was obtincluding 6:00 AM to 6:00 AM. 76). Interview with the on 09/30/2021 at 3:40 09/30/2021 at 3:20 Pt delivery tickets were to meetings Monday thromedications. A review identified concerns. 77). Interview with the 09/30/2021 at 5:05 Pt Consultant on 09/30/2021 at 4:17 Pt 09/30/2021 at 3:20 Pt being audited daily be ensure adequate staff review of the audits reconcerns. 78). Interview with the 09/30/2021 at 5:05 Pt on 09/30/2021 at 1:30 being monitored daily staffing. A review of thidentified concerns. 79). Interview with the Operations on 09/30/2021 at 1:30 daily audits had been	urther review of medication of that medication of that medication previewed on random shifts, 6:00 PM and 6:00 PM to expected and the Don on the property of the audit revealed no expected of the audit revealed no expected staffing was regional Nurse and the Don on the proviewed staffing was regional notation of the proviewed staffing was represented by the proviewed staffing was to ensure adequate the audits revealed no expected the proviewed staffing was to ensure adequate the audits revealed no expected the proviewed staffing was to ensure adequate the audits revealed no expected the proviewed staffing was to ensure adequate the audits revealed no expected the proviewed staffing was to ensure adequate the audits revealed no expected the proviewed staffing was to ensure adequate the audits revealed no expected the proviewed staffing was to ensure adequate the audits revealed no expected the proviewed staffing was to ensure adequate the audits revealed no expected the proviewed staffing was to ensure adequate the audits revealed the proviewed staffing was to ensure adequate the audits revealed the proviewed staffing was to ensure adequate the proviewed staffing was to ensure adequate the proviewed staffing was to ensure adequate the proviewed staffing was the proviewed the	{F 8	337}			
	80). Interview with the	Senior Marketing Liaison					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION G		(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	1 05	130/2021	
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(F 842) SS=D	identify any change in interviews revealed if identified, staff would An audit review revealed an audit review revealed for interviews revealed for interview of the question interviews revealed for eview of the question interviews revealed for everyone treating you have? Do you have a the Medical Records AM revealed she concesidents on 09/25/20 identified no concern Resident Records - Identified for interviews revealed for everyone treating you have a the Medical Records (identified for concerns Resident Records - Identified for concerns Resident Records - Identified for its dentifiable to accordance with a congress not to use or except to the extent to do so. §483.70(i) Medical residentification in accordance with a congressional standard for interviews for its description.	as an different shifts to a resident condition. Further a change in condition was complete a stop and watch, alled no concerns with the not being addressed by ews performed on a change in concerns. A change in concerns. A change completed during esidents were asked: Is a well? Do you feel safe any concerns? Interview with Staff on 09/29/2021 at 8:34 appleted the interviews with 1021, and she stated she is dentifiable information 483.70(i)(1)-(5) ant-identifiable information that is a change information that is an agent only in antract under which the agent disclose the information the facility itself is permitted cords.	{F 84			11/30/21	

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 N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE		VVIZVZ 1	
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{F 842}	all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, paraperations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research properations, for a serious threat to he by and in compliance §483.70(i)(3) The factive formation agrunauthorized use. §483.70(i)(4) Medical formation of time (ii) Five years from the there is no requireme (iii) For a minor, 3 years legal age under State §483.70(i)(5) The me	ented; e; and ganized ility must keep confidential ned in the resident's records, n or storage method of the release is- or their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, poses, organ donation surposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. Ility must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches	{F 8	42}				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION		
{F 842}	provided; (iv) The results of any and resident review endeterminations conduct (v) Physician's, nurse' professional's progres	ident's assessments; ve plan of care and services preadmission screening valuations and cted by the State; s, and other licensed s notes; and ogy and other diagnostic	{F 8⁴	42}		
	by: Based on interview ardetermined the facility fifty-seven (57) sample #321 and #323) media with accepted professi practices that were conaccurate documentation physician's orders to mer the facility's protocalled to obtain the Resilevels on 07/16/2021 and addition, Resident #32 Administration Recordialled to document that (medication used to local administered on 07/13. The findings include:	mplete and contained on. Resident #321 had nonitor blood glucose levels ol. However, the facility sident #321's blood glucose and on 07/17/2021. In 3's Medication s (MAR) revealed staff at the resident's insulin wer blood glucose) was //2021.		F 842 Resident Records Criteria 1: a) Resident #321 was discharged from the facility on 7-19-202 b) Resident #323 was discharged from the facility on 7-20-202 Criteria 2: On 11/24/2021 The MARs and blood sugar documentation for current residents with the diagnosis of diabetes were reviewed by the DON/ADON/Corporate Nurse Consultants/Designee to determine that these records were complete and in accordance with the facility protocol Criteria 3: The DON/Designee educate all licensed nurses on identifying signs/symptoms of	21	
	Review of the facility's	policy titled,		signs/symptoms of hyperglycemia/hypoglycemia, facility		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/	30/2021
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{F 842}	2020, revealed the far well-controlled diabeti daily if the resident wa Continued review of the would monitor any residence and a day. The facility indicated, if a resident procedure, had return significant absence, or infection Review of the facility's Documentation", unday the resident's conditionaccidents involving the toward or changes in objective will be documented including assessment findings obtained during indicated, and the signindividual documenting individual documenting of the signing of the facility and only including the facility and only including the signing individual documenting individual documenting of the facility and only including the facility and the facility and only including the facility and	stocol", dated November cility would monitor a c's blood glucose level twice as receiving insulin. The policy revealed the facility sident on intensive insuling the insulin three (3) to four (4) the would also monitor as a was fasting before a led to the facility after a red an acute illness or the care plan goals and mented in the medical revealed the include care-specific details date and/or any unusual legister and title of the ground and title of the ground and title of the ground and the resident on the staff, if the include the resident on the staff of the ground and the resident on the staff of the ground and the resident on the staff of the ground and the resident on the staff of the ground and the resident on the staff of the ground and the resident on the staff of the ground and the resident on the staff of the ground and the resident on the staff of the ground and the resident on the staff of the ground and the resident to have a Brief that us (BIMS) score of	{F 8	42}	diabetic protocol, monitoring to ensure insulin is documented given as ordered documenting resident change in conditi documentation of blood sugar in the medical record, documentation of administration of insulin in the medical record and notification of physician and following physician orders beginning 8-12-2021. Criteria 4 Beginning 11/24/2021 the DO or designee will review 5 random residents recorded blood sugars weekly ensure they are within physician parameters, until substantial compliance is achieved, any blood sugar falling outside parameters will be audited to ensure that the MD/NP was notified and new orders were received and followed Beginning 11/24/2021 the DON/designer will audit 5 random residents weekly the are receiving insulin to ensure insulin is documented in the electronic medical record as ordered, until substantial compliance is achieved Audits will be reviewed monthly in QAPI x3 months the quarterly until in substantial compliance. Criteria 5: Date of compliance: 11/30/2021	N to e dif	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG			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 842}	dated 07/16/2021, revealed interventions listed remonitoring Resident # Review of the Physici 07/16/2021, revealed order for staff to obtain levels as required and Continued review of the revealed staff was to a Glargine Insulin (long blood sugar) every more revealed staff was to a Glargine Insulin (long blood sugar) every more revealed staff was to a Glargine Insulin (long blood sugar) every more revealed staff was to a Glargine Insulin (long blood sugar) every more revealed staff was to a Glargine Insulin (long blood sugar) every more revealed staff was to a Glargine Insulin Record documentation that staff on 07/16/2021, until p 07/18/2021, although staff to conduct diabethypoglycemia/hypergl sugar), there was no a staff completed the more sident's blood gluco of 07/16/2021, or on 0 Interview with License on 07/30/2021, at 11:3 admitted Resident #32 care of the resident or until 7:00 PM. LPN #67 resident's blood gluco ordered, and thought:	321's baseline care plan yealed the care plan did not agnosis of diabetes listed. ed there were no garding obtaining or 321's blood glucose levels. an's Orders dated Resident #321 received an in his/her blood glucose If as needed (PRN). The Physician's Orders administer the resident facting medication to lower forning. 321's Medication If (MAR) and Treatment Ifs (TAR) revealed no faff obtained the resident's iter admission to the facility rior to breakfast on the resident's MAR directed thic monitoring every shift for yeemia (low/high blood documented evidence the onitoring or obtained the se readings on the evening 17/17/2021.	{F 8	42}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(SURVEY PLETED
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	<u> 09/</u>	/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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE OTHE APPROPRIA		(X5) COMPLETION DATE
	07/28/2021 at 4:25 Pl for Resident #321 on PM-7:00 AM on 07/16 #7 stated she obtaine glucose levels as orde what they were. The lidocumented the blood resident's medical recording forgot. Continued interoutinely her and one Aide (SRNA) working struggled to get the clinterview with Resides (Physician #1), on 08/2 revealed he expected document and monitor diabetic residents at a further stated his expected document and monitor diabetic medications to obtain levels on all diabetic revery shift. However, residents might require The DON stated she comonitoring to ensure stocumenting diabetic levels.	ered Nurse (RN) #7 ,on M, revealed that she cared night shift from 7.00 6/2021 and 07/17/2021. RN d the resident's blood ered, but could not recall RN stated she should have d glucose results in the cord, but she guessed she rview revealed that it was State Registered Nurse the entire floor, and she harting completed. nt #231's Physician	{F 84	42}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		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 Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 842}	resident's medical red unable to say how the residents to ensure th were staying within ad staff were not docume 2. Review of Residen	g blood glucose levels in the cord. The Administrator was a facility was monitoring eir blood glucose levels acceptable parameters if the	{F 8	42}			
	07/06/2021 with diagr Metabolic Encephalor Failure, Autistic Dison Mellitus, Dysphagia, f Review of Resident #	noses that included pathy, Acute Respiratory der, Sepsis, Diabetes Pneumonia and Aphasia. 323's Physician's Orders aled orders to administer					
	Humulin-R insulin bef Review of Resident # at 9:00 AM revealed r staff administered the Further review of the	ore meals and at bedtime. 323's MAR for 07/13/2021 to documented evidence resident's Levemir insulin. MAR for 07/13/2021 at Virevealed no documented					
	revealed she was res	mir and Humulin-R, ailed to document the					
	12:05 PM, revealed sidocument on the resid	ON/IDON, on 08/11/2021 at the expected staff to dent's MAR when they dication to a resident. The					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l'''	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	1 007	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		B€	(X5) COMPLETION DATE	
	concern with staff doc administration on the Interview with Adminis 1:50 PM, revealed sh were not documenting insulin on the residen QAPI/QAA Improvem CFR(s): 483.75(g)(2)(§483.75(g) Quality as §483.75(g)(2) The quassurance committee (ii) Develop and imple	the had not identified a cumenting medication MAR. Strator, on 08/10/2021 at e was unaware that staff g the administration of t's MAR. ent Activities iii) sessment and assurance.	{F 84			12/30/21	
	by: Based on interview, refacility's policy, and recorrection submitted was determined the facility performance which measured the sperformance of its plawere implemented, do and the facility maintal. The facility failed to emaintained at 42 CFF Deficiencies were cite 09/24/2020, 11/13/20. On the 12/12/2020 st.	record review, review of the eview of the facility's Plan of for the 12/12/2020 survey, it acility failed to have an improvement program success and tracked the ins to ensure interventions efficiencies were corrected ined substantial compliance insure compliance was 4 483.80 Infection Control. ed during the 07/14/2020, 20, and 12/12/2020 surveys. Invey, Immediate Jeopardy I cited at a Scope and		F 867 QAPI/QAA Improvement Action Criteria 1: An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of Immediate Jeopardy on 09/02/2021 of (F580, F600, F655, F656, F684, F687, F692, F755, F880). However, the ACC could not be verified based on observations, staff interviews, and result of facility documentation. Additional Immediate Jeopardy was identified for (F725, F835, F837, F867). The facility was notified of the Immediate Jeopard on 09/10/2021.	of f the on 5, C view view or y		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	' '		CONSTRUCTION	(X3) DATE COMP	
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		185256	B. WNG				30/2021
NAME OF PR	ROVIDER OR SUPPLIER			Ş.	TREET ADDRESS, CITY, STATE, ZIP CODE		
DADKVIEW	V DOST ACUTE AND DE	HABILITATION CENTER		20	00 NURSING HOME LANE		
PARNVIEV	Y POST-ACUTE AND RE	HABILITATION CENTER		Р	IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	The facility submitted achieved compliance However, the facility (Assurance Performar plans to ensure complimmediate Jeopardy 08/11/2021, at 42 CF (F880). The facility fawere positive for COV to other residents. To COVID-19. Refer to The facility's failure to Assurance Performar Program was in place cause serious injury, to a resident. Immed on 08/11/2021, and w 03/06/2021, at 42 CF (F580), 42 CFR 483. (F600), 42 CFR 483. (F602), 42 CFR 483. (F755) and 42 CFR 483. (F755) and 42 CFR 483. (F755) and 42 CFR 483. (F7880). The facility w Jeopardy on 08/11/20 An acceptable Allega was received on 09/0 removal of the Immed 09/02/2021. However verified based on obs	a Plan of Correction and effective 01/20/2021. failed to implement Quality note Improvement (QAPI) oliance was maintained. was identified again on R 483.80 Infection Control ailed to isolate residents who /ID-19 to prevent the spread wo (2) residents died due to F880. The ensure an effective Quality note Improvement (QAPI) is has caused or is likely to harm, impairment or death liate Jeopardy was identified, was determined to exist on R 483.10 Resident Rights 12 Freedom from Abuse 12 Comprehensive re Plans (F655) (F656), 42 of Care (F684) (F686) 45 Pharmacy Services 183.80 Infection Control as notified of Immediate 021.	{F &	367}	was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 9/26/2021. The State Sun Agency determined the Immediate Jeopardy was removed as alleged duri a revisit conducted on 09/28-30/2021, which lowered the scope and severity the for all tags, while the facility monitors the effectiveness of systemic changes and quality assurance activities. The Governing body has been involved in the development of the QAPI Plan and procedures and any recommended changes. 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) 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: Infect 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 weating, caring for pressure wounds, effective Pharmacy Services, dealing vabuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee The governing body replaced Administrator with an Interim	ng o D ne ne of the s 3) ion with with	
	Immediate Jeopardy	was identified at 42 CFR ces (F725), 42 CFR 483.70			Administrator on 9/13/21. The interim		
	403.35 IYUFSING SERVI	ces (r / 20), 42 UPK 483.70	1		administrator educated all QAPI		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CROSS-REFERENCED TO T				(X5) COMPLETION DATE
(F 867)	Continued From page	Continued From page 994 {F 867}			1		
	Administration (F835)	(F837), 42 CFR 483.75	,	-	committee team members on QAPI		
	Quality Assurance an				Committee Processes and Procedures	. A	
		The facility was notified of			permanent administrator was placed or		
		rdy on 09/10/2021. The			10-01-2021 and he was presented the		
	Immediate Jeopardy				education prior to assuming the role of		
	, ,			ļ	administrator.		
		allegation of compliance	ļ				
		5/2021, which alleged			Criteria 3: The Regional Director of		
	removal of the Immed				Operations and VP of Operations met	with	
	09/26/2021. The Sta				the Administrator, the DON, and the		
	determined the Imme		l		Medical Directors on 9/16/21 regarding	•	
	_	during a revisit conducted on			the duties of the Governing Body inclu	aing	
		i lowered the scope and R 483.10 Resident Rights			setting policy and procedures to be implemented in the facility and		
		orehensive Person-Centered			communicating information to other		
		656), 42 CFR 483.25			members of the Governing Body. Als	0	1
	, , ,	i) (F686), 42 CFR 483.35			reviewed the QAPI/QAA processes, th		
	,	25), and 42 CFR 483.45			need to participate regularly in QAPI	•	
		F755); and to "E" at 42 CFR			process, the need to identify Root Cau	se	
		n Abuse (F600), 42 CFR	,		(we will use the 5 whys) and auditing		
		re (F692), 42 CFR 483.70			systems per the QAPI Calendar. Durin	g	
	Administration (F835) (F837), 42 CFR 483.75			the Ad Hoc QAPI meeting 09-16-2021,	the	
	Quality Assurance an	nd Performance			interim administrator presented a new		
	Improvement (F867),				QAPI agenda, dashboard, and format	for	
	Infection Control (F88		1		QAPI Committee processes and		
		eness of systemic changes			procedures. This format included a rev	iew	
	and quality assurance	e activities.			of the current 802/672 report,		
	The Court and the footest				Performance Improvement Projects,		
	The findings include:				staffing reported by HR, Grievance log		
	Pavious of the facility	le Quality Assurance and			Resident/Family Council, Quality Revidence	ews	
		's Quality Assurance and ement (QAPI) Plan, dated			and Consultant Reports, Reportable Events, Regulatory Activity, Infection		
		API policy, last revised April			Control, Risk Management, Wound Ca	are	
		acility should develop,			Weight Loss, Hospitalizations, GDRs,	a. C,	
		ain an ongoing, facility wide			Falls, and Catheters. On 9/15/21 and		
		to monitor and evaluate the			education was provided by MED-NET		
		resident care, pursue			Healthcare Consulting, LLC for the		
		care quality and resolve			following members Regional Directors		
		According to the policy, QAPI			Divisional Vice President of Operation		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION : DATE	
{F 867}	be appropriate to mostaff turnover and assand deficiencies, care complaints, clinical or ulcers, infections and assessment and data input would be gathefamily members and involved in the care of were encouraged to it concerns as well as of improvement. The postacility's leadership welforts and systems we care and services and performance indicated action plans would be implemented to preveadverse events. Review of the "Admin May 2021, revealed to committed to serving members and would atmosphere, where the were of utmost important policy, the Administrative the day-to-day accordance with currostandards, guidelines nursing facilities to equality care was proving residents. The Admin make daily rounds of overall appearance of care provided to the	red and used in an ingful way. Areas that might intor and evaluate included: signments, State surveys a plans, resident/family utcomes such as pressure in MDS (Minimum Data Set) in the policy also indicated ared from staff, residents, individuals who were if the residents, and staff dentify/report quality opportunities for olicy stated members of the interest as accountable for QAPI evould be in place to monitor doutcomes utilizing instantial included in the policy also stated	{F 8	67}	Chief Nursing Officer, Regional MDS, Regional Certified Dietary Manager, and Regional Nurse Consultant. The Administrator is responsible for collecting audits and ensures the Department Heads understands the process and how to use the audit tools. 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, F867. The Administrator will monitor all audits on a weekly and/or until substancompliance is met and monthly thereaf as recommended by the QAPI committed and/or not reported immediately will rein 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 Administrator, Medical Director, Director Nursing, Dietary Manager, Social Service Director, and two other staff members to update progress and/or findings to determine recommendation feedback to continue current plan in place. The Administrator has forwarded all QAMeeting minutes to the members of the Governing Body including the Vice President of Operations, and regional nurse consultant for review of all audits results. Beginning 12/15/21 the Governing results. Beginning 12/15/21 the Governing results. Beginning 12/15/21 the Governing results.	and latial ter ee. sult h	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		IPLE	(X3) DATE SURVEY			
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		185256	B. WING			l .	R 30/2021
NAME OF P	ROVIDER OR SUPPLIER			Si	TREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	Further review reveal duties included ensur Team Meetings (IDT) review/manage staffir which included dining assistance was provie Administrator's weekl residents, identified p weight and pressure residents. Monthly Alensuring follow up har reports, which include ensure QAPI meeting as required. The man Administrator would revents to State and Fadministrator should residents and ensure residents were met. Administrator should daily and that nourish residents.	tor's duties included laining written and professional standards of the operation of the facility. ed the Administrator's daily ing the Interdisciplinary were occurring; ag; observe facility systems, and ensure personal ded to the residents. The y duties included monitoring roblems, and reviewing ulcer reports for the dministrator duties included d occurred for consultant ed dietary reports; and to us were conducted monthly	{F8	67}	Body member on site will attend the weekly QAPI committee meeting. Criteria 5: Date of compliance: 12/30/2021		
	for the surveys, dated and 11/13/2020, reve cited at 42 CFR 483.4 failure to prevent the COVID-19. Review of Deficiencies (SOD) for 12/12/2020, revealed	f 07/14/2020, 09/24/2020 aled the facility had been 30, infection control, for possible spread of of the Statement of or the survey date,					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		185256	B. WNG			09/3	30/2021	
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FARRAIE	FOST-ACUTE AND RE	ENABLE IATION CENTER		F	PIKEVILLE, KY 41501			
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PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
,,,,					DEFICIENCY)			
			1					
{F 867}	Continued From page	997	{F 8	367)	1			
		nd Severity "L" for failure to						
	prevent the spread of	f COVID-19.						
		- Place of Competing (BOC)					1	
		s Plan of Correction (POC), rvey, revealed the facility				1		
		facility's infection control						
		, COVID emergency plan,						
		e mask and PPE (personal						
) and handwashing. In						
		aff were required to complete				1		
		the Nursing Home Infection						
		on the Centers of Disease						
		on (CDC) website and were						
		os on "Keep COVID-19 Out", at COVID-19; and Use				1		
	l .	(PPE) Equipment Correctly".						
		ired to review the document						
		to Coronavirus (COVID-19)						
	in Nursing Homes" (Continued review of the POC	Ì					
		vould monitor to ensure						
		ction control. The POC						
		here to the facility's PPE,						
		t competency checks. The st with oversite from the						
		DON) or designee would					ļ	
		ecks of four (4) random					ĺ	
	housekeeping and no							
	compliance with the							
	procedures on cross	contamination for four (4)						
		egative findings were						
		uality Assurance (QA)						
		plan, compliance would be						
		Committee each month for ermine if the POC had been						
	1 ' '	he violations from recurring.						
		nd achieved compliance						
	effective 01/11/2021	•						
	However, the facility	failed to ensure they					:	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE : COMPL	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER	•	20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	1 0010	
(X4) ID PREFIX TAG				х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	with infection control and the facility's QAP the facility's fifth floor revealed although two #311 and #314) tested 07/28/2021 and two (and #82) tested position failed to isolate and sequired by the facility were open, all reside and residents were wunit. Further observationes existed to separate with the facility'd dated 07/28/2021, reand Resident #325 tested Review of the facility'd dated 07/28/2021, reand Resident #314 to Continued review of revealed Resident #86 for COVID-19 on 08/00 maintenance staff place across the doorway of Resident #311 and Resident #31	and evaluate compliance per the Plan of Correction I plan/policy. Observation of on 08/05/2021 at 10:54 AM, o (2) residents (Resident d positive for COVID-19 on (2) residents (Resident #329 ive on 08/02/21, the facility regregate the residents as y's policy. The fire doors not room doors were open, vandering the halls of the ation revealed no designated arate residents. Additionally, I positive on 08/07/2021 and I positive on 08/08/2021. Is COVID-19 test records, vealed both Resident #311 rested positive for COVID-19. COVID-19 test records 32 and #329 tested positive 02/2021. 5/2021 at 10:54 AM, revealed ared plastic zip barriers of a room where both desident #314 resided. ght (8) days following the DVID-19 results. In addition, ent #325, on 08/05/2021 at the resident was wandering the red biohazard waste ff were doffing COVID	{F 8	667}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		TE	(X5) COMPLETION DATE
	Further observation of 08/05/2021 at 10:54 A biohazard cans in the floor. These cans concontaminated PPE, while in residents' room positive. Interview with SRNA # AM, SRNA #16, on 08 SRNA #3 on 08/05/202 staff were doffing (remfrom COVID-19 positive) bio-hazard can in the I Review of the facility's dated 08/07/2021, reviewtested positive for COVID-19 positive for COVID-19 positive bio-hazard can in the I Review of Resident #3 08/09/2021 at 5:19 PN two (2) episodes of dianotified and the reside increase oral fluid intal Notes, dated 08/14/202 routine vital signs, staff have a low blood pression oxygen saturation, and Resident #327 waroom via an ambulance Review of Resident #3 summary, dated 08/15.	ted adjacent to COVID ms. In the fifth (5th) floor, on M, revealed large red hallway on each end of the stained large amounts of hich had been used by staff ms who were COVID In the fifth (5th) floor, on M, revealed by staff ms who were COVID In the fifth (5th) floor, on M, revealed by staff ms who were COVID In the fifth (5th) floor, on M, revealed by staff ms who were COVID In the fifth (5th) floor, on M, and the fifth floor, on M, revealed had been used by staff ms who were COVID In the fifth (5th) floor, on M, and the floor, on M, revealed had been used by staff ms who were COVID In the fifth (5th) floor, on M, and the floor, on M, revealed had been used by staff ms who were COVID In the fifth (5th) floor, on M, and the floor, on M, revealed the floor, on M, and t	{F 8	867}			

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	W POST-ACUTE AND RE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROI			(X5) COMPLETION DATE
	likely due to the COVI resident's diagnosis w Pneumonia. Review of the facility's dated 08/08/2021, rev positive for COVID-19 Review of the Nurse's 2:45 PM, revealed Rein condition and had c developed a fever of 1 respiratory distress remergency room for e Review of a Nursing R dated 08/12/2021 at 4:3325 was readmitted thospital. Continued review of th 08/19/2021 at 1:30 PM developed a low oxyge physician and resident notified. The Physicial and a Fentanyl patch (related to the resident' Do Not Resuscitate (D staff discussed the rescare, DNR status, and physician with resident resident's representating send Resident #325 be physician and DON we an ambulance transpolemergency room for exemples.	the resident's Sepsis was D-19 Pneumonia. The ras COVID-19 Viral as COVID-19 test records, realed Resident #325 tested on 08/08/2021. Notes, dated 08/09/2021 at sident #325 had a change ough, congestion and 00.2 F (Fahrenheit) and quiring transfer to the valuation. Readmission Assessment, readmission Assessment, readmission Assessment to the facility from the revealed Resident of the facility from the representative were in ordered palliative care from medication skin patch) as declined condition and a NR) status. Per the note, ident's condition, palliative new orders from the representative. The requested the facility ack to the hospital. The rere notified of request and red the resident to the valuation.	{F 8	67}			
	Review of hospital disc	charge summary, dated					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRE		10	9/30/2021
(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 CORRECT EACH CORRECTIVE ACTION SHOU DSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(XII) COMPLETION DATE
{F 867}	the hospital on 08/26/diagnoses included Adiagnoses included at 2:10 conducted with a prevesigned effective 06/Administrator stated pto monitor all deficience December 2020 survey continued to review all Assurance (QA) and videntified any concern He stated he lead QA. Administrator, the Director of Noworked together on QA. Reviewing records. The stated the former DON Interview with the ADO Nursing (IDON), on 08 revealed she had been for approximately one she was also serving a Nurse since Decembe the role of Interim DON	Resident #325 expired at 2021 and the resident's cute Hypoxic Respiratory COVID-19 Pneumonia. DPM, an interview was ious Administrator, who 01/2021. The former rior to leaving, he continued cies cited during the ey. He stated they I monitoring through Quality when he left, he had not s with information gathered. Per the Former ector of Nursing, the lursing (ADON) and he A by gathering the data and re Former Administrator I quit right after he did. DN/Interim Director of 6/18/2021 at 9:50 PM, in the ADON at the facility (1) year. The ADON stated as the Infection Control or 2020, and had assumed Naround 07/23/2021, she	{F 8				
	interview. She stated employed as the ADOI as a staff nurse more than ADON, due to the confacility. She also stated Managers, no Staff Demo QA Nurse since she She stated she recalle	N, she had worked the floor han she had functioned as ingoing short staffing in the facility had no Unit velopment Coordinator and the had worked at the facility. It done (1) Unit Manager ths ago, but the nurse left					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTIONS	N	(X3) DATI	E SURVEY PLETED
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER	1_	STREET ADDRES 200 NURSING HE PIKEVILLE, KY		09	//30/2021
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROI DEFICIENCY)			E ITE	(X5) COMPLETION DATE
	staffing problems in the ADON, she was unawe conducted by the DON employment at the factormer DON) always with short staffing." The Alcurrently and had never processes or gathered processes in the facilities revealed she had not a weekly or monthly, to since her employment the ADON, she was all infection control proce. However, she stated as she had worked the lanights on the floor and the required monitoring. Interview with the Administrator in June 2 there had been no QA she became Administrator also state. Coordinator and was reprogram/Processes in stated she had not conthe facility related to in she expected the ADO control monitoring. The acknowledged the facilino Staff Development of those positions were posted for hire since she	floor due to the ongoing be facility. According to the vare of any monitoring N, prior to her leaving sility. She stated, "She (the vorked the floor too, due to DON stated she was not er monitored any QA di any data related to QA by. Further interview attended any meetings, discuss quality processes at the facility. According to so responsible to monitor sees in the facility. It the time of the interview, st six (6) out of seven (7) was unable to complete g. Ininistrator, on 08/10/2021 at was not made aware of quality processes that were when she became the 2021. She also stated meetings conducted since after in June 2021. The ed she was the QA desponsible for the QA the facility. However, she ducted any monitoring in fection control, because N to complete infection e Administrator also ity had no Unit Managers, or QA Nurse. She stated	{F 8	57}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_			1	R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	Ē	<u> </u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFII TAG	1	SHOULD BE		(X5) COMPLETION DATE
{F 867}	staff nurse frequently, asked how the ADON was working the floor "Well I don't know." **The facility alleged t implemented to remove effective 09/26/2021: 1). Braden Scale Assed on all residents by fact and comprehensive further the facility utilized the and comprehensive further and comprehensive further and pressure injuries to the work and update care had pressure injuries to 2). The wound care philipped with the work and update care had pressure all pressure evaluated all current to the Medical Diagrams and Brade be completed, and the developed within 48 he pressure ulcer or potential pressure uniterventions to prevent development or worses.	tions. She also ON worked the floor as a During the interview, when could monitor, when she as a staff nurse, she stated the following was re Immediate Jeopardy resments were completed flity nurses on 08/28/2021 Il body skin assessments residents on 09/11/2021. Braden Scale Assessment Il body skin assessment to re plans of residents who re plans and reported rector/Physician #1 by 121, upon admission a skin ren Scale assessment will response to include any relation for pressure ulcer. A residents and reported within ren include pressure ulcers rectors and include	{F 8	367)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B. WNG	_			R	
PARKVIE	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE KEVILLE, KY 41501	<u> </u>	9/30/2021	
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ITE	(X5) COMPLETION DATE	
	care and moisturizing and assisted with dres clothing. Clean linens residents' beds on 09/were evaluated by soc 5). All residents were cinterviewed to obtain so by the Director of Nurs New bath/shower sche by nursing staff to according preference. Resident preference. Resident preference. Resident preference and State Registicare plans by the Registicare plans and State Registicare plans by the Registicare plans by the Registicare plans in the State Plans by the Registicare plans by the Regi	d including a shower, nail lotion applied post shower, sing 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 preferences for hygiene corporated into resident care stered Nurse Aide (SRNA) conal Nurse Consultant (13/2021. Registered Dietitian (RD) sidents' diets and made meal changes or the healing and to address are Pulmonary Disorder Pneumonia were assessed or Respiratory Therapist identified completed e reviewed all residents monitoring by 07/30/2021 died to include mandatory on the Medication (MAR).	{F 8	67}				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION			SURVEY
		185256	B. WNG				R /30/2021
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DDE	1 00.	3372021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
{F 867}	were delivered on time 10). Direct Care staffir recruitment efforts with provided through ager Direct care nursing staday will be reviewed of Nursing and the Admin levels are adequate to residents. The staff wire on the unit at the start Director of Nursing, Not Administrator or design staff call offs will be requalified staff to see if and/or calling agencie qualified staff to fill the cannot be replaced the Assistant Director of Nursing management of appropriate staffing leventer will prioritize residents with massist residents with massist residents with massist residents with massist residents are prepared and 12). On 08/11/2021, all #86 and #322, were residents with massist	gy was increased through additional staffing and travel contracts. If schedules for the next aily by the Director of a meet the acuity of the all be validated as present of each shift by the arising Supervisor, and present and present are they can fill the opening, as to see if they have opening. If direct care staff a Director of Nursing, arising, or member of the arising, or member of the arising, or member of the administration of a diministration of a served timely, and a seals served timely, and are are staffing forts and appropriate and appropria	(F 8	67}			

AND PLAN OF (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG			SURVEY
		185256	B. WNG			l .	R /30/2021
		HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	1 03	3012021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IN SHOULD BE E APPROPRIA	E STE	(X5) COMPLETION DATE
in F 1 th F C reference in the second in the	BIMS less than eight Licensed Nurse. Resi Dementia had their Cirevised, as necessary (MDS) Coordinator or residents were identificated and/or p. 13). The Regional Nurwandering risk assess (18/16/2021. All reside at risk for wandering hypotential interventions (14). Residents #39, #4/332 were weighed by Registered Dietician (16) comprehensive nutritic ecommendations by fool of the commendations were ecommended in the electronic medical Doctor (MD) and recommendations where interventions (14) in electronic medical record and tray card renformation on 09/17/2 (15). Beginning 09/15/2 nacks to all residents	ity reviews for residents with (8) were completed by dents with a diagnosis of are Plan reviewed and by the Minimum Data Set of 09/07/2021. No new ied as indicating any obysical harm. Itse Consultant completed a sment on all residents by onts who were identified as and care plans reviewed and Coordinator. A list of all er risk residents were g station with a list of for nursing to reference. It is in a session of the Director of Nursing 09/17/2021. The RD) completed a contained by the Director of Nursing 09/17/2021. Further, the oke with the attending and validated the diet orders are conic medical record and on pistered Dietician and ON), reviewed diet orders ecord to ensure both the effected accurate to 21.	{F 8	67)		φ	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED	
		185256	B. WING_				R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE	E	(X5) COMPLETION DATE
{F 867}	aide, dietary aides and 16). The facility evalua 08/11/2021, located or for compliance with C implemented yellow a identified two (2) reside exposed to positive rewas designated with exposed to partie and those two this zone on 08/11/20/21. The facility had the in the red zone on 08/4328 and #329). Reside have completed quarantine physician orders. Residentify and the physician's order. Residentify and physician's order. Residentify any new cases testing on 09/16/2021, tested for COVID-19 or 09/16/2021, test	mented by the restorative d/or licensed nursing staff. ated the COVID-19 unit on the 5th floor of the facility DC guidelines and not red zones. The DON lents who had been sidents and a yellow zone election of a plastic zip wall (2) residents were moved to 21. aree (3) residents who were 11/2021(Residents #327, dents #327, #328 and #329 antine per facility policy and idents #311 and #314 per COVID-19 policy and idents #311 and #314 were at testing were tested for D21. The facility did not is based on the employee All residents eligible were in 09/17/2021. The facility we positive cases. All residents eligible were in 09/17/2021. The facility we positive cases. All residents eligible were in 09/17/2021 and placed in the use of personal the facility will provide family notification and care on or designee will review 19 residents to ensure	(F 80	57}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CO	(X3	(X3) DATE SURVEY COMPLETED	
		185256	B, WING				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STRE 200 N	ET ADDRESS, CITY, STATE, ZIP CODE FURSING HOME LANE SVILLE, KY 41501		09/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE	
{F 867}	droplet precaution in if facility will provide phynotification and care pemployee testing protidesignated days effect requires all staff must days. If the employee not allow the employee negative COVID-19 to employee will be testefacility by the Infection designee. All testing oposted to the employee common areas. 20). The facility screen for signs and/or symptocumented on the MRecord (MAR). The famonitoring for signs an residents on 09/17/20. 21). Resident #9, Res Resident #326 and Rewere reviewed for usa administration times b 09/23/2021.	exposed will be placed in solation zone (yellow). The ysician notification, family plan revisions. The facility ocol will be twice weekly on the color will be twice weekly on the color will be twice weekly on the color will be tested on designated is not tested, the facility will be to work without a current est. During testing, the ed prior to entering the prevention Nurse or lates and times will be the page, time clock and the color will be the page, time clock and edication Administration cility implemented and/or symptoms on all color will be seident #321, Resident #324, the sident #351, medications ge and appropriate by the physician on all residents will receive dered beginning 09/23/2021 amacy and physician cation was unavailable.	{F 8	667}			
	physician regarding th 23). The facility formul	e unavailable medication. ated an agreement on acility's pharmacy to provide					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG	_	(X3) DATE SURVEY COMPLETED	
		185256	B, WING_	<u>-</u>	<u></u>	F	₹ 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	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)					(X5) COMPLETION DATE
{F 867}	for cost authorization 24). New admissions the facility after norm weekends will have dentered into the elect submitted to pharmaci integration. The facilifax transmittal as a bipharmacy integration electronic medical reality does not timely manner the phithe facility will utilize kit. If an emergency a unavailable, the physisubstitution and/or next and to fall residents' verified all medication facility by 09/25/2021 26). The facility cond Performance Improve 08/12/2021. The facility process, and a ensure compliance with Administrator over The QAPI committee Nursing, Administrator Services Director, Ac Maintenance, Dietary Services.	while pending cost review. and re-admissions entering all business hours and on ischarge orders submitted, ronic medical record and by through pharmacy ity implemented the use of ackup to the electronic by entering the order in the cord to receive medications. Treceive medications in a sarmacy will be notified, and the emergency medication is ician will be notified for aw orders. Tree Consultant, Director of a nursing staff completed an ordered medications and mes were available in the control of the control	{F 8	57}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(X3) DATE SURVEY COMPLETED	
		185256	B. WNG		ns	R 9/30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		LD BE	(X5) COMPLETION DATE	
{F 867}	guidance from the Re Regional Director of Colinical Nurse for 30 of the thirty-day oversight Administrative Team of determine if continued The administration has responsibility to direct communicate areas of improvement. 28). The Administration QAPI Committee revisionated person for call Activities of Daily Living timeliness of meal traiturning and reposition 29). The Vice Preside Clinical Operations and Consultants conducted 09/15/2021 with a conconsultation to review outcomes of the Survey roles of the Governing Rules and Regulation the following community for the following commun	The facility's Interim eive daily oversight and gional Vice President or Operations and Regional days. Upon completion of int, the Regional will audit the Administrator to d daily oversight is needed. s direct oversight and discipline, and f concern and process or, Medical Director, and ewed procedures for a d-ins, answering call lights, ing (ADL) Care, serving, and ing on 09/15/2021. ont of Operations, Director of and Regional Nurse d a conference call on intract company for a	{F 8	67}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B. WING			·	R 09/30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			50/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)			(X5) COMPLETION DATE				
{F 867}	beginning 09/16/2021 and/or revisions to the 19/16/2021 meeti standardized plan to reviewed as needed a agenda included revie catheters, enteral fee physical restraints, m management, infection readmission rate, reh social services, conceresident council, and grievances, admission development, vacant orientation, dietary value weight loss, work injuit employees on family absence, new hires, review, pharmacy repusiness office, and a Committee and Medic standardized agenda	r and Regional Nurse and revised the QAPI Plan and presented the reviews a 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 on control, hospital abilitation management, erns of grievance, activities, family council concerns, ns, discharges, census, staff positions, employee uriances, tray audit report,	{F 8	967}				
	Vice President of Ope Administrator, the DC on 09/16/2021 regard Governing Body, inch procedures to be imp communicating inform the Governing Body. QAPI processes, the in the QAPI process, causes with the utilization	N, and the Medical Director						

			(X3) DATE SURVEY COMPLETED			
		185256	B. WING			R 0 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	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	
{F 867}	medical Director of furneetings. 32). The Administrator reports before each (beginning 09/15/202 compliance with the compliance with the compliance with the compliance with the complemented QAPI model (4) weeks, as needed Administrator will forwind the Vice Proceeding to the Governmented VaPI model (4) weeks, as needed Administrator will forwind the Vice Proceeding the Vice Proceeding the Vice Proceeding to the Complemented VaPI model (4) weeks, as needed Administrator will forwind the Vice Proceeding the Vice Proceedin	pristrator will notify the siture QAPI Committee or will collect all monitoring QAPI Committee meeting It for review to ensure deficiencies cited during the API Meetings were held on a sabatement and develop we the jeopardy. The facility seetings weekly, times four Id, and monthly. The ward all QAPI Meeting ning Body members, esident of Operations, and the sultant, to review the audit mmittee will review the eetings. Committee for rator oversees the QAPI PI Committee consists of the administrator, Medical ces Director, Activities, intenance, Dietary and ses. Body will provide the facility's sources and education including but not limited to the last a Glance, and a resource applement the QAPI plan II. The Governing Body will be upcoming year and ancy after one (1) year.	{F 8	367}		
		eded effective 09/16/2021,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R	
NAME OF P	ROVIDER OR SUPPLIER	10000	D. 11110		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	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)				(X5) COMPLETION DATE
{F 867}	{F 867} Continued From page 1,013		{F 8	367}			
	complies with the star	of care is monitored and ndard of care and e and Federal requirements					
	35). All nursing staff w Director of Nursing, M designee on proper w obtaining, documenting changes to the Regist 09/17/2021.	IDS Coordinator, or eighing techniques, ng, and reporting weight	:				
	Manager on the provis	M) educated the Dietary sion of timely nutritional ediet order accuracy, on					:
	orders into the electro CDM educated the Did resident diet orders in the nurse enters the o written communication including diet and text meetings, staff will rev	ure. In the morning clinical riew diet orders from the					
:	37). Therapy provided staff on turning and po and transfer of resider chair to bed beginning completed on 09/17/2 and assigned addition and agency contracts	e accuracy. leducation to all nursing positioning range of motion, at from bed to chair and on 08/19/2021 and 021. The facility employed al staff through recruitment to ensure adequate staff to					
	all nursing staff on pre						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUILDI		CONSTRUCTION	SURVEY
		185256	B. WNG			R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE D NURSING HOME LANE KEVILLE, KY 41501	 /30/2021
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
(F 867)	to complete and docur assessment, and how dietician, physician, and impairment by 09/17/2 staff will call or email to Physician, and Reside new skin changes. 39). The DON or designation of the province of	n, positioning devices, how ment a head-to-toe skin to notify the registered and RP of a new skin 2021. The facility nursing the Registered Dietitian, ent Representative of any gnee educated all staff on ase. In addition, direct care	{F 8	67}	DEFICIENCY)	
	Nursing educated all li Registered Dietician, t and the MDS Nurses of into the electronic med and interventions. In a Director of Nursing educ existing care plan in the with new goals and int impairments identified 41). The facility's Resp Licensed nurses on ide residents with a chang 08/12/2021. In addition	ucated staff to update the se electronic medical record erventions for any new skin during their shift. Diratory Therapist educated entifying and assessing se in respiratory status on n, on 08/12/2021, the DON ated all licensed nurses on toms of ycemia, the facility's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				₹
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	09/	30/2021
(X4) ID PREFIX TAG			ID PREFI TAG		TION SHOULD B		(X5) COMPLETION DATE
{F 867}	sugar in the medical rephysician and followin facility licensed nursin work until they have red DON educated all clin of glucose levels on 0 during mandatory in-second during staff education was notified will not be allowed to received this education was notified will not be allowed to received this education 43). Beginning 08/12/2 staff on the facility's "call-off procedure for the vent a person needs dayshift, they are to not supervisor two hours to notify their immediate supervisor other qualified staff to off. If emergency staff Administrator and/or dassistance from staffin working will be in-served. All staff were proved.	documentation of blood ecord, notification of the eng physician orders. The eng staff will not be allowed to eceived this education. The elical staff on documentation 8/19/2021 and 08/20/2021 elevices. 2021, the DON educated empleting a baseline Care es and goals relevant to eatory diagnosis within 48 eviewing and providing a end/or the responsible party. I not working during d of ongoing education and ework until they have en. 2021, the DON educated all eall off" procedure. The the facility included: in the to call out of work for cotify their immediate defore the start of the shift. If on the night shift, they are the supervisor four hours or shift. If the facility does estaffing levels, the and/or designee will call replace the person calling fing is required, the	{F 8	367}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	por	185256	B. WING				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE			20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	09	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 867}	changes to the Regist 09/17/2021. On 09/13 the Dietary Manager of timely nutritional asses accuracy. When staff electronic medical recorder will send the wridietary staff. The Dietorder into the tray carreview diet orders from clinical meeting to ensure the dietary staff. The Regional CD Manager on 09/13/202 regarding meal service recipes including recipion fortified diets to ensure nutritional needs of restablished national groultural and ethnic needs of the established education with the dietary staff. As of 09/15/2021, completed education with the dietary staff, ordering food snack/hydration carts, procedures, approprial portion sizes.	vere educated by the IDS Coordinator, or eighing techniques, and reporting weight ered Dietician by //2021, the CDM educated on diet order accuracy and assment to ensure diet order enters diet orders into the tord, the nurse entering the ten communication to the tary Manager will enter the exystem. The facility will in the previous day in the sure accuracy. M educated the Dietary 21 on facility policy entires and the use of the sidents in accordance with uidelines to reflect religious, eds of the population. The Regional CDM with the dietary manager on inces, the facility's tray card based on menus, stocking snacks, and hydrations	{F 8	67}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/	<u> 30/2021 </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPROPR DEFICIENCY)			(X5) COMPLETION DATE
{F 867}	of Nursing educated in Manager on the proces and/or implementing to recommendations for 09/17/2021. 49). All staff were provided in the process of the proc	surses and the Dietary ses for entering, activating, the registered dietician's dietary orders on rided re-education by the by 09/17/2021 on the elines, handwashing, nal Protective Equipment zones. In addition, the ted, licensed staff on or Covid-19 symptoms 1, the DON/designee uding contract staff, who ting the QAPI meeting on -19 policy, the forning and doffing PPE, and monitoring residents the Covid-19 were and re-education on N, Regional DON, or oltant to enter COVID-19 orders on all new sident's record. and staff have been by rights of medication one right medication, right ont time, and right route. The designee educated all ovorking on 09/23/2021 on other a medication was not	{F 8	367)			
	available for administrated calification included calification, obtaining medication delivery times.	ling the pharmacy to obtain ng the anticipated					

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 V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	<u> </u>	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
{F 867}	outside of the ordered education also including given by the MD, doctand new orders from medical record. All off will be provided training to the provided training to the emergency in place for ensuring a notifying the physician re-admitting residents after-hours. 53). The Interim Admit on his contact information of the emergency in place for ensuring a notifying the physician re-admitting residents after-hours. 53). The Interim Admit on his contact information of the emergency in addition, education who to notify if unables shift. 54). The facility will at head-to-toe skin asset through Friday, for the 09/17/2021 to ensure weekly on each residing will notify the physician Responsible Party of and those new interversional expiration date on 08 conducted weekly for	ill either be omitted or given if medication time. The ed following new orders urnenting the conversation, the MD in the electronic her licensed nursing staffing as scheduled for shifts. The DON /Regional Nurse all licensed nursing staff, and/or agency staff, on the medication kit, the system medications are in-house, or a for new orders for new or a, including on weekend and inistrator educated all staffinistrator ed	{F 8	367}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u> </u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	,	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
{F 867}	Nursing (ADON), or National Progress and President progress note effective 09/13/2021, month. Staff will revie 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) was residents each shift for twenty-five percent of (4) weeks. The facility to 6:00 PM and 6:00 Fm and 6:00	dursing, Assistant Director of dursing Supervisor will audit es for daily four (4) weeks then weekly for one (1) w Progress notes for on Monday. The Nursing I 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 or four (4) weeks, and residents each shift for four thas two (2) shifts, 6:00 AM PM to 6:00 AM. The facility's leadership staffing and timing of call light ding the length of time call incross all shifts. Leadership 10) call light observations weeks and then five (5) call the shift for eight (8) weeks. The DON and/or Designee biratory assessments and Assessment and Assessment and ideal communications for ratory status Monday clinical morning meeting.	{F 8	167}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DE	1 09	/30/2021
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		E NTE	(X5) COMPLETION DATE
{F 867}	Plans were reviewed Audits will be daily for times a week for four 60). The MDS Nurse, began audits on 09/18 completion for all new re-admissions to ensubaseline Care Plan wi 61). All residents admidays with a diagnosis Obstructive Pulmonar Asthma, or current Pn Care Plan reviewed at the MDS Nurse(s) and interventions will be amorning meeting by thousing designee. 62). Beginning on 08/100N, and/or Designee admissions and re-adicare plans for complet with the resident and/ovariance or identified of immediately. Audits withrough Friday for all at to the facility for four (admissions for a week then ten percent of admissions for a weeks. 63). On 09/11/2021, the designee began auditimeal trays to residents All three (3) meals will (3) units daily for two (4).	and updated as needed. (4) weeks, then five (5) (4) weeks. DON, and/or Designee (5/2021 of baseline care plan admissions and are staff completed the thin 48 hours of admission. Attention of Diabetes, Chronic by Disease (COPD), aumonia had their baseline and updated as needed by allor designee. New dided to the care plan in the allor DON, ADON, and/or	{F 8	367}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u> 09/</u>	/30/2021
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{F 867}	weeks. 64). On 08/15/2021, til began audits of staff's quiz of identification a with a change in respisigns/symptoms of hy the facility's diabetic p change in a resident's physician and followin Leadership will quiz sishifts; ten (10) staff fo staff a week for four (465). On 08/13/2021, the began monitoring all diresults Monday throug morning meeting. The any blood sugar result range for MD notification any Physician's Order reviewed and updated designee will complete diabetic residents acrossigns and symptoms of hypoglycemia/hypergly resident was immediated one (1) week, then five (4) weeks. 66). On 08/13/2021, the designee implemented questionnaire on abus residents with wandering sidents with wande	and por four (4) the DON and/or Designee to knowledge with a verbal and assessment of residents ratory status, identifying perglycemia/hypoglycemia, rotocol, documenting a condition, notification of the g physician's orders. taff randomly across all r one (1) week and five (5) the DON and/or Designee tocumented blood sugar the Friday in the clinical DON/designee will review to outside of the normal on and implementation of s. Care plans will be a s needed. The DON or the a visual rounding on the state of the state of the teles of the teles to president with apparent to the teles of the delivers of the teles of the teles to president with apparent to the teles of the delivers of the teles to president with apparent to the teles of the delivers of the teles to president with apparent to the teles of the teles to president with apparent to the teles of the teles to president with apparent to the teles of the teles to president with apparent to the teles of the teles to president with apparent to the teles of the teles to president with apparent to president wi	(F 8	867			

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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200 N	ET ADDRESS, CITY, STATE, ZIP CODE IURSING HOME LANE VILLE, KY 41501	03	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 867}	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 quarte Set (MDS) assessment wandering will be discomorning meeting to reinterventions. Any varially be addressed immediate by the Director of Nursing Nursing, or nursing defeated by the Beginning on 08/ Services Director or drandom interviews of of eight (8) or greater the facility and have now itnessed abuse. The review random weekly residents with a BIMS to ensure no injuries of 08/13/2021. Any varial will be addressed immediate of the disconducted audits of reelectronic medical recommedical recommedi	questionnaire will be staff daily for one (1) week, week for two (2) weeks, our (4) weeks. Any variance will be addressed 13/2021, the Director of nee will review each risk assessment upon rily with their Minimum Data nt. Any resident identified as cussed in the clinical eview and initiate new inance or identified concerns nediately. New interventions in the morning meeting by 13, Assistant Director of esignee. 13/2021, the Social esignee will perform residents with a BIMS score to ensure they feel safe in ot been subject to or 10 DON or designee will viskin assessments for score of less than eight (8) of unknown origin beginning ince or identified concerns nediately. The Registered Dietician esident diet orders from the ord against orders entered of tware to ensure accuracy.	{F 8	67}			
	Manager will ensure a	nd audit meals leaving the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	SURVEY PLETED
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		ST 20	REET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE KEVILLE, KY 41501	09	/30/2021
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{F 867}	be conducted for randone (1) week, twice prand then weekly for our trays arrive at the unit assist in passing trays meal trays, and certification residents promptly. The designee will audit the trays to residents afte beginning 09/11/2021 observed on each unit two (2) meals on each weeks, one (1) meal of weeks. 71). The dietary mana admitted/re-admitted residents on the deverage preferences admission and enter the system for listing on the 109/16/2021. Review of completed bi-annually residents. Physician-be audited by the Diet (1) week, weekly for foafter that for four (4) monophysical process (HR) Director, and weekends the staff not screened will be through Friday for four Director, and weekends staff not screened will	the units timely. Audits will lom meals twice daily for er week for two (2) weeks, ne (1) month. Once meal , management staff will to ensure residents receive ed nursing assistants assist the Dietary Manager or etime it takes to pass meal or they arrive on the unit and ally for two (2) weeks, and unit daily for two (2) weeks, and unit daily for four (4) on each unit daily for four (4) on each unit daily for four (4) on each unit daily for and as needed for all ordered snack intakes will ary Manager daily for one our (4) weeks, and monthly nonths beginning of staff will be 18/25/2021 by the Human tor against time clock eening before beginning e completed Monday (4) weeks by the HR is audited on Mondays. Any be re-educated OVID-19 Screening Policy	(F &	367)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 96		NSTRUCTION		SURVEY
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STRE 200 N	ET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501	09	/30/2021
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{F 867}	Nurse, an infection codoors will remain lock entry by staff and screentry. 73). Beginning on 09/designee will round sefor eight (8) weeks, fiv. (4) weeks to audit infediffering shifts and uniobservation of handwand zones; donning/d PPE; and mask compidentified concerns will by the auditor. 74). The DON, ADON review all residents or pharmacy to ensure a beginning 09/23/2021 physician within two (2 expiration. 75). The Regional Nurand/or Director of Nurmedication pass observation pass observation of medication condobservation of twenty- 76). Beginning 09/25/2/2Friday, the DON, ADON, ADO	ID-19 policy by the Regional antrol preventionist. All entry ed. Visitors must be allowed bened by staff at the time of a the ti	{F 8	67}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	I .		CONSTRUCTION		SURVEY PLETED
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{F 867}	and/or DON will be renursing staff daily for adequate staffing is more adequate staffing is more adequate staffing op/11/2 Dietary Manager will be dietary staffing daily for adequate staffing. 79). Beginning 09/11/2 President of Operation monitor and audit the days to ensure complete with the days to ensure dentification and identification and ident	continue until the s removed. 2021, the Administrator sponsible for monitoring four (4) weeks to ensure naintained. 2021, the Administrator and pe responsible for reviewing per four (4) weeks to maintain and the responsible for reviewing per four (4) weeks to maintain and the responsible for reviewing per four (4) weeks to maintain and the responsible for reviewing per four (4) weeks to maintain and the conducted beginning and for residents' change of attended to the conducted beginning for residents' change of attended to the conducted beginning and for residents' change of attended to the conducted beginning and the conducted beginning for residents' change of attended the conducted beginning and the conducted beginn	{F 8	67}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		E CONSTRUCTION		SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	100230	D. 111110	_		09/	30/2021
TVAME OF F	ROVIDER OR SUPPLIER			ı	STREET ADDRESS, CITY, STATE, ZIP CODE		
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				L	PIKEVILLE, KY 41501		
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(F 867)	on 09/11/2021. A revier revealed eight (8) resi #324, #45, #14, #357, current pressure ulcer pressure injuries of two comprehensive care pressure injuries of the resident's current facility completed the A review of the facility revealed staff assess pressure ulcers with the Regional DOI revealed she complete assessment on all resturther revealed that the (20) total pressure injuries further revealed that the facility completed assessments on all recontinued interviews in Interdisciplinary Team assessments and Braupdate the residents' of Resident #65, #324, # and #358's care plans current pressure injuries with MDS Nurse #1 or revealed she updated reflect current pressure addition, she complete rounds on 09/15/2021 the Registered Dieticia DON, and the MDS No.	ew of the skin assessments idents (Residents #65, #27, #74, and #358) had so with a total number of venty (20). A review of the plans for Residents #65, #27, #74, and #358 if the care plans to reflect pressure injuries. The review on 09/17/2021. It is census on 08/28/2021 and all residents at risk for the Braden Scale. Interview N on 09/30/2021 at 4:17 PM and head-to-toe skin idents on 09/11/2021. She the facility identified twenty pries. She further stated that the Braden Scale sidents on 08/28/2021. The verse plans is she stated that the Braden Scale stated that the Braden Scale assessments to care plans. She stated that 45, #14, #357, #27, #74 were updated to reflect the set of the plans to be injuried at review of walking with Therapy Personnel, and the Medical Director, the purse for Residents #65, #27, #74 and #358. A	{F 8		DEFICIENCY)		
	reviewed	, current skin breakdown,					
	caon resident's orders	Current skill breakdown,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
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NAME OF D	ROVIDER OR SUPPLIER	103230	D. WING.			09/	30/2021
	W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 200 NURSING HOME LANE P!KEVILLE, KY 41501	CODE		
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{F 867}	2). Review of Resider revealed the Medical resident on 08/25/202 Stage four (4) pressure deep tissue injury (DT and a skin tear to the Resident #65's wound 08/26/2021 at 9:00 AN wound measured, "13 12.3 cm width and 0.2 at 10 o'clock measurin 12 o'clock that measu No palpable bone, sloremoved with wound continued to treat the ulcer with Aquacel Agevaluation completed Resident #65 had six including a stage two measuring 1.2 cm (ler 0.1 cm (depth), stage measuring 2.5 cm by stage two (2) to left high cm x less than 0.1 cm scapula measuring 1 cm by 0.6 cm. and for measuring 12 cm by 1 Interventions in place heel protectors while i weekly documentation mattress to bed, nutrit turning/repositioning. (for the sacral pressure	nented changes as needed. It #65's medical record Director assessed the It at 1:45 PM and noted a re ulcer on the sacrum; a It to the left and right heels; left inner leg. Review of It care note dated M, revealed the sacrum It cm (centimeter) (length) by It cm depth with undermining at a res 1 cm, muscle exposed. The facility resident's sacral pressure It A review of a wound on 09/15/2021 revealed It of pressure ulcers, It to the left superior calfingth) by 1.4 cm (width) by one (1) to the right hip It cm by less than 0.1 cm, pressuring 1.2 cm by 0.8, stage two (2) to left cm by 0.2 cm by less than oright heel measuring 0.6 ur (4) areas to the sacrum It.6 cm by 0.4 cm. If or the resident included on bed, diet as ordered,	{F 8				
	by 11 cm by 0.3 cm wi drainage and 95 perce	ith a scant amount of					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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{F 867}	Resident #65 declined observation of other precord review reveale PM, Physician #1 detiweight loss and wound 09/28/2021, Resident in-house wound care record revealed on 09 physician of the declinwith no new orders. Twith Failure to Thrive. 3). The facility admitted 09/10/2021, completed 09/10/2021, completed 09/10/2021, and compon 09/10/2021, and re-addisolated staff develop plan on 09/21/2021. Further revealed staff develop plan on 09/21/2021. Are-admission revealed admission skin assess 09/28/2021, Braden Staff develop plan on 09/21/2021. Are-admission skin assess 09/28/2021, Braden Staff develop plan on 09/21/2021. Are-admission skin assess 09/28/2021, Braden Staff develop plan on 09/21/2021. Are-admission skin assess 09/28/2021, Braden Staff develop plan developed the resident #308 or Resident #309 on 09/27 Resident #314 on 09/27 Resident #314 on 09/27 Resident #320 on 09/27 Resident #320 on 09/27 Residents' beds. Interveloping the time of the identified concerns. A	d would not consent to the pressure areas. A medical digital that on 09/21/2021 at 2:19 permined the resident's discovered wisits. On #65's family declined visits. Further review of the 1/29/2021, staff notified the president was diagnosed with the resident was diagnosed askin assessment on digital a baseline care plan pent #355 was discharged on mitted to the facility on periew of the medical record with the resident was discharged on mitted to the facility on periew of the medical record with the resident had an assent completed on 1/28/2021, and a peloped on 09/28/2021, and a peloped on 09/28/2021 at 1:40 an 09/29/2021 at 11:26 AM, 29/2021 at 11:52 AM, 29/2021 at 11:30 AM and 29/2021 at 11:13 AM appeared clean,	{F &	367}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		03/	50/2021
(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 FIX (EACH CORRECTIVE ACTION SHOULD BE G CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
{F 867}	Director interviewed thand had no concerns Interview with the ISS revealed she interview #308, #309, #311, #3 with no identified concerns on 09/28/2021 from 1 no identified concerns reviews revealed Res #309, #311, #314, and shower preference an obtained and included review of the resident the comprehensive caplan, revealed staff up to reflect the resident the Vice President of at 4:10 PM revealed s resident preferences. was interviewed for sh preference, and the faresident's care plan. A interviews revealed th preference was obtain shower schedule reve shower/hygiene preference of the preference was obtain shower schedule reversident diets on 08/20 that she implemented recommendations for loss and/or wound head documentation revealer eviewed all residents'	ne Interim Social Service ne residents on 09/15/2021 with resident hygiene. D on 09/30/2021 at 2:23 PM ved Residents #45, #65, 14, and #320 on 09/15/2021 cerns regarding hygiene. idents during the initial tour cidents #45, #65, #308, ci #320 each had their d hygiene preference on their care plan. A as medical record, including cire plan and SRNA care codated each resident's plan as preference. Interview with Departions on 09/30/2021 he assisted with obtaining She stated each resident cower and hygiene cidity updated each a review of resident cire shower/hygiene sed. A review of the facility's aled that the resident rences were honored. Dietician on 09/30/2021 at began reviewing all cidents to address weight	{F 8	967)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X	(3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	COMPLETION DATE	
{F 867}	revealed she complet and recommendations 7). A review of facility 08/13/2021 revealed the with a diagnosis of Dissigns and symptoms of hyperglycemia and the intervention. Interview 09/30/2021 at 4:17 PM the residents and did concerns. Observation 09/28/2021 at 1:36 PM 09/29/2021 at 11:35 PM 09/29/2021 at 11:35 PM 09/29/2021 at 11:52 PM review of facility ass 08/12/2021 revealed for diagnosis of Chronic CD Disorder (COPD), Astingsorder (COPD), As	o on 09/30/2021 at 4:17 PM ed the review of all diets as. assessments completed by hirty-nine (39) residents abetes were assessed for of hypoglycemia/ eneed for immediate with the Regional DON on M revealed she assessed not identify immediate as of Resident #348 on M, Resident #320 on M, and Resident #311 on M revealed no visible poglycemia/hyperglycemia. essments completed on iffy (50) residents with a Obstructive Pulmonary hama and Pneumonia were bry Therapist #1. Interview apist (RT) #1 on 09/30/2021 she assessed all residents onic Obstructive Pulmonary hama, and pneumonia entified concerns. Int #45 on 09/28/2021 at 1:40 on 09/28/2021 at 1:40 on 09/28/2021 at 2:03 PM. Ay distress. Regional Nurse Consultant PM revealed she reviewed gnosis of Diabetes and the	⟨F 8	67)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		200 N	ET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501		/30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 867)	orders revealed each the glucose value on review revealed no co having glucose levels than 400. 9). A review of audits revealed meals were with the Regional Cer (RCDM) on 09/28/202 09/30/2021 at 1:52 Ph observed on 09/11/20 within five (5) to ten (1 scheduled times. 10). A review of the fa 09/28/2021 from 6:00 two (2) licensed nurse assistants were schedicility. A review of the one (1) licensed nurse nursing assistants for 6:00 AM. A review of the staffing 09/30/2021 revealed to three (3) certified nurse from 6:00 AM to 6:00 staffing revealed one (2) certified nursing as 6:00 PM to 6:00 AM. Observation of facility 1:20 PM to 5:30 PM; of to approximately 6:00	dent #3, #41, and #357's order required staff to enter the resident's MAR. Further oncerns with residents less than 60 and/or greater completed on 09/11/2021 delivered timely. Interview tified Dietary Manager 21 at 2:26 PM, and M revealed lunch was 21 and arrived at the unit 10) minutes of the cility's staffing for AM to 6:00 PM revealed as and three (3) nursing fulled for each floor of the as facility's staffing revealed as and two (2) certified each floor from 6:00 PM to g for 09/29/2021 and wo (2) licensed nurses, and ing assistants on each floor PM. Further review of (1) licensed nurse and two assistants for each floor from staffing on 09/28/2021 from on 09/29/2021 from 8:11 AM PM and 09/30/2021 from evealed call lights were or, residents appeared	{F &	67)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER **POST-ACUTE AND RE			1	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09	/30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{F 867}	and meal trays were purchased with RN # AM and on 09/30/202 #4/Wound Care Nurse LPN (Licensed Practic at 12:44 PM; LPN #7 and 09/30/2021 at 1:50 Pat 10:31 AM; State Re (SRNA/certified nurse 3:40 PM; SRNA #11 os SRNA #7 on 09/29/20 on 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 stat 09/28/2021, 09/29/2021 revealed each day corone (1) evening cook, day aides, and two (2) Observation of the kitc PM reflected the staffing schedule. Interview wire at 1:12 PM, and Dietan 2:10 PM revealed kitch and they were able to their shift.	th baths/showers, was being conducted timely, bassed timely. If on 09/29/2021 at 11:55 If at 12:58 PM; RN If on 09/30/2021 at 2:54 PM; and Nurse) #6 on 09/30/2021 If on 09/29/2021 at 3:00 PM If PM; LPN #10 on PM; LPN #11 on 09/30/2021 If on 09/29/2021 at 3:23 PM; and 09/29/2021 at 3:23 PM; and 09/29/2021 at 3:23 PM; and 09/29/2021 at 4:10 If SRNA #21 on 09/29/2021 at 4:10 If in and 09/30/2021 at 4:10 If in and 09/	(F 8	867)			
	12). A review of assess withdrawn, crying, or o conducted for Residen 08/11/2021. No concer	ther abuse symptoms was ts #64, #86, and #322 on				į	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	MUST BE PRECEDED BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE
{F 867}	no identified concerns interviews conducted and 09/30/2021 reveal with psychosocial and including observations and #322. Interview w 09/29/2021 at 11:54 A with abuse. Interview 09/30/2021 at 1:39 PM a diagnosis of Demenreviewed and revised with the RDON on 09/2021, for all resulting of licensed nursing stationary including a description of the elopement of the	ments completed revealed and on 09/28/2021, 09/29/2021, olded no identified concerns allor physical abuse, of Residents #64, #86, with Resident #322 on the revealed no concerns with MDS Nurse #1 on the revealed all residents with the revealed all residents with the assistance and sidents, with the assistance and sidents, with the assistance and sidents, with the assistance and sidents completed by the or (SSD) for residents with a sidents had received a sment by 08/16/2021. The resident identified at risk. The resident identified at risk.	{F 8	367)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER 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				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
{F 867}	09/16/2021 for Reside Resident #81, 09/16/2021 for Reside recommendations madischarged. Interview Dietician on 09/30/202 Nurse Consultant on 08/30/202 resident had received assessment and review by nursing staff. Furth and Regional DON rettray card were reviewed information. 15). Observation of the at 2:22 PM, the fourth PM and the fifth floor or revealed snacks included at the same present, in juice. Observations on revealed snacks were Review of Resident #3 Resident #14's record intake of snacks. Inter 09/29/2021 at 4:10 PM educated on document 16). Observation of the yellow zone on 09/28/2 no identified concerns. residents.	2021 for Resident #39, ent #65, 09/16/2021 for Resident #90 and ent #330 with no dietary de. Resident #332 was with the Registered 21 at 3:53 PM, the Regional 29/30/2021 at 3:40 PM, the 30/2021 at 4:17 PM and 1 at 3:20 PM revealed each a comprehensive nutritional w of the recommendations er interview with the RD wealed both the record and ed to reflect accurate et third floor on 09/28/2021 floor on 09/28/2021 at 2:00 on 09/28/2021 at 2:00 on 09/28/2021 at 2:00 on 09/28/2021 at 0:00 on 09/28/2021 at 0:30 AM being passed on third floor. 331, Resident #65 and revealed documented view with SRNA #19 on 1 revealed she was tation of snacks. et facility's red zone and 2021 at 2:12 PM revealed . The zones contained no onts #327, #328 and #329 were isolated per CDC	{F 8	667}			

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		09/30/2021	
BARIOTEN BOOK A COLTE AND COLOR			200 NURSING HOME LANE			
PARKVIEW POST-ACUTE AND REHABI	ILITATION CENTER		PIKEVILLE, KY 41501			
PREFIX (EACH DEFICIENCY MUST	ENT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
(F 867) Continued From page 1,03 09/29/2021 at 11:41 AM ar 8/30/2021 at 10:36 AM rev or symptoms of COVID-19 been discharged from the f 18). Review of facility staff staff working on 09/16/202 COVID-19 with no identifie review of resident testing fo 09/17/2021, revealed no no 19). Interview with MDS Nu at 1:39 PM, MDS Nurse #2 PM, Maintenance Assistan 2:56 PM, Therapy Manage 1:18 PM, Housekeeping St 09/30/2021 at 1:24 PM, Hu Director (HR) on 09/30/202 Marketing Liaison on 09/30/ Medical Records on 09/29/ Central Supply on 09/29/20 on 09/29/2021 at 11:55 AM 12:58 PM, RN #4/Wound C 09/30/2021 at 2:54 PM, LP 12:44 PM, LPN #7 on 09/2 09/30/2021 at 1:54 PM, LP at 12:50 PM, LPN #11 on 0 AM, SRNA #1 on 09/29/202 #11 on 09/29/2021 at 3:23 09/29/2021 at 3:29 PM, SR at 4:10 PM, SRNA #21 on 0 SRNA #22 on 09/29/2021 at 4:10 09/29/2021 at 1:12 PM, Die 09/30/2021 at 2:10 PM, Fo Director/Dietary Manager # 1:30 PM revealed the facilii (2) times weekly. Interview Control Nurse on 09/30/202	nd Resident #329 on yealed no obvious signs b. Resident #327 had facility. It testing revealed all the testing revealed all the tested for ed new cases. Further for COVID-19 on ew cases. The testing revealed all the tes	(F 8	367)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	_ I	TIPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE ACTION :	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 867}	following CDC guidar tested revealed tested times weekly. 20). Review of Residuand #90's medical recresident had COVID-implemented. In additivesident's MAR revealmentering as ordered 21). Interview with the 09/30/2021 at 3:25 Pl Resident #321, Resident #321, Resident #321, Resident #321, Resident #351's for usage and approphe physician on 09/2 22). Observation of a 09/29/2021 at 4:35 Pl 09/30/2021 at 8:09 Al identified concerns with addition, observation floor on 09/30/2021 at 1:55 APM, N #4/Wound Car 2:54 PM, LPN #6 on 0 LPN #7 on 09/29/202 09/30/2021 at 1:54 Pt at 12:50 PM and LPN AM revealed no concendications. 23. Interview with the Operations on 09/30/2020.	esting two (2) times weekly ince. 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 illed staff was completing the d by the physician. e Medical Director on M revealed Resident #9, lent #324, Resident #326 medications were reviewed riate administration times by 3/2021. medication pass on M on 3rd floor and M on 3rd floor and M on 3rd floor seveled no of a narcotic count on 5th to 12:50 PM revealed no interview with RN #1 on the NM and 09/30/2021 at 12:58 e Nurse on 09/30/2021 at 12:44 PM, 1 at 3:00 PM and M, LPN #10 on 09/30/2021 #11 on 09/30/2021 at 10:31 erns with unavailable Vice President of	{F 8	67}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09	/30/2021
(X4) ID PREFIX TAG				ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	facility with a three-darequiring cost review. pharmacy agreement requiring a cost review the facility a minimum medication while being would communicate a guidance to the pharm Director of Operations the Vice President of 6 signed the agreement 24). Interview with RN AM and 09/30/2021 at 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 revealed they had recaware of the process of from the pharmacy. In they were aware that the physician if the pharm medication to the facility by 09/30/2021 at 3:40 09/30/2021 at 4:17 PM completed of all reside and verified all medica facility by 09/25/2021. pass on 09/29/2021 at 8:00 concerns with missing 26). Review of a QAPI	parmacy will supply the by supply for medication Review of the facility's revealed for any medication of the pharmacy would send of a three-day supply of the greviewed. The facility my changes or continuance macy within 72 hours. The for Guardian Pharmacy and Operations of the facility. #1 on 09/29/2021 at 11:55 to 12:58 PM, RN #4 on M, LPN #6 on 09/30/2021 at 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 on 09/30/2021 at 10:31 AM deived education and was for obtaining medications addition, they revealed the nurse would notify the acy could not deliver a sity. Regional Nurse Consultant PM, and Regional DON on M revealed an audit was ents' ordered medications sitions were available in the Observation of medication 4:35 PM on the third floor 9 AM revealed no identified medications.	{F 8	367]			
	the facility conducted a with the Regional DON	a meeting on 08/12/2021					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	FIPLE CONSTRUCTION NG	()	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
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{F 867}	Records, the Houseke Supply, MDS Nurse # Therapy Manager, the the Administrator, the Dietary Manager, and administration team. 27). Interview with the Operations on 09/30/2 Interview with the Interview with the Interview with the Uniterview with dail Uniterview with the Uniterview	esources, SSD #2, Medical eping Supervisor, Central eping Supervisor,	{F 8	67}			
_	outlined in the Rules a determined a plan for	ind Regulations, (3)					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	<u></u>	185256	B. WNG			09/	30/2021
	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>		
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{F 867}	and COVID-19 isolati facility to monitor/ass reposition residents, prepare and distribute residents with eating, effective Pharmacy S and neglect effectivel appropriate ADLS, and QAPI committee. 30). Interview with the 09/30/2021 at 3:40 Pic Consultant on 09/30/2 reviewed and revised presented the review. Committee during the facility developed a stall topics were review meetings. The plan in Foley catheters, entered contractures, physical usage, risk management, social grievance, activities, council concerns and discharges, census, so by department/position dietary variance tray work injuries, terminal medical leave of absonew hires, medical repharmacy reports, resoffice, and admission Committee and Medical standardized agendal but not be limited to terminal control of the committee of the co	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 and providing a functioning and providing a functioning and providing a functioning and providing and providing a functioning and/or revision to the QAPI	{F &	367)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZII 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	1 05	
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(F 867)	09/30/2021 at 1:39 Pt 09/30/2021 at 1:31 Pt Manager on 09/28/20 09/30/2021 at 1:52 Pt Director/Dietary Mana 1:30 PM, Medical Rec AM, Human Resource 09/30/2021 at 10:48 A 09/30/2021 at 1:18 Pt Supervisor on 09/30/2 Respiratory Therapist 12:45 PM and Central 2:40 PM, revealed the at the QAPI meeting by 31). Interview with the Operations on 09/30/2 Administrator on 09/30/202 meeting was conducted the duties of the Government	M, MDS Nurse #2 on M, Regional Certified Dietary 21 at 2:26 PM and M, Former Activities ager #3 on 09/30/2021 at 3 on 09/29/2021 at 8:34 birector (HR) on M, Therapy Manager on M, Housekeeping 021 at 1:24 PM, (RT) #1 on 09/30/2021 at Supply on 09/29/2021 at Supply on 09/29/2021 at Information was presented aeld on 09/16/2021. Vice President of 021 at 4:10 PM, the Interim 0/2021 at 3:40 PM, DON #2 PM, and the Medical 1 at 3:25 PM revealed a aeld on 09/16/2021 regarding arning Body including setting to be implemented in the aeting information to other ming Body. During the acting information to other ming Body. During the acting information and auditing Calendar were reviewed. Interim Administrator on I revealed he collected all are each QAPI meeting for compliance. A review of attertion of the proposition of the propos	{F &	367}			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	, , , , , , , , , , , , , , , , , , , ,	SHOULD BE	(X5) COMPLETION DATE	
	PM revealed they wer governing body, and of forwarded to them. 33). Interview with the Operations on 09/30/2 Regional Nurse Const. PM revealed the gove Administrator with resematerial for QAPI. Fur governing body would upcoming year. Intervi. Administrator on 09/30 he had been provided education regarding Qapt. Interview with the 09/30/2021 at 3:40 PN were conducted week ensure the quality of complied with the stancompliance. Further in President of Operation PM, Regional Nurse Capt. Among Nurse #2 on Regional Certified Diei 09/28/2021 at 2:26 PN PM, Former Activities I #3 on 09/30/2021 at 1: on 09/29/2021 at 8:34 Director (HR) on 09/30 Therapy Manager on Operator PM, Respiratory Thera at 12:45 PM and Centre Interview PM, Respiratory Thera at 12:45 PM and Centre Interview PM	ultant on 09/30/2021 at 3:40 e members of the DAPI meetings had been Vice President of 2021 at 4:10 PM and the ultant on 09/30/2021 at 3:40 rning body provided the ources and education ther interviews revealed the meet quarterly for the iew with the Interim 0/2021 at 3:40 PM revealed with resources and tAPI. Interim Administrator on If revealed QAPI meetings by effective 09/16/2021 to are is monitored and dard of care and terview with the Vice as on 09/30/2021 at 4:10 consultant on 09/30/2021 at 4:10 consultant on 09/30/2021 at 1:39 a 09/30/2021 at 1:31 PM, tary Manager on If and 09/30/2021 at 1:52 Director/Dietary Manager con PM, Medical Records AM, Human Resource	{F 8	367}			
	weekiy QAPI meetings	conducted on 09/16/2021					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE			200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501	09/	30/2021
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{F 867}	Medical Director/Phys 3:25 PM revealed he QAPI meetings on 09. Further interview with 09/30/2021 at 3:40 PM meeting had been conreview of the facility Conserview of the facility Conse	ddition, an interview with the sician #1 on 09/30/2021 at participated in the weekly /16/2021 and 09/23/2021. The Interim Administrator on M revealed the weekly QAPI inducted on 09/30/2021. A AAPI meeting attendance love interviews with no I #1 on 09/29/2021 at 11:55 tt 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 I4 PM, LPN #7 on M and 09/30/2021 at 1:54 B0/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on M, SRNA #11 on M, SRNA #11 on M SRNA #7 on 09/29/2021 9 on 09/29/2021 at 4:10 PM, 10:21 at 3:04 PM, SRNA #22 PM and SRNA #23 on M revealed they received 10:21. Interview with nursing realized understanding of obtaining, documenting, and to the Registered Dietician regional DON on 09/30/2021 staff was provided with 10:21 on proper weighing 10 documenting, and 10 ges to the Registered	{F 8	67}			
	current Dietary Manag PM revealed she rece	rmer Activities Director and ger on 09/30/2021 at 1:30 ived education on gional Certified Dietary					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		21	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	timely nutritional asset order accuracy. When the electronic medical the order sends writted dietary staff, which industrial further revealed that is the tray card system to orders. She stated that previous day would be meeting. Interview witt 09/28/2021 at 2:26 Pt PM revealed she comported former addition, she stated the provide additional assition to the rew role. 37). Interview with RN AM and 09/30/2021 at 3:00 Pt PM. LPN #10 on 09/30/000/00/29/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2021 at 3:17 09/29/2021 at 4:10 Pt education on turning/motion and transferring chair and from chair to turning, positioning, at on 09/29/2021 at 10:2 revealed no identified	set order accuracy and assements to ensure diet orders into a staff enter diet orders into a record, the nurse entering in communication to the cludes diet and texture. She she entered the order into oreflect the resident's diet at all diet orders from the ereviewed in the clinical that the Regional CDM on and 09/30/2021 at 1:52 apleted education with ctor/Dietary Manager #3. In that she had been on site to distance during the transition at the transition and 09/30/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 and 09/30/2021 at 1:54 B0/2021 at 12:50 PM, LPN #6 and 09/30/2021 at 1:54 B0/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on and SRNA #7 on 09/29/2021 at 3:04 PM, SRNA #22 and SRNA #23 on and revealed they received repositioning, range of a residents from bed to bed. Observations of and wound care with RN #11 and M for Resident #65 concerns. Interview with the 09/30/2021 at 1:18 PM	⟨F 8	967}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE ON 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	AM and 09/30/2021 at Care Nurse on 09/30/2021 at 12:4 09/29/2021 at 3:00 Pt PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 Pt 09/29/2021 at 3:23 Pt at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2 on 09/29/2021 at 3:17 09/29/2021 at 3:17 09/29/2021 at 3:17 09/29/2021 at 4:10 Pt education on pressure turning and reposition nutrition, Positioning and document a head and how to notify the RP of a new skin impaor email the Registere and the resident's rep changes. Interview with Consultant on 09/30/2 Regional DON on 09/2 revealed they educate prevention including to adequate hydration ar devices, how to comp head-to-toe skin asset the registered dietician new skin impairment, the nurse	221 regarding range of motion, and a from bed. 2 #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 and 09/30/2021 at 1:54 and 09/30/2021 at 1:50 PM, LPN 10:31 AM, SRNA #1 on and SRNA #7 on 09/29/2021 at 3:04 PM, SRNA #22 and revealed they received a ulcer prevention including ing, adequate hydration and devices, how to complete and one of the second of t	{F &	867}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		DULD BE	(X5) COMPLETION DATE	
{F 867}	at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 PM Director (HR) on 09/30 Marketing Liaison on Medical Records on 0 Central Supply on 09/43 on 09/29/2021 at 1 09/30/2021 at 2:10 PM Director/Dietary Mana 1:30 PM revealed the timely call light respor with RN #1 on 09/29/209/30/2021 at 12:58 PM Nurse on 09/30/2021 on 09/30/2021 at 12:58 PM Nurse on 09/30/2021 at 12:44 PM at 3:00 PM and 09/30/00 on 09/30/2021 at 12:509/30/2021 at 10:31 PM at 3:17 PM and SRNA #7 on 09/29/20 on 09/29/2021 at 3:04 PM at 3:17 PM and SRNA PM, revealed they recall light response, proresident plan of care, it staff dress residents in clothing and timely de interview with Cook #3 Dietary Aide #3 on 09/Former Activities Directory/20/2021 at 1:30 PM education on meal service.	S Nurse #1 on 09/30/2021 se #2 on 09/30/2021 at 1:31 sistant #1 on 09/30/2021 at 1:31 nager on 09/30/2021 at 10:48 AM, Senior 09/30/2021 at 10:55 AM, 9/29/2021 at 8:34 AM, 29/29/2021 at 2:40 PM, Cook 12 PM, Dietary Aide #3 on M, Former Activities ager #3 on 09/30/2021 at y received education on use. In addition, interviews 2021 at 11:55 AM and 20 RN, RN #4/Wound Care at 2:54 PM, LPN #6 on 20 RN, LPN #7 on 09/29/2021 at 1:54 PM, LPN #10 on PM, LPN #11 on 10 PM, LPN #11 on 10 PM, LPN #11 on 10 PM, SRNA #19 PM, SRNA #21 on 09/29/2021 at 3:23 PM 21 at 3:29 PM, SRNA #19 PM, SRNA #21 on 09/29/2021 at 4:10 eived education on timely by oviding timely hygiene per timely toileting, ensuring a their choice of clean livery of meal trays. Further 8 on 09/29/2021 at 2:10 PM, and 2tor/Dietary Manager #3 on 10 revealed they received	{F 8	367}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATÉ SURVEY COMPLETED	
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY. 200 NURSING HOME LA PIKEVILLE, KY 41501	NE	<u> 031</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 CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 867}	PM, RN #1 on 09/29// 09/30/2021 at 12:58 F Nurse on 09/30/2021 09/30/2021 at 12:44 F at 3:00 PM and 09/30 on 09/30/2021 at 12:5 09/30/2021 at 10:31 A education on ensuring entered into the electr Observation of RN #1 revealed the nurse wa knowledge of the educoncerns. 41). Interview with RN AM and 09/30/2021 at 12:4 09/29/2021 at 3:00 PN PM, LPN #10 on 09/30/ 409/29/2021 at 3:00 PN PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:29 PM at 3:29 PM, SRNA #19 SRNA #21 on 09/29/2 on 09/29/2021 at 3:17	se #2 on 09/30/2021 at 1:31 2021 at 11:55 AM and PM, RN #4/Wound Care at 2:54 PM, LPN #6 on PM, LPN #7 on 09/29/2021 /2021 at 1:54 PM, LPN #10 io PM, LPN #11 on M revealed they received g new care plans were ronic medical record. on 09/29/2021 at 11:55 AM as able to demonstrate cation with no identified 1 #1 on 09/29/2021 at 11:55 112:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 4 PM, LPN #7 on M and 09/30/2021 at 1:54 00/2021 at 12:50 PM, LPN 10:31 AM, SRNA #1 on M SRNA #1 on M SRNA #1 on M SRNA #7 on 09/29/2021 9 on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA #22 PM and SRNA #23 on M revealed they received ation and assessment of ge in respiratory status and mptoms of ycemia, facility diabetic a resident change in ion of blood sugar in the ation of the physician and ders. In addition, interviews dieducation on	{F 8	57}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			20	REET ADDRESS, CITY, STATE, ZIP CODE NO NURSING HOME LANE KEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	AM and 09/30/2021 at Care Nurse on 09/30/on 09/30/2021 at 12:4 09/29/2021 at 3:00 PI PM, LPN #10 on 09/3 #11 on 09/30/2021 at 3:40 PI 09/29/2021 at 3:40 PI 09/29/2021 at 3:23 PI at 3:29 PM, SRNA #1 SRNA #21 on 09/29/20 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PI education on complet with interventions and diagnosis of diabetes within forty-eight hour reviewing and providiresident/responsible put 44). Interview with MI at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 PI Director (HR) on 09/3 Marketing Liaison on Medical Records on 0 Central Supply on 09/30/2021 at 1:54 PI 12:58 PM, RN #4/Wo 09/30/2021 at 1:54 PI 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PI at 12:50 PM, LPN #11 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at	#1 on 09/29/2021 at 11:55 ti 12:58 PM, RN #4/Wound f2021 at 2:54 PM, LPN #6 f4 PM, LPN #7 on M and 09/30/2021 at 1:54 f0/2021 at 12:50 PM, LPN f0/2021 at 3:04 PM, SRNA #1 on f0/2021 at 3:04 PM, SRNA #22 f0/2021 at 3:04 PM, SRNA #22 f0/2021 at 3:04 PM, SRNA #22 f0/2021 at 6:30 PM f0/2021 at 6:30 PM f0/2021 at 6:30 PM f0/2021 at 6:30 PM f0/2021 at 10:48 AM, Senior f0/2021 at 2:40 PM, RN f1/29/2021 at 2:40 PM f1/29	{F 8	667}			

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 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	1 03	5072021
(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 X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
{F 867}	at 3:04 PM, SRNA #2 and SRNA #23 on 09/43 on 09/29/2021 at 1 09/30/2021 at 2:10 PN Director/Dietary Mana 1:30 PM revealed the process of identifying abuse as well as iden immediate intervention 45). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/0 on 09/30/2021 at 12:4 09/29/2021 at 3:00 PN PM, LPN #10 on 09/3 LPN #11 on 09/30/2021 they received education to the diet and texture, obtaining, reporting of weight ch. Dietician. In addition, Manager on 09/30/2021 had received education and provision of timely ensure diet order accurate put into the electronurse entering the ord communication to the diet and texture. She for orders from the previocal inical meeting, which Friday, to ensure accuration on facility peducation on facility peduca	M, SRNA #21 on 09/29/2021 2 on 09/29/2021 at 3:17 PM /29/2021 at 4:10 PM, Cook 1:12 PM, Dietary Aide #3 on M, Former Activities ager #3 on 09/30/2021 at y were educated on the h, preventing, and reporting tifying and implementing and for wandering residents. I #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 I4 PM, LPN #7 on M and 09/30/2021 at 1:54 00/2021 at 12:50 PM and 21 at 10:31 AM revealed on on proper weighing h documenting, and anges to the Registered an interview with the Dietary 21 at 1:30 PM revealed she on on diet order accuracy y nutritional assessment to uracy. When the diet orders onic medical record, the lier will send a written dietary staff that will include further revealed all diet further revealed all diet further revealed she received olicy regarding meal service ecipes, including recipes for	{F 8	67}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R 09/30/2021	
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		200 N	ET ADDRESS, CITY, STATE, ZIP CODE IURSING HOME LANE VILLE, KY 41501	1	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)		(XS) COMPLETION DATE
{F 867}	established national gcultural, and ethnic net 47). Interview with the 09/30/2021 at 1:30 Pl education on obtainin tray card system, ordes and/or portion sizes, scarts and snacks and 48). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/0 on 09/30/2021 at 12:4 09/29/2021 at 3:00 Pl PM, LPN #10 on 09/3 #11 on 09/30/2021 at Activities Director/Diecelog/30/2021 at 1:30 Pl education on the proceand/or implementing to recommendations for 49). Interview with the 09/30/2021 at 1:31 Pl 09/30/2021 at 1:32 Pl 09/30/2021 at 1:33 Pl 09/30/2021 at 1:34 Pl 09/30/2021 at 1:35 Pl 09/30/2021 at 1:38 Pl 09/30/2021 at 1:38 Pl 09/30/2021 at 1:38 Pl 09/30/2021 at 1:39 Pl 09/30/2021 at	sidents in accordance with ruidelines to reflect religious, reds of the population. Dietary Manager on of revealed she received good preference, facility er placement for meals, appropriate scoop sizes stocking snack/hydration hydrations. H 1 on 09/29/2021 at 11:55 tt 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 the PM, LPN #7 on of and 09/30/2021 at 1:54 the Dietary Manager #3 on of the registered dietician's dietary orders. Interim Administrator on of Dietary Manager #1 on of Maintenance Assistant #1 of PM, Therapy Manager on	{F 8	67)			

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	92.040	TIPLE CONSTRUCTION	()	(X3) DATE SURVEY COMPLETED	
		185256	B, WNG_			R 09/30/2021	
	DER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		<u> </u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	10.070	IOULD BE	E	(X5) COMPLETION DATE
Nur 09/3 at 3 on 0 09/3 at 3 SRI on 0 09/3 at 3 PM, Aide Acti 09/3 rece polii Pers red and reve wer con 09/3 the don (PP) 50). AM, Care (LP) #7 o 1:54 LPN they sym	30/2021 at 12:44 F 3:00 PM and 09/30 09/30/2021 at 12:5 30/2021 at 10:31 A 3:40 PM, SRNA #1 NA #7 on 09/29/20 1 at 3:04 PM and SRNA 6:17 PM and 19/30/2021 at 1:30 PM 6:10 PM	at 2:54 PM, LPN #6 on PM, LPN #7 on 09/29/2021 /2021 at 1:54 PM, LPN #10 /0 PM, LPN #11 on MM, SRNA #1 on 09/29/2021 /1 on 09/29/2021 at 3:23 PM /21 at 3:29 PM, SRNA #19 /0 PM, SRNA #21 on MM, SRNA #22 on 09/29/2021 /0 PM, SRNA #22 on 09/29/2021 /0 PM, SRNA #23 on 09/29/2021 /0 PM, SRNA #23 on 09/29/2021 /0 PM, Former /0 P	{F 8				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		5376012021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	COMPLETION DATE	
{F 867}	on 09/25/2021 and re 09/28/2021. A review Resident #355 reveale COVID-19 symptom resident orders. In ad #329, #328, #311, #69 records revealed each monitoring orders imp 51). Interview with RN AM, and 09/30/2021 at 3 Care Nurse on 09/30/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/202 #7 on 09/29/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/202 they had received edu of medication, right paties and right route. In add on the process to follow the process	dent #355 was discharged admitted to the facility on of re-admission for ed the resident had a nonitoring entered in the dition, a review of Resident 5, and #90's medical resident had COVID-19 lemented. I #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN (LPN) 2:00 PM and 09/30/2021 at 09/30/2021 at 12:50 PM, 21 at 10:31 AM revealed acation on the five (5) rights tration including right ent, right dose, right time, dition, they were educated by when a medication was mistration, which included to obtain the medication, ed medication delivery time, at if an ordered medication also worders given by the right conversation, and 10 in the electronic medical #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound	{F 8	967}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)		HOULD BE		(X5) COMPLETION DATE
{F 867}	LPN #11 on 09/30/2020 they had received educemergency medication floor three (3) on 09/29 four (4) on 09/29/2021 at 2 medication administration with an emergency multiple (LPN) #9 on 09/3 she was a new hire to received education remedication kit. 53). Interview with DC PM, MDS Nurse #1 on MDS Nurse #2 on 09/Maintenance Assistan PM, Therapy Manage Housekeeping Superv PM, Human Resource 09/30/2021 at 10:48 A Liaison on 09/30/2021 Records on 09/29/2021 Records on 09/29/2021 09/29/2021 at 11:55 A PM, RN #4/Wound Ca 2:54 PM, LPN (LPN) #7 on 09/30/2021 at 1:54 PM, LPN (LPN) #7 on 09/30/2021 at 1:55 PM, LPN #11 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #22 on 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #23 on 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #23 on 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #23 on 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #23 on 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #23 on 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #23 on 09/29/2021 at 3:29 PM at 4:20 on 09/29/2021 at 3:20 on 09/29/2021 at 3:2	21 at 10:31 AM revealed arcation on the use of the n kit (e-kit). Observation of 9/2021 at 3:10 PM, floor 1 at 2:57 PM, and floor five 2:50 PM revealed each action room was equipped edication kit. Interview with 80/2021 at 2:27 PM revealed at the facility and had garding the emergency 2N #2 on 09/30/2021 at 3:20 to 10/30/2021 at 1:31 PM, at #1 on 09/30/2021 at 1:18 PM, at #1 on 09/30/2021 at 1:18 PM, at #1 on 09/30/2021 at 1:18 PM, at #1 on 09/30/2021 at 1:24 to 10/30/2021 at 1:25 to 10/30/2021 at 1:25 to 10/30/2021 at 12:58 to 10/30/2021 at 12:58 to 10/30/2021 at 3:00 PM and 10/30/2021 at 3:00 PM and 10/20/20/2021 at 3:00 PM and 10/20/20/2021 at 3:00 PM and 10/20/20/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on 10/30/2021 at 3:17 PM and SRNA 4:10 PM revealed they Interim Administrator's direle as Abuse	{F 8	367)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION		SURVEY
		185256	B. WNG				R
NAME OF PI	ROVIDER OR SUPPLIER		1		TOSET ADDRESS CITY STATE TO ASSET	09	30/2021
	W POST-ACUTE AND RE			20	TREET ADDRESS, CITY, STATE, ZIP CODE DO NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION {EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	Abuse Coordinator po 54). Review of audits weekly head-to-toe sk no identified concerns	21, and 09/30/2021 ted with the Interim ct information and title of ested throughout the facility. beginning 09/17/2021 of cin assessments revealed c. Observation of Resident	{F8	67}			
	at 10:20 AM revealed	no identified concerns. A record for Resident #65, #27, #74, and #358					
	revealed the weekly we completed with physic notifications. Interview 09/30/2021 at 3:53 PM of new and/or worsen reviewed the residents with Medical Director revealed that he was a worsening skin impair	vound assessments cian and responsible party v with the Dietician on A revealed she was notified ing pressure ulcers and s as indicated. Interview on 09/30/2021 at 3:25 PM notified of new and/or ments and new					
	and discussed ongoin residents. Interview w on 09/30/2021 at 5:05 team discussed all au	cipated in QAPI meetings g audits and care of ith the Interim Administrator PM revealed the QAPI dits in QAPI meetings, worsening pressure injuries					
	at 2:40 PM revealed s all laboratory supplies revealed that the audit for four (4) weeks and months. A review of at Observation of floor th	ntral Supply on 09/29/2021 he completed the audits of on 08/28/2021. She further its were conducted weekly then monthly for three (3) udits revealed no concerns. iree (3), four (4), and five w of the audits revealed no					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	[09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
	Continued From page 56). Interview with the 09/30/2021 at 4:17 PN 09/30/2021 at 3:20 PN were audited during mensure all new areas obeen care planned with the area of concerns 57). Interview with the on 09/30/2021 at 10:5 completed visual roun hygiene, toileting, incorepositioning in additionally to the area of concerns 57). Interview of audits reversails, clothes, body odry, toileted as request hair clean and combectlean, call light within applicable and turned 58). Interview with the Operations on 09/30/2 Senior Marketing Liais AM revealed they part monitoring, and monitoring, and monitoring and mo	Regional DON on M, and DON #2 on M revealed progress notes forning clinical meetings to of skin impairment had the interventions to address a review of audits revealed staff were alled to the other leadership staff. The staff were auditing dor, incontinent clean and sted or every two (2) hours, downwest and blankets reach, facial hair shaved if and repositioned. Vice President of 2021 at 4:10 PM and the staff of time call lights go are revealed any call for the control of the control of the control of the control of the call lights go are revealed any call for the control of the call lights go are revealed on different units. RDON on 09/30/2021 at completed audits of	{F 8		DEFICIENCY)		
	respiratory assessmer communication Monda clinical meeting. She for	nts and SBAR by through Friday in the burther revealed that she					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY
		185256	B. WING				R
NAME OF P	ROVIDER OR SUPPLIER	700230	0. VIII VO.		REET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		20	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	respiratory status and completed had physici implementation of phy Resident #315 SBAR #324 SBAR complete completed on 08/15/2 physician notification, plans updated as indicervealed no identified 60). Review of Reside admitted on 09/10/2020 had a baseline care pi 09/10/2021. Resident 09/25/2021 and re-add 09/28/2021. Further refor Resident #355 revicomprehensive care pi (11) days after admission for Resident had a baseline 09/28/2021 at 1:39 PM 09/30/2021 at 1:39 PM 09/30/2021 at 1:31 PM admissions and re-add being reviewed during meeting Monday through the design of the add days from 07/16/2021 concerns with baseline MDS Nurse #1 on 09/2 revealed new/admissioned being updated as need 62). Interview with MD	nat any acute change in lor SBAR assessments sian notification and/or visician orders. Review of completed on 09/26/2021, don 09/27/2021, and #326 021 revealed assessment, interventions, and care cated. A review of audits concerns. Lent #355, who the facility 21, revealed the resident lan developed on #355 was discharged on mitted to the facility on eview of the medical record ealed staff completed the plan on 09/21/2021 (eleven sion). A review of dent #355 revealed the recare plan developed on with MDS Nurse #1 on M and MDS Nurse #2 on M revealed all new missions to the facility were at the morning clinical uph Friday to ensure	{F 8	667}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
<u> </u>		185256	B. WNG				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IQULD BE		(X5) COMPLETION DATE
{F 867}	completion, accuracy, was conducted with the responsible party with admission/re-admission revealed the audits withrough Friday. A revirevealed they included date, baseline care pladelivered to resident a and education as neer revealed no identified dates as indicated. 63). Review of the audit and/or CDM revealed stated with no identified the Regional Certified 09/28/2021 at 2:26 PM, and Dietary Mana 1:30 PM revealed tray ensure they arrived or timely. 64). Review of verbal at a staff members were question. Further review and five (5) staff in four (4) weeks from 08 on 09/13/2021 with no review of the verbal question. Interview of the verbal question. Interview of Consultant on 09/30/2 Regional DON on 09/3	ited Monday-Friday for and to ensure a review me resident and/or in 48 hours of on. Further interviews are conducted Monday ew of the audits completed diresident name, admission an completion, care plan and/or responsible party, ded. A review of the audits concern with completion dits completed by the DM they were completed as and concerns. Interview with Dietary Manager on Mand 09/30/2021 at 1:52 ager #3 on 09/30/2021 at s were audited for to a the unit and were passed and unit and were passed diew of verbal quizzes members were quizzed for 6/22/2021 and completed identified concerns. A viz revealed staff was status, and SBAR/physician with the Regional Nurse 021 at 3:40 PM, the 80/2021 at 4:17 PM, DON 20 PM, and MDS Nurse #2	{F 8	367}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		30/2021
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIA		- 1	(X5) COMPLETION DATE
{F 867}	assessment of resider respiratory status, ide hyperglycemia/hypogl protocol, documenting condition, notification on 09/29/2021 at 11:512:58 PM, RN #4/Word 09/30/2021 at 2:54 PM 09/30/2021 at 12:44 Fparticipated in verbal 65). Interview with the 09/30/2021 at 4:17 PM audits of documented Monday through Frida She further revealed to less than 60 and/or gr staff were expected to Responsible Party, an follow physician order stated she identified on 08/12/2021 to have a and one (1) on 09/20/3 glucose level of 465 we evidence the licensed process. She provided and LPN #5. A Review further concerns. A Re RN #2 and LPN #5 recthe facility process. 66). Review of verbal was verbally asked sig when to report, signs and wandering interve verbal quizzes revealed.	izes for identification and ints with a change in intifying signs/symptoms of sycemia, facility diabetic grace change in a resident's of the physician and iders. Interviews with RN #1 5 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 eater than 40, the facility on otify the physician, id Registered Dietician and s. The Regional DON ine (1) resident on blood glucose level of 430 2021 to have a blood	{F 8	67}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WNG			Ī	R
*****		183236	B. WING			09/	30/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	HARII ITATION CENTER		2	200 NURSING HOME LANE		
1 AKKIVILI				F	PIKEVILLE, 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)	PREFI: TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ITE	COMPLETION DATE
{F 867}	Continued From page	1,058	{F8	67}			
	08/19/2021 with no id-	entified concerns. Further	,	•			
		al quizzes were conducted					
	three (3) times a weel	k for two (2) weeks from					
	08/21/2021 to 09/02/2						
		verbal quizzes revealed					
		ere conducted one (1) time					
	per week for four (4) v	veeks from the week of					
	09/03/2021 to 09/24/2	021 with no identified					
		ith the Regional Nurse	i				
	Consultant on 09/30/2	021 at 3:40 PM, RDON on					
		/I, and MDS Nurse #1 on					
		/I revealed each assisted in					
	the completion of verb	al staff quizzes. Further					
İ		t each staff member was					
	verbally quizzed on th	e areas listed on the audit					
		oms of abuse, when to					
	report, signs and sym	ptoms of wandering and					1
	wandering intervention	ns), and any need for					
	education was comple	eted immediately with each					1
		RNA #11 on 09/29/2021 at					- 1
		6 on 09/30/2021 at 12:44					- 1
		09/29/2021 at 3:00 PM and					- 1
		/I, RN #1 on 09/29/2021 at					- 1
	11:55 AM and 09/30/2	021 at 12:58 PM, RN					
	#4/vvound Care Nurse	on 09/30/2021 at 2:54 PM,					- 1
	Medical Records on 09	9/29/2021 at 8:34 AM,					- 1
	Central Supply on 09/2	· · · · · · · · · · · · · · · · · · ·				[- 1
		09/30/2021 at 1:18 PM,				1	ĺ
	DM William Daniero	isor on 09/30/2021 at 1:24					J
	PM, Human Resource	Director (HK) on					
	09/30/2021 at 10:48 A						- 1
		2021 at 2:56 PM revealed					I
	they participated in ve	rbai quizzes regarding					ŀ
		, wandering and wandering				İ	
1	interventions.						
	67) Pavious of Basida	nt #255 00/40/2224					i
	revealed the resident h	nt #355 on 09/10/2021					
	wandering risk assess	ment completed on					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING	_	SURVEY
		185256	B. WNG			R /30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		 30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		HOULD BE	(X5) COMPLETION DATE
{F 867}	09/25/2021 and re-ad 09/28/2021. A review Resident #355 reveals admission wandering on 09/28/2021. The rebe at risk for wanderin Nurse #1 on 09/30/20 MDS staff will schedul assessments to ensur Regional Nurse Consiper Mand DON #2 on 0 revealed all-new admit in the morning clinical appropriate assessme wandering risk assess Further interviews revidentified as at risk for discussed during this interventions implementated the morning clinical appropriate assessme wandering risk assess Further interviews revidentified as at risk for discussed during this interventions implementated (10) resident interview weeks then five (5) 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 lethere are no injuries of no identified concerns Nurse Consultant on 0	#355 was discharged on mitted to the facility on of re-admission for ed the resident had an risk assessment completed esident was not identified to ag. Interview with MDS 21 at 1:39 PM revealed that le wandering risk re completion. Interview with altant on 09/30/2021 at 3:40 PM reviewed meeting to ensure ents, including the sment, had been completed. Healed that residents wandering would be meeting and appropriate inted. Bews performed for residents revealed and appropriate inted. Bews performed for residents revealed review revealed and on 08/13/2021 with ten residents for eight (8) weeks. In 09/30/2021 at 2:23 PM, in 09/30/2021 at 1:39 PM revealed residents for residents residents review of seessments for residents residen	{F 8	967}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUILDI	_	E CONSTRUCTION	(X3) DATE	SURVEY
		185256	B. WNG			l .	R
NAME OF P	ROVIDER OR SUPPLIER	100200	5, ,,,,,,		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
					200 NURSING HOME LANE		
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER		١.	PIKEVILLE, KY 41501		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	i ID	_	PROVIDER'S PLAN OF CORRECTION	_	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 867)	Continued From page	1.060	{F 8	671			
_	identified concerns. O		"	,	f		
		2021 of Resident #45 at					
	9:23 AM and on 09/30						
	Resident # 27 reveale	d no concerns with injuries	ŀ				
	of unknown origin.						
	69). Interview with the	Registered Dietician on					
	09/30/2021 at 3:53 PN	// revealed she started					' I
		of resident diet orders from					
	electronic medical rec	ords against orders entered					
	In the diet/tray card so	oftware to ensure accuracy.					
	Review of Resident #3	M, Resident #39's tray card					
		6 PM, and Resident #334					
		21 at 12:30 PM revealed					
	diets were served as o	ordered by the physician. A					
	review of audits revea	led audits were conducted					
	weekly for four (4) wee	eks.					
	70). Review of comple	ted audits revealed random			İ		
		rice daily for one (1) week					
	beginning 08/23/2021.	Starting 08/30/2021,					·
	random meals were of	bserved two (2) times per					- 1
	week for two (2) week	s and then weekly from					ŀ
	09/13/2021 for one (1)	month. Interview with					
		tor/Dietary Manager #3 on					
	Manager on 09/28/202	M, Regional Certified Dietary					i
		1 at 2.26 PM, and 1 revealed audits were					
	performed as indicated						
		ere served as scheduled.					
	including breakfast at	7:00 AM, lunch at 12:00					
	PM, and dinner at 5:00	PM. Observation on					
	09/28/2021 at 5:03 PM	I revealed the evening meal					
		e third floor. Observation					
		neal revealed meals arrived					
	at the third floor at app	roximately 12:16 PM, the					
	fifth floor at 12:16 PM	M and 12:24 PM, and the and 12:49 PM.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(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 COE 200 NURSING HOME LANE PIKEVILLE, KY 41501)E		30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	JD PREFI TAG		N SHOULD BE APPROPRIA		(X5) COMPLETION DATE
(F 867)	09/29/2021 at 12:04 Fon 09/29/2021 at 12:04 Fon 09/29/2021 at 12:04 Fon 09/29/2021 meals honored reside likes and dislikes. Interview of an audited daily for 09/15/2021 to 09/21/2 audits revealed snack beginning on 09/22/20 Regional Certified Die 09/28/2021 at 2:26 PM PM revealed she audited tidentified any conditional control of time clock punches. Sconcerns. Observation 09/28/2021, 09/29/2027 revealed no concerns. 73). Interview with the on 09/30/2021 at 3:40 at 4:17 PM, DON #2 conditional conditions of the original conducted with handwashing, isolation donning/doffing PPE, variance or identified of	ent #308's tray card on PM, Resident #39's tray card to PM, and Resident #334's 21 at 12:30 PM revealed the ent preferences, including enview with the Dietary 21 at 1:30 PM revealed she for obtaining food and is within seventy-two hours of the preferences into the udits revealed snack intakes one (1) week from 2021. Further review of the is were audited weekly 221. Interview with the stary Manager on M and 09/30/2021 at 1:52 ated snack intake and had cerns. Thuman Resource Director to 10:48 AM revealed she daily staff screening against the revealed no identified in of entry doors on 21, and 09/30/2021 Regional Nurse Consultant PM, RDON on 09/30/2021 at 3:20 PM, Control Nurse on M revealed audits were observations of	{F 8	367}			

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				TREET ADDRESS, CITY, STATE, ZIP CODE	09/	/30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	Continued From page		{F 8	67)			
	were conducted beging shifts and units.	nning 09/17/2021 on random					
	on 09/30/2021 at 3:40 responsible in addition review all residents or pharmacy to ensure the beginning 09/23/2021 no identified concerns 11:55 AM and 09/30/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/202 concerns with obtaining and/or receiving medic of medication pass on the third floor and 09/3 revealed no identified medications. In addition	n narcotics with the nat an active script is on file A review of audits revealed RN #1 on 09/29/2021 at 2021 at 12:58 PM, LPN 21 at 12:44 PM, LPN (LPN) 200 PM and 09/30/2021 at 209/30/2021 at 12:50 PM, 21 at 10:31 AM revealed no not scripts for medications cations timely. Observation 209/29/2021 at 4:35 PM on 30/2021 at 8:09 AM concerns with missing on, observation of the fifth floor on 09/30/2021 at					
	on 09/30/2021 at 3:40 responsible for complete	Regional Nurse Consultant PM revealed she was eting random medication					
	stated she had not ide residents not having n counts. A review of au	ginning 09/25/2021. She entified any concerns with medications or narcotic edits revealed the facility or Medicare Services Critical					
	Element Pathway for I conduct the medication twenty-five medication revealed a minimum of were observed daily from the second se	Medication Administration to n pass observation of us. A review of audits of twenty-five medications om 09/25/2021 with no urther review of medication					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ECONSTRUCTION	(X3) DATE	SURVEY
		185256	B. WNG				R
NAME OF P	ROVIDER OR SUPPLIER		0		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE\	W POST-ACUTE AND RE	HABILITATION CENTER		2	00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATÉMENT 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 867}	Continued From page	1,063	(F8	67}			
		served on random shifts, 3:00 PM and 6:00 PM to	,	•			
	on 09/30/2021 at 3:40 09/30/2021 at 3:20 PM delivery tickets were to meetings Monday thro	Regional Nurse Consultant PM. The DON on If revealed medication peing reviewed in clinical pugh Friday against ordered of the audit revealed no		!			
	09/30/2021 at 5:05 PM Consultant on 09/30/2 09/30/2021 at 4:17 PM 09/30/2021 at 3:20 PM being audited daily be	2021 at 3:40 PM, RDON on M, and the DON on M revealed staffing was aginning 09/11/2021, to fing was maintained. A					
	09/30/2021 at 5:05 PN	Interim Administrator on M, and the Dietary Manager PM revealed staffing was to ensure adequate e audits revealed no					
	Administrator on 09/30 daily audits had been	2021 at 4:10 PM and Interim 0/2021 at 5:05 PM revealed					
	80). Interview with the on 09/30/2021 at 10:5 completed observation						

	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 09/30/2021	
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER				200 N	ET ADDRESS, CITY, STATE, ZIP CODE JURSING HOME LANE VILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 880} SS=E	identify any change in interviews revealed if identified, staff would An audit review reveal change of conditions facility staff. 81). Review of interview of interview of the question interviews revealed review of the question interviews revealed reveryone treating you here? Do you have an the Medical Records AM revealed she commersidents on 09/25/20 identified no concerns Infection Prevention & CFR(s): 483.80(a)(1)(§483.80 Infection Confine facility must estatinfection prevention and designed to provide a comfortable environmedevelopment and transidiseases and infection program. The facility must establiand control program (Identified in the following service) in the following investigating resident condition. Further a change in condition was complete a stop and watch. led no concerns with the not being addressed by ews performed on onts with a BIMS score of 8 or identified concerns. A maire completed during esidents were asked: Is well? Do you feel safe by concerns? Interview with Estaff on 09/29/2021 at 8:34 pleted the interviews with 21, and she stated she control 2)(4)(e)(f) strol collish and maintain an and control program safe, sanitary and ent and to help prevent the smission of communicable is. revention and control pish an infection prevention in PCP) that must include, at	{F 8				12/30/21	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			l	R
NAME OF P	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
	W POST-ACUTE AND RE			2	200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	(X5) COMPLETION DATE
{F 880}	providing services und arrangement based up conducted according accepted national start §483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveill possible communicable infections before they persons in the facility; (ii) When and to whom communicable disease reported; (iii) Standard and trans to be followed to preve (iv) When and how isol resident; including but (A) The type and durate depending upon the interview in the interview of the circumstances. (v) The circumstances must prohibit employed disease or infected skir contact with residents contact will transmit the (vi) The hand hygiene possible time the possible circumstance in the circumstance of the circum	ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and orgram, which must include, ance designed to identify le diseases or can spread to other in possible incidents of e or infections should be smission-based precautions ent spread of infections; lation should be used for a not limited to: tion of the isolation, fectious agent or organism the isolation should be the le for the resident under the under which the facility es with a communicable in lesions from direct or their food, if direct e disease; and procedures to be followed ect resident contact.	{F 8	80}			

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 09/30/2021	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 880}	transport linens so as infection. §483.80(f) Annual rev The facility will conduct the facility will conduct the facility will conduct the facility will conduct the facility maintain an infection program to properly program to	le, store, process, and to prevent the spread of lew. It an annual review of its reprogram, as necessary. It is not met as evidenced in, interview, record review, lity's policies, it was realled to establish and prevention and control revent and contain the or seven (7) of 57 sampled layers and	{F 8	80}	F 880 Infection Prevention and Control Criteria 1: a) Resident #314 and #311 have completed quarantine for Covid-19 and are no longer in isolation. b) Resident #325 was discharged to hospital on 8-9-2021 c) Resident #82 was discharged to hospital on 8-9-2021 d) There are no current residents with Covid-19 diagnosis. Criteria 2: a) All residents are assesse for sign and symptoms of Covid-19 by staff nurse and documented on the MAI	9	
	attempt by the facility residents were expose effort to isolate the respread of the virus. In addition, the facility residents for COVID-1 Residents were not te (4) days after the staff	failed to immediately test 9 per the facility's policy, sted until 07/28/2021, four members tested positive.			every shift. Physician will be notified for any resident exhibiting any signs/symptoms of covid and staff will place them in isolation and test per our Covid policy for monitoring and treatme Criteria 3: The infection preventionist educated Facility staff on the following modules of the Nursing Home Infection Preventionist Training available on the CDC website at	nt.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	1	185256	B. WING_			ľ	R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	<u> 09/</u>	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 880)	the residents to prever others. Interviews with unable to isolate Resisted behavior of wandering continued to wander to the facility made no a residents until 08/05/2 residents tested position of the facility do routinely tested for CO However, State Regis #13 stated she was not scheduled shift on 07/2 through 6:00 AM on 0 at approximately 12:00 stated she started fee residents. She stated symptoms to the nursicovID-19 test, which From 07/28/2021 through 6:00 AM on 0 at approximately 12:00 stated she started fee residents. She stated symptoms to the nursicovID-19 test, which From 07/28/2021 through 6:00 AM on 0 at approximately 12:00 stated she started fee residents. She stated symptoms to the nursicovID-19 test, which From 07/28/2021 through additional three (3 resident #325, who recovID-19. Prior to the barrier being Resident #325, who recovID-19 positive resident #325 was not recovir to the state of the factor of the facto	the facility did not isolate nt the spread of infection to h staff revealed they were dent #311 due to his/her g; subsequently, the resident he hallways without a mask. Interprets to isolate the 2021, eight (8) days after the ve. cumented staff were 2021D-19 on 07/30/2021. Itered Nurse Aide (SRNA) of tested prior to starting her 130/2021 from 6:00 PM 7/31/2021. During her shift, 20 AM on 07/31/2021, she ling sick while caring for she reported her e who conducted a rapid was positive. Lugh 08/05/2021, an idents) tested positive for mig placed on 08/05/2021, esided across the hall from sidents, was observed as and sitting in a chair in the 20/ID-19 positive rooms. In the 20/ID-19 positive rooms. In the 20/ID-19 positive rooms. In the 20/ID-19 to 19/10/19. On 18/325 developed respiratory is ferred to the emergency. Resident #325 was	{F 8	80}	a. Module 1: Infection Prevention and Control Program-Licensed Staff to complete b. Module 2: The Infection Prevention Licensed Staff to complete c. Module 3: Integrating Infection Prevention and Control into the Quality Assurance Performance Improvement Program- Licensed Staff to complete d. Module 4: Infection Surveillance-Licensed Staff to complete e. Module 5: Outbreaks- Licensed Staff complete f. Module 5: Outbreaks- Licensed Staff complete g. Module 6A: Principles of Standard Precautions-All staff to complete g. Module 6B: Principles of Transmission Based Precaution-All staff to complete in. Module 7: Hand Hygiene-All staff to complete it Module 11D: Linen Management-All state complete it Module 11D: Linen Management-All state complete it Module 11D: Linen Management is attached of the completion. The credentials of the Infection Preventionist on staff is attached. See Attestation statement and the Credentials of ICP. All facility staff shall complete a review of the document entitled, Responding to Coronavirus (COVID-19) in Nursing Homes located at: https://www.cdc.gov/coronavirus/2019-rv/hcp/nursing-homes-responding.html; and	to aff	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/30/202	21	
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		CROSS-REFERENCED TO THE APPRO	BE COMP	(5) LETION NTE	
{F 880}	distress, had a decline back to the hospital at Interview with the Infe Preventionist/ADON/A 08/11/2021 revealed should have been test	eview revealed on #325 developed respiratory in condition and was sent and expired on 08/26/2021. Action Control Acting Interim DON on the was aware residents and immediately after the	(F 8	Keep COVID-19 Out! https://www.youtube.com/watch?v= 9MGdw; and Use Personal Protective Equipment correctly for COVID-19 https://www.youtube.com/watch?v= w9yav4	(PPE)		
	first COVID-19 positive staff member. She also stated she was aware residents who had COVID-19 should have been isolated. She stated not isolating residents with COVID-19 put others at risk for death. One (1) additional resident (Resident #327) tested positive for COVID-19 on 08/07/2021 and was hospitalized on 08/14/2021, and expired on 08/15/2021 at the hospital. Resident #82 and Resident #329 had also been hospitalized due to			All staff will completed the infection control modules as assigned by 11/24/2021. If a staff member has not completed them by 11/24/2021 they complete the assigned modules befortheir next scheduled shift. New emphired after 11/24/2021 will view assigned modules during the new employee orientation period.	will re pyees		
	likely to cause serious death to a resident. In identified, on 08/11/20 exist on 03/06/2021, a Rights (F580), 42 CFF Abuse (F600), 42 CFF Person-Centered Care CFR 483.25 Quality of (F692), 42 CFR 483.4 (F755) and 42 CFR 48 (F880). The facility wa Jeopardy on 08/11/20/20	I program has caused or is injury, harm, impairment or namediate Jeopardy was 21, and was determined to t 42 CFR 483.10 Resident 48 483.12 Freedom from 8 483.12 Comprehensive e Plans (F655), (F656), 42 FC Care (F684) (F686), 5 Pharmacy Services 13.80 Infection Control is notified of Immediate 21.		A consultant Infection Control Nurse (ICN)/ Infection Preventionist, with specialized training in infection preve and control has been contracted for twelve months starting on 11/23/202 See the attached contract of the condition Dated 11/15/21 and 12/17/2021. The Infection Preventionist consultant/infection preventionist/ Downstead Director/ Nurse Practitioner Regional Nurse consultant complete LTC infection control RISK assessmi 11/23/2021 A Root Cause Analysis (RCA) we conducted with assistance from the Infection Preventionist, members of Quality Assurance and Performance Improvement (QAPI) committee and members of Governing Body on	ract N/ and the nt on		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		185256	B. WING			l .	/30/2021
NAME OF PI	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DADKMEN	M BOST ACUTE AND DE	HADII ITATION OCNTOR		2(00 NURSING HOME LANE		
PARKVIE	V POST-ACUTE AND RE	HABILITATION CENTER		P	IKEVILLE, KY 41501		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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{F 880}	Continued From page		{F 8	80}			
	removal of the Immed	liate Jeopardy on			11/11/2021. See attached copy of the		
		r, the AOC could not be			Root Cause Analysis.		
	verified based on obs	ervations, staff interviews,			·		
		documentation. Additional			Beginning 12/7/2021 the Infection		
		was identified at 42 CFR			Preventionist updated the staff guideling	es	
		ces (F725), 42 CFR 483.70	1		for Isolation precautions to include that		
		(F837), 42 CFR 483.75			residents who are on precautions do no		
	Quality Assurance an	d Репогтапсе The facility was notified of			share a restroom with the resident who)	
		rdy on 09/10/2021. The			are not on precautions. A bedside		
	Immediate Jeopardy				commode is in the room of the resident precautions if they cannot have a	on	
	miniculate scoparty is origonig.				dedicated bathroom, Beginning 12/7/20	124	1
	A second acceptable	allegation of compliance			the infection preventionist educated all		
		5/2021, which alleged			nursing staff on the updated staff		li
	removal of the immed				guidelines.		
	09/26/2021. The Sta						
	determined the Imme	diate Jeopardy was			Criteria 4: Beginning on 12/18/2021		
	removed as alleged d	luring a revisit conducted on			Infection Control Round Audits are		
		lowered the scope and			conducted by the DON and/or designe	е	
		R 483.10 Resident Rights			daily on random units. The audits is do	ne	
		rehensive Person-Centered			by observation and includes		
	Care Plans (F655) (F						
) (F686), 42 CFR 483.35			Employees & Visitors enter Center		
		25), and 42 CFR 483.45 F755); and to "E" at 42 CFR			through only one entrance.		
	483 12 Freedom from	Abuse (F600), 42 CFR			2 Bossisster: Useigna/Court Stierratt	. 0	[[
		e (F692), 42 CFR 483.70			 Respiratory Hygiene/Cough Etiquett Hand Hygiene signs are posted ☐ Is thi 		1
	Administration (F835)	(F837), 42 CFR 483.75			observed during rounding.	5	
	Quality Assurance an				observed during rounding.		
	Improvement (F867),				3. Visitor Infection Control Instructions	are	
	Infection Control (F88				posted at screening location.	ui C	
		ness of systemic changes			production and an annual production in		
	and quality assurance				4. All staff/visitors are screened using t	he	
					most recent log upon entering the cent		
	The findings include:				_		1
					5. Adequate amount of hand sanitizer		{ I
	Review of the facility's	1 2			readily available.		ļ I
		Plan", dated 06/23/2020,			6. Immediately upon entrance to center		
	revealed staff will be	trained on the facility's			all staff performs hand hygiene and the	П]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER A. BUILDIN			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		185256	B. WING_			09/	30/2021
NAME OF PI	ROVIDER OR SUPPLIER		- 1	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	N POST-ACUTE AND RE	HARII ITATION CENTER	200 NURSING HOME LANE		200 NURSING HOME LANE		
- CANTAIL		HABIGIATION CENTER		1	PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 880)	Continued From page	e 1,070	(F8	80)			
	Pandemic COVID-19	plan and related policies	`	•	immediately apply a new surgical face		
		ff will be re-trained in Hand			mask.		
		ise of Personal Protective			7. Rooms of residents on precautions a	310	
		uding competency, and			clearly marked with correct	iie	
		gns and symptoms of			patient-specific precautions signs.		1
		ated in a private room with			patient opeonte presentions signs.		
		nitiate transmission based			8. Staff perform hand hygiene before &	,	
	precautions (TBP) ba	sed on CDC (Centers for			after resident care and/or contact with		
		Prevention) guidelines.			resident⊡s environment (even if gloves		
					worn).		
	Review of the facility's	s policy titled, "COVID-19			9. PPE is readily available. Ask staff		
		ns Plan", undated, revealed			where it is located and who do they		
		break of COVID-19, the			contact if unavailable.		
		be segregated away from			10. Staff perform hand hygiene and PP	E	!
	the rest of the populat	tion and the resident unit will			is donned appropriately (refer to poster) LI	
		d, Yellow, and Green zones.			gloves, gown, N95 respirator, face shie	ld.	
	Further review revealed						
		Yellow and Green Zones,			11. PPE removed appropriately (refer to		
		tains in semi-private rooms			poster) and placed in waste container.		
		fire doors will be closed			Container is covered. Staff perform har	nd	
		ssigned staff will work Red,			hygiene.	ļ	
	Yellow, and Green zo				12. If aerosol-generating procedure		
		igned. Further review of the			performed □appropriate PPE worn, doc	ıΓ	
		vere to be dedicated to work			closed, limited number of staff in room		
	in a designated area ((e.g. rea zone).			and surfaces cleaned and disinfected a	it	
	Review of the facility	s policy titled			end of procedure, doff gown.		
	Review of the facility's "CORONAVIRUS DIS				42 Basidant water		
		SEASE (COVID-19)- 'S", (undated) revealed			13. Resident water cups are		
		for the SARS-CoV-2 virus			replaced/sanitized.		
		e of current infections (viral			14. Resident hand hygiene performed		
		revent the transmission of]		before meals. Ask staff to explain how		
		ity. Further review revealed			they remind residents to do so.		
		eened daily for signs and			15. Gowns/Gloves are be donned and		
	symptoms of COVID-				doffed at the door prior to entering to ca	are.	
		ucted if there is an outbreak			for a resident on precautions.	31 C	
		reak is defined as any single			To a resident on precautions.		
		OV-2 infection in a resident			16. Gowns are single use and are not		
	or a single case of info				stored/saved for later use.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021	
	ROVIDER OR SUPPLIER ** POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, 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 880}	as a new confirmed c who test positive, incl pre-symptomatic residents free peated every 3 to 7 no new cases of SAR residents or healthcard days since the most of the facility records revealed on the facility records revealed on the facility records revealed on the facility records revealed on the facility records (RN) #2 and St (SRNA) #16 tested positive with SRNA and, revealed she work cared for residents the SRNA stated she test of the facility records residents the family mem for the facility is the facility of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the record for the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the next scheduled test of the facility is the f	g will be conducted as soon ase is confirmed. Residents uding asymptomatic and dents are cohorted and viral by negative residents will be days until testing identifies S-CoV-2 infection among the personnel for at least 14 ecent positive result. By's COVID-19 testing 17/24/2021, Registered ate Registered Nurse Aide positive for COVID-19. #2 for interview were #16, on 08/09/2021 at 11:47 ked on the fifth floor and roughout the unit. The end positive for COVID-19 on the did not think staff ularly or prior to working if the eral days. SRNA #16 further other and coworker SRNA hile at work after being SRNA stated SRNA #13 of starting her shift the night starting her shift the night at 6:00 PM on 143 on 08/01/2021 at 5:40 and positive for COVID-19 on 153 on 08/01/2021 at 5:40 and positive for COVID-19 on 154 on 155 on 156 on 15	{F 8	80}	17. Staff follow procedures for disposal PPE (mask, N95) at end of shift. 18. CPR Code Carts include required P and plastic sheet. 19. Staff change gloves between each patient and perform hand hygiene. Glownot worn in hallway. 20. Non-resident specific equipment is cleaned & disinfected between resident (scales, mech lifts, vital machines, stethoscopes, etc.) including ancillary svisits (phlebotomy, X-ray). If not able to observed, ask for verbalization of proced. 21. High touch surfaces (hand rails, elevator buttons, door knobs, etc.) are observed being cleaned and disinfected. 22. Food service workers are performin hand washing & proper PPE when storit preparing and handling food, and when cleaning dishes, food utensils and other cookware after the meal. 23. Resident who are on precautions do not share restroom with residents who and on precautions. A bedside commodis in the room of the resident on precautions if they cannot have a dedicated bathroom. I have attached a copy of the Audit form use by the DON or designee. We have copies of daily audits completed from the beginning of 11/18/21. See attach copy the audit form.	PE /es s taff be ss. f. g ng,	

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 D	20/2050 00 01/201/55	183236	D. WING			09/	30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		21	TREET ADDRESS, CITY, STATE, ZIP CODE DO NURSING HOME LANE IKEVILLE, KY 41501		
(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 880}	coworker and had tes Although the facility re and visitors prior to er stated the facility did related to contact trac SRNA #16. Per the St fifth floor and cared for She further stated she on 07/30/2021 and be of her shift. The SRN nurse that she felt ill. positive for COVID-19 Interview with Register 08/09/2021 at 10:55 Finight shift on the fifth for residents on the floor. did not require staff to on shift or after being stated the facility was specific days. Interview with the Corto8/09/2021 at 10:45 A conducting COVID-19 weekly on Mondays and residents. She state were responsible for to floor/unit and the Infection DON tests all staff. She roster to check off as the and a staff list was chefor testing. However, 07/30/2021 and it was staff testing on night staff testing on night staff.	s a family member and ted positive on 07/24/2021. Seported screening all staff intry to the facility, the SRNA not ask her any questions sing or being exposed to RNA, she worked on the or all residents on the floor. See began her shift at 6:00 PM segan feeling ill in the middle A stated she reported to the She stated she tested and was sent home. The RN stated the facility be tested prior to coming off for several days. RN #9 not testing staff on any porate Nurse Consultant, on the floor esting two (2) times are testing two (2) times are testing the facility was testing the facility was testing the facility of the floor esting residents on their estion Control/ADON/Interim testion Control/ADON/Interim testion the facility was not testing the facility was not the facility wa	{F 8	80)	Also attached are the Infection Control monitoring being done for infection consurveillance. Audits will be reviewed monthly in QAP x3 months then quarterly until in substantial compliance Criteria 5: Date of compliance: 12/30/2021		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		JOIZUZ I
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIECT OF THE AP	BE	COMPLETION DATE
{F 880}	not initiate resident te (4) days after the staf (a) Record review rev Resident #311 (who r tested positive for CO Record review reveale Resident #311 on 06/ Dementia, Alzheimer Fibrillation. Review of (MDS) dated 07/04/20 assessed the resident Mental Status (BIMS) indicated the resident impaired. Review of the Nurse's revealed staff had to a keep him/her in his/her resident became upse congestion was noted Nurse's Notes reveale #311 was doing well a Interview with RN #9 revealed Resident #3 unit after testing posit difficult to redirect and (b) Continued review testing records reveal #314 (who resided in #311) tested positive Record review reveal Resident #314 on 06/	dents for COVID-19, and did sting until 07/28/2021, four f members tested positive. realed on 07/28/2021, esides on the fifth floor) ovID-19. det the facility admitted 28/2021 with diagnoses of Disease, and Atrial of the Minimum Data Set D21, revealed the facility the with a Brief Interview for score of eight (8), which was moderately cognitively as Notes dated 07/30/2021, redirect Resident #311 to be room for isolation and the eat, though no cough or all Continued review of ed on 08/10/2021, Resident and was out of isolation. on 08/09/2021 at 10:55 PM 11 wandered the halls of the ive on 07/28/2021 and was discussed would get upset. of the facility's COVID-19 led on 07/28/2021, Resident the same room as Resident the same room as Resident.	{F 8	80}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021		
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		21	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	1 097.	30/2021	
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
(F 880)	Continued From page		{F 8	80}				
	revealed the facility a Brief Interview for Me ten (10), indicating the cognitively impaired. Review of Nurse's Not revealed Resident #3 no cough or congestion Nurse's notes dated (ut of isolation and doing well						
	(c) Review of COVID-19 testing records revealed Resident #329 tested positive for COVID-19 on 08/02/2021. Resident #329's room was next door to Resident #311 and #314's room on the fifth floor.							
	Resident #329 on 05/ Parkinson's Disease, and Dementia. Revie (MDS) dated 05/14/2/ assessed the residen of Mental Status (BIM	led the facility admitted 1/07/2021 with diagnoses of Congestive Heart failure w of Minimum Data Set 021 revealed the facility at to have a Brief Interview 1S) score of zero (0), at was severely cognitively						
	08/07/2021 at 5:29 Al developed at fever of	329 Nurse's Notes dated M revealed the resident 106.2 and was transported om for further evaluation.						
	was readmitted to the	M revealed Resident #329 e facility following eatment for Hypotension						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(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		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 880}	Continued From page	e 1,075	{F 88	0}		
	Resident #82 also tes on 08/02/2021. Resident months fifth floor, next Record review reveal Resident #82 on 05/1 Parkinson Disease at Review of the Minimuthe facility assessed Interview for Mental S (0), indicating the rescognitively impaired. Review of Resident #08/09/2021 at 12:55 developed tachypnes Resident #82 had a lest a sident #82 had a lest and the resident #82 had a le	82 Nurse's Notes dated PM revealed the resident (rapid respirations). ow oxygen saturation rate of				
	facility sent the reside for further evaluation Continued review of revealed the resident readmission to the fa from the hospital. The another facility.	Resident #82 clinical record did not return for cility following discharge are resident was admitted to ection Control Coordinator,				
	10:40 AM, revealed s facility approximately to newly diagnosed of facility staff and resident not responsible to co the facility for resider Control Coordinators	epartment on 08/09/2021 at she was in contact with the every other week in regards COVID-19 cases among lents. She stated she was induct contact tracing inside ints or staff. The Infection stated the facility was justing the contact tracing				

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				₹ 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	031	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 880}	staff was not conduct residents and staff ins Infection Control Coobig problem that they tracing properly." Per Coordinator, the facility could lead to a amongst residents and Interview with the Infe DON, on 08/11/2021 thought the local heat tracing in the facility aware the facility was contact tracing within Infection Control Nursaware residents should immediately for COV staff member testing no response as to wh four (4) days after sta 2021. Interview with Adminit 1:50 PM, revealed she was unaw responsible for compitracing. 3. Observation of the 08/05/2021 at 10:54 / (2) residents tested p 07/28/2021 and 08/07/28/2021	e stated she was not aware ing contact tracing for side the facility. The rdinator stated, "That is a fre not conducting contact in the Infection Control ity's failure to conduct sidents and staff inside the an outbreak of COVID-19 and staff. ection Control/ADON/Interim at 12:05 PM, revealed she lith department did contact. She stated she was not be responsible to do their own the facility. Per the se/ADON/DON, she was all have been tested ID-19 following the initial positive. However, she had be tested positive in July, strator, on 08/10/2021 at the thought the local health out tracing in the facility. She are the facility was leting their own contact	{F 8	80}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	103230	B. WIIVG	7	TREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021	
	W POST-ACUTE AND RE	HABILITATION CENTER		20	100 NURSING HOME LANE 11KEVILLE, KY 41501			
(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)		COMPLETION DATE	
{F 880}	Continued observation AM, revealed maintent barriers across the doto both Resident #311 at However, this was eight first resident on the floc COVID-19. Interview with Mainter 08/11/2021 at 11:30 A plastic zip barriers acrovided to covide the barriers acrovided the barriers. Motify the Maintenance another room converted place one of the plastic resident's doorway. Interview with SRNA #PM, revealed she dentraining related to PPE equipment) or COVID-second wave of outbre The SRNA stated she floor caring for both Conegative residents. Continued interview with Continued interview with contin	alls of the unit at will. evealed no designated trate residents. In, on 08/05/2021 at 10:54 trance staff placed plastic zip trance staff placed plastic zip trance and Resident #314 resided. In (8) days following the trance Assistant (MA) #1, on M, revealed he placed the trance and the desident rooms. MA #1 stated do the Maintenance the barriers prior to transe the first day the facility the first day the facility the first day the facility the A#1 stated staff was to the Department if a resident in the ded to positive so they could to zip barriers over the #3, on 08/05/2021 at 12:30 the daving received any the (personal protective the past the facility since the transe began in late July. Troutinely worked the fifth OVID -19 positive and the	{F 8	380}				
	08/09/2021 at 11:47 A	M, revealed she routinely		ſ				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER	1.	2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u> 09/</u>	30/2021	
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 880}	new residents became were not isolated or stated they continued negative residents. Slifor both COVID-19 poresidents all at the said the floor was the "undered wandered. She stated wander the hallways, residents' rooms. Interview with Certifier #1, on 08/05/2021 at who worked on the fift residents isolated in the unable to do so, becaused the door stated the door resident rooms, was the knowledge the facility isolate residents since COVID-19 infections to the residents' doorstated the only identified on the residents' doorstated the only identified on the residents on the door say; room. She stated the never been closed. The residents on the entire COVID-19 and those with the Infective w	e infected on the floor, they egregated to one area. She to be interspersed with RNA #16 stated she cared estive and negative me time. The SRNA stated efficial dementia" floor and who lived on the floor d many of the residents in and out of other d Medication Aide (CMA) 11:45 AM, revealed staff the floor attempted to keep their rooms, but they were use the residents did not end to leave their rooms. The ence placing the plastic zip ways of COVID-19 positive the first time to her had taken any action to the second wave of the second wave o	{F 8	80}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING_		00	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 09	13012021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE	
(F 880)	of residents who were wandering on the fifth one area, were discus Control Nurse/ADON/facility tried to keep pon the floor. However Nurse/ADON/DON stappead if positive residents off unit (isolated). Per Nurse/ADON/DON, stappead if positive residents to the unit if they were wand wear a facemask if the However, she mention nursing staff to utilize effective. Interview with the facion 08/09/2021 at 10:45 A a red zone where CO resided, a yellow zone admits or residents with facility more than twer stated when a resident and quarantined; a sign water indentifying the room at zip barrier curtain was doorway of the room to Nurse Consultant state the 5th floor were desother rooms on the 5th zone. She stated she rooms were not design	empted to isolate the neir rooms. Observations, positive for COVID floor and not isolated in issed with the Infection DON. She stated the ositive residents in one area or, the Infection Control ated the COVID virus could dents were not in a closed or the Infection Control ated the covid and the expected nursing staff to be expected nursing staff to be expected nursing staff to be closed off area on the ering and to ask them to be expected nursing one. The end is a covid and the facility is surse Consultant, on the end of the facility has one had been out of the inty-four (24) hours. She it was COVID-19 positive, their roommate were as placed on the door is red zone; and, a plastic immediately placed on the object of the positive rooms on ignated as red zone and all in floor should be yellow was not aware yellow zone	{F 8	880}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	<u> 09/</u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 880}	Resident #42 was wa floor outside the room COVID-19 positive. I wearing a facemask.	6/2021 at 6:02 PM revealed indering the hall on the fifth ins of residents who were The resident was not	{F8	80}			
	floor containing large PPE, which had been COVID positive reside was observed wander containers and staff was COVID contaminated	AM revealed large red hallway on each end of the amounts of contaminated used by staff while in ents' rooms. Resident #325 ring the hall walking past the					
	AM, revealed staff we PPE from COVID-19 bio-hazard can in the she was unsure why sinside the resident's ronly a couple of room to doff PPE. Continue on 08/05/2021 at 12:2 received recent trainin PPE or COVID-19 sin time. SRNA #19 state on the fifth floor, but work on that floor. The restorative aide and we throughout the building	g.					
	PM, revealed she had on PPE or COVID-19	#3, on 08/05/2021 at 12:30 I not received any training since the outbreak began staff doffed PPE in red					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND INCOME.		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	JOE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD B HE APPROPRIA		(X5) COMPLETION DATE
{F 880}	the fifth floor caring for COVID-19 virus and to virus. The SRNA state training recently on PICOVID-19. She further COVID-19. She further containers in the hallwing the rooms. SRNA areceptacles in the COWere the small person Interview with Certifier 08/05/2021 at 11:45 Areceived recent training on PPE donning and began. She further stawhether to doff contain outside of resident roopsitive, or where to positive, or where to positive, or where to positive rooms were for personal trash receptative rooms were for personal trash receptative with RN #1, revealed she had not COVID-19 and had not containers with bags is soiled linens and trash been doffing contaminary containers with bags is soiled linens and trash been doffing contaminary with states.	with SRNA #16, on MM, revealed she worked on or residents who had the hose who did not have the ted she had not received PE, handwashing, or er stated staff were doffing PPE in large red biohazard way with no PPE receptacle #16 stated the only VID positive resident rooms hal trash cans. In Medication Aide #1, on MM, revealed she had not had on COVID-19 or training doffing since this outbreak fated she was unsure minated PPE inside or long who were COVID polace contaminated PPE, so had been placing it in the direct biohazard containers. In the COVID por soiled linens and small facles. In 08/05/2021 at 11:50 AM, received training on the covid received training on the covid the covid received training on the covid received training or the covid received training or the covid received training or the covid received training ore	{F 8	180}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	()				(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER	<u> </u>	2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 09/	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
(F 880)	10:55 PM, revealed s training on donning as been inserviced since this time. She further a large red bio-hazard was the only place for contaminated PPE. Interview with the faci 08/09/2021 at 10:45 / biohazard containers floor were not for the PPE. The Nurse Contaware there were not residents' rooms for sight she could not explain biohazards containers. Interview with the Infe DON on 08/11/2021 a had not received new education on PPE or outbreak began in the were evaluated on do supervisory and visual competency. She stat were doffing PPE in the biohazard containers. doffing inside the resident stated she had not be since the COVID-19 of interview revealed residual contaminations and COVID-19.	with RN #9, on 08/09/2021 at the had not received any and doffing PPE, and had not a COVID-19 outbreak began a stated the facility provided a can in the hallway and that a staff to doff COVID lity's Nurse Consultant, on the fifth disposal of contaminated in the hallway on the fifth disposal of contaminated is ultant stated she was not trash containers in the staff to doff PPE. She stated the intended use of the red in the hallway. In the hallway. In the hallway of the red in the hallway. In the hallway of the red in the hallway. In the hallway of the red in the hallway in the red in the hallway in the red in the staff should be dents' room. She further en up on the 5th floor much putbreak began. Continued indents wandering in the hall atted PPE containers and	{F &	880}				
	1:50 PM, revealed the	strator, on 08/10/2021 at facility ensured staff were PPE through observation						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		00,	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		(X5) COMPLETION DATE
{F 880}	Control and Preventionshe was unsure if any conducted with staff soutbreak began. Per that also unaware staff we PPE in red biohazard where other residents stated there should be rooms to doff PPE. Shows specific auditing or was using to monitor observational monitor. 5. (a) Continued revies records revealed on the fifth flow the unit from the other positive for COVID-19. Record review revealed except the was a Brid and Alzheimer Diseas. Review of the Minimu 07/05/2021 revealed to the resident to have a Brid Status (BIMS) score or resident was severely. Review of Resident #108/05/2021 at 8:15 All stated to staff that he/had a fever of 100.3 difacility administered thest. Resident #328 to	C (Centers for Disease on) guidelines. She stated of retraining had been since this COVID-19 the Administrator, she was are doffing contaminated containers in the hallway awere wandering. She acontainers in COVID the further stated there was a documentation the facility infection control other than ring. By of the COVID-19 testing 08/05/2021 Resident #328 ov OID-19. Resident #328 ov OID-19. Resident #328 or on the opposite end of a residents who were 0. Bed the facility admitted 114/2021 with diagnoses of chemic Attack, Dementia sec. Im Data Set (MDS) dated the facility assessed the ef Interview for Mental of zero (0), indicating the cognitively impaired. 328 Nurse's Notes dated of revealed the resident (F). The the resident a COVID-19	{F 8	380}			

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 N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		03/	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		(X5) COMPLETION DATE	
(F 880)	#328 stated to staff he ambulating in his/her isolation. Continued revealed on 08/10/20: #328 was awake and congestion noted. (b) Review of the facili revealed on 08/07/20: (Resident #327) teste Resident #327's room floor near Resident #827 on 03/Dementia, Anemia and Review of the Minimu 07/22/2021 revealed for resident with a Brief In (BIMS) score of zero was severely cognitive Review of Resident #08/09/2021 at 5:19 Ph two (2) episodes of dinotified and the reside increase oral fluid inta Further review of the 108/14/2021 at 12:05 A staff found Resident # pressure, low heart ra saturation. The physical staff	21 at 5:17 PM, Resident e/she was feeling better and room while continuing on eview of Nurse's Notes 21 at 7:52 AM, Resident alert with no cough or lity's COVID-19 test records 21, an additional resident d positive for COVID-19. It was located on the fifth 32's room ed the facility admitted 15/2021 with diagnoses of d Chronic Peptic Ulcers. In Data Set (MDS) dated the facility assessed the interview for Mental Status (0), indicating the resident ely impaired. 327's Nurse's Notes dated of revealed the resident had arrhea. The physician was ent was encouraged to like and was drinking well. Nurse's Notes revealed on the AM during routine vital signs, factor of the control of the control of the emergency room further evaluation.	{F 8	880)				
		he resident had a blood						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER	1	S 2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, 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 880)	rate of 46 (normal ransaturation of 80% (no five (5) liters of oxyge temperature was 100, 98.6) prior to being so Review of Resident # summary reviewed the hospital on 08/15/202 diagnoses included Sometime President's Sepsis was Pneumonia. The resident's Sepsis was Pneumonia. The resident's Sepsis was Pneumonia. The resident's Sepsis was Pneumonia. The resident son the flocovid positive and the She stated there was or green zone, only in as red zone rooms. Continued interview word 11:47 And the fifth floor caring for COVID-19 virus and the fifth floor caring for COVID-19 virus and the fifth redirected. However, rooms and wandered interview with RN #9, revealed the only identification on the resident doors taped on door saying	rmal range 120/80), heart ge 60-100), and oxygen rmal range 95-100%) on n. The resident's control of the resident's control of the resident's admission resident expired at the serio of the resident's admission repsis and COVID-19 discharge summary, the likely due to the COVID-19 dent's discharge diagnosis representation of the residents who were nose who were negative. The residents who were nose who were negative. The residents who were dividual rooms designated with SRNA #16, on the residents who had the hose who did not have the ted many residents floor and had to be they did not stay in their the hallways on the unit. On 08/09/2021 at 10:55 PM, stiffers prior to the zip covers was a hand written paper if it was a red or yellow resident hall had never	{F &	80}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER	1	200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE SEVILLE, KY 41501	Ugi	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 880)	6. Continued observa AM revealed Resident the fifth floor in a chairesident was seated a residents' rooms while plastic zip barrier to a resident was observed AM wandering the hal biohazard waste conta doffing COVID contain Review of the facility's revealed Resident #32 COVID-19 on 08/08/2 Record review revealed Resident #325 on 09/ Dementia, Polyosteoa Disorder. Review of M dated 06/26/2021 revealed 08/26/2021 revealed the resident was moderate An attempt to interview 08/05/2021 at 11:05 A Resident #325 was re conversation. Resider room to lie down. Review of the Nurse's 2:45 PM, revealed Re in condition and had a developed a fever of 1 revealed the resident	e unit, both positive for who are not. tions on 08/05/2021 at 11:00 at #325 sat in the halfway on rewith no facemask. The adjacent to COVID positive emaintenance placed doorway. In addition, the doon 08/05/2021 at 10:54 at 10:5	{F 8	80}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER V POST-ACUTE AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
{F 880}	dated 08/12/2021 at #325 was readmitted hospital. Continued review of 08/19/2021 at 1:30 F developed a low oxy and the physician an were notified. The p care and Fentanyl patch) related to resi "Do Not Resuscitate' staff discussed the recare, DNR status, an physician with the re resident's representasend Resident #325 physician and DON and an ambulance the emergency room for Review of the Hospit revealed Resident #308/26/2021 and the 60 Acute Hypoxic Respi COVID-19 Pneumon Continued interview 08/09/2021 at 11:47 on the fifth floor woul wandered the hallwastated Resident #325	ag Readmission Assessment 4:40 PM revealed Resident It to the facility from the the Nurse's Notes dated M revealed Resident #325 gen saturation rate of 89% d resident's representative hysician ordered palliative atch (pain medication skin dent's declined condition and ODNR) status. Per the note, esident's condition, palliative and new orders from the sident's representative. The hive requested the facility back to the hospital. The were notified of the request ansported the resident to the evaluation. al Discharge Summary 325 expired at the hospital on discharge diagnoses included ratory Failure secondary to iia.	{F 88	30}		
	Continued interview	with RN #9, on 08/09/2021 at				

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PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE	
PIKEVILLE, KY 41501	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 880) Continued From page 1,088 10:55 PM, revealed Resident #325 roamed the halts, and residents were not staying in their rooms and fire doors were not closed to isolate positive residents to one end of the unit. Interview with Physician #1, who is also the Medical Director, on 08/04/2021 at 1:05 PM, revealed he expected the facility to isolate residents on the COVID Unit and monitor them for decompensation and signs and symptoms of COVID-19. He stated he was aware there were difficulties isolating residents due to cognitive dysfunction, lack of following directions and lack of wearing masks. He further stated he did not recall when he was made aware COVID-19 was back in the facility, but those residents who were positive were expected to be isolated in an area away from non-positive residents on the floor. The physician state he was not aware residents who were positive for COVID-19 were not isolated to one area of the unit. Interview with the Infection Control/ADON/Interim DON, on 08/11/2021 at 12.05 PM, revealed staff had not received new or recent training or education on PPE or COVID-19 since the outbreak began in the facility, but he stated staff were evaluated on donning and doffing PPE by supervisory and visual observation of their competency. She stated she was not aware resident stated she had not been up on the 5th floor much since the COVID-19 outbreak began. The ADON stated residents who wandered in the hall could touch contaminated PPE containers and spread COVID-19. She further stated he was aware plastic zip barriers were not of COVID-19 positive	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	()		SURVEY
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				PIKEVILLE, KY 41501			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	at	PROVIDER'S PLAN OF CORRE	CTION		(X5)
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{F 880}	Continued From page	1,089	{F 8	80}		i	
	residents' rooms until	08/05/2021. The Infection	'				
		stated the facility had initially	1				
	attempted to isolate th	ne positive residents in their					
	rooms. Observations	of residents, who were					
		andering on the fifth floor					l
	and not isolated in on-	e area, were discussed with					
	the Infection Control N	Nurse/ADON/DON, She					
	stated the facility tried	to keep COVID positive					
		on the floor. However, the					
		e/ADON/DON stated the				1	
		read if positive residents				ì	
		off unit and she stated a					
	closed off area of the	floor/unit could prevent the					
i		Per the Infection Control					
	Nurse/ADON/DON, st	ne expected nursing staff to					
		ne closed off area on the					
		lering and to ask them to					
		ey were not wearing one.					
		ned no further actions for					
	nursing staff to utilize	if redirection was not					
	effective.						
		ninistrator, on 08/10/2021 at					
		e facility ensured staff were					
		PPE through observation					
	she was usays if and	C guidelines. She stated					
i	she was unsure if any						
	conducted with staff si						
	outbreak began. When					ĺ	
	residents were current						
		nded there were initially four zed with COVID-19, but two					
						İ	ľ
		were back in the facility. sitive residents were kept					
}		floor in the red zone and					
		NOON Interim DON was					-
							- 1
		oring to ensure infection					
	stated she was unawa	in place. The Administrator are that all COVID 19					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING				R /30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	<u> </u>		200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 880}	floor. Per the Admini unaware staff were do red biohazard contain other residents were withere should be contained for PPE. She further auditing or documents monitor infection contimonitor infection contimonitor infection contimonitor infection contimonitor. 7. Review of Resident facility admitted the rediagnoses, which including the perfection of the	re not on one end of the 5th strator, she was also offing contaminated PPE in ers in the hallway where wandering. She stated iners in COVID rooms to stated there was no specific ation the facility was using to rol other than observation if #317's record revealed the esident on 07/23/2020 with uded Dementia and ling to his/her Annual sessment (MDS) dated the resident was not a Brief Interview for Mental of four (4). Per the MDS tent required assistance of a transfers and toileting. Resident #317's record 21 at 9:35 AM, the resident more assistance than in his/her lung fields and cough. Review of his/her hysician was notified of the dition and directed staff to for COVID-19; administer wice a day for seven (7) tal signs every four (4) is; and, isolate the resident will. Resident #317's vital a 97.7 F (normal 98.6 F) e was 86 (normal range overe 20 (normal 12-20) and	{F 8	80}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(3	X3) DATE COMP	SURVEY LETED
		185256	B. WING				₹ 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		037	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	E	(X5) COMPLETION DATE
{F 880}	5th floor, at 11:25 AM resident was ambulation his/her person. St staff were not observed mask and no staff were isolate him/her to his/hphysician. Further obsor/28/2021 at 11:20 A was ambulating arour conversing with staff, person. Staff was not offer/encourage him/hattempts to isolate him isolation due to a pote was observed. Observed observed observed a potential COVID-19 Interview with Registe 07/30/2021 at 9:50 AM Resident #317's physical potential COVID-19 RN, the physician ordinedications/treatment testing and ordered heroom. The RN stated he/she was negative. acknowledged she fail his/her door, and faile attempts to isolate him ordered by the physician ordered by the physician esident with a mask, resident with a mask,	ted on 07/27/2021 on the and 3:50 PM revealed the ing in the hallway, passing h no mask in use or noted aff were close by; however, ed to offer Resident #317 a re observed to attempt to her room as ordered by the servations conducted on M revealed Resident #317 and the nurse's station, with no mask on his/her to observed to her to wear a mask and no not/her to his/her room for ential COVID-19 infection vations of Resident #317's and 07/28/2021 revealed no ced on his/her door to do have been isolated due to infection. The Nurse (RN) #1, on M, revealed she contacted ician on 07/27/2021 at 9:35 at's change in condition and infection. According to the ered tes for the resident, COVID el/she be isolated to his/her she tested him/her and However, she led to place signage on	{F 8	380}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION	(X3	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	<u> </u>	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
{F 880}	resident and the ADO stated the ADON never testing of other reside the RN no further actionate residents. Interview with Physician 1:00 PM, confirmed his physician and was no change in condition, orders for staff to test a potential COVID-19 informed of staff's diffice specially those with estated he expected staway from the other resident in the stated the state of	sician's Orders to isolate the N just stated, "OK". She er directed any further nts to occur, and she gave ons to take to protect the an #1, on 08/04/2021 at e was Resident #317's tified of the resident's Physician #1 had given and isolate the resident for infection. He stated he was culty in isolating residents, dementia. However, he aff to isolate sick residents esidents to decrease the spreading in the facility and	(F 8				
	PM revealed Dietary A to retrieve a food tray where COVID-19 posi Further observations releaned/sanitized the taken from the 5th floodback to the kitchen so tray carts were observations revealed mask and had no other the cart, which had be the facility. Observationsed "Silver Power" to Interview with DA #1, of the retrieval of the cart, which had be the facility.	2021 at approximately 4:00 Aide (DA) #1 was observed cart from the 5th floor tive residents resided. The revealed no one cart before the cart was per, onto the elevator and filed dish area, where other red. Continued the DA utilized a surgical per PPE in use while cleaning en on the COVID-19 Unit in the salso indicated the DA oclean/sanitize the carts.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	IPLE CONSTI		(X3) DATE COMP	SURVEY
		185256	B. WNG				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200 NURS	DDRESS, CITY, STATE, ZIP CODE SING HOME LANE LE, KY 41501	<u> </u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 880}	anything different whe the COVID-19 unit in always utilized the "Siclean the food carts in been directed to chan Review of the Safety I indicated the agent was and further review of the evidence it was an eff COVID-19 virus. Interview with the Reg 08/18/2021 10:30 AM expected dietary staff with an effective agent carts were brought baprevent the potential stated she had not concelated to COVID-19 in and had not been directly limited in the limited in	ad not been directed to do en carts were retrieved from the facility. He stated he liver Power" degreaser to on the facility, and had not age any dietary processes. Data Sheet for Silver Power as utilized as a "presoak" the sheet provided no fective disinfectant for the ligistered Dietician (RD), on a revealed she would have to sanitize the food carts, at for COVID-19 before the lock into the kitchen to espread of COVID-19. She inducted training with staff infection control processes acted to do so. Section Control DON, on 08/18/2021 at 9:50 is not aware dietary staff had arts with an effective agent they were brought back in ag on the COVID-19. She would have expected coknowledged reeducation inducted in the facility, when is were identified for aned in the facility's policy, she had not conducted ecause she had been staff nurse.	{F 8	80}	DEFICIENCY)		
	**The facility alleged ti	he following was					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY
		185256	B. WNG	Ī		l .	R
NAME OF P	ROVIDER OR SUPPLIER	100200	1 2	_	TREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 880}	effective 09/26/2021: 1). Braden Scale Asse on all residents by fact and comprehensive for were completed on all The facility utilized the and comprehensive for review and update can had pressure injuries 2). The wound care pl #65 on 08/25/2021. Someasured all pressure evaluated all current to the Medical Di 09/17/2021. 3). Beginning 09/17/20 assessment and Bradibe completed, and the developed within 48 his pressure ulcer or pote comprehensive care per 21 days of admission or potential pressure unterventions to preventive to	essments were completed cility nurses on 08/28/2021 all body skin assessments be residents on 09/11/2021. The Braden Scale Assessment to be plans of residents who be open of the plans of residents who be open of the plans of residents who be open of the plans of residents who be open of the plans of residents who be open of the plans of residents who be open of the plans of residents who be open of the plans of residents and staff assessed and the injuries, and staff assessed and the present will be open of the plans of the plans will be open of the plans of	(F &	880}	DEFICIENCY)		
	clothing. Clean linens residents' beds on 09/	11/2021. The residents cial services on 09/15/2021.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			1	R 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	E	<u> </u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	. 100001	SHOULD B		(X5) COMPLETION DATE
{F 880}	by the Director of Nur New bath/shower sch by nursing staff to acc preference. Resident were obtained and inceplans and State Regist care plans by the Register plans by the Reg	shower/hygiene preferences sing (DON) or designee. edules were implemented commodate resident preferences for hygiene corporated into resident care stered Nurse Aide (SRNA) gional Nurse Consultant 2/13/2021. Re Registered Dietitian (RD) esidents' diets and made meal changes or ote healing and to address s. The diagnoses of Diabetes ive Pulmonary Disorder Pneumonia were assessed l/or Respiratory Therapist e identified completed Re reviewed all residents e monitoring by 07/30/2021 anded to include mandatory as on the Medication of (MAR). Iffied Dietary Manager meal service for breakfast, 9/11/2021, all three meals	{F 8	380)			
£6	recruitment efforts with provided through agen	h additional staffing ncy and travel contracts. aff schedules for the next					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY PLETED
		185256	B. WING_				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	, 63	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		THE APPROPRIA		(X5) COMPLETION DATE
{F 880}	levels are adequate to residents. The staff won the unit at the starf Director of Nursing, Nadministrator or design staff call offs will be requalified staff to see it and/or calling agencies qualified staff to fill the cannot be replaced the Assistant Director of Nursing management appropriate staffing lecenter will prioritize reachieved during emer required task including medication, no showe provided to incontiner that cannot turn self, it assist residents with restaffing levels have be meals are prepared at 12). On 08/11/2021, at #86 and #322, were reand physical forms of for Mental Status (BIM above and skin integribles) less than eight (Licensed Nurse, Residents).	nistrator to ensure staffing of meet the acuity of the sill be validated as present to of each shift by the sursing Supervisor, gnee. Direct care nursing eplaced by calling other of they can fill the opening, set to see if they have expensing. If direct care staffing sursing, or member of the team will fill the shift. If evels cannot be met, the sident care that can be gency staffing, prioritize gradministration of ers-sponge baths, care not residents, turn residents meals served timely, and meal if needed. Creased dietary staffing forts and appropriate een achieved to ensure and delivered timely. Il residents including #64, eassessed for psychosocial abuse with Brief Interview (1S) score of eight (8) or they reviews for residents with (8) were completed by dents with a diagnosis of are Plan reviewed and by the Minimum Data Set 109/07/2021. No new ed as indicating any	{F 8	80)			

	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
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 03	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)		COMPLETION DATE
{F 880}	Continued From page 13). The Regional Nu wandering risk asses 08/16/2021. All reside at risk for wandering updated by the MDS identified active wand placed at each nursing potential interventions 14). Residents #39, # #332 were weighed be Registered Dietician accomprehensive nutritive recommendations were recommendations by (DON) or designee of DON or designee, sp Medical Doctor (MD) and recommendation entered into the elect the tray card. The Re Director of Nursing (Din electronic medical	e 1,097 arse Consultant completed a sment on all residents by ents who were identified as had care plans reviewed and Coordinator. A list of all ler risk residents were g station with a list of s for nursing to reference. and the station with a list of s for nursing to reference. by 09/17/2021. The (RD) completed a son assessment and RD are reviewed for the Director of Nursing to 09/17/2021. Further, the oke with the attending and validated the diet orders s. Recommendations were ronic medical record and on gistered Dietician and DON), reviewed diet orders record to ensure both the	{F &		DEFICIENCY)		
	snacks to all resident afternoon by the restoraides, or designee. S physician will be doct aide, dietary aides and 16). The facility evaluation of the compliance with Compliance with Compliance of the compliance of the compliance of the compliance with Compliance of the compliance	2021. 2021, staff began offering so daily in the morning and prative nurse aide, activity nacks ordered by a sumented by the restorative ad/or licensed nursing staff. ated the COVID-19 unit on the 5th floor of the facility EDC guidelines and and red zones. The DON					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	l · ·	PLE CONST		(X3) DATE COMP	
		185256	B. WING_				R 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200 NUR	ADDRESS, CITY, STATE, ZIP CODE ISING HOME LANE LLE, KY 41501	031.	5072021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 880}	was designated with a barrier and those two this zone on 08/11/20 17). The facility had the time the red zone on 08 #328 and #329). Resignated quarantine physician orders. Rescompleted quarantine physician's order. Rescompleted quarantine physician's order. Rescompleted quarantine physician's order. Rescompleted quarantine physician's order. Rescompleted quarantine physician's order. Rescompleted quarantine physician's order. Resconding an 09/16/2021 tested for COVID-19 on 09/16/2021 tested for COVID-19 did not identify any new case testing on 09/16/2021 tested for COVID-19 did not identify any new control of the facility was controlled to the facility was controlled to placed in isolation zon droplet precautions was protective equipment physician notification, plan revisions. The Donewly positive COVID isolation precautions addition, any resident droplet precaution in facility will provide physician and care pemployee testing prodesignated days effect requires all staff must	esidents and a yellow zone erection of a plastic zip wall (2) residents were moved to 121. hree (3) residents who were 1/11/2021 (Residents #327, idents #327, idents #329 and #329 antine per facility policy and sidents #311 and #314 erection per facility policy and sidents #311 and #314 were 1/2021. The facility did not 1/2021. The facility erection 09/17/2021. The facility erection 09/17/2021. The facility erection of the employee on 09/17/2021. The facility erection of the employee on 09/17/2021. The facility erection of the employee on 09/17/2021. The facility erection of the employee on 09/17/2021. The facility erection of the employee on 09/17/2021. The facility erection of the employee	(F 8	30}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_				R 30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200 N	ET ADDRESS. CITY, STATE, ZIP CODE JURSING HOME LANE EVILLE, KY 41501	001	5012521	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 880}	negative COVID-19 to employee will be tested facility by the Infection designee. All testing of posted to the employer common areas. 20). The facility screet for signs and/or symptocumented on the MR Record (MAR). The famonitoring for signs a residents on 09/17/20. 21). Resident #9, Resident #326 and R were reviewed for use administration times 109/23/2021. 22). The facility states their medication as on and implemented phanotification if any medication regarding to 123). The facility will abide physician regarding to 123). The facility with a three medications that required for cost authorization 124). New admissions the facility after norm weekends will have designed to 124.	the to work without a current cest. During testing, the end prior to entering the in Prevention Nurse or dates and times will be ended and times will be ended and times of COVID-19 and dedication Administration acility implemented and/or symptoms on all total and appropriate by the physician on the physician of the physician dication was unavailable, by new orders from the end unavailable medication. Italiaded an agreement on facility's pharmacy to provide the facility's approval while pending cost review. In the physician on the facility's approval while pending cost review. In the physician on the facility's approval while pending cost review. In the physician on the facility's approval while pending cost review. In the physician on the facility's approval while pending cost review.	(F 8	BO}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185256	B. WING_				₹ 30/2021
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		200	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE
{F 880}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		{F 8	80}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R 09/30/2021	
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		_	(X5) COMPLETION DATE
{F 880}	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(F 8	80)			