STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pikeville Nursing and Rehab Center	260 South Mayo Trail Pikeville, KY 41501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50491 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure all medications were securely stored to restrict access to only authorized personnel as evidenced by one (1) of two (2) treatment carts observed unlocked, and unattended by staff on the North Main Hallway. The findings include: Review of the facility's policy, Storage of Medications revised date December 15, 2018, and the facility's Medication Administration policy revised on April 2019, revealed compartments containing medications were required to be locked when not in use: and trays or carts used to transport such items are not left unattended if unlocked. Observation, on 10/28/2024 at 10:22AM, revealed a treatment cart on the North Main Hallway unlocked and unattended by Registered Nurse (RN)1. RN1 was standing at the medication cart, which was approximately 12-15 feet away from the treatment cart. RN1 stated on 10/28/2024 at 10:25AM, he had been using the treatment cart but had entered a resident's room to administer medications thus leaving the treatment cart unattended and unlocked. During an interview, on 10/28/2024 at 10:25AM, RN1 stated it was not acceptable for a medication cart to be unlocked when not in use. RN1 stated medications should be securely stored because the facility would not want residents to have access to the contents of the cart. RN1 stated if the cart was not in use by one of the nurses, it should be locked. RN1 acknowledged there were cognitively impaired residents nearby who were independently mobile and could pass by the carts. RN1 stated it was important to lock the cart to prevent harm or injury to residents and visitors. During an interview, on 10/28/2024 at 10:40AM, with Licensed Practical Nurse/Unit Manager1(LPN/UM1) stated her expectations were for staff to provide a safe environment for residents. She stated treatment carts were to remain locked when not attended by staff because the facility had residents who might wander. LPN/UM1 further stated she would report any concerns to the administrator. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 10/28/2024 at 1:30PM, the Director of Nursing (DON) stated securing medications via locked storage was the facility's policy and was in place to prevent residents from having access to the contents of the carts. The DON stated the carts should always be locked when not in use. The DON stated it was important to prevent residents from coming by and getting a hold of and possibly ingesting some of the medications which could cause harm. The DON stated it was her desire to keep all residents safe. During an interview, on 10/30/2024 at 9:30AM, the Administrator stated the treatment cart should be locked when not in use. The Administrator stated this was important because of the potential harm for any resident. The Administrator stated she and her staff strive to provide a safe and happy home life for the residents and to attain as much quality of life as possible. She further stated all staff were her responsibility and the issues would be addressed immediately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44974 Based on observation, interview, and review of facility policy, the facility failed to maintain an infection control program to help prevent the development and transmission of communicable diseases and infections related to enhanced barrier precautions for 2 of 3 residents investigated for tube feeding care, Resident (R2 and R7). Additionally, observations revealed four unlabeled bed pans and one unlabeled wash basin lying in the bathroom floors were uncovered. The findings include:. Review of the facility policy, MDRO [multi-drug resistant organism] PPE [personal protective equipment]-Enhanced Barrier Precautions, dated 01/2024, revealed facility staff were to wear gowns and gloves when performing high-contact care for a resident with an indwelling device, such as a feeding tube. Review of the facility's policy, titled Infection Control, revised 03/2020, revealed the facility was committed to providing a safe and healthy environment for residents and to minimize or prevent the spread of infections. 46710 1a) Review of Resident (R) 7's Admission Record revealed the facility admitted the resident on 02/23/2023. Further review revealed R7's diagnoses on 10/27/2024 included Alzheimer's dementia, gastrostomy status, and adult failure to thrive. Review of the Orders tab in R7's electronic health record revealed the physician ordered enhanced barrier precautions. Observation 10/29/24 10:13 AM revealed Registered Nurse (RN)2 failed to don a gown while performing tube site care for R7. Further observation revealed a sign on R7's door for enhanced barrier precautions, as well as a container of PPE, including gowns and gloves. In an interview on 10/29/2024 at 10:57 AM, RN2 stated she thought the sign on R7's door indicated the resident had a history of a multi-drug resistant organism. She further stated she needed to ask her manager if she was supposed to wear PPE while providing care to R7. b) Review of R2's Admission Record revealed the facility admitted the resident on 08/23/2000. Further review revealed R2's diagnoses as of 10/28/2024 included cerebral palsy, gastrostomy status, and dysphagia. Observation on 10/29/24 10:50 AM revealed RN2 failed to don a gown while performing G-tube site care for R2. Further observation revealed there was no sign for enhanced barrier precautions (EBP) on R2's door, though appropriate PPE, including gowns, were available in the container hung on the door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 10/29/24 at 10:57 AM, RN2 stated she did not know why R2 had gowns hanging in a container on her door. She further stated there was no sign, so she did not know why the PPE was there or when staff were expected to wear PPE for R2. In an interview on 10/29/24 at 2:15 PM the South Unit Manager (SUM) stated the facility implemented enhanced barrier precautions (EBP) for residents colonized with multi-drug resistant organisms (MDROs), as well as for residents with indwelling devices, such as G-tubes and urinary catheters. In further interview, the SUM stated she expected staff to wear a gown and gloves for a resident in EBP any time they came into contact with the resident's bodily fluids or provided care to the G-tube or catheter. Per interview, RN2 asked the SUM if she needed to wear PPE for R2 because the sign had fallen off the door, so she did not know why the PPE was hanging on the door. In an interview on 10/29/24 at 2:23 PM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) stated the facility implemented EBP for every resident with a feeding tube, chronic wound, or foley catheter because those residents were at higher risk for developing infections. She further stated her expectations were for staff to wear a gown and gloves when providing care to a G-tube. In an interview on 10/29/24 at 2:31 PM, the Director of Nursing (DON) stated the facility policy was for staff to wear PPE, including gown and gloves when providing high-contact care, especially caring for a wound, G-tube, or other indwelling device. In an interview on 10/29/24 at 2:39 PM, the Administrator stated she expected staff to wear PPE, including gowns whenever providing care for an indwelling device, changing linens, or other high contact care. She further stated the facility maintained signage on the residents in EBP to alert staff to the PPE they needed to wear for care activities. In continued interview, the Administrator stated the importance of EBP was to protect vulnerable residents from potential bacteria on staff member clothing. 49360 2. Observation of the bathroom in room [ROOM NUMBER] on 10/27/2024 at 1:47 PM revealed one unlabeled, uncovered bed pan sitting on the floor. Observation of the bathroom in room [ROOM NUMBER] on 10/27/2024 at 2:36 PM revealed two unlabeled, uncovered bed pans and one unlabeled, uncovered wash basin sitting on the floor beside the commode. Observation of the bathroom in room [ROOM NUMBER] on 10/27/2024 at 2:53 PM revealed one unlabeled, uncovered bed pan sitting on the floor. Observation of the bathroom in room [ROOM NUMBER] on 10/27/2024 at 4:15 PM revealed one unlabeled, uncovered bed pan sitting on the floor beside the commode. In an interview with Certified Nursing Assistant (CNA) 1 on 10/27/2024 at 2:00 PM, she stated bedpans and wash basins were to be labeled with resident room number and bed number and had to be covered and placed in the bottom drawer in resident rooms. CNA1 stated if not labeled and stored properly it became an infection control issue and bacteria could be spread from resident to resident. CNA1 stated the bedpans and wash basin would be thrown away to prevent the spread of bacteria. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Licensed Practical Nurse (LPN) 1 on 10/29/2024 at 9:52 AM, he stated bedpans and wash basins were to be labeled and covered in a bag and stored in bottom drawer in a resident room to prevent the spread of infection. In an interview with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) on 10/30/2024 at 10:18 AM, the ADON/IP stated she did infection tracking every Monday and did a walk through daily to make sure there were no infection control issues such as items on medication carts or nursing counters. The ADON/IP stated all bedpans were to be stored labeled and in a bag in the bottom drawers of resident rooms. Also, the ADON/IP stated the wash basins were treated the same way and should be labeled and in a bag. The ADON/IP stated labeling should include the resident room number and the bed number. The ADON/IP stated it was her expectation that any staff member who found a bedpan or wash basin unlabeled or uncovered, then that item would be thrown away as it was an infection control issue, which would cause germs to be passed from resident to resident or germs could be spread to a staff member. The ADON/IP stated infection control trainings occurred at least quarterly but usually something regarding infection control was reviewed monthly with staff as during her daily walk through of the facility she found little things that needed to be re-educated on. In an interview with the DON on 10/30/2024 at 3:29 PM, the DON stated she did rounds on the hallway during room rounds to look for any infection control concerns such as foley catheters without dignity bag, bedpans not stored properly, and issues with enhanced barrier precautions. The DON stated it was her expectation that bedpans and wash basins be stored in a plastic bag in bottow drawers in resident rooms with appropriate labeling on it. The DON stated it was her expectation that if it was found unlabeled or uncovered, then it would be thrown away to prevent the spread of infection. The DON stated her IP would re-educate on the spot if any issues with infection control was found in the facility. In an interview with the Administrator on 10/30/2024 at 3:49 PM, the Administrator stated she completed room rounds daily but did not go into resident bathrooms on room rounds. The Administrator stated it was her expectation that bedpans and wash basins be labeled and covered and stored in bottow drawers. The Administrator stated she would not expect bedpans, urinals, or wash basins to be left lying on the bathroom floors as it could potentially spread infection to other residents or other staff members. The Administrator stated infection control issues were discussed in quality assurance performance improvement (QAPI) meetings and any issues with infection control was discussed and plans were implemented during that time. The Administrator stated the DON and the IP did audits and education over infection control at least quarterly but as needed if any issues arose that needed attention.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51157 Based on observation, interview, review of the facility's job descriptions, review of the facility's policies, and food establishment inspection reports, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Observations from 10/27/2024 through 10/30/2024, revealed blunt, metal plumbing protruding from the wall above the toilet in two bathrooms shared by four resident rooms, flooring was uneven in hallways, and resident bathrooms; lighting issues in resident bathrooms and the kitchen, odors permeating from the floor in resident bathrooms, leaking pipes from equipment in the kitchen, chipped and peeling paint/drywall in resident rooms as well as the kitchen, peeling paint on the floor in the kitchen, rust on the door frames in resident rooms, large scuff marks on doors and walls in resident rooms and bathrooms, and a crack in the glass of the main entrance door. These identified issues provided potential impalement concerns, fall risks, and did not provide a comfortable homelike environment for residents, staff, and visitors. The findings include: Review of the facility's Homelike Environment, policy undated, revealed residents would be provided with a safe, clean, comfortable, and homelike environment. Facility staff and management would maximize the characteristics of the facility that included a clean, sanitary, and orderly environment, comfortable yet adequate lighting, and pleasant, neutral scents. Additionally, the facility staff and management were to minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting which included institutional odors and institutional signage. Review of the facility's job description for the Environmental Supervisor dated 03/18/2016, revealed the Environmental Supervisor was responsible for ensuring the facility and grounds were maintained and safe for all residents, staff, and visitors. The Environmental Supervisor would recognize, remove, and/or report potential hazards. Review of the Maintenance Assistant Job Description dated 11/09/2016, revealed the Maintenance Assistant would collect and review maintenance requisitions from all units and departments of the facility. The Maintenance Assistant would maintain adequate and comfortable lighting level, appropriate for tasks. Review of the facility's document, titled Job Description: Environmental Supervisor, revised 03/08/2016, revealed the Environmental Supervisor had the following administrative responsibilities to supervise housekeeping staff with all aspects of maintaining the facility interior and grounds to ensure resident rooms were clean, safe, and comfortable. Continued review of the facility's document revealed the Environmental Supervisor would supervise maintenance staff and ensure the facility and grounds were maintained and safe for all residents, staff, and visitors by ensuring all maintenance staff comply with all life safety regulations. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's health department inspections, dated 01/09/2024 and 07/26/2024, revealed observations from the Health Department to include paint coming off the floor, the wall at the garbage disposal is not clean to sight or touch, and poor lighting. Continued review of the inspection report revealed these are repeat violations dating back to 12/18/2019. 1. Observation on, 10/27/2024 at 1:30 PM, revealed the facility's entry door had a crack in the glass in the lower right corner. Observation on 10/27/2024 at 1:50 PM, revealed the kitchen area had paint chipping on the floor under and in-front of the three-compartment sink, the piping for the ice machine was leaking, the sink drain for the garbage disposal had cracked and was leaking into a bin below the garbage disposal, and the dishwasher was leaking and had a bin below it catching water. Continued observation revealed, the wall behind the garbage disposal had residue buildup that had leaked from a chemical dispenser and was coating the wall. The wall behind the garbage disposal had several areas where paint was chipping off. A door from the dining area to the kitchen had rust at the bottom. Additionally, the hood above the cooking area was missing 2 light bulbs. Observation on, 10/27/2024 at 2:35 PM, revealed a bathroom shared between Resident rooms [ROOM NUMBERS] had plumbing protruding from the wall behind the toilet, a broken toilet paper dispenser, cracked and chipping drywall at the base of a grab bar, scuffed and chipped paint on the door, and rust around the door frames leading into the bathroom. Observation on, 10/27/2024 at 3:32 PM, in resident room [ROOM NUMBER] revealed lighting in the bathroom to be extremely low, making it difficult to see. The flooring was uneven and was raised beginning at the base of the toilet and continued around the wall on the opposite side of the bathroom, measuring 1-foot-wide X 3 feet long. Baseboards were separating from the wall behind the toilet measuring 4 feet. A urine splash guard located behind the toilet was separated from the wall. Observation on, 10/28/2024 at 4:05 PM, in the bathroom of resident room [ROOM NUMBER] revealed a gap in vinyl plank flooring that measured 7.5 inches. Drywall was peeling and scuffed on the wall opposite of the toilet measuring 2.5 feet in length. Continued observation revealed both doors into the bathroom have rust and scuff marks. Additionally, a light switch in R5's room revealed a missing status indicator light. In an interview on, 10/27/2024 at 2:37 PM, with Resident (R)59 he stated because of the broken toilet paper dispenser the toilet paper will sometimes be placed on the floor by someone else using the bathroom and when that happens, he will have to use the call bell and wait for nursing staff to come and assist him because he is unable to reach the toilet paper in the floor. R59 stated that this was frustrating, and he knew staff were aware because of how often they had to assist him. In an interview on, 10/27/2024 at 3:45 PM, R74 stated that the bathroom light was too dim, and he had notified the nurses. R74 stated that he would sometimes have to leave the door open so he can see what he was doing while in the bathroom. R74 stated that he felt like the lighting should be brighter so he could close the door while in the bathroom and still be able to see. 44974 (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 10/27/2024 at 2:15 PM of the bathroom between rooms [ROOM NUMBERS], revealed two metal plumbing pipes, by and just to the right of the commode, protruding 2 1/2 inches from the wall and 2 inches in diameter that could cause an impalement hazard to residents. Resident (R) 6 and R 29 both utilized this bathroom. Review of R6's Admission Record revealed R6 was admitted on [DATE] with diagnoses of congestive heart failure, scoliosis, osteoarthritis, and osteoporosis. Review of R6's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 09/01/2024 revealed a Brief Interview for Mental Status (BIMS) score of 12 of 15 which indicated R6 was cognitively intact. Further review of the MDS revealed R6 was independent with transfers from the wheelchair to the commode. Review of R6's Care Plan revealed a focus for at risk for Falls related to weakness, debility, difficulty walking and lack of coordination, initiated on 05/30/2019, and revised on 05/30/2019, and on 09/18/2024. Review of R29's Admission Record revealed R29 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease, Tremors, and vascular dementia. Review of R29's MDS with an ARD date of 09/13/2024 revealed a BIMS score of nine of 15, which indicated R29 was moderately cognitively impaired. Further review of the MDS revealed R29 was independent with transfers from the wheelchair to the commode. Review of R29's Care Plan revealed a focus for at risk for falls related to dementia, tremors, and a history of falls initiated on 09/20/2024. During an interveiw on 10/29/2024 at 1:57 PM with the Maintenance Director he stated he rarely looked at the (Technology Solutions and Services) TELS system (an electronic system used by facilities for communication for repairs). The Maintenance Director stated the only thing he did on TELS system was the routine tasks. The Maintenance Director stated he mainly looked at the maintenance book that was kept at each nursing station and they did work orders on paper. The Maintenance Director stated the staff would fill out what needed repaired, and then the Maintenance staff would write on the paper work order on what they fixed and how they fixed it. The Maintenance Director stated he does a walk through daily and would look at the books at the nursing station every morning and sometimes more, and would do those tasks first unless something bigger needed to be fixed. The Maintenance Director stated he was not aware of the flooring being raised up down the North Main hallway or outside room [ROOM NUMBER]. The Maintenance Director stated there was a 30 feet part of the flooring that a contracted company had repaired but the area continues to need repair. The Maintenance Director stated the uneven flooring, the clean out covers being cracked, and the uneven flooring was a hazard risk to both residents and staff that could cause injury. The Maintenance Director further stated the odor in the bathroom was where water had hooved up the flooring around the base of the commode, even though the odor was a strong urine odor. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/29/2024 at 2:15 PM of the maintenance repair log at the North Nurses station revealed needed repairs. There was no documented evidence of missing drywall, chipped paint, and/or impalement areas listed. Surveyor: [NAME], [NAME] 49360 3. Observation of the North Main Hallway on 10/27/2024 at 1:40 PM revealed the brown flooring had loosened adhesive and uneven flooring around the clean out covers, which caused cracked areas and gaps in the brown flooring. Observation of Resident (R) 79 on 10/27/2024 at 1:44 PM revealed R79's call light was lying on the floor and out of reach of R79. Observation of the bathroom in room [ROOM NUMBER] on 10/27/2024 at 1:47 PM revealed the bathroom had a strong urine odor. Observation of R58 on 10/27/2024 at 1:56 PM revealed R58's call light was lying on the floor under his bed and out of reach of R58. Continued observation revealed the brown flooring outside R58's room had loosened adhesive which caused the flooring to rise up from its base causing a trip hazard. Observation of room [ROOM NUMBER] on 10/27/2024 at 2:04 PM revealed scuffed, chipped paint on the door facing and door leading into resident room [ROOM NUMBER]. Observation of the bathroom in room [ROOM NUMBER] on 10/27/2024 at 2:08 PM revealed a strong urine odor with an unflushed commode. Observation of R73 on 10/27/2024 at 2:53 PM revealed R73 was lying in the bed with call light lying on the floor. Observation of R73's bathroom revealed the bathroom door had scuffed, chipped paint on both the door and the door facing. Further observations on 10/28/2024 at 8:44 AM and on 10/29/2024 at 3:16 PM revealed the issues remained with no signs of staff addressing the issues. In an interview on, 10/27/2024 at 2:00 PM, the Dietary Account Manager stated that she used a computerized reporting program to notify the Administrator and Maintenance Director of work orders for the kitchen. The Dietary Account Manager stated that she had reported the leaking pipes, chipped floors, and walls needing painting on this system. The Dietary Manager provided open and in progress work order requests submitted through the computerized reporting system dating back to 2023. The Dietary Manager stated that she followed the reporting process that was in place for her and would report issues multiple times to try to get them addressed. In an interview on, 10/27/2024 at 6:15 PM, the District Manager of Dining Services stated that when work orders were submitted through the computer reporting system the Dietary Account Manager also made him aware of the work order and he compiles a report that is given to the Administrator. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on, 10/28/2024 at 4:50 PM, the Maintenance Director stated that he and his assistant were responsible for the upkeep of the facility and grounds. The Maintenance Director stated he was unaware of the scuffs on resident doors, the broken toilet paper dispenser, the lighting issues, the plumbing protruding from walls, and the flooring issues in resident rooms and halls. The Maintenance Director stated that the crack in the entry door has been there for over a year and happened when a resident kicked it. He stated he was unsure if anyone had communicated with the appropriate parties to have it repaired or replaced. Continued interview with Maintenance Director revealed the uneven flooring could cause injury to residents, staff, or the public who walked on it. Additionally, the Maintenance Director stated that the plumbing sticking out from the walls could be hazardous to anyone in the bathroom if they fell into it. The Maintenance Director stated he believed the lighting in the bathroom of room [ROOM NUMBER] was too low of a wattage to provide adequate lighting. The Maintenance Director stated that he did not access work orders in the computerized reporting system. In an interview on, 10/27/2024 at 6:15 PM, the District Manager of Dining Services stated that when work orders were submitted through the computer reporting system the Dietary Account Manager also made him aware of the work order and he compiles a report that is given to the Administrator. In an interview on, 10/28/2024 at 4:50, the Maintenance Director stated that he and his assistant were responsible for the upkeep of the facility and grounds. The Maintenance Director stated he was unaware of the scuffs on resident doors, the broken toilet paper dispenser, the lighting issues, the plumbing protruding from walls, and the flooring issues in resident rooms and halls. The Maintenance Director stated that the crack in the entry door has been there for over a year and happened when a resident kicked it. He stated he was unsure if anyone had communicated with the appropriate parties to have it repaired or replaced. Continued interview with Maintenance Director revealed the uneven flooring could cause injury to residents, staff, or the public who walked on it. Additionally, the Maintenance Director stated that the plumbing sticking out from the walls could be hazardous to anyone in the bathroom if they fell into it. The Maintenance Director stated he believed the lighting in the bathroom of room [ROOM NUMBER] was too low of a wattage to provide adequate lighting. The Maintenance Director stated that he did not access work orders in the computerized reporting system. During an interview on 10/29/2024 at 2:16 PM with Licensed Practical Nurse (LPN)1 revealed the staff working the floor utilized the maintenace repair log, located at the nurse's station, to alert the Maintenance Director of needed repairs. LPN1 further stated she had not thought about the pipe protruding from the wall in the bathroom being an accident hazard. In an interview with the Environmental Services Director (ESD) on 10/30/2024 at 9:12 AM, the ESD stated her contracted staff were not allowed to touch bed pans and her staff knew to let the aides or nurses know so they could remove the bed pans and then the housekeeping staff would clean the bathrooms. The ESD stated the contracted company would not let her staff remove trash if it had soiled briefs in them. The ESD stated she was aware of the odors in some of the bathrooms and her staff cleaned those bathrooms at least twice a day but she believed the odors were in the flooring and she had told the facility Administrator but the flooring had not been replaced. The ESD stated she was aware of the uneven flooring but stated the area had flooded in the past and felt like water had gotten under the adhesive, which caused it to loosen. The ESD stated it was a safety hazard and could cause a resident or staff member to trip and fall, which could lead to injuries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pikeville Nursing and Rehab Center	260 South Mayo Trail Pikeville, KY 41501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on, 10/30/2024 at 3:30 PM, the Director of Nursing (DON) stated it was her expectation for the residents to live in a safe, clean, friendly, homelike environment. The DON stated that she was aware of uneven flooring in the hallways and that drain grates were sinking in the flooring. Continued interview with the DON revealed, that someone could get a puncture wound or a head injury if they fell into the visible plumbing sticking out from the wall. The DON stated occasionally she could smell odors but expected all odors not to linger in a homelike environment. In an interview on, 10/30/2024 at 3:50, the Administrator stated that she did room rounding every day but did not go into resident bathrooms during the rounds. The Administrator described a homelike environment as being free from odor, and flooring should be free of debris and cracks. Continued interview revealed the Administrator was unaware of issues with the flooring in resident rooms and hallways until 10/29/2024. Additionally, the Administrator stated that the uneven flooring could cause a tripping hazard to residents. The Administrator stated that she had access to the computerized reporting system but did not access it. Continued interview with the Administrator she stated she was not aware of the impalement issues in the bathrooms until it was brought to her attention yesterday and continued to state if a person fell into the areas it could cause injury. She further stated the nurses round twice daily and the Maintenance is to be rounding, but the Administrator was not sure there was a rounding log maintained. The Administrator further stated the Maintenance Director was required to be in the morning meeting every morning and reported to her on what repair or project he was working on for the day. The Administrator stated she followed up on larger repair projects, and the Maintenance Director makes her aware of the project he was working on. The Administrator stated with smaller jobs she normally does not follow up on their completion.