STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185195	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakview Nursing & Rehabilitation Center	10456 US Highway 62 Calvert City, KY 42029

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47798 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure a care plan was developed and implemented for one of five (5) sampled residents (Resident #66 (R66)). R66 was post-op from a surgical procedure performed on 04/26/2024. However, record review revealed the facility failed to develop a Comprehensive Person-Centered Care Plan to monitor the surgical incisions until 05/07/2024. On 05/15/2024, R66 was seen by the Podiatric Surgeon for complaints of left ankle pain and was transferred to the emergency room (ER) to be evaluated. The ER assessed and diagnosed R66 with diffuse redness, swelling, purulent and foul smelling drainage of the left ankle surgical incisions. R66 was admitted to the hospital for intravenous antibiotic therapy on 05/15/2024 and discharged on [DATE]. The facility's failure to have an effective system to ensure each resident received care and treatment in accordance with professional standards of practice has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 05/30/2024 and was determined to exist on 05/03/2024 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; 42 CFR 483.25 Quality of Care, F684; and Substandard Quality of Care (SQC) was also identified at 42 CFR 483.25 Quality of Care, F684. The facility was notified of the Immediate Jeopardy on 06/06/2024. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on 06/08/2024, alleging removal of the IJ on 06/08/2024. An Extended Survey was initiated on 06/12/2024, and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on 06/13/2024. The SSA validated the immediacy of the IJ had been removed on 06/08/2024, as alleged. The findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 04/06/2015 and revised 02/09/2024, revealed the facility would develop and implement a comprehensive person-centered care plan for each resident, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185195	A. Building B. Wing	06/13/2024

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Closed record review of R66's face sheet revealed the facility admitted the resident on 04/22/2024. R66's readmission on 05/15/2024 included diagnoses of: unspecified fracture of the left lower leg; subsequent encounter for closed fracture with routine healing; personal history of Transient Ischemic Attack (TIA/stroke); and cerebral infarction without residual deficits, and difficulty in walking, not elsewhere classified. Review of the Admission Minimum Data Set (MDS) Assessment, dated 04/25/2024, revealed the facility assessed R66 to have a Brief Interview for Mental Status (BIMS) score of twelve out of fifteen. This score indicated the resident was cognitively intact. Review of R66's hospital records dated 04/26/2024, revealed she underwent an open reduction internal fixation trimalleolar due to multiple fractures of the left ankle. R66 returned to the facility the same day. Review of an office visit report from R66's Podiatric Surgeon, dated 05/03/2024, revealed new orders were given to cleanse R66's surgical incisions with saline and to change the dressing once a day. Review of an emergency room visit note, dated 05/15/2024, revealed R66 presented with diffuse redness, swelling of the left ankle, purulent and foul-smelling drainage from the surgical incisions. Further review revealed R66 met sepsis criteria (sepsis is a life threatening condition that may occur when the body's immune response to an infection causes injury to its own tissues and organs). R66 was admitted to the hospital with a diagnosis of Cellulitis (a deep infection of the skin caused by bacteria). R66 was treated with intravenous (IV) antibiotics (vancomycin and cefepime). Review of the Infectious Disease Physician's consultation note, dated 05/20/2024, revealed R66 remained on IV antibiotics (vancomycin and cefepime); some serous drainage was noted, and a portion of the incision on the left ankle remained open. Further review revealed positive blood cultures for Staphylococcus hominis and Staphylococcus epidermidis. The vancomycin and cefepime were discontinued. R66's antibiotic was changed to clindamycin 600 mg (milligrams) orally every eight hours for fourteen days. Review of R66's hospital discharge summary revealed a discharge date of [DATE] to a skilled nursing facility for continuation of wound care and rehabilitation. Review of a Physician's Order to apply Medi-Honey to the wound, clean with saline solution and change dressing every day. The order was dated 05/03/2024. However, the order was not scanned into R66's medical record until 05/16/2024, which was after the resident discharged from the facility. Record review revealed no documented evidence the facility developed a Comprehensive Care Plan for R66 related to skin integrity or for incisional wound care until 05/07/2024. During an interview with the Minimum Data Set (MDS) Coordinator on 06/06/2024 at 11:12 AM, she stated R66 should have had a Comprehensive Care Plan implemented when she returned from her surgical procedure on 04/26/2024. (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Assistant Director of Nursing (ADON) on 05/31/2024, she stated she was also responsible for wound care but was not certified. The ADON stated she also tracked wounds and monitored surgical incisions. She stated after R66's ankle surgery on 04/26/2024, she did assess her wounds but was not sure if she had documented those assessments. She stated she was notified on 05/14/2024 that R66's wound dressing was saturated with drainage. The ADON stated the surgeon was notified at that time. She stated R66 was seen in the surgeon's office the following day. The surgeon had R66 admitted to the hospital due to the surgical incisions being infected. She stated R66's care plan should have ben implemented when she returned to the facility after her surgery to reflect the need for monitoring of the surgical incisions. She stated the MDS Nurse was responsible to implement or revise a care plan. However, if she was providing care or monitoring a wound then she would be the one responsible to implement the care plan. The ADON stated she did not implement a care plan for R66. She stated she would expect the nurse to call the physician for orders if orders were not received and for care plans to be implemented and revised as needed. During an interview with the Director of Nursing (DON) on 06/06/2024 at 10:06 AM, she stated each resident should have a person-centered Comprehensive Care Plan and the MDS Coordinator was responsible for implementing the care plans. The DON stated her expectations were for each resident to have the appropriate care plan implemented. During an interview with the Administrator on 06/06/2024 at 10:41 AM, he stated he expected all residents to have a comprehensive care plan and for staff to follow the facility's policies.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47798 Based on interview, record review, and facility policy review, it was determined the facility failed to ensure residents received care and treatment in accordance with professional standards of practice for one (1) of five (5) sampled residents (Resident #66 (R66)). The facility admitted R66 from the hospital post-treatment for an ankle fracture. On 04/26/2024, R66 underwent an open reduction internal fixation trimalleolar to repair the left ankle. The facility failed to implement the physician's orders or provide wound care to R66's incisional cites as ordered. On 05/15/2024, R66 was seen by the Podiatric surgeon for complaints of left ankle pain and was transferred to the emergency room (ER) to be evaluated. The ER assessed R66 for diffuse redness, swelling, purulent and foul smelling drainage of the left ankle surgical incisions. Further review revealed R66 met sepsis criteria. (Sepsis is a life threatening condition that may occur when the body's immune response to an infection causes injury to its own tissues and organs). R66 was admitted to the hospital on 05/15/2024 with a diagnosis of Cellulitis (a deep infection of the skin caused by bacteria). R66 was treated with intravenous (IV) antibiotics (vancomycin and cefepime). R66 was discharged on [DATE]. The facility's failure to have an effective system to ensure each resident received care and treatment in accordance with professional standards of practice has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 05/30/2024 and was determined to exist on 05/03/2024 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; 42 CFR 483.25 Quality of Care, F684; and Substandard Quality of Care (SQC) was also identified at 42 CFR 483.25 Quality of Care, F684. The facility was notified of the Immediate Jeopardy on 06/06/2024. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on 06/08/2024, alleging removal of the IJ on 06/08/2024. An Extended Survey was initiated on 06/12/2024, and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on 06/13/2024. The SSA validated the immediacy of the IJ had been removed on 06/08/2024, as alleged. The findings include: Review of the facility's policy titled, Skin Integrity, dated 06/09/2022 and revised 09/15/2023, revealed the facility would ensure a resident received care, consistent with professional standards of practice, to prevent avoidable skin integrity issues unless the individual's clinical condition demonstrated that they were unavoidable and a resident with impaired skin integrity would receive necessary treatment and services, to promote healing, and prevent infection. The Nurse Leader/Wound nurse would document all impaired skin integrity areas such as pressure, stasis, surgical incision, or diabetic ulcers in the Electronic Medical Record on an ongoing basis or until closed or the resident had been discharged . (continued on next page)

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	185195	A. Building B. Wing	06/13/2024

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility policy titled, Admission and Readmission to the Facility, dated 07/30/2018 and reviewed 04/02/2024, revealed the facility would admit and readmit residents whose needs could be met. The Objectives of the policy were to assure that the facility received appropriate medical and financial records prior to or upon the resident ' s admission. Closed record review of a face sheet revealed the facility admitted R66 on 04/22/2024 and discharged on [DATE] with diagnoses of: Unspecified fracture of left lower leg; subsequent encounter for closed fracture with routine healing, Personal history of Transient Ischemic Attack (TIA), and cerebral infarction without residual deficits, and difficulty in walking, not elsewhere classified. Review of an Admission Minimum Data Set (MDS) Assessment, dated 04/25/2024, revealed R66 was assessed to have a Brief Interview for Mental Status (BIMS) of a twelve out of fifteen, indicating the resident was cognitively intact. Review of R66 ' s hospital records dated 04/26/2024, revealed she underwent an open reduction internal fixation trimalleolar due to multiple fractures of the left ankle and returned to the facility the same day. Record review revealed no documented evidence the facility developed a Comprehensive Care Plan for R66 related to skin integrity or incisional care until 05/07/2024. Review of an office visit with R66 ' s Podiatric surgeon, dated 04/29/2024, revealed a well-padded below-the-knee splint with plaster cast material was placed on the left lower extremity, R66 was to remain non-weight bearing, use rest, ice, compression, and elevation to the left lower extremity and return to the clinic in one week for a follow up and x-ray evaluation. Review of an office visit with R66 ' s Podiatric surgeon, dated 05/03/2024, revealed R66 was to remain non-weight-bearing. An order was given for Medi-Honey to be applied to the anterior wound daily after a sterile saline cleanse was performed. A sterile below the knee pneumatic boot was fitted and dispensed. New orders were given to cleanse the wound with saline and change the dressing once a day. Review of an emergency room visit note, dated 05/15/2024, revealed R66 had been seen at her Podiatric Surgeon ' s office earlier that day and presented with diffuse redness, swelling of the left ankle, purulent and foul-smelling drainage from her wounds. Further review revealed R66 met sepsis criteria and a sepsis workup was ordered. R66 was admitted with Cellulitis and treated with Intravenous Antibiotics (Vancomycin and Cefepime). Review of a consult note from the Infectious Disease physician, dated 05/20/2024, revealed R66 remained on Intravenous Antibiotics (Vancomycin and Cefepime), some serous drainage with minimal cloudiness to the incision sites as well as an open portion of the incision on the left ankle being open. Further review revealed a result of positive blood cultures for Staphylococcus hominis and Staphylococcus epidermidis which resulted in Vancomycin and Cefepime being discontinued and R66 was ordered Clindamycin 600 mg orally every eight hours for fourteen days. Review of R66 ' s hospital discharge summary revealed she was discharged on [DATE] to a Skilled Nursing Facility for continuation of wound care and rehabilitation. (continued on next page)

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	185195	A. Building B. Wing	06/13/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a physician ' s order to apply Medi-Honey to the wound, clean with saline solution and change dressing every day. The order was dated 05/03/2024 however, the order was not scanned into R66 ' s medical record until 05/16/2024, which was after the resident discharged from the facility. During an interview with Family Member #4 (FM4) on 05/30/2024 at 3:09 PM, he stated R66 had a fall at home on 04/07/2022 and remained in the hospital until 04/22/2024. He stated R66 had surgery to repair the fractures to her ankle on 04/26/2024 and returned to the facility the same day. He further stated after a follow up appointment with her podiatric surgeon on 05/03/2024, he brought R66 back to the facility with orders for R66's dressing to be changed once a day. He stated he handed the orders to the front desk staff. He stated the bandages were not changed for seven-eight days. He stated the nurse told the family that R66 ' s incisions were not infected on 05/14/2024. However, the family took photographs of the incision and forwarded to the Podiatric surgeon which wanted to see R66 in his office and then sent her to the hospital to be admitted . He stated the nurses just did not take care of her ankle like they should have. During an interview with Family Member #5 (FM5) on 05/30/2024 at 3:19 PM, she stated on two separate occasions, the family had brought orders to the facility after returning R66 from follow up surgeon appointments and handed the orders to the lady at the front desk. FM5 stated staff would tell the family that they were doing dressing changes on R66 but the family did not believe it was getting done. FM5 stated on 05/14/2024 during a visit, she had asked Licensed Practical Nurse #8 (LPN8) to look at R66 ' s dressing. FM5 stated the dressing was saturated, had an odor, yellow/green drainage, the skin was red and the ankle was swollen. FM5 stated LPN8 informed her the incision was not infected or swollen and if it were infected, the drainage would have been bright green in color. FM5 stated she took pictures of the dressing and incisions and forwarded to R66 ' s Podiatric surgeon. She stated the surgeon requested to see R66 in his office as soon as possible. She stated the family transported R66 to the Podiatric office on 05/15/2024, the surgeon was very upset and knew immediately the incisions were infected so he recommended R66 go to the hospital to be admitted for intravenous antibiotics. FM5 stated R66 was currently in the hospital and continued to receive intravenous antibiotics at the time of the interview. During an interview with Registered Nurse #1 (RN1) on 05/31/2024 at 10:41 AM, she stated she was an agency nurse and had worked at the facility for two (2) months. She stated she could not recall receiving orders from R66 ' s family when she returned to the facility after her follow up appointments. RN1 stated when a resident returned to the facility, they should have orders either brought by family or the nurse should call the physician ' s office or hospital for orders. RN1 stated the nurse should then enter and scan the orders into the Electronic Medical Record (EMR). RN1 further stated the Minimum Data Set (MDS) nurse was responsible for all care plans. She stated the floor nurses do not create or revise care plans but are asked for input. RN1 stated she was told during report that R66 ' s wounds were not to be touched right after she had surgery. RN1 further stated if a resident ' s wounds were not assessed in a seven (7) day timeframe, the wound could become infected. (continued on next page)

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	185195	A. Building B. Wing	06/13/2024

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Assistant Director of Nursing (ADON) on 05/31/2024, she stated she was also the wound care nurse but was not certified. The ADON stated she was responsible for tracking wounds and did monitor surgical incisions. She stated after R66 ' s ankle surgery on 04/26/2024, her wounds were assessed but was not sure if she had documented the assessments. She stated she was notified on 05/14/2024 that R66 ' s wound dressing was saturated with drainage. The ADON stated the surgeon was notified at that time, the R was seen in the surgeon ' s office the following day and admitted due to the surgical incisions being infected. She stated R66 ' s care plan should have ben implemented when she returned to the facility after her surgery to reflect the need for monitoring of the surgical incisions. She stated the MDS nurse was responsible to implement or revise a care plan. However, if she was providing care or monitoring a wound then she would be the one responsible to implement the care plan. The ADON stated she did not implement a care plan for R66. The ADON stated she would expect the nurse to call the physician for orders if they did not receive them and for care plans to be implemented and revised as needed. During an interview with Licensed Practical Nurse #8 (LPN8) on 05/31/2024 at 2:01 PM, she stated she had not assessed R66 ' s wound until 05/14/2024 when the daughter asked her to. She stated she had been told in report that the wounds were not to be touched and was under the impression R66 ' s surgical wounds had actually healed. However, LPN8 stated she had not seen any orders for R66 related to the care of her surgical wounds. LPN8 stated R66 should have had orders to monitor the surgical wounds. LPN8 stated she assessed R66 ' s surgical wounds on 05/14/2024 and the incisions had a scant amount of drainage that had no color, no odor, was not red but was pink and was not swollen. She described the skin around the incisions as moist appearing. LPN8 stated she notified the wound care nurse which assessed and measured R66 ' s wounds on 05/14/2024. LPN8 stated she relied solely on the report given to her by the offgoing shifts. She stated she did notify the surgeon ' s office and R66 was taken into his office the following day. She stated she only called the surgeon because R66 ' s family was concerned. LPN8 stated she assumed R66 ' s wound needed orders or at least more than a gauze wrap but she did not call to obtain orders. During an interview with LPN9 on 05/31/2024 at 2:32 PM, she stated she was an agency nurse and worked primarily the weekend shift. She stated she did not recall seeing any orders for wound care or monitoring for R66 but it would be normal protocol to monitor surgical incisions. During an interview with the Podiatric Surgeon on 05/31/2024 at 3:00 PM, he stated he saw R66 for a follow up appointment on 05/03/2024 and wrote orders for Medi-Honey to be applied to a fracture blister, clean surgical incisions with saline solution and do dressing changes daily. He stated the family took orders back to the facility. He stated he had no further contact until 05/14/2024 when R66 ' s family had e-mailed photographs of R66 ' s surgical incisions that appeared to be very concerning. He stated he saw R66 in his office on 05/15/2024 and she had developed Cellulitis and no one from the facility had notified his office. He stated if the ordered dressing changes had not been done, that was the problem. He stated R66 was transferred to the hospital and admitted for intravenous antibiotics due to Cellulitis and sepsis. The Podiatric Surgeon stated R66 continued to be followed by Infectious Disease and remained on intravenous antibiotics. During an interview with the Signature Care Consultant on 06/04/2024 at 1:00 PM, she stated the wound care nurse had not received any formal wound care certification. She stated she had received some wound training with her leadership training and online through Relias which was the same training the floor nurses received. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with LPN3 on 06/05/2024 at 8:02 PM, she stated she works night shift and did not provide any surgical wound care for R66. LPN3 stated she was responsible for the daily skilled charting note and on 05/02/2024 under special treatments checked incisional care was done, on 05/03/2024. 05/08/2024 and 05/09/2024, marked incision was clean, well approximated with signs of healing, then on 05/10/2024 and 05/14/2024 that incision care was provided per order. However, she further stated she never assessed R66 ' s wounds at all and she was apparently completing the daily skilled charting note incorrectly. LPN3 stated she thought if a resident was admitted with that skill then she should be charting it on the skilled charting note. LPN3 further stated the facility dropped the ball on R66 and that was why the facility was unable to provide any documentation related to her wound care. LPN3 stated R66 should have had orders to monitor her surgical wound and provide any care the physician ordered. LPN3 stated R66 returned to the facility prior to her shift beginning on 05/03/2024 and she was given report by RN1 that all orders were completed and R66 had been assessed. LPN3 stated there should not have been a reason she would have had to double check what was told to her. During an interview with the MDS coordinator on 06/06/2024 a 11:12 AM, she stated when R66 returned to the facility with a surgical wound on 04/26/2024, she should have had a care plan developed. The MDS coordinator stated she did do an admission observation assessment and developed an enhanced barrier precaution care plan related to R66 ' s surgical wound on 05/07/2024. During an interview with the Medical Director on 06/06/2024 at 11:00 AM, he stated he expected staff to follow orders and if there was any deviation from the physician orders, he would expect a telephone call to clarify. He stated the orders are there for a purpose and should be followed. He stated he was not familiar with R66 care and was not her attending but was aware of the situation. He stated there were times when a dressing should be left in place, however, if you don ' t now what is going on, you must find out because you should not work autonomously or above your scope of practice. During an interview with the Director of Nursing (DON) on 06/06/2024 at 10:06 AM, she stated R66 should have had orders in place to at least monitor her surgical wounds. The DON stated the facility had attempted to look for orders from 05/03/2024 but were unable to find them. She further stated the facility had called the surgeon ' s office on four (4) occasions, did not receive a return call, and had some communication issues. However, the DON stated she failed to document the failed attempts to contact R66 ' s surgeon. The DON stated she personally did not provide wound care for R66 and did not know what happened. The DON stated the facility should have called the physician ' s office and obtained orders and implemented a care plan within forty-eight hours after she returned from surgery. The DON stated she expected nurses to obtain and follow physician orders, assess the resident ' s, do the ordered treatments, complete an event and care plan and notify the resident ' s family. The DON stated she was not sure why R66 did not have a care plan but should have had one when she returned from surgery. She stated the MDS coordinator was responsible for Comprehensive Care plans and she expected each resident to have person centered Comprehensive Care plans implemented and revised as needed. During an interview with the Administrator on 06/07/2024 at 10:41 AM, he stated he expected all residents to have the necessary orders for staff to provide the care the resident may need. He stated if orders were not received, he expected staff to call the physician or hospital to obtain them. He further stated he expected each resident to have a Comprehensive Care Plan in place to ensure the staff would know how to provide care to the residents.