STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 49267 Based on observation, interview, record review, and facility policy review, the facility failed to ensure accurate assessments for one of 29 sampled residents. The facility failed to document Resident (R) 25's skin lesion identified on 10/07/2022 until the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/24/2024. Review of the facility's policy titled, Resident Assessment Instrument (RAI) Process, dated 10/2019, revealed the facility will use the most current version of the RAI Manual and follow guidelines therein as set forth by the Centers for Medicare and Medicaid services (CMS) for all RAI processes and completion of the MDS unless otherwise outlined in the manual. Further review revealed the facility will complete the RAI process according to state guidelines as applicable. Review of the MDS 3.0 RAI User's Manual Section M with an effective date of 10/2023 revealed the following steps for assessment: review the medical record, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer/injury risk assessments; speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident; examine the resident and determine whether any ulcers, wounds, or skin problems are present. Review of R25's, Face Sheet, revealed the facility admitted the resident on 08/05/2020 with diagnoses of Alzheimer's Disease, peripheral vascular disease (PVD), and heart failure. Review of R25's MDS with an ARD of 05/24/2024 revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15 indicating severe cognitive impairment. Review of R25's skin check dated 10/07/2022 revealed a documented raised lesion to the chest. Review of R25' s care plan dated 10/10/2022 revealed a focus of potential or actual skin integrity impairment related to skin lesions to chest. Further review revealed interventions that included treatment as ordered or per facility skin care protocol; observation daily/weekly; notification to nurse of changes or development of new skin impairment. Review of R25's Treatment Administration Record (TAR) for 10/2022 revealed treatment in place to chest lesion ordered 10/08/2022. (continued on next page)

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
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R25's Quarterly MDS assessment with an ARD of 10/10/2022 revealed Section M/Skin Conditions: Other Ulcers, Wounds, and Skin Problems marked as not present. Review of R25's TAR for 06/2023 revealed Hibiclens topical treatment in place for cutaneous chest abscess 06/26/2023 - 07/06/2023. Review of R25's, Lab Results Report, dated 07/09/2023 revealed a result of negative for a wound culture submitted on 07/07/2024. Review of R25's progress notes dated 12/22/2023 revealed documentation of several small, clustered lesions to the chest area. Lesions were described as raised, red, and circular with no drainage. Further review revealed a history of abscesses to this area. The Nurse Practitioner (NP) ordered treatment with antibiotics and Hibiclens topical solution. Review of R25's TAR for 12/2023 revealed Hibiclens topical treatment in place for chest abscess 12/23/2023 - 12/31/2023. Review of R25's Quarterly MDS assessment with an ARD of 12/26/2023 revealed Section M/Skin Conditions: Other Ulcers, Wounds, and Skin Problems marked as not present. Review of R25's progress note dated 03/21/2024 revealed resident received antibiotic for chest abscess. Review of R25's Quarterly MDS assessment with an ARD of 03/26/2024 revealed Section M/Skin Conditions: Other Ulcers, Wounds, and Skin Problems marked as not present. Observation on 07/15/2024 at 2:27 PM revealed R25 resting on her bed. State Survey Agency (SSA) surveyor observed a lesion approximately one and a half inches in diameter to R25's upper chest. Additional observation revealed the lesion was surrounded by four smaller scabbed areas In an interview on 07/15/2024 at 2:27 PM, R25 stated she did not know what the place was on her chest. She further stated the sore had been there forever but was getting better. In an interview with the MDS nurse on 07/18/2024 at 3:03PM, she stated, she obtained information for MDS assessments through interviews with residents, data collected from hospital documentation and facility charts. She stated she reviewed pressure ulcer flowsheets, Treatment Assessment Records (TARs), skin notes, and any other documentation that provided information related to skin. She further stated she visited most every area of a resident's medical record when collecting data for an MDS assessment. The MDS nurse stated in the past she had not participated in skin assessments, but a couple of months ago started rounds with the treatment nurse on skin assessment days. In a continued interview with the MDS nurse on 07/18/2024 at 3:44 PM, she stated from her recollection, R25's skin problem was intermittent rather than an ongoing issue. She further stated problems were not required on the MDS assessment unless they were ongoing, and resident received treatment. She stated everybody made mistakes and could not provide an answer (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without looking through the resident's records. Additionally, she stated she remembered she spoke with the Regional MDS Consultant, and they decided the wound failed to meet criteria under the section for other skin problems. She also stated it was not considered a problem unless the resident received treatment. In an interview with the Regional MDS Consultant on 07/18/2024 at 5:58PM, she stated the MDS was coded based on documentation at the time related to R25's skin problem. She further stated it would have had to be open at the time to include on section M for skin. The Regional MDS Consultant stated as far as she knew, they did not have a policy related to MDS and they utilized the RAI manual. In an interview on 07/19/2024 at 8:47 AM, the Director of Nursing (DON) stated Interdisciplinary Team (IDT) meetings were held every weekday morning and changes were discussed. The DON stated she did not really have a part in the MDS assessments. She further stated she thought the RAI manual was used and was not aware of a facility policy related to MDS assessments. In an interview with the facility Administrator on 07/19/2024 at 9:12 AM, she stated the facility had no specific MDS assessment policy. She further stated, the facility followed guidelines from the RAI manual for MDS assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 46710 Based on interview, record review, and facility policy review, the facility failed to develop and implement a baseline care plan within 48 hours for each resident that included instructions needed to provide effective and person-centered care of the resident (R) to meet professional standards of quality care for one of 29 residents sampled for care plans, R49. The findings include: Review of the facility policy titled, Resident Care Plan, dated 11/13/2017, revealed the facility was to initiate a baseline care plan immediately upon admission by the admitting Registered Nurse (RN). Continued review revealed the baseline care plan was to include instructions needed to provide effective and resident-centered care for residents that met professional standards of care. Further review revealed the baseline care plan was to include the initial goals for the resident, physician orders, and other services to be administered for the resident in the first 48 hours. Review of the Admission Record, located in the facility's clinical record for R49, revealed the facility admitted the resident on 06/27/2024, with diagnoses including end-stage renal failure, chronic obstructive pulmonary disease (COPD), and dysphagia (trouble swallowing). Review of R49's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/04/2024, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact. Further review revealed the facility also assessed the resident as requiring dialysis. Continued review of the clinical record revealed no documented evidence of a baseline care plan for R49. Review of the facility's care plan for R49 revealed the first dates for documentation were on 07/01/2024 by social work areas and 07/02/2024 for nursing related areas. Observation and resident interview not conducted due to the resident being out of the facility on an approved leave of absence. In an interview on 07/19/2024 at 10:34 AM, Registered Nurse (RN) 7 stated she was the nurse responsible for R49's admission. She further stated she had not been aware she was responsible for initiating a baseline care plan for R49's and no one had ever shown her how to do that. In an interview on 07/18/2024 at 4:52 PM, the Staff Development Coordinator (SDC) stated the facility did not document the skills check-off for nurses on orientation that included initiating a baseline care plan. The SDC further stated however, she always did the newly hired nurse's first admission with them so they could see everything they needed to do. In an interview on 07/18/2024 at 4:39 PM, the Quality Improvement (QI) Nurse stated her process, for residents admitted on night shift, was to review their baseline care plans the next morning. She stated she did not know how the facility's process failed for initiating R49's baseline care plan within 48 hours as required. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/18/2024 at 4:01 PM, the MDS Nurse stated baseline care plans should be initiated within 48 hours of a resident's admission. She stated if she was in the building when a newly admitted resident arrived at the facility, she assisted the admitting nurse with assessments and documenting a baseline care plan. The MDS Nurse stated however, sometimes residents, including R49, were admitted late on the evening and in those cases, the process was for facility management to review the baseline care plans the next day. In an interview on 07/19/2024 at 8:31 AM, the Director of Nursing (DON) stated the facility process for initiating a new residents' baseline care plan was for the admitting nurse to initiate a baseline care plan with interventions that addressed the resident's immediate needs. The DON stated those interventions (for a resident like R49) should include resident safety concerns, location of dialysis fistula or port and precautions related to the fistula, and monitoring for dialysis complications. She further stated she believed some management staff had been on vacation when R49 was admitted , leading to a process breakdown in checking for and ensuring R49's baseline care plan. In an interview on 07/19/2024 at 9:09 AM, the Administrator stated it was her expectation for the admitting nurse, or member of management team present for an admission, to enter a baseline care plan within 48 hours of a new resident's admission. She further stated she did not know how (the facility's) process had failed in the case of R49.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 - Minimal harm or potential for actual harm 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. 46710 Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, to include measurable objectives and timeframes as identified in the comprehensive assessment for two of 29 residents sampled for care planning, R10 and R39. 1. The facility failed to implement R10's care plan related to respiratory care, to include ensuring the resident's supplemental oxygen was running at the prescribed liters per minute. Observation on 07/17/2024, revealed R10's oxygen running at 2.5 liters per minute (LPM); however, the Physician's order was for the resident to receive her oxygen at 4 LPM. 2. In addition, the facility failed to add resident-centered interventions regarding R39's repeated refusals of his dressing changes for his wound. The findings include: Review of the facility policy titled, Resident Care Plan dated 11/13/2017, revealed the facility was to develop and implement a multidisciplinary care plan based on the resident's comprehensive assessment. 1. Review of R10's Admission Record, located in the facility's clinical record, revealed the facility admitted the resident on 09/10/2020, with diagnoses including cerebral palsy, chronic obstructive pulmonary disease (COPD), and obesity. Review of R10's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/08/2024, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) of 13 out of 15, indicating the resident was cognitively intact. Further MDS review revealed the facility also assessed R10 to have received oxygen therapy while a resident. Review of R10's Care Plan dated 01/25/2021, revealed the facility care planned the resident as at risk for ineffective breathing and included interventions such as keeping the resident's head of bed elevated; checking the resident's oxygen saturations per facility protocol; and administering supplemental oxygen as ordered. Review of the Physician's order for R10 dated 11/16/2023, revealed an order for the resident to receive supplemental oxygen at 4 liters per minute (LPM) via nasal cannula. Observation on 07/15/2024 at 3:48 PM revealed R10's oxygen concentrator set to 2.5 LPM, not at the Physician ordered rate of 4 LPM. Additional observation on 07/17/2024 at 11:44 AM revealed R10's supplemental oxygen running at 2.5 liters per minute, which was again not at the ordered rate of 4 LPM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/18/2024 at 1:49 PM, State Registered Nurse Aide (SRNA) 8 stated following the care plan was important so staff knew what each resident needed for their care. She further stated the SRNA's role with oxygen was only to assist and remind residents to keep their (nasal) cannula in their nose, not to monitor or adjust the flow of the oxygen. In an interview on 07/18/2024 at 4:52 PM, Registered Nurse (RN) 6 stated following the care plan was important so the resident received the care they needed. She stated it was not part of any facility protocol for nurses to check the supplemental oxygen flow rate every shift. In continued interview, she stated the only time a nurse would need to look at the flow meter on the oxygen concentrator was when they changed oxygen tubing, which occurred on Sunday nights. The RN stated she did not believe it was necessary to check the rate every day because no one would adjust the oxygen flow except when changing oxygen tubing. Per interview, RN 6 was not able to verify that staff followed R10's care plan as related to receiving oxygen as ordered, because she did not know how long the supplemental oxygen concentrator had been running at the incorrect rate. In an interview on 07/19/2024 at 8:31 AM, the Director of Nursing (DON) stated following the care plan was important to promote resident safety and well-being. She stated the care plan intervention (for R10) to ensure supplemental oxygen was administered as ordered meant staff needed to check the resident was wearing the cannula. The DON stated the facility did not have a process in place to check the flow meters on the oxygen concentrators to ensure the resident was receiving the correct rate of supplemental oxygen. She additionally stated that was not a daily nursing task per the resident's TAR. In an interview on 07/19/2024 at 9:09 AM, the Administrator stated she expected nursing staff to follow residents' care plans. She stated she expected care plans to reflect residents' needs, such as making sure the resident was wearing their nasal cannula. In continued interview, the Administrator stated R10's care plan did not specify checking the flow meter on the oxygen tank, so staff might not have noticed it running at the wrong rate, unless the resident began complaining of shortness of breath. 49267 2. Review of R39's Admission Record, revealed the facility admitted the resident on 03/15/2024, with diagnoses which included type 2 diabetes; and third degree burns to both lower extremities (BLE), genitals, and buttocks. Review of R39's Quarterly MDS with an ARD of 05/20/2024, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Further MDS review revealed the facility also assessed R39 to have burns (second or third degree) and to be receiving application of nonsurgical dressings. Review of R39's Care Plan, dated 03/29/2024, revealed the resident was not care planned for behaviors related to refusing care. Review of R39's Treatment Administration Record (TAR), dated 07/16/2024 revealed documentation noting the resident's wound care was not provided due to refusals from resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of R39's, Nursing Note, dated 07/16/2024 revealed resident refused wound care to third degree burns. Further review revealed Treatment Registered Nurse (RN) 2 educated resident on potential risks of refusal and he verbalized understanding. On 07/18/2024 at 7:11 AM, the State Survey Agency (SSA) Surveyor attempted to observe R39's dressing change; however, the resident refused the dressing change. Treatment RN 2, who was to perform the dressing change, explained the risks versus benefits of dressing changes and informed R39 his burn wounds would heal faster if the dressings were changed daily; however, the resident still refused. In an interview with SRNA 8 on 07/18/2024 at 1:51 PM, she stated when residents refused care, she notified the nurse. She further stated she used resident care plans to determine the type of care a resident needed. SRNA 8 stated nurses updated the care plans when changes occurred. SRNA 8 stated the behavior tab of the care plan displayed recent or updated behaviors for residents, including refusals. In an interview with Treatment RN 2 on 07/17/2024 at 11:41 AM, she stated she typically performed R39's dressing changes early in the morning. She further stated R39 preferred the morning, and she tried to accommodate because that helped with compliance. Treatment RN 2 stated R39 refused care yesterday but allowed her to change his dressings today. In interview on 07/18/2024 at 7:11 AM, Treatment RN 2 stated she had only been working at the facility a few days, but she had noticed improvement in R39's burns since she started. In an interview with the MDS nurse on 07/18/2024 at 3:03 PM, she stated changes to care plans were addressed immediately. She further stated, when issues or concerns were discovered, they were addressed the following day in the morning meeting and changes were made as needed. Additionally, she stated morning meetings were Monday through Friday, so occurrences on a weekend were addressed first thing Monday morning. The MDS nurse stated the Quality Improvement (QI) RN and MDS RN were primarily responsible for care plan updates; however, floor nurses also made changes to care plans as needed. The MDS nurse state refusals of care were placed on care plans, and it was important for the care plan to be up to date and correct so the aides knew how to care for the residents. Attempt was made on 07/18/2024 at 3:14 PM to reach the former treatment nurse, Treatment RN 1. State Survey Agency (SSA) surveyor left a message for Treatment RN 1, but return call was not received. In an interview with the QI RN on 07/18/2024 at 4:02 PM, she stated meetings were held daily to look at changes that had occurred, and then care plans were updated to include those changes. She further stated refusals of care were behaviors that were added to care plans. The QI RN stated resident changes were ascertained by her and staff in numerous ways: examined resident charts, read progress notes, communicated with Nurse Practitioner (NP) and other staff, and looked at care guides. In a continued interview on 07/18/2024 at 4:13 PM, the MDS nurse stated it was her expectation for nurses to update care plans as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/19/2024 at 8:47 AM with the DON, she stated floor nurses sometimes updated care plans, but the MDS nurse primarily made revisions. The DON stated care plans were updated with any change in condition or new orders. She further stated, if a resident exhibited a new behavior today, it was placed on the care plan as soon as possible. She clarified as soon as possible meant today or tomorrow. The DON stated care refusals should be on a care plan. She further stated it was important updates to care plans were made as soon as possible to protect the safety and well-being of residents. In an interview with the facility Administrator on 07/19/2024 at 9:12 AM, she stated it was her expectation all staff followed residents' care plans. She further stated it was her expectation updates to care plans were made at the time a change occurred. The Administrator stated if a new behavior with a resident occurred today, it would be added to the care plan within one day. She further stated if a resident chronically refused care, the behavior should be added to the care plan. The Administrator stated in order to provide proper care to residents, it was necessary to update care plans in a timely manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46710 Based on observation, interview, record review, and facility policy review, the facility failed to provide respiratory care consistent with professional standards for 1 of 3 residents (R) sampled for respiratory care (R10), out of the total sample of 29 residents. The findings include: Review of the facility policy titled, Oxygen Therapy, dated 04/2013, revealed the facility's procedure for administering oxygen included adjusting the oxygen flow meter to the prescribed rate. Review of R10's Admission Record, revealed the facility admitted the resident on 09/10/2020, with diagnoses including chronic obstructive pulmonary disease (COPD), obesity with hypovolemia (low fluid/blood volume), and cerebral palsy. Review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/08/2024 for R10, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) of 13 out of 15. indicating the resident was cognitively intact. In addition, review revealed the facility assessed R10 to have received oxygen therapy while a resident. Review of R10's Care Plan, dated 01/25/2021, revealed the facility identified a problem of the resident being at risk for ineffective breathing. Further review revealed the interventions included keeping the head of the resident's bed elevated and administering supplemental oxygen as ordered. Review of the Physician's order for R10 dated 11/16/2023, revealed an order for the resident to receive supplemental oxygen at 4 liters per minute (LPM). Review of R10's Treatment Administration Record (TAR) for 07/2024 revealed orders for facility staff to check the resident's pulse and oxygen saturations (O2 sats) once per week. Further review revealed facility staff charted daily from 07/01/2024 through 07/18/2024, the hours the resident was on oxygen under the order, Oxygen flow is 4 L/min . nasal cannula. Observation on 07/15/2024 at 3:48 PM and on 07/17/2024 at 11:44 AM, revealed R10's oxygen concentrator set at 2.5 LPM (not the 4 LPM as ordered by the Physician). In interview on 07/17/2024 at 11:48 AM, with Registered Nurse (RN) 6, who was at R10's bedside, she stated the resident's oxygen concentrator was set to 2.5 liters per minute. Observation at the time of interview revealed RN 6 left R10's room without adjusting the oxygen flow meter to the 4 LPM as ordered by the Physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In further interview on 07/17/2024 at 12:11 PM, RN 6 stated she did not know what R10's oxygen orders were. During the interview, RN 6 accessed R10's Physician's orders and stated the Physician ordered the resident's supplemental oxygen to run at 4 LPM. Observation, at the time of interview, revealed RN 6 went to R10's room, attempted to adjust the dial on the resident's oxygen flow meter. She stated however, the machine was malfunctioning because it would not turn above 2.5 LPM. Continued observation revealed RN 6 went to storage and brought in a different oxygen concentrator machine and adjusted the flow meter to 4 LPM (as ordered) and connected R10's oxygen tubing to the new oxygen concentrator. In an additional interview on 07/18/2024 at 4:52 PM, RN 6 stated the facility did not train nurses to check the residents' oxygen every day. She stated nurses charted R10's O2 sats and number of hours the resident used supplemental oxygen every shift; however, not the LPM the resident received. RN 6 stated the only time a nurse would routinely check a resident's oxygen flow meter was when they changed the oxygen tubing, which typically occurred on Sunday nights. The RN said other times a nurse would check the oxygen flow rate included if the resident was complaining of shortness of breath, or if the oxygen concentrator alarmed to indicate a malfunction. RN 6 further stated R10's oxygen concentrator had not alarmed to indicate it was not maintaining a flow above 2.5 LPM In an interview on 07/18/2024 at 10:08 AM, the Advanced Practice Registered Nurse (APRN) stated R10 required supplemental oxygen for treatment of the diagnosis of COPD and the hypovolemia related to obesity. The APRN further stated she expected nursing staff to check residents' oxygen equipment to ensure the equipment was delivering the oxygen flow rate as ordered. She said residents could have low oxygen saturations (if not on the correct flow rate). In an interview on 07/19/2024 at 8:31 AM, the Director of Nursing (DON) stated her expectations for nursing staff caring for residents receiving supplemental oxygen was for staff to ensure the resident's nasal cannula stayed in their nose, assess for shortness of breath, and check the resident's O2 sats once per shift. She stated the facility did not have a process in place to ensure nurses checked residents' oxygen concentrators to see if they were running at the correct rate. In continued interview, the DON further stated she expected residents to receive their supplemental oxygen as ordered. She additionally stated residents could experience shortness of breath (if not on the ordered flow rate for oxygen). In an interview on 07/19/2024 at 9:09 AM, the Administrator stated she expected residents to receive oxygen as ordered. The Administrator further stated however, there was not an auditing process in place to ensure residents had oxygen running at the prescribed rate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 50442 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure drugs and biologicals were labeled with residents' names. Observation of the four (4) medication carts and two (2) medication refrigerators on 07/16/2024 at 2:08 PM and 2:13 PM and on 07/18/2024 at 4:36 PM, revealed three (3) of the four (4) carts contained unlabeled medications. The findings include: Review of the facility's policy titled, Medication Storage, Version 09/2020, revealed medications were to be stored in the containers in which they were dispensed. Further policy review revealed under no circumstances should any person, other than the Pharmacist, be allowed to transfer medications from one container to another, except for immediate use. Observation on 07/16/2024 at 2:08 PM, revealed Medication Cart #2 contained a medication cup with one white pill in it. Per observation, the white pill was out of its package and the cup was labeled only with a resident's name, Resident (R) 32. Additional observation on 07/16/2024 at 2:13 PM, revealed Medication Cart #4 also had an unpackaged white pill located in a medication cup. Observation revealed the pill cup was not labeled with a resident's name and there was also a bottle of copper for R39 that was not labeled with his name; however, stored in the compartment with the resident's other medications. In an interview with Registered Nurse (RN) 1 on 07/16/2024 at 2:10 PM, she stated R32's medication (on Medication Cart #2) was opened and sitting in the medication cup because she had been unable to locate the resident to administer the medication. She stated when she did not find R32, she wrote his name on the medication cup containing the opened pill and placed it back into the section of Medication Cart #2 that contained the remainder of R32's unopened medications. RN 1 stated she should not have placed the opened pill in the cup back into the medication cart. She further stated she should have thrown the pill and cup away. In an interview with Licensed Practical Nurse (LPN) 4 on 07/16/2024 at 2:13 PM, she stated the reason the bottle of copper (on Medication Cart #4) did not have R39's name on it was because the copper had not came from the pharmacy service the facility used, the Nurse Practitioner (NP) had purchased it from an outside source. LPN 4 stated she knew the supplement belonged to R39 because no one else in the facility took that medication. She further stated the unlabeled white pill in the medicine cup was for R5. The LPN said R5 was outside smoking when she went to give his belly pill. In addition, she stated she was not supposed to place unlabeled medications in the medication cart and was observed to immediately dispose of the pill in the red biohazard container on the medication cart. Observation on 7/18/2024 at 4:36 PM, revealed Medication Cart #3 had an insulin pen labeled only with the opened date. Further observation revealed the insulin pen was not labeled with a resident's name. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LPN 1 on 07/18/2024 at 4:36 PM, she stated because the insulin pen was not labeled with a resident's name it should be discarded as she did not know to which resident it belonged. The State Survey Agency (SSA) Surveyor attempted a telephonic (phone) interview with the Pharmacist covering the facility on 07/18/2024 at 3:10 PM, with no answer received and a message was left requesting a return phone call. However, no return phone call was ever received. In an interview with the Director of Nursing (DON) on 07/19/2024 at 8:30 AM, she stated she expected anyone giving a medication, that could not be given at the time it was opened, to label the medication and place it in a secure area, such as the medication cart until they were able to give the medication. She stated the reason for labeling the medication was to prevent it being given to the incorrect resident and to make certain the medication was given at the appropriate time. The DON stated insulin pens were stored in the medication refrigerator until they were opened. She said upon opening an insulin pen, the person administering the medication, should label the pen with the resident's name and the date it was opened. The DON stated after being opened the insulin pen could be stored in the medication cart. When the SSA Surveyor asked the DON what should happen to insulin pens without a resident's name and opened date on them, she stated the pen should be thrown away. In an interview with the Facility Administrator on 07/19/2024 at 9:10 AM, she stated any medication not administered to a resident should be discarded immediately. The Administrator stated her expectation was for medications not to be set up in advance, but for the medications to be given immediately after they were opened. She further stated she was unsure of how the insulin pens were to be labeled and stored, but the pens should have a resident's name on them once they were opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 50442 Based on interview, record review, review of the facility's local health department inspection, and review of the local health department's website, the facility failed to provide education to food handlers related to safe food handling practice to enable the food handlers to effectively carry out the functions of the food and nutrition service department. This deficient practice affected 53 residents receiving meals from the kitchen. The findings include: Review of the local health department's, Food Service Establishment Inspection Report, dated 08/17/2023, revealed the facility had been cited for areas of the kitchen floors needing cleaning; equipment needing cleaning; and three (3) overhead lights needing repair. Review of the local county health department's website, Environmental - Bell County Health Department (bellcohealthky.org), revealed an annual Food Handler Training Course for all employees who worked in the food service industry was required. Continued review revealed newly hired food service workers were to complete the food handlers online training course before beginning to work at their place of employment. Further review revealed the website noted the online Food Handler Training Course covered food safety laws and regulations and proper hygiene practices and food handling techniques. Review of the facility's dietary staffs' personnel records revealed three (3) of nine (9) dietary employees (Cook 2, Dietary Aide 1, and Dietary Aide 2) did not have a Food Handlers Card, nor documentation of having received ServSafe training, or the Clinical Dietary Manager (CDM) training. Observation on 07/15/2024 at 2:25 PM and 5:03 PM, revealed [NAME] 2 and Dietary Aide 1 were the only dietary staff members working in the kitchen area preparing and serving dinner. In an interview with [NAME] 2 on 07/15/2024 at 5:10 PM, she stated she did not have a Food Handlers Card. [NAME] 2 went on to say she and Dietary Aide 1 had both not been here (at the facility) but a couple of months. She further stated neither she or Dietary Aide 2 had done the training yet, but needed to do it. In a telephonic (phone) interview with the Dietary Manager on 07/17/2024 at 4:52 PM, she stated her cooks all had Food Handlers cards and/or ServSafe certifications. In an interview with Dietary Aide 2 on 07/18/2024 at 8:27 AM, she stated she had only worked at the facility two months and had not yet obtained her Food Handlers Card or ServSafe certification. In an additional phone interview with the Dietary Manager on 07/18/2024 at 10:27 AM, she stated a dietary worker had 30 days after starting work to obtain their Food Handlers Card. She stated the facility did not have a policy stating that requirement however, and she had never been told what action were to be taken for employees who did not comply within 30 days. The Dietary Manager expressed verbal agreement regarding a process failure and despite her asking [NAME] 2 to get her Food Handlers Card the [NAME] had not done so. She further stated [NAME] 2 continued to work at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview with the Registered Dietician (RD) on 07/18/2024 at 10:53 AM, she stated her expectations for all dietary workers was for them to have a ServSafe or a Food Handlers certification. When the SSA Surveyor asked what should be done if a dietary staff member was working in the kitchen without one of those certifications, she stated the staff needed to be certified as soon as possible, within the week. The RD further stated her expectation was that there should always be someone with ServSafe, Food Handlers Card, or RDM certification working in the kitchen to provide supervision. When informed of the observation on 07/15/2024 at 2:25 PM and 5:03 PM, when [NAME] 2 and Dietary Aide 1 were the only dietary staff members working in the kitchen are preparing and serving dinner, the RD stated [NAME] 2 and Dietary Aide 1 needed to get their certification within the week. During interview with the Administrator on 07/19/2024 at 9:10 AM, she stated all dietary staff had 30 days to obtain their Food Handlers Card. The Administrator stated it was the duty of the Dietary Manager to follow up with new dietary staff to make sure their training was done in a timely manner. She stated she would not take the individual off the schedule if they did not do the training within the first 30 days of being hired, because there was always someone in the facility with a Food Handlers Card, ServSafe certification, or CDM. When the SSA Surveyor informed the Administrator of the observation on 07/15/2024 at 2:25 PM and 5:03 PM, when [NAME] 2 and Dietary Aide 1 were the only dietary staff working in the kitchen, the Administrator stated she would need to have better oversight of the kitchen staff in the future and ensure they received their certification before hire. The Administrator further stated dietary staff were trained on safe food handling and hand hygiene while on the job.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50442 Based on observation, interview, and review of the facility's policies, it was determined the facility failed to provide a safe sanitary environment for food production and appropriate trash storage and disposal, which affected 54 residents receiving their meals from the kitchen. The findings include: Review of the facility's policy titled, Cleaning Procedures-Garbage Cans, Buckets, and Disposals, dated 08/2013, revealed kitchen garbage cans were to have plastic liners and those liners were to be changed as needed and disposed of frequently in the outside dumpster. Review of the facility's policy titled, Preparation of Food, dated 08/2013 and revised on 02/09/2026, revealed the preparation of foods served to residents and personnel were the responsibility of the Food Service Manager. Further review revealed food was to be produced using sanitary guidelines and served according to established rules and regulations. Review of the facility's Cleaning Assignment Sheet for July of 2024, revealed it noted all garbage can were to be emptied twice daily and the bathroom garbage can was to be emptied nightly. Observation on 07/16/2024 at 11:35 AM, during lunch tray line setup, revealed a garbage can without a lid, overflowing with trash located in the kitchen area. The State Survey Agency (SSA) Surveyor observed Dietary Aide (DA) 2 roll the trash can without a lid, overfull with trash, past the area where [NAME] 1 was setting up the steam table for the lunch service. Observation on 07/18/2024 at 8:27 AM, revealed a trash can located in the dining room that had no lid on it. In interview with DA 2 at 8:27 AM on 07/18/2024, she stated the trash can in the dining room did not have a lid. When the SSA Surveyor asked DA 2 about the process for trash removal from the dining room and the kitchen, DA 2 stated all the trash cans in the kitchen were always to be covered by a lid. When asked by the SSA Surveyor, if trash cans in the kitchen were ever overflowing with so much trash no lid could be placed on them, she stated no. DA 2 stated the process was to take out the garbage before the trash can overflowed. She stated the large trash can from the dining room and from the kitchen were rolled out to the dumpster to empty. DA 2 said the three (3) small trash cans in the dining room were emptied into the large rolling trash can that had no lid also located in the dining room, prior to it being taken from the kitchen to the dumpster. In an interview with [NAME] 1 on 07/18/2024 at 8:35 AM, she said trash cans in the kitchen should be covered with a lid. She further stated when trash cans were full they were to be taken out to the dumpster to empty. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185243	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Nursing and Rehabilitation Center	39 Ferndale Apartments Road Pineville, KY 40977

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with DA 3 on 07/18/2024 at 8:55 AM, the DA stated all trash cans in the kitchen and in the dining room had lids and those lids should be placed on them when trash was not being put in them. When the SSA Surveyor asked if the trash cans in the kitchen were ever overfilled and ran over or were so full the lid could not be placed back on them, DA 3 stated yes, that did occur. In an interview with the facility's Registered Dietician (RD) on 07/18/2024 at 10:53 AM, she said garbage cans in the kitchen needed to be covered with a lid. In an interview with the Facility Administrator on 07/19/2024 at 9:10 AM, she stated her expectation were that lids should be on garbage cans when they were not being directly used.