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	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Healthcare 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy the facility failed to implement changes to the Care Plan for 1 of 14 Sampled residents, (R46).The findings include:Review of the facility policy titled Comprehensive Care Plan not dated, revealed it was the policy to the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment. Further review of the policy revealed the interdisciplinary team (IDT) would develop resident specific interventions, and the comprehensive care plan would be reviewed and revised by the IDT after each comprehensive and quarterly Minimum Data Set (MDS) assessment. Furthermore, the qualified staff responsible for carrying out interventions specified in the care plan would be notified of their roles and responsibilities for carrying out the interventions, initially and when changes were made,Review of Resident (R)46's admission Face Sheet revealed R46 was admitted on [DATE] with diagnoses of major depressive disorder, bipolar disorder, and difficulty walking.Review of R46's MDS dated [DATE] revealed resident was dependent with chair/bed to chair transfers.Review of R46's care plan revealed a focus for assistance with activities of daily living and personal care related to impaired cognition and impaired mobility initiated on 08/09/2024. The goal was that activities of daily living and personal care would be completed with staff support as appropriate to maintain or achieve the highest practical level of functioning through the next review, initiated 08/09/2024. Interventions listed on the care plan for this goal were, resident was dependent with maximal non-weight bearing assistance of two staff using a mechanical lift. This intervention was initiated 05/01/2025.Review of R46's Kardex revealed handling and/or movement for transfers, resident was dependent/maximal/non-weight bearing assistance for two staff using mechanical lift.During an observation on 09/24/3035 at 11:32 AM, Certified Nurse Assistant (CNA) 4 and CNA 5 was in the room with R46 preparing to get her out of bed. The CNA's closed the door. When the door reopened R46 was in the rock and go chair. There was no mechanical lift observed in R46's room at any time.During an observation on 09/25/2025 at 11:25 AM, CNA 4 and CNA 5 were coming out of R46's room with R46 in the Rock and go chair. There was no mechanical lift observed at any time in R46's room.During an interview on 09/25/2025 at 11:26 with CNA6, who was in R46's room just after the transfer, she stated R46's transfers required the use of a mechanical lift. She further stated she did not assist with transferring R46 today.During an interview on 09/25/2025 at 11:30 AM with CNA5 revealed she and CNA4 had completed a 2 person assist with R46 without the use of a lift. CNA5 stated R46 was a two-person transfer. She further stated she looked at the Kardex to know what type of assistance a resident needed, and usually the nurses would tell her if changes were made to the resident's care needs.During an interview on 09/25/2025 at 11:35 AM with CNA 4 revealed she and CNA 5 had completed a two person assist transfer from the bed to the rock and go chair with R46 without the use of a lift. CNA4 stated she was not aware that R46 was care planned for a mechanical lift. She further stated she could look at the Kardex in the kiosk to view resident specific care needs. She (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated usually therapy assesses residents when there is an increase in care needs and then makes the CNAs aware of the change. She further stated not following the care plan could result in injury to the resident and/or staff.During an interview on 09/25/2025 at 12:25 PM with CNA6 she stated she was mistaken and thought that R46 could be transferred by two persons with a lift or without the lift depending on how the Resident was functioning at that time.During an interview on 09/25/2025 at 12:30 PM with the MDS coordinator she stated she made the change to R 46's care plan on 05/01/2025 for transfers to be completed using the mechanical lift. She stated this was completed during the IDT meeting after discussion with staff. She further stated the information for the change in care should have been relayed to staff via a text messaging app the facility uses, and/or the communication board at the nursing station. The MDS coordinator stated she reviews and updates the care plan at the required MDS timepoints.During an interview on 09/25/2025 at 4:17 PM with Registered Nurse (RN) 1, she stated R46 required a lift for transfers due to decline. RN1 further stated that R46 assistance needs change often. She further stated the process was to either have physical therapy to assess the resident, if a lift was needed, the order would then be put in the system. The care plan would then be updated to reflect the change and would be added to the Kardex. RN1 stated the nurses could update the care plan when needed when changes in care occurred. RN1 further stated not following the care plan could result in injury to staff and/or the resident.During an interview on 09/25/2025 at 4:30 PM with the Director of Nursing (DON) she stated the Quality Assurance Nurse was responsible for doing oversight audits. She stated staff should be made aware by in-service or verbally of any change in resident care. She further stated her expectation was for staff to follow the plan of care. She stated not following the plan of care could result in injury to staff and/or the resident.During an interview on 09/25/2025 at 5:35 PM with the Administrator she stated her expectation was for the staff to follow the care plan specific for each resident to provide the safest care for that resident and not following could result in a fall and/or injury to staff or resident. She stated the CNAs are aware to report any change with a resident to the nurse and the nurse could update the care plan and make the IDT aware. Furthermore, the MDS coordinator updates with each required MDS. The Administrator further stated there were currently no set audits in place for monitoring the care plan, but spot checks were done randomly to ensure accuracy of the care plans.