STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185270	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Valley Nursing & Rehabilitation Center	301 South Main Street Burkesville, KY 42717

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. Based on observation, interview, and facility policy review, the facility failed to ensure proper food handling practices were followed, which had the potential to affect all residents who received meals from the dietary department. Specifically, two kitchen staff with facial hair (Cook 1 and [NAME] 2) were observed without beard restraints in place while handling food items in the kitchen. Findings included: An undated facility policy titled, Employee Sanitary Practices revealed a section titled, Procedure that specified, All employees will: 1. Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food. An observation of the kitchen on 09/09/2025 at 10:47 AM revealed that while checking the temperatures of food items [NAME] 1's mustache was not covered by a hair restraint. An additional observation on 09/09/2025 at 11:15 AM revealed [NAME] 2 was observed in the kitchen assisting with food preparation and retrieving items from the refrigerator to place on residents' trays with his mustache uncovered. During an interview on 09/09/2025 at 1:13 PM, [NAME] 1 stated that the facility expected staff to cover their facial hair with beard restraints. [NAME] 1 stated sometimes the beard restraint shifted when he was working a long time, but it should have been covering all of his facial hair. During an interview on 09/10/2025 at 12:46 PM, [NAME] 2 stated that he did not realize that his beard restraint was not covering his mustache, but it was supposed to. During an interview on 09/12/2025 at 10:39 AM, the Assistant Dietary Manager stated kitchen staff with facial hair were expected to use facial hair restraints. During a concurrent interview on 09/12/2025 at 8:56 AM, the Administrator (ADM) and the Director of Nursing (DON) both stated that staff should follow the facility policy regarding beard restraints.

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview, record review, and facility policy review, the facility failed to ensure each resident was treated with dignity and respect for 1 (Resident 74) of 2 sampled residents reviewed for dignity and respect.Findings included: A facility policy titled, Resident Rights, reviewed 08/20/2025, indicated, Policy Statement - All residents have the right to be treated with respect, dignity and in a manner and in an environment that promotes maintenance and enhancement of quality of life. An admission Record indicated the facility admitted Resident(R)74 on 04/24/2024. According to the admission Record, the resident had a medical history that included diagnoses of major depressive disorder and anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/16/2025, revealed R74 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff for personal hygiene, moving from lying to sitting on the side of the bed, and chair/bed to chair transfers. R74's Care Plan Report included a focus area, revised 03/20/2025, that indicated the resident had a history of verbally degrading comments to others and a history of yelling at staff. An intervention dated 10/23/2023 directed staff to be reassuring and listen to the resident's concerns. During an interview on 09/10/2025 at 1:04 PM, State Registered Nurse Aide (SRNA) 6 stated that on 03/21/2025 at 1:20 PM she was in the process of getting R74 into their wheelchair, and the resident started screaming at her. SRNA 6 stated she told the resident that having a temper tantrum like a five-year-old was not helping the situation. SRNA 6 stated she knew she should not have said that to the resident. During an interview on 09/09/2025 at 3:38 PM, R 74 stated they did not want to discuss the incident involving SRNA 6, as the incident had already been investigated and resolved. During a follow-up interview on 09/10/2025 at 11:55 AM, R74 stated the incident was old news, as the facility had already handled the situation. R74 stated they had no concerns with facility staff members and indicated SRNA 6 was a great aide and very professional. R74 said he did not recall the SRNA making any unprofessional comments toward them. During an interview on 09/11/2025 at 8:59 AM, the Social Services Director (SSD) stated R74 reported staff were not listening to them, the resident was upset, but the resident did not appear to fear staff or feel unsafe. The SSD stated she learned from other staff members that SRNA 6 had said R74 was throwing a temper tantrum like a five-year-old. The SSD stated she considered the remark inappropriate. During an interview on 09/11/2025 at 9:39 AM, the Administrator stated she expected her staff to treat the residents with respect and dignity.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff assisted dependent residents with activities of daily living (ADLs) for 2 (Resident 2 and Resident 74) of 4 sampled residents reviewed for ADLs. Specifically, the facility failed to provide nail care for Resident 2 and Resident 74. Findings included: A facility policy titled, Activities of Daily Living (ADLs), reviewed 08/20/2025, indicated, 5. For those residents who are unable to perform their own activities of daily living, the facility will provide the needed assistance for completion of cares. Some residents based on medical conditions, co-morbidities, and disease processes may have unavoidable decline in ADLs or lack the potential to improve in their ability to be more independent with self-performance of ADLs. 1. An admission Record revealed the facility readmitted Resident (R) 2 on 09/04/2025. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus with diabetic neuropathy, hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, and stiffness of the left hand. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/12/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated R2 was dependent on staff for personal hygiene. R2's Care Plan Report included a focus area, revised 03/04/2025, that indicated the resident was at risk for complications associated with type 2 diabetes. Interventions directed staff to provide nail care per licensed staff or a podiatrist, revised 03/04/2025. R2's Care Plan Report included a focus area, revised 06/17/2025, that indicated the resident was at risk for a decrease in ADL function related to hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the left dominant side, convulsions, rheumatoid arthritis, gout, peripheral vascular disease, type 2 diabetes mellitus with diabetic neuropathy, and chronic obstructive pulmonary disease. Interventions directed staff to assist Resident #2 with hygiene, revised 08/06/2025. An observation on 09/08/2025 at 10:41 AM revealed R2 had long fingernails. An observation on 09/09/2025 at 3:38 PM revealed R2 had long fingernails. During an interview on 09/10/2025 at 12:22 PM, Unit Coordinator (UC) 3 stated nail care was provided on the residents' shower days or as needed. UC #3 stated state registered nurse aides (SRNAs) were responsible to clean all residents' nails and trim the non-diabetic residents' fingernails. UC 3 stated residents who had diabetes had their nails trimmed by nurses. During a concurrent observation and interview on 09/11/2025 at 2:19 PM, SRNA 4 stated nail trim/cleaning was a task that was completed every day for all residents. SRNA 4 stated the nurses trimmed the fingernails if the resident was diabetic. SRNA 4 observed R2's fingernails and stated he did not clean the resident's nails that day, and he should have cleaned them. During a concurrent observation and interview on 09/11/2025 at 2:28 PM, UC 3 stated the administration team checked the residents on their assigned units daily to ensure things like personal hygiene which included cleaning and the trimming fingernails were done. UC #3 stated she had completed the rounds (scheduled staff visits) for her unit that day and she had no concerns. However, on observing R2's fingernails UC 3 stated the resident's nails were dirty and long. UC 3 stated she expected her staff to keep the residents' fingernails clean and trimmed. During an interview on 09/11/2025 at 4:40 PM, SRNA 4 stated he had given R2 their bed bath that day and was responsible for making sure the resident's fingernails were clean. SRNA 4 stated he cleaned R2's hands but did not clean the resident's fingernails. SRNA 4 stated cleaning fingernails was part of the SRNA's job duties. SRNA 4 stated he did not offer to clean R2's fingernails that day. During an interview on 09/11/2025 at 4:43 PM, Licensed Practical Nurse (LPN) 5 stated diabetic residents' fingernails were cleaned once a week and as needed. During an observation on 09/11/2025 at 4:48 PM, LPN 5 confirmed R2's fingernails needed to be trimmed. LPN 5 stated the nurses were responsible for trimming the fingernails of the diabetic residents. During an interview on 09/12/2025 at 9:59 AM, the Administrator (ADM) stated she expected her aides to keep the residents' nails clean and trimmed. The Administrator stated the nurses were responsible for trimming the diabetic (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents' fingernails. During an interview on 09/12/2025 at 10:05 AM, the Director of Nursing (DON) stated she expected her aides to keep the residents' nails clean and trimmed, and she stated the nurses were responsible to trim the diabetic residents' fingernails. 2. An admission Record indicated the facility admitted R74 on 04/24/2024. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus and morbid obesity. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/16/2025, revealed R74 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff for personal hygiene. R74's Care Plan Report included a focus area, revised 08/20/2024, that indicated the resident at risk for impaired ability to perform selfcare related to morbid obesity. Interventions directed staff to provide hygiene, 09/28/2023. R74's Care Plan Report included a focus area, revised 07/15/2024, that indicated the resident was at risk for pressure related skin problems. Interventions directed staff to attempt to keep R74's nails short and clean as the resident allowed, 07/15/2024. During a concurrent observation and interview on 09/08/2025 at 10:47 AM, R74 was observed to have long, dirty fingernails. R74 stated that the staff did not offer to provide nail care. R74 stated they would like their fingernails to be clean and trimmed. During a concurrent observation and interview on 09/09/2025 at 12:03 PM, R74 was observed to have long, dirty fingernails. R74 stated no staff had offered to trim their fingernails, and they would like them to be trimmed. During a concurrent observation and interview on 09/10/2025 at 12:14 PM, R74 was observed to have long, dirty fingernails. R74 stated they had not asked the staff to trim their fingernails, but they wished the staff would trim and clean their fingernails when the staff had time. During an interview on 09/10/2025 at 12:22 PM, Unit Coordinator (UC) 3 stated nail care was provided on the residents' shower days or as needed. UC 3 stated State Registered Nurse Aides (SRNA) were responsible to clean all residents' nails and trim the non-diabetic residents' fingernails. UC 3 stated residents who had diabetes had their nails trimmed by nurses. During a concurrent observation and interview on 09/11/2025 at 2:19 PM, SRNA 4 stated nail trim/cleaning was a task that was completed every day for all residents. SRNA 4 stated the nurses trimmed the fingernails if the resident was diabetic. SRNA 4 observed R74's fingernails and stated he did not clean the resident's nails that day, and he should have cleaned them. During a concurrent observation and interview on 09/11/2025 at 2:28 PM, UC 3 stated the administration team checked the residents on their assigned units daily to ensure things like personal hygiene, which included cleaning and the trimming fingernails, were done. UC 3 stated she had completed the rounds (scheduled staff visits) for her unit that day and she had no concerns. However, on observing R74's fingernails UC 3 stated the resident's nails were dirty and long. UC 3 stated she expected her staff to keep the residents' fingernails clean and trimmed. During an interview on 09/11/2025 at 3:16 PM, R74 stated they had already had their bed bath for the day, and staff had not cleaned or trimmed their fingernails. A concurrent observation of R74's fingernails revealed the resident's nails were long and dirty. ^ During an interview on 09/11/2025 at 4:40 PM, SRNA 4 stated he had given R74 their bed bath that day and was responsible for making sure their fingernails were clean. SRNA 4 stated R74 was moving their hands, and he did not clean the resident's fingernails that day. SRNA 4 stated cleaning fingernails was part of the SRNA's job duties, but he had not offered to clean R74's fingernails that day. During an observation on 09/11/2025 at 4:50 PM, LPN 5 confirmed 74's fingernails were long and dirty and should have been trimmed and cleaned by staff. LPN 5 stated the SRNAs were responsible for cleaning the residents' fingernails, and the nurses were responsible for trimming the diabetic residents' fingernails. During an interview on 09/12/2025 at 9:59 AM, the Administrator (ADM) stated she expected her aides to keep the residents' nails clean and trimmed. The Administrator stated the nurses were responsible for trimming the diabetic residents' fingernails. During an interview on 09/12/2025 at 10:05 AM, the Director of Nursing (DON) stated she expected her aides to keep the residents' nails clean and trimmed, and she stated the nurses were responsible to trim the diabetic residents' fingernails. ^ ^ ^