STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and facility policy review, the facility failed to provide a dignified dining experience for 2 (Resident #81 and Resident #91) of 2 sampled residents.Findings included: A facility policy titled, Assistance with Meals, revised 09/2013, indicated, 3. Residents Requiring Full Assistance: a. Nursing staff will remove food trays from the food cart and deliver the trays to each resident's room. b. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity. A facility policy titled, Dignity, revised 02/2021, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1. Residents are treated with dignity and respect at all times. The policy continued, 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: e. provided with a dignified dining experience. An admission Record revealed the facility admitted Resident #81 on 03/18/2022. According to the admission Record, the resident had a medical history that included diagnoses of dementia and dysphagia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/02/2025, revealed Resident #81 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a staff assessment for mental status (SAMS). Per the MDS, the resident was dependent on staff assistance for eating during the seven-day look back period. Resident #81's Care Plan Report, included a focus area, revised 02/14/2024, that indicated the resident had a self-care deficit related to impaired range of motion, weakness, and cognitive deficits. Interventions directed staff to provide assistance with eating (initiated 03/23/2022). An admission Record revealed the facility admitted Resident #91 on 10/05/2022. According to the admission Record, the resident had a medical history that included diagnoses of dementia, dysphagia, blindness in one eye and low vision in the other. A significant change MDS, with an ARD of 06/14/2025, revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Per the MDS, the resident was dependent on staff for eating during the seven-day look back period. Resident #91's Care Plan Report, revised on 10/06/2022, revealed a focus area the indicated the resident had a self-care deficit related to disease process. Interventions directed staff to provide assistance with eating (initiated 03/31/2025). During an observation on 07/28/2025 at 12:18 PM, State Registered Nursing Assistant (SRNA) #6 and SRNA #13 were observed providing eating assistance to Resident #81 and Resident #91 in their room. SRNA #6 was providing eating assistance to Resident #81 and SRNA #13 was providing eating assistance to Resident #91. SRNA #6 and SRNA #13 conversed with each other on topics unrelated to work. SRNA #13 and SRNA #6 discussed Resident #91 aloud in the third person and did not include the resident in the conversation, stating I'm surprised [the resident] ate this much. This is the most [the resident's] had. If it's like pasta or something [the resident] will kick it. If you get [the resident] calm enough right now [he/she] will pass out after this. In an interview on 07/31/2025 at 11:34 AM, SRNA #6 stated he received training on how to provide feeding assistance to residents who required assistance. He stated if the resident was included in the conversation, then they (SRNA #6) could converse with other people during the meal. He stated if the (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
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was not included in the conversation, then it would not be appropriate to talk to the resident about someone else. He stated that he recalled talking to SRNA #23 on 07/28/2025 at lunch time while providing feeding assistance to Resident #81, and felt it was inappropriate. In an interview on 07/31/2025 at 4:52 PM, SRNA #13 stated that Resident #91 was verbal, though the resident did not always understand when staff would speak to them. SRNA #23 stated that she recalled speaking to SRNA #6 on 07/28/2025 during lunch, but neither resident was cognitively intact. She stated that typically staff would never talk about one resident in front of another due to privacy reasons, and it was not appropriate. In an interview on 07/31/2025 at 11:15 AM, SRNA #14 stated that when providing feeding assistance to a resident, he conversed with the resident. He stated that even if the resident was not cognitively intact or verbal, it was inappropriate and rude to have side conversations with other staff. He stated the facility provided training on that aspect of resident dignity. In an interview on 07/31/2025 at 2:22 PM, the Staffing Development Coordinator (SDC),stated nurse assistants received training regarding feeding assistance. The SDC stated that when doing a competency check for feeding assistance, she looked to see if staff positioned themselves in front of the resident and in a seated position. She stated that when staff were assisting a resident with a meal, the staff were to focus on the resident, converse with the resident if the resident wished to talk and were not to converse with other staff members. In an interview on 07/31/2025 at 4:13 PM, the Director of Nursing (DON) stated that her expectation regarding dignity and the feeding assistance experience was that staff's sole focus be on the resident and not anyone else. The DON stated sometimes the resident conversed with their roommate, and that was fine, but staff should not converse with other staff. Per the DON, while it was acceptable to have momentary interruptions, it would not be okay to have conversations about a resident with another staff member. The DON stated it would be a dignity concern if that occurred. She stated when providing feeding assistance, the focus should be only on assisting the resident to eat. In an interview on 07/31/2025 at 6:30 PM, the Administrator stated that he would expect a dignified dining experience that met the resident's expectations. The Administrator stated the staff and residents had good rapport, and staff had conversations amongst each other all the time. The Administrator stated if staff were not talking about something inappropriate, he did not have an issue with them talking to each other while providing feeding assistanc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility document review, and facility policy review, the facility failed to protect a resident's right to be free from misappropriation of property, which affected 1 (Resident #4) of 3 residents reviewed for personal property. Specifically, a staff member stole Resident #4's credit cards and made multiple unauthorized charges.Findings included: A facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 04/2021, indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. A facility policy titled, Resident Rights, revised 12/2016, indicated, Employees shall treat residents with kindness, respect, and dignity. The policy revealed, 1. Federal and state laws guarantee certain basic rights to residents of this facility. These rights include the resident's right to, including, c. be free from abuse, neglect, misappropriation of property, and exploitation. An admission Record indicated the facility admitted Resident #4 on 11/26/2024. According to the admission Record, the resident had a medical history that included a diagnosis of dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/24/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident #4's Care Plan Report included a focus statement dated 01/27/2025, that indicated the resident had impaired cognitive ability related to dementia. An Initial Report document, dated 07/07/2025 and completed by the Social Services Director (SSD), indicated that the Kentucky State Police (KSP) notified the Administrator that Licensed Practical Nurse (LPN) #1 was seen on video at a retail drug store and a retail supermarket using Resident #4's credit card. A Final Report/5 Day Follow-Up document, dated 07/11/2025 at 1:45 PM and completed by the SSD, revealed LPN #1 was observed on video provided by the KSP using Resident #4's credit card, which she did not have permission to use. The document indicated that LPN #1 was arrested at the facility on 07/07/2025 by the KSP. During an interview on 07/29/2025 at 11:10 AM, Resident #4 stated that their family member, Family Member (FM) #15, told them credit cards that were in their (Resident #4's) wallet were stolen. Resident #4 stated FM #15 would know all the details. During a telephone interview on 07/29/2025 at 11:38 AM, FM #15 stated the stolen credit cards had been in a wallet in a dresser next to Resident #4's bed. FM #15 stated they received notification from a credit card company on 07/03/2025 that there was fraud detected. FM #15 stated that someone attempted to use a credit card at a retail drug store and a retail supermarket. FM #15 stated that some of the charges were denied but some were not, and the charges totaled $1,700. FM #15 stated that on 07/04/2025 at approximately 12:00 PM, they reported to LPN #2 and another staff member, who LPN #2 asked to be present, that Resident #4's credit cards had been stolen. FM #15 stated that LPN #2 stated she would report it immediately to the Administrator and the Director of Nursing (DON). FM #15 stated that the police came to the facility on Monday (07/07/2025) with pictures, and staff were able to identify the person using the stolen credit cards. FM #15 stated they thought the alleged perpetrator was arrested on 07/07/2025. During a telephone interview on 07/29/2025 at 4:40 PM, LPN #2 stated that on 07/04/2025 at approximately 3:30 PM, FM #15 came into the facility and reported to her and Registered Nurse (RN) #3 that Resident #4's credit cards had been stolen, and the alleged perpetrator had attempted to use them. LPN #2 stated FM #15 showed her and RN #3 the resident's handbag/wallet and showed them where the credit cards had been stored prior to being stolen. LPN #2 stated she immediately told the Assistant Director of Nursing (ADON), who advised her to call the SSD. LPN #2 stated she notified the SSD, who told her that she would take care of it on Monday morning since it was a weekend. LPN #2 stated she thought the alleged perpetrator, who was a staff member, was identified, suspended, and arrested on Monday (07/07/2025) at the facility. During a telephone interview on 07/29/2025 at 5:06 PM, RN #3 stated LPN #2 asked her to be present as a witness when FM #15 came to the facility on [DATE] to report that Resident #4's credit cards had (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been stolen. RN #3 stated FM #15 told her and LPN #2 that Resident #4 had a handbag with a wallet that contained some credit cards, inside of a dresser in the resident's room; but the resident's credit cards had been stolen, and someone had attempted to use them that day (07/04/2025). RN #3 stated FM #15 showed her and LPN #2 the handbag and there were no credit cards in it. RN #3 stated FM #15 told them the alleged perpetrator attempted to use the credit cards at a retail drug store, a retail supermarket, and gas stations. During an interview on 07/30/2025 at 12:12 PM, the ADON stated she remembered LPN #2 called her on 07/04/2025, and she told LPN #2 to call SSD and report to her. The ADON stated she also called the SSD and reported it to her. The ADON stated the KSP came to the facility on Monday, 07/07/2025, with photos, but they were not clear, so they were not able to identify the alleged perpetrator at that time. She stated that the KSP brought in better pictures later that day and staff were able to identify the person in the photos as a staff member who was attempting to use Resident #4's credit card. She stated that the KSP requested the facility to allow the alleged perpetrator to report for work on 07/07/2025 so they could make the arrest at the facility. The ADON stated the alleged perpetrator was asked to come to her office and was informed of her suspension pending the investigation, and that was when KSP arrested the alleged perpetrator. During an interview on 07/30/2025 at 1:50 PM, the SSD stated she was notified on 07/04/2025 that FM #15 had come into the facility and had reported to LPN #2 that someone tried to use Resident #4's credit cards that had been in Resident #4's handbag inside a dresser next to the resident's bed. The SSD stated that she told the ADON she would handle it on Monday (07/07/2025). The SSD stated the KSP came to the facility on [DATE] with videos and photos, but they were not good quality, but the KSP came back later that day with other videos and photos, and the ADON or the Administrator were able to identify the staff member as the alleged perpetrator. The SSD stated the staff member was scheduled to work the evening of 07/07/2025 and the KSP asked the facility to allow the nurse to come into work, call her to the office prior to her shift starting, then she would be arrested. During an interview on 07/31/2025 at 8:30 AM, the Administrator stated that on 07/07/2025, the KSP came to the facility with photos from a retail drug store, but they were poor quality. He stated that the KSP came back the same day with clearer photos from a retail supermarket, and two different staff members, the Admissions Director and the Business Office Manager (BOM), were able to positively identify the alleged perpetrator as LPN #1. During an interview on 07/31/2025 at 8:56 AM, the Admissions Director stated the KSP brought in pictures on 07/07/2025 from a retail drug store, and she was not able to identify the person, but the KSP came back to the facility the same day with photos from a retail supermarket, and she was able to positively identify the person in the photos as LPN #1. During an interview on 07/31/2025 at 9:18 AM, the BOM stated that on 07/07/2025, KSP brought some pictures, but she was not able to identify the person. She stated that the KSP brought in more photos from a retail supervisor later that same day and she was able to positively identify the person in the photos as LPN #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility document review, and facility policy review, the facility failed to report an allegation of misappropriation of resident's property to the state survey agency timely, which affected 1 (Resident #4) of 3 residents reviewed for personal property. Specifically, an allegation was made on 07/04/2025 that Resident #4's credit cards that were kept in the resident's room were stolen and unauthorized charges had been made, and the facility did not report the allegation to the state survey agency until 07/07/2025.Findings included: A facility policy titled, Abuse, Neglect, Exploitation and Misappropriation-Reporting and Investigating, revised 04/2021, indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. The policy revealed, 1. If resident abuse, neglect, exploitation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies, which included a. The state licensing/certification agency responsible for surveying/licensing the facility. The policy revealed, 3. ?Immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. An admission Record indicated the facility admitted Resident #4 on 11/26/2024. According to the admission Record, the resident had a medical history that included a diagnosis of dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/24/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident #4's Care Plan Report included a focus statement dated 01/27/2025, that indicated the resident had impaired cognitive ability related to dementia. During an interview on 07/29/2025 at 11:10 AM, Resident #4 stated that their family member, Family Member (FM) #15, told them credit cards that were in their (Resident #4's) wallet were stolen. Resident #4 stated FM #15 would know all the details. During a telephone interview on 07/29/2025 at 11:38 AM, FM #15, stated the stolen credit cards had been in a wallet in a dresser next to Resident #4's bed. FM #15 stated they received notification from a credit card company on 07/03/2025 that there was fraud detected. FM #15 stated that someone attempted to use a credit card at a retail drug store and a retail supermarket. FM #15 stated that some of the charges were denied but some were not, and the charges totaled $1,700. FM #15 stated that on 07/04/2025 at approximately 12:00 PM, they reported to Licensed Practical Nurse (LPN) #2 and another staff member, who LPN #2 asked to be present, that Resident #4's credit cards had been stolen. FM #15 stated that LPN #2 stated that she would report it immediately to the Administrator and the Director of Nursing (DON). An Initial Report document, dated 07/07/2025 and completed by the Social Services Director (SSD), indicated that the Kentucky State Police (KSP) notified the Administrator that LPN #1 was seen on video at a retail drug store and a retail supermarket using Resident #4's credit card. An email from the SSD to the state survey agency, dated 07/07/2025 at 4:29 PM indicated the Initial Report was submitted to the state survey agency at that time. During a telephone interview on 07/29/2025 at 4:40 PM, LPN #2 stated that on 07/04/2025 at approximately 3:30 PM, FM #15 came into the facility and reported to her and Registered Nurse (RN) #3 that Resident #4's credit cards had been stolen, and the alleged perpetrator had attempted to use them. LPN #2 stated FM #15 showed her and RN #3 the resident's handbag/wallet and showed them where the credit cards had been stored prior to being stolen. LPN #2 stated she immediately told the Assistant Director of Nursing (ADON), who advised her to call the SSD. LPN #2 stated she notified the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SSD, who told her that she would take care of it on Monday (07/07/2025) morning since it was a weekend. During a telephone interview on 07/29/2025 at 5:06 PM, RN #3 stated LPN #2 asked her to be present as a witness when FM #15 came to the facility on [DATE] to report that Resident #4's credit cards had been stolen. RN #3 stated FM #15 told her and LPN #2 that Resident #4 had a handbag with a wallet that contained some credit cards, inside of a dresser in the resident's room; but the resident's credit cards had been stolen, and someone had attempted to use them that day (07/04/2025). RN #3 stated FM #15 showed her and LPN #2 the handbag and there were no credit cards in it. RN #3 stated FM #15 told them the alleged perpetrator attempted to use the credit cards at a retail drug store, a retail supermarket, and gas stations. During an interview on 07/30/2025 at 12:12 PM, the ADON stated she remembered LPN #2 called her on 07/04/2025, and she told LPN #2 to call SSD and report to her. The ADON stated she also called the SSD and reported it to her. During an interview on 07/30/2025 at 1:50 PM, the SSD stated she was notified on 07/04/2025 that FM #15 had come into the facility and had reported to LPN #2 that someone tried to use Resident #4's credit cards that had been in Resident #4's handbag inside a dresser next to the resident's bed. The SSD stated that she told the ADON she would handle it on Monday (07/07/2025). The SSD stated she should have come in on 07/04/2025 and reported the allegation to the state survey agency and started the investigation process. During an interview on 07/31/2025 at 3:55 PM, the DON stated the facility had two hours to report an allegation of abuse to the state survey agency, and 24 hours for other allegations. She stated that the Abuse Coordinator should report within the timeframe. During an interview on 07/31/2025 at 4:13 PM, the Administrator stated he expected the staff to notify the Abuse Coordinator immediately upon an allegation of misappropriation of resident property. He stated that there was no reason to report the allegation unless it was a true allegation. He stated that it was his understanding that FM #15 did not accuse anyone at the facility, just that they had a conversation about a missing credit card.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review, interview, and review of the Centers for Medicare & Medicaid Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to complete a discharge Minimum Data Set (MDS) upon discharge and transmit the data for 1 (Resident #101) of 1 resident reviewed for resident assessment.Findings included: The Centers for Medicare & Medicaid Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2024, revealed, OBRA [Omnibus Reconciliation Act] Discharge assessments consist of discharge return anticipated and discharge return not anticipated. The manual revealed, 09. Discharge Assessment-Return Not Anticipated (A0310F=10), which included Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days, Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days), and Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days). An admission Record revealed the facility admitted Resident #101 on 03/05/2025. According to the admission Record, the resident had a medical history that included a diagnosis of acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure. The admission Record indicated the facility discharged the resident on 03/20/2025. An admission MDS, with an Assessment Reference Date (ARD) of 03/11/2025, revealed Resident #101 had a Brief Interview of Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Resident #101's Care Conference Summary, dated 03/20/2025, indicated the facility care plan team met for an admission review. The record indicated Resident #101 chose not to attend, had no questions or concerns, and planned to discharge home that day. Resident #101's Progress Notes revealed a note, dated 03/20/2025 at 1:35 PM, that revealed Resident #101 was discharged home. Resident #101's record revealed no evidence that the facility completed a discharge MDS or transmitted data for the resident's discharge. During an interview on 07/31/2025 at 6:25 PM, the MDS Nurse stated a discharge MDS should have been completed with an ARD of 03/20/2025. She stated that it should have been completed within 14 days after the resident discharged , and she was not sure why it was missed. During an interview on 07/31/2025 at 3:01 PM, the Director of Nursing (DON) stated she had limited knowledge of the MDS process and was unable to provide a time frame of when or how assessments were to be completed; however, the DON stated she expected them to be completed accurately and timely. During an interview on 07/31/2025 at 3:28 PM, the Administrator stated he did not know much about the MDS process but expected the assessments to be completed accurately and timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 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, facility document and policy review, the facility failed to provide nail care for 1 (Resident #126) of 3 sampled residents for activities of daily living (ADL).Findings included: A facility policy titled, Activities of Daily Living (ADL), Supporting, dated 03/2018, revealed, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The policy continued, 1. Residents will be provided with care, treatment and services to assist them maintaining their highest functional status. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care). An admission Record revealed the facility admitted Resident #126 on 02/04/2025. According to the admission Record, the resident had a medical history that included diagnoses of age-related physical debility, lack of coordination, and muscle weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/13/2025, revealed Resident #126 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident required substantial/maximal assistance from staff with personal hygiene. Resident #126's Care Plan Report, included a focus area initiated 02/05/2025 that indicated the resident had a self-care ADL deficit related to their disease process, obesity, and weakness. Interventions directed staff to assist with bathing and personal hygiene. Resident #126's Point of Care Audit Report, for the timeframe from 05/01/2025 through 07/29/2025, revealed the resident received a bed bath daily. During a concurrent observation and interview on 07/28/2025 at 10:54 AM, Resident #126's nails were observed to be long with a brown-colored substance visible underneath the nail. Resident #126 stated staff did not provide nail care when assisting with the resident's bath. During an interview on 07/30/2025 at 9:27 AM, Resident #126 stated they had gotten a bed bath, but their nails were not trimmed. Resident #126 stated their nails had dirt under them and needed to be trimmed. During a concurrent observation and interview on 07/31/2025 at 8:34 AM, Resident #126 held out their hands and stated their nails had not been cut or cleaned. The residents' nails remained long and with a brown-colored substance visible underneath the nails. During an interview on 07/31/2025 at 8:38 AM, State Registered Nursing Assistant (SRNA) #9 stated they tried to do nail care during a bed bath if they had time. If they did not have time during the bath, they returned later to provide nail care. SRNA #9 stated if the resident was not a diabetic, they were allowed to trim the nails, and if the resident was diabetic, the nurses trimmed the nails. SRNA #9 stated she would provide nail care for Resident #126 on that day. During an interview on 07/31/2025 at 4:28 PM, the Director of Nursing (DON) stated her expectation was that nail care be provided when residents were given a bed bath. During an interview on 07/31/2025 at 4:31 PM, the Administrator stated he deferred clinical concerns to the DON.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0684 Level of Harm - Minimal harm or potential for actual harm 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** Based on interview, record review, and facility policy review, the facility failed to follow up on a urologist's orders and did not ensure that the physician's orders were transcribed and administered for 1 (Resident #11) of 2 residents sampled for catheter care.Findings included: A facility policy titled, Administering Medications, revised 04/2019, indicated, Medications are administered and as prescribed. The policy continued, 2. Medications are administered in accordance with prescriber orders, including any required time frame. An admission Record revealed the facility admitted Resident #11 on 03/17/2023. According to the admission Record, the resident had a medical history that included diagnoses of obstructive and reflux uropathy, retention of urine, and benign prostatic hyperplasia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/15/2025, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident had intact cognition. The MDS indicated Resident #11 had an indwelling catheter during the seven-day look back period. Resident #11's Care Plan Report, indicated a focus area, initiated on 11/20/2024, that indicated the resident had an alteration in urinary elimination and required an indwelling urinary catheter. Interventions directed staff to provide catheter care each shift and as ordered/as needed, to observe for signs and symptoms of urinary tract infection (UTI), and change the catheter and drainage bag as ordered. A document titled, Office Visit Report dated 07/16/2025 from Resident #11's urology provider, under the heading Assessment & Plan, indicated, Instruct nursing home to replace the catheter monthly. Further, Prescribe Hiprex [a urinary anti-infective drug] to be taken twice daily to maintain clean urine and prevent UTIs. The document revealed a fax date and time of 07/18/2025 at 1:27 PM. Resident #11's Order Summary Report, dated 07/31/2025, revealed no evidence of an order for the Hiprex. Resident #11's Medication Administration Record and Treatment Administration Record, dated 07/01/2025 - 07/31/2025, revealed no evidence of an order entry for the Hiprex. A review of Resident #11's Progress Notes, from 07/01/2025 through 07/31/2025, revealed no evidence the Hiprex was ordered and administered as recommended by the resident's urologist, or that the recommendation or order for the Hiprex by the urologist was followed up on by the facility staff. A review of the Progress Notes revealed a health status note, dated 07/28/2025 at 6:36 PM, that indicated Resident #11 had a new diagnosis of a UTI, had started on an antibiotic, and nursing staff was monitoring. During an interview on 07/31/2025 at 2:54 PM, the Infection Preventionist (IP) stated that Resident #11 had gone to the urologist on 07/16/2025. The IP reviewed the urology paperwork from the 07/16/2025 visit and confirmed that there was an order for Hiprex. She stated it was the responsibility of the nurse on duty to transcribe new orders when a resident returned from an appointment. During an interview on 07/31/2025 at 3:53 PM, the urology Medical Assistant (MA) stated that Resident #11 was seen in their office on 07/16/2025. She stated when a resident left their office, they provided a verbal report over the phone to the nursing home, gave the patient a verbal explanation of the visit and orders, and then sent a note with whoever accompanied the resident to the appointment. The MA stated they would also faxed a letter with the prescriptions to the facility. Per the MA, they sent a fax to the facility on [DATE] for Resident #11. During an interview on 07/31/2025 at 4:00 PM, the urology Nurse Practitioner stated Resident #11 was at elevated risk for a UTI due to their age and having an indwelling catheter. Per the NP, the Hiprex order was to keep the bladder cleaner, and that could help prevent a UTI. As far as not starting Hiprex, it could be linked to Resident #11 getting a UTI on 07/29/2025, but she would not say it was the direct cause. Hiprex could have reduced the risk, but it depended on the hygiene practices and how much perineal care Resident #11 received. With an indwelling catheter, the risk was always there. If someone did get a UTI with Hiprex, that meant it would not be as bad. The NP stated when a resident visited the urologist, the office sent paperwork with the resident and then faxed any orders over to the nursing home. In an interview with Licensed Practical Nurse (LPN) #4 on 07/31/2025 at (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4:45 PM, she stated that if a resident went to an appointment, they were accompanied by a staff member. Either the staff member who accompanied them would bring the nurse the paperwork, or the doctor's office would fax the orders to the facility. Any new orders were entered into the resident's chart after review with the provider. If there was no paperwork from the visit, then medical records would reach out to the outside provider's office for follow-up. In an interview with Medical Records on 07/31/2025 at 4:48 PM, she stated that nursing staff would drop off a resident's paperwork from outside appointments in the medical records box. If they were in her box, that meant they had already been reviewed and had orders inputted into the resident's chart. She would then scan them in. If a resident did not get paperwork from the doctor's office she would send out for it. Once received, she would then take it to the nurse to get the order put in. For Resident #11, she stated the uploaded time stamp in the electronic health record was the same day she received their urology visit report. She stated it said 07/21/2025 so that was when she received the urology visit paperwork. In an interview on 07/31/2025 at 4:13 PM with the Director of Nursing, she stated it was her expectation that orders were transcribed from an offsite doctor's visit. She stated that she expected that upon return from an appointment, nursing staff would talk to the resident and the staff who transported the resident and review the visit paperwork. They would then be expected to call the doctor to implement orders from the visit. She expected that the nurse on duty when the resident came back would input the orders and coordinate with the doctor.During an interview 07/31/2025 at 6:32 PM, the Administrator stated that he expected orders to be entered and followed as ordered if a resident returned from an appointment with new orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview, record review, and facility document and policy review, the facility failed to prevent a fall for 1 (Resident #95) of 3 sampled residents reviewed for accidents. Specifically, on 06/01/2025, State Registered Nursing Aide (SRNA) #6 was providing bathing assistance to Resident #95, who was dependent upon one staff member for bed mobility, when the SRNA rolled the resident onto their left side and then stepped to the resident's doorway to notify a nurse of a soiled bandage needing changed on the resident's coccyx, leaving the resident unattended. The resident fell from their bed and sustained a bruise to their right neck, a 2-centimeter (cm) skin-tear to their left inner wrist, and two skin tears (4 cm and 13 cm) to their right forearm.Findings included: A facility policy titled, Falls and Fall Risk, Managing, revised 03/2018, revealed, According to the MDS [Minimum Data Set], a fall is defined as: Unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. An admission Record revealed the facility admitted Resident #95 on 05/02/2025. According to the admission Record, the resident had a medical history that included diagnoses of peripheral vascular disease (PVD), type II diabetes mellitus, hypertension secondary to other renal disorders, muscle weakness, difficulty walking, and lack of coordination. A quarterly MDS, with an Assessment Reference Date (ARD) of 07/22/2025, revealed Resident #95 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident required partial/moderate assistance from staff to roll from lying on their back to their left and right side and to return to their back, substantial/maximal assistance from staff for showering/bathing themself and personal hygiene, and was dependent on staff for sit to lying, lying to sitting on the side of the bed. The MDS indicated Resident #95 had sustained one fall with injury since their prior assessment. Resident #95's Care Plan Report, included a focus area initiated05/02/2025 that indicated the resident had a self-care ADL (activity of daily living) deficit related to deconditioning, weakness, and PVD (peripheral vascular disease). Interventions directed staff to perform bathing (including bed bath) and bed mobility with the assistance of one staff member. The Care Plan Report also indicated a revision was made on 06/01/2025 that directed staff to perform bathing (including bed bath) and bed mobility with the assistance of two staff members. The Care Plan Report also included a focus area revised 05/02/2025 that indicated the resident was at risk for injury, falls related to ambulation/elimination status, history of falls, medications, PVD, with vascular wounds bilateral, and history of amputation of toes. Interventions indicated ADL and bed mobility assistance was reassessed and updated to two-person staff assistance on 06/01/2025. A document titled, #3252 Un-witnessed Fall, completed by Registered Nurse (RN) #8, dated 06/01/2025 at 11:00 AM, revealed a nurse aide called from Resident #95's room for assistance. The document indicated that when staff entered the resident's room, the resident was on the floor lying on their right side. Per the document, the resident stated they were not in pain, but they were unable to state whether they had hit their head. The resident was assisted back to bed, vital signs measurements were obtained, and neurological checks were initiated. The document further revealed the resident was found to have the following injuries:- a bruise to their right neck,- a 2 cm skin tear to left inner wrist with steri-strips (wound closure adhesive strips) and bandage applied,- a 4 cm right, forearm skin tear with 10 steri-strips, a liquid band-aid, non-adhesive bandage applied, and the area wrapped with gauze,- a second skin tear to the right forearm 13 cm in length with 30 steri-strips, a liquid band-aid, non-adhesive bandage applied, and the area wrapped with gauze.The document indicated that the resident's family member and physician were notified, treatments were initiated for all areas, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders were received for x-rays. The document further revealed, Resident Description: When I was getting my bath, I was rolled on my side and my legs began to come off the bed. Before I knew it, I just slid into the floor. I am not sure if I hit my head or not. Nothing hurts and I am not going to the hospital because I am just fine. During an interview on 07/28/2025 at 10:43 AM, Resident #95 stated they experienced a fall while a male staff member was providing bathing assistance. During an interview on 07/31/2025 at 10:44 AM, SRNA #6 indicated he provided bathing assistance to Resident #95 during his shift on 06/01/2025. He stated that at the time of the fall, the resident required one staff physical assistance for bed mobility and bathing. He stated that while providing Resident #95 a bed bath, he had disrobed the resident's upper and lower body and had cleaned the resident's front portion of their body. SRNA #6 stated that when he turned the resident to the left side, he noticed a bandage on the resident's coccyx area was soiled and needed to be replaced. SRNA #6 stated that while the resident was on their left side, he ran to the resident's door to alert the nurse of the bandage. He stated that while at Resident #95's door, he heard a [thud] and heard the resident begin to scream. SRNA #6 said he then alerted the nurse that the resident had fallen and then immediately returned to the resident. SRNA #6 indicated the resident was positioned on the floor on the window side of the bed, lying on their right side with their head somewhat underneath the bed. SRNA #6 stated he glanced over the resident to see if there were any immediate injuries while waiting for the nurse and stated he noticed a large cut on the resident's right arm that was bleeding a good amount. He stated Resident #95 informed him that they did not think they had hit their head during the fall. Once the nurse arrived and assessed the resident, SRNA #6 stated he, SRNA #7, and RN #8 placed a sheet under the resident and transferred the resident back to their bed. He stated the resident did not have any pain at the time but recalled later the resident began to report some pain in the lower extremities and the arm, stating they were sore. SRNA #6 stated that following the resident's fall, the resident's bed mobility and bathing assistance was increased to require the assistance of two staff. He stated he thought the reason the fall occurred was due to the linens being wet from the bath and the resident throwing their leg too far over to the edge of the bed. During an interview on 07/31/2025 at 10:38 AM, SRNA #7 stated she was on duty on 06/01/2025 but was not in the room when the incident occurred. She stated she heard SRNA #6 call for assistance saying Resident #95 was on the floor. SRNA #7 stated when she entered the room, the resident was completely disrobed and lying on the floor on their right side. SRNA #7 stated she assisted SRNA #6 and RN #8 place a sheet under the resident and transferred the resident back to their bed. Per SRNA #7, when Resident #95 rolled onto their side, they sometimes threw themself close to the edge of the bed. During an interview on 07/31/2025 at 10:10 AM, RN #8 stated she was on duty on 06/01/2025 when Resident #95 sustained a fall from their bed while being bathed by SRNA #6. RN #8 stated she recalled that at the time, Resident #95 required one-person physical assistance for bathing, and SRNA #6 was providing the resident with a bed bath and had approached the door to alert her that the resident's sacral dressing was soiled when the fall occurred. She stated that while SRNA #6 was at the door, the resident began to scream out and fell to the floor. RN #8 stated that when she arrived to the room, Resident #95's bilateral side rails were both up, and the resident was lying on the floor on the left side of their bed, on their right side. RN #8 indicated that at the time, Resident #95 did not complain of any pain, but had sustained multiple skin tears, and one large skin tear on the right upper extremity was bleeding. RN #8 said she assessed each area, treated the areas, and assessed the resident's pain. RN #8 stated the resident denied pain and refused to be transferred to the hospital for evaluation. RN #8 stated she notified the resident's family and the medical provider and received orders for x-rays. RN #8 stated the x-ray results were all negative. During an interview on 07/31/2025 at 3:01 PM, the Director of Nursing (DON) stated Resident #95 sustained a fall from their bed on 06/01/2025 while SRNA #6 was providing bathing assistance. She stated she was aware SRNA #6 thoroughly cleaned the resident, which caused the bed to be more saturated potentially than others; however, she stated SRNA #6 should not have left the resident unattended to alert the nurse of the need for the bandage change but (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instead should have used the resident's call light. During an interview on 07/31/2025 at 3:28 PM, the Administrator stated he deferred his expectation of falls to the DON.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview, record review, facility document and policy review, the facility failed to ensure medications were stored safely when a medication was found at the bedside for 1 (Resident #38) of 3 residents sampled for medication administration.Findings included: A facility policy titled, Administering Medications, revised 04/2019, revealed, 2. Medications are administered in accordance with prescriber orders, including any required time frame. An admission Record revealed the facility admitted Resident #38 on 02/24/2025. According to the admission Record, the resident had a medical history that included diagnoses of Huntington's disease, bipolar disorder, anxiety disorder, and insomnia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/02/2025, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. Resident #38's Order Summary Report, dated 07/31/2025 contained an order for mirtazapine 30 milligrams (mg) one tablet by mouth at bedtime. An observation on 07/31/2025 at 9:00 AM revealed a single, pink, oval-shaped pill in a medicine cup on Resident #38's overbed table, which was located near the resident's bed. On 07/31/2025 at 9:02 AM, during the medication administration task, Registered Nurse (RN) #10 observed the single pill in the medication cup on Resident #38's overbed table. RN #10 identified the single pill as a mirtazapine 30 mg tablet by comparing it against other medication supply cards in their medication cart. RN #10 said Resident #38 was scheduled to receive the mirtazapine at bedtime. RN #10 stated she had not entered Resident #38's room prior to the observation and therefore had not noticed the medication at the resident's bedside prior. Resident #38's July 2025 Medication Administration Record (MAR), revealed an order entry for mirtazapine 30 mg one tablet at bedtime. The MAR revealed Licensed Practical Nurse (LPN) #12 documented that they administered the mirtazapine on 07/30/2025 at 9:00 PM. During an interview on 07/31/2025 at 9:30 AM, LPN #11 stated medications were not allowed to be left at bedside. LPN #11 verified that LPN #12 was the nurse who worked from 7:00 PM on 07/30/2025 until 7:00 AM on 07/31/2025 and who would have administered the medication to Resident #38. During a telephone interview on 07/31/2025 at 6:48 PM, LPN #12 verified she worked from 7:00 PM on 07/30/2025 until 7:00 AM on 07/31/2025. LPN #12 said she recalled taking Resident #38 their medication and stated the resident took the cup of pills and threw them back into their mouth. LPN #12 said she thought the resident had swallowed their pills. LPN #12 indicated Resident #38 often discarded the medication cup themselves; therefore, she did not check the cup afterwards to verify that all the medications were taken prior to leaving the resident's room. LPN #12 indicated she should have checked the cup to verify all pills were swallowed by Resident #38 before leaving the room. An interview was held on 07/31/2025 at 3:01 PM, with both the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The DON stated she was made aware a single mirtazapine pill had been left at the bedside of Resident #38. She stated LPN #12 had worked in the facility for a very long time and had knowledge not to leave any medications at the resident's bedside. The DON said she expected the nurse administering the medication to stand at the resident's bedside until all medications were administered. The ADON stated that when she became aware that the medication was left at bedside, she had attempted to contact LPN #12 and had completed a medication error report for the resident who did not receive the mirtazapine. During an interview on 07/31/2025 at 3:28 PM, the Administrator stated he deferred his expectation for medication administration to the DON.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, facility policy review, and review of a Centers for Disease Control publication, the facility failed to maintain infection control practices during catheter care for 1 (Resident #11) of 2 residents sampled for urinary catheter. Specifically, a nursing assistant failed to don a gown as recommended for enhanced barrier precaution (EBP) while providing catheter care and placed a soiled washcloth into the same water basin as the clean washcloths, then continued to provide catheter care with the contaminated washcloths. Findings included: A facility policy, titled, Infection Prevention and Control Program, revised 12/2023, indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. A facility policy titled, Catheter Care, Urinary, revised 09/2014, under the heading, Steps in the Procedure: included, 13. With nondominant hand separate the labia of the female resident or retract the foreskin of the uncircumcised male resident. Maintain the position of this hand throughout the procedure. The policy continued, 15. For a male resident male [sic]: Use a washcloth with warm water and soap to clean around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. 16. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion side to approximately four inches outward.A review of a Centers for Disease Control (CDC) publication, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 07/12/2022, indicated, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. Further, Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. An admission Record revealed the facility admitted Resident #11 on 03/17/2023. According to the admission Record, the resident had a medical history that included diagnoses of obstructive and reflux uropathy, retention of urine, and benign prostatic hyperplasia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/15/2025, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident had intact cognition. The MDS indicated Resident #11 had an indwelling catheter during the seven-day look back period. Resident #11's Care Plan Report, indicated a focus area, initiated on 11/20/2024, that indicated the resident had an indwelling urinary catheter. Interventions directed staff to provide catheter care each shift and as ordered/as needed, to observe for signs and symptoms of urinary tract infection (UTI) and change the catheter and drainage bag as ordered. During an observation of catheter care performed on 07/31/2025 at 12:58 PM, State Registered Nursing Assistant (SRNA) #14 entered Resident #11's room, donned clean gloves, retrieved a wash basin from the closet, and emptied the supplies from inside the basin. SRNA #14 filled the basin with warm water, placed the basin on the resident's overbed table, and pulled the privacy curtain. SRNA #14 placed clean washcloths in the basin of water, added perineal wash to the water, then retrieved a washcloth from the basin to wipe the end of the penis tip and the scrotum. SRNA #14 did not clean the penis shaft. SNRA #14 then placed the soiled washcloth in the basin of water on top of the clean washcloths. SRNA #14 then retrieved another washcloth from the same basin of water, rinsed the area, and then placed the washcloth back into the basin of water. SRNA #14 retrieved a towel from on top of the comforter on the bed and dried the area. SRNA #14 did not don a gown at any time during the care. During an interview on 07/31/2025 at 1:04 PM, SRNA #14 stated Resident #11 had a urinary catheter for about a year. SRNA (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185414	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor of Paintsville	1025 Euclid Avenue Paintsville, KY 41240

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#14 stated he was familiar with how to provide catheter care. SRNA #14 verified the resident was on EBP by the signage on the door and stated he should have donned a gown and gloves for the task but forgot to don a gown before providing care. SRNA #14 stated he knew to pull back the foreskin of the penis to clean the area but stated the resident's penis shaft was difficult to get to so he did not do it. SRNA #14 acknowledged he placed the soiled washcloth in the basin on top of the clean washcloths, contaminating the water and remaining clean washcloths prior to using a clean washcloth to rinse the area. He stated the soiled washcloths should have been placed in a bag rather than the basin to prevent contaminating the water. A concurrent interview was held on 07/31/2025 at 3:01 PM with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The ADON stated when providing catheter care for a male resident, the foreskin should be pulled back and cleaned in a circular motion from the tip to the base of the penis, and then the scrotum area should be cleaned. The ADON stated the washcloths should be discarded into a plastic bag to be taken to the dirty linen barrels. The DON stated SRNA #14 should not have placed the soiled washcloth back into the clean basin for any reason. The DON stated Resident #11 was on EBP requiring a gown and gloves for incontinence care. She stated the aide should have donned a gown before providing the care. The DON stated catheter care should be performed properly each time, including pulling back the foreskin, to help prevent catheter-associated UTIs.