| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185094 | A. Building<br>B. Wing | 01/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pikeville Nursing and Rehab Center | 260 South Mayo Trail<br>Pikeville, KY 41501 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on interview, record review, and facility document and policy review, the facility failed to protect the resident's right to be free from physical abuse by another resident for 1 (Resident #100) of 2 residents reviewed for abuse. Specifically, on 07/01/2025, staff heard Resident #99 yell at Resident #100 and saw Resident #100 holding their right shoulder/arm. Resident #99 reported that they hit Resident #100 on the arm.Findings included: An undated facility policy titled, Abuse Protection, indicated, 1. Each resident has the right to be free from abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of property. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The policy also revealed, 3. Physical abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. An admission Record revealed the facility admitted Resident #100 on 04/23/2025. According to the admission Record, the resident had a medical history that included diagnoses of a wedge compression fracture of thoracic vertebrae number 11 and 12 (upper mid-back area of the spine), subsequent encounter for fracture with routine healing (onset date 04/23/2025); unspecified dementia; anxiety; and repeated falls. A five day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2025, revealed Resident #100 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Resident #100's Care Plan Report included a focus area initiated on 05/05/2025, that indicated the resident had impaired cognitive function or impaired decision making related to a diagnosis of dementia. Interventions directed staff to observe for any changes in cognitive function (initiated 04/23/2025). An admission Record revealed the facility originally admitted Resident #99 on 10/02/2023. According to the admission Record, the resident had a medical history that included diagnoses of major depressive disorder, adjustment disorder with other symptoms, low back pain, peripheral vascular disease, and acquired absence of the right leg below the knee. A quarterly MDS, with an ARD of 04/30/2025, revealed Resident #99 had a BIMS score of 13, which indicated Resident #99 was cognitively intact. Per the MDS, Resident #99 utilized a wheelchair during the last seven days of the assessment look-back period. Resident #99's Care Plan Report included a focus area initiated on 02/08/2024, that indicated the resident had/had a history of behavior problems that included aggressive behavior. Interventions directed staff to minimize potential for the resident's disruptive behavior by offering tasks which diverted attention and provide non-pharmacological interventions to prevent and/or reduce behaviors (initiated 05/22/2025). Resident #99's Psychiatry Progress Note dated 07/01/2025 revealed Psychiatric Mental Health Nurse Practitioner (NP) #2 documented that Resident #99 stated I got mad yesterday, someone took my wheelchair, and I hit [the resident]. I told [the resident] the last time that if [the resident] took it again I would hit. An undated Final Report/5 Day Follow-Up revealed on 07/01/2025, Resident #99 punched Resident<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | #100 on the arm as they passed in the hallway. According to the report, the facility investigated the incident and determined that staff heard Resident #99 curse and heard the resident say that they hit Resident #100. The facility's report also revealed that Resident #99 stated during an interview that they hit Resident #100 on the arm. The report revealed that Resident #100 sustained no injuries. Per the facility report, After concluding our investigation abuse cannot be substantiated due to no physical and/or emotional harm sustained. Licensed Practical Nurse (LPN) #3's, (who was a Certified Nursing Assistant [CNA] at the time of the incident) undated written statement revealed at approximately 2:00 AM, he heard Resident #99 call Resident #100 a name and Resident #99 stated, You won't do anything about it. Per the statement, LPN #3 observed Resident #100 holding their right shoulder. LPN #4's written statement revealed at approximately 2:00 AM on 07/01/2025, she was notified that Resident #99 and Resident #100 had a physical altercation. LPN #4's statement revealed that the LPN immediately assessed Resident #100 and found the resident holding their right arm. Per the statement, Resident #100 did not recall what happened. According to LPN #4's statement, prior to talking to Resident #99 about the incident, she heard the resident state, I don't understand why you have to be a [expletive] [expletive] all the time. During an interview on 01/07/2026 at 1:35 PM, LPN #3 stated that the statement he gave to the facility was on 07/01/2025 and was true and accurate. He stated that he did not observe either resident hitting. He stated staff separated the residents and nurses assessed Resident #100 and found no injury. During an interview on 01/07/2026 at 12:05 PM, LPN #4 stated Resident #99 got mad at Resident #100, because they thought Resident #100 had stolen their wheelchair. Per LPN #4, Resident #99 told her that they had hit Resident #100, and a CNA had reported they heard yelling between the two residents. She stated that she assessed both residents and did not find any physical injuries and stated that Resident #100 could not recall what happened. During an interview on 01/07/2026 at 11:25 AM, NP #2 stated that Resident #99 told her that they had hit another resident when the other resident had taken Resident #99's wheelchair. She stated that Resident #99 did not specify which resident they had hit. Per NP #2, that was the first time that Resident #99 had been involved in an incident with another resident. During an interview on 01/07/2026 at 2:38 PM, the Administrator stated a nurse notified of her of the incident in middle of the night on 07/01/2025. She stated that this was an isolated incident and Resident #100 was discharged approximately one week after the incident. Even though Resident #99 told staff that they hit Resident #100 on the arm and staff observed Resident #100 holding their arm/shoulder, the Administrator stated that there was no physical or emotional harm to either resident and the facility did not substantiate physical or verbal abuse. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on record review, interview, and facility document and policy review, the facility failed to ensure that an allegation of resident-to-resident physical abuse was reported to the state survey agency (SA) no later than two hours after the allegation was made for 1 (Resident #100) of 2 residents reviewed for abuse.Findings included: An undated facility policy titled, Abuse Protection, revealed 6. Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern, as a minimum: Reporting/response - The reporting and filing of accurate documents relative to incidents of abuse; reporting to State agencies as required, analyze and implement necessary changes to prevent future occurrences of abuse. The policy did not address timeframes for reporting abuse allegations to state agencies. An admission Record revealed the facility admitted Resident #100 on 04/23/2025. According to the admission Record, the resident had a medical history that included diagnoses of a wedge compression fracture of thoracic vertebrae number 11 and 12 (upper mid-back area of the spine), unspecified dementia, anxiety, and repeated falls. A 5 Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2025, revealed Resident #100 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. An admission Record revealed the facility originally admitted Resident #99 on 10/02/2023. According to the admission Record, the resident had a medical history that included diagnoses of major depressive disorder, adjustment disorder with other symptoms, low back pain, peripheral vascular disease, and acquired absence of the right leg below the knee. A quarterly MDS, with an ARD of 04/30/2025, revealed Resident #99 had a BIMS score of 13, which indicated Resident #99 was cognitively intact. Per the MDS, Resident #99 utilized a wheelchair during the last seven days of the assessment look-back period. A Long Term Care Facility - Self-Reported Incident Form dated 07/01/2025, revealed an allegation of physical abuse had occurred on 07/01/2025 (time of incident not documented) when Resident #99 punched Resident #100 on the arm as they passed in the hallway. A Final Report/5 Day Follow-Up revealed the facility documented that state agencies were notified of the allegation via electronic mail on 07/01/2025 (time not documented). An Automatic reply email from the SA to the facility dated 07/01/2025 at 11:30 AM revealed the SA received the facility complaint related to abuse and/or deficient practice. During an interview on 01/07/2026 at 12:05 PM, Licensed Practical Nurse (LPN) #4 stated she notified the Administrator and the Director of Nursing (DON) of the allegation at approximately 2:30 AM, not long after the incident occurred at 2:00 AM on 07/01/2025. She stated staff were required to report allegations immediately to the Abuse Coordinator, who was the Administrator at that time. Per LPN #4, abuse allegations were required to be reported to the SA within two hours. During an interview on 01/07/2026 at 2:38 PM, the Administrator stated a nurse called her about the allegation in the middle of the night (exact time unknown) because the incident occurred at approximately 2:00 AM or 3:00 AM on 07/01/2025. According to the Administrator, she was aware that allegations or incidents of abuse were supposed to be reported to the SA within two hours and expected abuse allegations to be reported timely. However, the Administrator stated she did not report the allegation of abuse until 11:30 AM on 07/01/2025, which was approximately nine hours after the allegation occurred. |