STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185221	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salyersville Nursing and Rehabilitation Center	662 Parkway Drive Salyersville, KY 41465

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy, the facility failed to notify the Responsible Party (RP) when) a decision was made to transfer or discharge the resident from the facility to the hospital for one of 14 sampled residents. (Resident (R) 3). The findings include:Review of the facility policy titled Admission, Discharge, and Transfer Standard of Practice dated 10/2020 revealed before the facility transfers a resident, the facility shall notify the resident and resident's representative to include the reason in a language and manner they understand.On 06/18/2025, R3 was transferred to the hospital from the facility. The RP was not informed of the transfer by the facility. Review of R3's admission Face Sheet revealed R3 was admitted to the facility on [DATE] with diagnoses of Diastolic Heart Failure; Vascular Dementia, severe; and Diabetes.Review of R3's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/01/2025 revealed a Brief Interview for Mental Status (BIMS) score of three of 15 which indicated severe cognitive impairments.During an interview on 07/31/2025 at 8:55 PM with R3's RP, she stated R3 was transferred to the hospital on [DATE] and she was not notified of the transfer. The RP further stated she was made aware of the transfer when the hospital called and made her aware.During an interview on 08/01/2025 at 4:11 PM with RN3, she stated she was assigned to R3 on 06/18/2025. She stated R3 was having breathing issues that day. RN3 had contacted in house respiratory to assist. RN3 further stated Unit Manager (UM) 1 was also assisting. RN3 stated while she was caring for other residents, R3 was noted to be out of her room. RN3 further stated she was informed by the UM1, R3 was transferred via ambulance to the hospital. UM1 further told her that the physician had been contacted, and all paperwork was completed and there was nothing further she needed to do. RN3 stated she started at the facility in May 2025 and was still learning the facility processes. RN3 further stated it was common for the UM to take care of the calls and forms required for resident transfers to the hospital.UM 1 is no longer employed by the facility. There were no answer to phone calls to UM1.During an interview on 08/01/2025 at 11:30 AM with the Interim Director of Nursing (DON), she stated her expectation was the staff follow the policy and always contact the RP with any transfer.During an interview on 08/01/2025 at 5:57 PM with the Administrator he stated his expectation was that staff follow the policy with transfers and notify accordingly.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185221	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salyersville Nursing and Rehabilitation Center	662 Parkway Drive Salyersville, KY 41465

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure a care plan was developed and implemented for four of 14 sampled residents (Resident #1 (R1), R3, #6, and R8. The findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 04/06/2015 and revised 02/09/2024, revealed the facility would develop and implement a comprehensive person-centered care plan for each resident, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment. Closed record review of R1's face sheet revealed the facility admitted the resident on 04/22/2024. R1 was readmitted to the facility on [DATE] included diagnoses of: subsequent encounter for closed fracture with routine healing; personal history of Transient Ischemic Attack (TIA/stroke); and cerebral infarction without residual deficits, and difficulty in walking, not elsewhere classified. Review of the admission Minimum Data Set (MDS) Assessment, dated 04/25/2024, revealed the facility assessed R1 to have a Brief Interview for Mental Status (BIMS) score of zero out of 15. This score indicated the resident was not cognitively intact. Record review revealed no documented evidence the facility developed a Comprehensive Care Plan for R1 that was resident specific. R1’s care plan had unachievable interventions in place such as “Encourage resident to not yell at other residents”. Record review revealed that R1’s care plan was not updated quarterly. During an interview with the Minimum Data Set (MDS) Coordinator on 07/31/2025 at 11:12 AM, she stated R1 should have had a Comprehensive Care Plan implemented when he was admitted to the facility on [DATE]. During an interview with the Director of Nursing (DON) on 07/31/2025 at 10:06 AM, she stated each resident should have a person-centered Comprehensive Care Plan and the MDS Coordinator was responsible for implementing the care plans. The DON stated her expectations were for each resident to have the appropriate care plan implemented. During an interview with the Administrator on 07/31/2025 at 10:41 AM, he stated he expected all residents to have a comprehensive care plan and for staff to follow the facility's policies. He also stated that all care plans should be revised and reviewed quarterly, at minimum. Review of Resident (R) 3’s face sheet revealed the resident was admitted on [DATE] with diagnoses of Dementia and Delirium. Review of R3’s Minimum Data Set (MDS), assessment reference date (ARD) 06/01/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of three of 15, indicating severe mental impairment. Review of R3’s Behavior Care Plan, established 07/01/2025, identified problems of smearing feces on self and walls (07/01/2024) and a resident-to-resident incident (07/23/2025). 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
	185221	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salyersville Nursing and Rehabilitation Center	662 Parkway Drive Salyersville, KY 41465

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions included, “resident separated immediately,” “psychiatrist to visit PRN,” and “psychologist to visit as needed,” were reactive and failed to address the resident’s cognitive limitations or provide individualized strategies to prevent recurrence. Review of R6’s face sheet revealed the resident was admitted on [DATE] with diagnoses of Depression and Anxiety. Review of R6’s MDS, dated [DATE], revealed the resident had a BIMS score of five of 15, indicating severe mental impairment. Review of R6’s Behavior Care Plan, established 12/08/2022, revealed the care plan listed multiple behavioral concerns, including depression, anxiety, fabrication, sexual inappropriateness, verbalizing a desire to die, hitting/biting/exit seeking, and repeated resident-to-resident contacts/altercations between 07/15/2025 and 07/28/2025. Interventions such as “resident separated immediately,” “Q 15-minute checks,” and “1:1 related to resident-to-resident altercation” were reactive, and implemented after incidents occurred. Review of R8’s face sheet revealed the resident was admitted on [DATE] with diagnoses of Alzheimer's Disease, dementia, and anxiety. Review of R8’s MDS, dated [DATE], revealed the resident had a BIMS score of one of 15, indicating severe mental impairment. Review of R8’s Behavior Care Plan, established 11/05/2021, revealed documented behaviors including elopement attempts, increased agitation, exit-seeking, and physical altercations with other residents. Interventions listed included redirection, one-on-one visits, encouraging activity participation, monitoring for increased agitation, and providing reassurance. While the interventions addressed behaviors after they occurred, there was no evidence of proactive, individualized interventions designed to prevent recurrence of these behaviors. In an interview on 08/01/2025 at 5:50 PM, the Director of Nursing (DON) stated she was unaware the residents were having recurring behaviors. The DON continued to state care plans were not resident-specific and required work to ensure residents received the care they deserved. The DON continued to state that she had not looked at any resident care plans since 07/17/2025. In an interview on 08/01/2025 at 6:16 PM, the Social Services Director (SSD) stated that behaviors were overlooked in the past and “tossed to the side and not addressed.” The SSD continued to state that it never “clicked with her” to be proactive with resident care planning and look at patterns of behaviors residents were having, to try to prevent future incidents. In continued interview, the SSD stated that it was her responsibility to ensure resident care plans were updated, but she could not answer why interventions to prevent additional incidents were not placed on care plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185221	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salyersville Nursing and Rehabilitation Center	662 Parkway Drive Salyersville, KY 41465

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 and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents. On 07/28/2025, Resident (R)8 was in the dining room and hit R6; only one staff member, out of three scheduled, was present during the altercation.The findings include:Review of facility policy titled, Resident Rights Standard of Practice, review date 04/2025, revealed residents have the right to have a safe, clean, comfortable, and homelike environment.Review of facility policy titled, Abuse Prohibition Standard of Practice, review date 04/2025, revealed neglect was the failure of the center, its team members or service providers to provide services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect included cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could result in physical harm, pain, mental anguish, or emotional distress.Review of a mealtime staffing sheet, undated, revealed three staff members were required to be present for each mealtime. Additional review revealed staff must stay in the dining room for the entire meal.In an interview on 08/01/2025 at 2:09 PM, Kentucky Medication Aide (KMA)1 stated she was working alone in the dining room for dinner service on 07/28/2025. KMA1 stated that Resident (R)8 was walking around the dining room and started a verbal altercation with R6. KMA1 stated she separated the two residents and placed them on opposite sides of the dining room, but was unable to leave to get additional staff to ensure the residents stayed separated, as she was the only staff member in the dining room. KMA1 continued to state she was getting drinks for residents when she turned around and saw R8 walk to R6 and hit her on the arm and then hit her with a bologna sandwich. KMA1 stated she never witnessed R6 hit R8, but R6 did start crying. KMA1 then walked R8 to the door and asked the resident to leave the dining room. KMA1 stated she waited until dinner service was over to report the incidents because she didn't want to leave the residents unsupervised. KMA1 continued to state that there should have been three staff members present during the meal service but she was not sure why no one else was where they were scheduled to be. In an interview on 08/01/2025 at 3:05 PM, Activities Assistant 2 stated that he was scheduled to leave at noon on 07/28/2025 for an appointment and was unsure if anyone covered his shift in the dining room. Activities Assistant 2 stated it was important to have an adequate number of staff in the dining room to ensure residents were safe and taken care of.In an interview on 08/01/2025 at 3:14 PM, Activities Assistant 1 stated that Activities Assistant 2 was scheduled to be in the dining room for dinner on 07/28/2025, but he left early, and she was not sure if anyone from the activities department was present for that meal. In an interview on 08/01/2025 at 3:25 PM, the Activities Director stated he was responsible for ensuring activities staff were present during each meal service in the dining room, but he forgot Activities Assistant 2 had an appointment on 07/28/2025 and did not schedule anyone to replace him. The Activities Director stated it is important to have staff present at mealtimes for resident safety.In an interview on 08/01/2025 at 3:34 PM, Registered Nurse (RN) 3 stated it was too difficult for only one staff member to be in the dining room and you can't keep your eyes on everyone. RN3 stated that the facility trained staff to separate residents if there was an incident and immediately report the incident; however, it was impossible to separate residents and report the incident if only one staff member was present. RN3 continued to state there should have been more staff in the dining room for the safety of residents.In an interview on 08/01/2025 at 4:00 PM, Licensed Practical Nurse (LPN)1 stated that she did not know she was scheduled to be in the dining room during dinner. LPN1 continued to state that no one told her she was responsible for being in the dining room. LPN1 additionally stated that having staff present during mealtimes was important for resident safety and to prevent verbal (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185221	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salyersville Nursing and Rehabilitation Center	662 Parkway Drive Salyersville, KY 41465

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	altercations from becoming physical. LPN1 continued to state that she was aware there was a schedule for staff being present in the dining room, but she was not aware it was her day to be there, as she was passing medications. In an interview on 08/01/2025 at 5:50 PM, the Director of Nursing (DON) stated the facility did not have any staff members who were responsible for ensuring staff members were going to the scheduled shift in the dining room for meal services and continued to state, we assume that staff go. The DON stated she expected that staff follow the posted staffing schedule for resident safety and to prevent resident altercations. The DON continued to state that she created the staffing schedule for meal times and distributed them to the nursing staff on the floor.In an interview on 08/01/2025 at 5:57 PM, the Administrator stated one staff member being present during a meal service was not sufficient to prevent resident altercations or ensure resident safety. The Administrator stated that he expected staff to follow their posted schedules.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185221	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salyersville Nursing and Rehabilitation Center	662 Parkway Drive Salyersville, KY 41465

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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of state law, the facility failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes. Review of employee medical records revealed facility staff had not received tuberculosis (TB) testing within the required timeframe.Review of 902 [NAME] 20:205 revealed the administrative regulation established requirements for TB testing of healthcare workers in healthcare facilities or settings. The procedures were necessary to minimize the transmission of infectious TB disease among staff, patients, and residents of health facilities. Continued review revealed healthcare workers consisted of physicians, nurses, nurse aides, therapists, housekeeping, laundry, maintenance, and billing. Healthcare workers were required to have annual TB screening risk assessments and annual education about the signs and symptoms of active TB disease.The facility did not provide facility-specific policies for TB testing when requested.Review of a facility staffing sheet, undated, revealed the facility has 131 active employees. The facility provided TB testing records for 70 of the 131 active employees but failed to provide TB records for 61 active employees. Further review of the 70 TB records revealed 23 active employees who were in compliance with state and local TB testing guidelines. The remaining employee files revealed that 47 active employees had either lapsed TB testing or their medical records did not show consistent annual testing. Additional review revealed the Infection Preventionist, who was responsible for ensuring staff had TB tests completed on time, was hired on 09/22/2021 and only had records for TB test being completed on 09/03/2024.During an interview on 08/01/2025 at 11:22 AM, a Registered Nurse (RN) representing the local health department stated the county expected TB testing to be completed annually in the same month as the employee was hired.The Director of Nursing (DON) stated in interview, on 08/01/2025 at 11:30 AM, that the facility did not have an acting Infection Preventionist (IP) as the current IP was on medical leave, and the facility did not have any way to ensure that current staff were getting their TB testing on time. The DON stated that staff should be current on all TB testing for the safety of residents, visitors, and staff.During an interview on 08/01/2025 at 5:57 PM, the Administrator stated it was his expectation for all facility staff to follow all federal, state, and local regulations for the safety of staff and residents.Multiple calls to the IP on 07/31/2025 and 08/01/2025 were unanswered and unreturned.