DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		185281	B. WING			08/	11/2020
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
EDIENDO				7	400 FRIENDSHIP DRIVE		
FRIENDSF	IP HEALTH AND REHAD	5, 220		F	PEWEE VALLEY, KY 40056		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORI ORI		TAG		DEFICIENCY)	112	
	1						
F 000	INITIAL COMMENTS		F	000			
1 000							
	An Abbrevieted Cum						
		ey initiated on 08/05/2020 /11/2020 investigating					
	KY#00032199, KY#0	8 8					
		dition, a COVID-19 Focused					
	Infection Control Surv						
	08/05/2020 and conc	•					
		was partially substanciated					
	with deficiencies cited						
	KY32143 were unsub	estantiated with no					
	deficiencies cited. To	otal census 117.					
F 656	Develop/Implement C	Comprehensive Care Plan	F	656			
SS=D	CFR(s): 483.21(b)(1)						
	§483.21(b) Comprehe						
		cility must develop and					
		nensive person-centered					
	-	sident, consistent with the the states the s					
	§483.10(c)(3), that in	•					
		ames to meet a resident's					
	-	mental and psychosocial					
	-	ied in the comprehensive					
	assessment. The con	nprehensive care plan must					
	describe the following) -					
		are to be furnished to attain					
		ent's highest practicable					
		psychosocial well-being as					
		24, §483.25 or §483.40; and					
		would otherwise be required					
		25 or §483.40 but are not					
		esident's exercise of rights					
	-	ling the right to refuse					
	treatment under §483 (iii) Any specialized se						
		the nursing facility will					
	provide as a result of						
		a facility disagrees with the					
		===============================					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

PRINTED: 09/24/2020

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.

	-	ID HUMAN SERVICES				FORM): 09/24/2020 MAPPROVED
STATEMENT (S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	_	(X3) DATE	D. 0938-0391 SURVEY LETED
		185281	B. WING			08/	11/2020
NAME OF P	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, S	STATE, ZIP CODE	-	
FRIENDSI	HIP HEALTH AND REHAD	3, LLC		7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 4			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	findings of the PASAF rationale in the reside (iv)In consultation with resident's representat (A) The resident's goa desired outcomes. (B) The resident's pre- future discharge. Fact whether the resident's community was asses local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, for	RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and efference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate	F 65	6			
	by: Based on interview, r review, it was determi implement the individ of four (4) sampled re Resident #2. Staff fa and care planned mer failed to provide gastr treatments and ordere planned for Resident The findings include:	ed medications as care #2. and procedure, "Care Plans, on-Centered" dated					

Facility ID: 100355

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		185281	B. WING _			08/	11/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
FRIENDSI	HIP HEALTH AND REHAD	3, LLC			00 FRIENDSHIP DRIVE EWEE VALLEY, KY 40056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	person-centered care implemented for each physical, psychosocia The facility admitted F Current diagnoses inc Convulsions, Gastros Diabetes Mellitus with Additional diagnoses Traumatic Brain Injury Persistent Vegetative Observation of Reside revealed the resident and sitting up in a cha odor-free, and appear dressed appropriately Diabetasource at sev hour was infusing via gastrostomy tube. Ga with staff, and appear resident's abdomen w Review of the Annual signed and dated 06/ Interview for Mental S ninety-nine (99) and t resident was not inter revealed the facility a a feeding tube. Review of the plan of focus of a potential fo related to nothing per feeding. Interventions provide tube feeding a focus was Resident # which placed him/her	plan was developed and resident to meet their al and functional needs. Resident #2 on 01/17/06. cluded Unspecified tomy Status, and Type II nout Complications. included Personal History of 7, Quadriplegia, and State. ent #2 on 08/05/2020 to be non-verbal, awake, air. The resident was red clean. He/she was red clean. He/she was r for the season. enty (70) milliliters (ML) per pump through a astrostomy tube observed red dry and intact to the <i>i</i> thout leakage or odor. Minimum Data Set (MDS), 10/2020, revealed a Brief Status Exam score of he facility determined the viewable. Continued review ssessed the resident to have care (no date) revealed the r alteration in nutrition oral (NPO) need for tube s listed included NPO and as ordered. An additional 2 has a seizure disorder,	F	556			

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PRINTED: 09/24/2020

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/24/2020 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	
		185281	B. WING			08/	/11/2020
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRIENDS	IP HEALTH AND REHAE	3, LLC			7400 FRIENDSHIP DRIVE		
					PEWEE VALLEY, KY 40056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	effects and effectiven Review of the Medica dated 07/01/2020 thro staff omitted the follow #2 from 07/27/2020 th omitted treatments ind tube feeding formula) continuously, and leve anticonvulsant) one h (MG) per ML, give fifth tube two (2) times a d Continued review of F	observe/document side ess. tion Administration Record, bugh 07/31/2020, revealed ving treatments for Resident prough 07/31/2020. The cluded Diabetasource AC (a at seventy (70) ML per hour etiracetam solution (an undred (100) milligrams een (15) ML via gastrostomy ay related to Convulsions. Resident #2's MAR dated 8/31/2020 revealed the	F	656	}		
	administered 08/01/20 physician orders. The medications included seventy (70) ML per h levetiracetam solution give fifteen (15) ML vit times a day related to 2. The facility re-adm 11/12/2019 from an a diagnoses included A Cerebrovascular Acci diagnoses included A Depression, Chronic I to Thrive, Dementia w Insufficiency, and Gas Disease without Esop Review of the Signific dated 05/15/2020 rev	200 through 08/03/2020 per e missed treatments and Diabetasource AC at your continuously, and o one hundred (100) MG/ML, a gastrostomy tube two (2) Convulsions. itted, Resident #1 on cute care hospital. Current nemia, Arthritis, and dent (CVA). Other Izheimer's disease, Lung Disease, Adult Failure with Behaviors, Venous stro-Esophageal Reflux hagitis (GERD). ant Change in Status MDS, ealed Resident #1 to have ong term memory problems,					

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NUMBER: A. BU	BUILDING WING S ⁻ 74	CONSTRUCTION		(X3) DATE S		
ENCIES	S ⁻	TREET ADDRESS, CITY, STAT			(X3) DATE SURVEY COMPLETED	
	74	TREET ADDRESS, CITY, STAT	1	08/11/2020		
			FE, ZIP CODE			
		400 FRIENDSHIP DRIVE				
	Р	EWEE VALLEY, KY 400	56			
	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	IVE ACTION SHOULD BE CED TO THE APPROPRIATION		(X5) COMPLETION DATE	
	F 656					
t risk for agulant ower T). edications Resident #1 ed to egeneration n testing due luded s of breath s. redications 07/01/2020 I not lowing 20/2020: grams one (1) time liquis U-D outh two (2) Thrombosis nissed cluded re percent es two (2) sed c (0.1%), s a day						
	ENCIES ED BY FULL FORMATION) To date, trisk for agulant ower T). hedications Resident #1 ed to legeneration in testing due cluded s of breath s. hedications 07/01/2020 d not lowing 20/2020: ograms one (1) time Eliquis U-D outh two (2) Thrombosis hissed cluded /e percent es two (2) sed t (0.1%), s a day	ID ENCIES ID ED BY FULL PREFIX FORMATION) F 656 No date, F 656 of guarantee F 656 <td>PEWEE VALLEY, KY 400 PROVIDER'S F D BY FULL ORMATION) F 656 no date, t risk for agulant ower T). redications Resident #1 ed to legeneration n testing due duded s of breath s. redications 07/01/2020 d not lowing 20/2020: ggrams one (1) time Eliquis U-D outh two (2) Thrombosis nissed cluded (c percent est two (2) sed (0.1%), s a day AR revealed ion of the</td> <td>PEWEE VALLEY, KY 40056 ENCIES ED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION ED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION ECONSECTION ECONSECTION F 656 no date, t risk for agulant wer T). tedications Resident #1 ed to legeneration testing due Juded s of breath s. tedications 07/01/2020 th not lowing 20/2020: ograms one (1) time Eliquis U-D outh two (2) Thrombosis hissed Studed te percent as two (2) sed t (0.1%), s a day NR revealed ion of the</td> <td>PEWEE VALLEY, KY 40056 ENCIES ID PRCFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) no date, t risk for agulant F 656 F wwer T). redications F redications F 656 of not lowing 20/2020: orgrams one (1) time citiquis U-D outh two (2) Thrombosis issed cluded F revealed cluded F F revealed con of the F</td>	PEWEE VALLEY, KY 400 PROVIDER'S F D BY FULL ORMATION) F 656 no date, t risk for agulant ower T). redications Resident #1 ed to legeneration n testing due duded s of breath s. redications 07/01/2020 d not lowing 20/2020: ggrams one (1) time Eliquis U-D outh two (2) Thrombosis nissed cluded (c percent est two (2) sed (0.1%), s a day AR revealed ion of the	PEWEE VALLEY, KY 40056 ENCIES ED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION ED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION ECONSECTION ECONSECTION F 656 no date, t risk for agulant wer T). tedications Resident #1 ed to legeneration testing due Juded s of breath s. tedications 07/01/2020 th not lowing 20/2020: ograms one (1) time Eliquis U-D outh two (2) Thrombosis hissed Studed te percent as two (2) sed t (0.1%), s a day NR revealed ion of the	PEWEE VALLEY, KY 40056 ENCIES ID PRCFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) no date, t risk for agulant F 656 F wwer T). redications F redications F 656 of not lowing 20/2020: orgrams one (1) time citiquis U-D outh two (2) Thrombosis issed cluded F revealed cluded F F revealed con of the F	

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	-					FORM): 09/24/2020 MAPPROVED
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	
		185281	B. WING			08/ [.]	11/2020
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
FRIENDSH	HIP HEALTH AND REHAE	3, LLC		400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40	0056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 F 684 SS=D	07/28/2020: Fluticasc Micrograms (MCG) or one (1) time a day rel Other medications inc tablet one (1) tablet by related to Embolism a of the Lower Extremit Ketorolac Trometham (0.5%) drops one (1) f times a day related to morning dose), and C (antihistamine) zero p (1) drop in both eyes morning dose). Telephonic interview of revealed a resident's and made staff aware resident. He stated a occur if the plan of ca Telephonic interview of 08/11/2020 at 12:54 F expectation staff follow plan to meet the need Quality of Care CFR(s): 483.25 § 483.25 Quality of care assessment of a residents. Base assessment of a residents receive accordance with profe	one Propionate fifty (50) ne (1) spray in both nostrils ated to Allergic Rhinitis. clude Eliquis U-D five (5) MG y mouth two (2) times a day and Thrombosis of arteries ies (missed morning dose), nine zero point five percent drop in both eyes two (2) o Glaucoma (missed DIOPatadine HCL boint one percent (0.1%) one two (2) times a day (missed with Registered Nurse #1 care plan was individualized a of how to take care of each a negative outcome could are was not followed. with the Administrator on PM revealed it was a facility w the individualized care ds of each resident. are ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure a treatment and care in essional standards of nensive person-centered	F 656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION G		(X3) DATE COMPI	SURVEY
		185281	B. WING			08/ [,]	1/2020
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, S	STATE, ZIP CODE		
FRIENDS	HIP HEALTH AND REHAU	3, LLC		7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 4			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	≥6	F 6	84			
	by: Based on interview, it policy review, it was of to ensure two (2) of for received treatment ar the physician orders (Resident #1 did not re ordered and Resident	is not met as evidenced record review, and facility determined the facility failed our (4) sampled residents and care in accordance with (Residents #1 and #2). eceive medications as t #2 did not receive dings and medications as					
	Review of the policy a Administering Medica revealed medications a safe and timely man 1. The facility admitte Diagnoses included L Gastrostomy Status, Mellitus without Comp included Personal His	tions, dated 04/2019, were to be administered in nner, and as prescribed. d Resident #2 on 01/17/06. Jnspecified Convulsions,					
	signed and dated 06/ Interview for Mental S ninety-nine (99) and t	Minimum Data Set (MDS), 10/2020, revealed a Brief Status Exam scored at he facility determined the viewable. Additionally the					

Facility ID: 100355

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PRINTED: 09/24/2020

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/24/2020 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		185281	B. WING			08/	11/2020
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRIENDSH	IIP HEALTH AND REHAE	3, LLC			7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 684	tube. Observation of Reside	resident to have a feeding	F	684	ŀ		
	and sitting up in a cha odor-free, and appear dressed appropriately Diabetasource (a tube	air. The resident was red clean and he/she was / for the season. e feeding formula) at s (ML) per hour was infusing astrostomy tube. served with staff, and act to the resident's					
	an acute care hospita 07/27/2020 by the phy #2 presented to the E from the nursing home gastrostomy tube as c list stated no changes during this visit and the	rge Summary Report from Il, signed and dated ysician, revealed Resident mergency Department (ED) e with reports of his/her dislodged. The medication s made to your prescriptions he hospital discharged the acility in stable condition.					
	1:30 PM, revealed Re hospital ED with no ne current orders.	' note, dated 07/27/2020 at esident #2 returned from the ew orders and to continue					
	focus the potential for	care (no date) revealed the r alteration in nutrition r oral with need for tube					

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	-	D HUMAN SERVICES			FORM	D: 09/24/2020
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		185281	B. WING		08/	/11/2020
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
EDIENDO				7400 FRIENDSHIP DRIVE		
FRIENDS	HIP HEALTH AND REHAE	3, LLC		PEWEE VALLEY, KY 40056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	mouth), and provide t Continued review reve had a seizure disorder risk of injury. Interver for staff to give seizur doctor, observe/docur effectiveness. Review of the Medica (MAR), dated 07/01/2 revealed staff omitted Resident#2 from 07/2 Diabetasource AC at per hour continuously Omeprazole Suspens per ML, one (1) time a Gastroesophageal Re Amantadine HCL Synvia gastrostomy tube, related gastrostomy s revealed levetiracetar (100) MG/ML, give fift gastrostomy tube two Convulsions; and Poly seventeen (17) grams (2) times a day related Continued review of F 08/01/2020 through 0 following treatments a administered 08/01/20 physician orders: Dia (70) ML per hour cont and Omeprazole Sus (MG) per ML one (1) f Gastroesophageal Re treatments included A	s included NPO (nothing by ube feeding as ordered. ealed the focus Resident #2 r, which placed him/her at nations for this focus included e medication as ordered by ment side effects and tion Administration Record 020 through 07/31/2020; the following treatments for 7/2020 through 07/31/2020: seventy (70) milliliters (ML) . Other treatments included ion, two (2) milligrams (MG) a day related to effux Disease; and up, one hundred (100) MG every twelve (12) hours tatus. Further review in Solution, one hundred eeen (15) ML via (2) times a day related to yethylene Glycol Powder is via gastrostomy tube two d to constipation. Resident #2's MAR, dated 8/31/2020, revealed the and medications were not 020 through 08/03/2020 per obetasource AC at seventy inuously one (1) time a day; pension two (2) milligram time a day related to	F 684	4		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/24/2020 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		185281	B. WING			08/	11/2020
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRIENDSH	IP HEALTH AND REHA	3, LLC			7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056		
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page	9	F	684			
	twelve (12) hours rela levetiracetam Solution	ted gastrostomy status; and one hundred (100)					
	MG/ML, give fifteen (two (2) times a day re Further review reveal						
		Powder, seventeen (17)					
	grams via gastrostom	y tube two (2) times a day					
	related to constipatior	1.					
	-	with Licensed Practical)8/07/2020 at 12:58 PM,					
	revealed she sent Re	sident #2 out of the facility to					
		rtment on 07/27/2020 at M for a gastrostomy tube					
	placement. She state						
	returned to the facility	, she reconnected the tube					
	-	e did not verify a medical e she was familiar with the					
		ding machine was set up, so					
	she just turned the fee						
		with Assistant Director of					
		on 08/06/2020 at 12:08 PM d care to Resident #2 on					
		observed an empty bottle of					
	tube feeding hanging	in the residents room. She					
	•	e resident received the tube					
	feeding during the nig						
		with LPN #1, on 08/07/2020					
		d she provided care to /2020. She stated she did					
	administer the resider						
	previously ordered. S	She stated the resident did					
	-	ions ordered and assumed tions were administered on					
	another shift.						
	Telephonic interview	with LPN #4, on 08/10/2020					

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	-	D HUMAN SERVICES				RINTED: 09/24/2020 FORM APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		MB NO. 0938-0391 (3) DATE SURVEY COMPLETED
		185281	B. WING			08/11/2020
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP	CODE	
			74	400 FRIENDSHIP DRIVE		
FRIENDSI	HIP HEALTH AND REHAE	3, LLC	P	EWEE VALLEY, KY 40056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 684	08/02/2020. She reverse medications or tube for because the orders we Administration Record Administration Record Telephonic interview we at 11:18 AM, revealed 08/04/2020, that Resi medication orders we resident had his/her g on 07/27/2020. He st resident's medical record well as a progress no continue current med He revealed the previous revealed the resident going when she had of The LPN continued to medications and tube placed on hold while to facility for a gastrosto however, it appeared medications/tube feed 07/27/2020. Telephonic Interview of on 08/10/2020 at 1:20 resident received serv Department, and retu facility, the medication be discontinued, and She stated staff should the resident returned and the orders for the tube feeding should he	d care to Resident # 2 on ealed she did not administer eeding to the resident ere not on the Medication d (MAR) or the Treatment d (TAR). with LPN #2, on 08/07/2020 d he identified on dent #2's tube feeding and re not continued after the pastrostomy tube replaced ated he reviewed the cord, and noted an order as te dated 07/27/2020 to ication/tube feeding orders. ous night shift nurse had did have the tube feeding come on duty 08/03/2020. o reveal the resident's feeding should have been the resident was out of the my tube replacement;	F 684			

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	-	D HUMAN SERVICES //EDICAID SERVICES				FORM	: 09/24/2020 APPROVED . 0938-0391
STATEMENT OF D AND PLAN OF CC	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY
		185281	B. WING		_	08/ [,]	11/2020
NAME OF PROV	IDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
FRIENDSHIP	HEALTH AND REHAB	, LLC		7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 44	0056		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684 C	ontinued From page	11	F 684				
08 by fe m ex ar 2. 11 di C di C D ar E R da sth in R refo m ex in TI al m paco of ha	3/11/2020 at 9:17 AN / the facility that Res edings, and had mis edications. The Mer (pectations was resident and medications was resident and medications exaccon The facility readmit 1/12/2019 from an action agnoses included Ar erebrovascular Accident sease. Other diagnon- hronic Lung Disease ementia with Behavin and Gastro-Esophage sophagitis (GERD). eview of the Signification atted 05/15/2020 reverses and 05/15/2020 reverses and 100/15/2020 reverses atted 05/15/2020 reverses atted 05/15/2020 reverses atted 05/15/2020 reverses atterviewable. eview of Resident #* evealed the focus that r complications related edication and a history (tremity Deep Vein T terventions included he focus that Resident teration related to G acular degeneration articipate in vision tere ognition. The focus of shortness of breath ad allergies, and the	dical Provider revealed his dents received treatments tly as ordered. ted Resident #1 on cute care hospital. Current hemia, Arthritis, dent (CVA), and Alzheimer's oses included Depression, e, Adult Failure to Thrive, ors, Venous Insufficiency, al Reflux Disease without ant Change in Status MDS, ealed Resident #1 had both erm memory problems, and the resident was not I's plan of care, undated, it Resident #1 was at risk ed to use of anticoagulant ory of bilateral lower 'hrombosis (DVT). The medications as ordered. nt #1 was a risk for/actual laucoma, impaired vision,					

Facility ID: 100355

If continuation sheet Page 12 of 15

						D. 0938-039	
· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		185281	B. WING		08	/11/2020	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE			
				7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 684			F 684	ı			

Facility ID: 100355

If continuation sheet Page 13 of 15

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/24/2020 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185281	B. WING			08/11/2020	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRIENDS	HIP HEALTH AND REHA	3, LLC			7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	IP HEALTH AND REHAB, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 a day for supplement; Calcium Tablet, five-hundred (500) MG one (1) tablet by mouth one (1) time a day related to Hypocalcemia. Other medications included Cranberry five-hundred (500) MG one (1) tablet by mouth once (1) time a day related to Depressive Episodes; and Fluticasone Propionate fifty (50) Micrograms (MCG) one (1) spray in both nostrils one (1) time a day related to Depressive Episodes; and Fluticasone Propionate fifty (50) Micrograms (MCG) one (1) spray in both nostrils one (1) time a day related to Allergic Rhinitis. Further medications included Eliquis U-D five (5) MG tablet one (1) tablet by mouth two (2) times a day related to Embolism and Thrombosis of arteries of the Lower Extremities (missed morning dose); Ketorolac Tromethamine zero point five percent (0.5%) drops one (1) drop in both eyes two (2) times a day related to Glaucoma (missed morning dose); Memantine HCL F/C ten (10) MG tablet one (1) tablet by mouth two (2) times a day related to Dementia (missed morning dose); and OloPatadine HCL zero point one percent (0.1%) one (1) drop in both eyes two (2) times a day (missed morning dose). Telephonic interview with the Director of Nursing, on 08/10/2020 at 1:20 PM, revealed she assisted Resident #1 with his/her morning meal, and idi recall the ADON administered Resident #1's morning medications, however, the nurse must have failed to sign the medications as given. She revealed the facility normally checked all the MARS/TARS monthly for any errors, however, with the advent of COVID19, the facility has not had time to check the MARs/TARS monthly for errors since around June 2020. She stated medications not signed and initialed by staff were assumed as not given to a resident.		F	684			

Facility ID: 100355

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/24/2020 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
185281		B. WING			08/11/2020		
NAME OF PROVIDER OR SUPPLIER			•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
FRIENDSI	HIP HEALTH AND REHAE	B, LLC			7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	08/11/2020 at 12:54 F	with the Administrator, on PM, revealed the Quality nce Improvement (QAPI) ist quarterly, and had on of medication and	F	684			

Facility ID: 100355

If continuation sheet Page 15 of 15

		AND HUMAN SERVICES				FORM	08/25/2020 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY
		185281	B. WING			1	C
NAME OF F	PROVIDER OR SUPPLIER		·	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 08/	11/2020
FRIENDSHIP HEALTH AND REHAB, LLC					400 FRIENDSHIP DRIVE		
				P	EWEE VALLEY, KY 40056		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
	was initiated on 08/ 08/11/2020. The fa compliance with 42 regulations and has Medicare & Medical Centers for Disease	ed Infection Control Survey 05/2020 and concluded on cility was found to be in CFR 483.80 infection control implemented the Centers for id Services (CMS) and control and Prevention ed practices to prepare for nsus 117.					
				- 1			
i							
		8					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE

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.

PRINTED: 09/24/2020 FORM APPROVED

Office of Inspector General STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100355			(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		B. WING		08/11/2020					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7400 FRIENDSHIP DRIVE									
RIENDSI	HIP HEALTH AND REHA	AB. LLC	VALLEY, KY 40056						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
N 000	Initial Comments		N 000						
	concluded on 08/11/ KY32145, and KY32 Focused Infection C 08/05/2020 and conc Complaint KY32199	y initiated on 08/05/2020 and 2020 investigating KY32199, 143. In addition a COVID-19 ontrol Survey was initiated on cluded on 08/11/2020. was partially substanciated ad, and KY32145, and bstantiated with no							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE