		ND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		
	ROVIDER OR SUPPLIER	105250			09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	N POST-ACUTE AND R	EHABILITATION CENTER			
	1		P	IKEVILLE, KY 41501	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	(X5) COMPLETION
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	
				DEFICIENCY)	
F 000	INITIAL COMMENTS	3	F 000		
1 000		-	1 000		
	A Otomological Description				
		cation Survey was conducted			
	investigating Compla	n Abbreviated Survey			
	0 0 1	034030, KY00034031, and			
		ing on 06/15/2021 and			
	concluded on 06/19/	0			
		33745, KY00034030,			
		Y00034032 were determined			
		vith deficient practice			
		practice was identified with			
		nd Severity identified at an			
	"F" level. Census: 1	-			
	After supervisory rev	iew, the Standard			
		y and Abbreviated Surveys			
	investigating KY0003				
		34031, and KY00034032			
	were reopened on 0	7/27/2021, in conjunction with			
	complaints KY00034	173, KY00034237,			
	KY00034238, KY000)34299, KY00034400, and			
	KY00034404. KY00	034299 and KY00034404			
	were unsubstantiate	d. KY00033911,			
)34030, KY00034031,			
)34173, KY00034237,			
		034400 were substantiated			
		ardy was identified, on			
	08/11/2021, and was				
		R 483.10 Resident Rights			
		12 Freedom from Abuse			
	(F600), 42 CFR 483.	•			
		re Plans (F655), 42 CFR			
		re (F684), and 42 CFR trol (F880). The facility was			
	notified of the Immed				
		nediate Jeopardy on nediate Jeopardy is ongoing.			
		iculate deoparty is ongoing.			
	The facility failed to r	protect Resident #64,			
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	 [TITLE	(X6) DATE

Electronically Signed

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: 12/08/2021

CENTER		HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING	09/10/202 <u>1</u>		
		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		200 NURSING HOME LANE			
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER	F	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETIO
F 000	Continued From	page 1	F 000		
		Resident #322 from abuse of			
		esident #82 displayed behaviors			
		elf/herself numerous times to			
		vandered in/out of other			
		and was verbally/physically			
		residents. The facility failed to			
		ve interventions to prevent			
	· ·	n abusing other residents.			
		ehaviors resulted in the following			
		ent abuse: On 05/18/2021,			
		bbed Resident #322 causing a			
	, ,	04/2021, Resident #82 grabbed			
		rist and would not let go; On			
		dent #317 held Resident #82's			
		sident #82 wandered into			
		would not leave; On			
		dent #82 hit Resident #86 with a			
		arge bruise to the resident's			
		On 07/31/2021, Resident #82 hit			
	Resident #64 on	the left wrist. Interviews with			
	residents and sta	ff revealed Residents #64, #86			
	and #322 were af	fraid of Resident #82. Interview			
	with Resident #86	6 on 07/27/2021 revealed the			
	resident was afra	id to sleep because Resident			
	#82 still came in I	his/her room and the facility had			
	taken no action to	o protect the resident.			
	· ·	to develop a baseline care plan			
		1 and Resident #323 and failed			
		idents received treatment and			
		ce with professional standards of			
		morning of 07/18/2021, at			
		30 AM, staff obtained Resident			
		cose level, which was sixty-seven			
		rams per deciliter) (normal range			
		mg/dL). Although the nurse held			
		ulin injection, she administered			
		ral hypoglycemic medication.			
	I he nurse stated	after breakfast she re-checked			

Facility ID: 100599

If continuation sheet Page 2 of 401

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES			FORM APPROVI 2013 OMB NO. 0938-03
TATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		09/10/2021	
		STE	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		. 200	NURSING HOME LANE		
			(EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 000	Continued From	page 2	F 000		
		od glucose level, which was then	1 000		
		y-nine (139) mg/dL. However,			
		dence the staff continued to			
		ent or re-check the resident's			
		/el, until sometime later that			
	,	etime after 3:00 PM, staff found			
		sponsive with a blood glucose			
		mg/dL. Interviews with staff			
		ministered Resident #321 both,			
	· ·	al glucose, and the resident			
	regained conscio	usness. However, there was no			
	documented evid	lence staff continued to monitor			
	the resident's blo	od glucose level, until			
	approximately 12	2:30 AM on 07/19/2021, when			
		as found unresponsive and			
	-	ws and record review revealed			
		od glucose was thirty-two (32)			
		in administered the resident			
		on and oral glucose. Resident			
		nresponsive and developed			
	-	g. The facility transferred			
		the hospital, where he/she was			
		cute metabolic encephalopathy			
		ondary to prolonged Resident #321 was admitted to			
	the Intensive Car				
	In addition the fa	acility admitted Resident #323, on			
		being on a ventilator at the			
		oximately 7:30 AM on			
		rse aide entered the resident's			
		ered the resident was sweaty,			
		ing difficulty breathing. Although			
		nurse revealed she administered			
		(2) breathing treatments, there			
		staff re-assessed the resident			
	until the resident'	s family came to visit and			
		ty transfer the resident to the			
		Resident #323's arrival to the			

Facility ID: 100599

If continuation sheet Page 3 of 401

		ND HUMAN SERVICES			FORM APPROVED
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	7()(185256	B. WING		09/10/202 <u>1</u>
NAME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				IKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 000	hospital, the residen and was diagnosed insufficiency, and lef versus atelectasis (In Further, the facility fa maintain an infectior program to properly spread of COVID-19 #311, Resident #327 #325, Resident #328 On 07/24/2021, two for COVID-19 at an of Although, the facility positive, there was n determine which res infected staff in an e prevent further spreat the facility failed to in COVID-19 per the fac were not tested until after the staff memb 07/28/2021 resident Resident #311 tester However, the facility residents to prevent others until 08/05/20 residents tested pos barrier was placed of Further, the facility of routinely tested for Of However, SRNA #13 prior to starting her s from 6:00 PM throug During her shift, at a 07/31/2021, she staff	t required high flow oxygen, with acute hypoxic respiratory t lower lobe pneumonia	F 000		

Facility ID: 100599

If continuation sheet Page 4 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	positive. Again, then evidence the facility a which residents SRN shift. From 07/28/2021 the additional three (3) re COVID-19, Resident Resident # 328. Res #329 were also hosp Prior to the barrier be Resident #325, who COVID-19 positive re walking in the hallwa hallway adjacent to C Resident #325 was r 08/08/2021, Residen COVID-19. On 08/09 developed respirator transferred to the em hospitalized. Residen the hospital to the fac 08/19/2021, Residen distress again, and w where he/she expired One (1) additional re tested positive for CC hospitalized on 08/14 08/15/2021 at the ho	ms to the nurse who OVID-19 test, which was e was no documented attempted to determine IA #13 cared for during her ough 08/05/2021, an esidents tested positive for # 329, Resident #82, and sident #82 and Resident italized due to COVID-19. eing placed on 08/05/2021, resided across the hall from esidents, was observed ys and sitting in a chair in the COVID-19 positive rooms. not wearing a mask. On t #325 tested positive for 9/2021, Resident #325 y distress and was nergency room and nt #325 was readmitted from cility on 08/12/2021, and on t #325 developed respiratory /as sent back to the hospital d on 08/26/2021. sident (Resident #327) DVID-19 on 08/07/2021, was 4/2021, and expired on	F 000	DEFICIENCY)	
	The facility was notifi Jeopardy on 08/20/2				

Facility ID: 100599

If continuation sheet Page 5 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	Continued From page	e 5	F 000		
	Resident #330, Resid Resident #81 and Re acceptable parameter body weight and faile were notified of weigh Review of Resident # #327, Resident #82, #39, Resident #332, records revealed eac significant weight loss to have a systemic pur resident weight loss. resident weight loss. resident weight loss. resident weight loss. resident sustained we dietary recommendat weight loss, failed to preferences to preve to ensure residents we portions to prevent we In addition, Immediat 08/27/2021 at 42 CFI Person-Centered Ca 483.25 Quality of Car notified of the Immed 08/27/2021. The facility failed to co care plan to address ulcer risk, failed to er	ent #327, Resident #82, dent #39, Resident #332, esident #40 maintained ers of nutritional status and/or ed to ensure their physicians int loss. 465, Resident #90, Resident Resident #330, Resident and Resident #81's medical th of the residents sustained is due to the facility's failure rocedure in place to monitor The facility failed to obtain ording to policy, failed to Dietitian (RD) when a eight loss, failed to provide tions to prevent further honor resident food int weight loss, and/or failed vere served adequate eight loss. re Jeopardy was identified on rmined to exist on R 483.12 Comprehensive re Plans (F656) and 42 CFR re (F686). The facility was			
		tment was provided to vent infection and/or prevent			

Facility ID: 100599

If continuation sheet Page 6 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	AME OF PROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		2	200 NURSING HOME LANE		
			F	PIKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	Continued From page	je 6	F 000		
	new pressure ulcers	from developing.			
	03/23/2021 without p failed to turn and rep required. On 05/02/ developed a deep tis The facility failed to (measurements, app etc.) as required. Su failed to identify the until 05/28/2021, wh transferred to the Er due to worsening of #65 was admitted to sacral wound and w decubitis [pressure] infection including or abscess". Resident debridement on 05/3 tissue was removed the bone". Resident #65 was re However, the facility reposition Resident weekly skin and/or p Resident #65 develou ulcers, a Stage I (on 06/23/2021, a DTI to 06/26/2021, an unst back of the left, lowe (2) Stage II (2) press 08/26/2021, Eurthen assessed Resident a on 08/26/2021, at 9: wound had worsene	ssue injury to the coccyx. assess the pressure ulcer bearance, drainage, odor, ubsequently, the facility also pressure ulcer had worsened en the resident was mergency Department (ED) the pressure ulcer. Resident the hospital for worsening as, "clinically septic with large ulcer with associated ellulitis and possible #65 underwent surgical 30/2021, when all necrotic and "excision was down to eadmitted to the facility. continued to fail to turn and #65 and failed to conduct pressure ulcer assessments. oped five (5) more pressure e) to the left heel on ageable pressure ulcer to the er leg on 08/12/2021, and two sure ulcers to the left hip on r, a wound care specialist #65's sacral pressure ulcer, 00 AM, and documented the			

Facility ID: 100599

If continuation sheet Page 7 of 401

ENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	1		PRINTED: 12/08/2 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
IAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
		REHABILITATION CENTER	2	00 NURSING HOME LANE	
	A FOST-ACOTE AND I		F	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETI
F 000	Continued From no	ao 7	Г 000		
F 000	Continued From pa	-	F 000		
		2021 and the facility alleged			
		ediate Jeopardy effective			
		ial extended survey was 021 and completed on			
		termined that the Immediate			
		emoved prior to exit on			
		diate Jeopardy was also			
		2021 at 483.35 Nursing			
		CFR 483.70 Administration			
		nd 42 CFR 483.75 Quality			
		formance Improvement			
	(F867). The Immed	liate Jeopardy is ongoing.			
	Based on the findin	gs of the partial extended			
		on 09/10/2021, it was			
	-	lity failed to utilize their			
		vely manage the facility in			
		e highest practicable physical,			
		social well-being of each			
		dministration and the			
	Governing Body fai	led to ensure Quality			
		ance Improvement activity			
		nd failed to provide oversight			
		were in place to ensure the			
	-	f residents in the facility. The			
		the facility would complete			
		ts" on 08/26/2021 and weekly			
		s would be audited daily to en completed. Review of			
	-	Resident #45's medical record			
		ented evidence the facility			
		sure ulcers on 08/26/2021, as			
		C. Further, there was no			
		ice the facility was conducting			
		sure ulcer assessments for			
		sure ulcers as stated in the			
		y, there were no wound			

If continuation sheet Page 8 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO. (APPROVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		185256	B. WING		09/10)/202 <u>1</u>
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000 F 557 SS=F	residents would be w as of 09/10/2021, ter weighed since 08/03, residents who had no 08/06/2021. Additional deficient p F585, F609, F623, Fr at "D" level; F584, F8 level; F557, F802, F8 level; and F657 and D After supervisory rev Immediate Jeopardy 09/22/2021, and dete 03/26/2021 at 42 CF (F755). The facility v Jeopardy on 09/22/20 The facility failed to p services to meet the Resident #326, Resident #32 Resident #321. The fa administer prescribed needs of Resident #32 In addition, the facilitit 07/16/2021 with the o Invasive Bladder Car to receive an antibiot The pharmacy requir over-ride" the medica dispensed. However the cost over-ride an receive the physician	facility's AOC revealed reighed monthly. However, a (10) residents had not been /2021, and seven (7) of been weighed since ractice was identified at 641, F689, F695, and F842 804, F809 and F925 at an "E" 803, F806, and F812 at "F" F697 at "G" level. iew, on 09/22/2021, was identified, on ermined to exist on R 483.75 Pharmacy Services vas notified of the Immediate 021. provide pharmaceutical needs of Resident #321, dent #351, Resident #9, and facility failed to acquire and d medications to meet the 826, Resident #351, Resident 4. y admitted Resident #321 on diagnoses of Urosepsis and neer with Physician's Orders ic to treat the Urosepsis. ed the facility to "cost ation before it could be r, the facility failed to address d Resident #321 did not	F 000			

Facility ID: 100599

If continuation sheet Page 9 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 557	Continued From pag CFR(s): 483.10(e)(2 §483.10(e) Respect The resident has a ri and dignity, including) and Dignity. ght to be treated with respect	F 557		
	§483.10(e)(2) The rig possessions, includir as space permits, ur	g. ght to retain and use personal ng furnishings, and clothing, iless to do so would infringe alth and safety of other			
	by: Based on observation policy review, it was to protect residents' (108) out of one hun the facility. Observat 06/15/2021, revealed observed to have plac cups, and styrofoam observation of the br revealed residents w styrofoam bowls and meal trays.	eakfast trays on 06/16/2021, ere being served food in styrofoam cups on their			
	Rights", dated June would be treated with full recognition of the care for their needs. resident had a right the Observation of the lu	's policy titled," Resident 2020, revealed each resident n consideration, respect, and ir dignity and individuality in The policy also stated the o a dignified existence.			

Facility ID: 100599

If continuation sheet Page 10 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVED OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 557	at 8:30 AM, revealed styrofoam cups and s Group interview cond (Residents #3, #16, s 06/16/2021 at 10:13 supper trays had pla hard to cut anything, residents also stated styrofoam cups and Continued interview the plastic silverware for a few weeks. Interview with Dietar at 2:00 PM, revealed silverware, styrofoan for a few weeks. The out of bowls, cups, a styrofoam bowls and Interview with DA #2 revealed they had be styrofoam cups, and had worked there, tw stated they had beer silverware. Interview with the Die 06/16/2021 at 1:30 F 06/15/2021. The DM silverware, cups, and was aware this was a disposable dishes an	ith plastic silverware,	F 557		

Facility ID: 100599

If continuation sheet Page 11 of 401

		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			MB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING		X3) DATE SURVEY COMPLETED	
185256		B. WING		09/10/2021	
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
		200 1	URSING HOME LANE		
PARAVIEN	V POST-ACUTE AN	D REHABILITATION CENTER	PIKE	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE
F 557	Continued From	page 11	F 557		
		lies from the supply company but oplies. The DM stated it was a			
	(RD) on 06/18/20 was aware the fa silverware, styrof interview with the was enough silve using it. Per inte they must use readignity issue. The	ted with the Registered Dietician 121 at 4:18 PM, revealed she cility was using plastic foam cups and bowls. Continued a RD revealed she was told there erware that they were just not rview, she had informed the DM gular silverware as it was a a RD stated the DM had told her uld not provide the cups and needed.			
	1:30 PM, reveale facility for two (2) talked with the D told her about us and plastic silven there was no pro cups and bowls.	e Administrator on 06/19/2021 at d she had only been at the weeks. She stated she had M and the RD and they had not ing styrofoam cups and bowls ware. The Administrator stated blem with ordering replacement s (Injury/Decline/Room, etc.) g)(14)(i)-(iv)(15)	F 580		
	 (i) A facility must consult with the r consistent with hi representative(s) (A) An accident in results in injury a physician interve (B) A significant of mental, or psychol 	nvolving the resident which nd has the potential for requiring			

Facility ID: 100599

If continuation sheet Page 12 of 401

	LTH AND HUMAN SERVICES ARE & MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
DM	185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPI	JER		TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE	AND REHABILITATION CENTER		00 NURSING HOME LANE	
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
clinical compli (C) A need to a need to disc treatment due commence a r (D) A decision resident from t §483.15(c)(1)((ii) When mak (14)(i) of this s all pertinent in is available an physician. (iii) The facility resident and th when there is- (A) A change i as specified in (B) A change i State law or re (e)(10) of this (iv) The facility update the ad phone number representative §483.10(g)(15 Admission to a that is a comp §483.5) must its physical co locations that part, and must	r life-threatening conditions or cations); alter treatment significantly (that is, ontinue an existing form of to adverse consequences, or to new form of treatment); or to transfer or discharge the the facility as specified in ii). ing notification under paragraph (g) section, the facility must ensure that formation specified in §483.15(c)(2) d provided upon request to the must also promptly notify the ne resident representative, if any, n room or roommate assignment §483.10(e)(6); or n resident rights under Federal or egulations as specified in paragraph section. must record and periodically dress (mailing and email) and r of the resident (s).) a composite distinct part. A facility osite distinct part (as defined in disclose in its admission agreement nfiguration, including the various comprise the composite distinct a specify the policies that apply to between its different locations	F 580		

Facility ID: 100599

If continuation sheet Page 13 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED
	$2 \cap ($	185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		KEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 580	Continued From pag	e 13	F 580		
	by: Based on interview, facility policy, it was to notify the physicia (57) sampled resider experienced a signifineed to alter treatme #323, Resident #90, #82, Resident #330, #332, and Resident # On the morning of 0 staff obtained Reside level, which was 67 deciliter) (normal ran However, there was the resident's physic glucose levels. Later after 3:00 PM, staff f unresponsive with a mg/dL. Interviews with administered Reside oral glucose, and the consciousness. How documentation made record regarding the hypoglycemia, or that	7/18/2021, before breakfast, ent #321's blood glucose mg/dL (milligrams per ige 70 mg/dL to 110 mg/dL). no evidence the staff notified ian of the resident's low that afternoon, sometime ound Resident #1 blood glucose level of 40 th staff revealed they int #321 both injectable and e resident regained			

Facility ID: 100599

If continuation sheet Page 14 of 401

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES				FOR	D: 12/08/20 M APPROV D. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		DNSTRUCTION	1 · /	E SURVEY PLETED
185256 NAME OF PROVIDER OR SUPPLIER		B. WING		ETN/	09	/10/202 <u>1</u>	
			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
			200 NURSING HOME LANE		NURSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			PIKE	EVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 580	Continued From p	page 14	F 58	30			
	AM staff found Re	esident #321 unresponsive and					
		vs and record review revealed					
	•	od glucose was 32 mg/dL. Staff					
		ed the resident injectable					
	glucagon and ora	l glucose. The facility					
	transferred Resid	ent #321 to the hospital, where					
	the resident was	diagnosed with acute metabolic					
	encephalopathy a	and hypoxia secondary to					
	prolonged hypogl	ycemia. The hospital admitted					
	Resident #321 to	the Intensive Care Unit (ICU).					
	Further, the facilit	ty admitted Resident #323 on					
	07/06/2021 after	being on a ventilator at the					
	hospital. At appro	oximately 7:30 AM on 7/20/2021,					
	a nurse aide ente	red the resident's room and					
		sident was sweaty, clammy, and					
		reathing. However, there was					
		staff notified the resident's					
		esident's status, until the					
		came to visit and insisted the					
	•	e resident to the hospital.					
		as admitted to the hospital and					
		cute hypoxic respiratory					
	•	left lower lobe pneumonia					
	versus Atelectasis	s (lung collapse).					
	In addition, the fa	cility failed to ensure Resident					
		27, Resident #82, Resident					
		39, Resident #332, and					
		nysicians were notified when the					
	residents sustaine	ed significant weight loss.					
	The facility's failu	re to ensure residents received					
		re in accordance with					
		dards of practice, has caused or					
		serious injury, harm, impairment					
		dent. Immediate Jeopardy was					
		11/2021, and was determined to					
	exist on 03/06/20	21, at 42 CFR 483.10 Resident					

Facility ID: 100599

If continuation sheet Page 15 of 401

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/202 <u>1</u>	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	-
PARKVIEV	V POST-ACUTE AND	REHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLÉTIC
F 580	Rights (F580), 42 Abuse (F600), 42 Person-Centered CFR 483.25 Qual	CFR 483.12 Freedom from CFR 483.12 Comprehensive Care Plans (F655), (F656), 42 lity of Care (F684) (F686),	F 58	ס	
	(F755) and 42 CF (F880). The facilit Jeopardy on 08/1				
	was received on (removal of the Im 09/02/2021. How verified based on and review of fact	egation of Compliance (AOC) 09/03/2021, which alleged mediate Jeopardy on vever, the AOC could not be observations, staff interviews, ility documentation. Additional			
	483.35 Nursing S Administration (Fa Quality Assurance Improvement (F8	rdy was identified at 42 CFR ervices (F725), 42 CFR 483.70 835) (F837), 42 CFR 483.75 e and Performance 67). The facility was notified of opardy on 09/10/2021. The rdy is ongoing.			
	The findings inclu	de:			
	Condition Change March 2018, reve physician about a nursing staff would	ility's policy titled, "Acute es-Clinical Protocol", dated ealed prior to contacting the in acute change in condition, the d collect pertinent details to			
	present illness an results for compa the nurse would a baseline informat	ician, such as the history of d previous and recent test rison. Further review, revealed assess, document, and report ion including; vital signs, us, current pain level, level of			
	consciousness, conset, duration ar	ognitive and emotional status, nd severity of illness, recent sychiatric disturbances, mental			

Facility ID: 100599

If continuation sheet Page 16 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE IKEVILLE, KY 41501	
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 580	Continued From pag	je 16	F 580		
	· ·	n, all active diagnoses, and all The nurse would then			
	situation, and for em	n based on urgency of the aergencies, they would call or and request a prompt			
	of Hypoglycemia", d revealed staff may n notification to the ph had not eaten well o for two (2) or more o Hypotension, letharg who was lethargic, b might include oral gl buccal mucosa, intra	ysician if a diabetic resident r consumed sufficient fluids lays and had a fever, gy or confusion. For a resident out not comatose, treatment ucose paste rubbed into amuscular glucagon, or the ravenous dextrose and			
	revealed the facility 07/16/2021 with diag	nt #321's medical record admitted the resident on gnoses that included Mellitus, and Invasive			
	(MDS) assessment the facility assessed Interview for Mental	#321's Minimum Data Set dated 07/19/2021 revealed the resident to have a Brief Status (BIMS) score of acility assessed the resident act.			
	dated 07/16/2021, re	#321's Baseline Care Plan evealed the care plan did not s diagnosis of Diabetes			
	Review of Resident	#321's Physician Orders			

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE	
			P	VIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 580	Continued From pag	e 17	F 580		
		vealed Physician's Orders hich stated staff were to			
	monitor for signs/syn hypoglycemia/hyperg sugar) every shift, ob needed and to notify				
	revealed the MAR ha monitoring every shif hypoglycemia/hyperg finger sticks as need	d (MAR) for June 2021, ad an entry stating diabetic t for glycemia, may complete			
	3:20 PM, revealed at 07/18/2021, Licensed obtained a blood glud #321, which was 67 after breakfast, LPN blood glucose level, 139 mg/dL. Howeve documentation that L physician when the r dropped below 70 m no evidence the LPN resident for signs/syr hypoglycemia/hyperg resident's blood gluc	lycemia or re-checked the			
	08/02/2021 at 5:30 F resident on 07/18/20 at 10:45 AM for a sch	M, revealed she visited the 21 and arrived to the facility neduled visit. She stated er his/her blood sugar had			

Facility ID: 100599

If continuation sheet Page 18 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2 FORM APPRO OMB NO. 0938-0	VED
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ION
F 580	Continued From pag dropped to 67 mg/dL daughter stated no s blood glucose level of signs/symptoms of h while she was at the approximately 3:00 F Interview with Reside 07/28/2021 at 2:19 F with Resident #321 of on 07/18/2021, and t like his/her blood glu resident told the spo not re-checked his/h that morning when h Interview with LPN # revealed on the morn obtained a blood glu Resident #321. She resident's glucose af was back up to 139 f could not recall if she the resident's blood gluc she probably though and she did not need the resident's blood gluc she probably though and she did not need the resident's blood gluc she probably though	e 18 that morning. However, the taff re-checked the resident's or assessed the resident for ypoglycemia/hyperglycemia facility from 10:45 AM until PM. ent #321's Spouse on PM, revealed he/she talked on the phone numerous times the resident reported feeling cose was low. However, the use at 4:00 PM, that staff had er blood sugar since early is/her blood glucose was low. 6 on 07/27/2021 at 4:10 PM, hing of 07/18/2021, she cose of 67 mg/dL for stated she re-checked the ter the breakfast meal and it mg/dL. LPN #6 stated she e notified the physician that glucose had dropped below the LPN stated that since the ose came up to 139 mg/dL, t the resident was doing well, d to notify the physician that glucose had dropped below	F 580			
	PM, revealed she wa during day shift from stated she did recall blood sugar of 67 mg interview with SRNA PM, revealed later th	#1 on 07/27/2021 at 4:40 as working on 07/18/2021 6:00 AM to 6:00 PM. She Resident #321 having a g/dL that morning. Additional #1 on 08/03/2021 at 3:19 nat same day, she entered m late in the afternoon, exact				

Facility ID: 100599

If continuation sheet Page 19 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	N POST-ACUTE AND R	EHABILITATION CENTER			
	CLIMMA DV C			KEVILLE, KY 41501	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 580	Continued From pag	e 19	F 580		
	time unknown, and for non-responsive and She stated LPN #6 g	ound the resident immediately alerted LPN #6. got RN #1 from the other end r, and both nurses were			
	revealed that Reside episode during the la but could not recall the stated it was after lur entered the room the and she obtained a b mg/dL. She stated she end of the unit to asse injection of Glucagor oral glucose and the LPN #6 stated follow the resident's blood g "around 139 mg/dL", stated she notified the hypoglycemic event. #321's medical record documentation of the of the resident's blood documentation that L of the event.	e incident, no documentation od glucose levels, and no _PN #6 notified the physician			
	07/30/2021 at 10:54 working on 07/18/202 to 7:00 PM, and reca LPN #6 came to her Resident #321, who 40 mg/dL. RN #1 sta room the resident was stated they administed injection, and the resident	tered Nurse (RN) #1 on AM revealed she was 21 on day shift from 7:00 AM alled late in the afternoon requesting assistance with had a blood glucose level of ated when she arrived to the as non-responsive. RN #1 ered the resident a Glucagon sident began to regain rever, according to RN #1,			

Facility ID: 100599

If continuation sheet Page 20 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		00 NURSING HOME LANE	
		-	F	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 580	Continued From pag	e 20	F 580		
		sugar remained low, and LPN resident oral glucose. RN #1			
		ering the oral glucose, od glucose came up to 111			
	0	she then returned to her end			
		ot know if LPN #6 contacted ing the hypoglycemic event			
		w blood glucose level.			
		#321's Nursing Notes			
		ted 07/19/2021 at 12:23 AM,			
	-	nd the resident unresponsive of 32 mg/dL. The note			
	stated staff administe				
		and oral glucose. However,			
		ined un-responsive and breathing. Staff notified the			
		and received orders to send			
		ospital. Continued review of			
	-	/ealed Emergency Medical			
		ne facility at 1:00 AM and			
	transferred the reside Emergency Departm	•			
		ecords for Resident #321			
		d interview with the ED			
		2021 at 8:22 PM, revealed arrived to the ED on			
		dent was unresponsive and			
		Continued review of the			
	-	with the physician revealed			
		n acute respiratory failure			
	and was hypoxic due	e to prolonged hypoglycemia.			
	Interview with Physic	cian #1, Resident #321's			
		2021 at 1:05 PM revealed he			
		tifying him of Resident			
		t on 07/18/2021 before oxic event that afternoon,			
	Dieakiasi ol ille liypo				

Facility ID: 100599

If continuation sheet Page 21 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 1 FORM AI OMB NO. 0	PPROVED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SUF COMPLET	
		185256	B. WING		09/10/	2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE		
			P	PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) OMPLETION DATE
F 580	Physician #1 stated morning of 07/18/202 a blood glucose of 67 the resident to the ho Physician #1 also sta remembered staff no #321 was during the 07/19/2021, when st nonresponsive. Interview with the Din 08/11/2021 at 12:05 expected nursing sta resident had a chang a nursing assessment stated she was not at two hypoglycemic ep notification occurring the hospital on 07/19 with the DON reveals routine monitoring of	resident unresponsive. if staff had notified him on the 21, when Resident #321 had 7 mg/dL, he would have sent ospital for evaluation.	F 580			
	1:50 PM, revealed sl conduct a nursing as had a change in com and the family. The A unaware Resident #3 episodes of hypoglyo staff should have cal 2). Review of Reside revealed the facility a 07/06/2021, with diag Metabolic Encephalo Failure, Autistic Diso	ministrator on 08/10/2021 at the expected nursing staff to esessment anytime a resident dition and notify the physician Administrator stated she was 321 had two previous cemia However, she stated led the physician. ent #323's medical record admitted the resident on gnoses that included opathy, Acute Respiratory rder, Sepsis, Diabetes Pneumonia and Aphasia.				

Facility ID: 100599

If continuation sheet Page 22 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AND RE	EHABILITATION CENTER		NURSING HOME LANE EVILLE, KY 41501	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION
F 580	Continued From pag	e 22	F 580		
	(MDS) Admission as revealed the facility a severely impaired co Interviews on 07/28/2 Registered Nurse Aid PM with SRNA #15, 1 07/20/2021 at approx observed Resident # red faced, and having they stated was not r SRNA #14 stated sho resident's change in administered the resi but the resident contri breathing. SRNA #14 "breathing pretty hard administered the resi treatment "a couple f SRNAs stated Resid difficulty breathing. C the resident's family a approximately 11:15 send the resident to f	2021, at 11:43 AM, with State de (SRNA) #14, and at 2:35 revealed on the morning of kimately 7:15 AM, they 323 to be sweaty, clammy, g difficulty breathing, which normal for the resident. e notified RN #6 of the condition, and the nurse ident a breathing treatment, inued to have difficulty 4 stated the resident was d". SRNA #15 stated RN #6 ident another breathing nours later". However, the ent #323 continued to have Continued interview revealed arrived at the facility at AM and insisted the facility the ED.			
	revealed on 07/20/20 AM, staff notified her "congested". She sta assigned nurse to Re went to the room to co stated when she enter resident had audible accessory muscles to stated she had last s approximately 6:15 A	on 07/28/2021 at 3:45 PM, 021 at approximately 7:15 that Resident #323 was ted she was not the esident #323. However, she check on the resident. She ered the resident's room, the wheezing and was using to aide in breathing. RN #6 een Resident #323 at M, and the resident was not thing at that time, and the			

Facility ID: 100599

If continuation sheet Page 23 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	N POST-ACUTE AND RE	EHABILITATION CENTER	2	00 NURSING HOME LANE	
			P	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 580	Continued From pag		F 580		
		vas new for the resident.			
		ed that she did not notify the to report the resident's			
		because LPN #3 was the			
		nurse. RN #6 stated it was			
	LPN#3's responsibili	ty to call the physician.			
	Continued interviews	with RN #6 on 07/28/2021 at			
		of Resident #6's Treatment			
		d (TAR) revealed she			
		hing treatment to Resident			
		ich provided the resident with			
		n breathing. However,			
	-	the improvement did not last t's status declined. RN #6			
	-	red the resident another			
		at 11:34 AM, and assumed			
	-	otify the physician of the			
	resident's condition.				
	Intonyiow with I DN #	3 revealed she was the			
		esident #323 on 07/20/2021.			
		proximately 6:30 AM on			
	07/20/2021, Residen				
	However, at approxir	mately 7:30 AM she realized			
		g on" with the resident. She			
		the resident to be breathing			
		sory muscles to aide in ated she notified Physician			
	•	and received a new order for			
	a chest x-ray. Howey				
		e in the resident's medical			
		at LPN #3 notified the			
		d that following the breathing			
		ered by RN #6, Resident			
	#323 condition "staye	ed about the same". with LPN #3 revealed that			
	-	came in around 11:00 AM,			
		uested the resident go to the			

Facility ID: 100599

If continuation sheet Page 24 of 401

	-	AND HUMAN SERVICES			PRINTED: 12/08/203 FORM APPROVE 2005 NO. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 185256		(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING	-FTNZ	09/10/202 <u>1</u>		
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND	REHABILITATION CENTER		NURSING HOME LANE EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 580	Continued From p	age 24	F 580			
		d she called Physician #1, and to transfer the resident to the				
	08/02/2021 at 8:50 the facility on 07/2 AM. She revealed he/she could hear hallway. The famil	sident #323 family member on 0 AM revealed she arrived to 20/2021 at approximately 11:00 that upon arriving to the unit, the resident breathing from the y member stated that she dent go to the hospital for				
	07/20/2021, reveat the facility staff no until after the reside the facility. Review change of condition which stated the re air, abnormal lung breathing and cour documentation that #1 at 11:45 AM, and	the medical record for iled no documented evidence tified the resident's physician dent's family member arrived to v of the record revealed a on form completed at 12:12 PM, esident was having shortness of sounds, labor or rapid gh. Continued review revealed at the facility notified Physician nd obtained an order to send the ED for evaluation.				
	PM revealed he di him of a change in Physician #1 state chest x-ray would for a resident exhi sound from breath difficulty breathing have initiated increased and instructed the signs/symptoms of	rsician #1 on 08/04/2021 at 1:00 id not recall the facility notifying a Resident #323 on 07/20/2021. ed if the facility had called him, a not have been standard of care biting stridor (high pitched ning indicating a restriction) and biting stridor (high pitched ning indicating stridor (high pitched ning stridor (

Facility ID: 100599

If continuation sheet Page 25 of 401

	-	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVI OMB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING		09/10/2021	
NAME OF PR	ROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COL	DE
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200 NURSING HOME LANE			
	VPOST-ACOTE AN			PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE
F 580	Continued From	page 25	F 580		
	exhibiting stridor.	Continued interview with			
	0	ealed he expected staff to notify			
	him with changes of condition.				
	Poviow of Posido	ent #323's ED record revealed			
		essed the resident to have			
		icreased respiratory effort, was			
		muscles to breathe and had mild			
		eral lungs. Continued review of			
		hospital record revealed the			
	resident was adm	nitted to the ICU (Intensive Care			
		 The hospital admitted 			
		ith diagnoses of Acute Hypoxic			
		ficiency, Left Lower Lobe			
		us Atelectasis (collapsed lung),			
	flow of oxygen le	Lactate level (results from low vel).			
	Interview with the	Administrator on 08/10/2021 at			
		Interim Director of Nursing on			
		:05 PM, revealed they expected			
		resident's physician immediately			
	•	f condition such as difficulty			
		ed. In addition, the Interim			
		ng and Administrator stated the			
		stem in place to monitor			
		s to ensure staff notified the			
		a resident's condition warranted			
	appropriately.	n was being made timely and			
		ident #90's medical record			
		lity admitted the resident on			
		diagnoses that included			
		ecified Protein-Calorie			
	Malnutrition and I	Dysphagia.			
	Review of Reside	ent #90's Minimum Data Set			
		ent dated 02/19/2021, revealed			
		sed the resident to have a Brief			

Facility ID: 100599

If continuation sheet Page 26 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 580	 (8) which indicated the cognitive impairment resident weighed 97 Review of Resident # plan in place on 02/1 identified the resident concerns and was at dependence on staff Dysphagia and Vitam Review of Resident # on 03/06/2021, the repounds. This weight fifteen days. However, physician was notifier loss. Review of the Regist documentation dated RD noted Resident # weight loss in 30 day Continued review of revealed on 06/08/20 was 84.7 pounds, an resident's weight was RD's documentation RD noted an 11.9 % 12.9 % weight loss in 180 dat Further review of Resident # weight loss in 180 dat Further review of Resident % weight loss in 180 dat 	Status (BIMS) score of eight ne resident had moderate . The assessment stated the pounds. 490's comprehensive care 9/2021, revealed the facility t had a potential for weight risk for malnutrition due to for eating, diagnosis of nin B12 deficiency. 490's weight record revealed esident weighed 86.8 reflected a loss of 10.5% in er, there was no evidence the d of the resident's weight ered Dietitian's (RD) 104/09/2021, revealed the 90 had sustained a 8.8% rs, and 10.5 % in 180 days. Resident #90's weight record 021, the resident's weight d on 06/15/2021, the s 82.5 pounds. Review of the on 06/16/2021, revealed the weight loss in 30 days, a n 90 days, and an 11.5 %	F 580		
	82.3 pounds. Review 07/07/2021, revealed	of RD documentation dated I the RD documented the			

Facility ID: 100599

If continuation sheet Page 27 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 580	Continued From pag	je 27	F 580		
		esident #90's weight record 021, the resident's weight			
		weighing Resident #90 on d the resident weighed 81.1			
	record from 02/19/20 no evidence the faci	Resident #90's medical 021 thru 08/05/2021, revealed lity notified the physician of weight loss in approximately			
		5			
	assessment dated 0 facility assessed the cognitively impaired the resident complai swallowing. The fac	#327's MDS admission 3/22/2021 revealed the resident to be severely . The assessment also stated ned of difficulty or pain with illity assessed the resident to meals requiring set up help 05 pounds.			
		#327's baseline care plan did ion concerning Resident atus.			
	revealed Resident # and the RD docume	luation dated 03/26/2021, 327 weighed 194.2 pounds, nted the resident had ght loss in one week.			
	Review of the RD's	documentation dated			

Facility ID: 100599

If continuation sheet Page 28 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2 FORM APPROV OMB NO. 0938-0	VED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	ION
F 580	 #327 weighed 184.2 loss of 10% in 30 day report revealed the F the resident to the ph review due to the fac resident's intake was experience weight lo evidence the facility of physician. Review of the RD's of 05/07/2021, revealed #327 on 05/07/2021, weighed 182.5 pound documented the resident body weight in the pa body are the resident 06/01/2021, the RD's of 06/01/2021, the RD of because the resident 06/01/2021, a signified 90 days. Continued review of revealed the resident 08/03/2021, which w in 30 days. Observation of staff of 08/05/2021, revealed pounds. However, review of F record from 03/22/20 	d on 04/06/2021, Resident pounds, a significant weight ys. Further review of the RD recommended referring hysician for a medication cility's documentation that the s "fair", but continued to ss. However, there was no contacted the resident's documentation dated d she evaluated Resident because the resident ds on 04/27/2021. The RD dent had lost 6% of his/her ast 30 days and 10.8 % of ast 90 days. documentation revealed on evaluated Resident #327 t weighed 178.5 pounds on cant weight loss of 11.4% in Resident #327's record t weighed 170 pounds on as a 5.5 percent weight loss weighing Resident #327 on d the resident weighed 170.3 Resident #327's medical 021 thru 08/05/2021, revealed ity notified the physician of 6 weight loss in	F 580			

Facility ID: 100599

If continuation sheet Page 29 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 580	Continued From pag	e 29	F 580		
	revealed the facility a 05/12/2021 with diag Disease, Alzheimer's Vitamin D Deficiency Further review of Resident on 05/12/2021. Review of Resident # assessment dated 08 resident was severel was independent with only. The assessmen weight was 148 pour in one week. Review of Resident # on 06/01/2021, the re pounds, a 5.5 % weig Review of the RD assident # weight loss in 30 day days. Continued review of revealed on 06/08/20 143.2 pounds. Further review of Resident the resident weighed 07/20/2021, 137.3 po 132.9 pounds on 08/ loss of 13.4% in the l	sident #82's admission data t's weight was 153.6 pounds (82's MDS admission 5/18/2021, revealed the y cognitively impaired, but n eating, requiring set up nt also stated the resident's ads, a 5.6 pound weight loss (82's weight record revealed esident weighed 145.1 ght loss in less than 30 days. sessment dated 06/05/2021, 32 had sustained a 5.5 % s, and a 13.4 % loss in 90 Resident #82's weight record 021, the resident weighed 139.1 pounds on punds on 07/27/2021 and 03/3021, a significant weight ast 90 days.			
		Resident #82's medical 21 thru 08/05/2021, revealed			

Facility ID: 100599

If continuation sheet Page 30 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
		EHABILITATION CENTER	2	00 NURSING HOME LANE	
FARRAIEV	FOST-ACOTE AND R	ERABILITATION CENTER	F	PIKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 580	Resident #82's 13.4 approximately 85 da 6. Review of Resider revealed the facility 03/11/2020 with diag Infarction, Diabetes Aphasia. Review of Resident 05/12/2021, reveale resident to have a B indicating the reside Further review revea resident to have swa residual food in his/f the assessment reve resident to require th (1) staff member at a stated the resident's Review of Resident 05/12/2021, reveale potential weight con the resident's diagno the facility identified body weight and wa initiated on the care physician of significa Review of Resident revealed on 06/08/2 was 213.6 pounds. I dated 06/28/2021, re the resident had lost in 180 days.	lity notified the physician of % weight loss in ays. nt #330's medical record admitted the resident on gnoses that included Cerebral Mellitus, Hemiplegia and #330's MDS dated d the facility assessed the IMS score of four (4), nt was cognitively impaired. aled the facility assessed the allowing difficulties and held her mouth. Further review of ealed the facility assessed the ne limited assistance of one meals. The assessment weight was 239 pounds. #330's care plan in place on d the resident was at risk for cerns/malnutrition because of osis of Dysphagia. However, the resident was above ideal s obese. Interventions plan included notifying the ant weight loss. #330's weight record 021, the resident's weight Review of a RD assessment evealed the RD documented t 10.6% of his/her body weight	F 580		
		#330's weight on 08/03/2021,			

Facility ID: 100599

If continuation sheet Page 31 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
- E		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 580	Observation of Resider 08/05/2021, revealed pounds. However, review of F record from 05/12/20 no evidence the facil the resident's 12% w 85 days. 7. Review of Resider revealed the facility r 04/03/2018 with diag Mellitus, GERD, and Failure. Review of Resident # dated 03/01/2021 rev the resident to have indicating the resider assessment also rev independent with eat pounds. Review of Resident # the resident weighed and 253.3 pounds or However, review of F record from 03/01/20 no evidence the facil the resident's 14.4% 113 days. 8. Review of Resider	t weighed 210 pounds. dent #330's weight on d the resident weighed 210 Resident #330's medical 021 thru 08/05/2021, revealed lity notified the physician of veight loss in approximately nt #39's medical record re-admitted the resident on gnoses that included Diabetes Chronic Diastolic Heart #39's MDS assessment vealed the facility assessed a BIMS' score of 15, nt was cognitively intact. The realed the resident was ting and weighed 296 #39's weight record revealed d 290 pounds on 04/04/2021 n 06/22/2021. Resident #39's medical 021 thru 06/22/2021, revealed lity notified the physician of weight loss in approximately nt #332's medical record admitted the resident on gnoses that included	F 580		

Facility ID: 100599

If continuation sheet Page 32 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	N POST-ACUTE AND R	EHABILITATION CENTER		IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 580	Continued From pag	ge 32	F 580		
	Gastro-Esophageal Hypertension, Atrial Neck Fracture.	Reflux Disease, Fibrillation, and Femoral			
	Collection assessme at 5:39 PM, revealed 199.9 pounds and th	t #332's Dietary-Nutrition Data ent completed on 03/16/2021 d the resident's weight was ne resident's intake was the resident's needs.			
	dated 03/19/2021, re the resident to have indicating intact cog assessment reveale	#332's MDS assessment evealed the facility assessed a BIMS' score of 14 nition. Further review of the ed the resident was ating, and weighed 200			
	revealed the resider 04/05/2021. Review Note by the RD, date	#332's weight record nt weighed 182.6 pounds on of the Nutrition Progress ed 04/11/2021, revealed sustained a 9% weight loss in			
	revealed the resider 05/04/2021. Review for Resident #332 da	#332's weight record nt weighed 184.9 pounds on of a Nutrition Progress Note ated 05/27/2021, revealed the weight loss in 90 days.			
	revealed the resider	esident #332's weight record nt weighed 183.6 pounds on pounds on 07/05/2021 and 5/03/2021.			
	record from 03/19/20	Resident #39's medical 021 thru 08/05/2021, revealed ility notified the physician of			

Facility ID: 100599

If continuation sheet Page 33 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING	N / /	09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 580	Continued From pag	ge 33	F 580		
		veight loss in approximately			
	revealed the facility	nt #81's medical record re-admitted the resident on mentia, Anemia, Anxiety and isorder.			
		#81's MDS assessment evealed the resident weighed			
	on 06/01/2021, the r pounds. Review of a Resident #81, comp	#81's weight record revealed resident weighed 109.2 a RD assessment for leted on 06/05/2021 revealed ed a 6.5% weight loss in 30 tht loss in 90 days.			
	#81 dated 07/07/202 the resident's weigh	documentation for Resident 21, revealed on 07/06/2021, t was 108.7 pounds, o weight loss in 90 days.			
		#81's weight on 08/03/2021, nt weighed 107.1 pounds.			
	record from 03/19/2 no evidence the faci	Resident #81's medical 021 thru 08/05/2021, revealed lity notified the physician of weight loss in approximately			
	PM and on 08/27/20 could recall being no to residents that had unable to recall spec	cian #1 on 08/04/2021 at 1:00 021 at 1:18 PM revealed he otified by staff at times related d lost weight; however, he was cific dates or residents. He the facility to follow its policy			

If continuation sheet Page 34 of 401

	-	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03
TATEMENT (S FOR MEDICAR OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		09/10/202 <u>1</u>	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		200 N	IURSING HOME LANE		
	VPOST-ACOTE AN	D REHABILITATION CENTER	PIKE	VILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 580	Continued From	page 34	F 580		
	to weigh resident	ts monthly and notify him of			
	•	sician #1 stated he usually			
		n (a medication used as an			
		t) when a resident was not			
		weight. He also stated he follow their policies related to			
	•	ation in the facility.			
	Interview with the	e Assistant Director of			
		Director of Nursing			
	-	n 08/18/2021 at 9:50 PM,			
		been the ADON at the facility			
		one (1) year, and was placed in			
		n a few weeks ago. The			
		ted she had never monitored			
		s, and never monitored to			
	lost weight in the	cian was notified when residents facility.			
		e Administrator, on 08/11/2021 at			
		08/18/2021 at 3:30 PM, revealed e facility's Administrator since			
		Administrator stated the facility			
		in place to monitor residents'			
	-	tritional needs. She stated she			
	-	ng to ensure the residents'			
		otified when residents			
		ght loss. She stated she was not			
		ian had not been notified of			
	been.	loss, but stated he should have			
F 584 SS=E		fortable/Homelike Environment)(1)-(7)	F 584		
	§483.10(i) Safe I	Environment.			
	,	a right to a safe, clean,			
	comfortable and	homelike environment, including			
	but not limited to	receiving treatment and			

Facility ID: 100599

If continuation sheet Page 35 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 584	homelike environme use his or her perso possible. (i) This includes ens receive care and set physical layout of the independence and c (ii) The facility shall the protection of the or theft. §483.10(i)(2) House	ing safely. vide- , clean, comfortable, and nt, allowing the resident to nal belongings to the extent uring that the resident can rvices safely and that the e facility maximizes resident loes not pose a safety risk. exercise reasonable care for resident's property from loss keeping and maintenance to maintain a sanitary, orderly,	F 584			
	in good condition; §483.10(i)(4) Private resident room, as sp §483.10(i)(5) Adequ levels in all areas; §483.10(i)(6) Comfo levels. Facilities initi 1990 must maintain 81°F; and	bed and bath linens that are e closet space in each becified in §483.90 (e)(2)(iv); ate and comfortable lighting rtable and safe temperature ally certified after October 1, a temperature range of 71 to e maintenance of comfortable				

If continuation sheet Page 36 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		HABILITATION CENTER	2	00 NURSING HOME LANE	
			P	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 584	Continued From pag	e 36	F 584		
		Γ is not met as evidenced			
	by:				
		on, interview and review of			
		was determined the facility			
		ean, comfortable, and			
		nt for nine (9) of fifty-seven nts (Resident #3, Resident			
		Resident #96, Resident			
		Resident #39, Resident #92			
		The facility failed to ensure			
	,	Resident #86 had a clean and			
	odor free bathroom;	Resident #39 had clean			
		s #39's and #3's floor was			
	free from soiled linen	l.			
	Additionally, the facil	ity failed to ensure Resident			
		Resident #316 and Resident			
	#15 had properly fun				
		showerhead in the unit			
	shower room was bro	oken and non-functioning for			
	five (5) days before b	peing repaired.			
	The findings include:				
	Review of the facility	's policy titled, "Quality of			
		nment", revised on 05/2017			
	revealed residents w	ere provided with a safe,			
		omelike environment and			
	-	neir personal belongings to			
	-	Further review revealed staff			
	-	all maximize, to the extent			
	•	eristics of the facility that			
	-	zed, homelike setting. These led: a clean, sanitary and			
		comfortable yet adequate			
		s and décor, personalized			
		rrangements, clean bed and			
		in good condition, pleasant			

Facility ID: 100599

If continuation sheet Page 37 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
STATEMENT (S FOR MEDICARE 8 OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF P	ROVIDER OR SUPPLIER	185256	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 584	appropriate, comfort (71- 81 degrees Fat noise levels. Further staff and manageme extent possible, the that reflected a depo- setting. These chara paging, institutional medication carts, ar 1. Observation on 0 revealed trash and s the floor in residents Further observation bedside tables were throughout the room linens were observe #39's room. Odors of in residents' rooms floor in Resident #33 Observations and in on 07/27/2021 at 11 setting on the side of resident's urinal was observation reveale as the resident held urine was noted in the the resident's perso am always spilling p I can't get anyone to to his/her urinal. Fut the floor in the resid substance and the S Surveyor's shoes st observations were of	is and flowers where table and safe temperatures in the it, and comfortable review revealed the facility's ent shall minimize, to the characteristics of the facility ersonalized, institutional acteristics included: overhead odors, institutional signage, d chair and bed. 7/27/2021 at 10:45 AM soiled laundry and linens on crooms #312 and #316. revealed the floors and soiled with sticky substances as on the third floor. Soiled d on the floor of Resident of feces and urine were noted with full urinals sitting on the 32's room. terview with Resident #332 :00 AM revealed he/she was f his/her bed and the s full of urine. Continued d urine spilled onto the floor the urinal. A strong odor of ne resident's room, and on n. Resident #332 stated, "I ee all over the place because of empty this for me." referring rther observations revealed ents room had a sticky State Survey Agency's uck to the floor while onducted. Three (3) pieces linen were also observed on	F 584		

Facility ID: 100599

If continuation sheet Page 38 of 401

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 584 Continued From page 38 F 584 Observation of Resident #17 on 08/05/2021 at 11:02 AM revealed a fitted sheet with a large brown discoloration and two (2) pillows without pillow cases. Interview with Resident #17 revealed that he/she would like to have clean F 584	2/08/2021 PPROVED 938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PARKVIEW POST-ACUTE AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE PARKVIEW POST-ACUTE AND REHABILITATION CENTER District of the state	
200 NURSING HOME LANE PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONSS-REFERENCED TO THE APPROPRIATE CONSS-REFERENCED TO THE APPROPRIATE <th>2021</th>	2021
PARKVIEW POST-ACUTE AND REHABILITATION CENTER PARKVIEW POST-ACUTE AND REHABILITATION CENTER PIKEVILLE, KY 41501 (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM F 584 Continued From page 38 F 584 F 584 Observation of Resident #17 on 08/05/2021 at 11:02 AM revealed a fitted sheet with a large brown discoloration and two (2) pillows without pillow cases. Interview with Resident #17 revealed that he/she would like to have clean F 584	_
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM F 584 Continued From page 38 F 584 F 584 Observation of Resident #17 on 08/05/2021 at 11:02 AM revealed a fitted sheet with a large brown discoloration and two (2) pillows without pillow cases. Interview with Resident #17 revealed that he/she would like to have clean F 584	
Observation of Resident #17 on 08/05/2021 at 11:02 AM revealed a fitted sheet with a large brown discoloration and two (2) pillows without pillow cases. Interview with Resident #17 revealed that he/she would like to have clean	(X5) OMPLETION DATE
11:02 AM revealed a fitted sheet with a large brown discoloration and two (2) pillows without pillow cases. Interview with Resident #17 revealed that he/she would like to have clean	
linens and pillow cases on his/her two (2) pillows on the bed. Review of Resident #17's medical record revealed the facility admitted him/her on 03/15/2021 with Diabetes, Hypertension and Cancer. Review of his/her Quarterly MDS assessment dated 06/16/2021 revealed the resident had intact cognition with a BIMS score of 15. Interview with Resident #39, on 07/27/2021 at 10:50 AM, revealed his/her sheets were not changed unless he/she requested them to be changed unless he/she requested them to be changed unless he/she requested the floor of his/her room and stayed until housekeeping picked them up. Interview with Resident #3 on 07/27/2021 at 11:00 AM revealed the facility piled his/her solied laundry on the floor until housekeeping picked it up. Interview with Family Member #1, on 07/28/2021 at 2:19 PM, revealed Resident #321 had dirly blankets and washcloths. She stated the blankets were stained when provided, and when the blankets were solied with pus and blood they stuck to the resident. Further interview revealed the facility had no clean blankets or washcloths	

Facility ID: 100599

If continuation sheet Page 39 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 584	Interview with State I (SRNA) #4, on 07/28 resident rooms were residents' rooms were stated some of the c feces on them and h the curtains or mopp rooms. She further s rooms for cleanlines: now. SRNA #4 state "nasty", and it had ne Interview with the Ho 07/27/2021 at 4:08 F present on blankets, facility would re-wast stated all clean linen by housekeeping sta remained present aff However, the House linens were not check resident floor. Per th resident rooms were cleanliness. She sta pick up soiled linen, resident rooms timel environment for reside expected to be done 2. Observation on 07 revealed Resident #3 shared a restroom at and urine. Significar both resident rooms. Interview with Reside 11:45 AM, revealed I been full of feces and	Registered Nurse Aide 3/2021 at 7:35 PM, revealed dirty and the floors in the e not cleaned regularly. She urtains in the rooms had ousekeeping never changed ed the floors in the resident tated they used to check the s, but no one seemed to care d the residents' rooms were ever been like that before. Dusekeeping Supervisor, on 'M, revealed if stains were linens, or washcloths, the n those items. She further s were visually checked daily ff and disposed if stains er being laundered. keeping Supervisor stated ked again when sent to the the Housekeeping Supervisor, checked weekly for ted staff was expected to aundry, and trash from y to ensure a clean tents. She stated this was daily. 2/27/2021 at 11:45 AM 816 and Resident #86's hd the toilet was full of feces at odor was noted throughout	F 584	4	

Facility ID: 100599

If continuation sheet Page 40 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-039	ED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED	
- E		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	N
F 584	could not use the rest having to go across of room to use the restr the facility said they of Interview with Reside 11:55 AM, revealed for order and full of fece days. He/she further restroom, "it stinks", yet. Interview with Reside 12:15 PM revealed F #86, were having to because their restrood of feces and urine. R bad Resident #316's was not fixed and it w Interview with the Ma 07/27/2021 at 4:00 F issues were reported in the maintenance b resident floor. He sta two (2) to three (3) the attention was needed repairs immediately. Supervisor stated he that Resident #86 and toilet was clogged ar 3. Observation of 5th 07/27/2021 at 12:20 head had been insta in the tub in the show Interview with Reside	stroom and he/she was the hall to another resident's room. He/she further stated would fix it, but they had not. ent #86, on 07/27/2021 at his/her toilet had been out of s and urine for about two (2) stated it was a shared and no one had come to fix it ent #15, on 07/27/2021 at Resident #316 and Resident use his/her restroom on was out of order and full resident #15 stated it was and Resident #86's toilet was not their fault. aintenance Supervisor, on PM, revealed maintenance d by staff placing repair slips boxes located on each ated the boxes were checked mes daily, and if immediate d, maintenance would make The Maintenance was not aware until "today" and Resident #316's shared and full of feces/urine. a floor shower room on PM revealed a new shower lled with the old showerhead	F 584	4		

Facility ID: 100599

If continuation sheet Page 41 of 401

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 185256 B. WING 09/10/202 STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE 09/10/202		TMENT OF HEALTH AN RS FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT (T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · /		(X3) DATE SURVEY
200 NURSING HOME LANE			185256	B. WING		09/10/202 <u>1</u>
	NAME OF PROVIDER OR SUPPLIER					
PARKVIEW POST-ACUTE AND REHABILITATION CENTER PIKEVILLE, KY 41501	PARKVIEW POST-ACUTE AND REHABILITATION CENTER					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	BE COMPLETION
F 584 Continued From page 41 F 584 Interview with SRNA #7, on 07/27/2021 at 12:15 PM, revealed the shower head on the fifth floor had been broken. She stated staff reported to maintenance when repairs were needed. They could fill out a silp and put in maintenance box or call maintenance. Interview with the Maintenance Supervisor, on 07/27/2021 at 4:00 PM, revealed he was not aware the shower head on the 5th floor was broken until two (2) days ago. He stated he had replaced it just that morning. Per the Maintenance Supervisor, maintenance issues were reported by staff placing repair silps in the maintenance boxes located on each floor. He further stated the boxes were checked two (2) to three (3) times daily, and if immediate attention was needed, maintenance would repair them immediately. Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed she expected to cleat floor. She further stated resident rooms were expected to be mopped and doors minimized. She stated housekeeping was expected to check rooms for cleanliness. The Administrator stated staff was expected to cleanlines, and notify maintenance of any immediate repairs and notify maintenance of any immediate repairs and notify maintenance of any immediate repairs and notify maintenance of any immediate repairs and notinor backets, chronek Kidney	F 584	unit/floor was not wor for about a week. Interview with SRNA PM, revealed the sho had been broken. Sh maintenance when re could fill out a slip an call maintenance. Interview with the Ma 07/27/2021 at 4:00 P aware the shower he broken until two (2) d replaced it just that m Supervisor, maintena staff placing repair sli boxes located on eac boxes were checked daily, and if immediat maintenance would r Interview with Admini 1:50 PM, revealed sh to be clean and free or laundry on the floor rooms were expected minimized. She state expected to check ro Administrator stated and notify maintenan and those repairs we timely. The Administ soiled linens, or non- equipment were not a 4. Review of Resider	<pre>#7, on 07/27/2021 at 12:15 bwer head on the fifth floor le stated staff reported to epairs were needed. They d put in maintenance box or intenance Supervisor, on M, revealed he was not ad on the 5th floor was lays ago. He stated he had horning. Per the Maintenance ance issues were reported by ips in the maintenance ch floor. He further stated the two (2) to three (3) times te attention was needed, epair them immediately. istrator, on 08/10/2021 at ne expected resident rooms of trash and no soiled linen or. She further stated resident d to be mopped and odors ed housekeeping was oms for cleanliness. The staff was expected to call ce of any immediate repairs re expected to be done rator stated unclean rooms, working toilets and shower acceptable. </pre>	F 58	4	

Facility ID: 100599

If continuation sheet Page 42 of 401

	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/08/2021 APPROVED . 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/1	0/2021
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	revealed the residem cognition with a BIMS Observation of Resid 08/05/2021 at 11:00 toilet seat with stool s Interview with Reside stool has been there not clean it when {her resident stated that th "bothers" him/her. Observation of Resid on 08/05/2021 at 11: smeared on the back stated that the facility bothers" him/her. Grievances CFR(s): 483.10(j)(1)- §483.10(j) Grievances grievances to the fac that hears grievances reprisal and without f reprisal. Such grieva respect to care and t furnished as well as furnished, the behav	s. Review of his/her sement dated 06/30/2021 t had moderately impaired S' score of 09. lent #92's toilet on AM revealed an elevated smeared on the back rim. ent #92 revealed that the for hours and the "staff will /she} tells them". The he facility not being clean lent #92's elevated toilet seat 54 AM revealed stool still a rim. Resident #92, again y not being clean "really	F 584	DEFICIENCY)		
	§483.10(j)(2) The res facility must make pr	sident has the right to and the ompt efforts by the facility to ne resident may have, in paragraph.				

Facility ID: 100599

If continuation sheet Page 43 of 401

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/08/2021 1 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PF	ROVIDER OR SUPPLIER	185256	B. WING _	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	09/	10/202 <u>1</u>
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		HABILITATION CENTER			IURSING HOME LANE EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F 585	Continued From page §483.10(j)(3) The fact on how to file a grieve to the resident. §483.10(j)(4) The fact grievance policy to en- of all grievances rega- contained in this para provider must give a to the resident. The grievances rega- contained in this para provider must give a to the resident. The grievances anonymo- facility of the right to (meaning spoken) or grievances anonymo- of the grievance offic can be filed, that is, h address (mailing and number; a reasonabl- completing the review to obtain a written de grievance; and the co- independent entities be filed, that is, the p Quality Improvement Agency and State Lo- program or protection	e 43 ility must make information ance or complaint available ility must establish a nsure the prompt resolution arding the residents' rights agraph. Upon request, the copy of the grievance policy grievance policy must individually or through t locations throughout the file grievances orally in writing; the right to file usly; the contact information ial with whom a grievance his or her name, business email) and business phone e expected time frame for v of the grievance; the right cision regarding his or her contact information of with whom grievances may ertinent State agency, Organization, State Survey ng-Term Care Ombudsman n and advocacy system;	F 5	585			
	receiving and trackin conclusions; leading by the facility; mainta information associate example, the identity grievances submitted	vance Official who is eeing the grievance process, g grievances through to their any necessary investigations ining the confidentiality of all ed with grievances, for of the resident for those I anonymously, issuing cisions to the resident; and					

If continuation sheet Page 44 of 401

		ND HUMAN SERVICES			FORM APPROVED	
	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
			200	NURSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		PI	KEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 585	necessary in light of (iii) As necessary, ta prevent further pote right while the allege investigated; (iv) Consistent with reporting all alleged abuse, including inju and/or misappropria anyone furnishing s provider, to the adm as required by State (v) Ensuring that all include the date the summary statement the steps taken to in summary of the per- regarding the reside as to whether the gr confirmed, any corre- taken by the facility and the date the wri (vi) Taking appropria accordance with Sta- of the residents' righ or if an outside entit the State Survey Ag Organization, or loc confirms a violation rights within its area (vii) Maintaining evid result of all grievand 3 years from the iss decision.	ate and federal agencies as i specific allegations; aking immediate action to ntial violations of any resident ed violation is being §483.12(c)(1), immediately violations involving neglect, uries of unknown source, tion of resident property, by ervices on behalf of the inistrator of the provider; and	F 585			
	by:					

If continuation sheet Page 45 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 585	Based on interview, of the facility grievan the facility failed to re dietary/food complain (57) sampled resider Resident #156 comp dietary/food service of there was no docum utilized their grievan document and resolv #156. The findings include: Review of the facility "Grievances/Compla Investigating" with a revealed the grievan completed for all grie grievance officer woo grievance/complaint. would report findings attach the investigatii grievance/complaint results were made a on behalf of the residen Review of the closed #156 revealed the fa 03/05/2021 with diag Diabetes Mellitus Ty To Excess Calories. Review of Resident a Data Set (MDS) Ass revealed the residen Brief Interview for Me	record review, and a review ce policy, it was determined asolve grievances related to ints for one (1) of fifty-seven its (Resident #156). lained to the facility about on 04/26/2021; however, ented evidence the facility ce procedure to investigate, re the grievance for Resident 's grievance policy titled ints, Recording and revision date of April 2017, ce/complaint form would be evance and complaints and a uld investigate the The Grievance Officer to the administrator and on to the form and the grievance vailable to the person acting lent. I medical record for Resident cility admitted the resident on noses, which included be II and Morbid Obesity Due	F 585		

Facility ID: 100599

If continuation sheet Page 46 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 585	Continued From pag	e 46	F 585		
		#156's Nutrition Progress			
	-	2021 at 05:53 PM, revealed tary Manager had spoken			
		04/26/2021 for forty-five (45)			
		dent had voiced complaints			
		vices. According to the note, ed satisfaction with the			
	outcome of the conve				
	Interview with the Die	etary Manager (DM), on			
	06/17/2021 at 8:05 P	PM, reveled the DM had not			
		ce/complaint form because			
		f the facility's grievance stated she was unaware she			
	was required to com	plete a grievance/complaint			
		rm to the facility grievance			
		strator. Further interview I started at the facility in			
		as not trained on the facility			
	grievance/complaint	procedure.			
	Interview with the So	cial Worker, on 06/17/2021			
	at 2:12 PM, revealed	she was the person			
	-	wing and investigating			
	•	not aware of any complaints esident #156. The Social			
	Worker stated she ha				
		stigations related to food			
	complaints or dietary	concerns for Resident #156.			
		rmer Administrator, who was			
		record on 04/26/21, on PM, revealed he was aware of			
		d complaints. According to			
	the Administrator, he	instructed Dietary to talk			
	with the resident to a	-			
		laints/concerns and was not ns had not been completed.			

Facility ID: 100599

If continuation sheet Page 47 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/ FORM APP OMB NO. 093	ROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/20	21
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE NKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) IPLETION DATE
F 585	Continued From pag	e 47	F 585			
F 600 SS=K	According to the Adm consider the complained would often change Administrator, if griev completed there was grievance not being Interview with the cu 06/19/2021 at 1:30 F employment at the fa The Administrator sta morning meetings st with grievances and Social Worker, were grievances. The Adm grievance should be Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misappropri and exploitation as d includes but is not lin corporal punishment any physical or chem treat the resident's m §483.12(a) The facili	ninistrator, he did not ints grievance because the often about the food and his/her mind. Per the vance forms were not a potential for the resident's resolved or addressed. rrent Administrator, on PM, revealed she started acility in early June 2021. ated this week during the aff had discussed concerns how staff, including the not investigating the ministrator stated all forwarded to her for action. d Neglect) om Abuse, Neglect, and right to be free from abuse, ation of resident property, lefined in this subpart. This nited to freedom from , involuntary seclusion and nical restraint not required to nedical symptoms. ty must- se verbal, mental, sexual, or oral punishment, or	F 600			

Facility ID: 100599

If continuation sheet Page 48 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039	Ð
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		1
F 600	Continued From pag	le 48	F 600			
	by: Based on observation and review of the fact the facility failed to he ensure four (4) of fift residents were free fift #82, #86 and #322). Interviews and recorn admitted Resident # admission, the residen numerous times to on in/out of other residen verbally/physically at However, the facility interventions to prev abusing other reside behaviors resulted in incidents and on 05/ grabbed Resident #3 06/04/2021, Resider #64's wrist and woul Resident #317 held Resident #82 wander would not leave; On hit Resident #86 with bruise to the residen 07/31/2021, Resider left wrist. Interviews with resid Residents #64, #86 Resident #82. Interviews	T is not met as evidenced on, interview, record review cility policy it was determined ave an effective system to y-seven (57) sampled from abuse (Resident #64, d reviews revealed the facility 82 on 05/12/2021 and since ent exposed him/herself ther residents, wandered ent's rooms and was busive to other residents. failed to implement effective ent Resident #82 from ints. Resident #82's ongoing n resident-to-resident abuse 18/2021, Resident #82 322 causing a skin tear. On it #82 grabbed Resident d not let go; On 06/30/2021, Resident #82's wrist because ered into his/her room and 0 07/15/2021, Resident #82 in a shoe causing a large t's upper arm and on it #82 hit Resident #64 on the ents and staff revealed and #322 were afraid of view with Resident #86 on I he/she was afraid when				

Facility ID: 100599

If continuation sheet Page 49 of 401

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE ANI	D REHABILITATION CENTER		IURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 600	Continued From	page 49 eep because Resident #82 still	F 600			
		oom and the facility had taken no				
	place to ensure rehas caused or is harm, impairment Immediate Jeopa 08/11/2021, and 0 03/06/2021, at 42 (F580), 42 CFR 4 (F600), 42 CFR 4 Person-Centered CFR 483.25 Qua (F692), 42 CFR 4 (F755) and 42 CF	re to have an effective system in esidents were free from abuse, likely to cause serious injury, t or death to a resident. rdy was identified, on was determined to exist on 2 CFR 483.10 Resident Rights 83.12 Freedom from Abuse 83.12 Comprehensive Care Plans (F655) (F656) 42 lity of Care (F684) (F686) 83.45 Pharmacy Services FR 483.80 Infection Control ty was notified of Immediate				
	was received on a removal of the Im 09/02/2021. How verified based on and review of fac Immediate Jeopa 483.35 Nursing S Administration (F Quality Assurance Improvement (F8	1/2021. egation of Compliance (AOC) 09/03/2021, which alleged imediate Jeopardy on vever, the AOC could not be observations, staff interviews, ility documentation. Additional rdy was identified at 42 CFR services (F725), 42 CFR 483.70 835) (F837), 42 CFR 483.75 e and Performance 67). The facility was notified of opardy on 09/10/2021. The				
	Immediate Jeopa	rdy is ongoing.				
	Review of the fac Prohibition/Invest					

Facility ID: 100599

If continuation sheet Page 50 of 401

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039	
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING	-ETNI	09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			20	00 NURSING HOME LANE		
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER	Р	IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL / OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO	
F 600	would ensure it w control to prevent neglect. Accordin defined as the wi deprivation by an caretaker, of goo necessary to atta and psychosocial	reglect. Per the policy, the facility was doing all, that was within its t occurrences of abuse and g to the policy, abuse was llful infliction of injury, and individual, which included a ds or services which were in or maintain physical, mental well-being. The policy also	F 600			
	gestured languag disparaging and of their families or w regardless of their disability. Sexual as non-consensu with a resident ar facility's failure to resident, which w harm, pain, ment	use was the use of oral, written or ge that willfully included derogatory terms to residents or vithin their hearing distance, ir age, ability to comprehend or I abuse was defined in the policy al sexual contact of any type nd neglect was defined as the provide goods and services to a vere necessary to avoid physical al anguish or emotional distress.				
	actions to preven included identifyin situations in whic and developing a appropriate interv of abuse. Exampl included incidents and suspicious bu unknown origin.	tated the facility would take t abuse in the facility which ng, correcting and intervening in h abuse was more likely to occur care plan that identified ventions to prevent occurrences les of abuse, per the policy, s of resident to resident abuse ruising, and any injury of The policy also stated the				
	of the policies/pro and neglect in the Review of the fac Status (BIMS) list	s responsible for implementation ocedures which prohibit abuse e facility. ility's Brief Interview for Mental t for facility residents indicated as interviewable with a BIMS				
	score of twelve (1	12) and Resident #86 was also n a BIMS score was ten (10).				

Facility ID: 100599

If continuation sheet Page 51 of 401

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED DMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED
NAME OF PI	ROVIDER OR SUPPLIER	185256	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 600	was eight (8). Review of the medica admitted Resident #8 diagnoses, which inc with behavioral distur Disease. Review of Resident & Set (MDS) assessme revealed the facility a a Brief Interview for M of zero (00) out of fift resident was not inter MDS, Resident #82 H directed towards othe wandered, one (1) to assessment period. F revealed he/she requi one (1) staff member surfaces and walking Review of Resident # Plan revealed on 05/2 resident had behavio easily directed such a the resident was also to others. Review of I also revealed he/she residents rooms and review of the care pla developed on 05/20/2 the resident calmly/que reason for behavior s or toileting, administer medications as need	d Resident #64's BIMS score al record revealed the facility 22 on 05/12/2021 with luded Unspecified Dementia bances and Parkinson's 22's Quarterly Minimum Data ent, dated 07/14/2021, issessed the resident to have Mental Status (BIMS) score een (15), indicating the rviewable. According to the had physical behaviors ers, rejected care and three (3) days during the Resident #82's MDS also hired extensive assistance of when transferred between 482's Comprehensive Care 20/2021, staff identified the r symptoms that were not as: wandering, agitation and physically/verbally abusive Resident #82's care plan	F 60		

Facility ID: 100599

If continuation sheet Page 52 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	N POST-ACUTE AND RE	EHABILITATION CENTER	2	00 NURSING HOME LANE	
			P	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 600	Continued From pag	e 52	F 600		
	ongoing behaviors in	the facility, the only time			
	07/14/2021, when int	d his/her care plan was on terventions were added for eting needs, thirsts and			
	07/27/2021 at 12:20	cted of Resident #82, on PM and at 4:20 PM, revealed ndering in the facility hallways resident's rooms.			
	at 8:02 AM, revealed staff another residen bathroom while he/sl review revealed whe to remove the other r Resident #322's arm	dent report dated 05/18/2021 Resident #322 reported to t wandered into his/her ne was "in there". Further n Resident #322 attempted resident, he/she "grabbed" which resulted in a 1 cm skin tear to his/her arm.			
	Review of Resident # revealed no docume reported on 05/18/20	nted evidence of the incident			
	approximately 12:30 afraid of Resident #8 "a while back" Reside bathroom while he/sh he/she attempted to his/her bathroom, Re Resident #322's arm skin. Resident #322 s to staff he/she was a Continued interview also exposed him/he	and "ripped" the residents stated he/she had reported			
	multiple occasions. H	lowever, he/she stated ne to protect the resident			

Facility ID: 100599

If continuation sheet Page 53 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		S [.]	TREET ADDRESS, CITY, STATE, ZIP CODE	
			20	00 NURSING HOME LANE	
PARKVIEV	W POST-ACUTE AND R	EHABILITATION CENTER	Р	IKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 600	room. Interview with Regis 07/30/2021 at 9:50 / the incident report for resident reported to into his/her bathroom he/she attempted to his/her bathroom the arm and caused a s acknowledged the in resident abuse and incident immediately Nursing (ADON). Ho direct staff to take an further incidents of r concerning Residen Resident #82 has co Resident #100 Residen #64 and Resident #8 were fearful of Residen Interview with the As (ADON)/Interim Dire 08/11/2021 at 12:00 stated in interview s #82 exhibited abusive residents in the facil about the incident th with Resident #322, incident and acknow incident to her. The was an allegation of and interventions sh to protect residents stated no action was	tered Nurse (RN) # 1, on AM, revealed she completed or Resident #322 when the her Resident #82 wandered m. The resident reported remove Resident #82 from e resident grabbed his/her kin tear. The RN noident was resident to stated she reported the / to the Assistant Director of owever, the ADON failed to my actions to prevent any esident to resident abuse t #82. RN #1 stated ontinued to wander in/out of m, as well as other residents ed Resident #322, Resident 86 verbalized to her that they dent #82. esistant Director of Nursing ector of Nursing, on PM, revealed she initially he was not aware Resident ve behaviors towards other ity. However, when asked nat occurred on 05/18/2021 she was able to recall the vledged staff reported the ADON stated the incident resident to resident abuse iould have been implemented from abuse; however, she is taken. Per the ADON, she	F 600		
	reported the inciden	t to the Administrator at the			

Facility ID: 100599

If continuation sheet Page 54 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER			
				PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 600	Continued From pag	e 54	F 600		
		urred, but was unsure if he			
	-	te Agencies or not and he			
		yed at the facility. According as not responsible to report			
		State Agencies; however she			
	was responsible to in	vestigate allegations of			
		vestigated this incident			
	because she was no	t directed to do so.			
	2. Continued review	of Resident #82's medical			
		5/21/2021 at 10:20 AM and			
		9 AM, the resident continued ther resident's rooms and			
		ally abusive with other			
	residents."	,			
	Interview with RN # 1	1, on 07/30/2021 at 9:50 AM,			
		an entry in Resident #82's			
		5/21/2021 regarding the			
	residents. She state	lly abusive with other d the resident was			
		esident rooms and would "yell			
	•	the other residents, as they			
		It #82 to exit their personal trecall which residents were			
	· ·	while back" but stated, she			
		ncident report. The RN			
		he abuse incidents to			
		emember who;" however, irected to take any actions to			
	prevent further abuse	•			
	Interview with RN # 9	9, on 07/29/2021 at 9:30 PM,			
	revealed she docume	ented Resident #82's			
		2021 regarding the resident's			
		residents, which had been e was admitted at the facility			
		aff have taken no action to			
		Continued interview revealed			

Facility ID: 100599

If continuation sheet Page 55 of 401

		H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP COI	DE
				200 NURSING HOME LANE	
PARKVIE	V POST-ACUTE AN	D REHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 600	Continued From	page 55	F 60	0	
			1 00		
	Resident #82 wandered into other residents personal space "constantly" and was difficult to redirect. She stated he/she would go into others				
		h their personal belongings and			
v 2 #		ot upset due to this behavior,			
	-	to leave their rooms, Resident			
		akes growling noises and scares			
	•	ts." According to the RN, she			
		incident reports related to the			
w to		s, but the incidents were reported			
	to the previous A	dministrator, the current ADON			
	and the Administ	rator "too many times to count";			
	however, nothing	had been done to prevent			
	further abuse from	m occurring.			
	Review of Reside	ent #82's medical record			
	revealed, on 06/0)2/2021, he/she was evaluated			
	by the facility Psy	chiatry services for the first time			
	since admission.	Review of documentation			
	indicated the resi	dent's initial complaints were			
		onfusion and the findings			
		dent was "compliant with current			
		ecommendations were made to			
		nt any associated side effects,			
		hosis and/or changes in mental			
	status, mood, bei	havior, sleep, or appetite.			
	3. Review of Res	sident #82's facility reported			
		6/04/2021, revealed at 1:15 PM			
		oise coming from the hallway			
		valuated where the noise was			
	coming from, Re	sident #82 was found in			
		oom "holding onto" Resident			
		rm and would not let go. Review			
		vealed staff "had to remove"			
		and from Resident #64's arm			
		sist Resident #82 from Resident			
		use the resident was not able to			
	be verbally redire	ected. According to the facility			

Facility ID: 100599

If continuation sheet Page 56 of 401

<u>CENTER</u>	-	AND HUMAN SERVICES					RM APPROV <u>NO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		NSTRUCTION		TE SURVEY MPLETED
		185256	B. WING			09/10/202 <u>1</u>	
NAME OF PF	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
	V POST-ACUTE ANI	D REHABILITATION CENTER		200 N	URSING HOME LANE		
				PIKE	VILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 600	Continued From	page 56	F 60	00			
	reported incident,	Resident #82 was transferred					
		an "overnight" evaluation on					
		when the resident returned from					
		blowing day, Resident #82 was					
		eased level of supervision; every					
	fifteen (15) minute	e checks for seven (7) hours,					
	. ,	ninutes for twelve (12) hours,					
		or twelve (12) hours (totaling					
	approximately thi	rty-one (31) hours), and a stop					
fa	sign was placed o	over Resident #64's door and the					
	facility psychiatris	st was ordered to evaluate					
	Resident #82's be	ehaviors.					
	Review of Reside	ent #82's medical record					
		4/2021 at 1:10 PM, staff heard					
		and when staff "went to check					
		s wrong" one resident was					
		her residents room and he/she					
		I wrapped around" the other					
		earm and wrist. Continued					
		ord revealed the resident (no					
		I) "would not lessen grip" and					
		ove" his/her hand and assist the					
		his/her room. The record also					
		dent was transferred to the					
	hospital on 06/04	/2021 at 2:10 PM.					
	Review of Reside	ent #82's medical record					
		dent returned to the facility on					
		80 AM. Even though the resident					
		ncreased level of supervision,					
		ses notes revealed he/she					
	continued to wan	der in/out of other resident's					
	rooms and was d	ifficult to redirect. Further review					
	of the record reve	ealed at 8:30 AM on 06/05/2021,					
	Resident #82 was	s "walking in front of other					
		ng to grab them both male and					
	-	esident continued to wander into					
	other residents ro	ooms and "they start yelling and					

Facility ID: 100599

If continuation sheet Page 57 of 401

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PR	ROVIDER OR SUPPLIER	e de la constante de	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
			200 N	IURSING HOME LANE	
PARKVIEV	V POST-ACUTE AN	D REHABILITATION CENTER	PIKE	VILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 600	Continued From	page 57	F 600		
		tinued review of Resident #82's			
	-	evealed the resident continued to			
	wander in/out of	other residents rooms on			
	06/07/20 21 and	again on 06/10/2021.			
		sident #64, on 07/27/2021 at			
		ed he/she had been abused by			
		d he/she was afraid of the			
		I reported his/her fear to facility he resident stated nothing was			
		im/her and even though			
	•	ndered into his/her room and			
		and wouldn't let go". The			
		esident #82 continued to wander			
	in/out of his/her r	oom at times, and "no one does			
	anything to stop"	him/her from coming "in here on			
	me again."				
	Review of Reside	ent #82's medical record			
		was evaluated by the facility			
		es again, on 06/14/202,1 and			
	his/her chief com				
		ropriate behaviors, the resident			
		ect, talked to him/herself and			
	-	iolence towards others.			
	•	evaluation, the resident's family			
		had a history of violence and			
		resident would become "wild as			
		d to redirect and he/she went nt rooms and residents were			
		around Resident #82.			
		Iso indicated the residents			
		nendations was "psychiatric			
		gement." However, no			
	medication chang	ges were recommended during			
	the evaluation.				
	Inton in the D	ciptored Nurse (DNI) # 4			
	Interview with Re 07/30/2021 at 9:5	gistered Nurse (RN) # 1, on			

Facility ID: 100599

If continuation sheet Page 58 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/ FORM APF OMB NO. 093	ROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURV COMPLETED	ΞY
		185256	B. WING		09/10/20	21
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE NKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) PLETION DATE
F 600	 #64 on 06/04/2021 a Administrator. She s resident was transfere turned the followin continued. The RN s he/she was afraid of resident continued to resident continued to resident's rooms and to protect the resider Review of facility reported to 06/04/2021 which im Resident #64. Accor RN #1 heard a noise and when the nurse Resident #82 in Ress resident had hold of and would not let go removed Resident # he/she was sent to the evaluation and return 06/05/2021. Further review of the dated 06/04/2021, reference to be redired monon-injury to resider recommended psych the resident's behavior indicate if abuse was 4. Review of a facilition 06/30/2021 Resident #317's root 	cident occurred with Resident and she notified the stated even though the rred to the hospital and g day, his/her behaviors stated, Resident #64 reported Resident #82; however, the o wander in/out of other d no actions had been taken nts. portable incidents indicated he incident that occurred on volved Resident #82 and ding to the reported incident, e coming from the hallway went to investigate she found ident #64's room and the Resident #64's wrist and arm . Staff intervened and 82 from his/her room and he hospital for an overnight ned to the facility on e facility reported incident, evealed the facility did egations" that Resident #82 o" Resident #64's wrist, was cted which resulted in	F 600			

Facility ID: 100599

If continuation sheet Page 59 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROV OMB NO. 0938-03	ΈD
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC)N
F 600	Continued From pag	e 59	F 600			
		holding onto" Resident #82's				
	room. According to t the facility determine abuse between Resi Continued review of "medical condition of Disease" Resident # room, looking for" his transferred to the hos treatment. Review of Resident # revealed the resident inpatient psychiatric returned to the facility according to staff the	t was transferred to an stay on 07/01/2021 and y on 07/08/2021; however, re were no changes in viors when he/she returned				
	revealed, on 07/13/2 #86 called the State was coming in his/he him/herself. Howeve revealed RN #1 infor our residents had De wander". Per the re Police a resident had him/herself to Reside also documented she Resident #86 "has be	cord, the RN informed the				
	07/30/2021 at 9:50 A working on 07/13/20 contacted the State F incident were reported	M, revealed she was 21, when Resident #86 Police. The nurse stated the ed to the Administrator; had been taken to protect				

Facility ID: 100599

If continuation sheet Page 60 of 401

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	185256	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 600	allegation. She state the incident had not not witnessed it; how incident was an alleg have been reported/ interventions should protect the resident. 6. Review of Resider incident, dated 07/15 #82 wandered into F "picked up" Resident to leave the resident incident report, Resi personal alarm provi water on Resident # report also indicated implemented to prev into his/her room, ho "frequently takes it d the investigation rev Resident #82 was all the report also stated further abuse was the encourage Resident up when he/she was Review of Resident # 07/15/2021, revealed Resident #82 had wa room and "picked up According to the reco staff that he/she was resident woke up, th room and the reside he/she was going to him/her and also info	restigate the resident's ed she informed the police occurred because she had vever, acknowledged the gation of abuse which should investigated and have been implemented to nt #86's facility reported 5/2021, revealed Resident Resident #86's room and t #86's shoes and then turned ts room. According to the dent #86 pressed his/her ided by the facility and threw 82. Documentation on the a stop sign had been rent residents from wandering owever Resident #86 lown." Continued review of ealed the facility determined oused by Resident #86, and d steps taken to prevent iat the facility would #86 to keep his/her stop sign	F 600			

Facility ID: 100599

If continuation sheet Page 61 of 401

	-				FORM APPROVED
STATEMENT	S FOR MEDICARE 8 OF DEFICIENCIES F CORRECTION	X MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND F	REHABILITATION CENTER		NURSING HOME LANE KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 600	medical record also informed staff his/he the time of the incid preferred not to utilit Observations condu 07/27/2021 at 1:00 was in place and no on the resident's per residents from enter observations reveal approximately 6 x 8 in color to the resider resident informed th the bruising when R shoe. An interview with Re approximately 1:00 the facility was not to resident did not kno resident stated Res room, "beat me up" liked it". Per the rese exposed him/herset times since Resider facility. The resider incidents to facility shelping me. Resider done anything" to he also stated he/she w the opposite end of away from him/her; continues to come i after he/she was hit #86 stated, on 07/15 his/her bed and Res	revealed Resident #86 er stop sign was not in use at ent, and he/she stated he/she ze the stop sign. ucted of Resident #86, on PM, revealed no stop sign o personal alarm was in use rson, to prevent other ring his/her room. Further	F 600		

Facility ID: 100599

If continuation sheet Page 62 of 401

		AND HUMAN SERVICES				FOR	D: 12/08/20 MAPPROVE O. 0938-039
TATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI			(X3) DAT	E SURVEY PLETED
		185256	B. WING			09	/10/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
			20	00 NURSING HOME LANE			
		PIKEVILLE, KY 41501		IKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 600	Continued From p	age 62	F	600			
	and picked up the	residents shoe and hit him/her,					
		he left upper arm. The resident					
		w water on the resident to get					
		her room, and he/she reported					
		ent #82 exposed him/herself to					
		wever, no actions have been					
	•	m/her from further abuse from					
	Resident #82.						
		te Registered Nurse Aide					
	· / ·	7/27/2021 at 8:10 PM, revealed					
		ident #82 since he/she has					
		he facility and he/she wandered					
		s rooms, "picks up their" gs and exposes him/herself to					
		he SRNA stated Resident #82					
		g him/herself to Resident # 86					
	•	She stated the concern had					
		RN #9 and the RN had					
		lity Administrator; however, staff					
		move Resident #86's room					
		n't done anything wrong,"					
		ents resided across the hall					
	from each other w	hen the incident occurred,					
	sometime in "early	/ June" 2021. According to the					
	SRNA, even thoug	gh the resident's room had been					
	moved, Resident #	#82 continued to wander in/out					
	the resident's room	n, and continued to expose					
		resident. SRNA #16 stated					
		d to be reported to nursing					
		ed the SRNA they had reported					
		ns to the Administrator;					
		ns had been taken to protect					
		thers from abuse. The SRNA					
		I the night shift (6 PM-6 AM)					
		5/2021 after the incident					
		Resident #82 and Resident					
		upon her initial rounds at					
	approximately 6:3	0 PM, Resident #86 reported					

Facility ID: 100599

If continuation sheet Page 63 of 401

	-	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
ATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		09/10/202 <u>1</u>	
			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
			200 NURSING HOME LANE		
			PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC E APPROPRIATE DATE
F 600	Continued From	page 63	F 60		
	the incident and	stated Resident #82 came in			
	his/her room, exp	bosed him/herself to the resident			
		/her with a shoe. The SRNA			
		dent #86 had a "large purple			
		left arm at the beginning of			
		she reported the resident's injury tical Nurse (LPN) #8. She stated			
		was on the unit after the			
		; however, she had not been			
	questioned about	t the incident until questioned by			
	•	cording to the SRNA, Resident			
		wander in/out of other resident's			
	rooms and no ac residents from ab	tions were taken to protect			
	residents nom at	Juse.			
	Interview with SF	RNA #18, on 07/27/2021 at 10:00			
		she also worked the night shift			
		nd observed a large bruise and a			
		t #86's left upper arm. The			
		sident #86 reported that Resident			
		her room, exposed him/herself to hit the resident with a shoe. The			
		sident #82 frequently wandered			
		nt's rooms, and Resident #86			
		numerous occasions Resident			
	•	/herself to the resident and			
		of his/her room; however, no			
		en to protect the resident. The			
		she could not understand why			
		unished" and "acted like it was" ault, especially since this was not			
		resident had exposed			
		sident #86. According to the			
		ent's large bruise and "knot" was			
	reported to LPN a	# 8.			
	Interview with LD	N #8, on 07/27/2021 at 9:30 PM,			
		ked the night shift (6 PM-6 AM)			
		hen the incident occurred, and			

Facility ID: 100599

If continuation sheet Page 64 of 401

		E & MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIEF	र	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
			200 NURSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			PIKE	VILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 600	Continued From	page 64	F 600		
		icident occurred right before she	1 000		
		lift. She acknowledged Resident			
		ff Resident #82 entered his/her			
	room, exposed h	im/herself to the resident, and hit			
	the resident with	a shoe. She also stated staff			
		bruise on Resident #86, which			
		d reported the bruising to the			
		the ADON failed to implement			
	any interventions	to protect residents from abuse.			
	Interview with the	e ADON/Interim Director of			
	Nursing, on 08/1	1/2021 at 12:00 PM, she was			
		#86 was afraid of Resident #82;			
		she thought the resident was just			
	-	in the facility" and felt like			
		unrelated to Resident #82, and			
	-	't like" Resident #82. She also			
		to the unit, on 07/15/2021, when andered into Resident #86's			
		stated no one informed her			
		ported to staff Resident #82			
		self to the resident that day, or			
	•	the also stated staff had notified			
	her of a bruise or	n Resident #86's left arm;			
	however, stated	she felt the residents bruise was			
		ause someone told her Resident			
	#86 had been ob	served "poking at" his/her arm.			
	7. Review of Res	sident #64's record revealed			
		tered his/her room again on			
		proximately 4:50 AM, was going			
	-	ents personal belongings and			
		64 asked Resident #82 to exit			
		sident #82 hit Resident #64 on			
	-	ccording to the record, a small served to his/her right wrist.			
	Interview with RN	√#9, on 07/29/2021 at 9:30 PM,			

Facility ID: 100599

If continuation sheet Page 65 of 401

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	Contractorion		A. BUILDING		
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			2	00 NURSING HOME LANE	
PARKVIEV	V POST-ACUTE AND	REHABILITATION CENTER	F	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTIC
F 600	she provided caree was admitted to th his/her abusive be residents had been The RN stated Re of other resident's other residents an also stated Reside Resident #86 had Resident #82 and been reported to th Administrator, on the actions have been However, the RN se exact date unknow Resident #86 infor exposed him/herset the RN, she report the Administrator at the RN to move Re the hall, because the hall from each other was moved as dire however, Residen down the hall, into him/herself and has shoe, resulting in a since he/she had the RN, Resident #82 room and hit the re She stated Reside	d to Resident #82 since he/she e facility in May 2021, and havior towards staff and other n continuous since admission. sident #82 had wandered in/out rooms, "yelled/growled" at d created fear in others. She ent #64, Resident #322 and reported they were afraid of even though the concerns have	F 600		
	on 07/31/2021 after resident was "in ter was reported to th was instructed to th however, the RN s	n she assessed Resident #64 er the incident occurred, the ars." The 07/31/2021 incident e Administrator, and the RN keep the resident a 1:1; stated she informed the to staffing, that was not			

Facility ID: 100599

If continuation sheet Page 66 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				200 NURSING HOME LANE	
PARKVIE	N POST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501	
			I		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
	Review of nursing dr at 3:15 PM, Resident "wandering into roor after he/she hit Resi Interview with the AI Nursing, on 08/11/20 worked at the facility year and had just be interim DON within t stated since being A worked the floor as a had been able to co complete any monitor residents. She also system in place to m which could result in incidents; however, free from abuse in the afraid. Interview with the Ac 6:00 PM, revealed s Coordinator and was informed staff he/sh However, the Admin Resident #86 targete stated she thought F and stated she felt the	ge 66 ther direction was taken to 5. ocumentation, on 08/01/2021 at #82 was alert, and ms," approximately 10 hours dent #64 for the second time. DON/Interim Director of 021 at 12:00 PM, she had y for approximately one (1) sen moved into the position of the last few weeks. She also DON at the facility, she had a staff nurse, more than she nduct morning meetings, or oring in the facility for the stated the facility had no nonitor resident behaviors a resident to resident abuse stated residents should be the facility and should not be dministrator, on 08/11/2021 at		CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DATE
	free from abuse in the provided the resider ring when incidents a stop sign at his/he	ensure Resident #86 was he facility, she stated she had ht with a personal alarm to occurred, and had staff place r door; however, the resident interventions and stated			

Facility ID: 100599

If continuation sheet Page 67 of 401

		AND HUMAN SERVICES			PRINTED: 12/08/202 FORM APPROVE
TATEMENT (DF DEFICIENCIES CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		MB NO. 0938-03 X3) DATE SURVEY COMPLETED
	185256 NAME OF PROVIDER OR SUPPLIER		B. WING		09/10/202 <u>1</u>
NAME OF P			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE
F 600	Continued From p	bage 67	F 600		
	resident or to help She acknowledge wandering into oth resident to reside asked what interv to protect other re Resident #82 she him/her somewhe wanders. She al place to monitor r because this was stated meetings w to discuss nursing sure who attended the ADON frequen nurse due to shor she stated she ha meetings since sh 06/07/2021 becau	been implemented to protect the o him/her feel safe in the facility. Ad however, Resident #82's her residents rooms did trigger int abuse incidents, and when rentions had been implemented asidents from abuse, as well as a stated, "I can attempt to place" are else because he/she so stated she had no system in resident's behaviors in the facility a "nursing thing." She also vere being held Monday-Friday g issues; however, she was not d those meetings. Per interview ntly worked the floor as a staff t staffing in the facility. Further ad not attended any of those he became Administrator on use "this place is such a mess" t of issues in the facility kitchen."			
F 609 SS=D	Reporting of Alleg CFR(s): 483.12(c §483.12(c) In resp	ged Violations	F 609		
	involving abuse, r mistreatment, incl source and misap are reported imme hours after the all that cause the alle serious bodily inju- the events that ca	sure that all alleged violations neglect, exploitation or luding injuries of unknown opropriation of resident property, ediately, but not later than 2 egation is made, if the events egation involve abuse or result in ury, or not later than 24 hours if ause the allegation do not involve result in serious bodily injury, to			

Facility ID: 100599

If continuation sheet Page 68 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 609	the administrator of t officials (including to adult protective serv for jurisdiction in long accordance with Sta procedures. §483.12(c)(4) Repor investigations to the designated represen accordance with Sta Survey Agency, with incident, and if the a	the facility and to other the State Survey Agency and rices where state law provides g-term care facilities) in the law through established	F 609		
	by: Based on interview, the facility's policy, it failed to ensure all a abuse or neglect, we no later than two (2) was made, if the eve allegation involved a Agency and Adult Pr	IT is not met as evidenced , record review, and review of t was determined the facility illeged violations involving ere reported immediately, but hours after the allegation ents that caused the abuse, to the State Survey rotection for two (2) out of pled residents (Resident #206			

Facility ID: 100599

If continuation sheet Page 69 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		00 NURSING HOME LANE	
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LIST MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 609	Continued From pag	e 69	F 609		
	and Resident #64).				
	of hip pain on 05/26/ and revealed a Left F (fractured left hip). T fracture as an injury to report the allegation addition, on 06/04/20 Resident #64's arm a facility failed to report the state agencies. The findings include: Review of the facility Investigation and Re of December 2016, r neglect, exploitation, property, mistreatme origin shall be report agencies and thorou management. Findir reported. The policy would assign the inve individual. The polic involving abuse, neg mistreatment, or inju misappropriation of r reported by the Admit to the state licensing Ombudsman, the Re Adult Protective Serv Officials, the residem Director within two (2	d Resident #206 complained 2021. An x-ray was ordered Femoral Neck Fracture The facility investigated the of unknown source but failed on to the state agencies. In 021, Resident #82 grabbed and refused to let go. The t the allegation of abuse to "s policy, "Abuse porting", with a revision date evealed all reports of abuse, misappropriation of resident nt and/or injuries of unknown ed to local, state, and federal ghly investigated by facility ngs of abuse would also be stated the Administrator estigation to an appropriate y stated all alleged violations lect, exploitation, ries of unknown origin, or esident's property would be inistrator or his/her designee /certification agency, the esponsible Party of record, vices, Law Enforcement t's physician, and the Medical			

If continuation sheet Page 70 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AND RE	EHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 609	Polyarthritis, Vascula Coordination, Atrial F Paranoid Personality Syndrome, Osteopor Incontinence. The m resident had been dia the facility on 05/26/2 Review of a Discharg Assessment for Resi 05/26/2021, revealed resident to have a Br Status (BIMS) score indicating cognitive in MDS had been comp been discharged from assessment was com Review of nurses nor revealed an entry, da by RN #1 which state his/her head, stomad note, the left hip pain tender to touch. The notified with an order left hip. Review of an X-ray m hip, dated 05/26/202 resident had an Acut Neck Fracture. Further review of Res revealed an entry, da by the Director of Nu resident was transfer	diagnoses which included ir Dementia, Lack of Fibrillation, Insomnia, Disorder, Chronic Pain osis, and Stress hedical record revealed the scharged to the hospital from 2021. ge Minimum Data Set (MDS) dent #206, dated d the facility assessed the rief Interview for Mental of six (6) out of fifteen (15), mpairment. No Admission bleted due to the resident had n the facility before the	F 609		

Facility ID: 100599

If continuation sheet Page 71 of 401

		E & MEDICAID SERVICES			<u>OMB NO. 0938-03</u> I
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
	AME OF PROVIDER OR SUPPLIER		B. WING		09/10/2021
			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	
			200	NURSING HOME LANE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			РІК	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 609	Continued From	page 71	F 609		
	Continued From page 71 Review of a facility investigation, dated 05/26/2021, revealed Resident #206 was observed by staff to have left hip pain and guarding. Registered Nurse (RN) #1 notified the physician and an X-ray was obtained. The investigation revealed upon the nurse notification of the Responsible Party (RP), the RP had alleged to the nurse he/she felt the resident had been neglected. The investigation revealed Resident #206 had sustained a Left Femoral Neck Fracture (fractured left hip) which was an injury of unknown origin. According to the investigation, Resident #206 had initially told staff she had fallen, and then later denied he/she had fallen. However, there was no documented evidence the facility had notified the state agencies, per the facility's policy.				
	Nursing Assistant 1:30 PM, and SR PM, revealed whe Resident #206 to approximately 7:3 complaining of pa stated RN #1 was Interview conduct	ted with RN #1, on 06/18/2021 at			
	notified by SRNA #205 was compla stated she assess resident was com- left hip pain. The rounds at approxi- resident was slee pain. The RN sta- physician and ha	40 PM, revealed she had been #3 and SRNA #7 that Resident aining of left hip pain. The RN sed the resident, and the aplaining of head, stomach, and RN stated she had first made imately 6:45 AM to 7:00 AM, the eping and no apparent signs of ated she had notified the d obtained an order for an X-ray pontinued interview revealed she			

Facility ID: 100599

If continuation sheet Page 72 of 401

CENTER	<u>S FOR MEDICARE</u>	E & MEDICAID SERVICES			OMB NO. 0938-0
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PF	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	
			20	00 NURSING HOME LANE	
PARKVIEV	V POST-ACUTE ANL	OREHABILITATION CENTER	PI	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET
F 609	Continued From p	bage 72	F 609		
		pted to reach the resident's RP			
		ut had reached the RP a few			
	•	e RN stated when she had			
	initially asked the	resident what happened, the			
		her he/she had fallen. The RN			
		had gone with Licensed			
		PN) #7 later the resident had			
		not fallen. The RN stated the			
	•	confused. Further interview			
		lent's RP had told her she felt neglected. The RN stated she			
		nformed the Administrator.			
	Intonviowa conduc	atad with LDN #7 ap 06/19/2021			
		cted with LPN #7, on 06/18/2021 A #10 on 06/18/2021 at 8:05 PM,			
		n 06/18/2021 at 8:20 PM,			
		I provided care for Resident			
	-	PM to 6:00 AM shift, on			
		5/26/2021. The staff revealed			
	Resident #206 ha	d slept all night and they had			
	not been aware o	f any falls. The staff further			
		t #206 had not complained of			
		NA #10 and SRNA #11 had went			
		room at approximately 5:00			
		lent had complained of back			
		nmediately reported to LPN #7. PN #7 went into the room, the			
		ady fallen back asleep, and the			
		d no signs of pain.			
	Interview conduct	ed with Department of			
		d Services (DCBS) Worker, on			
	-	0 PM, revealed there was no			
		ad been notified of the			
	allegation of negle source.	ect or of the injury of unknown			
	Interview conduct	ed with the Director of Nursing			
		2021 at 9:00 AM, revealed she			

Facility ID: 100599

If continuation sheet Page 73 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE	
		-	P	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 609	Continued From pag	e 73	F 609		
		e investigation. The DON the Abuse Coordinator, but			
	former Administrator, faxed the report to the have a confirmation of The DON stated she needed a confirmation on previous occasion ambulating in his/her stated she felt at som fallen but nothing have Attempted to reach the 06/19/2021 at 8:30 A AM were unsuccessfe Interview conducted 06/19/2021 at 1:30 P been the Administrated should be reported to (2) hours. The Admin now be using both far	he former Administrator on M, and 06/19/2021 at 9:30			
	"Facility Investigation RN #1 on 06/04/2021 coming from the hall RN #1 found Residen room holding onto Re After trying to redirect success, RN #1 and Resident #82's hand Immediately after the	ility investigation titled, " dated 06/04/2021, revealed 1 at 1:15 PM, heard a noise way and upon investigation nt #82 in Resident #64's esident #64's wrist and arm. et Resident #82 without SRNA #7 had to remove from Resident #64's arm. e release, Resident #82 and ssessed for injuries. RN #1 Coordinator (former			

Facility ID: 100599

If continuation sheet Page 74 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW	V POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 609	Continued From pag Administrator) and re Resident #82 was pla	eported the incident.	F 609		
	supervision by staff t have the resident as Room. Resident #6	until the ambulance arrived to sessed at the Emergency 4 had an x-ray ordered for found to have no injury.			
	revealed the residen on 04/28/2021 with o Unspecified Dement				
	(MDS) Assessment, Resident #64, reveal resident to have a Br Status (BIMS) score	sion Minimum Data Set dated 05/05/2021, for led the facility assessed the rief Interview for Mental of eight (8) out of fifteen I the resident was moderately			
	revealed the residen on 05/12/2021 with o Parkinson Disease, I	al record for Resident #82 t was admitted by the facility liagnoses including Unspecified Dementia with nce and Alzheimer's Disease.			
	Assessment, dated 0 facility assessed the score of zero (00) ou	#82's Admission MDS 05/18/2021, revealed the resident to have a BIMS It of fifteen (15), and ent was severely cognitively			
	11:46 AM, revealed t	CBS worker, on 06/18/2021 at the agency had not received the facility regarding esident #82.			

If continuation sheet Page 75 of 401

	-	HAND HUMAN SERVICES					ED: 12/08/20 RM APPROV
ATEMENT (S FOR MEDICAR	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		TRUCTION	(X3) DA	NO. 0938-03 TE SURVEY MPLETED
		185256	B. WING		EINI)9/10/202 <u>1</u>
IAME OF PI	ROVIDER OR SUPPLIER	2		STREET	ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE AN	D REHABILITATION CENTER			RSING HOME LANE		
					•		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 609	Continued From	page 75	F 60)9			
	Interview with RN	I #1, on 06/18/2021 at 1:58 PM,					
		as the incident happened and					
		e safe and secure, she phoned					
		inator (former Administrator) and					
		se. RN #1 revealed an					
		who was responsible to report					
	to the state agen						
	Interview with the	e DON, on 06/19/2021 at 12:27					
		former Administrator was the					
		or and she was the Assistant					
		e DON also revealed the facility					
		s to report to the state agencies abuse that is witnessed or					
		revealed she had faxed a report					
		the state agencies; however,					
		any confirmation showing it had					
	been received by	the agency.					
	Interview with the	Administrator, on 06/19/2021 at					
		d she had only been the					
		the past two (2) weeks. The					
		her revealed it was the					
		he Abuse Coordinator to notify					
		ithin two (2) hours of the abuse					
	-	llegation of abuse.	– – –				
F 623 SS=D	Notice Requirements CFR(s): 483.15(c	ents Before Transfer/Discharge :)(3)-(6)(8)	F 62	23			
	\$483,15(c)(3) No	tice before transfer.					
	,	ransfers or discharges a					
	resident, the facil						
	(i) Notify the resid	dent and the resident's					
		of the transfer or discharge and					
		ne move in writing and in a					
		anner they understand. The					
	lacility must send	l a copy of the notice to a					

Facility ID: 100599

If continuation sheet Page 76 of 401

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/08/2021 1 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	185256	B. WING _	S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	10/202 <u>1</u>
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER			00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	accordance with para and (iii) Include in the noti paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, discharge required ur made by the facility a resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indi- be endangered under this section; (B) The health of indi- be endangered, under this section; (C) The resident's he allow a more immedia under paragraph (c)(7 (D) An immediate tran required by the reside under paragraph (c)(7 (E) A resident has no days. §483.15(c)(5) Conter- notice specified in para must include the follo (i) The reason for tran	Office of the State budsman. Is for the transfer or lent's medical record in ligraph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 tts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge;	F	523			

Facility ID: 100599

If continuation sheet Page 77 of 401

PRINTED: 12/08/2021

	-	ND HUMAN SERVICES			FORM APPROVED
CENTER	RS FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF F	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
	W POST-ACUTE AND R	EHABILITATION CENTER	20	0 NURSING HOME LANE	
			P	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 623	transferred or discha (iv) A statement of the including the name, and telephone number receives such request to obtain an appeal completing the form hearing request; (v) The name, addrest telephone number of Long-Term Care On (vi) For nursing facil and developmental disabilities, the mailing telephone number of the protection and and developmental disabilities, the mailing disorder or related of email address and the agency responsible advocacy of individu established under the for Mentally III Individu §483.15(c)(6) Chang If the information in effecting the transfer must update the reco as practicable once becomes available. §483.15(c)(8) Notice In the case of facility	arged; ne resident's appeal rights, address (mailing and email), per of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State abudsman; ity residents with intellectual disabilities or related ing and email address and of the agency responsible for dvocacy of individuals with polities established under Part and Disabilities Assistance at of 2000 (Pub. L. 106-402, 5. 15001 et seq.); and lity residents with a mental lisabilities, the mailing and elephone number of the for the protection and als with a mental disorder are Protection and Advocacy duals Act.	F 623		

If continuation sheet Page 78 of 401

PRINTED: 12/08/2021

		E & MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIEF	2	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AN	D REHABILITATION CENTER		0 NURSING HOME LANE	
			PII	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 623	Continued From	page 78	F 623		
		n prior to the impending closure			
		ey Agency, the Office of the			
	State Long-Term	Care Ombudsman, residents of			
		ne resident representatives, as			
		or the transfer and adequate			
		residents, as required at §			
		ENT is not met as evidenced			
	by: Based on intervi	ew, record review, and review of			
		ies, it was determined the facility			
	· · ·	one (1) of fifty-seven (57)			
		ts (Resident #82) with a written			
	discharge notice.				
	0 00/00/000/				
		Resident #82 was transferred to tachypnea (abnormally rapid			
		8/13/2021, the hospital case			
		cumented that the facility was			
		t Resident #82 back to the			
	facility due to his	/her behavior of wandering. The			
		d the resident on 08/09/2021,			
	without issuing th	ne resident a discharge notice.			
	The findings inclu	ude:			
	Review of the fac	cility's policy "Transfer or			
		aring a Resident for" revised			
		revealed residents would be			
		nce for discharge. When a			
		eduled for transfer or discharge, ce would notify nursing services			
		discharge so that appropriate			
		be implemented. A			
		lan was developed for each			
		nis/her transfer or discharge.			
		pe reviewed with the resident,			
		mily, at least 24 hours before the			
	resident's discha	rge or transfer. Further review of			

If continuation sheet Page 79 of 401

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETE	
185256 B. WING 09/10/2	/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BECOTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)CO	(X5) COMPLETION DATE
F 623 Continued From page 79 F 623 the policy revealed nursing services was responsible for obtaining orders for the discharge or transfer, completing the discharge note in the medical record, and preparing the discharge summary and post discharge plan. Nursing services was also responsible for providing the reguired documents, including the discharge summary and post discharge sentative with required documents, including the discharge summary and plan. Review of the facility's policy "Resident Rights" dated December 2016, revealed the policy did not address resident rights concerning resident discharge. Review of Resident #82's medical record revealed the facility admitted Resident #82 on 05/12/2021, with diagnoses that included Parkinson's Disease, Alzheimer's Disease, and Unspecified Dementia with Behavioral Disturbances. Review of Resident #82's Quarterly Minimum Data Set (MDS) Assessment, dated 07/14/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BMS) score of zero (0) out of fiften (15), indicating the resident #82's was experiencing resident #82's hospital record revealed Resident #82's hospital record revealed Status Review of Resident #82's hospital record revealed freadem t	

If continuation sheet Page 80 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
F 623	Continued From pag	e 80	F 623		
	facility, the resident v to wandering behavio	vould not be readmitted due ors.			
	attempted on 08/30/2	ent #82's family member was 2021 at 1:17 PM with a n the call. However, no /ed.			
	on 09/01/2021 at 2:4 aware that she was r his/her family, or the notice. She stated sh position approximate	cial Services Director (SSD), 0 PM, revealed she was not required to send the resident, Ombudsman a discharge he was employed in this ly one (1) and a half months ned on discharge notices.			
	6:49 PM, revealed R discharge notice but SSD was responsible	ministrator, on 09/10/2021 at esident #82 did not receive a should have. She stated the e to ensure appropriate residents and responsible			
F 641 SS=D	•	nents	F 641		
	§483.20(g) Accuracy The assessment mus resident's status.	of Assessments. st accurately reflect the			
	by: Based on interview, the facility's policy, it failed to ensure the M assessment was acc	oled residents (Resident #65			

Facility ID: 100599

If continuation sheet Page 81 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AND RE	EHABILITATION CENTER			
			I	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 641	Continued From pag	e 81	F 641		
	36.6 pound, or 20.28 thirty (30) days. Furt resident developed a coccyx/sacrum while However, the facility 05/05/2021 that state sustained a weight for was present on admit completed an MDS of pressure ulcer was p Review of Resident # revealed the resident the right and left butt completed an MDS a and documented tha pressure ulcer. The findings include: Review of the policy, revised November 20 Interdisciplinary Asse Minimum Data Set (M mandated by Federa conduct the resident 1. Review of the MD Federal and State re revealed the facility r pressure ulcer was " instructions stated, "I ulcer/injury, determin was present at the tim	 b)21, the resident sustained a % weight loss in less than ther on 05/02/2021, the a deep tissue injury to the a resident at the facility. completed an MDS on ed the resident had not on the ses and the pressure ulcer tession. The facility also on 08/05/2021 that stated the resent on admission. c)23/20/2021 that stated the resent on 07/13/2021 the resident had one (1) c)20/2021 the resent the must use the MDS) form currently and State regulations to assessment". c)20/2021 the resent on M0300, nust determine whether a present on admission". The 			
		ng home. Consider current			

Facility ID: 100599

If continuation sheet Page 82 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	V POST-ACUTE AND RE	HABILITATION CENTER	2	00 NURSING HOME LANE	
			P	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 641		of tissue involvement".	F 641		
	K0300, revealed when MDS assessment for must answer whethe weight loss of five per last month or less or or more in the last six the manual, staff wer indicating yes, when physician-prescribed had experienced a w the past 30 days or 1 days, and the weight prescribed by a phys Review of Resident # revealed the facility a 03/24/2021, with diag Cerebral Infarction, D Chronic Obstructive I Paraplegia. Review of Resident 6 Data Set (MDS) asse revealed the resident two (2) staff with Acti occasionally incontin- indwelling catheter, a Further review revea	465's medical record admitted the resident on gnoses that included Dysphagia, Polyarthritis, Pulmonary Disease and 55's Admission Minimum essment, dated 03/30/202,1 t was totally dependent on vities of Daily Living, was ent of bowel, had an and had no pressure ulcers. led Resident #65 weighed no weight loss/gain or the			
	#65 was discharged for shortness of brea resident's medical re	al record revealed Resident to the hospital on 04/08/2021 th. Continued review of the cord revealed Resident #65 e facility on 4/29/2021 with			

Facility ID: 100599

If continuation sheet Page 83 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08 FORM APPR OMB NO. 0938	OVED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202	1
NAME OF P	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ETION
F 641	Acute Respiratory Fa Infection. The record documented evidence resident upon readm of an Admission/Rea for Resident #65, dar revealed the resident bilateral buttocks upon hospital, with no other noted. Review of Resident # on 04/06/2021, the re pounds (a weight los admission or 20.28% Review of a change 05/02/2021 at 10:35 had developed a dee purple or maroon loc intact skin or blood-fi underlying soft tissue shear) to the coccyx. was obtained to "cleat water, pat dry, apply border gauze every of Continued review of revealed on 05/04/20 135 pounds, another in one month and 24 However, review of F MDS assessment, dat the facility document	ded Sepsis, Pneumonia, ailure, and Urinary Tract d revealed the was no e the facility weighed the ission to the facility. Review dmission Nursing Evaluation ted 04/29/2021 at 6:00 PM, t had "scratches" to his/her on readmission from the er impaired skin integrity 465's weight record revealed esident weighed 142.7 s of 36.6 pounds since o loss). of condition form, dated AM, revealed Resident #65 ep tissue injury (DTI is a alized area of discolored lled blister due to damage of e from pressure and/or A new physician's order an coccyx with soap and zinc oxide and cover with day". Resident #65's weight record 021, the resident weighed 7.7 pound weight loss (5.4% .58% in less than 180 days). Resident #65's Quarterly ated 05/05/2021, revealed ed the resident's pressure on admission and the	F 641			

Facility ID: 100599

If continuation sheet Page 84 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		NURSING HOME LANE EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 641	Review of Resident # assessment, dated 0 facility identified the f weight loss. Howeve document that Resid present upon admiss Interview with MDS N 4:55 PM, revealed sh Assessment Instrum guide for coding resid was responsible for of Resident #65. She s code Resident #65's was not present upon also failed to accurat March 2021 MDS reg the MDS should have the resident. 2. Review of the MD Federal and State re revealed the facility r "Current number of u ulcers/injuries at eac Review of Resident # revealed the resident on 07/06/2021 with of Metabolic Encephalo Failure, Autistic Diso Diabetes, Dysphagia Review of progress r revealed Resident #2 pressure ulcer to the left buttock. Howeve #323's Admission MI	 #65's Quarterly MDS 08/05/2021, revealed the resident had sustained a er, the facility continued to dent #65's pressure ulcer was sion to the facility. Nurse #1, on 09/10/2021 at he utilized the Resident ent (RAI) MDS manual as a ident MDS assessments and completing Section M for stated she failed to accurately a pressure ulcer because it on admission. She stated she tely code Resident #65's garding weight loss, stating re reflected a weight loss for OS Manual, mandated by egulation, Section M0300, must answer the question, unhealed pressure ch stage". #323's medical record it was admitted by the facility diagnoses that included opathy, Acute Respiratory 	F 641		

Facility ID: 100599

If continuation sheet Page 85 of 401

CENTER	S FOR MEDICARE	E & MEDICAID SERVICES			DMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	<u></u>
			. 200 M	NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND	OREHABILITATION CENTER	PIKE	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 641	Continued From p	page 85	F 641		
	- 1	that the resident had one (1)			
		pressure ulcer/injuries.			
		MDS Nurse #1, on 08/09/2021			
		aled she utilized the Resident ument (RAI) manual for coding			
		assessments. She revealed that			
		ble for completing Section M for			
	· ·	She stated that she overlooked			
	and failed to accu	rately code the resident's			
	pressure ulcers o	n the Admission MDS.			
		Assistant Director of			
		irector of Nursing (ADON/DON),			
		9:50 PM, revealed she had t the facility for approximately			
		s placed in the interim DON			
		eeks ago, when the Director of			
		signed from the facility. The			
	ADON/Interim DC	N stated MDS assessments			
	should be comple	ted accurately to ensure			
		d care they required. She stated			
		onitored any clinical processes			
		uding assessments because she staff nurse "all the time."			
	Interview with the	Administrator on 08/11/2021 of			
		Administrator, on 08/11/2021 at d she was responsible for the			
		vithin the regulatory guidelines			
	• •	assessments should be			
	accurate. Howev	er, according to the			
		e had had no systems in place			
		cy of assessments.			
F 655 SS=J	Baseline Care Pla CFR(s): 483.21(a		F 655		
	§483.21 Compret Planning	nensive Person-Centered Care			

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 1 FORM AI OMB NO. 0	PPROVED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SUF COMPLET	RVEY
		185256	B. WING		09/10/	202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	N POST-ACUTE AND RE	EHABILITATION CENTER		IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 655	 §483.21(a) Baseline §483.21(a)(1) The faimplement a baseline that includes the instemation of the section of the baseline care plation of the baseline care care plan if the comprehensive care plan if the comprehensive care plan if the comprehensive care care plan if the comprehensive care plan if the care plan plan plan plan plan plan plan plan	Care Plans cility must develop and e care plan for each resident ructions needed to provide -centered care of the resident al standards of quality care. an must- in 48 hours of a resident's mum healthcare information y care for a resident ited to- d on admission orders.	F 655			

Facility ID: 100599

If continuation sheet Page 87 of 401

CENTER	S FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-03	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
			20	0 NURSING HOME LANE		
PARKVIE	V POST-ACUTE AND	REHABILITATION CENTER	PI	KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIC	
F 655	Continued From p	bade 87	F 655			
		-	1 000			
		nformation based on the details				
	of the comprehen	sive care plan, as necessary.				
	This REQUIREM	ENT is not met as evidenced				
H fa to b ir	by:					
	Based on intervie	ew, record review, and review of				
	facility policy, it w	as determined the facility failed				
	to have an effectiv	ve system in place to ensure				
		ns were developed with				
		ninimum healthcare information				
		vide effective person-centered				
		provide a summary of the				
		tments to be provided by the				
		of fifty-seven (57) sampled				
		nt #321 and #323).				
		as admitted to the facility on				
		liagnoses of diabetes,				
		vasive bladder cancer. The				
		evelop a baseline care plan				
		dent's diabetes diagnosis and				
		resident's blood sugar.				
		e facility failed to monitor the				
		ugar to ensure the resident's				
		stable. At approximately 12:00				
		on 07/19/20201, a laboratory				
		Resident #321 unresponsive.				
		od sugar was 32. Staff				
		cagon again and attempted oral				
	-	ident began having trouble				
		IS was notified. The resident				
		o the hospital where he/she was				
	diagnosed with ad	cute metabolic Encephalopathy				
		oglycemia and hypoxia. The				
	record stated ther	e was also some concern for				
	aspiration due to	attempted administration of oral				
		ident #321 was non-responsive,				

Facility ID: 100599

If continuation sheet Page 88 of 401

		ND HUMAN SERVICES			FORM APPROVED
STATEMENT O	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF PI	ROVIDER OR SUPPLIER	185256	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>
PARKVIEW	V POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 655	intubation. Resident #323 was a 07/06/2021 following Respiratory Failure. family, the resident r resident with breathi to develop a baselin related to the resided failure and failed to p care to be provided party. Subsequently the resident received 07/14/2021, eight (8 failed to monitor/ass respiratory status. C #323's family visited having difficulty breat resident be transferr #323 was admitted to that included Dyspire Respiratory Insufficient cannula with Vapoth Lower Lobe Pneumon Elevated Lactate. R upon admission to the the resident had mile accessory muscle for respiratory effort and The facility's failure to place to ensure based developed and imple likely to cause serioor death to a resident. identified, on 08/11/2 exist on 03/06/2021,	admitted to the facility on a hospital admission for According to the resident's equired BiPAP to assist the ng at night. The facility failed e care plan for Resident #323 nt's history of respiratory provide a summary of the to the resident's responsible r, the facility failed to ensure d a BiPAP machine until) days after admission and ess Resident #323's On 07/20/2021, Resident and found the resident was thing. They requested the ed to the hospital. Resident o the hospital with diagnoses ea, Stridor, Acute Hypoxic ency requiring high flow nasal erm (high flow oxygen), Left onia versus Atelectasis, and eview of the nurses notes ne emergency room revealed d wheezes bilateral, use of r breathing, increased	F 655		

Facility ID: 100599

If continuation sheet Page 89 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 655	Continued From pag	e 89	F 655		
		R 483.12 Comprehensive			
	Person-Centered Ca	re Plans (F655) (F656), 42			
	-	of Care (F684) (F686)			
		45 Pharmacy Services 483.80 Infection Control			
	· · ·	as notified of Immediate			
	Jeopardy on 08/11/2				
	An acceptable Allegation of Compliance (AOC)				
		03/2021, which alleged			
	removal of the Imme				
		er, the AOC could not be			
		servations, staff interviews, documentation. Additional			
		was identified at 42 CFR			
		ices (F725), 42 CFR 483.70			
		6) (F837), 42 CFR 483.75			
	Quality Assurance ar				
		. The facility was notified of			
		ardy on 09/10/2021. The			
	Immediate Jeopardy	is ongoing.			
	The findings include:				
	Review of a facility p	-			
		ed December 2016, revealed			
		to meet the resident's			
		uld be developed within of the resident's admission.			
	,	led the Interdisciplinary Team			
		ent a baseline care plan to			
		mmediate care needs,			
		ted to, initial goals based on			
	-	nysician orders, dietary			
	orders, therapy servi				
		ning, and Resident Review			
	, , , , ,	cy stated resident and their I be provided a summary of			
		in that included, but not			

Facility ID: 100599

If continuation sheet Page 90 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AND RI	EHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 655	Continued From pag	e 90	F 655		
		oals of the resident, a lent's medications and			
	dietary instructions, a to be administered b	any services and treatments y the facility, and any based on the details of the			
	revealed the facility a	nt #321's medical record admitted the resident on noses of Urosepis, Diabetes e Bladder Cancer.			
	assessment, dated 0 facility assessed the Interview for Mental	Minimum Data Set (MDS) 7/19/2021, revealed the resident to have a Brief Status (BIMS) score of teen (15), indicating the rely intact.			
	hypoglycemia (low b hyperglycemia (high times daily) for diabe complete finger stick Further review revea	an order to monitor gns and symptoms of lood sugar) and blood sugar) every shift (two tic monitoring, and may per required need (PRN). led staff were required to f the resident's blood glucose 70) or greater than			
	dated 07/16/2021, re documented evidenc Diabetes Mellitus, ar interventions in place	e to identify the resident had			

Facility ID: 100599

If continuation sheet Page 91 of 401

		ND HUMAN SERVICES MEDICAID SERVICES				12/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SU COMPLE	
		185256	B. WING		09/10)/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		00 NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) COMPLETION DATE
F 655	on 07/28/2021 at 6:5 assigned to care for 07/16/2021, when th the facility. She state the resident for a few completed the admiss care of the resident at day shift nurses com and she did not know process or developm plan. Interview with LPN # AM, revealed she pro on 07/16/2021 and 0 shift (7:00 AM to 7:00 admission paperworf admitting nurse was the baseline care pla care plan should incl Diabetes; however, to that information on th Review of nursing no 3:20 PM, revealed at LPN #6 obtained a b #321 of 67 mg/dL, th resident and obtaine (exact time unknown review revealed Res arrive at approximate Interview with Family at 5:30 PM, revealed 10:45 AM on 07/18/2 She stated Resident talking to her as norr	ed Practical Nurse (LPN) #2, 2 AM, revealed she was Resident #321 at 3:00 AM on e resident was admitted to ed she only provided care for 7 hours then LPN #6 sion process and took over at 7:00 AM. LPN #2 stated pleted resident admissions of a lot about the admission eent of the baseline care 6, on 07/30/2021 at 11:30 ovided care to Resident #321 7/17/2021 during the day 0 PM) and completed his/her c. LPN #6 stated the responsible for completing ns She stated the baseline ude information regarding here was no place to add ne baseline care plan form. ets, dated 07/18/2021 at approximately 7:30 AM, lood glucose on Resident en delivered a tray to the d a repeat blood glucose) of 139 mg/dL. Further ident #321 had a visitor	F 655			

Facility ID: 100599

If continuation sheet Page 92 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	N POST-ACUTE AND RI	EHABILITATION CENTER			
				KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 655	Continued From pag	e 92	F 655		
	sugar had dropped to per deciliter (mg/dL) stated she left at app	o sixty-seven (67) milligram that morning. However, she proximately 3:00 PM and staff epeat blood sugar during her			
	at 2:19 PM, revealed Resident #321 on the was aware the reside that morning. She fu #321 told staff his/he repeatedly on 07/18/ 07/18/2021 when she taken staff an hour to	Wember #1, on 07/28/2021 I she had spoken with e phone on 07/18/2021 and ent's blood sugar was low urther stated that Resident er blood sugar was low 2021, and at 4:00 PM on e last spoke to him/her, it had o respond to the resident's d still not checked his/her			
	(SRNA) #1, on 08/03 she entered Residen after lunch, late after of exact time), and for non-responsive. She and the resident's blo further stated that sh resident blood sugar resident was better p evening between 6:0 Continued interview of at 11:30 AM, reveale hypoglycemic episod 07/18/2021, (could m stated when she enter was not responsive at	e stated she alerted LPN #6 bod sugar was low. She was at that time, but that the orior to shift change that 00 PM and 6:30 PM. with LPN #6, on 07/30/2021 d Resident #321 had a le late afternoon on ot recall the exact time). She ered the room, the resident and the resident's blood			
	stated she administe	ately forty (40) mg/dL. She red an injection of Glucagon ood sugar) and oral glucose.			

Facility ID: 100599

If continuation sheet Page 93 of 401

		ND HUMAN SERVICES				FORM	D: 12/08/2021 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			09/	10/2021
NAME OF P	ROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	REHABILITATION CENTER		200 NURSING HOM			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		OVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH	I CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
F 655	Continued From pag	ge 93	F 6	55			
		thought the blood sugar					
		mately one hundred and					
		/dL, but was unsure. f Resident #321's medical					
		documentation of the incident					
		mented evidence the facility					
	monitored the reside incident.	ent's blood sugar after the					
	Review of nursing n	otes, dated 07/19/2021 at					
		Registered Nurse (RN) #7					
		dent #321's room by a SRNA					
		s found to be clammy and lood glucose was obtained					
	and was thirty-two (
		igon and oral glucose, the					
		o be non-responsive and the					
		eriencing labored breathing. rsing notes, the resident was					
		ospital at 1:00 AM on					
	07/19/2021.						
	Review of emergen	cy room record, dated					
	-	ed resident #321 arrived to the					
		1:36 AM, was non-responsive					
		commands. Further review					
		4321 was intubated at 1:50 AM he hospital and admitted to					
		Jnit (ICU) with a diagnosis of					
		us, Hypoxia, and Pneumonia					
		c Encephalopathy (problem in					
		chemical imbalance in the le from hypoglycemia and					
	hypoxic respiratory						
	Interview with MDS	Coordinator #1, on					
		AM, revealed the facility					
		zed form to complete for a and the form did not ask about					

Facility ID: 100599

If continuation sheet Page 94 of 401

		ND HUMAN SERVICES					APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN			(X3) DATE COMP	SURVEY LETED
		185256	B. WING			09/	10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER	1.1		NURSING HOME LANE		
	1			PIK	EVILLE, KY 41501		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 655	specific diagnoses/c further stated that if would not be on the comprehensive care Coordinator #1 state specific resident pro baseline care plans they were not review representatives, and attention of the Direc Interview with Assist (ADON)/Acting Direc 08/11/2021 at 12:05 unsure if all nursing regarding admission She stated she was on the baseline care problems such as Di Interview with Admir 1:50 PM, revealed b reviewed with the re representative. She reviewed with the re comprehensive care Administrator stated Diabetes should be plan and implemente admitting nurse. 2. Review of Reside revealed the residem on 07/06/2021 after failure. The residem Metabolic Encephale Failure, Autistic Disc	onditions like Diabetes. She a resident was a Diabetic, it care plan until the plan was developed. MDS ed, she had identified that blems were not listed on and had also identified that ved with residents/resident I had brought it to the ctor of Nursing (DON). cant Director of Nursing ctor of Nursing (DON), on PM, revealed she was staff had been trained as and baseline care plans. aware there was not a place plan to include resident iabetes.	F 6	55			

Facility ID: 100599

If continuation sheet Page 95 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2 FORM APPRO OMB NO. 0938-03	VED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETI	ION
F 655	revealed prior to adm Resident #323 was a Care Unit (ICU) after home. The summary diagnosis of Autism a hand sanitizer resulti Intoxication. The reside with Pneumonia and while in the ICU. Acc summary, the reside skilled nursing facility for nebulizer treatme Emergency Departm to the discharge sum were clear upon disc Review of Resident # developed by the fac 07/06/2021 at 5:19 F regarding Resident # interventions/instruct for the resident to me the resident's respira machine. According care plan was review however, a copy was Review of Resident # Data Set (MDS) asse revealed the facility i required non-invasive (BiPAP/CPAP), and o Review of Resident # address Resident #3	al Discharge Summary hission to the facility, admitted to the Intensive being found unresponsive at y stated the resident had a and drank an entire bottle of ng in severe Alcohol sident was also diagnosed had Cardiopulmonary Arrest cording to the discharge nt was discharged to the y for rehabilitation with orders nts and to return to ent if worsening. According mary, the resident's lungs tharge from the hospital. #323's baseline care plan, sility and effective on PM, revealed no information #323's care needs or tions for staff to use to care eet his/her needs regarding atory status or BiPAP to the form, the baseline yed with the resident's family; s not provided. #323's Admission Minimum essment, on 07/13/2021, dentified the resident e mechanical ventilation	F 65	5		

Facility ID: 100599

If continuation sheet Page 96 of 401

-				PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/202 <u>1</u>
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	2
DOST ACUTE AND				
FOST-ACOTE AND	Renablemention center		PIKEVILLE, KY 41501	
(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	I SHOULD BE COMPLETIC
Continued From p	bage 96	F 65	5	
-	-			
the facility provide	ed Resident #323 with a BiPAP			
	-			
to the facility, she	notified nursing staff the			
non-invasive vent	ilation via a mask, usually with			
Continued intervie	ew with the resident's family			
	-			
She stated that at	approximately 7:30 AM she			
	6			
included Dyspnea	a and Stridor. Review of the			
•				
	-			
	S FOR MEDICARE F DEFICIENCIES CORRECTION POST-ACUTE AND SUMMAR (EACH DEFIC REGULATORY Continued From p the facility). Ther the facility provide machine until date Interview with Rei 08/02/2021 at 8:5 to the facility, she resident required non-invasive vent added oxygen, ur Continued intervie revealed the facilit baseline care plan a copy. Subsequi resident did not re admission. Interview with LPI nurse assigned to She stated that at realized "somethii resident. She sta fast and using act breathing. She st breathing treatme "stayed about the revealed the resid approximately 10 the resident be set Review of Reside revealed the resid and using act breathing. She st breathing treatme "stayed about the revealed the resid approximately 10 the resident be set Review of Reside revealed the resid and using act breathing treatme	CORRECTION IDENTIFICATION NUMBER: 185256 ROVIDER OR SUPPLIER POST-ACUTE AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 96 the facility). There was no documented evidence the facility provided Resident #323 with a BiPAP machine until date 07/14/2021. Interview with Resident #323's family member, on 08/02/2021 at 8:50 AM, revealed upon admission to the facility, she notified nursing staff the resident required BiPAP (a machine that provides non-invasive ventilation via a mask, usually with added oxygen, under positive pressure) at night. Continued interview with the resident's family revealed the facility did not review the resident's baseline care plan with them, nor did they receive a copy. Subsequently, they were not aware the resident did not receive a BiPAP machine upon	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPL A BUILDING 185256 B. WING ROUDER OR SUPPLIER 185256 VPOST-ACUTE AND REHABILITATION CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX Continued From page 96 F 655 the facility). There was no documented evidence the facility provided Resident #323's family member, on 08/02/2021 at 8:50 AM, revealed upon admission to the facility, she notified nursing staff the resident required BIPAP (a machine that provides non-invasive ventilation via a mask, usually with added oxygen, under positive pressure) at night. Continued interview with the resident's family revealed the facility did not review the resident's baseline care plan with them, nor did they receive a copy. Subsequently, they were not aware the resident did not receive a BIPAP machine upon admission. Interview with LPN #3 revealed she was the nurse assigned to Resident #323, on 07/20/2021. She stated that at approximately 7:30 AM she realized "something was going on" with the resident. She stated the resident received a breathing accessory muscles to aide in breathing. She stated the resident received a breathing treatment and the resident's condition "stayed about the same". Continued interview revealed the resident #323's hospital record revealed the resident mas admitted on 07/20/2021 at 12:48 PM with	S FOR MEDICARE & MEDICAID SERVICES P DEFICIENCIES CORRECTION (x1) PROVIDER/SUPPLIERCLIA DENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING IBB256 B. WING IBB256 STREET ADDRESS, CITY, STATE, ZIP CODI 200 NURSING HOME LANE PREVILLE, KY 41501 VPOST-ACUTE AND REHABILITATION CENTER D PROFERS PLAN OF COL REACH DEFICIENCY NUST BE PRECEDED BY FULL REACH DEFICIENCY NUST BE PRECEDED BY FULL RECOLL TORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG Continued From page 96 the facility, There was no documented evidence the facility provided Resident #323' with a BIPAP machine until date 07/14/2021. F 655 Interview with Resident #323's family member, on 08/02/2021 at 8:50 AM, revealed upon admission to the facility, she notified nursing stringht. Continued Interview with the resident's family revealed the facility did not review the resident's baseline care plan with them, nor did they receive a copy. Subsequently, they were not aware the resident required BIPAP machine upon admission. F State dthe resident #323's no 07/20/2021. Interview with LPN #3 revealed she was the nurse assigned to Resident #323's no 07/20/2021. She stated the resident was breathing fast and using accessory muscles to aid in breathing. She stated the resident was breathing fast and using accessory muscles to aid in breathing. She stated the resident to visit at approximately 1:0:0:0 to 1:1:0:0 AM and requested the resident #323's hospital record revealed the resident #323's hospital record revealed the resident #323's hospital record revealed the resident the amild wheezes bilateral, use of accesory muscle, increased respiratory effort and audibe

Facility ID: 100599

If continuation sheet Page 97 of 401

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER N POST-ACUTE AND R	185256 EHABILITATION CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE NO NURSING HOME LANE PIKEVILLE, KY 41501	09/10/202 <u>1</u>
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 655	Hypoxic Respiratory flow nasal cannula v oxygen), Left Lower Atelectasis and Elev Interview with Interir on 08/11/2021 at 12 expected staff to dev baseline care plan u facility, within twenty Continued interview responsible for ensu completed, but did m #323's baseline care complete and accura DON, she was not a to complete a baseli (48) hours of a resid summary of care to representative. She care plan summary of properly, it could hav facility's failure to tim BiPAP for the reside Interview with the Ac 1:48 PM, revealed s the pertinent baselin resident care needs revealed that she wa required to complete forty-eight (48) hours provide a summary of resident/resident rep	diagnosis that included Acute Insufficiency requiring high vith Vapotherm (high flow Lobe Pneumonia versus ated Lactate. In Director of Nursing (DON), c05 PM, revealed she velop and implement a pon resident admission to the v-four (24) hours of admission. revealed she was ring baseline care plans were ot recall reviewing Resident e plan to ensure it was ate. According to the Interim ware the facility was required ne care plan within forty-eight ent's admission, or provide a the resident/resident further stated if the baseline of care was completed ve potentially identified the nely obtain wound care and nt. dministrator, on 08/10/2021 at he expected staff to develop e care plans to ensure were met. She further as not aware the facility was e a baseline care plan within s of a resident's admission, or of care to the presentative.	F 655		
F 656 SS=J	Develop/Implement CFR(s): 483.21(b)(1	Comprehensive Care Plan)	F 656		
FORM CMS-256	7(02-99) Previous Versions Of	psolete Event ID: ELK	411 Fa	cility ID: 100599 If continu	ation sheet Page 98 of 401

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/08/2021 (I APPROVED): 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN			(X3) DATE SURVEY COMPLETED	
		185256	B. WING _			09/	10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER			KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 656	implement a compret care plan for each re resident rights set for §483.10(c)(3), that in objectives and timefr medical, nursing, and needs that are identif assessment. The cor describe the following (i) The services that or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the r under §483.10, include treatment under §483. (iii) Any specialized se rehabilitative services provide as a result of recommendations. If findings of the PASA rationale in the resided (iv)In consultation wite resident's representat (A) The resident's pro- future discharge. Fact whether the resident' community was asset local contact agencies entities, for this purpor (C) Discharge plans	ensive Care Plans cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's d mental and psychosocial fied in the comprehensive mprehensive care plan must g- are to be furnished to attain ent's highest practicable l 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 ding the right to refuse 8.10(c)(6). ervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and eference and potential for cilities must document s desire to return to the ssed and any referrals to s and/or other appropriate	F6	656			

If continuation sheet Page 99 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES				FORM): 12/08/2021 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN			(X3) DATE COMP	SURVEY LETED
		185256	B. WING _			09/	10/2021
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER			NURSING HOME LANE EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	section. This REQUIREMEN by: Based on interview, the facility's policies, failed to develop a c one (1) of five (5) sa #65) who had press fifty-seven (57) sam pressure ulcers (Res to implement the can fifty-seven (57) sam who exhibited abusir residents and expos residents. The facilit care plan for one (1) residents (Resident ulcer. The facility admitted with no pressure ulc	th in paragraph (c) of this T is not met as evidenced record review, and review of it was determined the facility omprehensive care plan for mpled residents (Resident ure ulcers, and for one (1) of oled residents at risk for sident #66). The facility failed	F 6	556			
	with no pressure ulc Scale dated 03/23/2	ers. According to the Braden					

Facility ID: 100599

If continuation sheet Page 100 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/20 FORM APPROVI OMB NO. 0938-03	ED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETIO	Ņ
	Continued From pag mobility, potential for Review of the reside (MDS), also revealed pressure ulcers. Ho develop and implem plan, including meas timeframes to meet to pressure ulcers. On 05/02/2021, Res tissue injury (DTI) to staff documented the worsened and was u the pressure ulcer has measuring 16.5 cent wide. The facility co care plan to address and risk for pressure On 05/28/2021, Res had worsened and h hospital. Review of revealed the residen "smells like dead fles admitted due to "clin decubitis [pressure] infection including co abscess". Resident debridement on 05/3 was removed and ex	ge 100 r friction and shearing. ent's Minimum Data Set d the resident was at risk for wever, the facility failed to ent a comprehensive care surable objectives and the resident's risk for ident #65 developed a deep the coccyx. On 05/11/2021, e pressure ulcer had unstageable. On 05/26/2021, ad increased in size, timeters (cm) long by 10 cm intinued to fail to develop a the resident's pressure ulcer e ulcers. ident #65's pressure ulcer the resident's hospital record that a pressure ulcer that sh". The resident was incally septic with large ulcer with associated		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
	facility on 05/24/201 for pressure ulcers. developed a compre Resident #14 was at	t #14 was admitted to the 8 and assessed to be at risk On 09/10/2020, the facility chensive care plan stating that t risk for development of a o decreased mobility,				

Facility ID: 100599

If continuation sheet Page 101 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		
F 656	Peripheral Vascular comprehensive care included to follow fac prevention/treatment Observe/document/r changes in skin statu healing, signs and sy size (length x width x) Resident #14 develo and on 06/22/2021, of Resident #14 had ne Stage II (two) pressu (hip). However, the pressure ulcers wee to a wound clinic/spe photograph Residen weekly as required b Interviews with staff Residents' rooms, exp other residents and of towards other reside behaviors resulted in incidents between 08 However, the facility resident's plan of can decrease/prevent Resident's failure to The facility further fac comprehensive care interventions for Resident ulcers.	M), and a diagnosis of Disease (PVD). The plan listed interventions that cility policies/protocols for the c of skin breakdown. eport as needed (PRN) any us: appearance, color, wound (mptoms of infection, wound (mptoms of infection, wound d depth), and stage. ped abrasions to the left hip documentation revealed ew skin impairment, three (3) are ulcers the left trochanter facility failed to assess the kly, failed to refer the resident ecialist, and failed to t #14's pressure ulcers by the resident's care plan. and record review revealed red in and out of other posed himself/herself to exhibited abusive behaviors nts. Resident #82's of five (5) resident-to-resident for (5) resident-to-resident there in an attempt to esident #82's behaviors.	F 656			

If continuation sheet Page 102 of 401

		E & MEDICAID SERVICES			OMB NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/2021	
NAME OF PF	OVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	
			200	NURSING HOME LANE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		PIK	EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 656	Continued From p	page 102	F 656		
	-	as caused or is likely to cause			
		rm, impairment or death to a			
		ate Jeopardy was identified, on			
	08/11/2021, and v	was determined to exist on			
		CFR 483.10 Resident Rights			
	· /·	83.12 Freedom from Abuse			
	().	83.12 Comprehensive			
		Care Plans (F655) (F656), 42			
		lity of Care (F684) (F686)			
		83.45 Pharmacy Services R 483.80 Infection Control			
	· /	y was notified of Immediate			
	Jeopardy on 08/1	-			
		egation of Compliance (AOC)			
		09/03/2021, which alleged			
		mediate Jeopardy on vever, the AOC could not be			
		observations, staff interviews,			
		facility's documentation.			
		iate Jeopardy was identified at			
		ursing Services (F725), 42 CFR			
		ation (F835) (F837), 42 CFR			
	483.75 Quality As	ssurance and Performance			
		67). The facility was notified of			
		opardy on 09/10/2021. The			
	Immediate Jeopa	rdy is ongoing.			
	The findings inclu	de:			
		ility's policy, "Care Plans,			
		Person-Centered", revised			
		evealed the Interdisciplinary			
		njunction with the resident and			
	-	egal representative, developed			
		a comprehensive,			
	•	care plan for each resident. y stated each resident's			
		erson-centered care plan would			

Facility ID: 100599

If continuation sheet Page 103 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 656	completion of the red assessment (MDS). assessments of reside plans were revised a residents and the residents and the residents and the residents Review of the facility Injuries Policy, revise purpose of the policy for specific risk facto were required to kee hydrated, clean promin incontinence, and rejute at risk of pressure up schedule as determin Team (IDT). 1. Review of Residen revealed the facility a 03/23/2021 with diag Infarction, Dysphagia Obstructive Pulmona Review of a Braden Sore Risk form dated revealed Resident #6 ulcers with a score o chair fast, having slig adequate nutrition, fr potential problem. Review of Resident 6 (MDS) admission as revealed the residen two (2) staff with Acti	seven (7) days of the quired comprehensive According to the policy, dents were ongoing and care s information about the sidents' condition changed. 's Prevention of Pressure ed April 220, revealed the r was to provide interventions rs. The policy revealed staff p the skin clean and optly after episodes of position all residents with or cers on an individualized ned by the Interdisciplinary ht #65's medical record admitted the resident on noses that included Cerebral a, Polyarthritis, Chronic ary Disease and Paraplegia. Scale for Predicting Pressure f o3/23/2021 at 3:03 PM, 65 was "at risk" for pressure f eighteen (18), due to being ghtty limited mobility, with iction, and shearing being a	F 656	DEFICIENCY)	
	occasionally incontin indwelling catheter, a				

Facility ID: 100599

If continuation sheet Page 104 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 656	assessment. Accord 03/30/2021, Residen pressure reduction d on a turning/reposition have nutrition or hyd skin problems. Furth resident weighed 17 ⁷ loss/gain or his/her w unknown, and the re difficulty or pain whe revealed Resident # chronic disease that expectancy of less th According to the MD malnutrition or was a Review of Resident ; revealed no docume developed a compre resident with interven resident's pressure up prevent pressure up no evidence the facili malnutrition/malnutri address the risk. Review of Resident ; the resident weighed admission to the faci 04/06/2021 (36.6 po Review of the medic evidence the facility addressed Resident interventions to prev	ased on a formal ent (Braden) and clinical ling to the MDS dated at #65 did not have a evice for the chair; was not oning program, and did not ration intervention to manage her review revealed the 9 pounds and had no weight veight loss/gain history was sident had complaints of n swallowing. Further review 65 did not have a condition or may result in a life han six (6) months. S, Resident #65 had tt risk for malnutrition. #65's medical record nted evidence the facility hensive care plan for the htions to address the licer risk in an attempt to ers. Further review revealed ity addressed the resident's tion risk with interventions to #65's weight record revealed 179.3 pounds upon lity and 142.7 pounds on und weight loss). al record revealed no developed a care plan that #65's weight loss, with ent further weight loss. scharged to the hospital on	F 656		

Facility ID: 100599

If continuation sheet Page 105 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	N POST-ACUTE AND R	EHABILITATION CENTER	2	00 NURSING HOME LANE	
			P	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 656	Continued From pag	e 105	F 656		
	#65 was re-admitted with diagnoses that if Acute Respiratory Fa Infection. The record resident was weigher facility. Review of the Situati Assessment and Re- Communication form PM revealed Reside tissue injury (DTI) to or maroon localized or blood-filled blister soft tissue from pres coccyx. Interview wi (LPN) #4 on 08/25/2 identified the deep ti coccyx/sacrum area was reddened and re size of a quarter. He documented evidence	al record revealed Resident to the facility on 04/29/2021 ncluded Sepsis, Pneumonia, ailure and Urinary Tract revealed no evidence the d upon admission to the on, Background, commendation (SBAR) a dated 05/02/2021 at 5:29 nt #65 developed a deep the coccyx (a DTI is a purple area of discolored intact skin due to damage of underlying sure and/or shear) to the th Licensed Practical Nurse 021 at 4:00 PM revealed she ssue injury to Resident #65's She stated that the area bund and approximately the owever, there was no ce the facility developed a the resident's pressure			
	obtained a weight fo of 135 pounds. Rev Collection revealed t Dietitian assessed th and documented the 5.4% in 30 days and Registered Dietitian fortified foods three (frozen cup at dinner. Data Collection asse	al record revealed the facility r Resident #65 on 05/04/2021 iew of a Nutrition Data he facility's Registered he resident for the first time resident's weight was down 24.7% in 60 days. The recommended adding (3) times a day and to add a According to the Nutrition heresident the resident had elated to weight loss. Again,			

Facility ID: 100599

If continuation sheet Page 106 of 401

			FORM APPROVED OMB NO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	EVENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER		REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
 F 656 Continued From page 106 there was no documented evidence the facility developed a care plan to address the resident's weight loss, nor the resident's risk for further weight loss. Review of Resident #65's Quarterly MDS assessment dated 05/05/2021 revealed the facility documented the resident weighed 135 pounds. According to the assessment the resident had not lost any weight, but had malnutrition or was at risk for malnutrition. In addition, the facility documented the resident had an unhealed pressure ulcer, a deep tissue injury and was at risk for developing pressure ulcers. According to the assessment, Resident #65 had a pressure reducing device for the chair and bed and received pressure ulcer care. However, there was no documented evidence the facility developed a comprehensive care plan after the MDS assessment with interventions to guide staff on the care needs of the resident. Review of a Head to Toe Weekly Skin Check for Resident #65 dated 05/08/2021 at 3:38 PM, revealed the resident's suspected deep tissue injury measured 6.5 centimeters (cm) in length by 9.3 cm wide, with no depth. Review of a Change of Condition form on 05/11/2021 at 2:40 PM revealed Resident #65's pressure ulcer to the resident's coccyx was "worsening". The deep tissue injury was now an unstageable pressure ulcer (full thickness tissue loss (death) in which the base of the ulcer is covered by slough (yellow, tan, green or brown) and/or eschar (tan, brown, or black) in the wound bed) that measured 6.5 cm long and 9.7 cm wide. 	F 656		

Facility ID: 100599

If continuation sheet Page 107 of 401

	-				FORM APPROVED
STATEMENT	S FOR MEDICARE 8 OF DEFICIENCIES F CORRECTION	X MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		185256	B. WING	IN/	09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND F	REHABILITATION CENTER		00 NURSING HOME LANE IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 656	Resident #65, revea at 3:17 PM, the uns resident's coccyx ha long by 10 cm wide Record review reve documented eviden comprehensive care #65's pressure ulce worsening. Review of the Nutrit 05/18/2021 at 10:46 weighed 142.6 pour weight loss of 3% in days. Continued review o Weekly Skin Check pressure ulcer to th sacrum and measur cm in width. Contin Weekly Skin Check PM revealed the res sacrum increased in long and 17.7 cm w Review of a Change 05/28/2021 at 3:54 had a "worsening w revealed the physic and laboratory testi of condition form, "N decided to send res evaluation and treat area."	aled the next day, 05/12/2021 tageable pressure ulcer to the ad increased in size to 10 cm aled there was no ice the facility developed a e plan to address Resident r with interventions to prevent ion Progress Note on 6 PM revealed Resident #65 nds, which was a significant of 7 days and 20.5% in 90 f Resident #65's Head to Toe s revealed on 05/19/2021, the e coccyx now included the red 9.5 cm in length and 10 nued review of the Head to Toe s dated 05/26/2021 at 5:37 sident's pressure ulcer to the n size, measuring 16.5 cm	F 656		

If continuation sheet Page 108 of 401

PRINTED: 12/08/2021

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	03/10/2021
PARKVIEW POST-ACUTE AND REHABILITATION CENTER) NURSING HOME LANE	
PARKVIE	V POST-ACUTE AND R	EHABILITATION CENTER		KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 656	05/28/2021. Review 05/28/2021 at 9:24 I was "clinically septic [pressure] ulcer with including cellulitis and abscess". The reco "smells like dead flee Review of Resident Department (ED) nut at 5:36 PM revealed decubitus (pressure cm with central skin necrosis, the wound with mild purulent du of the wound picture AM revealed the resider 05/30/2021, per oper tissues were remove to the bone. Intraop grew gram-negative ESBL". Interview with Surge PM revealed Resider (4) pressure ulcer to the slough, necrotic pressure ulcer on 05 surgeon stated failu improper nutrition and could contribute to p	v of a Progress Note dated PM revealed Resident #65 c with large decubitus associated infection ad possible developing rd stated the pressure ulcer sh". #65's Emergency urse's notes dated 05/28/2021 I the resident had a "large) ulcer proximally 15 cm by 8 sloughing and underlying I has surrounding erythema rainage to bandage". Review es dated 05/29/2021 at 5:40 sident's sacrum was black es. The pressure ulcer ag by 15 cm wide. Review of se Consult on 06/01/2021 at "underwent debridement on erative note, all necrotic ed and the excision was down berative specimen culture a rods/Proteus mirabilis eon #1 on 08/31/2021 at 1:30 ent #65 had a large stage IV of the sacrum. He debrided and non-viable tissue in the 5/30/2021 to bone depth. The re to turn and reposition, and an improper mattress pressure ulcers and the yound. Surgeon #1 stated, y" in the	F 656		

Facility ID: 100599

If continuation sheet Page 109 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
STATEMENT	S FOR MEDICARE 8 OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 656	Continued review of record revealed the the facility on 06/09/ Resident #65's med documented eviden comprehensive care 06/16/2021. The far had a stage IV (4) p over two (2) months developed. Further 06/21/2021, over tw resident sustained a facility identified the weight concerns and related to a history of Interview with Minim on 08/27/2021 at 11 responsible for initia residents were adm responsible for and She revealed Resid comprehensive care according to the Res (RAI) that the facility practice. She stated was utilized to provi should have been in Resident #65's need Resident #65's need Resident #65's com likely not completed person completing M plans in May 2021. facility did not have new and/or worsenii loss, etc. Therefore	Resident #65's medical resident was readmitted to 2021. Further review of ical record revealed no ce the facility developed a e plan for the resident until cility identified the resident ressure ulcer to the sacrum, after the pressure ulcer review revealed on o (2) months after the a significant weight loss, the resident had a potential for d/or at risk for malnutrition	F 656		

Facility ID: 100599

If continuation sheet Page 110 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	03/10/2021
		EHABILITATION CENTER	2	00 NURSING HOME LANE	
PARAVIEN	WPOST-ACUTE AND R	ERABILITATION CENTER	P	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 656	Continued From pag	ge 110	F 656		
		dministrator on 09/03/2021 at			
		he expected nursing staff to			
	perform skin assess				
		y. She stated she had not			
		y wound assessments were			
		l until immediate jeopardy			
		stated the Interdisciplinary d comprehensive care plans			
		ey were up to date and			
		stated she began reviewing			
	-	ine 2021 and identified that			
	-	updated and implemented			
	appropriately.				
		ent #14's medical record			
		nt was admitted to the facility			
		was readmitted to the facility			
		diagnoses of Type II Diabetes			
		c Polyneuropathy, Stage III ease, Peripheral Vascular			
	Disease, and a Hist				
	Review of a compre	hensive care plan dated			
	09/10/2020 revealed	d Resident #14 had the			
		e ulcer development related			
		ty, Diabetes Mellitus (DM),			
		Peripheral Vascular Disease			
		developed interventions to			
		y policies/protocols for the t of skin breakdown; and			
		report as needed (PRN) any			
		us, appearance, color, wound			
		ymptoms of infection, wound			
		X depth), and stage.			
	Review of Head to T	oe Weekly Skin Checks			
		evealed Resident #14 had			
		ion to his/her left hip and			
	received barrier crea	am. There was no evidence			
	that measurements	or an assessment (color,			

Facility ID: 100599

If continuation sheet Page 111 of 401

	-	AND HUMAN SERVICES			PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER		B. WING	-ETNIZ	09/10/202 <u>1</u>	
			ET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	N POST-ACUTE AND	REHABILITATION CENTER		IURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 656	Continued From p	page 111	F 656		
	•	ic) of the area was completed as required by the resident's			
	Checks dated 05/ 06/07/2021, 06/14 revealed Residen abrasion to his/he	of a Head to Toe Weekly Skin 24/2021 and 05/31/2021, 4/2021, and 06/21/2021 t #14 continued to have an er left hip; however, there was no ence the appearance of the area			
	dated 06/22/2021 developed three (the left trochanter measured as follo centimeters (cm) (2) was 1.4 cm x 2 1 cm x 1 cm. How of the wound's co	I to Toe Weekly Skin Check , revealed Resident #14 3) Stage II (two) pressure ulcers (hip). The pressure ulcers ws: wound one (1) was 1.4 long by 1.4 cm wide, wound two 2 cm, and wound three (3) was wever, there was no description lor, whether odor or drainage as required by the resident's			
	Check forms date 07/19/2021, revea document Reside impairment/press However, there w facility assessed t	a Weekly Head to Toe Skin ed 07/05/2021, 07/12/2021, and aled the facility continued to nt #14 had skin ure ulcers to the left hip. as no documented evidence the the pressure ulcer's size, color, drainage was present.			
	Plan dated 07/23/ revised the reside Stage II Pressure the new physician	nt #14's Comprehensive Care /2021, revealed the facility ent's care plan to include the Injury (ulcer) to the left hip and orders. Review of ealed the facility was required to			

If continuation sheet Page 112 of 401

<u>CENTER</u>	S FOR MEDICARE	E & MEDICAID SERVICES			FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING	-EINZ	09/10/202 <u>1</u>	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 656	arrange for evalua as needed; encou when up in chair, to lift weight from avoid prolonged s encourage the us off affected area; status progression notify MD and fan follow up weekly a head to toe skin a needed; weekly p wounds-refer to s locations; and ma Clinic to screen, e	bage 112 ation at outpatient wound clinic irage frequent position changes if possible; encourage resident side to side while up in chair; sitting; limit time out of bed; e pillows to help with positioning measure and monitor wound n or deterioration every week; hily of changes; wound care to and as needed; nurse to perform assessment weekly and as hoto and measurement of kin assessment for specific by consult with Wound Physician evaluate, and treat as indicated; as needed/as prescribed per	F 656		
	medical record re evidence the facil ulcer's size, color present; took wee Wound Clinic/Phy physician and/or in plan. Review of Reside Skin Check dated resident had one (the three areas the measured 4.0 cm deep to the left hi Weekly Head to T 08/02/2021, 08/11 08/24/2021 reveal	ed review of Resident #14's vealed no documented ity assessed the pressure , nor whether odor/drainage was ekly photos, nor consulted with a vsician as ordered by the required by the resident's care nt #14's Weekly Head to Toe 07/26/2021 revealed the (1) Stage II (2) pressure ulcer became one pressure ulcer) that long by 4.5 cm wide by 0.5 cm p. Further review revealed a foe Skin Check dated 1/2021, 08/23/2021, and led the facility documented the d to have a Stage II (2) to the			

Facility ID: 100599

If continuation sheet Page 113 of 401

		ND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	V POST-ACUTE AND R	EHABILITATION CENTER	2	00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 656	on 08/27/2021 at 10 measure Resident # told the wound nurs wound measuremen really don't know wh the wounds. We ha she is going to do tr day." Interview with Regis 08/27/2021 at 8:30 #4) was responsible measurements/asse was told she would measurements and hired." Interview with RN # 08/25/2021 at 8:30 Physician #1/Medic 07/23/2021 at 8:30 Physician #1/Medic 07/23/2021 at 8:30 Physician #1/Medic 07/23/2021 at 8:30 Som the would of not to consult the clip pressure ulcer. She not been taken of R According to the RN supposed to purcha Administrator had n she worked the floo than performing her She stated she thou performing weekly s measurements whe stated she had not n	blan. sed Practical Nurse (LPN) #5 0:45 AM revealed she "tried" to 414's pressure ulcer, but was e was responsible for weekly nts. LPN #5 stated, "So, I no is responsible to measure to ask the wound nurse if eatments or not on any given stered Nurse (RN) #3 on PM the wound care nurse (RN e for completing weekly wound essments. RN #3 stated, "I be doing the wound wound care when I was	F 656		

If continuation sheet Page 114 of 401

	-	AND HUMAN SERVICES			PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185256		B. WING	09/10/202 <u>1</u>	
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIC
F 656	5:02 PM revealed perform skin asses assessments wee identified that wee not being perform was identified. 3. Review of the r facility admitted R diagnoses, which with behavioral di Disease. Review of Reside Set (MDS) assess revealed the facili have a BIMS scor indicating he/she Continued review had assessed the behaviors directed care/wandered, o the assessment p Review of Reside revealed staff iden was cognitively in Interventions implied included; staff to a monitor side effect	Administrator on 09/03/2021 at I she expected nursing staff to essments and wound ekly. She stated she had not ekly wound assessments were hed until immediate jeopardy medical record revealed the Resident #82 on 05/12/2021 with included Unspecified Dementia sturbances and Parkinson's ent 82's Quarterly Minimum Data sment, dated 07/14/2021, ity had assessed the resident to re of zero (00) out of fifteen (15), was not interviewable. of the MDS revealed the facility e resident to have physical d towards others, rejected ne (1) to three (3) days during	F 656		
	him/her. Review of Reside Plan, dated 05/20 he/she had behav	ns, cue/reorient and supervise ent #82's Comprehensive Care 0/2021, revealed staff identified vior symptoms that were not ch as: agitation, wandering, and			

Facility ID: 100599

If continuation sheet Page 115 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		VORSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
F 656	According to his/her into other residents urinated. Further rev interventions develo to approach him/her discover reason for needs or toileting, ar review medications consults and send to Continued review of indicated staff revise on 06/16/2021 with ask him/her yes/no or routine consistent/pr monitor/document/re his/her cognitive fun The care plan review revision to Resident 07/14/2021, when in staff to check for toil hunger. Review of Resident revealed on 05/21/2 05/22/2021 at 3:29 / in/out of other reside "becoming verbally a Interview with Regis 07/30/2021 at 9:50 / documented in Resi	Illy/verbally abusive to others. care plan, he/she wandered rooms and sometimes view of the care plan revealed ped on 05/20/2021 included calmly/quietly, attempt to behavior such as pain, wants, dminister medications and as needed, psychiatric o hospital as needed. Resident #82's care plan ed his/her Dementia care plan the following interventions: questions, keep the resident's rovide consistent caregivers, eport as needed changes in ction. w revealed the only other #82's care plan was on herventions were added for eting needs, thirsts and #82's medical record 021 at 10:20 AM and on AM, he/she was wandering ent's rooms and was abusive with other residents."	F 656		
	abusive with other re was wandering in ot and argue back" with were asking Resider	hin/her being verbany esidents. She stated he/she hers rooms and would "yell h the other residents, as they nt #82 to exit their personal nowledged the staff failed to			

Facility ID: 100599

If continuation sheet Page 116 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 656	implement the resider to determine the cau behavioral symptoms Review of an incident 8:02 AM, revealed R reported to staff anot his/her bathroom wh When Resident #322 other resident, he/sh arm and caused a 1 tear to his/her arm. Interview with Regist 07/30/2021 at 9:50 A the incident report for resident reported Re his/her bathroom, an remove Resident #82 Resident #82 grabbe skin tear. Further review of Re Monitoring, for May 2 documented evidence exhibited abuse to R Review of Resident # incident reported dat 1:10 PM, staff heard staff "ran toward the Resident #64's room hand "around" Resid wrist. The incident re	ent's plan of care and attempt use of the resident's s. at report, dated 05/18/2021 at the resident #82 Resident #322 ther resident wandered into ile he/she was "in there". 2 attempted to remove the re "grabbed" Resident #322's centimeter (cm) by 1 cm skin tered Nurse (RN) #1, on M, revealed she completed or Resident #322 when the esident #82 wandered into ad when he/she attempted to 2 from his/her bathroom ed his/her arm and caused a sident #82's MAR/Behavior 2021, revealed no ce the resident wandered or	F 656		

If continuation sheet Page 117 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 656	his/her record, Resid the hospital for an "o PM on 06/04/2021. It the hospital the follow report indicated Resi increased level of su checks for 7 hours, e hours, and every hou approximately thirty-o sign was placed over facility psychiatrist w Resident #82's beha According to Resider resident returned to the 6:30 AM. Even though he/she should have b supervision, docume continued to wander rooms and was diffic Further review of the on 06/05/2021, Resider front of other residen both male and female to wander into other start yelling and scre record also indicated in/out of other reside and again on 06/10/2 Interview with Regist 07/30/2021 at 9:50 A working when the inc #64 on 06/04/2021 a	dent report and review of lent #82 was transferred to vernight" evaluation at 8:25 When he/she returned from wing day (06/05/2021) the dent #82 was placed on an pervision; every 15 minute every 30 minutes for 12 ur for 12 hours (for one (31) hours and a stop r Resident #64's door and the as ordered to evaluate viors. ht #82's medical record, the the facility on 06/05/2021 at gh the report indicated been on an increased level of ntation indicated he/she in/out of other resident's ult to redirect. record revealed at 8:30 AM dent #82 was "walking in ts and trying to grab them e" and as he/she continued residents rooms and "they aming." Resident #82's he/she continued to wander nts rooms on 06/07/2021 2021. ered Nurse (RN) # 1, on M, revealed she was cident occurred with Resident nd she notified the tated even though the	F 656	DEFICIENCY)	
		red to the hospital and g day, his/her behaviors			

Facility ID: 100599

If continuation sheet Page 118 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/08/2021 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING		09/	10/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From pag continued.	e 118	F 656	3		
	06/14/2021, he/she was ervices again and have and ering/inapproprimard to redirect, talke had a history of viole According to the evaluation the evaluation the evaluation also indice the resident recomment recomment medication manager medication changes the evaluation. Review of another far 06/30/2021, revealed Resident #317's room Resident #82's D7/29/2021 at 9:30 Fat 9:50 AM there were the set of the revealuation of the revealuation of the revealuation of the revealuation of the facility on 07/08/2 interviews with Regis 07/29/2021 at 9:30 Fat 9:50 AM there were the set of the revealuation of the facility on of the revealuation of the revealuation was the revealuation of the review	luation, the resident's family a history of violence and sident would become "wild as redirect and he/she went ooms and residents were and Resident #82. The ated Resident #82's indations were "psychiatric nent." However, no were recommended during acility reported incident, dated d Resident #82 wandered into m. According to the report, asking the resident to leave sident #317 was "holding is wrist. Staff escorted his/her room, and the				

Facility ID: 100599

If continuation sheet Page 119 of 401

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED	
185256 NAME OF PROVIDER OR SUPPLIER		185256	B. WING		09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				200 NURSING HOME LANE PIKEVILLE, KY 41501		
				,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 656	Continued From pag	ge 119	F 656			
	room, looking for" hi	is/her room and he/she was ospital for evaluation and				
	Review of Resident	#82's Medication ord (MAR) dated June 2021,				
		monitoring the resident for				
		; his/her behavior monitoring				
		ented evidence staff				
		ent for his/her abusive				
	behaviors directed t	owards other residents.				
		#86's record revealed on				
		AM, Resident #86 called the				
		se Resident #82 came in				
		as exposed him/herself. d revealed the police were				
		that "95% of our residents had				
	-	e do wander". Per the record,				
		Police a resident had not				
	been exposing him/l	herself to Resident #86 or				
	others. The RN also	o documented she informed				
		#86 "has been known to				
	exaggerate."					
	Interview with Regis	stered Nurse (RN) # 1, on				
	07/30/2021 at 9:50	AM, revealed she was				
		021, when Resident #86				
		Police. The nurse stated the				
		ed to the Administrator;				
	,	ok no action to determine the nt's behaviors in an attempt to				
		aviors. The RN also stated				
	•	hitor Resident #86's ongoing				
		e the safety of others, was to				
		with an increased level of				
		er, stated the residents				
	behavior was unable because the facility	e to be properly monitored				

Facility ID: 100599

If continuation sheet Page 120 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		IKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 656	Continued From pag	je 120	F 656		
	incident report dated approximately 5:50 f wandered into Resid "picked up" the resid report, Resident #86 alarm provided by th unknown) and threw Documentation also been implemented to wandering into his/h #86 "frequently take indicated the investig #82 was abused by threw water on him/h residents room and abuse was that the f Resident #86 to kee he/she was in his/he Interview with SRNA PM, revealed Reside into other resident's their personal belong him/herself to other these behaviors had was admitted. Howe of any interventions residents from Reside his/her sleeve and a color, approximately to his/her left upper a informed the survey	water on Resident #82. indicated a stop sign had o prevent residents from er room, however Resident s it down." The incident report gation determined Resident Resident #86 because he/she her when he/she entered the steps taken to prevent further facility would encourage p his/her stop sign up when er room. A # 18, on 07/27/2021 at 10:00 ent #82 frequently wandered rooms, attempted to take			

Facility ID: 100599

If continuation sheet Page 121 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVED OMB NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 656	Continued From pag	e 121	F 65	6	
	07/27/2021 at 12:20 he/she was wanderin going in/out of other staff were not observe the cause of the resi to determine if the re- needed to use the re- of Resident #82's way was not observed to of his/her behaviors, Review of Resident if Resident #82 entere 07/31/2021 at appro- through the resident when Resident #64 a room, Resident #82 wrist. According to t was observed to his/ Interview with RN #9 and again on 08/02/2 she cared for Reside admitted to the facilit abusive behavior tow residents had been of The RN stated Resident Resident #86 has re Resident #82 would behaviors; however,	, on 07/29/2021 at 9:30 PM 2021 at 2:00 PM, revealed ent #82 since he/she was ty in May 2021, and his/her			

If continuation sheet Page 122 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER			
				PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D 475
F 656	Continued From pag	e 122	F 656		
	Review of nursing do	ocumentation on 08/01/2021			
		Resident #82 was alert, and			
		ns," approximately 10 hours dent #64 for the second time.			
		#82's MAR, dated July 2021,			
	revealed no docume	nted evidence staff nd the MAR provided no			
	documented evidence	-			
		, or he/she displayed abusive			
	behavior toward Res	ident #86 or Resident #64.			
	Interview with Minim	um Data Set (MDS) Nurse			
		12:00 PM, revealed it was			
		onsibility to ensure resident			
		lemented in the facility. The ed the facility had no process			
		are plans were implemented,			
		ted staff to ensure they were			
		ired. The MDS Nurse stated			
		ny Resident #82's care plan			
	it should have been.	nented as required, but stated			
	Interview with the AD	ON/Interim Director of			
		21 at 12:00 PM, revealed			
		hibited ongoing behaviors,			
		residents in the facility. The aff nurses were responsible			
		are plans were implemented			
		rding to the ADON, the facility			
		ace to ensure resident care			
	plans were implemer	nted as required.			
		ministrator, on 08/11/2021 at			
		ne expected nursing to			
		interventions, to prevent			
	iuitinei benaviors froi	m occurring. However, the			

Facility ID: 100599

If continuation sheet Page 123 of 401

		ND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		00/40/2024
	ROVIDER OR SUPPLIER	100200		REET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>
	to the little to			0 NURSING HOME LANE	
PARKVIEV	V POST-ACUTE AND R	EHABILITATION CENTER		KEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 656	to monitor/ensure re- implemented when I facility. 4. Record review re- Resident #66 to the diagnoses to include Dementia, and Athe without Angina Pect Review of Resident (MDS) Annual asses revealed the resider Mental Status (BIMS moderate cognitive i assessed the resider staff members for be the MDS revealed th care during the look Review of Resident 04/23/2021, reveale Living (ADL) Care P the resident required related to decreased condition, and receiv facility developed an resident was totally for repositioning and review of the resider facility identified the pressure ulcers and included following fa prevention/treatmen care plan did not inco	 she had no system in place esident care plans were behaviors occurred in the evealed the facility admitted facility on 02/15/2021 with e: Adult Failure to Thrive, rosclerotic Heart Disease oris. #66 Minimum Data Set essment dated 05/05/2021 at had a Brief Interview for 6) score of nine (9), indicating impairment. The facility had int to be total assist of two (2) ed mobility. Further review of he facility had no rejection of back period. #66 Care plan, dated d under Activities of Daily lan focus the facility identified d assistance with ADL's d mobility, multiple medical ving hospice services. The h intervention that stated the dependent upon two (2) staff d turning in bed. Further nt's care plan revealed the resident was at risk for developed interventions that acility policies/protocols for the t of skin breakdown. The clude specifics on how often d turning and repositioning. 	F 656		
	Review of Resident	#66 "Nurse Tech Information			

Facility ID: 100599

If continuation sheet Page 124 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER				
			I	PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 656	Continued From pag	e 124	F 656			
		evealed the resident required	1 000			
	assistance of two (2)	staff for bed mobility, and				
		esn't get up". There was no taff should turn/reposition				
	dated 06/02/2021 rev bedridden incontinen	#66 "Hospice Plan of Care", vealed the resident was it of bowel and bladder for				
	more than 2 years." the resident's skin wa	According to the plan of care as intact.				
	(SRNA) #5, on 06/17	Registered Nursing Assistant 7/2021 at 10:15 AM, revealed				
		d be turned ever two (2) eveloping skin breakdown."				
		e was unaware of the				
		f Resident #66's care plan or				
		are plan). When asked how				
		care the resident required, ovide details and stated, she				
		s should be turned every 2				
	hours".					
	Interview with the MI	OS Coordinator on				
		PM, revealed she was				
		loping the care plan. The				
		ated residents requiring				
		mobility needed a care plan turn and reposition every two				
		dent would be at high risk for				
	pressure ulcer develo					
	-	d Resident #66's care plan				
	and could not find the	e intervention to turn and				
	· ·	nt. The MDS Coordinator				
		for Resident #66 should have				
		ntion (turn and reposition). e Care Plan would trigger the				
		rse Aide (SRNA) care plan;				

Facility ID: 100599

If continuation sheet Page 125 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 656 F 657 SS=G	the Comprehensive (did not carry over on Interview with Directo 06/19/2021 at 12:29 should be turned and hours. She stated if repositioned, the out breakdown. The DO have turned Residen and the RN should he ensure the resident v stated she was unaw turning and reposition Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Compreh §483.21(b)(2) A com be- (i) Developed within the comprehensive at (ii) Prepared by an in includes but is not lin (A) The attending ph (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pra-	he intervention was not on Care Plan, the intervention the SRNA care plan. For of Nursing (DON) on PM revealed all residents d repositioned every two (2) residents were not come could be skin N stated the SRNA should t #66 every two (2) hours ave been observing to vas turned. She further vare of any concerns with ning residents. d Revision (i)-(iii) ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that hited to	F 656	DEFICIENCY)		
		participation of the resident presentative is determined e development of the				

Facility ID: 100599

If continuation sheet Page 126 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	N POST-ACUTE AND R	EHABILITATION CENTER		KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 657	disciplines as determ or as requested by th (iii)Reviewed and rev	e staff or professionals in nined by the resident's needs he resident. vised by the interdisciplinary essment, including both the	F 657			
	by: Based on interview, the facility policies, it failed to revise the ca fifty-seven (57) samp #65); and failed to er (57) sampled resider #27, and Resident # representative was in resident's care plan his/her care. Resident #65 develo The facility failed to r after the development address treatment for to prevent the develop Resident #1 develop	T is not met as evidenced record review, and review of t was determined the facility are plan for one (1) of oled residents (Resident nsure three (3) of fifty-seven nts (Resident #57, Resident 17) and/or the resident's nvolved in developing the and making decisions about upped five (5) pressure ulcers. revise the resident's care plan nt of each pressure ulcer to or the ulcer and interventions opment of new ulcers. ued a Stage I (one) pressure on 06/23/2021, a DTI (deep				

Facility ID: 100599

If continuation sheet Page 127 of 401

					FORM APPROVED
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND F	REHABILITATION CENTER		00 NURSING HOME LANE IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 657	unstageable pressu lower leg on 08/12/2 pressure ulcers to the The findings included 1. Review of the fa Comprehensive Per December 2016 rev residents were ongo revised as informating the residents' condi Review of the facilither Injuries Policy, revise purpose of the policy regarding identification factors and interven The policy stated the report and document skin, and review intre effectiveness on an Review of Resident revealed the facility 03/23/2021 with dia Infarction, Dysphag Obstructive Pulmon Paraplegia. Review of Resident Data Set (MDS) asso revealed the facility weighed 135 pound pressure ulcer, and Review of Resident	right heel on 06/26/2021, an re ulcer to the back of the left, 2021, and two (2) Stage II (2) he left hip on 08/26/2021. cility's policy, "Care Plans, rson-Centered", revised realed assessments of bing and care plans were on about the residents and tions changed. y's Prevention of Pressure sed April 2020, revealed the y was to provide information ion of pressure ulcer risk tions for specific risk factors. e facility should evaluate ht potential changes in the erventions and strategies for	F 657		

Facility ID: 100599

If continuation sheet Page 128 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER	- T	200 NURSING HOME LANE	
	1			PIKEVILLE, KY 41501	I
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 657	sacrum. The facility address the pressure and repositioning app hours; weekly treatm measurement of eac width, length, depth, and any other notabl encourage good nutr blood work (including any open wounds as and, follow the facility Review of a change #65 dated 06/23/202 resident had acquire ulcer to the left heel th (centimeters) (length resident's physician of protectors while in be heel daily". However evidence that the fac care plan to reflect th and no documented revised to include the bilateral heel protector Review of Resident # note dated 06/26/202 resident had acquire (DTI) pressure ulcer received a new order pressure ulcer; howe revise the care plan to	 IV (4) pressure ulcer to the developed interventions to a ulcer that included turning proximately every two (2) ent documentation to include h area of skin breakdown; type of tissue and exudate e changes or observation; ition and hydration; obtain g culture and sensitivities) of ordered by the physician; y's protocols for treatment. of condition note for Resident 1 at 10:30 AM revealed the d a new Stage one pressure that measured 6.5 cm) by 4 cm (width). The ordered, "Bilateral heel ed, apply sure prep to left r, there was no documented ility revised the resident's ne new area to the left heel, evidence the care plan was a new Physician's Orders for ors while in bed. 465's change of condition 21 at 10:10 PM revealed the d a new deep tissue injury to the right heel. The facility r for a treatment to the ever, the facility failed to to reflect the new pressure ns to address healing and 	F 65		
		Resident #65's care plan 021, the facility implemented			

Facility ID: 100599

If continuation sheet Page 129 of 401

		E & MEDICAID SERVICES		ſ	FORM APPROV MB NO. 0938-03
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIEF	2	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER					
			I	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE
F 657	Continued From	page 129	F 657		
		for the Stage IV (4) pressure			
		al area. The facility revised the			
		de interventions to administer			
		dered and monitor for			
		sess and document status of , wound bed and healing			
		improvements and declines to			
		onitor dressings every shift, and			
		sure intact and adhering; report			
		o the treatment nurse; and two			
		uired to turn and reposition the			
		every two (2) hours, more often			
		uested because the resident			
		ndent on staff. However, the to fail to revise the care plan			
	-	s to address the Stage I pressure			
		#65's left heel and the Deep			
		I) to the right heel.			
		ent #65's Quarterly MDS			
		d 08/05/2021 revealed the			
	•	the resident had a weight loss,			
		tion or was at risk. In addition, d the facility was aware the			
		Stage I (1) pressure ulcer, one			
		e ulcer, and one pressure ulcer			
	• .	able. However, there was no			
	-	lence the facility revised			
		are plan with interventions to			
		he pressure ulcers to the heels			
		ted evidence the facility			
	pressure ulcers.	entions to prevent further			
	Review of a Head	d to Toe Weekly Skin Check			
		ted 08/12/2021 at 11:52 AM, for			
		ealed the resident had			
		stageable pressure ulcer to the			
	back of his/her le	eft, lower leg. The facility			

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/0 FORM APPR OMB NO. 0938	ROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202	1
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE AND RI	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	SE COMPL	(5) LETION ATE
		,		DEFICIENCY)		
F 657	with Santyl Ointment no documented evid care plan to reflect th ulcer to Resident #68 facility revise the car prevent further press Review of a change dated 08/26/2021 at revealed the residem pressure ulcer to the physician was notifie received to treat the Continued review of revealed no docume revised the care plan developed pressure plan to prevent new Interview with MDS N 11:10 AM revealed s updating/revising car Resident #65's care regarding the resider worsening pressure According to MDS N have a system/proce and/or worsening pre-	a daily. However, there was ence the facility revised the ne new unstageable pressure 5's lower left leg, nor did the e plan with interventions to sure ulcers. of condition assessment 6:39 PM for Resident #65 t developed a Stage II (2) left hip. The resident's ed and new orders were area with sure prep. the resident's care plan inted evidence the facility not oreflect the newly ulcer nor revised the care pressure ulcers. Nurse #1 on 08/27/2021 at he was responsible for re plans. She stated	F 657			
	Interview with MDS I 10:43 AM revealed F should have been up pressure ulcers. MD facility did not have a	Nurse #2 on 08/27/2021 at Resident #65's care plan odated to reflect the resident's PS Nurse #2 also stated the a process/procedure to formation to MDS staff. She				

Facility ID: 100599

If continuation sheet Page 131 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
- E		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE NKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 657	loss and/or pressure the care plan. Interview with the Ad 5:02 PM revealed the reviewed comprehene ensure they were act stated she began rev June 2021 and ident updated appropriatel 2a). Review of the fa Plans, Comprehensive revised in December resident's comprehene plan will be consister participate in the dev implementation of his including the right to: process." Record review revea Resident #57 on 04/2 completed a Minimum Assessment dated 00 facility assessed the Interview for Mental 3 indicating no cognitive review of the residened documented evidence resident to the care p Interview on 06/16/20 Resident #57 revealed meetings at another However, the facility	aware a resident had weight ulcers she could not revise ministrator on 09/03/2021 at e Interdisciplinary Team (IDT) usive care plans weekly to curate and up-to-date. She viewing care plans in mid- ified that care plans were not y. acility's policy titled, "Care ve Person-Centered", 2016, revealed, "Each nsive person-centered care nt with the resident's right to relopment and s or her plan of care, participate in the planning led the facility admitted 23/2021. The facility m Data Set (MDS) Admission 4/29/2021 in which the resident to have a Brief Status (BIMS) sore of 15 re impairment. Further t's record revealed no the facility invited the olan meeting. 021 at 10:19 AM, with ed he/she had care plan facility where he/she lived. had not invited him/her and ded a care plan meeting	F 657			

Facility ID: 100599

If continuation sheet Page 132 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039	Ð
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			2	00 NURSING HOME LANE		
	PARKVIEW POST-ACUTE AND REHABILITATION CENTER			IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		1
F 657	Continued From pag	e 132	F 657			
	Resident #27 on 01/2 Quarterly MDS Assess revealed the facility a a BIMS score of 15, i impairment. Further record revealed no d facility invited Reside for this assessment. Interview on 06/16/20 Resident #27 reveale remember anyone ta plan of care 2c). Record review re Resident #17 on 03/2 completed an Admiss 03/21/2021, and the to have a BIMS score cognitive impairment resident's record review evidence in the progra being invited to a car Interview on 06/16/20 Resident #17 reveale a care plan meeting resident stated facilit his/her care or care p Interview with the ME 06/18/2021 at 3:50 F not had care plan meeting 2020 due to COVID- December 2020, the a BIMS of eight (8) o	ed the resident could not Iking to him/her about their evealed the facility admitted 15/2021. The facility sion MDS assessment dated facility assessed the resident e of 15, indicating no . Further review of the ealed no documented ress notes of the resident e plan meeting. 021 at 9:55 AM, with ed he/she was not sure what was and when explained, the y staff had not discussed plan with him/her.				

Facility ID: 100599

If continuation sheet Page 133 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
STATEMENT (S FOR MEDICARE 8	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER			200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE REVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 684 SS=J	did not wish to atten them, staff was required conversation in the re- Interview with the Act 1:30 PM, revealed s facility for two (2) we whether the facility we meetings. The Adm problem with not hav would be missed or Quality of Care CFR(s): 483.25 § 483.25 Quality of of Quality of care is a f applies to all treatment facility residents. Ba assessment of a ress that residents receiv accordance with pro	ing. She stated if the resident d or had someone attend for irred to document the resident's medical record. Administrator, on 06/19/2021 at he had only been at the beks and was not aware vas having care plan inistrator stated a potential ving care plan meetings unidentified problems. Care undamental principle that ent and care provided to sed on the comprehensive ident, the facility must ensure e treatment and care in fessional standards of chensive person-centered	F 657		
	This REQUIREMEN by:	T is not met as evidenced			

If continuation sheet Page 134 of 401

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		00/40/0004
				09/10/202 <u>1</u>	
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AND	REHABILITATION CENTER		NURSING HOME LANE	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETIO
F 684	Continued From pa	age 134	F 684		
	-	v, record review and review of			
		s, it was determined the facility			
		o (2) of fifty-seven (57)			
		(Resident #321 and Resident			
		atment and care in accordance			
	,	tandards of practice.			
	On the morning of	07/18/2021, before breakfast,			
		dent #321's blood glucose			
		7 mg/dL (milligrams per			
		ange 70 mg/dL to 110 mg/dL).			
		held the resident's insulin			
	-	nistered the resident an oral			
	-	ication. The nurse stated that			
		re-checked the resident's			
		I, which was then 139 mg/dL.			
	-	s no evidence the staff			
		or the resident or re-check the			
		icose level, until sometime			
	-	, sometime after 3:00 PM,			
		esident #1 unresponsive with a			
		l of 40 mg/dL. Interviews with			
		administered Resident #321			
		d oral glucose, and the resident			
		sness. However, there was no			
	-	de in the resident's medical			
	record regarding th	e resident's second episode of			
		uding staff finding the resident			
		ddition, there was no evidence			
		to monitor the resident or			
	re-check the reside	ent's blood glucose level, until			
		0 AM on 07/19/2021,when			
		found unresponsive and			
		and record review revealed			
	the resident's blood	d glucose was 32 mg/dL. Staff			
		I the resident injectable			
		glucose. Resident #321			
		nsive and developed difficulty			
		lity transferred Resident #321			

Facility ID: 100599

If continuation sheet Page 135 of 401

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 185256 B. WING 09/10/202 PARKVIEW POST-ACUTE AND REHABILITATION CENTER B. WING 09/10/202 V(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X3) DATE SURVEY COMPLETED F 684 Continued From page 135 to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit F 684		-	AND HUMAN SERVICES			FORM APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 185256 B. WING 09/10/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 09/10/202 PARKVIEW POST-ACUTE AND REHABILITATION CENTER B. WING 09/10/202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PIKEVILLE, KY 41501 09/10/202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL 0 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CONSS-REFERENCED TO THE APPROPRIATE COMPLETED F 684 Continued From page 135 to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit F 684 F 684 F	CENTERS	S FOR MEDICARE &	& MEDICAID SERVICES			OMB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE PIKEVILLE, KY 41501 (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x) COMPL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 684 Continued From page 135 to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit F 684						(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE PARKVIEW POST-ACUTE AND REHABILITATION CENTER PIKEVILLE, KY 41501 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) COMPL (EACH CORRECTIVE ACTION SHOULD SHOULD			185256	B. WING		09/10/2021
PARKVIEW POST-ACUTE AND REHABILITATION CENTER PREVILLE, KY 41501 (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 Continued From page 135 to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit F 684	NAME OF PRO	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER PREVILLE, KY 41501 (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX TAG F 684 Continued From page 135 to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit F 684						
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x COMPL DEFICIENCY) F 684 Continued From page 135 to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit F 684	PARKVIEW	V POST-ACUTE AND F	REHABILITATION CENTER			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPL DA F 684 Continued From page 135 to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit F 684 F 684 Continued From page 135 to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia F 684 F 684 F 684 F 684						
to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	
In addition, the facility admitted Resident #323 on 07/06/2021 after being on a ventilator at the hospital. At approximately 7:30 AM on 07/20/2021, a nurse aide entered the resident's room and discovered the resident was sweaty, clammy, and having difficulty breathing. Although interview with a nurse revealed she administered the resident two (2) breathing treatments, there was no evidence staff re-assessed the resident until the resident two (2) breathing treatments, there was no evidence staff re-assessed the resident until the resident's family came to visit and insisted the facility transfer the resident to the hospital. Upon Resident #323's arrival to the hospital, the resident required high flow oxygen, and was diagnosed with acute hypoxic respiratory insufficiency, and left lower lobe pneumonia versus atelectasis (lung collapse). The facility's failure to ensure residents received treatment and care in accordance with professional standards of practice, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 22 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F685) (F656), 42 CFR 483.25 Quality of Care Plans (F686) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F680). The facility was notified of Immediate Jeopardy on 08/11/2021.	tu as ##() 	to the hospital, whe acute metabolic end secondary to prolor #321 was admitted (ICU). In addition, the facil 07/06/2021 after be hospital. At approx 07/20/2021, a nurse room and discovere clammy, and having interview with a nur the resident two (2) was no evidence st until the resident's f insisted the facility thospital. Upon Resi hospital. Upon Resi hospital, the resider and was diagnosed insufficiency, and le versus atelectasis (The facility's failure treatment and care professional standa is likely to cause se or death to a reside identified, on 08/11/ exist on 03/06/2021 Rights (F580), 42 C Person-Centered C CFR 483.25 Quality (F692), 42 CFR 483 (F755) and 42 CFR (F880). The facility	re he/she was diagnosed with cephalopathy and hypoxia aged hypoglycemia. Resident to the Intensive Care Unit ity admitted Resident #323 on ing on a ventilator at the imately 7:30 AM on e aide entered the resident's ed the resident was sweaty, g difficulty breathing. Although se revealed she administered breathing treatments, there aff re-assessed the resident amily came to visit and ransfer the resident to the dent #323's arrival to the nt required high flow oxygen, with acute hypoxic respiratory off lower lobe pneumonia lung collapse). to ensure residents received in accordance with rds of practice, has caused or rious injury, harm, impairment nt. Immediate Jeopardy was 2021, and was determined to , at 42 CFR 483.10 Resident FR 483.12 Freedom from FR 483.12 Comprehensive are Plans (F655) (F656), 42 of Care (F684) (F686) 3.45 Pharmacy Services 483.80 Infection Control was notified of Immediate	F 684		

Facility ID: 100599

If continuation sheet Page 136 of 401

	-	H AND HUMAN SERVICES			PRINTED: 12/08/20 FORM APPROV
TATEMENT (S FOR MEDICAR OF DEFICIENCIES CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
	185256		B. WING	09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIEF	3	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			2	00 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AN	D REHABILITATION CENTER	P	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 684	Continued From	page 136	F 684		
		legation of Compliance (AOC)			
		09/03/2021, which alleged			
		nmediate Jeopardy on			
		vever, the AOC could not be			
	verified based on	observations, staff interviews,			
		ility documentation. Additional			
		ardy was identified at 42 CFR			
		Services (F725), 42 CFR 483.70			
		835) (F837), 42 CFR 483.75			
	-	e and Performance			
		367). The facility was notified of			
	Immediate Jeopa	eopardy on 09/10/2021. The			
		ardy is ongoing.			
	Findings include:				
	Review of the fac	cility's policy titled, "Acute			
	Condition Chang	es-Clinical Protocol", dated			
		ealed if a resident had a change			
		nursing staff would collect			
		to report to the physician, such			
		present illness and previous and			
		s for comparison. Further review,			
		se would assess, document, and			
	· ·	nformation including, vital signs, us, current pain level, level of			
		cognitive and emotional status,			
		nd severity of illness, recent			
		sychiatric disturbances, mental			
		sion, all active diagnoses, and all			
	current medicatio	ons.			
	Review of the fac	cility's policy titled, "Management			
		", dated November 2020,			
		ity had adopted a hypoglycemia			
		sified hypoglycemia as follows.			
		emia was a blood glucose level			
		but above 54 mg/dL, Level 2			
		as a blood glucose level below			

Facility ID: 100599

If continuation sheet Page 137 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08 FORM APPRO OMB NO. 0938-	OVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 ²	1
NAME OF P				TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	ETION
F 684	altered mental and/o assistance for treatm review of the protoco Level 3 hypoglycemi should call 911, adm provider immediately place resident in a co monitor vital signs. 1. Review of Resident revealed the facility a 07/16/2021, with diag Diabetes Mellitus, an Review of Resident # (MDS) assessment of the facility assessed Interview for Mental thirteen (13) indicatin cognitively intact. Review of Resident # dated 07/16/2021, re include the resident so Mellitus. Review of Physician revealed an order for #321 for signs and so (low blood sugar) an sugar) every shift. Review of Nursing N 3:20 PM, and intervie Nurse (LPN) #6 on 0 revealed at approxim 07/18/2021, LPN #6	el 3 hypoglycemia- was r physical status requiring pent of hypoglycemia. Further of revealed, if a resident had a and was unresponsive staff inister glucagon, notify the r, remain with the resident, omfortable safe place and ht #321's medical record admitted the resident on gnoses of Urosepsis, ad Invasive Bladder Cancer. #321's Minimum Data Set dated 07/19/2021, revealed the resident to have a Brief Status (BIMS) score of ag the resident was #321's Baseline Care Plan evealed the care plan did not s diagnosis of Diabetes s Orders dated 07/16/2021, r staff to monitor Resident ymptoms of hypoglycemia d hyperglycemia (high blood otes dated 07/18/2021 at ew with Licensed Practical 7/27/2021 at 4:10 PM,	F 684			

Facility ID: 100599

If continuation sheet Page 138 of 401

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			200	NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER	РІК	EVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 684	(milligrams per decil staff delivered the re- time unknown) and I glucose level after b documented as 139 no further document indicate LPN #6 con- resident's condition of levels for the resider Resident #321's Nur approximately 1:30 F called the facility and stated the Spouse w information his/her of facility visiting the re- and reporting to him the Spouse requester regarding getting the and transferred to an documented she gav information for the A Nursing (DON) and Spouse's call. Interview with Resid Member #3) on 08/0 she arrived at the fac 07/18/2021 at 10:45 #321 was awake, ale normally during the v Resident #321 told f had dropped to 67 m Family Member #3 s at approximately 3:0 member obtained th level during her visit	iter). The note further stated esident's breakfast tray (exact LPN #6 obtained a repeat reakfast which was mg/dL. However, there was ration or evidence found to tinued to monitor the or obtain further glucose nt. Continued review of rsing Note revealed at PM, Resident #321's Spouse d spoke to LPN #6. The note	F 684		

Facility ID: 100599

If continuation sheet Page 139 of 401

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		00/40/0004	
				09/10/202 <u>1</u>		
NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND I	REHABILITATION CENTER	200 PIK			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PECCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETIC	
F 684	Continued From pa	qe 139	F 684			
	-	brought Resident #321 a				
		eft it with the resident to use.				
		the phone because when the				
		call and check on the				
	· ·	's phone would frequently go				
	unanswered.	1 1 3 3				
	Interview with Resid	dent #321's Spouse on				
	07/28/2021 at 2:19	PM, revealed his/her her				
	daughter visited Re	esident #321 on 07/18/2021.				
	The Spouse stated	the daughter reported that the				
	resident's glucose v	was low that morning, the				
	facility smelled of u	rine, the resident's blanket and				
		biled from the resident's				
		tomy (bags that collected				
		the kidney) bags were leaking,				
	-	as told the facility had no				
		hcloths to give the resident.				
		voiced talking to Resident				
		one numerous times that day.				
		v revealed the resident had t he/she could tell his/her				
	-	nning low because of the way er, the resident told the				
		1:00 PM, the staff still had not				
		blood sugar since that				
		e daughter's arrival to the				
		. The Spouse confirmed				
	-	#6 on 07/18/2021 but, he/she				
		DON or Administrator because				
	the resident was se	ent to the hospital that night.				
		evealed the spouse stated at				
	approximately 4:00	PM on 07/18/2021, was the				
		oke to Resident #321. The				
	spouse stated, that	at that time, the resident				
	reported that he/sh	e had rang the call light (exact				
	time unknown) and	it had taken an hour before				
	staff answered the	light. The Spouse stated they				
	had only admitted F	Resident #321 to the facility for				

Facility ID: 100599

If continuation sheet Page 140 of 401

3 NO. 0938-03	
DATE SURVEY COMPLETED	
09/10/2021	
(X5) COMPLETIC DATE	
h	

Facility ID: 100599

If continuation sheet Page 141 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARE	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	03/10/2021
				00 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND F	REHABILITATION CENTER		IKEVILLE, KY 41501	
	1		F	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 684	Continued interview time it was nearing she gave the reside before the supper the revealed no evidence resident's hypoglyco resident's blood glu was no evidence the resident's condition remainder of her she 07/30/2021 at 11:30 was standard nursin staff found a residen resident had a hypo a resident was adm Glucagon. Howeven explain why she have occurrences for Res that it was difficult to complete document Interview with RN # revealed she was w recalled LPN reque Resident #321, due unresponsive and h 40 mg/dL. She state exact time the incid afternoon sometime and 5:00 PM. She s the resident's blood glu recall exact reading	 a could not recall exactly. a with LPN #6 revealed by that time for the supper meal, so nt an oatmeal pie to eat ays arrived. #321's medical record ce the LPN documented the emic incident or any of the cose levels. In addition, there e LPN monitored the or blood glucose levels the ift. Further interview, on 0 AM, with LPN #6 revealed it ng practice to document when an unresponsive, when a glycemic episode, and when inistered emergency r, the LPN was unable to d not documented all these sident #321. LPN #6 stated to care for all the residents and 	F 684		
F 684	139 mg/dL" but, she Continued interview time it was nearing she gave the reside before the supper the Review of Resident revealed no evidence resident's hypoglyco resident's blood glu was no evidence the resident's condition remainder of her sh 07/30/2021 at 11:30 was standard nursin staff found a resident resident was adm Glucagon. Howeven explain why she har occurrences for Res that it was difficult to complete document Interview with RN # revealed she was w recalled LPN reque Resident #321, due unresponsive and h 40 mg/dL. She state exact time the incid afternoon sometime and 5:00 PM. She s the resident a gluca began to wake up. I resident's blood glu recall exact reading the resident oral glu	 a could not recall exactly. a with LPN #6 revealed by that time for the supper meal, so nt an oatmeal pie to eat ays arrived. #321's medical record the emic incident or any of the cose levels. In addition, there is LPN monitored the or blood glucose levels the iff. Further interview, on 0 AM, with LPN #6 revealed it no practice to document when an unresponsive, when a glycemic episode, and when inistered emergency to the LPN was unable to d not documented all these sident #321. LPN #6 stated to care for all the residents and ation. 8, on 07/30/2021 at 10:54 AM, rorked on 07/18/2021, and sting her assistance with to the resident being aving a blood glucose level of ea she could not recall the ent occurred but, it was late a probably between 4:00 PM tated LPN #6 administered gon injection and the resident however, RN #8 stated the cose remained low, (unable to) and LPN #6 administered 	F 684		

Facility ID: 100599

If continuation sheet Page 142 of 401

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		09/10/2021	
		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	01104045		PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 684	Continued From	page 142	F 684		
		creased to 111 mg/dL. She d with the resident until he/she			
	•	RN #8 stated she called down to			
· ·		equested orange juice with sugar			
		the floor for the resident.			
	, ,	stated she returned to her side			
	of the unit and did delivered the juic	d not know if the kitchen e to the resident.			
r	Review of Reside	ent #321's Nursing Notes			
		/ dated 07/19/2021 at 12:23 AM,			
	-	ound the resident un-responsive			
		e documentation stated staff			
		dent's blood glucose and it was			
		dministered the resident a e resident's blood glucose came			
		The documentation then stated			
		d Resident #321 the oral			
		resident's blood glucose			
		g/dL. Continued review revealed			
		d a second glucagon injection			
		s blood glucose came up to 110 the resident remained			
	•	ad experienced labored			
		w of the Nursing Notes revealed			
	at 1:00 AM, Eme	rgency Medical Services (EMS)			
		ility and transported Resident			
		ital. Further review of the			
		evealed staff notified the that the facility had transferred			
	the resident to the	-			
	Interview with SR	RNA #4, on 07/28/2021 at 7:35			
		e worked from 6:00 PM on			
		6:00 AM on 07/19/2021, and was			
	-	for Resident #321. SRNA #4 came on shift at 6:00 PM on			
		vas told in report that the			
		glucose level had dropped to 50			

Facility ID: 100599

If continuation sheet Page 143 of 401

CENTER	S FOR MEDICARI	E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039	
TATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
	185256		B. WING		09/10/2021	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
		200 N	IURSING HOME LANE			
PARKVIE	V POST-ACUTE ANI	D REHABILITATION CENTER	PIKE	VILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTIO	
F 684	Continued From	page 143	F 684			
	remainder of day trays were late or come out of the k PM. However, SF on the resident, e and changed the supper. She state at approximately fine. SRNA #4 sta next round some laboratory technic drawing labs. SR laboratory technic found SRNA #4, f not responding. S	he day but was "good" the shift. SRNA #4 stated supper n 07/18/2021 and she did not itchen until sometime after 6:00 RNA #4 stated she had checked emptied the nephrostomy bags resident's clothes prior to ed she observed Resident #321 8:45 PM, and the resident was ated she was about to begin her time after 11:00 PM, when the cian arrived on the floor to begin NA #4 stated soon after the cian arrived, she came and to report that Resident #321 was SRNA #4 stated she found RN e went to check on Resident				
	revealed she was 7:00 PM until 07/ stated she receive #321's blood gluo the day. RN #7 st PM and 8:00 PM, light and reported sugar was low. Th resident's blood g mg/dL. However, document that sh glucose or the res record. RN #7 sta were the only stat and she was busy document. Contin the resident some	I #7 at 4:25 PM, on 07/28/2021, s working on 07/18/2021 from 19/2021 at 7:00 AM. RN #7 ed in shift report that Resident cose levels had been low during tated sometime between 7:30 , Resident #321 rang the call I he/she thought his/her blood he nurse stated she checked the glucose level, and it was 106 RN #7 stated she did not e obtained the resident's blood sult in the resident's medical ated that she and and one SRNA ff working the floor that night, y and probably forgot to nued interview revealed she took e peanut butter and crackers, stated that he/she "just felt				

Facility ID: 100599

If continuation sheet Page 144 of 401

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES		(MB NO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER		B. WING		09/10/2021	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		200 N	URSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		PIKE	VILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F 684	Continued From p	page 144	F 684		
	she returned to ch	heck on the resident. The nurse			
	stated Resident #	321 had not eaten the peanut			
	butter and cracke	rs, so she offered the resident			
		but the resident declined and			
		petter. The RN stated she did not			
	re-check the resid	dent's glucose level.			
	Continued intervie	ew with RN #7 at 4:25 PM, on			
		aled she completed her			
		and sat down to chart at			
		:45 PM-11:00 PM. RN #7 stated			
		hnician arrived on the unit. She			
		he did not look at the clock, the			
	technician usually	arrived around 12:00 AM. RN			
		d gone into another resident's			
		A #4 came in the room and told			
		1 would not wake up. She stated			
		d Resident #321's room, the			
		esponsive, and she could			
		he resident's blood glucose was resident was clammy. RN #7			
		ed the resident's blood glucose,			
		/dL. RN #7 stated she			
		ucagon injection to the resident,			
	•) minutes, and rechecked the			
		ch was then 52 mg/dL. She			
	stated the resider	nt was still not responding so			
	she attempted to	give the resident oral glucose			
	-	. RN #7 stated that she and			
		the entire floor, so she called			
		er floors to assist her and call the			
		ued interview revealed the			
		d her to administer the resident a injection and call an ambulance			
		ent to the hospital for further			
		7 stated she administered the			
		injection, while waiting for the			
	-	ive. She stated Resident #321			
		sponsive and developed agonal			

Facility ID: 100599

If continuation sheet Page 145 of 401

					FORM APPROVED
STATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF PI	ROVIDER OR SUPPLIER	185256	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 684	tried to obtain an int Resident #321, beca was going to code (i RN #7 stated when resident to the hosp was "around 67 mg/ Interview with the La on 08/02/2021 at 4:- at Resident #321's resident #321's resident would not r found the SRNA on resident was hard o SRNA accompanied room and stated the normal and went to the resident did not was present, and th the resident's blood stated she left the fa Interview with the El Physician on 07/19/ #321's ED record da resident #321 arrive 1:36 AM, was non-re follow commands. F hospital staff intubat and admitted the res Unit (ICU) with diag enough oxygen to s Metabolic Encephal failure, secondary to	or air). RN #7 stated they ravenous access (IV) on ause they thought the resident require cardiac resuscitation). EMS arrived to transport the ital, the resident's blood sugar	F 684		

Facility ID: 100599

If continuation sheet Page 146 of 401

PRINTED: 12/08/2021

		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI F	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
185256		B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200 NURSING HOME LANE			
				VIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC
F 684	Continued From p	page 146	F 684		
	Resident #321 un	responsive on the afternoon of			
		stated staff had never notified			
		ent's family was upset. The			
		ed staff should have ypoglycemic incidents in the			
		l record. In addition, the			
		ted staff should have			
	re-assessed Resi	dent #321 on 07/18/2021, after			
		od glucose level was low that			
		inued to re-assess the resident			
		cian as warranted. sident # 323's medical record			
		ity admitted the resident on			
		liagnoses that included			
		nalopathy, Acute Respiratory			
		isorder, Sepsis, Diabetes			
	Mellitus, Dysphag	jia, Pneumonia and Aphasia.			
	Review of Reside	nt #323's Admission MDS			
		d 07/13/2021, revealed the			
		the resident to have severely			
		n and rarely/never understands. sessment stated Resident #323			
		erapy and a Positive Airway			
		e (Bi-pap/C-pap). Further review			
		t #323 did not exhibit shortness			
		ertion, at rest, sitting, or when			
	lying flat.				
	Interview with SR	NA (State Registered Nurse			
		28/2021 at 11:43 AM, revealed			
		07/20/2021 at approximately			
		AM, she found Resident #323			
		and having difficulty breathing.			
		she notified Registered Nurse ange in the resident's condition,			
		ministered the resident a			
		ent. However, SRNA #14 stated			
	the resident conti	nued to have difficulty breathing,			

Facility ID: 100599

If continuation sheet Page 147 of 401

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
185256		B. WING	-FTNZ	09/10/202 <u>1</u>	
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 684	was "breathing pr she did not see R room to check on treatment was ad family came to vis AM. The SRNA's and observed the facility send the r Interview with SR PM revealed on C AM to 7:30 AM, s was having troub face was red. SR administered the however, the resi difficulty breathing that RN #6 admir treatment to the r However, SRNA continued with lal knowledge, RN # #15 stated she di in the room to ass family came in to	page 147 rried" about the resident, who retty hard". SRNA #14 stated 2N #6 go back into the resident's the resident after the breathing ministered, until the resident's sit the resident around 10:30 tated when the family arrived e resident, they insisted the esident to the hospital. 2NA #15 on 07/28/2021 at 2:35 07/20/2021 at approximately 7:00 he observed that Resident #323 le breathing and the resident's NA #15 stated RN #6 resident a breathing treatment, dent still appeared to be having g. Continued interview revealed histered a second breathing esident "a couple hours later." #15 stated the resident bored breathing, but to her 6 took no further action. SRNA d not visualize any staff go back sess Resident #323 until the visit at approximately 10:30 AM, e facility send Resident #323 to	F 684		
	revealed on 07/20 to 7:30 AM, one of her that Resident stated she was no Resident #323; h resident's room. So room, she could b	I #6 on 07/28/2021 at 3:45 PM D/2021 at approximately 7:00 AM of the nursing assistants notified #323 was "congested". She of the nurse assigned to care for owever, she went to the She stated when she entered the near the resident wheezing and ident using accessory muscles			

Facility ID: 100599

If continuation sheet Page 148 of 401

<u>CENTER</u>	<u>S FOR MEDICAR</u>	E & MEDICAID SERVICES			<u>DMB NO. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
185256		B. WING	-ETN/2	09/10/202 <u>1</u>	
NAME OF P	ROVIDER OR SUPPLIEF	2	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200 N	NURSING HOME LANE		
	AT COTACCTE AN		PIKE	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 684	Continued From	page 148	F 684		
	the diaphragm m	uscle to breathe). RN #6 stated n Resident #323 at			
		15 AM. The RN stated the			
		lifficulty breathing was "new" for #6 stated she administered a			
	•	ent to the resident at 7:43 AM,			
		proved the resident's breathing. stated the improvement did not			
		resident's status declined. She			
	stated she thoug	ht LPN #3, the resident's			
		notified the resident's physician			
	treatment.	ne resident a second breathing			
		N #3 revealed she was the			
		o Resident #323 on 07/20/2021. proximately 6:30 AM on			
		ident #323 "seemed ok".			
	However, at appr	roximately 7:30 AM she realized			
		going on" with the resident. She			
		nt was breathing fast and using es to aide in breathing. LPN #3			
	-	ed the resident's physician,			
		ound 8:15 AM, and received a			
		ain a chest x-ray for the resident.			
		llowing the breathing treatments RN #6, Resident #323's			
		about the same". LPN #3			
		#323's family arrived at the			
	• • • •	mately 10:30 AM, and insisted he resident to the ED. The LPN			
		d Physician #1 of the family's			
		acility sent the resident to the			
		ximately 12:30 PM			
	(approximately find having trouble br	ve hours after the resident began eathing).			
		esident #323's family member on 50 AM, revealed she arrived at			

Facility ID: 100599

If continuation sheet Page 149 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING	-FINZ	09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER			
				KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 684	AM. She stated that could hear the reside hallway approximate stated the breathing if the resident was try straw. The family me the resident had a na airway. Continued in the facility send the r evaluation. Further review of Res for 07/20/2021, revea at the facility and req to the hospital, staff of having shortness of a rapidly labored breat staff completed a cha 12:12 PM, which staf at 11:45 AM of the re- received new orders ED. Review of Resident # the ED staff assesse audible stridor, increa- using accessory mus wheezing to bilateral Resident #323's hos resident was admitte at 10:54 PM, and dia Respiratory Insufficie Pneumonia versus A and an elevated Lacd flow of oxygen level)	2021 at approximately 11:00 upon arriving to the unit, she ent trying to breathe from the ly two (2) doors down. She was a high-pitched sound, as ying to breathe through a mber stated it sounded as if arrow or partially blocked terview revealed she insisted esident to the hospital for sident #323's medical record aled after the family arrived uested the resident be sent documented the resident was air, abnormal lung sounds, hing, and cough. In addition, ange of condition form at ted they notified Physician #1 sident's assessment and to send the resident to the #323's ED record revealed d the resident to have ased respiratory effort, was scles to breathe and had mild lungs. Continued review of pital record revealed the d to the Intensive Care Unit ignosed with Acute Hypoxic ency, Left Lower Lobe telectasis (collapsed lung), tate level (results from low	F 684		
		ian #1 on 08/04/2021 at 1:00 d not recall if he spoke to			

Facility ID: 100599

If continuation sheet Page 150 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
		MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER			
	1		P	IKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 684 F 686 SS=J	LPN #3 about Resid 07/20/2021. However to assess a resident condition occurred. I resident was experie would expect staff to assessment of the re- further decompensa Interview with the Ad 1:48 PM, and the Int 08/11/2021 at 12:05 staff to immediately change in condition revealed that they enursing assessment Treatment/Svcs to F CFR(s): 483.25(b)(1) §483.25(b) Skin Inter §483.25(b)(1) Press Based on the compri- resident, the facility (i) A resident received professional standar pressure ulcers and ulcers unless the inter demonstrates that the (ii) A resident with pri- necessary treatment with professional standars	ent #323 once or twice on er, he stated he expected staff when a change in their He further stated that if a encing respiratory distress, he o increase monitoring and esident and monitor for tion of respiratory status. dministrator on 08/10/2021 at terim Director of Nursing on PM, revealed they expected assess a resident when a occurred. Further interview xpected the staff to document s in the medical record. Prevent/Heal Pressure Ulcer)(i)(ii) egrity ure ulcers. ehensive assessment of a must ensure that- es care, consistent with rds of practice, to prevent does not develop pressure dividual's clinical condition hey were unavoidable; and ressure ulcers receives t and services, consistent andards of practice, to event infection and prevent	F 684		

Facility ID: 100599

If continuation sheet Page 151 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039	D
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		_
F 686	Continued From pag	e 151	F 686			1
	by: Based on observation and review of the faci determined the facilit five (5) sampled resid Resident #66) receiv ulcers and failed to e was provided for four with pressure ulcers #45, Resident #14, a promote healing, pre- new pressure ulcers The facility admitted without pressure ulcers and reposition the re- Resident #65 develor the coccyx. The faci pressure ulcer (meas drainage, odor, etc.). also failed to identify worsened. On 05/28 transferred to the Em due to worsening of t "clinically septic with ulcer with associated and possible abscess debridement on 05/3 tissue was removed the bone". Resident #65 was re- However, the facility reposition Resident # weekly skin and/or pr	vent infection and/or prevent				

Facility ID: 100599

If continuation sheet Page 152 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 686	Continued From pag worsened.	e 152	F 686		
	a Stage III (3) pressu the left sacrum. How documented evidence in accordance with the assessment form, ind appearance, etc. On 06/30/2021, a wo Resident #45 and no left buttock was a Statexcisional debrideme The facility failed to a pressure ulcer during from 07/02/2021 thro 08/13/2021, a foul-sr depth and drainage finoted. The resident where he/she require wound care. The pre- level of the left ischia Resident #45 was dia (infection of the bone Review of Resident # revealed the facility in pressure ulcers on the (hip) on 06/22/2021. the resident's skin ar as required. Further, the facility ar 07/06/2021 with Physi- his/her pressure ulcers (collagenase). The fit reatment to the resident	the the wound was assessed the facility's wound cluding measurements, wound care specialist assessed ted the pressure sore to the age IV (four) and required tent to the level of the muscle. The sesses the resident's the weekly skin assessments bugh 08/08/2021. On melling odor and increased from the wound bed was was transferred to the ED ted antibiotics and inpatient tessure ulcer extended to the all tuberosity (hip bone). agnosed with Osteomyelitis etc).			

Facility ID: 100599

If continuation sheet Page 153 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 686	Continued From pag facility.	e 153	F 686		
		y failed to turn and reposition 16/2021 from 9:27 AM until			
	care to prevent press failure to ensure a re- received the necessa promote healing and caused or is likely to impairment or death Jeopardy was identifi determined to exist of 483.10 Resident Rig Freedom from Abuse Comprehensive Pers (F655) (F656), 42 CF (F684) (F686) (F692 Services (F755) and Control (F880). The Immediate Jeopardy An acceptable Allega was received on 09/0	ation of Compliance (AOC) 03/2021, which alleged			
	verified based on ob- and review of facility Immediate Jeopardy 483.35 Nursing Serv Administration (F835 Quality Assurance an Improvement (F867)	er, the AOC could not be servations, staff interviews, documentation. Additional was identified at 42 CFR ices (F725), 42 CFR 483.70 i) (F837), 42 CFR 483.75 ind Performance . The facility was notified of ardy on 09/10/2021. The is ongoing.			

Facility ID: 100599

If continuation sheet Page 154 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 686	Continued From pag	le 154	F 686		
	Injuries Policy, revise purpose of the policy regarding identificati factors and intervent The policy stated a r completed upon adn changes in condition also required upon a assessment, as indic resident's risk factors policy revealed staff skin clean and hydra episodes of incontine with or at risk of pres individualized sched Interdisciplinary Teat for repositioning bas factors and current of The policy further sta evaluate, report and in the skin, and revise strategies for effectiv Review of the facility "Repositioning", date "Repositioning is a c intervention for prevo promoting circulation relief." Further revie "Residents who are an every two hour (o schedule". Interview with the As (ADON)/Acting Direc 08/11/2021 at 12:05	ule as determined by the m (IDT), choose a frequency ed on the resident's risk linical practice guidelines. ated the facility should document potential changes ew interventions and veness on an ongoing basis. t's policy titled, ed May 2013, revealed,			

Facility ID: 100599

If continuation sheet Page 155 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501	
	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	E COMPLETION
F 686	Continued From pag	e 155	F 686		
		expectation was for staff to			
	assess pressure ulce	ers upon admission and			
	J. U	asurements and to assess			
		According to the ADON, all turned and repositioned at			
		ours; and, incontinent care			
	should be provided e	every two (2) hours.			
	Further interview with	h the ADON, on 08/11/2021			
		ed staff should conduct a			
		nent and document the			
		ad to Toe Weekly Skin			
		tion, if a resident had a should assess the wound,			
		is, and notify the resident's			
	physician/family whe	n required.			
	Review of the "Week	ly pressure wound note"			
		vere required to document			
	-	e of a pressure ulcer; wound			
		percentage of wound tissue rainage was present and the			
	amount; whether an	•			
	tunneling/underminin	ig was present; a description			
	•	whether there were signs of			
		ss of the wound (improved, ng, etc.); notifications for any			
		or new orders; whether the			
	care plan was review	ved and updated; and any			
	other pertinent progr	ess notes.			
	1. Review of Reside	nt #65's medical record			
		admitted the resident on			
		dmitted the resident on			
		noses that included Cerebral			
		a, Polyarthritis, Chronic ary Disease and Paraplegia.			
	Review of Resident 6	65's Minimum Data Set			

Facility ID: 100599

If continuation sheet Page 156 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/08/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/1	10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	revealed the residen two (2) staff with Act occasionally incontin indwelling catheter, a Further review revea for pressure ulcers b assessment instruma assessment. Accord 03/30/2021, Resider pressure reduction d on a turning/reposition have nutrition or hyd manage skin probler Review of a Braden Sore Risk form dated Resident #65 was "a with a score of eight fast; slightly limited r adequate nutrition, fit Review of the Admiss Evaluation on 04/29/ Braden Scale assess Resident #65. The r (14), indicating the re pressure ulcers. The limited sensory prob confined to bed (bed potential problems w friction, and shearing Review of Resident a dated 03/23/2021 at though the resident w	sessment dated 03/30/2021 t was totally dependent on ivities of Daily Living, was eent of bowel, had a and had no pressure ulcers. Ided the resident was at risk ased on a formal ent (Braden) and clinical ting to the MDS dated tt #65 did not have a evice for the chair, was not oning program, and did not ration interventions to ms. Scale for Predicting Pressure d 03/23/2021 revealed t risk" for pressure ulcers een (18), due to being chair nobility; and, problems with iction, and shearing. sion/Readmission Nursing 2021 at 6:00 PM revealed a sment was completed for esident scored a fourteen esident was at "high risk" for e risk was due to slightly lems; occasionally moist; fast); very limited mobility; ith adequate nutrition; and, g. #65's Baseline Care Plan 11:00 AM revealed even was at high risk for pressure i not implement any pressure	F 686			

If continuation sheet Page 157 of 401

CENTER	-	HAND HUMAN SERVICES E & MEDICAID SERVICES		C	PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER		B. WING	-FTNIZ	09/10/202 <u>1</u>	
		STREET ADDRESS, CITY, STATE, ZIP CODE			
PARKVIE	V POST-ACUTE AND	D REHABILITATION CENTER		IURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 686	Further review of revealed no docu completed a com resident with inter resident's high ris attempt to preven April, or May 202 documented evid individualized turn as required by the the resident's risk Continued review record review rev discharged to the shortness of brea facility on 04/29/2 included Sepsis, Failure, and Urina Admission/Readm Resident #65 date revealed the resid bilateral buttocks hospital, with no o noted. Continued review record revealed no facility turned/rep every two (2) hou requirement. Review of a chan 05/02/2021 at 100 had developed a purple or maroon intact skin or bloo	Resident #65's medical record mented evidence the facility prehensive care plan for the rventions to address the sk for pressure ulcers in an at pressure ulcers in March, 1. Subsequently, there was no ence the IDT determined an ning and repositioning schedule, e facility's policy, and based on	F 686		

Facility ID: 100599

If continuation sheet Page 158 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 686	pat dry, apply zinc or gauze every day". T evidence the facility (measurements, app completed a Weekly 05/02/2021, when the Interview with Licens on 08/25/2021 at 4:0 the deep tissue injury coccyx/sacrum area. was reddened, round of a quarter. LPN #4 measured the area b overwhelmed" relate further stated that no education regarding a pressure ulcer. Co prior to the "new con the wound care nurs all pressure ulcers. I the protocol for asse ulcers. Review of a Head to (skin assessment) fo 05/08/2021 at 3:38 F measured the reside Injury" as 6.5 centim deep, and 0 cm in de documented evidence wound per the Week (assessment of the p wound bed appearar wound edges; the pr [improved, unchange]	boccyx with soap and water, kide and cover with border here was no documented assessed the pressure ulcer learance, etc.) and Pressure Wound Note on e DTI was identified. The Practical Nurse (LPN) #4 0 PM revealed she identified y (DTI) to Resident #65's She stated that the area d, and approximately the size d stated she should have but she was "probably d to not enough staff. She o one had ever provided her measuring and/or assessing ontinued interview revealed hopany" taking over the facility, e assessed and measured However, she was unsure of ssing, measuring pressure Toe Weekly Skin Check or Resident #65 dated PM, revealed the facility nt's 'Suspected Deep Tissue eters (cm) in width by 9.3 cm epth. However, there was no be the facility assessed the dy Pressure Wound Note pressure ulcer including the noc, a description of the ogress of the wound	F 686		

Facility ID: 100599

If continuation sheet Page 159 of 401

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVI OMB NO. 0938-03
ATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
185256		B. WING	-ETNIZ	09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200 1	NURSING HOME LANE		
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER	PIKE	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 686	pressure ulcer to The deep tissue i	0 PM revealed Resident #65's the coccyx was "worsening". njury (DTI) was now an	F 686		
	loss [death] in wh covered by sloug and/or eschar [tai	sure ulcer (full thickness tissue ich the base of the ulcer is h [yellow, tan, green or brown] n, brown, or black] in the wound			
	According to the i was contacted an clean the coccyx	ed 6.5 cm long and 9.7 cm wide. note, the resident's physician id new orders were obtained to with soap and water, pat dry, inate (Ag) and cover with a			
	dressing every da Review of a Head	ay. I to Toe Weekly Skin Checks for			
	at 3:17 PM, the u resident's coccyx long by 10 cm wid	vealed the next day, 05/12/2021 nstageable pressure ulcer to the had increased in size to 10 cm de. Seven (7) days later, on			
	coccyx/sacrum m cm in width. Con	pressure ulcer to the leasured 9.5 cm in length and 10 tinued review of the Head to Toe cks dated 05/26/2021 at 5:37			
	PM revealed the sacrum increased long and 17.7 cm	resident's pressure ulcer to the d in size, measuring 16.5 cm wide. Further review revealed			
	assessed the wou drainage or odor	umented evidence the facility und's appearance, or whether was present for any date. The to treat Resident #65's wound			
	with calcium algin documented evid	nate. However, there was no ence the resident's physician the pressure ulcer had increased			
	in size.				
	on 08/25/2021 at #65's wound "pro	ensed Practical Nurse (LPN) #6 7:45 PM revealed Resident gressed rapidly". She stated purth floor and provided care for			

Facility ID: 100599

If continuation sheet Page 160 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 686	Resident #65. Howe if she notified the phy resident's pressure u care nurse was resp monitoring pressure "assumed" the woun the physician. LPN# change in a pressure ulcer she would notif should notify the phy Review of a Change 05/28/2021 at 3:54 F had a "worsening wo revealed the physicia and laboratory testin of Condition form, "M decided to send resid evaluation and treat area." Interview with State I (SRNA) #4 on 08/26/ Resident #65's press about a month and n stated she knew the bad and smelled bac provided care to Res 40 other residents ur Resident #65 and ottl pressure ulcers, were but not every two (2) not enough staff. Interview with Regist 08/24/2021 at 3:49 F Resident #65's press resident being sent to	ever, she was unable to recall ysician of the decline in the alcer. She stated the wound onsible for measuring and ulcers; therefore, she d care nurse was contacting #6 stated if she noticed a e ulcer or a new pressure y the wound care nurse, who sician. of Condition form on PM revealed Resident #65 ound". Review of the form an ordered a wound culture g. However, per the Change 1D later called back and dent to Emergency Room for for possible debridement of Registered Nurse Aide (2021 at 12:36 PM revealed sure ulcer had an odor for ursing staff was aware. She resident's wound "looked I". SRNA #4 stated she bident #65 and approximately ntil August 2021. She stated her residents who had e turned and repositioned, hours because there was	F 686		

Facility ID: 100599

If continuation sheet Page 161 of 401

				
CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
DM	185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND			200 NURSING HOME LANE	
PARTIEN POST-ACOTE AND			PIKEVILLE, KY 41501	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
felt "lack of nutrition pressure ulcer. Review of Residem revealed he/she wa 05/28/2021. Revie 05/28/2021 at 9:24 was "clinically sept [pressure] ulcer with including cellulitis a abscess". Accordi ulcer "smells like d Review of Residem Department (ED) N 05/28/2021 at 5:36 a "large decubitus cm by 8 cm with ce underlying necrosis erythema with mild bandage". Accord ulcer "smells like d wound pictures dat revealed the reside wound edges. The cm long by 15 cm v Review of Residem 05/30/2021 reveale a large necrotic ap sacrum. The opera extremely extensiv amount of fat necro as necrotic tissue". read, "debrided all level of the bone".	a ulcer had declined quickly and h" could be contributing to the t #65's hospital record, as admitted to the hospital on w of a Progress Note dated PM revealed Resident #65 ic with large decubitus th associated infection and possible developing ing to the record, the pressure ead flesh". t #65's Emergency Jurse's Notes dated PM revealed the resident had (pressure) ulcer proximally 15 entral skin sloughing and s, the wound has surrounding purulent drainage to ing to the record, the pressure ead flesh". Review of the ead 05/29/2021 at 5:40 AM ent's sacrum was black with red a pressure ulcer measured 14	F 68		

Facility ID: 100599

If continuation sheet Page 162 of 401

PRINTED: 12/08/2021

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVI OMB NO. 0938-03
ATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
185256		B. WING	09/10/202 <u>1</u>		
NAME OF PF	ROVIDER OR SUPPLIER	R	S	TREET ADDRESS, CITY, STATE, ZIP CODI	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200 NURSING HOME LANE			
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER	F	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIC
F 686	Continued From	page 162	F 686		
		ident #65 had a large Stage IV			
		r to the sacrum. He debrided			
	•	tic and non-viable tissue in the			
	•	n 05/30/2021 to bone depth.			
		erative report, Surgeon #1 stated			
		er measured 6 cm in depth prior			
		He further revealed that post area measured 15 cm in length			
		and that the wound was very			
		eon #1 stated he was unaware of			
	-	ss or diagnosis that contributed			
		Icer. He stated failure to turn			
		nproper nutrition and an			
		s could have contributed to the			
		and the progression of the			
	wound.				
		vealed the facility readmitted			
		06/09/2021. Upon return to the			
	-	imented the resident had a			
	•	the "coccyx" and a treatment AG to the wound. Review of a			
		Wound Note dated 06/11/2021,			
		ity assessed the pressure ulcer			
		s coccyx/sacrum for the first time			
		since the pressure ulcer			
	•	02/2021. According to the note,			
		er measured 17 cm (length) by			
	12 cm (width) and	d 1.3 cm (depth), with			
	undermining betw	veen three (3) and nine (9)			
		n to 2.3 cm. Further review			
	revealed the facil				
		Stage IV (4), described as			
		n and tissue loss with slough			
	•	vering 50% of the wound, with			
		und edges. The facility			
		ident's pressure ulcer to be free , and signs of infection. The			
		pressure ulcer was changed to			

Facility ID: 100599

If continuation sheet Page 163 of 401

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
		200 1				
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 686	Continued From pag	ge 163	F 686			
	apply a wet to dry k	erlix to the wound twice daily.				
	facility assessed the completed a Weekly 06/11/2021 at 2:00 I weeks after the press Review of Resident note dated 06/23/20 resident had acquire ulcer to the left heel the pressure ulcer n wide. The facility re	 Pressure Wound Note until PM, approximately six (6) ssure ulcer developed. #65's Change of Condition 121 at 10:30 AM revealed the ed a new Stage I (1) pressure Review of the note revealed neasured 6.5 cm long by 4 cm ceived a new order for ctors while in bed, apply sure 				
	revealed no docume assessed the reside days later, 06/26/20 Toe Weekly Skin Ch 06/26/2021 at 10:03 Wound Note dated revealed the Stage resident's sacrum m wide by 1.3 cm dee cm (length) by 4.4 c Continued review of resident had a new right heel that meas (width) and 0 cm (da notified and an order for the right heel. R revealed the pressu sacrum was noted t 50% of the wound w	Resident #65's assessments ented evidence the facility ent's sacrum until fifteen (15) 21. Review of the Head to neck assessment dated PM and a Weekly Pressure 06/26/2021 at 10:25 PM, IV (4) pressure ulcer to the neasured 11 cm long by 15 cm o. The left heel measured 5.8 m (width) and 0 cm (depth). The assessment revealed the deep tissue injury (DTI) to the ured 3.1 cm (length) by 3 cm epth). The physician was r was obtained for treatment eview of the Wound Note re ulcer to Resident #65's o have slough tissue covering <i>i</i> th a small amount of inage. Further review ated the wound edges were				

Facility ID: 100599

If continuation sheet Page 164 of 401

PRINTED: 12/08/2021

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		09/10/2021	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		200 NURSING HOME LANE			
PARKVIE	V POST-ACUTE ANI	D REHABILITATION CENTER	PIKE	VILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F 686	Continued From	bage 164	F 686		
	infection. The fac	ere free of odor and signs of cility continued to provide wet to gs to the resident's sacral			
	Weekly Skin Chew Wound Notes rew the facility assess pressure ulcers u later. On 07/05/2 documented the p measured 11 cm 1.5 cm (depth). T appears to be heat large DTI to two s and outer heel. T cm (length) by 2.8 the left outer heel 1.3 cm (width) by revealed the press measured 3 cm (l cm (depth). Acco Wound Note date Resident #65's pr	r of Resident #65's Head to Toe cks and Weekly Pressure ealed no documented evidence sed the resident's skin and ntil 07/05/2021, nine (9) days 021 at 7:10 AM, the facility pressure ulcer to the sacrum (length) by 14 cm (width) and The "left heel deep tissue injury aling and has went from one smaller DTI's" on the left inner The left inner heel measured 3.2 8 cm (width) by 0 cm (depth) and I measured 1.8 cm (length) by 0 cm (depth). Further review usure ulcer to the right heel length) by 2.5 cm (width) and 0 prding to the Weekly Pressure ad 07/05/2021 at 7:23 AM, ressure ulcer to the sacrum had e amount of serosanguinous ns of infection.			
	07/05/2021 at 7:3 physician was no obtained for a wo dressing change. Treatment Admini 2021, revealed th change was to be	nge of Condition form dated 3 AM, revealed the resident's tified and a new order was und culture with the next Review of the Resident #65's istration Record (TAR) for July re resident's next dressing completed on 07/06/2021 at ver, review of the Progress			

Facility ID: 100599

If continuation sheet Page 165 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2 FORM APPRO OMB NO. 0938-0	VED
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 686	resident be sent to the sacral pressure ulcer Review of the Emerge Resident #65 arrived 07/06/2021 at 11:09 record revealed their pain on (his/her) butte than normal". Review Notes revealed their diameter wound on the bone, appears to be surrounding cellulitis resident was transfer 07/06/2021. Further review of the 07/06/2021 at 2:45 P appointment was ma 07/15/2021 at 8:30 A Advanced Practice R Review of the wound 07/07/2021 revealed culture of Resident # 07/07/2021. Howeves swab had been "expil laboratory was unable culture. Further record no documented evide culture of the pressur resident's physician. Record review reveat 3:15 PM, the facility of Weekly Skin Check at ulcer to Resident #65 cm (length) by 11 cm	the ED for evaluation of the c. pency Room record revealed to the hospital on AM for "wound check". The resident "complained of mild ocks but states it is no worse w of the Physical Exam esident had a "15 cm in puttocks that goes to the healing, no drainage, no had packing inside." The red back to the facility on Progress Notes dated, PM revealed a wound care de for Resident #65 on M with Wound Care Registered Nurse (APRN) #1.	F 686			

MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
185256	B. WING			
			09/10/202 <u>1</u>	
	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HABILITATION CENTER	-	0 NURSING HOME LANE KEVILLE, KY 41501		
	ID PREFIX TAG		D BE COMPLÉTIO	
depth), the left inner heel h) by 2.5 cm (width) and 0 t outer heel measured 1.2 (width) and 0 cm (depth). o documented evidence the ressure ulcers per the und Note. The Weekly d staff to document the cer; wound bed appearance und tissue coverage; present and the amount; nneling/undermining was of the wound edges; gns of infection; and the I (improved, unchanged, dent #65's medical record ted evidence the facility 's skin from 07/08/2021 no documented evidence Resident #65's pressure a Weekly Pressure Wound to 08/25/2021. Care Office Visit notes for 7/29/2021 revealed the ed ridden, friction/rubbing in changes." The note acrum wound had increased y's last assessment on sured 15.5 cm (length) by cm (depth). Further, the	F 686			
	166 depth), the left inner heel h) by 2.5 cm (width) and 0 t outer heel measured 1.2 (width) and 0 cm (depth). o documented evidence the ressure ulcers per the ind Note. The Weekly id staff to document the cer; wound bed appearance und tissue coverage; present and the amount; nneling/undermining was of the wound edges; gns of infection; and the d (improved, unchanged, ident #65's medical record ted evidence the facility 's skin from 07/08/2021 no documented evidence Resident #65's pressure a Weekly Pressure Wound to 08/25/2021. Care Office Visit notes for 7/29/2021 revealed the ed ridden, friction/rubbing in changes." The note acrum wound had increased y's last assessment on sured 15.5 cm (length) by cm (depth). Further, the te serosanguinous exudate a wound was assessed to ulation and 34%-66% th bone exposed. The an "Excisional debridement	MUST BE PRECEDED BY FULL PREFIX SCIDENTIFYING INFORMATION) PREFIX 166 F 686 depth), the left inner heel h) by 2.5 cm (width) and 0 to uter heel measured 1.2 (width) and 0 cm (depth). o documented evidence the ressure ulcers per the and Note. The Weekly d staff to document the cer; wound bed appearance und tissue coverage; present and the amount; nneling/undermining was of the wound edges; gns of infection; and the d (improved, unchanged, ident #65's medical record ted evidence the facility 's skin from 07/08/2021 no documented evidence Resident #65's pressure a Weekly Pressure Wound to 08/25/2021. Care Office Visit notes for 7/29/2021 revealed the ed ridden, friction/rubbing n changes." The note acrum wound had increased y's last assessment on sured 15.5 cm (length) by cm (depth). Further, the te serosanguinous exudate e wound was assessed to ulation and 34%-66% th bone exposed. The	INUST BE PRECEDED BY FULL PREFIX TAG (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) 166 F 686 depth), the left inner heel h) by 2.5 cm (width) and 0 t outer heel measured 1.2 (width) and 0 cm (depth). F 686 o documented evidence the ressure ulcers per the ind Note. The Weekly d staff to document the cer; wound bed appearance und tissue coverage; is present and the amount; nneling/undermining was of the wound edges; gns of infection; and the I (improved, unchanged, ident #65's medical record ted evidence the facility 's skin from 07/08/2021 no documented evidence Resident #65's pressure a Weekly Pressure Wound to 08/25/2021. Care Office Visit notes for 7/29/2021 revealed the ad ridden, friction/rubbing n changes." The note acrum wound had increased y's last assessment on sured 15.5 cm (length) by cm (depth). Further, the te serosanguinous exudate = wound was assessed to ulation and 34%-66% th bone exposed. The	

Facility ID: 100599

If continuation sheet Page 167 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		00/10/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>
				NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		KEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 686	wound bed to health physician changed to Aquacel Ag daily and Review of the Head assessment dated 0 first skin assessmen Resident #65 had de pressure ulcer to the However, there was facility assessed the evidence the facility physician that the re pressure ulcer. Interview with LPN # revealed if a new pre- she was required to condition form and n she stated she was responsible for mean stated she should ha 08/12/2021, when the identified to the back Review of Resident Skin Checks assess completed another si 08/19/2021 at 11:02 revealed the residen pressure ulcer to the heel (deep tissue inj and an unstageable (rear). However, the evidence the facility pressure ulcers.	h and exudate from the y granular borders". The he wound care to treat with d cover with a mepilex border to Toe Weekly Skin Checks 8/12/2021 at 11:52 AM, (the t since 07/08/2021); revealed eveloped an unstageable b back of the left, lower leg. no documented evidence the new pressure ulcer and no notified the resident's sident had developed a new 7 on 08/25/2021 at 7:56 PM essure ulcer was identified, complete a change of otify the physician. However, never notified that she was suring wounds. LPN #7 ave notified the physician on e pressure ulcer was a of Resident #65's left leg. #65's Head to Toe Weekly ment revealed the facility kin assessment on AM. This assessment t continued to have a e left heel (Stage I), the right ury), the sacrum (Stage IV), ulcer to the left lower leg ere was no documented measured or assessed the	F 686		
	Observation of wour	nd care on 08/25/2021 at 1:33			

If continuation sheet Page 168 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER			
				IKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 686	Continued From pag	je 168	F 686		
		not completed a pressure nce 07/05/2021) with RN #4			
	(Wound Care Nurse) and the ADON/Acting DON,			
		Resident #65's left heel was I the area was healed;			
		mained "boggy". Continued			
		d the right heel measured 0.4			
		m (width) and 0 cm (depth). Nurse) stated the area was			
	a "scabbed area."				
		eg to be 3.2 cm (length) by			
		cm (depth). The RN stated edges with slough and			
		of the wound. Further			
		d the sacral pressure ulcer			
		ngth) by 13.3 cm (width) with			
	no measurement ob	tained for depth. oted at 11 o'clock at 1.9 cm			
		the wound from 12 to 4			
		the pressure ulcer had			
	-	0% slough, eschar at 6			
	o'clock, and eschar a o'clock to 12 o'clock.	and undermining at 10			
		ge of Condition assessment			
		6:39 PM revealed Resident			
		e two (2) pressure ulcer to ident's physician was notified			
		e received to cleanse the			
		water, pat dry, apply sure			
	prep to area area an	d cover with a dressing.			
		#65's wound care note dated			
		AM, revealed the "context			
		en and infrequent position nt consists of changing			
		debridement of necrotic			
		Ag". "Pertinent negatives			
	include blackened tis	ssue, blistering, erythema,			

Facility ID: 100599

If continuation sheet Page 169 of 401

M APPROV O. 0938-03	
O. 0938-03 E SURVEY IPLETED	
09/10/2021	
(X5) COMPLETIO DATE	

If continuation sheet Page 170 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		S.	IREET ADDRESS, CITY, STATE, ZIP CODE		
		20	00 NURSING HOME LANE		
	N FOST-ACOTE AND R		Р	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 686	Continued From pag rounds.	e 170	F 686		
	revealed staff had no reposition residents of they were so short st horrible!", stating she two (2) days in a row had notified her they (including turning and hours. She stated st DON. RN #3 further Resident #65's wound that the wound was of debridement in May) Interview with RN #7 and on 08/24/2021 a worked the fourth flo stated there was not reposition residents a revealed skin assess however, they were to because there was no confusion about whe due. RN #7 further s she was responsible assessing wounds. Interview with Regist Care Nurse on 08/25 she became the wou returned from materr June 2021. She stated her regarding her res nurse. RN #4 stated	d repositioning) every two (2) ne directed them to notify the stated she had completed id care and she never felt getting better (prior to the on 08/01/2021 at 11:40 AM t 3:49 PM revealed she or with one SRNA. She enough staff to turn and as required. She further sments were required weekly; not always being completed ot enough staff and due to n skin assessments were stated she was unaware that			

Facility ID: 100599

If continuation sheet Page 171 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 686	performed duties as Wound Care Nurses provide wound care/s staff nurses were pro- assisting with assess there were no system assessments were of were not being comp determine if a wound further stated, "I'm no- can't physically do the Interview with the AE 08/18/2021 at 10:00 were responsible for measurements, a nu- notifying the physicia of condition. She sta had been working the provided to ensure w appropriately. She fit that Resident #65's w declined, but she wa the resident to declin ADON/Interim DON not address wounds place to ensure pres and assessed. Interview with Advan Nurse (APRN) #1, w Care Clinic on 08/27. Resident #65's press bony prominence. H appear to be able to himself/herself and w	e floor as much as she the wound care nurse. The stated since she could not assess wounds as required, oviding wound care and sments. However, she stated ns in place to ensure the ompleted; subsequently, they oleted and it was hard to declined or improved. She of monitoring the wounds, I em all." OON/Interim DON on PM revealed nursing staff assessing wounds, including rsing assessment, and an and family with any change ated she and the former DON e floor and no oversight was rounds were being managed urther stated she was aware wound had significantly s unaware of what caused e. Further interview with the revealed the facility's IDT did and there was no system in sure ulcers were identified ced Practice Registered ho worked at the Wound /2021 at 3:14 PM, revealed sure ulcer developed over a e stated the resident did not turn and reposition /as unable to move on amined. APRN #1 further	F 686		

Facility ID: 100599

If continuation sheet Page 172 of 401

	-	AND HUMAN SERVICES			FORM APPROVE 2015 OMB NO. 0938
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
185256		B. WING	ETN/	09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	
			200 NURSING HOME LANE		
PARKVIE	V POST-ACUTE ANI	D REHABILITATION CENTER	РК	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 686	Continued From	page 172	F 686		
	slough and fibroti infection could ha the wound. Furth resident had to w repositioned, it co APRN #1 was un illness or medical palliative care. Interview with Phy 08/27/2021 at 1:1 Resident #65 had bottom, but was r developed other p stated he was not turned and reposi to decreased staff could develop and turned and reposi provided for more was reasonable to pressure ulcers a ulcers to be turne hours and inconti every two (2) hou was not aware the not performed we to determine the s measurements.	Administrator on 08/11/2021 at			
	resident care was professional stand facility operated v	d she was responsible to ensure provided in accordance with dards of practice and that the vithin the regulatory guidelines.			
	no systems in pla	ng to the Administrator she had ce to monitor the care delivered a facility to ensure pressure			

Facility ID: 100599

If continuation sheet Page 173 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW	N POST-ACUTE AND RE	EHABILITATION CENTER		NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 686	pressure ulcers recei services. 2. Review of Resider revealed the facility a 10/07/2020 with diag Osteomyelitis, Parap and a Right Above th Review of Resident # Data Set (MDS) asse revealed the facility a a Brief Interview for N of 13, indicating that intact. Further review revealed the resident bed mobility and tran Resident #45 to be a pressure ulcers, but I the assessment was Review of Resident # Plan initiated 01/11/2 identified the residen pressure ulcer develo ulcers, immobility, an Interventions in place resident/family/careg breakdown: transfer/ importance of taking ambulating/mobility, g repositioning.	ad or to ensure residents with ived the necessary care and nt #45's medical record admitted the resident on inoses of Chronic idegia, History of COVID-19, ne Knee Amputation. #45's Quarterly Minimum essment dated 04/19/2021, assessed the resident to have Mental Status (BIMS) score the resident was cognitively w of the MDS assessment t required assistance with isfers. The facility assessed it risk for development of had no pressure ulcers when conducted. #45's Comprehensive Care 2021 revealed the facility it had the potential for opment due to a history of nd incontinence. e included: educate the givers as to causes of skin positioning requirements,	F 686	DEFICIENCY)	
	resident stated the a				

If continuation sheet Page 174 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			200 NURSING HOME LANE PIKEVILLE, KY 41501		
				·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 686	Continued From pag	e 174	F 686		
		not color when positioned on			
		t #45 stated he/she did not			
	have any concerns w	vith wound care.			
	Review of Resident #	#45's Weekly Skin			
		6/01/2021 revealed a Stage			
		s identified to the resident's			
		skin assessment noted the			
	area had minimal dra surrounding the wou	nd bed was pink. According			
	-	ent, the resident had a history			
	of a pressure ulcer ir	the same location.			
		no documented evidence the			
	wound was assessed accordance with the	d for size, color, etc., in Pressure Wound			
	Assessment.				
	Review of the Situati	on Background Appearance			
	Review Form (SBAR) dated 06/01/2021, stated			
		Stage III pressure ulcer to			
		a. The SBAR stated the lie on his/her back and			
		encouraged by staff. Staff			
		lent to turn/reposition every			
		needed (PRN) to relieve			
	1	ected area. New treatment			
		from Physician #1 to wound cleanser, pat dry,			
		wound bed, and cover with a			
		daily and, PRN if needed, for			
	dislodgement or soile	ed dressing.			
	Interview with Licens	ed Practical Nurse (LPN) #5			
	on 08/27/2021, at 10	:45 AM, revealed she			
		e ulcer to Resident #45's			
		06/01/2021. She stated she			
	should have assesse	ed the wound and measurements. LPN #5			
		ne wound care nurse was			

Facility ID: 100599

If continuation sheet Page 175 of 401

			FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
185256	B. WING		09/10/202 <u>1</u>	
NAME OF PROVIDER OR SUPPLIER		TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				
	P	IKEVILLE, KY 41501		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
 F 686 Continued From page 175 measuring/assessing wounds weekly. Review of a Nurse's Note dated 06/10/2021 at 4:58 AM revealed when completing wound care to Resident #45's buttock, odor and yellowish drainage were present. The note further stated that the physician was notified. Review of a SBAR dated 06/10/2021 at 12:28 PM revealed Resident #14's physician ordered a wound culture. However, there was no further assessment of the resident's pressure ulcer. Continued review of Resident #45's medical record revealed no documented evidence the facility conducted another skin assessment until 06/12/2021, (eleven {11} days since the resident's skin had been assessed). Further review of the skin assessment revealed the resident had existing skin impairment with a Stage III pressure ulcer to his/her right buttock. However, there was no documentation the facility assessed the pressure ulcer's appearance. Review of a Nurse's Note dated 06/13/2021, at 3:03 PM, revealed changes were noted to Resident #45's pressure ulcer. The wound bed had yellow/beige slough and drainage, the surrounding peri-wound tissue was blanchable and pink, and the depth was unable to determined due to the present of slough. The note stated a wound culture was pending and the physician was notified with a new order received for treatment. According to the note, Resident #45 was educated on the importance of turning and repositioning due to the resident's ability/independence to turn and reposition himself/herself, and the resident verbalized understanding. 	5			

Facility ID: 100599

If continuation sheet Page 176 of 401

PRINTED: 12/08/2021

	-	ND HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
		2	00 NURSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			P	IKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 686	dated 06/14/2021 re MRSA (Methicillin R Aureus is a staph int because of resistand Enterococcus Faeca Agalactiae-Group B, two (2) different Gra infections. According to a Nurse 1:28 PM, revealed F ordered Zyvox 600 r days to treat the wor Lactobacilli's capsul- fourteen (14) days. Review of a Wound dated 06/16/2021, re seen by a wound ca the note, Resident # worsened. The spec pressure ulcer had b measuring 3.5 centif cm, with slough (yell adheres to the ulcer clumps, or is mucino bed, scant serosang surrounding skin tiss tissue edema noted Review of a Head to dated 06/25/2021, (t facility completed the Resident #45's skin) the resident's pressu-	#45's Wound Culture report vealed heavy growth of esistant Staphylococcus fection that is difficult to treat ce to antibiotics), alis, Streptococcus Diphtheroid Bacillus, and m Negative Rod (GNR) e's Note dated 06/17/2021 at Resident #45's Physician ng twice daily for ten (10)	F 686		

Facility ID: 100599

If continuation sheet Page 177 of 401

PRINTED: 12/08/2021

		HAND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER		B. WING	-ETN/	09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
	V POST-ACUTE ANI	D REHABILITATION CENTER		0 NURSING HOME LANE	
			PI	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL / OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTIC
F 686	Continued From	page 177	F 686		
	Review of a SBA	R Form dated 06/26/2021,			
		nt #45's physician was notified of			
		ts and that yellow slough was no			
		wound bed. The note stated			
	the peri- wound w	vas pink and blanchable, and			
	serosanguineous	drainage was noted. The			
		d a normal saline (NS) wet-			
	to-dry dressing da	aily, and to follow-up with the			
	wound care clinic	as scheduled.			
		ound Clinic Progress Note dated			
		aled Resident #45 was assessed			
		ic for the assessment and			
		age IV pressure ulcer to his/her			
		assessment stated the			
	•	ulceration measured 3.5 cm x			
		with slough present and good			
	U U	e. Documentation revealed that			
		d he/she was utilizing a sliding njury occurred and worsened			
		w of the patient plan revealed			
		ement to the level of the muscle			
		ith removal of all non-viable			
	· ·	bugh, and exudate from the			
		althy granular borders. Wound			
		to cleanse the wound daily with			
		ply Aquacel AG, and cover with			
		dressing. Further review of the			
		vealed recommendations for the			
	-	wound vac (Vacuum-assisted			
		nd is a device placed on the			
		ves the pressure over the area			
		d heal more quickly) for the			
		. Resident #45 was to follow up linic in four (4) weeks.			
	Review of the He	ad to Toe Weekly Skin Checks			
	for Resident #45	dated 07/02/2021, 07/09/2021,			
	07/17/2021, and	07/23/2021, revealed no			

Facility ID: 100599

If continuation sheet Page 178 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD		
			200 NURSING HOME LANE PIKEVILLE, KY 41501		
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLETION
F 686	Continued From pag	ge 178	F 68	36	
		ce that the facility conducted			
		nts weekly, nor assessed the esident's pressure ulcer			
		slough present, etc.).			
	07/28/2021, reveale	Clinic Progress Note dated d measurements of the dement were 3.5 cm x 2.1 cm			
		I debridement to the level of			
	the muscle was perf	formed removing all ofilm, slough, and exudate			
		to healthy granular borders.			
	Wound measureme	•			
		.5 cm x 1.0 cm x 4.2 cm. nt Plan revealed staff were to			
	continue with Woun	d Vac and Aquacel AG.			
	Resident #45 was to clinic in three (3) we	o follow up with the wound eeks.			
		o Toe Weekly Skin Check nd 08/06/2021, revealed staff			
	documented Reside	nt #45 had a pressure ulcer			
		as in use. However, again,			
		nented evidence that facility ressure ulcers' size, nor			
		arance of the resident's			
	etc.)	nage, odor, or slough present,			
		dated 08/13/2021 revealed			
		foul-smelling odor from the pth of the wound had			
		drainage. Physician #1 was			
		le assessed Resident #45			
	department (ED) for	resident to the emergency possible wound			
	debridement.				
	Review of the hospi	tal record History and			

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2 FORM APPROV OMB NO. 0938-03	/ED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE			
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETI	NC
F 686	Continued From pag	e 179	F 686			
	-	3/2021 revealed Resident #45	1 000			
	-	e to a left buttock wound with				
		e. The record stated the				
		(3) cm decubitus ulcer that tibiotics and inpatient wound				
	•	assessment/plan revealed				
	· ·	on extended to the level of				
		sity (hip bone) where there ity of the ischial tuberosity,				
	the finding was most					
	-	myelitis (infection of the				
		5 was started on Vancomycin iotics), and had infectious				
	disease and wound of					
	Review of Resident #	#45's Hospital Discharge				
	-	8/2021, the resident was				
	_	ne facility with diagnoses of age IV Pressure Ulcer. The				
	-	r to continue Ceftriaxone NA				
		ams (GM) daily for 37 days				
	and to continue local	wound care.				
	Review of the Admis	sion/Readmission Nursing				
		18/2021, revealed no				
		e the facility assessed sure ulcer upon readmission				
	to the facility.					
	Further review of the	Head to Toe Skin				
		evealed on 08/24/2021, staff				
		nt #45 had a pressure ulcer.				
		e was no documented staff assessed the pressure				
		essed the appearance of the				
		llcer (drainage, odor, or				
	Observation of woun	d care to Resident #45's left				

Facility ID: 100599

If continuation sheet Page 180 of 401

	MENT OF HEALTH AN				FORM APPROVED
	S FOR MEDICARE & I				OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		00/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>
				200 NURSING HOME LANE	
	W POST-ACUTE AND RE	HABILITATION CENTER	1	PIKEVILLE, KY 41501	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
F 686		1 at 3:19 PM revealed the	F 686		
	dressing was change	d per Physician's Order.			
	Review of a Nursing S Assessment dated 08				
		tage IV Pressure Ulcer to			
		d measuring 2.9 cm x 2.6 foul odor and moisture was			
	within normal limits.				
	Interview with State R	-			
	, ,	/2021 at 3:00 PM revealed fused to turn and reposition.			
	She stated the reside	nt liked to sit straight up in			
	bed so he/she could o				
	often.	ent to turn and reposition			
		ered Nurse (RN) #4/Wound			
		2021 at 8:30 PM revealed floor as a staff nurse and			
	could not measure/as				
	weekly. She stated w	hen she was working the			
		e required to complete			
		ver, she stated there were o ensure the assessments			
	were completed.				
		an #1/Medical Director on M revealed he was aware			
		ncompliant with turning and			
		ind vac treatment. He			
		anted to stay in the same However, he stated he was			
		asurements/assessments			
		veekly, He stated it would			
	be hard to determine without weekly measu				

Facility ID: 100599

If continuation sheet Page 181 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 1 FORM AF	PROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B. WING		09/10/	2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE C	(X5) OMPLETION DATE
F 686	revealed the facility a 05/24/2018. Reside facility on 05/21/202 Diabetes Mellitus with Stage III Chronic Kic Vascular Disease, and Review of Resident i Data Set (MDS) assist revealed the facility a a Brief Interview for of 9, which indicated impaired. The facility independent with be the MDS assessment at risk for pressure up present when the ass Review of a compret 09/10/2020 revealed potential for pressure to decreased mobilit and a diagnosis of P (PVD). The facility of included: follow the f the prevention/treatmos observe/document/mos changes in skin statu healing, signs and se size (length x width of 08/24/2021 at 2:32 F a diabetic ulcer to his amputation, and a S his/her left hip. Obse Resident #14 on 08/	ent #14's medical record admitted the resident on nt #14 was readmitted to the 1 with diagnoses of Type II th Diabetic Polyneuropathy, Iney Disease, Peripheral nd a History of COVID-19. #14's Quarterly Minimum essment dated 05/27/2021, assessed the resident to have Mental Status (BIMS) score I the resident was cognitively y assessed the resident to be d mobility. Further review of nt revealed the resident was ilcers, and no ulcers were sessment was conducted. hensive care plan initiated I Resident #14 had the e ulcer development related y, Diabetes Mellitus (DM), 'eripheral Vascular Disease leveloped interventions that facility's policies/protocols for nent of skin breakdown; and eport as needed (PRN) any us, appearance, color, wound ymptoms of infection, wound	F 686			

Facility ID: 100599

If continuation sheet Page 182 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 686	Continued From pag	ge 182	F 686		
	a bandage to his/he stated he/she repos Resident #14 stated	r left foot intact. The resident itioned himself/herself. I he/she preferred to lay on en though staff had educated			
	revealed an order to with soap and water cream, and cover wi (DPD) every shift for According to a Head dated 05/10/2021, re abrasion to his/her li- cream. There was re measurements or an	an's Order dated 05/09/2021 b wash Resident #14's left hip r, pat day, apply barrier ith a dry protective dressing r 14 days until 05/24/2021. d to Toe Weekly Skin Checks evealed Resident #14 had an eft hip and received barrier no evidence that n assessment (color, of the area was completed			
	revealed an order to	an's Order dated 05/10/2021, o change the treatment to hip to calmospetine cream			
	dated 05/24/2021 ai 06/14/2021, and 06/				
	dated 06/22/2021, ro new skin impairmen pressure ulcers to th pressure ulcers mea wound was 1.4 cent wide; wound #2 was	o Toe Weekly Skin Check evealed Resident #14 had t, three (3) Stage II (two) ne left trochanter (hip). The asured as follows: one (1) imeters (cm) long by 1.4 cm s 1.4 cm x 2 cm; and, wound . However, there was no			

Facility ID: 100599

If continuation sheet Page 183 of 401

CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
185256	B. WING		09/10/202 <u>1</u>	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
 F 686 Continued From page 183 description of the wound's color, whether odor of drainage was present, etc. Review of a Situation Background Appearance Review Form (SBAR) dated 06/22/2021 revealed Resident #14's physician was notified of the new pressure ulcers. Review of a Physician's Order dated 06/22/2021 and 07/06/2021 revealed an order to cleanse the three (3) Stage II pressure ulcers with wound cleanser and/or soap and water, pat dry, apply Opticel, and cover with DP daily and as needed. Review of Resident #14's Physician's Orders dated 07/23/2021, revealed an order that stated "May" consult with wound physicians to screen, evaluate, and treat as indicated and an order to measure and photo the pressure ulcers to the lef hip every Monday. Review of Resident #14's Comprehensive Care Plan dated 07/23/2021, revealed the facility revised the resident's care plan to include the Stage II Pressure Injury (ulcer) to the left hip and the new Physician's Orders. Review of interventions revealed the facility was required t arrange for an evaluation at an outpatient woun- clinic as needed; encourage frequent position changes when up in chair, if possible; encourage resident to lift weight from side to side while up chair; avoid prolonged sitting; limit time out of bed; encourage the use of pillows to help with positioning off affected area; measure and monitor wound status progression or deteriorativ every week; notify MD and family of changes; wound care to follow up weekly and as needed; nurse to perform head to toe skin assessment weekly and as needed; weekly photo and measurement of wounds-refer to skin 	ed w 2D d to d d to d d in on			

Facility ID: 100599

If continuation sheet Page 184 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARE	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
		REHABILITATION CENTER	2	00 NURSING HOME LANE	
PARRVIE	W POST-ACUTE AND P		P	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 686	assessment for spe consult with Wound evaluate, and treat as needed/as preso However, continued medical record reve evidence the facility ulcer's size, color, n present; took weekl Wound Clinic/Physi physician and/or red plan. Review of a Weekly forms dated 07/05/2 07/19/2021, reveale Resident #14 had s ulcers to the left hip documented eviden pressure ulcer's siz odor/drainage was Review of Resident Skin Check dated 0 resident had one (1 that measured 4.0 o cm deep to the left Weekly Head to Too 08/02/2021, 08/11/2 08/24/2021 reveale resident had existin (2) to the left hip. H documented assess Further review reve skin assessment or	cific locations; and may Physician Clinic to screen, as indicated; and wound clinic ribed per physician. I review of Resident #14's valed no documented assessed the pressure or whether odor/drainage was y photos, nor consulted with a cian as ordered by the quired by the resident's care T Head to Toe Skin Check 2021, 07/12/2021, and ed the facility documented kin impairment/pressure . However, there was no ce the facility assessed the e, color, nor whether present. #14's Weekly Head to Toe 7/26/2021 revealed the) Stage II (2) pressure ulcer cm long by 4.5 cm wide by 0.5 hip. Further review revealed e Skin Checks dated 2021, 08/23/2021, and d the facility documented the g skin impairment, a Stage II lowever, there was no sment of the pressure ulcer. aled the resident refused a 108/09/2021, and there was n assessment or pressure	F 686		

Facility ID: 100599

If continuation sheet Page 185 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE IKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 686	Continued From pag Review of a Nursing Assessment dated 0 #4/Wound Nurse co Resident #14's left h 3.4 cm. Review of t documentation rever was present. Interview with Licens on 08/27/2021 at 10 measure Resident # told the wound nurse wound measuremer really don't know wh the wounds. We ha she is going to do the day." Interview with Regis 08/27/2021 at 8:30 H Nurse (RN #4) was weekly wound meas #3 stated, "I was told wound measuremer was hired." Interview with RN #4 08/25/2021 at 8:30 H Physician #1/Medica 07/23/2021 and sind consult the wound c not to consult the cli pressure ulcer. She	ge 185 Services Basic Skin 08/26/2021, revealed RN mpleted measurements of hip which measured 3.6 cm x he skin assessment aled no foul odor or moisture sed Practical Nurse (LPN) #5 :45 AM revealed she "tried" to i14's pressure ulcer, but was e was responsible for weekly hts. LPN #5 stated, "So, I to is responsible to measure ve to ask the wound nurse if eatments or not on any given tered Nurse (RN) #3 on PM revealed the Wound Care responsible for completing surements/assessments. RN d she would be doing the tts and wound care when I A/Wound Nurse on PM revealed she reviewed al Director's orders for ee the order stated "May" linic, she made the decision nic for Resident #14's further stated pictures had	F 686		
	According to the RN supposed to purcha Administrator had no she worked the floor	esident #14's pressure ulcer. , the Administrator was se a camera; however, the ot purchased one. She stated [,] just as much, if not more, duties as the Wound Nurse.			

If continuation sheet Page 186 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			0 NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 686		e 186 ght the floor nurses were kin assessments and wound	F 686		
	measurements when	she was not. She further eceived any formal education			
	08/27/2021 at 1:18 F weekly pictures of Re pressure ulcer on 07, of the wound. He sta thing." He stated he measured weekly to of the wound. He sta have been completed and he was not awar 4. Review of Resider revealed the facility a 07/06/2021, with diag Metabolic Encephalo Failure, Autistic Diso Diabetes, Dysphagia	/23/2021 to track the healing ated, "Pictures are a good expected all wounds to be monitor improvement/decline ated a wound consult should d as ordered on 07/23/2021 e it had not been. ht #323's medical record admitted the resident on gnoses that included pathy, Acute Respiratory rder, Sepsis, Type 2 , Pneumonia, and Aphasia.			
	dated 07/06/2021 at resident had a press coccyx measuring siz length and four (4) cr Review of Resident #	ion Nursing Evaluation 5:06 PM revealed the ure ulcer (no stage) to the (6) centimeters (cm) in m in width. #323's hospital Discharge			
	continue Santyl (colla for pressure ulcers) a wound bed. Howeve facility Admission Ord revealed the facility of	rders for the facility to agenase ointment treatment apply a thin layer to the er, review of Resident #323's ders, dated 07/06/2021, lid not transcribe the ent to the admission orders.			

Facility ID: 100599

If continuation sheet Page 187 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 686	record revealed on 0 admission, the facility physician for a treat The physician ordered cleansed with soap a Santyl Ointment topic tissue). Review of R Administration Record revealed no treatment resident's pressure ut 12:00 PM, five (5) dat Further review of the 07/12/2021 at 10:13 pressure area had w wound to both sides stated the pressure ut measured two (2) cm buttock pressure ut five (5) cm. Interview with Regist 07/28/2021 at 9:48 A nurse was responsib verifying physician's the nurse who admitt aware of the Physicia ointment. RN #6 stat the resident's pressure ut RN ensured treatment resident's pressure ut Interview with the Int 08/11/2021 at 12:05 nurse was responsib	Resident #323's medical 7/10/2021, four (4) days after y contacted the resident's nent for the pressure ulcer. ed the pressure ulcers be and water, pat dry, and apply cally to sloughed areas (dead esident #323's Treatment rd (TAR) for July 2021, nt was provided for the ilcers until 07/11/2021 at anys after admission. Nursing Notes dated AM, revealed Resident 323's orsened to an unstageable of the buttocks. The note ilcer to the right buttock n by three (3) cm and the left er measured four (4) cm by ered Nurse (RN) #6 on M revealed the admitting le for transcribing and orders. She stated she was ted Resident #323 and was an's Order for Santyl ed she wanted to evaluate re ulcer before the facility th Santyl ointment. no documented evidence the nt was provided to the	F 68	36	

Facility ID: 100599

If continuation sheet Page 188 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039	ED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
- E		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		1
F 686	the physician to ensu treatment in place ar Continued interview check medical record re-admissions to ensu obtained and implem she worked the floor her from having time she did not recall rev admission record. Interview with the Ad 5:55 PM revealed nu responsible for overs Physician's Orders. was not aware of any orders for Resident # 5. Record review ref Resident #66 on 02/ included Adult Failur Atherosclerotic Hear Pectoris. Review of Resident # (MDS) Annual asses revealed the facility a a Brief Interview for I of nine (9), which inco impairment. The fac be total assist of two Further review of the had no rejection of c period. Review of Resident #	he nurse should have notified ure there was an appropriate of medications ordered. revealed she attempted to ds for new admissions and sure physician's orders were hented. However, she stated as a floor nurse preventing for DON duties. She stated riewing Resident #323's ministrator on 08/11/2021 at trising management was sight of Admission She further revealed she y issues related to physician's #323. vealed the facility admitted (15/2021 with diagnoses that e to Thrive, Dementia, and t Disease without Angina #66 Minimum Data Set assessed the resident to have Mental Status (BIMS) score licated moderate cognitive ility assessed the resident to (2) staff for bed mobility. MDS revealed the resident are during the look back	F 686			
	04/23/2021, revealed	d under the Activities of Daily an focus the facility identified				

Facility ID: 100599

If continuation sheet Page 189 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF F	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		-	00 NURSING HOME LANE IKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		
F 686	the resident required (activities of daily livi mobility, multiple me receiving Hospice se developed an interve was totally depender repositioning and tur care plan did not dire resident was to be tu Review of Resident # revealed Registered on 06/16/2021 at 9:0 SRNA "straightened resident off his/her "r Observation of Resident 9:27 AM revealed a 1 the resident a bath. with care, the Assista his/her right side and pillows. Continued of revealed the residen side on 06/16/2021 at 3:13 PM, and at 4:14 Observation on 06/17 Resident #66's skin i skin breakdown or pi Attempts to interview 06/16/2021 at 5:21 F 10:00 AM were unsu not respond verbally Interview with State 1 (SRNA) #5, on 06/17 she had not attempted	assistance with ADL's ng) related to decreased dical conditions, and rvices. The facility ention that stated the resident at upon two (2) staff for ning in bed. However, the ect staff how often the rned and repositioned. #66's Nursing Notes, Nurse (RN) #3 documented 4 AM, that she observed a resident up to move" the ight side." Hent #66 on 06/16/2021 at Hospice Assistant was giving When the Assistant finished ant placed the resident on I positioned the resident with bservation of the resident t remained on his/her right at 11:47 AM, at 1:40 PM, at PM. 7/2021 at 10:00 AM of revealed the resident had no ressure ulcers.	F 686			

Facility ID: 100599

If continuation sheet Page 190 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND RI	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501		
	CUMMADY C			•	(15)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 686	Continued From pag	e 190	F 686			
	comfortable". The S	SRNA stated the resident was himself/herself in bed.				
F 689 SS=D	06/17/2021 at 10:30 aware Resident #66 9:30 AM until 4:14 Pl stated "breakdown" of the resident lying on of time. Interview with the Din 06/19/2021 at 12:29 should be turned and hours. She stated if repositioned, the out breakdown. The DC have turned Resident She stated the RN sl ensure the resident v stated she was unaw turning and repositio Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ens §483.25(d)(2)Each re	come could be skin N stated the SRNA should t #66 every two (2) hours. hould have been observing to was turned. The DON further vare of any concerns with ning residents. cards/Supervision/Devices 0(2)	F 689			

Facility ID: 100599

If continuation sheet Page 191 of 401

ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
185256	B. WING	- $ -$	09/10/202 <u>1</u>	
EHABILITATION CENTER				
TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	- · · · · ·	
ge 191	F 689			
T is not met as evidenced on, interview, record review, view, it was determined the tre the environment remained at hazards as possible for one) sampled residents ed to medication found in 5/2021, revealed a aining Valproic Acid two 50) milligrams (mg) tion), Metoprolol Tartrate fifty sure medication), and ve (25) mg (antipsychotic n Resident #12's overbed : policy titled,"Administering April 2019, revealed diministered in a safe and as prescribed. However, the ss ensuring the resident had tion prior to leaving the #12's medical record admitted the resident on				
	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256 EHABILITATION CENTER TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESCIDENTIFYING INFORMATION) ge 191 T is not met as evidenced on, interview, record review, view, it was determined the tre the environment remained at hazards as possible for one) sampled residents ed to medication found in 5/2021, revealed a aining Valproic Acid two 50) milligrams (mg) tion), Metoprolol Tartrate fifty sure medication), and ve (25) mg (antipsychotic n Resident #12's overbed E policy titled, "Administering April 2019, revealed dministered in a safe and as prescribed. However, the as ensuring the resident had tion prior to leaving the #12's medical record	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE C A. BUILDING 185256 B. WING TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RELSC IDENTIFYING INFORMATION) ID PREFIX TAG ge 191 F 689 T is not met as evidenced on, interview, record review, view, it was determined the tre the environment remained th hazards as possible for one) sampled residents ed to medication found in 5/2021, revealed a aining Valproic Acid two 50) milligrams (mg) ion), Metoprolol Tartrate fifty sure medication), and ve (25) mg (antipsychotic n Resident #12's overbed : bolicy titled, "Administering April 2019, revealed dministered in a safe and as prescribed. However, the ss ensuring the resident had tion prior to leaving the #12's medical record admitted the resident on	MEDICAID SERVICES (X1) IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 185256 Junce 185256 STREET ADDRESS, CITY, STATE, ZIP CODE 200 MURSING HOME LANE PIKEVILLE, KY 41501 D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD B CROSS-REFERENCED BY FULL LISC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD B CROSS-REFERENCED TO THE APPROPRIU DEFICIENCY) je 191 F 689	

Facility ID: 100599

If continuation sheet Page 192 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 689	Hypertension, Seizur Brain Injury. Review of the Quarte (MDS) assessment f 03/10/2021, revealed assessed by the faci for Mental Status (BI out of fifteen (15), wh was interviewable. Review of Resident a dated 06/01/2021, re receive Metoprolol Ta twice daily (blood pre Quetiapine twenty-fit twice daily (antipsych hundred and fifty (25 medication). Observation in Reside 06/15/2021 at 3:34 F cup containing Valpre (250) milligrams (mg Metoprolol Tartrate fi lowering medication) (25) mg (antipsychot the resident's overbe Interview with Reside 3:35 PM, revealed th medications on the o not taken them yet. Interview with Licens on 06/15/2021 at 3:4 supposed to observe	schemic Heart Disease, re Disorder, and Traumatic erly Minimum Data Set or Resident #12, dated d the resident had been lity to have a Brief Interview MS) score of thirteen (13) nich indicated the resident #12's physician's orders, evealed the resident was to artrate seventy-five (75) mg essure lowering medication); ve (25) mg one half tablet notic); and Valproic Acid two i0) mg twice daily (antiseizure ent #12's room, on PM, revealed a medication oic Acid two hundred and fifty) (antiseizure medication), fty (50) mg (blood pressure ic) one half tablet sitting on ed table. ent #12, on 06/15/2021 at	F 689		

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	12/08/2021 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10	0/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) COMPLETION DATE
F 689 F 692 SS=K	observed the resider however, she should another resident cour medication intended it. Interview with the Di 06/19/2021 at 12:00 medication administri identified any concer were required to ensi- their medications pri- The DON stated the medication as well a the medication as well a the medication as well a the medication being left Interview with the Act 12:36 PM, revealed ensure residents had to leaving the reside medication being mis- to the resident as we pick up the medication Nutrition/Hydration S CFR(s): 483.25(g)(1 §483.25(g) Assisted (Includes naso-gastri both percutaneous endos enteral fluids). Base	how why she had not in taking the medications; if have. The LPN stated and have picked up the for Resident #12 and taken rector of Nursing (DON), on PM, revealed she monitored ration randomly and had not rns. The DON stated nurses sure residents had ingested or to leaving the resident. resident missing a dose of s another resident picking up aking it were some of the be caused by the resident's t on the overbed table. Iministrator, on 06/19/2021 at nurses were required to d taken their medication prior int and should never leave a dent's bedside due to the ssed it could be detrimental ell as another resident could on and ingest it. Status Maintenance)-(3) nutrition and hydration. ic and gastrostomy tubes, endoscopic gastrostomy and copic jejunostomy, and ed on a resident's essment, the facility must	F 689			

Facility ID: 100599

If continuation sheet Page 194 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE AND R	EHABILITATION CENTER			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 692	Continued From pag	e 194	F 692		
		ains acceptable parameters			
		such as usual body weight or nt range and electrolyte			
		resident's clinical condition			
		is is not possible or resident			
	preferences indicate	otnerwise;			
	§483.25(g)(2) Is offe maintain proper hydr	red sufficient fluid intake to ation and health;			
	§483.25(g)(3) Is offe	red a therapeutic diet when			
		problem and the health care			
	This REQUIREMEN	T is not met as evidenced			
		on, interview, record review			
		policy, it was determined the re eight (8) of fifty-seven (57)			
	sampled Residents (Resident #65, Resident #90,			
		dent #82, Resident #330, ent #332, and Resident #81),			
		ble parameters of nutritional			
	status and/or body w	-			
	Review of Resident :	#65, Resident #90, Resident			
	#327, Resident #82,	Resident #330, Resident			
		and Resident #81's medical ch of the residents sustained			
		s as a result of the facility's			

Facility ID: 100599

If continuation sheet Page 195 of 401

NU PLAN OF	CORRECTION		() = = =	INSTRUCTION	X3) DATE SURVEY
	IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		09/10/2021	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		200 NURSING HOME LANE PIKEVILLE, KY 41501			
	CUMMAR		I	PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE
F 692	Continued From p	bage 195	F 692		
		systemic procedure in place to			
		weight loss. The facility failed to			
		eights according to policy, failed			
		stered Dietitian (RD) when a			
		d weight loss, failed to provide			
		ndations to prevent further I to honor resident food			
	•	event weight loss, and/or failed			
		t's were served adequate			
	portions to prever	•			
		re to ensure residents			
		otable parameters of nutritional			
		y weight, has caused or is likely			
		injury, harm, impairment or nt. Immediate Jeopardy was			
		11/2021, and was determined to			
		21, at 42 CFR 483.10 Resident			
		CFR 483.12 Freedom from			
		CFR 483.12 Comprehensive			
		Care Plans (F655) (F656) 42			
		lity of Care (F684) (F686)			
		83.45 Pharmacy Services R 483.80 Infection Control			
	· /	ty was notified of Immediate			
	Jeopardy on 08/1				
		egation of Compliance (AOC)			
		09/03/2021, which alleged			
		mediate Jeopardy on			
		vever, the AOC could not be observations, staff interviews,			
		ility documentation. Additional			
		rdy was identified at 42 CFR			
	483.35 Nursing S	ervices (F725), 42 CFR 483.70			
		835) (F837), 42 CFR 483.75			
	•	e and Performance			
		67). The facility was notified of opardy on 09/10/2021. The			

Facility ID: 100599

If continuation sheet Page 196 of 401

	-	ND HUMAN SERVICES			FORM	D: 12/08/2021 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185256	B. WING		09/	10/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	10/2021
				200 NURSING HOME LANE		
PARAVIEN	WPOST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	Continued From pag	ne 196	F 69	2		
1 002	Immediate Jeopardy	-	1 03			
		y to origoning.				
	The findings include	:				
	Review of the facility	y's policy titled "Weight				
		ervention," not dated,				
		sciplinary team would strive to				
		id intervene for undesirable esidents. According to the				
	•	would measure resident				
		on, the next day and weekly				
		after. According to the policy,				
		ive (5) percent or more since				
		ssment, would result in				
		t again the next day for ing staff verified the weight,				
		e dietitian immediately and				
		nt the notification. Further				
		revealed the dietitian would				
		ty-four (24) hours of receipt of				
		nd would review the unit				
		e fifteenth of the month to ght trends over time. The				
		Id evaluate negative trends				
		resident had met the criteria				
		t change. The policy defined				
	• •	ange as, a five (5) percent				
		nonth, greater than five (5)				
	-	severe; seven and one-half t loss in ninety (90) days was				
		ter than seven and one-half				
		lered severe; ten (10) percent				
) months was significant and				
) percent considered severe.				
	- · ·	licy, the facility should base				
		undesirable weight loss on				
		n of resident choices and tritional needs of facility				
	residents.	unional needs of lacility				
	1					1

Facility ID: 100599

If continuation sheet Page 197 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
F 692	Continued From pag	e 197	F 692			
	revealed the facility	nosis that included Cerebral				
	assessment, dated (facility assessed the hundred and sevent totally dependent on Daily Living, includin revealed the residen his/her weight loss/g had no pressure ulco Resident #65 had co	65's Admission MDS 03/30/202,1 revealed the resident weighed one y-nine (179) pounds, and was two (2) staff with Activities of g eating. Further review t had no weight loss/gain or ain history was unknown and ers. The MDS revealed omplaints of difficulty or pain d had malnutrition or was at				
	on 04/06/2021, the r hundred forty-two ar pounds, a weight los (36.6) pounds since 03/23/2021. Review revealed there was r	-				
	discharged to the ho shortness of breath. facility on 4/29/2021 Sepsis, Pneumonia, and Urinary Tract Inf there was no docum	w revealed Resident #65 was spital on 04/08/2021 for and was re-admitted to the with diagnoses that included Acute Respiratory Failure, fection. The record revealed ented evidence the facility t upon readmission to the				

Facility ID: 100599

If continuation sheet Page 198 of 401

	MENT OF HEALTH AND HUMA				FORM APPROVED
	S FOR MEDICARE & MEDICA	ID SERVICES			OMB NO. 0938-0391
		/IDER/SUPPLIER/CLIA FIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
			2	00 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND REHABILITA	TION CENTER	P	IKEVILLE, KY 41501	
(X4) ID	SUMMARY STATEMENT C	F DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	۱ (X5)
PRÉFIX TAG	(EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTI		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
F 692	Continued From page 198 facility.		F 692		
	Review of the Situation, Backg Assessment and Recommend Communication form, dated 09 PM, revealed the Resident #6 deep tissue injury (DTI) to the	ation (SBAR) 5/02/2021 at 5:29 5 had developed a			
	Review of the medical record #65 weighed one hundred and pounds on 05/04/2021, anothe tenths (7.7) pound weight loss weight on 04/06/2021.	I thirty-five (135) er seven and seven			
	Approximately one (1) month a initial weight loss, the RD asse #65. Review of a Nutrition Da assessment, dated 05/06/202 resident's weight was 135 pour calculated the resident's weigh and four tenths (5.4) percent in and twenty-four and seven ter in sixty (60) days. According to assessment, Resident #65 has malnutrition related to weight I recommended fortified foods to day and a frozen cup at dinne documented evidence the RD resident had a DTI and address resident needed anything for w	essed Resident ta Collection 1, revealed the nds, and the RD nt was down five n thirty (30) days ths (24.7) percent o the RD's d severe oss. The RD hree (3) times a r. There was no identified the ssed whether the			
	Interview with the RD, on 08/2 PM, revealed the facility had n her of resident skin breakdown She stated she was unaware t had a pressure ulcer when she resident on 05/06/2021. She known she would have increas protein to aide in pressure ulce	ot been notifying and weight loss. hat Resident #65 assessed the stated had she sed the resident's			

Facility ID: 100599

If continuation sheet Page 199 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 692	Continued From pag	e 199	F 692		
	stated ideally she wo of new pressure ulce	uld like to be notified weekly rs.			
	revealed the pressur coccyx was "worseni revealed the deep tis unstageable pressur loss (death) in which covered by slough (y and/or eschar (tan, b bed) that measured s centimeters (cm) long (9.7) cm wide. Review of a Nutrition 05/18/2021 at 10:46 weight was one hund (142.6) pounds, a sig (3) percent in seven (20.5) percent in nine revealed the RD was unstageable pressur Based on the progres receiving fortified foo a frozen nutrition cup ideal body weight (IB forty-eight (148) pour recommendations. Continued interview at 12:16 PM, reveale #65's pressure ulcer assessed the resider stated, had she know	05/11/2021 at 2:40 PM, e ulcer to the resident's ng". Continued review sue injury (DTI) was now an e ulcer (full thickness tissue the base of the ulcer was rellow, tan, green or brown) rown, or black) in the wound six and one-half (6.5) g and nine and seven tenths Progress Note, dated on PM, revealed Resident #65's dred forty-two and six tenths gnificant weight loss of three (7) days, twenty and one-half ety (90) days. Further review a aware the resident had an e ulcer to the sacrum. ss note, the resident was ds three (3) times a day and o at dinner. The resident's EW) was one hundred nds. The RD had no with the RD, on 08/26/2021 d she was unaware Resident was worsening when she nt on 05/18/2021. She wn she would have erventions to address the			

Facility ID: 100599

If continuation sheet Page 200 of 401

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	TTAL	
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 692	revealed the resid fifty-one and one- 5/27/2021. Review of a Nutri assessment, data resident had a tw percent weight ga sustained a fiftee weight loss in nin revealed the resid his/her needs; ho for malnutrition du days, a pressure required a therap revealed no nutrit made. Review of a chan 05/28/2021 at 3:5 had a "worsening a wound culture a However, per the later called back a	Resident #65's weight record dent weighed one hundred thalf (151.5) pounds on tion Data Collection ed 06/13/2021, revealed the elve and two tenths (12.2) ain in thirty (30) days and had in and one-half (15.5) percent ety (90) days. Further review dent's intake was greater than wever, the resident was at risk ue to a weight loss in ninety (90) wound, and the resident eutic diet. Continued review tional recommendations were ge of condition form, dated 44 PM, revealed Resident #65 wound". The physician ordered and laboratory testing. change of condition form, "MD and decided to send resident to in for evaluation and treat for	F 692		
	revealed he/she v 05/28/2021. Rev Department (ED) 05/28/2021 at 5:3 a "large decubitus fifteen (15) cm by sloughing and un	ent #65's hospital record, was admitted to the hospital on iew of the resident's Emergency nurse's notes, dated 66 PM, revealed the resident had s (pressure) ulcer approximately r eight (8) cm with central skin derlying necrosis, the wound erythema with mild purulent			

Facility ID: 100599

If continuation sheet Page 201 of 401

		HAND HUMAN SERVICES E & MEDICAID SERVICES		C	FORM APPROV OMB NO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		09/10/202 <u>1</u>	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		200 NURSING HOME LANE PIKEVILLE, KY 41501			
	SLIMMAR	RY STATEMENT OF DEFICIENCIES	 	PROVIDER'S PLAN OF CORRECTION	(YE)
(X4) ID PREFIX TAG	(EACH DEFIC	IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 692	Continued From p	page 201	F 692		
	-	s "clinically septic with large			
		ure] ulcer with associated			
		g cellulitis and possible			
		ess". According to an Infectious			
		note, dated 06/01/2021, the			
		ent debridement on 05/30/2021, e, all necrotic tissues were			
		excision was down to the bone".			
	Interview with Su	rgeon #1, on 08/31/2021 at 1:30			
	PM, revealed he debrided the large stage four-(4)				
		Resident #65's sacrum on			
	•	stated there was non-viable			
	tissue in the wour	nd and it had to be debrided			
		. He stated the pressure ulcer			
)) cm in length by six (6) cm in			
		oridement, and post debridement ed fifteen (15) cm in length by			
		Ith and was very extensive.			
	· · ·	d, "Nutrition is a big key" in the			
	-	sening of pressure ulcers.			
	Further review of	the hospital record revealed, on			
		38 PM, Resident #65's Albumin			
	•	indicate malnutrition) was "low"			
		tenths (1.3) gram per deciliter			
		al range of three and four tenths			
		g/dL. Further review revealed al Protein (measures the total			
		in and globulin in blood) was			
		six tenths (5.6) g/dL with normal			
		Four tenths (6.4) to eight and four			
	tenths (8.4) g/dL	(low protein levels can be seen			
		ition). Resident #65 was to the facility on 06/09/2021.			
	Continued Review	<i>w</i> of Resident #65's weight			
		o readmission weight was			
	documented for the	he resident. The resident			

If continuation sheet Page 202 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	NAME OF PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER) NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION
F 692	Continued From pag	e 202	F 692		
	weighed one hundre (152.2) pounds on 06 and six tenths (150.6	ed fifty-two and two tenths 6/15/2021, one hundred fifty 6) pounds on 06/22/2021 and ree and one tenth (143.1)			
	06/29/2021 at 9:52 F had sustained a sign percent in less than t and two tenths (20.2 ninety (90) days. Th weight (IBW) was on pounds. Further revi developed a Deep Ti and left heels and co (4) pressure ulcer to progress note, the re fortified foods three (current intake was in resident's protein new recommended addin	Progress Note, dated PM, revealed Resident #65 ificant weight loss of six (6) hirty (30) days and twenty) percent weight loss in e resident's ideal body e hundred forty-eight (148) ew revealed the resident had ssue Injury (DTI) to the right ntinued to have a Stage IV the coccyx. According to the sident continued to receive 3) times a day; however, the adequate to meet the eds for healing. The RD g large protein portions at to better meet energy needs			
	record revealed on 0 weighed one hundred (142.7) pounds. Review of the resided dated 07/13/2021, re significant weight los (6.3) percent in thirty one-half (20.5) perce eighty (180) days. T	Resident #65's medical 7/08/2021, the resident d forty-two and seven tenth nt's Nutrition Progress Note, vealed the resident had a s of six and three tenths (30) days and twenty and ent in less than one hundred he resident also had a DTI to) stage one (1) pressure			
	ulcers to left heel, an) stage one (1) pressure d stage four (4) to coccyx. e resident received fortified			

Facility ID: 100599

If continuation sheet Page 203 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	PARKVIEW POST-ACUTE AND REHABILITATION CENTER				
			I	VIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 692	Continued From pag	e 203	F 692		
		lay and large protein portions			
		er. According to the RD, the atly exceeded the resident's			
		and recommendations were			
		#65's tray card revealed the ve large protein portions and eals.			
		lent #65 dinner tray, on M, revealed no evidence the ge protein portions.			
	the resident was not approximately one (1 The resident weigher and two tenths (133.) tenths (6.6) percent w (30) days. There was the RD assessed the documented evidence the resident's weight revealed the resident one and four tenths (08/11/2021, a seven percent loss in approx	 month later on 08/06/2021. d one hundred thirty three 2) pounds, a six and six weight loss in less than thirty s no documented evidence resident and no that the facility addressed loss. Continued review t weighed one hundred thirty 131.4) pounds on and nine tenths (7.92) oximately five (5) weeks. nented evidence the RD 			
	dated 08/22/2021 at resident's weight was and eight tenths (137 significant loss of nin days and twenty-thre percent in one hundr	 #65's Nutrition Progress note, 2:41 PM, revealed the s one hundred thirty-seven 7.8) pounds, which was a e (9) percent in ninety (90) e and one tenth (23.1) ed eighty (180) days. gress note, the resident 			

Facility ID: 100599

If continuation sheet Page 204 of 401

STATE NUMP OF DEFICIENCIES AND FLAN OF CORRECTION (X) IDATE SURVEY DEMINIFICATION NUMBER: (X) UNLTIFIE CONSTRUCTION A BUILDING (X) DATE SURVEY A BUILDING INVECOF PROVIDER OR SUPPLIER 185256 B. WING STREET ADDRESS, CITY, STATE 2P CODE PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE 200 NURSING HOME LANE 09/10/2021 INVECOF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES INCOL DEFICIENCY MAIN THE PROCEEDED BY FULL REGULATION OF LOSE DETITIONS INFORMATION DB TREE DEFICIENCY PREVILES, COMPACTIVE AND CORRECTION ESTIMATION DB TREE DB TREE CONTINUE OF DEFICIENCIES INTERNATION OF LOSE DETITIONS AND/LD BE CORRECTION ADD/DE ADDRESS PLAN OF CORRECTION EACU ADDRESS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES INTERNATIONAL DEFICIENCY MAIN THE PROCEEDED BY FULL PREVILES, COMPACTIVE ADD DECREMY MAIN THE PROVEMANTON DB TREE DB TREE <t< th=""><th></th><th></th><th>ND HUMAN SERVICES MEDICAID SERVICES</th><th></th><th></th><th>PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039</th><th>D</th></t<>			ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039	D
NAME OF PREVAIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZP CODE PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE PREVIEW POST-ACUTE AND REHABILITATION CENTER D PREVIEW POST-ACUTE AND REHABILITATION CENTER	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ° <i>1</i>		(X3) DATE SURVEY	-
NME OF PROVIDER OR SUPPLIER STREET ADDRESS. CTV 2 AND REHABILITATION CENTER PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE Majo R SUMMARY STREMENT OF DEFICIENCES DE PREET MADRESS.CTV 2 AND REHABILITATION CENTER DE PROVIDER OF CORRECTION Majo R SUMMARY STREMENT OF DEFICIENCES DE PROVIDER OF CORRECTION SHOULD BE CONTENTION PREET MADRESS.CTV 2 AND REHABILITATION CENTER DE PROVIDER OF CORRECTION SHOULD BE CONTENTION PREED ADDRESS TO THE APPROPRIATE DE CONTENTION DE CONTENTION SHOULD BE CONTENTION TAG Continued From page 204 F 692 Continued to have a DTI to right heel, a stage four-(4) pressure ulcer to left lower extremity. Review of the note revealed the resident continued to lave to left lower extremity. Review of the note revealed the resident continued to lose weight. The resident weighed one hundred thiry-weight record revealed the resident continued to lose weight. The resident weighed one hundred thiry-one and four tenths (131.7) pounds on 08/23/2021, no bundred to 8/23/2021, no bundred to 8/23/2021, no bundred to 1/14/2004, no 8/23/2021, no bundred to 1/14/2004, no 8/23/2021, no bundred to 1/14/2004, no 8/23/2021, no 8/23/2021, no bundred to 1/14/2004, no 8/23/2			185256	B. WING		09/10/2021	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER PIKEVILLE, KY 41501 (M) ID PRETK TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION MATCH ERECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRETK TAG PRETK PRETK TAG PROVEMENT ACTION SHOULD BE CACH CORRECTION (EACH CORRECTION THE APROPRIATE DEFICIENCY OF LSC IDENTIFYING INFORMATION) D PRETK TAG PROVEMENT ACTION SHOULD BE CACH CORRECTION (EACH CORRECTION THE APROPRIATE DEFICIENCY) C(M) CACH CORRECTION (EACH CORRECTION (EACH CORRECTION	NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
With ID PRETRY TXG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETRY TAG PROVIDE'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROBE REFERENCED TO THE APROPRIATE DEFICIENCY) (0) (EACH CORRECTIVE ACTION SHOULD BE CROBE REFERENCED TO THE APROPRIATE DEFICIENCY) F 692 Continued From page 204 continued to have a DTI to right heel, a stage one-(1) pressure ulcer to left heel, a stage four- (4) pressure ulcer to left heel, a stage four- extremity. Review of the note revealed the resident had a desired weight gain of four and six tenths (4.6) pounds over the "past few weeks" and no recommendations were made. F 692 Further review of Resident #65's weight record revealed the resident continued to lose weight. The resident weighed one hundred thiry-two (132) pounds on 08/23/2021, one hundred thirdy-one and seven tenths (131.7) pounds on 08/24/2021 and one hundred thiry-two (132) pounds on 08/25/2021. Interview with the RD, on 08/11/2021 at 4:10 PM an 004/18/2021 at 10:30 AM, revealed she was not aware the facility was not torthing extent the facility was not torthing regording and frout tenths (131.4) pounds on 08/25/2021. Interview with Strgeon #1, on 08/31/2021 at 1:30 PM, revealed there ongoing significant weight loss that occured for this resident would have been prevented. Interview with Surgeon #1, on 08/31/2021 at 1:30 PM, revealed the registage four-(4) pressure ulcer to Resident #55's sacrum on 05/30/2021. He stated there was non-viable use in the wound and it had to be defided				2	00 NURSING HOME LANE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 692 Continued From page 204 continued to have a DTI to right heel, a stage one-(1) pressure ucer to left heel, a stage four- (4) pressure ucer to left heel, a stage four- extremity. Review of the note revealed the resident had a desired weight gain of four and six tenths (4.6) pounds over the "past few weeks" and no recommendations were made. F 692 Further review of Resident #65's weight record revealed the resident continued to lose weight. The resident weighed one hundred thirty-two (132) pounds on 08/23/2021, one hundred thirty-one and seven tenths (131.7) pounds on 08/24/2021 at 10:30 AM, revealed she was not aware the facility was not fortifying foods, nor providing large protein portions as recommended. She stated if the facility had fortified Resident #65's foods and added large protein portions as recommended, the on-going significant weight loss that occurred for this resident would have been prevented. Interview with Surgeon #1, on 08/31/2021 at 1:30 PM, revealed the elarge stage four-(4) pressure ucer to Resident #65's sacrum on 05/30/2021. He stated there was non-viable tissue in the wound and it had to be dehided	PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER	F	PIKEVILLE, KY 41501		
 continued to have a DTI to right heel, a stage four- (4) pressure ulcer to left heel, a stage four- (4) pressure ulcer to sacrum, and had developed an unstageable pressure ulcer to left lower extremity. Review of the note revealed the resident had a desired weight gain of four and six tenths (4.6) pounds over the "past few weeks" and no recommendations were made. Further review of Resident #65's weight record revealed the resident continued to lose weight. The resident weighed one hundred thirty-two (132) pounds on 08/23/2021, one hundred thirty-one and seven tenths (131.7) pounds on 08/22/2021 at one hundred thirty-one and four tenths (131.4) pounds on 08/25/2021. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed she was not aware the facility was not fortifying foods, nor providing large protein portions as recommended. She stated if the facility had fortified Resident #65's foods and added large protein portions as recommended, the on-going significant weight loss that occurred for this resident would have been prevented. Interview with Surgeon #1, on 08/31/2021 at 1:30 PM, revealed he debrided the large stage four-(4) pressure ulcer to Resident #65's accum on 05/30/2021. He stated there was non-viable tissue in the wound and it had to be debrided 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	E COMPLETION	
down to the bone. He stated the pressure ulcer measured ten (10) cm in length by six (6) cm in depth prior to debridement, and post debridement the area measured fifteen (15) cm in length by ten (10) cm in width and was very extensive.Surgeon #1 stated, "Nutrition is a big key" in the	F 692	continued to have a l one-(1) pressure ulcer (4) pressure ulcer to an unstageable press extremity. Review of resident had a desire tenths (4.6) pounds of and no recommenda Further review of Res revealed the resident The resident weighed (132) pounds on 08/2 thirty-one and seven 08/24/2021 and one tenths (131.4) pound Interview with the RE and 08/18/2021 at 10 not aware the facility providing large prote She stated if the facil #65's foods and adde recommended, the o loss that occurred for been prevented. Interview with Surged PM, revealed he deb pressure ulcer to Res 05/30/2021. He state tissue in the wound a down to the bone. H measured ten (10) cr depth prior to debride the area measured fi ten (10) cm in width a	DTI to right heel, a stage er to left heel, a stage four- sacrum, and had developed sure ulcer to left lower f the note revealed the ed weight gain of four and six over the "past few weeks" tions were made. sident #65's weight record t continued to lose weight. d one hundred thirty-two 23/2021, one hundred tenths (131.7) pounds on hundred thirty-one and four s on 08/25/2021. 0, on 08/11/2021 at 4:10 PM 0:30 AM, revealed she was was not fortifying foods, nor in portions as recommended. lity had fortified Resident ed large protein portions as n-going significant weight r this resident would have on #1, on 08/31/2021 at 1:30 rided the large stage four-(4) sident #65's sacrum on ed there was non-viable and it had to be debrided le stated the pressure ulcer m in length by six (6) cm in ement, and post debridement fteen (15) cm in length by and was very extensive.	F 692			

Facility ID: 100599

If continuation sheet Page 205 of 401

		ND HUMAN SERVICES			PRINTED: 12/0 FORM APPR OMB NO. 0938	ROVED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	ŕ
		185256	B. WING		09/10/202	21
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPI	(5) LETION ATE
F 692	revealed the facility 10/07/2016 with diag Unspecified Protein- Dysphagia. Review of Resident (MDS) assessment the facility assessed score of eight (8) our resident had modera MDS also revealed dependent on staff f stated the resident w pounds and was at the Review of Resident the resident weigher on 02/02/2021. Review of Resident plan in place on 02/ identified on 11/20/2 potential for weight malnutrition due to o eating, diagnosis of deficiency. Review of Resident on 03/06/2021, the n and eight tenths (86 pounds in thirty-two was no documented	nt #90's medical record admitted the resident on gnoses including Dementia, -Calorie Malnutrition and * #90's Minimum Data Set dated 02/19/2021, revealed I the resident to have a BIMS t of fifteen (15), indicating the ate cognitive impairment. The the resident was totally for eating. The assessment veighed ninety-seven (97)	F 692			
		Resident #90's weight record 021, the resident weighed nths (86.6) pounds.				

If continuation sheet Page 206 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVEI OMB NO. 0938-039	D
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	-
- E		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 692	Continued From pag	e 206	F 692			
	revealed the RD note sustained an eight ar weight loss in thirty (one-half (10.5) perce (180) days. The docu recommended servir with meals, ice crear whole milk with meal Med Pass (nutritiona twenty (120) milliliter However, review of F administration record through July 2021, re administer the reside House Supplement to of one hundred twen by the RD on 04/09/2 Continued review of revealed on 05/04/20 weight and weighed (93.6) pounds. Howe documented evidence resident the next day weight was accurate policy. Review of Resident # on 06/08/2021, the re eighty-four and seven on 06/15/2021, the re eighty-two and one-f Review of Resident # 06/16/2021, revealed	he eight tenths (8.8) percent 30) days, and ten and bot in one hundred eighty umentation stated the RD or the resident fortified foods in with lunch and supper, is and administer the resident I supplement) one hundred is (mI), three (3) time per day. Resident #90's medication is (MAR), dated April 2021 evealed staff continued to ent ninety (90) ml of the hree (3) times a day, instead ty (120) ml as recommended 2021. Resident #90's weight record 021, the resident had gained ninety-three and six tenths ever, there was no the the facility re-weighed the in to ensure the increased as required by the facility's #90's weight record revealed esident's weight was in tenths (84.7) pounds, and esident's weight was				

Facility ID: 100599

If continuation sheet Page 207 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROV OMB NO. 0938-03	/ED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ON
F 692	weight loss in ninety one-half (11.5) perce- hundred eighty (180) documented the resi exceeds the resident weight". The RD reco- resident's Med Pass Review of Resident a Administration Reco- 2021, revealed the N administered to the r day. Review of Resident a on 06/29/2021, the r and three tenths (82) Review of RD docum revealed the RD doc lost thirteen and one (90) days and elever percent loss in one h However, the RD ma recommendations. Further review of Re revealed on 07/08/20 was eighty and two to Review of Resident a 07/27/2021, revealed foods at meals and in supper meals.	ine tenths (12.9) percent (90) days, and an eleven and ent weight loss in one o days. However, the RD dent's intake "greatly a needs yet continues to lose ommended increasing the to four (4) times per day. #90's Medication rds, for June 2021 and July Med Pass continued to be esident three (3) times per #90's weight record revealed esident weighed eight-two 3) pounds. hentation dated 07/07/2021, umented Resident #90 had tenth (13.1) percent in ninety and seven tenths (11.7) undred eighty (180) days. de no new sident #90's weight record 021, the resident's weight enths (80.2) pounds. #90's meal tray card on d the card listed fortified ce cream with lunch and	F 692			
	meal services, on 07	ident #90 during the lunch /27/2021 and 07/28/2021, t's tray did not include ice				

Facility ID: 100599

If continuation sheet Page 208 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 692	Continued From pag	e 208	F 692		
	cream on either day.				
	08/05/2021, from 2:0 Resident #90 weigher (81.1) pounds. Hower documented evidence that the resident was Interview with the RE and 08/18/2021 at 10 facility had fortified R recommended and p recommended supple have prevented the c loss that occurred for stated she assumed recommendation the unless she was notifis she did not conduct a ensure residents wer recommendations sho observations. The RE routinely notify her if weight loss, and the that information was came to the facility.	e the facility notified the RD continuing to lose weight. 0, on 08/11/2021 at 4:10 PM 0:30 AM, revealed if the resident #90's foods as rovided the resident with the ements and snacks, it would on-going significant weight this resident. The RD if she made a facility implemented it, ed otherwise. The RD stated any type of monitoring to re getting the e had made, such as meal D stated the facility did not a resident had experienced only way for her to obtain to run a report when she			
	revealed the facility a 03/15/2021 with diag Anemia, and Hyperlin documented the resid two hundred one and Review of Resident #	dent's admission weight as I one-half (201.5) pounds. ¢327's admitting physician			
	provide the resident	2021, revealed staff were to with a mechanical soft diet provide the resident with Med			

Facility ID: 100599

If continuation sheet Page 209 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER			
				IKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 692	Continued From pag	ge 209	F 692		
	Pass four (4) times	per day.			
	for Resident #327 re staff to provide fortif	mentation, dated 03/17/2021, evealed she recommended ied foods with all meals, es a day and finger foods			
	assessment, dated (facility assessed the cognitively impaired the resident complai swallowing, and was requiring set up help	#327's Admission MDS 03/22/2021, revealed the resident to be severely . The assessment also stated ined of difficulty or pain with s independent with meals o only, and the resident ed and five (205) pounds.			
		#327's baseline care plan,)21, revealed the plan failed to .tatus.			
	revealed Resident # ninety-four and two the RD documented five (5) percent weig recommended addir	luation, dated 03/26/2021, 327 weighed one hundred tenths (194.2) pounds, and the resident had sustained a ght loss in one week. The RD ng whole milk and ice cream ch and supper meals.			
	#327 weighed one h tenths (184.2) pound ten (10%) percent in review of the report recommended refer physician for a medi facility's documentat	d on 04/06/2021, Resident hundred eighty-four and two ds, a significant weight loss of h thirty (30) days. Further			

Facility ID: 100599

If continuation sheet Page 210 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2 FORM APPROV OMB NO. 0938-0	VED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE		
		-	P	IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	ON
F 692	Continued From pag	e 210	F 692			
	loss. However, there evidence in the resid	was no documented ent's medical record to				
	indicate the facility in recommendation and the staff notified the i					
	revealed she evaluat 05/07/2021, because hundred eighty-two a on 04/27/2021. The I had lost six (6) perce thirty (30) days and t percent of body weig days. However, the F recommendations, st	e the resident weighed one and one-half (182.5) pounds RD documented the resident ant of body weight in the past en and eight tenths (10.8) ht in the past ninety (90) RD made no further rating the resident's intake because the resident's				
	on 05/09/2021, reveat the resident was at ri- related to dementia a problems. The resident that although the res- loss, the resident wa weight. The intervent plan included assistin needed, RD consults and administer the re- Supplement as order Review of RD docum 06/06/2021, the RD of because the resident	ent's care plan also stated ident had sustained weight is still above ideal body tions on the resident's care ing the resident with meals as a sneeded, obtain weights, esident the House red. mentation revealed on evaluated Resident #327 t weighed one hundred				
		e-half (178.5) pounds on cant weight loss of eleven				

Facility ID: 100599

If continuation sheet Page 211 of 401

		ND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	- L
PARKVIE	W POST-ACUTE AND R	REHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 692	Continued From pag	ge 211	F 692		
		4) percent in ninety (90) days. ade no recommendations for			
	07/07/2021, the RD who weighed one hi tenths (179.9) poun- made no new recom	mentation revealed on evaluated Resident #327, undred seventy-nine and nine ds on 07/06/2021. The RD nmendations stating the id remained stable in the past			
	meal, on 07/27/202 ² revealed the resider	ident #327 during the lunch 1 at approximately 2:00 PM, nt was not served ice cream ne RD recommendation.			
	revealed the resider seventy (170) pound a five and one-half (f Resident #327's record ht weighed one hundred ds on 08/03/2021, which was (5.5) percent weight loss in vever, there was no evidence d the resident.			
	facility on 08/05/202 PM, revealed Resid	weighing residents in the 21, from 2:00 PM until 5:00 lent #327 weighed one ld three tenths (170.3)			
	and 08/18/2021 at 1 opinion, if the facility resident's diet order resident would not h significant weight los failure to provide for supplements such a	D, on 08/11/2021 at 4:10 PM 10:30 AM, revealed in her y had consistently followed the rs and recommendations, the nave experienced on-going ss. The RD stated the facility's rtified foods, snacks, and as ice cream could have all esident's continued weight			

Facility ID: 100599

If continuation sheet Page 212 of 401

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/08/2021 APPROVED . 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE S COMPL	SURVEY
Dr		185256	B. WING		09/1	0/2021
NAME OF PROVIDER O	R SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-A	CUTE AND RE	HABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501		
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
loss. The informer stated the resident she was sustaine 07/06/2 4. Review revealed 05/12/2 Disease Vitamin admissi was one pounds Review revealed mechan 05/18/2 supplen times pe ordered adminis Review assess resident was ind only. The weight v a five an one (1) Review initiated	d her of Resident he only way s 's weight loss a the facility a not aware the d additional s 021 to 08/03/2 ew of Resident d the facility a 021 with diag p, Alzheimer's D Deficiency on data revea e hundred fifty on 05/12/202 of the Physic d Resident #8 ical soft diet v 021 the physic nent to be pro- er day and on Periactin (ap tered every si of Resident # nent, dated 00 s was severely ependent witt e assessment was one hund d six tenths (week. of Resident #	acility staff had never dent #327's weight loss. She he was aware of the s, was to run a report when 7. Therefore, the RD stated hat the resident had significant weight loss from 2021. It #82's medical record dmitted the resident on noses including Parkinson's Disease, Insomnia and . Further review of the filed the resident's weight 7-three and six tenths (153.6) 1. ian Admission orders, 22 was to receive a with thin liquids, and on cian ordered the house vided to the resident four (4) 07/27/2021 the physician petite stimulant) to be	F 692			

Facility ID: 100599

If continuation sheet Page 213 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
		EHABILITATION CENTER	2	00 NURSING HOME LANE	
PARAVIE	W POST-ACUTE AND RI	ENABLITATION CENTER	P	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 692	Continued From pag	e 213	F 692		
	on 06/01/2021, the reforty-five and one terrand one-half (5.5) per thirty (30) days. How documented evidence #82 until 06/05/2021 admission and eighteresident sustained a Review of the RD as identified Resident # one-half (5.5) percendays, and a thirteen percent loss in ninety recommended to add fortified foods to the Continued review of revealed on 06/08/20 one hundred forty-thepounds. Review of Resident # developed on 06/17//identified the resident # developed on 06/17//identified the resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified the resident forty-thepounds. Review of Resident # developed on 06/17//identified thepounds # Review of Resident	 we the RD evaluated Resident , twenty-four (24) days after een (18) days after the weight loss. sessment, dated 06/05/2021, 82 had sustained a five and and four tenths (13.4) y (90) days. The RD d a nighttime snack and Resident's diet. Resident #82's weight record 021, the resident weighed ree and two tenths (143.2) #82's nutritional care plan, 2021, revealed the facility and a potential for weight for malnutrition due to and a history of weight loss. 			

Facility ID: 100599

If continuation sheet Page 214 of 401

	AND HUMAN SERVICES			FORM APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
DM	185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND		2	200 NURSING HOME LANE	
PARKVIEW POST-ACUTE AND	REHABILITATION CENTER	F	PIKEVILLE, KY 41501	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
 months and a ten ((6) months. Further review of F the resident weight one-half (142.5) pc hundred thirty-nine on 07/20/2021, one three tenths (137.3 132.9 pounds on 0 loss of 13.4% in th was no evidence th resident after 06/03 facility notified the weight loss. Observation of stat 08/05/2021 from 2 Resident #82 weig Interview with the F and 08/18/2021 at opinion, if the facilit foods as recomme with an adequate a would have preven significant weight loss. She stated th the resident's weig when she was at th stated she did not times, staff failed to into the system, so trigger. Therefore, aware that the resident the resident the resident to reside the time she was at the stated she did not times, staff failed to into the system, so trigger. Therefore, aware that the resident to resident to resident the resident to resident to resident the resident t	percent weight loss in three (3) (10) percent weight loss in six Resident #82's record revealed ed one hundred forty-two and bunds on 07/13/2021, one and one tenth (139.1) pounds e hundred thirty-seven and B) pounds on 07/27/2021 and 8/03/3021, a significant weight e last 90 days. However, there he RD re-evaluated the 5/2021, and no evidence the resident's physician of the ff weighing residents on :00 PM thru 5:00 PM, revealed	F 692		

Facility ID: 100599

If continuation sheet Page 215 of 401

PRINTED: 12/08/2021

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
			200	0 NURSING HOME LANE	
PARKVIE	V POST-ACUTE AND R	REHABILITATION CENTER	PII	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 692	 Review of Resider revealed the facility 03/11/2020 with diag Infarction, Diabetes Aphasia. Review of Resident May 2021, revealed mechanical soft dief Review of Resident assessment, dated facility assessed the Interview for Mental (4) out of fifteen (15 cognitively impaired and held residual fo the assessment rev resident to require li staff member at mea the resident's weigh (239) pounds. Review of Resident 05/12/2021, revealed potential weight con the resident's diagn the facility identified body weight and wa the resident had a fa nutrition. Interventio included RD consult and monitor/report a malnutrition to the p signs/symptoms of the weight loss of three 	ent #330's medical record admitted the resident on gnoses including Cerebral Mellitus, Hemiplegia and #330's physician orders for the resident was to receive a	F 692		

Facility ID: 100599

If continuation sheet Page 216 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
			PI	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 692	Continued From pag	je 216	F 692		
	importance of mainta Explain consequence obesity/malnutrition resident being sever requiring staff assista Review of Resident a revealed on 06/08/20 was two hundred thin pounds. However, the	risk factors", despite the rely cognitively impaired and			
	sustained a ten and weight loss in approx	(20) days after the resident six tenths (10.6) percent ximately thirty (30) days.			
	revealed the RD doo lost ten and six tenth	essment, dated 06/28/2021, cumented Resident #330 had ns (10.6) percent of his/her nundred eighty (180) days, but ommendations.			
	07/06/2021, revealed	Resident 330's weight on d the resident weighed two one-half (215.5) pounds.			
	4:15 PM, revealed st to the third floor for a The note stated with floor staff were callin stating the resident's noted stated the spo starving the resident the writer went to the resident crying, and "resident was hungry	note, dated 07/18/2021 at taff took Resident #330 down an in-person visit with spouse. in ten (10) minutes, the third ng up to the resident's floor, is spouse was very upset. The buse told staff "they were t". The nurse's note indicated e third floor and found the the spouse stating the y and facility was starving use stated the resident had			

Facility ID: 100599

If continuation sheet Page 217 of 401

	-	HAND HUMAN SERVICES			PRINTED: 12/08/20 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
	$2 \cap$	185256	B. WING		09/10/202 <u>1</u>
NAME OF PF	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER		NURSING HOME LANE	
04.0.15	CLIMMAT	RY STATEMENT OF DEFICIENCIES	I	PROVIDER'S PLAN OF CORRECTION	(17)
(X4) ID PREFIX TAG	(EACH DEFIC	IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F 692	Continued From	page 217	F 692		
		nt." The note further stated the			
		she was not hungry.			
		sident #330's spouse, on			
		80 PM, confirmed the spouse			
	0	esident on 07/18/2021. The			
	•	e resident all of a sudden wanted			
	to come home an	nd was crying. The spouse			
	stated the resider	nt had never acted that way on			
	prior visits and th	e resident looked like he/she			
	had lost weight.	The spouse reported caring for			
	the resident at ho	ome after the stroke, which had			
	left the resident u	nable to speak. The spouse			
		esident was home, they had			
		unicate through actions and			
		buse stated when the resident			
		motion" on the arm it meant the			
		gry. The spouse stated when			
		uring the visit on 07/18/2021,			
		was crying, the spouse reported			
		nt what was wrong. The spouse			
	•	nt immediately began making a			
		on his/her arm. The spouse			
	0 0	he resident are you hungry and			
		nt answered yes by shaking			
		e spouse then told the resident			
		ourchased a "pop and bag of			
		/ to the facility and asked the			
		wanted it. The Spouse reported			
		the resident who immediately			
	•	drank the soda. The spouse			
		ng the interview and voiced			
		to care for the resident at home			
		r facility to transfer the resident esident was "going hungry."			
		ent #330's weight on 08/03/2021,			
		dent weighed two hundred and			
	ten (210) pounds	, a five and one-half (5.5) pound			

Facility ID: 100599

If continuation sheet Page 218 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVEI OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
- E		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 692	was no documented re-evaluated the resi addition, there was r notified Resident #33 resident had sustain the facility. Observation of staff 08/05/2021, from 2:0 Resident #330 weigh (210) pounds. Interview with the RE and 08/18/2021 at 10 Resident #330 had s loss on 06/28/2021, resident, the residen above ideal body we stated no interventio the RD stated facility of Resident #330's c stated the only way s resident's weight loss she was at the facilit she did not always ru staff failed to enter th system, so a weight Therefore, the RD st the resident had con 6. Review of Residen revealed the facility a 11/25/2011, and re-a facility on 04/03/2018	 /06/2021. However, there evidence the RD ident after 06/28/2021. In the odocumented evidence staff 30's physician that the ed significant weight loss in weighing residents on 00 PM thru 5:00 PM, revealed the two hundred and ten 0, on 08/11/2021 at 4:10 PM 0:30 AM, revealed although sustained a significant weight when she evaluated the t still remained significantly sight, so therefore the RD ins were warranted. However, a staff had never informed her ontinuing weight loss. She she was aware of the s, was to run a report when y. However, the RD stated un that report and at times, he resident's weights into the loss would not trigger. ated she was not aware that tinued to lose weight. Int #39's medical record admitted the resident to the 8 with diagnoses including ERD, and Chronic Diastolic 	F 692		

Facility ID: 100599

If continuation sheet Page 219 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE NKEVILLE, KY 41501	
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 692	Continued From pag	le 219	F 692		
		3/01/2021 revealed the			
	-	resident to have a BIMS			
	score of fifteen (15) the resident was cog	out of fifteen (15), indicating			
		vealed the resident was			
		ting, weighed two hundred			
	physician ordered we	nds, and was not on a eight loss plan.			
		#39's weight record revealed I two hundred ninety (290)			
		21, and refused to be			
	weighed in May 202				
		#39's comprehensive care 21, revealed the facility			
	identified the resider	nt was at risk for impaired			
		eceiving a mechanical soft			
	-	is of Diabetes. Interventions 17/2021 included staff			
	honoring the residen	t's food			
		s, monitoring the residents the resident with diet as			
	ordered.	i i le resident with diet as			
	Review of Resident	#39's weight record revealed			
		two hundred fifty-three and			
	· · · ·	pounds on 06/22/2021,			
		een (14) percent weight loss hundred eighty (180) days.			
	Review of an RD ass	sessment, dated 06/22/2021,			
	revealed the RD reco	ommended to honor the			
	resident's dietary pre resident fortified food	eferences and serve the ds at meals.			
	Further review of Re	sident #39's weight record			
		tion that the resident refused in weight in July 2021.			

Facility ID: 100599

If continuation sheet Page 220 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE FORM 0938-039 MB NO. 0938-039	D
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		200 NURSING HOME LANE		
				PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	1
F 692	Continued From pag	e 220	F 69	2		
	Observation of staff v 08/05/2021, from 2:0 Resident #39 weighe seven tenths (261.7) Interview with Reside 10:45 AM, revealed t available for resident same food several tir the supper meal. Res hardly get anything a resident stated the fa and stated, "I get hur Interview with Reside meal, on 08/17/2021 resident preferred sa eat Fruit Loops cerea not served the reside resident stated, "I've past year because the and cold". The Resid requested salads for received a salad for I asking staff in the pa received salads, and different excuse, the lettuce." Resident #30	weighing residents on 0 PM thru 5:00 PM, revealed ed two hundred sixty-one and pounds. ent #39, on 07/27/2021 at he facility had no snacks s and the facility served the mes a week, especially for sident #39 also stated, "You t supper to eat anyway". The facility never passes snacks ngry". ent #39 and during the lunch at 1:20 PM, revealed the lads for lunch, and liked to al. However, the facility had ent a salad for the meal. The lost a lot of weight in the e food here is always late ent stated he/she had lunch but had never unch. The resident reported				
	his/her favorite cerea facility. However, Re- give me that here eith "Why would someon wanted to eat, if they makes no sense." T was frequently cold a until lunch. However,	Il before admission into the sident #39 stated, "they won't her." The resident stated, e ask me what I liked or 're not gonna give it to me, he resident stated breakfast and he/she remains hungry the resident stated "but if I al I could eat that, I could				

Facility ID: 100599

If continuation sheet Page 221 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES			PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-03	ED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO	'n
F 692	Continued From pag make it myself." Reg refusing to allow stat Interview with the R and 08/18/2021 at 1 #39's food preference resident would most significant weight los weight loss would ha resident, but a sudd not desirable. 7. Review of Resider revealed the facility 03/12/2021 with diag Chronic Kidney Dise Reflux Disease, Hyp and Femoral Neck F Review of Resident 03/12/2021, reveale a two thousand (200 Diabetes Associatio Review of a Dietary assessment, comple PM, revealed Resid hundred ninety-nine pounds and the resi to meet the resident the assessment reve add fortified foods to energy needs. Review of Resident assessment, dated	ge 221 sident #39 also denied ever ff to weigh him/her. D, on 08/11/2021 at 4:10 PM 0:30 AM, revealed if Resident ces had been honored, the likely not have experienced a ss. The RD stated a gradual ave been beneficial for the en significant weight loss was nt #332's medical record admitted the resident on gnoses including Diabetes, ease, Gastro-Esophageal bertension, Atrial Fibrillation, Fracture. #332's diet orders, dated d the resident was to receive 00) calorie ADA (American	F 692	DEFICIENCY)		
	score of fourteen (1					

If continuation sheet Page 222 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 692	Continued From pag	e 222	F 692		
	assessment revealed independent with eat hundred (200) pound	ing, and weighed two			
		#332's weight record t weighed one hundred nths (182.6) pounds on			
	dated 04/11/2021, re sustained a nine (9) (30) days. Further re intake remained inac needs. The progress	on Progress Note by the RD, vealed Resident #332 had percent weight loss in thirty view revealed the resident's lequate to meet the resident' note stated the resident was ds, large protein portions at at bedtime.			
		#332's weight record t weighed one hundred tenths (184.9) pounds on			
	#332, dated 05/27/20 had a seven and six loss in ninety (900 da the note the resident	Progress Note for Resident 021, revealed the resident tenths (7.6) percent weight ays. However, according to 's "current intake exceeds has remained weight stable".			
	RD evaluated Reside noted the resident re sandwiches with tom and dinner per the re the RD again notes " stability despite exce	RD evaluations revealed the ent #332 on 06/29/2021 and ceived two (2) bologna ato and mayonnaise at lunch esident's request. However, has a history of weight eding (his/her) needs so do sting interventions at this			

Facility ID: 100599

If continuation sheet Page 223 of 401

		ND HUMAN SERVICES			FORM	: 12/08/2021 APPROVED . 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE S COMPL	
		185256	B. WING		09/1	0/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE VIKEVILLE, KY 41501		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 692	Continued From pag	je 223	F 692			
	Review of a subsequ	uent RD evaluation for				
		7/25/2021, revealed there				
		since 05/04/2021". The RD t intake exceeds needs", so				
		v dietary recommendations.				
		rative Weight Record Book				
		ed Resident #332 on 021, and 08/03/2021.				
		to enter the weights into the				
		medical record. Review of				
	•	Resident #332 continued to				
		g one hundred eighty-three δ) pounds on 06/07/2021, one				
		and nine tenths (182.9)				
	pounds on 07/05/202					
	seventy-nine and nir 08/03/2021.	ne tenths (179.9) pounds on				
	Observation of staff	weighing residents on				
		00 PM thru 5:00 PM, revealed				
	Resident #332 weigh (180) pounds.	ned one hundred and eighty				
	Observation of Resid	dent #332's supper meal tray,				
		28 PM, revealed the resident				
	did not have bolognations on the meal	a sandwiches or large protein l tray.				
		ent #332, on 7/27/2021 at				
		the food was always cold, orted losing weight since				
		dent stated he/she was				
	supposed to get a bo	ologna sandwich on the meal				
		oper. However, the resident				
		got the sandwiches at lunch ent further stated when				
		he sandwich were, staff				

Facility ID: 100599

If continuation sheet Page 224 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	12/08/2021 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10)/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692	bologna. In addition, facility never had sna reported going to sle stated staff would tel morning when the kit Interview with Cook a PM, revealed the fac had been out for wea Interview with the RE and 08/18/2021 at 10 facility had fortified R large protein portions two (2) bologna sand and provided a night prevented the reside weight loss. In addition likely the resident wo The RD stated she of documented in the re- record, and denied h book". The RD stated facility was providing he/she was ordered she made. However, never discussed the the resident. The RD facility she reviewed not physically observe 8. Review of Resider revealed the facility a 10/12/2015, and re-a	he kitchen was out of Resident #332 stated the acks especially at night and ep hungry. The resident I me I have to wait till in the tchen opens. #2, on 08/05/2021 at 5:20 ility was out of bologna, and eks. 0, on 08/11/2021 at 4:10 PM 0:30 AM, revealed if the tesident #332's foods, added s, provided the resident with lwiches at lunch and supper, ly snack, it would have nt's on-going significant on, the RD stated, "most ould have gained weight". nly looks at weights esident's electronic medical aving knowledge of a "weight d she could only assume the the resident with the diet and the recommendations the RD stated she had resident's weight or diet with stated when she was at the records and weights, but did re or talk to residents. ht #81's medical record admitted the resident on idmitted the resident on idmitte	F 692			

Facility ID: 100599

If continuation sheet Page 225 of 401

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 185256 B. WING 09/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 09/10/2021 PARKVIEW POST-ACUTE AND REHABILITATION CENTER PIKEVILLE, KY 41501 09/10/2021			ND HUMAN SERVICES			FORM APPROVED
AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING COMPLETED 185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER PIKEVILLE, KY 41501 COMPLETED COMPLET	CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE PIKEVILLE, KY 41501 PIKEVILLE, KY 41501						
PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE PIKEVILLE, KY 41501			185256	B. WING		09/10/202 <u>1</u>
PARKVIEW POST-ACUTE AND REHABILITATION CENTER PIKEVILLE, KY 41501	NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
PIKEVILLE, KY 41501		N POST-ACUTE AND R		2	200 NURSING HOME LANE	
				F	PIKEVILLE, KY 41501	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET		(EACH DEFICIEN			CROSS-REFERENCED TO THE APPROPRIA	BITE
F 692 Continued From page 225 assessment dated 05/18/2021, revealed the facility assessed the resident to have a BIMS score of six (6) out of fifteen (15), indicating the resident was cognitively impaired. Further review of the MDS assessment revealed the resident required extensive assistance for eating, and the resident weighed one hundred and seventeen (117) pounds. F 692 Review of Resident #81's comprehensive care plan, in effect on 05/18/2021, revealed the resident had a history of unplanned weight loss and poor nutritional intake and was at risk for malnutrition. Review of Resident #81's weight record revealed on 06/01/2021, the resident weighed one hundred nine and two tenths (109.2) pounds. Review of a BD assessment for Resident #81, completed on 06/05/2021, revealed the resident sustained a six and one-half (6.5) percent weight loss in thirty (30) days and an eight and nine tenths (8.9) percent weight loss in ninet (90) days, Further revealed the residents current intake was inadequate to meet resident needs. The assessment truther stated Resident #81 was "inadequate to meet resident favel was inadequate to meet resident set off way supposed" to get fortified foods, whole milk and sandwiches with meals, and an ice cream oup with dinner. The RD recommended discontinuing the ice cream cup and adding a frozen nutrition cup with dinner. Review of a Nutrition Progress Note for Resident #81, dated 07/07/2021, revealed on 07/06/2021, the resident work of on Nutrition nutre work of and cup with dinner.	F 692	assessment dated (facility assessed the score of six (6) out of resident was cognition of the MDS assessor required extensive a resident weighed or (117) pounds. Review of Resident plan, in effect on 05 resident had a histon and poor nutritional malnutrition. Review of Resident on 06/01/2021, the nine and two tenths Review of a RD ass completed on 06/05 sustained a six and loss in thirty (30) da tenths (8.9) percent days. Further review the resident's current meet resident needs stated the resident needs stated the resident malnutrition due to stated Resident #81 get fortified foods, w with meals, and an The RD recommend cream cup and addid dinner. Review of a Nutrition #81, dated 07/07/20	 b5/18/2021, revealed the e resident to have a BIMS of fifteen (15), indicating the vely impaired. Further review nent revealed the resident assistance for eating, and the ne hundred and seventeen #81's comprehensive care /18/2021, revealed the ry of unplanned weight loss intake and was at risk for #81's weight record revealed resident weighed one hundred (109.2) pounds. essment for Resident #81, /2021, revealed the resident one-half (6.5) percent weight ys and an eight and nine weight loss in ninety (90) wof the assessment revealed number to riteria for severe weight loss. The assessment further met criteria for severe weight loss. The assessment was "already supposed" to chole milk and sandwiches ice cream cup with dinner. ded discontinuing the ice ng a frozen nutrition cup with 	F 692		

If continuation sheet Page 226 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES			PRINTED: 12/ FORM APP OMB NO. 093	ROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVI COMPLETED	EY
		185256	B. WING		09/10/20)21
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		_
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COM	(X5) IPLETION DATE
F 692	and four tenths (9.4 (90) days. However resident's weight wa and implemented no Review of Resident revealed the resider seven and one tenth Observation of staff 08/05/2012, reveale hundred seven and Observation of Resi 08/05/2021 at 3:10 received two (2) per received two (2) per received no sandwid Review of a Nutritio #81, dated 08/22/20 sustained a significa three tenths (8.3) per ten and seven tenth one hundred eighty the resident's weigh sixty (60) days. How resident's body mass normal limits for the weight of one hundr (107.1) pounds. In a resident's current nu exceeded the reside and nutritional statu Further interview wi 4:10 PM, and 08/18 when she documen) pounds, representing a nine) percent weight loss in ninety , the RD also documented the as stable for thirty (30) days, o new recommendations. #81's weight on 08/03/2021, and weighed one hundred the (107.1) pounds. weighing Resident #81, on a d Resident #81 weighed one nine tenths (107.9) pounds. dent #81's lunch tray, on PM, revealed the resident cent milk with the meal and ch. In Progress note for Resident 121, revealed the resident had ant weight loss of eight and ercent in ninety (90) days and s (10.7) percent in less than (180) days. The note stated the resident thad remained stable for vever, the note also stated the is index (BMI) was below resident's age and body ed seven and one tenth addition, the note stated the utritional intake greatly ent's need to maintain weight 	F 69	2		

Facility ID: 100599

If continuation sheet Page 227 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
	N POST-ACUTE AND R	EHABILITATION CENTER	20	00 NURSING HOME LANE	
			Р	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 692	on to explain that if i what was ordered a documented correct not be losing weight Review of Resident 08/26/2021 at 2:33 I notified the resident weight loss. The pro- resident's appetite v resident's appetite v resident required cu further stated the ca was assessing the r received nutritional is Observations of the storage areas on the 11:30 AM, revealed were available for th Observations of the storage areas on the at 11:45 AM, , revealed were available for th Observations of the storage areas on the at 11:45 AM, , revealed were available for th Interviews on 07/27 SRNA #1, and at 5:0 07/28/2021 at 5:10 I the facility did not pr residents. In addition	ve a problem". The RD went the resident was receiving ind the resident's intake was dy, then the resident would "" #40's progress note, dated PM, revealed staff had 's daughter of the resident's ogress note stated the vas improving, and the eing for meals. The note iller told the daughter the RD esident and the resident supplements. snack refrigerator and snack e third floor, on 07/27/2021 at no snacks, drinks or juices he residents. snack refrigerator and snack e fourth floor, on 07/27/2021 alled no snacks, drinks or e for the residents. snack refrigerator and snack e fifth floor, on 07/27/2021 at d no snacks, drinks or juices he residents. snack refrigerator and snack e fifth floor, on 07/27/2021 at d no snacks, drinks or juices he residents.	F 692		

PRINTED: 12/08/2021

<u>CENTER</u>	S FOR MEDICARE	E & MEDICAID SERVICES			FORM APPROVI MB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
	\mathbf{D}	185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE AND	REHABILITATION CENTER		IURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F 692	Interview with RN revealed the facili hungry and stated problem at the fac works from 6:00 F resident supper tr until 7:30 or 8:00 staffed with only of and assist/feed al assistance, stating residents to get a stated she assiste best she could; ho for approximately had to pass even Review of the me 08/05/2021, revea received three (3) mashed potatoes addition, the "Died indicated forty-two foods, including F #332, #81, and #6 Observation of the revealed staff sem mashed potatoes addition, when sta protein to ensure functioning scale In addition, there designated as "fo revealed three (3) sandwiches with r and #81, and thre supposed to get s	#9, on 07/29/2021 at 9:30 PM, ty's residents complain of being d it had been an ongoing cility. RN #9 stated she routinely PM until 6:00 AM, and at times, ays do not arrive on the floor PM. Per interview the facility one SRNA to pass all the trays I residents who required g, "It's impossible for the dequate nutrition. The RN ed the aide with meal service the owever, she was the only nurse forty (40) residents, and she ing medications at that time. nu for the lunch meal on aled the residents should have o unces of protein, 1/2 cup of , and ½ cup of vegetable. In the Roster" provided by the facility o (42) residents required fortified Residents #90, #327, #82, #39,	F 692		

Facility ID: 100599

If continuation sheet Page 229 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER			
	1		F	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 692	Continued From pag		F 692		
		did not have lunchmeat,			
		dwich ingredients available.			
		led to be served to residents			
		00 PM, the last food tray did			
	not exit the kitchen u	ntil 2:45 PM.			
	Interview with Cook	#2, on 08/05/2021 at 5:20			
		d worked full time at the			
		tely one (1) year. Cook #2			
		ver trained her or directed her			
	-	cility residents. She stated			
		lays a week and cooks all le days she works, and had			
		" or had instruction on how to			
	-	re, Cook #2 stated she had			
	never prepared or se	erved fortified foods for the			
		lso stated she had never			
		or training on scoop sizes or			
		to serve residents. In			
		ated she never knew she was neat or protein. She stated			
		ently out of food items. The			
		esidents continuously asked			
		but the Administrator			
		food item. The cook also			
		partment should prepare and			
		residents, especially those at However, the cook stated,			
		snacks in six months or			
		there was not an adequate			
		s purchased to fulfill the			
		not enough" purchased at			
	the facility to provide	snacks.			
	Interview with Dietar	y Aide (DA) #1, on			
		PM, revealed the facility was			
		e items that the residents			
	wanted and required	to fulfill dietary interventions.			

Facility ID: 100599

If continuation sheet Page 230 of 401

TATEMENT (DF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING		COMFLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	
			200	NURSING HOME LANE	
PARKVIEV	N POST-ACUTE AND F	REHABILITATION CENTER	РІК	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 692	Continued From pa	ge 230	F 692		
	-	he facility rarely had bologna,			
		ind other food items that were			
	08/18/2021 11:40 A	ry Manager (DM) #1, on M, revealed the facility did not ager at this time, but she was			
	the DM at a sister fa	acility and had placed some facility. The DM stated she			
		toring of resident weights or etings or discussions related oss.			
		RD, on 08/11/2021 at 4:10 PM 10:30 AM, revealed she had			
	for approximately o	provide services at the facility ne (1) year and had never			
	RD stated she ran h	t of resident to evaluate. The ner own reports in the system own list of residents to			
	evaluate. The RD s	stated she had many ongoing lity. The RD stated she had			
	identified concerns	with weight loss for the that her recommendations			
	were not being impl choice/preference r				
	she had discussed	n nursing staff. The RD stated the concerns on multiple			
	facility had taken no	Administrator; however, the action to correct the			
	and there was not e	stated meals were always late enough food purchased to			
	she was not aware	ne residents. The RD stated staff did not know how or did n" on fortifying foods. The RD			
	stated not fortifying	foods, not utilizing the correct n out residents servings,			
	failing to provide sn	acks, not weighing protein ring supplements she had			

Facility ID: 100599

If continuation sheet Page 231 of 401

PRINTED: 12/08/2021

		HAND HUMAN SERVICES E & MEDICAID SERVICES				FORM): 12/08/20: 1 APPROVE 0. 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		DNSTRUCTION	(X3) DATE	
		185256	B. WING _		-EIN/	09/ [,]	10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		EET ADDRESS, CITY, STATE, ZIP CODE		
				200 N	NURSING HOME LANE		
PARKVIE	V POST-ACUTE ANI	D REHABILITATION CENTER		PIKE	EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 692	Continued From	page 231	F 6	92			
		ich as ice cream, and not					
		their preferences, could all lead					
	-	d malnutrition for the residents.					
		RD, the dietary department was					
		ut of food items to follow the					
		ated nursing staff had never					
		any of the resident had a					
		ht loss. The RD stated the only					
		much as she did, was by					
		nd investigating on her own. The					
		ne believed for each of the					
		ed, if the facility had					
		recommendations, provided the					
		e planned meals, and offered the					
		, the majority, if not all the					
		not have sustained significant					
	weight loss. The	RD also stated in the year the					
	facility had contra	acted her services, she had					
	never been invite	d or attended a nutrition meeting					
	to discuss weight	loss or any nutritional concerns					
	for facility residen	nts. The RD stated she could					
	evaluate resident	s on a daily basis, however, if					
	•	t implement recommendations,					
		to feed residents or ensure					
		wed, it would not prevent weight					
	loss and malnutri	tion from occurring in the facility.					
	Interview with the	Assistant Director of					
		Director of Nursing					
	(ADON/IDON), or	n 08/18/2021 at 9:50 PM,					
	revealed she had	been the ADON at the facility					
		one (1) year, and was placed in					
		n a few weeks ago when the					
		ng (DON) resigned from the					
	-	N/IDON stated since she had					
		y, there had been very few					
	-	neetings conducted, because					
		f available to participate. The					
	ADON/IDON state	ed her and the former DON					

Facility ID: 100599

If continuation sheet Page 232 of 401

		AND HUMAN SERVICES			FORM APPROVE OMB NO. 0938-039		
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185256	B. WING		09/10/202 <u>1</u>		
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
			. 2	200 NURSING HOME LANE			
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER	F	PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTIO		
F 692	Continued From	bage 232	F 692				
	ADON/IDON state weights in the face not conduct week meetings since sl ADON/IDON state responsible to me implementing RD ADON/IDON State recommendations Administrator after time to follow-up of working the floor. had never provide to evaluate and w	urses more often than not. The ed she had never monitored ility, and stated the facility had dy Nutrition At Risk (NAR) he had been at the facility. The ed she was not sure who was onitor or ensure staff was recommendations. The ed the RD sent her is to the DON, ADON and the er her visits, but she did not have on them because she was The ADON/IDON stated she ed the RD with a list of residents vas not sure who was onitor residents for weight loss in					
	RD when a reside the facility had no In addition, the Al conducted no mo received meal tra palatable, that sn	no was responsible to notify the ent lost weight. Per interview, o unit managers to track weights. DON/IDON, stated she nitoring to ensure residents ys timely, the food was acks were available and served, ented RD recommendations,					
	and that staff wer residents requirin	e able to get meals passed and g assistance were assisted d, "I just don't have time to					
	6:00 PM and on 0 she had been the 06/07/2021. The knowledge that st the facility did not residents, that sta	Administrator, on 08/11/2021 at 08/18/2021 at 3:30 PM, revealed facility's Administrator since Administrator denied having aff were not fortifying foods, that have snacks to provide aff was not weighing food/protein					
	nutritional /weight	sing was not communicating loss concerns with the RD, or tions were not being					

Facility ID: 100599

If continuation sheet Page 233 of 401

	S FOR MEDICARE			1	MB NO. 0938-03		
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION (X3) DATE SURVEY COMPLETED		
		185256	B. WING		09/10/202 <u>1</u>		
IAME OF PF	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
		REHABILITATION CENTER	200 N	IURSING HOME LANE			
			PIKE	VILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE		
F 692	Continued From p	page 233	F 692				
	had no systems in weight loss or nut Administrator stat the RD after she of Administrator stat information was in read them. The A resident preference honored at the fac planned on talking on the resident's fac provide. The Adm should be able to prevent weight los ordered. The Adm had not conducte been the Adminis working on getting Administrator cour	Administrator stated the facility in place to monitor resident irritional needs. The ted she received e-mails from conduced visits. However, the ted she was not sure what in them, because she had not dministrator acknowledged that ces could not always be cility, and stated she had g to the RD about all the items tray cards that the facility did not inistrator stated that the RD make recommendations to ss with items the facility routinely inistrator confirmed the facility d NAR meetings since she had trator, but stated she was g those established. The lid not voice any monitoring or					
F 695 SS=D	everything possib loss.	o ensure the facility was doing le to prevent resident weight neostomy Care and Suctioning	F 695				
	tracheostomy car The facility must en needs respiratory care and tracheal care, consistent w practice, the com	ratory care, including e and tracheal suctioning. ensure that a resident who care, including tracheostomy suctioning, is provided such vith professional standards of prehensive person-centered idents' goals and preferences,					

Facility ID: 100599

If continuation sheet Page 234 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	12/08/2021 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE S COMPLE	
		185256	B. WING		09/1	0/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		_
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 695	Continued From pag	e 234	F 695			
	by: Based on interview a determined the facilit care for one (1) of fiff residents (Resident # required a bilevel pos (BiPAP) machine (a r non-invasive ventilati added oxygen, under Resident #323 was a 07/06/2021 with a dia Failure and required when sleeping. The physician orders for t machine for the resid eight (8) days after a The findings include: Interview with the As- (ADON)/Interim Direc 08/11/2021 at 12:05 not have a policy reg She stated the facility to supply and mainta machines and had m facility for use. She s per physician's order Review of Resident # revealed the resident on 07/06/2021 with d Metabolic Encephalo Failure, Autistic Diso	admitted by the facility on agnosis of Acute Respiratory the use of a BiPAP machine facility failed to obtain the machine and set up a lent's use until 07/14/2021, dmission. sistant Director of Nursing ctor of Nursing (DON), on PM, revealed the facility did arding BiPAP machines. y used a respiratory company in residents' BiPAP achines available at the stated they should be utilized 4323's medical record t was admitted by the facility liagnoses that included pathy, Acute Respiratory				

Facility ID: 100599

If continuation sheet Page 235 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 695	(MDS) Assessment, Resident #323 was in Continued review of resident was coded in mechanical ventilator resident in the facility However, further review obtain a physician's until 07/14/2021. Review of the resided dated 07/14/2021, review of the resided Administration Recorno documented evid was applied until 07/ Interview with Reside 08/02/2021 at 8:50 A nursing staff at the fa 07/11/2021, that Reside 08/02/2021 at 8:50 A nursing staff at the fa 07/11/2021, that Reside 08/02/2021 at 8:50 A nursing staff at the fa 07/11/2021, that Reside to be worn at night. wore BiPAP well at h further revealed she wearing BiPAP contriver re-hospitalization of Interview with State (SRNA) #13, on 07/2 she worked on the ur resided on 07/07/202 07/16/2021, 07/17/202	sion Minimum Data Set dated 07/13/2021, revealed rarely/never understood. the MDS revealed the to utilize a non-invasive r (BiPAP/CPAP) while a y. tiew of Resident #323's aled the facility failed to order for the BiPAP machine eview of the Physicians order, evealed Resident #323 2/5, 18, 50% QHS [at night]" piratory Failure. th's Medication rd (MAR) revealed there was ence Resident #323's BiPAP 14/2021. ent #323's family member, on AM, revealed she notified the acility, approximately sident #323 required a BiPAP She stated Resident #323 nome with no problems. She felt Resident #323 not ibuted to the	F 695		

Facility ID: 100599

If continuation sheet Page 236 of 401

CENTER	-	HAND HUMAN SERVICES E & MEDICAID SERVICES		C	FORM APPROV MB NO. 0938-03
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PF	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER		NURSING HOME LANE	
	SUMMAE	RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFIC	OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETIO
F 695	Continued From	page 236	F 695		
	Interview with SR	NA #16, on 07/28/2021 at 8:00			
		worked night shift and provided			
		#323 on 07/07/2021,			
		2/2021, 07/13/2021 and multiple			
		to the resident leaving the			
	#323 wear his/he	ed she never observed Resident r BiPAP.			
	Interview with SR	NA #18, on 07/28/2021 at 9:54			
		provided care for Resident #323			
	on 07/06/2021, 0	7/09/2021, 07/10/2021 and the			
		vear a BiPAP that night. He			
		e dates, (exact date unknown),			
	he did recall the r	esident wearing BiPAP at night.			
	Interview with Lic	ensed Practical Nurse (LPN) #3,			
		4:16 PM, revealed she was			
	U U	/2021 when Resident #323 was			
		icility. She stated she was			
		\$323 required a BiPAP machine;			
		as no order from the hospital. nd Registered Nurse (RN) #6			
		hine from facility stock on			
	•	ever, they did not set up the			
		e they did not have an order for			
		for Resident #323. She stated			
	•	ne oncoming nurse, LPN #8, that			
		led for the settings for the			
		However, LPN #3 stated the ice the resident on BiPAP until			
	•	n Respiratory Therapist (RT) #1			
		ng orders had been obtained.			
		N #8, on 07/28/2021 at 9:29 PM,			
		s not notified Resident #323			
		r his/her BiPAP. She stated the ave had orders for the BiPAP if			
		one for breathing. She further			
	•	ring a BiPAP could have			

Facility ID: 100599

If continuation sheet Page 237 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08 FORM APPR OMB NO. 0938	OVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202	1
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ETION
F 695	07/29/2021 at 9:17 F did not wear his/her admission. She stat resident required a E unable to obtain a ph machine settings. S was not obtained unit Nursing/Assistant Di obtained an order on the resident should F BiPAP prior to 07/14, BiPAP could have a breathing. Interview with RN #6 and 3:45 PM, confirm Resident #323 a BiP stock on admission of	ereathing. PM, revealed Resident #323 BiPAP for several nights after ed the family notified her the BiPAP; however, she was hysician's order for BiPAP he stated a physician's order til the Interim Director of rector of Nursing (ADON) n 07/14/2021. RN #9 stated have had an order for the /2021 because not wearing	F 69			
	machine and treatme 07/14/2021, the Res came to the unit to d required respiratory of she notified RT #1 al however, the RT did for the equipment. F she identified the res nights without the Bil Resident #323 shoul 07/14/2021. She sta have potential negat Interview with Respin 08/04/2021 at 8:28 A the facility and was u	ent was not initiated. On piratory Therapist (RT) #1 etermine any residents who equipment. RN #6 stated				

Facility ID: 100599

If continuation sheet Page 238 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	
F 695 F 697 SS=G	not wearing BiPAP at resident had a machinal Interview with Emerg 08/03/2021 at 10:47 presented to the Emerg 07/20/2021, exhibitin medical assessment upper airway problem Interview with the As- (ADON)/Interim Direct 08/11/2021 at 12:05 there were concerns #323's BiPAP. She r recall how the order re expected staff to obta admissions timely (we those orders for BiPA resident not having at decline in respiratory Interview with the Ad 6:00 PM, revealed sh since June 2021, and systems to monitor to respiratory care as re Pain Management CFR(s): 483.25(k) §483.25(k) Pain Man The facility must ens provided to residents consistent with profe- the comprehensive p	ted she entered the 7/14/2021 and resident was and did not notice whether the ne in the room. ency Room Physician #1, on AM, revealed Resident #323 ergency Department (ED) on g stridor. He stated his revealed the resident had an an. sistant Director of Nursing ctor of Nursing (ADON), on PM, revealed she was aware with obtaining Resident evealed she was unable to was obtained, however, she ain orders for new ithin 24 hours) including AP machines. She stated a BiPAP could result in status. ministrator on 08/11/2021 at he had been at the facility d had not developed any b ensure resident's received equired. agement. ure that pain management is who require such services, ssional standards of practice, erson-centered care plan,	F 695		
	and the residents' go				

Facility ID: 100599

If continuation sheet Page 239 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/08/2021 1 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING		09/	10/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE AND R	EHABILITATION CENTER				
0(0)5	CLIMMA DV C	TATEMENT OF DEFICIENCIES		IKEVILLE, KY 41501 PROVIDER'S PLAN OF CORRECTION		(//5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From pag	e 239	F 697			
	by: Based on observation and review of the facility management was pre- fifty-seven (57) samp #326) who required a professional standar comprehensive perse the resident's goals a Observations and re- Resident #326 comp his/her head and back PM on 08/05/2021 (abservations, because medication, because medication, because medication, because medication was not a The findings include: Review of the facility Assessment and Ma 2020, revealed the p was based on a facility appropriate assessme based on profession comprehensive care choices. Further revide fined "pain manage alleviating the resided clinical condition and Review of Resident a revealed the facility a Friday 07/30/2021, w	ty failed to ensure pain ovided for one (1) of oled residents (Resident such services consistent with ds of practice, the on-centered care plan, and and preferences. cord review revealed blained of severe pain in ck, from 10:01 AM until 5:15 approximately 7.25 hours) ered the resident pain the resident's prescribed available in the facility.				

Facility ID: 100599

If continuation sheet Page 240 of 401

		ND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
		EHABILITATION CENTER	2	200 NURSING HOME LANE	
FARRAIEN	W POST-ACUTE AND R		F	PIKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 697	Compression Fractu Review of Resident (MDS) assessment the facility assessed Interview for Mental (9), indicating the re cognitively impaired Review of Resident only care developed 08/05/2021, was the Plan, which had bee days prior). The Bas contain any informar pain or pain manage Review of Resident dated 07/30/2021, ro medication for the re Acetaminophen (Pe mouth every six (6) moderate/severe pa 07/31/2021. Review of the Nurse 10:01 AM, revealed complaining of head pain as an eight (8) with one (1) representing further review of the medication was ava resident. The note s pharmacy and reque delivery of the medication	ardial Infarction, and Spinal rres. #326's Minimum Data Set dated 08/06/2021, revealed the resident to have a Brief Status (BIMS) score of nine sident was moderately #326's care plan revealed the for the resident as of e resident's Baseline Care en initiated on admission (six se Line Care Plan did not tion related to the resident's ement. #326's Physician's Orders evealed the only ordered pain esident was Oxycodone rcocet) to be administered by hours as needed for in. The order start date was cost of the form of the start date was the Notes dated 08/05/2021 at Resident #326 was and back pain, and rated the out of ten (10) on a pain scale nting minimal discomfort and g severe pain. However, note revealed no pain ilable to administer to the tated staff notified the ested a "STAT" (urgent) cation.	F 697		
	-	erview with Resident #326 on			

If continuation sheet Page 241 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12 FORM AP OMB NO. 09	PROVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SUR COMPLETE	VEY
		185256	B. WING		09/10/2	2021
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER						
				PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) DMPLETION DATE
F 697	Continued From pag	e 241	F 697			
		AM, revealed the resident				
		ourting all over", and was cation. The resident voiced				
	•	pain "all morning" and rated it				
	Administration Record Percocet medication administered every se pain. However, none	#326's admission Medication rd (MAR) revealed the was on the MAR to be six (6) hours, as needed, for e of the medication was g administered to the				
	on 08/05/2021 at 11: #326 did not have ar facility and they were from pharmacy. She #326 was not her res RN (Registered Nurs medication for the re had no idea why Res medication at the fac physician had ordered					
	revealed they were a #326's medication fro unaware of any eme facility. RN #8 stated	o on 08/05/2021 at 11:57 AM, attempting to get Resident om the pharmacy and was rgency medication kit in the d she did not know why n medication was not				
	08/05/2021 at 1:42 F had not received the #326 stated, "My hea	erview with Resident #326 on PM, revealed the resident still pain medication. Resident ad is still killing me". The pate the pain as an eight (8)				

Facility ID: 100599

If continuation sheet Page 242 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 697	Continued From pag on a scale of one (1)		F 697		
	Continued interview 1:50 PM, revealed the administered pain mubecause "there is no (him/her)". The nurse resident needed som resident was in seve revealed she did not resident's medication Observation and inter 08/05/2021 at 4:45 F still in pain, and cont (8). Interview with RN #8 revealed the pharma pull the medication fr kit and administer it to Interview with RN #8 revealed she was no that the facility had a medications available ever trained her or to medications. Observation of the fa administration pass of revealed RN #5 adm Percocet tablet from Resident #326 contir an eight (8).	with RN #8 on 08/05/2021 at e nurse had not edication to Resident #326, thing in the building to give e stated she knew the nething for pain, because the re pain. Further interview know how to get the n any sooner. Trview with Resident #326 on PM, revealed the resident was inued to rate it as an eight on 08/05/2021 at 4:47 PM, cy had just directed her to rom the facility's emergency to the resident. on 08/05/2021 at 5:00 PM, t aware, prior to this incident, n emergency kit with e. She stated no one had old her about the emergency			

Facility ID: 100599

If continuation sheet Page 243 of 401

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES		(FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		09/10/202 <u>1</u>	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		200 NURSING HOME LANE			
			PIKE	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 697	Continued From	page 243	F 697		
	#326's Percocet.	However, the pharmacy was			
		ney had not sent the Percocet to			
		sident #326. The pharmacy			
		tated they did maintain an			
		t the facility, which contained			
		er, the representative stated that			
		ting the medication was required resident information to the			
		equently, the pharmacy would			
		se an electronic code to			
	-	ecific dose of medication.			
		₩10 on 08/25/2021 at 4:28 PM,			
		een more difficult lately to get			
		s for narcotics. The RN stated a resident on a			
		sident may not have any or only			
		dications available for			
		nd frequently they did not have			
		ons available. RN #10 stated it			
	was a "routine" p	roblem for residents not to get			
		timely. However, RN #10 did not			
		why Resident #326 did not have			
	medication at the	e facility.			
		√#1 on 08/05/2021 at 1:55 PM,			
		en had to notify Physician #1 and			
		ltiple times to obtain a			
		refill for narcotic medications.			
		residents "often" go multiple			
	-	dication while waiting for a refill			
		nedication. RN #1 stated she did			
	-	sident #326's medications were			
	not available.				
	Interview with Ce	rtified Medication Aide (CMA) #1			
		1:00 PM revealed residents			
	often run out of n	arcotic medications. CMA #1			
	stated residents r	must go without medication until			

Facility ID: 100599

If continuation sheet Page 244 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	PARKVIEW POST-ACUTE AND REHABILITATION CENTER		2	00 NURSING HOME LANE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		Р	IKEVILLE, KY 41501		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 697	Continued From pag	e 244	F 697		
			1 097		
	the facility could obta	an a reim.			
	PM, and on 08/27/20 was aware there wer narcotic pain medica facility. However, he residents were going medication. The phys acceptable for a resid hours and not have r administration. Conti expected medication upon admission to th staff to follow admiss immediate care to re stated he had ordere medication upon adm	nission to the facility and he facility did not have it			
	(ADON)/Interim Direct 08/27/2021 at 12:00 not have a back-up p was aware that resid without narcotic pain medications not bein ADON/IDON stated f there was an issue w not being available for interview revealed sh (Resident #326) didn the facility. In addition she was unaware that of the facility's emerge However, the ADON/ conducted any training	g available. The Physician #1 was aware that vith narcotic pain medications or administration. Continued			

Facility ID: 100599

If continuation sheet Page 245 of 401

		E & MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		09/10/2021	
		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
		20	00 NURSING HOME LANE		
		PI	IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO
F 697	Continued From	page 245	F 697		
		had no system in place to track			
	•	e stated the facility had not			
		the problem was yet. The			
		ed she was not aware that			
		as without pain medication and			
		vere pain on 08/05/2021, for ven hours and fifteen minutes.			
	•••	stated that a resident being in			
		hout medication was not an			
	acceptable stand				
	Interview with Ad	ministrator on 08/10/2021 at			
		d she expected the admission			
		followed, and that medications			
		le for residents prior to lity. She stated the facility			
		missions to ensure the facility			
		needs prior to admitting the			
		ministrator stated she was not			
		#326's pain medication was not			
		y on 08/05/2021. She further			
		not acceptable for residents to			
	medication.	s before receiving pain			
F 725	Sufficient Nursing	n Staff	F 725		
	CFR(s): 483.35(a		1 725		
	§483.35(a) Suffic	ient Staff.			
		have sufficient nursing staff with			
	•	ompetencies and skills sets to			
		ind related services to assure			
		nd attain or maintain the highest			
		cal, mental, and psychosocial			
		h resident, as determined by nents and individual plans of care			
		he number, acuity and			
		facility's resident population in			
		the facility assessment required			

Facility ID: 100599

If continuation sheet Page 246 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	PARKVIEW POST-ACUTE AND REHABILITATION CENTER				
			Pił	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 725	Continued From pag at §483.70(e).	je 246	F 725		
	§483.35(a)(1) The fa by sufficient numbers types of personnel o nursing care to all re resident care plans: (i) Except when waiv this section, licensed (ii) Other nursing per limited to nurse aides §483.35(a)(2) Excep paragraph (e) of this designate a licensed nurse on each tour o This REQUIREMENT by: Based on observation review of the facility's facility failed to ensu available to provide to to maintain the higher mental, and psychos of fifty-seven (57) sa #321, #65, #320, #30 Review of Resident a revealed the residen Diabetes, which requires igns/symptoms of h (low/high blood suga #321 experienced tw low blood glucose le	rsonnel, including but not s. t when waived under section, the facility must I nurse to serve as a charge of duty. T is not met as evidenced on, interview, record review, s policy, and review of the t, it was determined the re sufficient staff was nursing and related services est practicable physical, social well-being for seven (7) impled residents (Residents 08, #314, #311 and #3). #321's medical record			

Facility ID: 100599

If continuation sheet Page 247 of 401

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES		C	FORM APPROV MB NO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		09/10/202 <u>1</u>	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		200 NURSING HOME LANE			
FARRUL	W POST-ACOTE ANI	D REHABILITATION CENTER	PIKE	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 725	Continued From	page 247	F 725		
	However, due to	the facility's lack of available			
	staff the resident'	s level of monitoring was not			
		/19/2021, at approximately			
		ound Resident #321			
		h a critically low blood glucose			
		r transferred the resident to the e/she was intubated. The			
	· ·	Resident #321 to the Intensive			
	· ·	vith diagnoses of Hypoxemia			
	, ,	jen to sustain life), Pneumonia,			
		Encephalopathy, and Acute			
		re, secondary to prolonged			
	Hypoglycemia (lo	w blood glucose).			
		ent #65's medical record			
		dent was at risk for pressure			
		ed assistance of staff for turning, d incontinent care. Interviews			
		d there was not enough staff to			
		on residents, including Resident			
		nt developed a Stage IV (4)			
	pressure ulcer to	the sacrum that became			
		ired hospitalization on			
		ording to the resident's hospital			
		ure ulcer required debridement			
		and infected tissue) down to the			
	-	/ re-admitted Resident #65 to 09/2021. Resident #65			
	-	l) additional pressure ulcers. On			
		vound care clinic documented			
		ackened tissue, blistering,			
		numbness and swelling			
		e resident being bed ridden and			
	having infrequent	position changes.			
		vations conducted during the			
	-	residents' hair was oily, one (1)			
		same clothes on for three (3)			
	uays and (1) resid	dent had body odor.			

Facility ID: 100599

If continuation sheet Page 248 of 401

		ND HUMAN SERVICES			FORM APPROVED
	RS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF F	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
D D D D			20	0 NURSING HOME LANE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			PI	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 725	Additionally, intervie resident family mem answer call lights tin toileting timely, resid scheduled showers; late and the food wa staffing. The facility's failure available to provide or is likely to cause impairment or death Jeopardy was identi determined to exist 483.10 Resident Rig Freedom from Abus Comprehensive Per (F655) (F656) 42 CH (F684) (F686) (F692 Services (F755) and Control (F880). The Immediate Jeopardy An acceptable Alleg was received on 09/ removal of the Imme 09/02/2021. Howev verified based on ot and review of the fa Additional Immediat 42 CFR 483.35 Nur 483.70 Administratio 483.75 Quality Assu-	www.ith staff, residents, and abers revealed staff did not nely, did not assist with dents were not receiving and, residents' meals were as cold, due to insufficient to ensure sufficient staff was nursing services has caused serious injury, harm, to a resident. Immediate fied, on 08/11/2021, and was on 03/06/2021, at 42 CFR ghts (F580), 42 CFR 483.12 e (F600), 42 CFR 483.12 son-Centered Care Plans FR 483.25 Quality of Care 2), 42 CFR 483.45 Pharmacy d 42 CFR 483.80 Infection facility was notified of y on 08/11/2021. ation of Compliance (AOC) /03/2021, which alleged ediate Jeopardy on yer, the AOC could not be oservations, staff interviews, cility's documentation. e Jeopardy was identified at sing Services (F725), 42 CFR urance and Performance). The facility was notified of ardy on 09/10/2021. The y is ongoing.	F 725		

Event ID: ELK411

Facility ID: 100599

If continuation sheet Page 249 of 401

PRINTED: 12/08/2021

	-	HAND HUMAN SERVICES			PRINTED: 12/08/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING	-ETNI	09/10/202 <u>1</u>	
		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		20 P			
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC
F 725	Continued From p	page 249	F 725		
	revised October 2	ility's policy titled "Staffing," last 2017, revealed the facility would numbers of staff with the			
	skills/competency services for all re- resident care plar	/ necessary to provide care and sidents in accordance with ns and facility assessment. The			
	assistants would hours a day and s	nsed nurses and nursing be available twenty-four (24) staffing numbers would be d on residents' needs and each care.			
	dated 08/18/2017 eight (8) to nine (9 to fifteen (15) Sta Assistants (SRNA	acility Assessment Staffing Plan," 7, revealed the facility required 9) licensed nurses, thirteen (13) te Registered Nursing A), and four (4) to six (6) dietary our (24) hour day to ensure the ent needs.			
	6:00 PM, revealed the building was t (4) SRNAs on eac AM-7:00 PM) and	Administrator, on 08/11/2021 at d the facility's goal for staffing in to have two (2) nurses and four ch floor for day shift (7:00 d two (2) nurses and three (3) ift (7:00 PM-7:00 AM).			
	facility scheduled	altime schedule revealed the breakfast at 7:00 AM, lunch at e evening meal at 5:00 PM.			
	revealed the facili 07/16/2021, with	sident #321's medical record ity admitted the resident on diagnoses of Urosepsis, , and Invasive Bladder Cancer.			
	Data Set (MDS) a	ent #321's Admission Minimum assessment, dated 07/19/2021, ity assessed the resident to have			

If continuation sheet Page 250 of 401

	H AND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
DA	185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIE	R		TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AN	ID REHABILITATION CENTER		00 NURSING HOME LANE IKEVILLE, KY 41501	
PREFIX (EACH DEFI	IRY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
of thirteen (13) of resident was cou- Review of the PI 07/16/2021, reve Resident #321 ff hypoglycemia (k hyperglycemia (k hyperglycemia (k Review of Resid dated 07/16/202 address the resi the resident's bla Review of Nursin 3:20 PM, reveal was sixty-seven (mg/dL). The no- resident's break and Licensed Pr a repeat glucose documented as mg/dL. Interview #6 on 07/27/202 approximately 7 obtained a blood #321, which was deciliter (mg/dL) documented evi monitor the resid glucose levels for Review of a hos revealed the res Department (ED non-responsive The resident reo	for Mental Status (BIMS) score but of fifteen (15), indicating the gnitively intact. hysician's Orders, dated ealed an order for staff to monitor or signs and symptoms of bw blood sugar) and high blood sugar) every shift. lent #321's baseline care plan, 1, revealed the facility did not dent's diabetes and/or monitoring bod sugar. Ing Notes, dated 07/18/2021 at ed Resident #321's blood glucose (67) milligrams per deciliter ote stated staff delivered the fast tray (exact time unknown) actical Nurse (LPN) #6 obtained e level after breakfast which was one hundred thirty-nine (139) w with Licensed Practical Nurse 1 at 4:10 PM, revealed at 30 AM on 07/18/2021, LPN #6 d glucose reading for Resident s sixty-seven (67) milligrams per . However, there was no dence LPN #6 continued to dent's condition or obtain further	F 725		

Facility ID: 100599

If continuation sheet Page 251 of 401

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	09/10/2021
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				NURSING HOME LANE	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 725	diagnoses of hypoxe sustain life), Pneum Encephalopathy, an secondary to prolon Interview with Resid 08/02/2021 at 5:30 I the facility for a sche 10:45 AM. She state his/her blood sugar (67) mg/dL that mor stated that she left t 3:00 PM that day an the resident's blood She stated Resident his/her lunch meal w Interview with Resid 07/28/2021 at 2:19 I daughter visited Resident his/her lunch meal w Interview with Resid 07/28/2021 at 2:19 I daughter visited Resident's glucose w facility smelled of ur and washcloths wer unemptied nephrost spouse further state Resident #321 on th that day, and the resident had still not re-check 4:00 PM, since that daughter's arrival to spouse stated at ap 07/18/2021, was the	emia (not enough oxygen to onia, Acute Metabolic d acute respiratory failure, ged hypoglycemia. ent #321's Daughter, on PM, revealed she arrived at eduled visit on 07/18/2021 at ed Resident #321 told her had dropped to sixty-seven ning. However, the daughter he facility at approximately of no staff member obtained glucose level during her visit. t #321 had not received when she left the facility. ent #321's Spouse, on PM, revealed his/her her sident #321 on 07/18/2021. the daughter reported that the vas low that morning, the ine and the resident's blanket e soiled from the resident's omy bags leaking. The d he/she had talked to be telephone numerous times sident had told him/her that /her blood sugar was running way the resident felt. int told the spouse the staff ked his/her blood sugar as of morning and prior to the the facility at 10:45 AM. The proximately 4:00 PM on a last time he/she spoke to the resident reported ringing	F 725		

Facility ID: 100599

If continuation sheet Page 252 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE		
			P	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 725	Continued From pag	e 252	F 725		
	(SRNA) #1, on 07/27 08/03/2021 at 3:19 F working on 07/18/202 and remembered Re being low that mornin stated she did not ch until sometime after resident non-respons she and one other Si on day shift for the e caring for approxima stated that lunch had the floor that day and PM when she found stated it was difficult multiple times during not enough staff to d resident was able to probably checked on could let you know if SRNA #1 stated she of the resident's cond Interview with Licens on 07/30/2021 at 11: recall Resident #321	ed Practical Nurse (LPN) #6, 30 AM, revealed she did having another			
	on 07/18/2021 (exac SRNA #1 summonse and she found the re stated she obtained level and recalled it " mg/dL". The LPN sta recollection, she had nephrostomy around able to check on the	le during the late afternoon t time unknown). She stated ad her to the resident's room, sident unresponsive. LPN #6 the resident's blood glucose was around forty (40) ated to the best of her cared for the resident's 1:00 PM, but had not been resident since that time. ot Registered Nurse (RN) #1			

Facility ID: 100599

If continuation sheet Page 253 of 401

		E & MEDICAID SERVICES			OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER	-			
				KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTIC	
F 725	Continued From	page 253	F 725			
	-	d of the unit to assist her and	_			
		sident #321 an injection of				
	Glucagon (hormo	one injection used to treat a				
		d glucose) and oral glucose.				
		e resident regained				
		nd it was close to the supper e the resident an oatmeal pie to				
	•	pper trays arrived. Review of				
		medical record revealed no				
		ence the LPN documented the				
	resident's hypogly	ycemic incident or any of the				
	resident's blood g	lucose levels. In addition, there				
		ted evidence the LPN monitored				
		ndition or blood glucose levels				
		her shift. LPN #6 stated it was r all the residents and complete				
	documentation.					
		ent #321's Nursing Notes, dated				
		:23 AM, revealed a SRNA found				
		sponsive and clammy. The				
		ated staff obtained the resident's dit was thirty-two (32) mg/dL.				
		equently transferred the resident				
		he hospital admitted the resident				
	to the ICU.	'				
		NA #4, on 07/28/2021 at 7:35				
		e worked from 6:00 PM on				
		6:00 AM on 07/19/2021, and was				
		for Resident #321. SRNA #4				
		e nurse were the only staff on or approximately forty (40)				
		RNA stated at 8:45 PM, the				
		. She stated she did not check				
	on the resident a	gain. SRNA #4 stated she was				
	about to begin he	er next round, when the				
		cian arrived on the floor and				
	found Resident #	321 unresponsive. Continued				

Facility ID: 100599

If continuation sheet Page 254 of 401

CENTER	-	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(PRINTED: 12/08/20 FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
_		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	
		REHABILITATION CENTER	200	NURSING HOME LANE	
PARNVIEV	WPOST-ACUTE AND P	CERTABILITATION CENTER	PIP	(EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 725	Continued From pa	ae 251	F 725		
1 720			F 725		
		A #4 revealed she had			
		nat the resident's glucose / that day. However, the			
		was no way for her to check			
		bre frequently, when she was			
	the only SRNA on t				
	Interview with the L	aboratory Technician (LT) #1,			
	on 08/02/2021 at 4:	45 PM, revealed she arrived			
	at Resident #321's	unit, on 07/19/2021 at			
		5 AM, and found Resident			
	#321 unresponsive				
	Interview with DN #	7 on 07/28/2021 of 4:25 DM			
		7, on 07/28/2021 at 4:25 PM, d on 07/18/2021 from 7:00			
		1 at 7:00 AM. RN #7 stated			
		t report that Resident #321's			
		s had been low during the day.			
	The RN stated som	etime between 7:30 PM and			
		#321 rang the call light and			
		ught his/her blood sugar was			
		ed she checked the resident's			
	-	, and it was one hundred and			
		wever, RN #7 stated she the blood glucose. RN #7			
		one SRNA were the only staff			
		or that night, and she was busy			
		to document. She stated she			
		ome peanut butter and			
		esident stated he/she "just felt			
		ed at approximately 9:00 PM,			
		ck on the resident. The nurse			
		21 had not eaten the peanut			
		, so she offered the resident			
		It the resident declined and			
		ter. Further interview revealed eck the resident's glucose			
		l at approximately 12:15 AM			
		laboratory technician arrived			

Facility ID: 100599

If continuation sheet Page 255 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 725	Resident #321 was u when she entered R resident was unresp immediately tell the r low because the resi stated she checked f and it was thirty-two because it was only worked the entire flo other floors to assist 2. Review of Resider revealed the facility a 03/24/2021 and re-a 04/29/2021 with diag Infarction, Dysphagia Obstructive Pulmona Review of Resident for Data Set (MDS) assi revealed the resident two (2) staff with Act review revealed the pressure ulcers base According to the MD Resident #65 was at to being chair fast ar Continued review of facility turned/reposit	n after discovered that unresponsive. She stated esident #321's room, the onsive, and she could resident's blood glucose was dent was clammy. RN #7 the resident's blood glucose, (32) mg/dL. RN #7 stated she and (1)SRNA that or, she called for staff from her and call the physician. ant #65's medical record admitted the resident on dmitted the resident on gnoses that included Cerebral a, Polyarthritis, Chronic ary Disease and Paraplegia. 65's Admission Minimum essment, dated 03/30/2021, t was totally dependent on ivities of Daily Living. Further resident was at risk for ed on a formal assessment. S dated 03/30/2021, ot on a turning/repositioning Scale for Predicting Pressure d 03/23/2021, revealed risk for pressure ulcers due	F 725	DEFICIENCY)	
	every two (2) hours.				

If continuation sheet Page 256 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE PIKEVILLE, KY 41501		
	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LIST MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 725	Continued From pag	e 256	F 725		
		of Condition form, dated	_		
		AM, revealed Resident #65			
		ep tissue injury (a purple or ea of discolored intact skin or			
		e to damage of underlying			
	soft tissue from press coccyx.	sure and/or shear) to the			
	Interview with Licens	ed Practical Nurse (LPN) #4,			
	on 08/25/2021 at 4:0	0 PM, revealed she identified			
	the deep tissue injury	y to Resident #65's on 05/02/2021. However,			
	-	did not measure the area due			
	to being "overwhelme not enough staff.	ed" with her workload due to			
	Review of a Change	of Condition form, on			
		M, revealed the resident's			
		coccyx was "worsening" and ne-half (6.5) centimeters (cm)			
		even tenths (9.7) cm wide.			
	-	Resident #65's medical			
	-	ekly skin checks, revealed re ulcer continued to decline.			
		of Condition form, dated			
		PM, revealed Resident #65			
	-	ound". The form stated the			
		sident to the Emergency luation and treatment.			
		Registered Nurse Aide			
		6/2021 at 12:36 PM, revealed			
		sure ulcer had an odor for ursing staff were aware.			
	She stated she knew	the resident's wound			
		elled bad". SRNA #4 stated			
	-	Resident #65, and tried to rned and repositioned, but			
		le to do so every two (2)			

Facility ID: 100599

If continuation sheet Page 257 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 725	care for. SRNA #4 st turn and reposition re as much as needed, staff. Review of Resident # revealed the hospital 05/28/2021, and diag Clinically Septic with Associated Infection possible developing a record, the pressure flesh". Review of an Operation for Resident #65, rev with a large necrotic sacrum. The operative extremely extensive amount of fat necross as necrotic tissue". read, "Debrided all d level of the bone". Interview with Surger PM, who debrided R revealed he was not or diagnosis that com pressure ulcer. He s reposition and impro- to pressure ulcers ar Further review of fac facility re-admitted R 06/09/2021. Per the resident's sacral wou resident developed r	had forty other residents to ated staff were not able to esidents with pressure areas due to not having enough #65's hospital record admitted the resident on gnosed the resident as being a Pressure Wound and including Cellulitis and Abscess. According to the ulcer "smells like dead ive report, dated 05/30/2021, realed the resident presented appearing area on his/her /e report stated, "It was down to the base large is was encountered as well The operative report further evitalized tissue down to the on #1, on 08/31/2021 at 1:30 esident #65's wound, aware of any terminal illness tributed to the resident's tated failure to turn and per nutrition could contribute ad progression of wounds.	F 725	DEFICIENCY)	

Facility ID: 100599

If continuation sheet Page 258 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		00 NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION	
F 725	heel on 06/26/2021. Review of Wound Ca Resident #65, dated resident's wounds we resident being bed ri infrequent position cl revealed the sacrum since the facility's las 07/05/2021, and mea (15.5) cm (length) by one and eight tenth (Review of Head to To Assessment, dated 0 revealed Resident #6 pressure ulcer to the and on 08/26/2021 th pressure ulcer to the and on 08/26/2021 at circumstances result was consistent with t ridden and infrequent Interview, with SRNA and with SRNA #10 of revealed they provide The SRNAs stated th turn and reposition R hours. Interview with SRNA PM, revealed she co turn, reposition, and including Resident #6	eep tissue injury to the right are Office Visit notes for 07/29/2021, revealed the ere consistent with the dden, friction, rubbing and hanges. The note further wound had increased in size at assessment, on asured fifteen and one-half fifteen (15) cm (width) and 1.8) cm (depth). be Weekly Skin Check 08/12/2021 at 11:52 AM, 55 had developed a new back of the left, lower leg he resident developed a new left hip. Care note for Resident #65, 9:00 AM, revealed the ing in the resident's wounds he resident being "bed t position changes." A#1 on 8/5/2021 at 5:15 PM on 08/27/2021 at 11:15 AM, ed care for Resident #65. here was not enough staff to tesident #65 every two (2) #11, on 08/27/2021 at 3:00 uld not perform rounds and check/change residents, 65, every two (2) hours when	F 725	DEFICIENCY)		
	-	65, every two (2) hours when				

Facility ID: 100599

If continuation sheet Page 259 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 725	stated when they we took four (4) hours to Interview with SRNA AM, SRNA #12 on 07 LPN #2 on 07/28/202 facility did not have e reposition residents of Interview with Regist 08/27/2021 at 9:55 A been able to turn and two (2) hours, includi they were so short st horrible!" RN #3 state for two (2) days in a (40) resident assigne stated the SRNAs ha rounds every two (2) directed them to notif Interview with RN #7 and 08/24/2021 at 3: not enough staff to tu as required. She fur assessments were re- they do not always co was not enough staff Interview with Regist Care Nurse, on 08/29 she could not take ca appropriately, becaus more than she worked because of short staff Nurse stated since s	 40 residents. The SRNA re short staffed it sometimes o complete just one round. #14 on 07/28/2021 at 11:43 7/28/2021 at 6:08 AM, and 21 at 6:52 AM, revealed the enough staff to turn and every two (2) hours. ered Nurse (RN) #3, on M, revealed staff had not d reposition residents every ing Resident #65, because affed. She stated, "It is ed she had worked by herself row with approximately forty ed to her care. She further ave told her they cannot do hours. She stated she fy the DON. , on 08/01/2021 at 11:40 AM 49 PM, revealed, there was un and reposition residents ther revealed skin equired weekly; however, omplete them because there ther is a state of resident wounds se she had to work the floor ed as the wound nurse ffing. The Wound Care he could not provide wound wounds as required, she 	F 725		

Facility ID: 100599

If continuation sheet Page 260 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
			P	IKEVILLE, KY 41501	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 725	Continued From pag	e 260	F 725		
	physically could not				
	Nurse (APRN) #1, w Care Clinic on 08/27 Resident #65's press bony prominence. H appear to be able to Continued interview to wait more than two repositioned, it could Interview with Physic 08/27/2021 at 1:18 F Resident #65 had a bottom, but was not developed other press stated he was not av turn and reposition re due to decreased sta ulcer could develop a was not turned and r care not provided for 3. Review of Resider revealed the facility a 09/30/2015 with diag and Hemiparesis. Review of Resident a assessment, dated 0 facility assessed the Interview for Mental (8) out of fifteen (15) moderately cognitive the resident required personal hygiene.	cause wound decline. Sian #1/Medical Director, on PM, revealed he was aware pressure ulcer to his/her aware the resident had soure ulcers. He further ware staff were not able to esidents every two (2) hours affing. He stated a pressure and/or decline if a resident epositioned, or incontinence more than two (2) hours. ant #320's medical record admitted the resident on inoses including Hemiplegia			

If continuation sheet Page 261 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
				VIKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 725	Continued From page		F 725		
	11:20 AM, revealed black jogging pants	the resident was wearing and a blue t-shirt			
		8/2021 at 9:00 AM revealed			
		aring the same clothes as on			
		ation of Resident #320, on AM, revealed the resident			
		le same clothes as on			
	07/272021 and 07/2				
		d an unpleasant odor was se to the resident and the			
	resident's hair had a				
		ent #320, on 07/28/2021 at ne resident frequently had to			
	-	nis/her clothes. Resident			
		lly have to ask two (2) or e they will help me." The			
	. ,	ing a shower twice weekly as			
	scheduled, stating, t here".	here was "not enough help			
	Interview with the D	ON/IDON, on 08/18/2021 at			
	9:50 PM, revealed the record for Resident is the second for Resident is the second sec	ne facility had no shower #320.			
	4. Review of Reside	ent #308's medical record			
		admitted the resident on			
		gnoses that included a Lack Abnormal Gait/Mobility.			
	Review of Resident	#308's Quarterly MDS			
		07/26/2021, revealed the			
		resident to have a BIMS out of fifteen (15), indicating			
		gnitively intact. Further review			
	revealed the resider with transfers and to	t required staff assistance ileting.			
	Observation of Resi	dent #308, on 07/27/2021 at			

Facility ID: 100599

If continuation sheet Page 262 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 725	room in bed or chair. revealed the resident uncombed. Interview with Reside 11:10 AM, revealed s with a bath in nine (9 "For about a year it's help you around here meals were late and worth eating most of stated it took up to an call light. The reside everyone about not e taken care. Howeve had been done to co Interview with the DO 9:50 PM, reveled the record for Resident # 5. Review of Reside revealed the facility a 06/03/2021 with diag Coordination. Review of Resident # assessment, dated 0 facility assessed the score of ten (10) out resident was modera The facility assessed staff assistance with Interview with Reside 12:50 PM, revealed the had received only on	he resident was in his/her Continued observation I's hair was oily and ent #308, on 07/27/2021 at staff had not assisted him/her) days. The resident stated, been hard to get anyone to e." Resident #308 stated the food was "cold and not the time". Resident #308 n hour for staff to answer a nt reported complaining to enough help and not being r, the resident stated nothing rrect the problems. DN/IDON, on 08/18/2021 at facility had no shower 4308. nt #314's medical record admitted the resident on noses that included Lack of #314's Quarterly MDS 7/30/2021, revealed the resident to have a BIMS of fifteen (15), indicating the itely cognitively impaired. I Resident #314 to require	F 725			

Facility ID: 100599

If continuation sheet Page 263 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROV OMB NO. 0938-03	ED
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	N POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501		
	SLIMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETIC	iN
F 725	Continued From pag	le 263	F 725			
	revealed the facility especially at night.	did not have enough help				
		DN/IDON, on 08/18/2021 at a facility had no shower #314.				
		-				
	assessment, dated (facility assessed the score of eight (8) our resident had mild co	#311's Admission MDS)7/04/2021, revealed the resident to have a BIMS t of fifteen (15), indicating the gnitive impairment. Resident ance of one (1) staff member sing.				
	12:40 PM, revealed only received three (to the facility twenty- #311 stated the facili workers and he/she	ent #311, on 07/27/2021 at the resident reported he/she (3) showers since admission three (23) days go. Resident ity didn't have enough had stopped using the call nission, because "no one				
		DN/IDON on 08/18/2021 at a facility had no shower #311.				
	revealed the facility a 01/27/2014, with dia	nt #3's medical record admitted the resident on gnoses that included and Diabetes Mellitus.				
	Review of Resident	#3's Quarterly MDS				

If continuation sheet Page 264 of 401

	-	HAND HUMAN SERVICES			PRINTED: 12/08/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
	$2 \cap$	185256	B. WING		09/10/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER			TREET ADDRESS, CITY, STATE, ZIP CODE		
			200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC
F 725	Continued From p	-	F 725		
	facility assessed	ed 07/22/2021, revealed the the resident to have a BIMS' 5) out of fifteen (15), indicating			
	the resident was of the MDS revea	cognitively intact. Further review led the resident required			
		ressing and extensive pileting and personal hygiene.			
	10:00 AM, reveal	sident #3, on 07/28/2021 at ed the resident routinely council meetings. The resident			
	stated every mee residents always	voiced concerns over cold food, e, call lights not answered,			
	showers not give	n, and not enough staff to wever, the resident stated,			
	service, revealed	n 08/05/2021 of the lunch meal the first fourth floor meal cart it at 1:59 PM (approximately two			
	hours later than s on the cart. Furth	cheduled) with twenty (20) trays er observation revealed RN #8 passing meal trays from 1:59			
	· ·	. Staff passed the last tray at			
	08/05/2021 at ap the pureed meat	e test tray food temperatures, on proximately 2:16 PM, revealed was ninety (90) degrees			
	Fahrenheit , pure degrees Fahrenh	oes ninety-two (92) degrees ed green beans ninety (90) eit , pureed bread eighty (80)			
		eit and cold chocolate pudding grees Fahrenheit .			
	fourth floor meal o	8/05/2021 revealed the second cart arrived on the unit at 2:10 ly 2 hours and 10 minutes later			

Facility ID: 100599

If continuation sheet Page 265 of 401

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
_		185256	B. WING	-ETNZ	09/10/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	KEVILLE, KY 41501 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 725	than scheduled) with Observation reveale was passing trays. resident tray at 2:35 Observation of the s food temperatures, of approximately 2:35 If steak with gravy was degrees Fahrenheit, hundred twelve (112 mashed potatoes or degrees Fahrenheit, fifty-eight (58) degree hundred eight (108 of chocolate pudding w Fahrenheit. Interview with State (SRNA) #16, on 07/2 the facility was shor The SRNA stated th SRNAs for night shift had only been one (for forty (40) residen service was always PM before the kitcher The SRNA stated th could pass trays and some of which requi	h fifteen (15) trays. d only one (1) staff person Staff delivered the last PM. econd meal cart test tray on 08/05/2021 at PM, revealed chicken fried s one hundred and four (104) whole kernel corn one et) degrees Fahrenheit, ne hundred twenty-four (124) two (2) percent milk was es Fahrenheit, coffee one degrees Fahrenheit and cold vas sixty-eight (68) degrees Registered Nurse Aide 27/2021 at 8:10 PM, revealed t staffed especially at night. ere should be three (3) ft. However, for months there 1) SRNA scheduled to care tts. SRNA #16 stated meal late and at times, it was 8:00 en delivered trays to the floor. ere was no way one (1) staff d assist forty (40) residents, red total feeding. tered Nurse (RN) #9, on PM, revealed the RN v was short staffed. RN #9 be three (3) SRNAs working he night shift 6:00 PM until RN #9 stated most of the time 1) SRNA. The RN stated	F 725		

Facility ID: 100599

If continuation sheet Page 266 of 401

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		185256	B. WING		09/10/2021
NAME OF PR	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
			200	NURSING HOME LANE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		РІК	EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 725	•	ige 266 ne Administrator on multiple	F 725		
	occasions. RN #9 a resident call light co	also stated she reported omplaints and shower			
	or a resolution. Fur	e had never received feedback ther interview revealed RN #9 t which occurred a few weeks			
	to provide 1:1 supe	the Administrator directed her rvision to a resident.			
	Administrator that t	ated she informed the here were forty-seven (47) or and that she and one SRNA			
	were the only staff	on the unit to care for them, sident supervision was not			
	her to do the best s	ated the Administrator directed whe could and did not attempt			
		aff to provide assistance on the resident's safety.			
	Interview with the A Nursing/Interim Dire	ssistant Director of			
	(ADON/IDON), on (08/18/2021 at 9:50 PM, vorked at the facility for			
	been inadequately	(1) year and the facility had staffed with nurses and aides			
	stated she had wor	h there. The ADON/IDON ked the floor as a staff nurse been able to complete her			
	administrative nurs	ing tasks. The ADON/IDON ked the last six (6) of seven			
	(7) nights on the flo	or due to short staffing. She are that residents were not			
	care, not being turn	ot getting timely incontinent ned and re-positioned, and not			
	the lack of staff. Th	te feeding assistance due to ne ADON stated she was also /ere served consistently late,			
	which made it diffic	ult for staff and residents at DON/IDON stated when the			

If continuation sheet Page 267 of 401

CENTER	S FOR MEDICARE	E & MEDICAID SERVICES		\cap	MB NO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
			. 200 M	NURSING HOME LANE	
PARKVIE	V POST-ACUTE AND	REHABILITATION CENTER		EVILLE, KY 41501	
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	
F 725	Continued From p	age 267	F 725		
	-	ening, it was difficult to serve			
		its because there was only one			
		nurses were administering			
		at time and could not help.			
	Interview with the	Administrator, on 08/11/2021 at			
	6:00 PM, revealed	she was aware the facility was			
	short staffed and o	did not have enough nurses or			
	nurse aides. The	Administrator stated optimally a			
	"good ratio" was te	en (10) residents per nursing			
		t was the goal for staffing in the			
		nistrator stated there should be			
		d four (4) nurse aides on each			
		(7:00 AM-7:00 PM) and two (2)			
		(3) aides for night shift (7:00			
	,	wever, the Administrator stated			
	-	t met those staffing numbers			
		en at the facility. The			
		ed she was aware there was			
		A and one (1) nurse providing			
		tely forty (40) residents			
		y was short staffed. However,			
		stated the facility had not met			
	•	bers since she had been at the histrator stated when staff called			
	-	to come, there was no one to			
		ulting in short staffing.			
		ninistrator stated she continued			
	,	ident admissions, even though			
		equate number of staff to care			
		ninistrator stated that although			
		at one (1) nurse and (1) SRNA			
		ing for approximately forty (40)			
	-	ed knowledge that residents			
		showers as scheduled or that			
		mplaining of call light wait			
F 755		Procedures/Pharmacist/Records	F 755		
SS=J					

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	2: 12/08/2021 1 APPROVED 2: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMPI	
		185256	B. WING		09/*	10/202 <u>1</u>
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE		
PARKVIE	V POST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	Continued From pag	je 268	F 755	5		
	CFR(s): 483.45(a)(b)(1)-(3)				
	drugs and biological them under an agree §483.70(g). The fac personnel to adminis permits, but only und a licensed nurse. §483.45(a) Procedur pharmaceutical serv that assure the accur dispensing, and adm biologicals) to meet §483.45(b) Service 0 must employ or obta pharmacist who- §483.45(b)(1) Provid aspects of the provis the facility. §483.45(b)(2) Estab receipt and dispositie sufficient detail to en reconciliation; and §483.45(b)(3) Detern order and that an acc	vide routine and emergency s to its residents, or obtain ement described in ility may permit unlicensed ster drugs if State law der the general supervision of res. A facility must provide ices (including procedures rate acquiring, receiving, ninistering of all drugs and the needs of each resident. Consultation. The facility in the services of a licensed les consultation on all sion of pharmacy services in lishes a system of records of on of all controlled drugs in				

Facility ID: 100599

If continuation sheet Page 269 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
	PARKVIEW POST-ACUTE AND REHABILITATION CENTER		20	00 NURSING HOME LANE	
PARRVIEN	POST-ACUTE AND RE	ENABLITATION CENTER	P	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 755	Continued From pag	e 269	F 755		
	by: Based on observation and review of the facilit pharmaceutical servit (5) of fifty-seven (57 (Resident #321, Resident #321, Resident #321, Resident #321, Resident #351,	y failed to provide ces to meet the needs of five) sampled residents ident #326, Resident #351, sident #324). The facility administer prescribed the needs of Resident #326, dent #9 and Resident #324. y admitted Resident #321 on diagnoses of Urosepsis and neer with Physician's Orders ic to treat the Urosepsis. ed the facility to "cost ation before it could be ", the facility failed to address d Resident #321 did not			

Facility ID: 100599

If continuation sheet Page 270 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
STATEMENT C	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	TAL	COMPLETED
		185256	B. WING	/ / / /	09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW	V POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 755	Jeopardy on 08/11/2 An acceptable Allega was received on 09/0 removal of the Imme 09/02/2021. Howeve verified based on ob and review of facility Immediate Jeopardy 483.35 Nursing Serv Administration (F835 Quality Assurance at Improvement (F867) the Immediate Jeopardy The findings include: Review of the facility Pharmacy Requirem revealed regular and services were availa prescription and non services, and related Further review revea perform routine and and emergency phar (24) hours per day, s addition, the pharma determining the appr dispensing and adm and biologicals to me the residents, accura based on authorized provide, maintain, ar	vas notified of Immediate 021. ation of Compliance (AOC) 03/2021, which alleged diate Jeopardy on er, the AOC could not be servations, staff interviews, documentation. Additional was identified at 42 CFR fices (F725), 42 CFR 483.70 b) (F837), 42 CFR 483.75 and Performance . The facility was notified of ardy on 09/10/2021. The is ongoing. 's policy titled, "Provider ents", revised 01/2021, I reliable pharmaceutical ble to provide residents with prescription medications, d equipment and supplies. Ided the provider agreed to timely pharmacy services, macy services twenty-four seven (7) days a week. In, cy would assist the facility in ropriate acquisition, receipt, inistration of all medications eet the medication needs of ately dispense prescriptions prescriber orders, and nd replenish emergency ed and properly labeled	F 755		

Facility ID: 100599

If continuation sheet Page 271 of 401

		AND HUMAN SERVICES		C	FORM APPROVE MB NO. 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE		
			PIKE	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F 755	Continued From	page 271	F 755		
	Ordering and Rec as revised on 01/ pharmacy service basis. Staff will of using the facility's medication supply provider pharmac supplies emerger emergency drugs substances, and quantities, in the with applicable st revealed telephor emergency pharm nurses stations a physician on call were posted at th medication storag revealed the phar "stat" medications	ility's policy titled, "Medication ceiving from Pharmacy," dated 2021 revealed emergency as were available on a 24-hour btain emergency medications by a approved emergency y or by special order from the cy. The provider pharmacy ney medications including a, antibiotics, controlled products for infusion in limited emergency kit in compliance ate regulations. Further review ne/fax (facsimile) numbers for nacy services were posted at the nd/or medication storage rooms, 24/7 and telephone numbers e nurses stations and/or ge rooms. Continued review rmacy supplied emergency or as according to the pharmacy f available, should be obtained ncy kit until the provider ed the appropriate medications.			
	Medications", dat revealed medicat and timely manner revealed medicat accordance with required time-fran administered with	ility's policy titled, "Administering ed as revised on 04/2019 ions were administered in a safe er, as prescribed. Further review ions were administered in prescriber orders, including any mes and medications were in one (1) hour of their unless otherwise specified, such meals.			
	revealed the facil	sident #321's medical record ity admitted the resident on diagnoses of Urosepis, Diabetes			

Facility ID: 100599

If continuation sheet Page 272 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW	N POST-ACUTE AND RE	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 755	Continued From pag Mellitus, and Invasive		F 755		
	Discharge assessme revealed the facility a a Brief Interview for I of thirteen (13), indic cognitively intact.	assessed the resident to have Mental Status (BIMS) score ating the resident was			
	record revealed the f	Resident #321's medical facility transferred the tal on 07/20/2021 related to plood sugar).			
	Orders, dated 07/16/ the staff to administe Thromethamine (anti Saturday to treat the Urosepsis. Staff was	ibiotic) by mouth every resident's diagnosis of to administer the medication starting on 07/17/2021 and			
	revealed the Fosform medication was due but was not administ was not available. F	#321's Medication rd (MAR), dated 07/17/2021, nycin Thromethamine at 9:00 AM on 07/17/2021, tered because the medication further review of the MAR proval" was pending for the			
	on 07/27/2021 at 4:1 contacted the pharm attempt to obtain Res However, the pharma required cost approv	ed Practical Nurse (LPN) #6, 0 PM, revealed she bacy on 07/17/2021 in an sident # 321's medication. acy stated the antibiotic ral from the facility before the facility. She further stated			

Facility ID: 100599

If continuation sheet Page 273 of 401

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES		(FORM APPROV OMB NO. 0938-03
TATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		200 M	NURSING HOME LANE		
		PIKE	EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 755	Continued From	page 273	F 755		
	she notified Phys	sician #1 that the medication was			
		asked if he could order a			
	substitute antibio	tic. However, the physician			
		at he could not substitute the			
		the resident needed the			
		dered. LPN #6 stated she			
		tor of Nursing/Interim Director of			
	•	ON) of the need for a cost			
		ver, when she provided care for			
		next day, on 07/18/2021, the still not available for the resident.			
		I #6, someone should have			
	-	dication required a cost approval			
		ent's admission to the facility.			
		Admission Coordinator, on			
		:34 AM, revealed before the			
		a resident from the hospital, the			
		on Coordinator met with the Aanager for the referral, and she			
		dent's needs, bed availability,			
		stated staff faxed the resident's			
	admission medic	ation orders to the pharmacy			
		ent's admission and the cost of			
	each medication	was reviewed. According to the			
		linator, she had not had any			
		approvals, though she had only			
		y for three (3) months. She			
	-	has knowledge of a resident's			
		nd therefore, the resident's			
		uld be available and ready for the ival to the facility.			
	Interview with Ph	armacist #1 on 07/28/2021 at			
	4:05 PM, reveale	d the pharmacy received			
		medication list on 07/16/2021 at			
		ated the pharmacy had not sent			
		the facility because they were			
	waiting cost appr	oval from the ADON/IDON. She			

Facility ID: 100599

If continuation sheet Page 274 of 401

		ND HUMAN SERVICES			FORM APPROVED
					OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				200 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
F 755	non-formulary, experimentary, experimentary in the experimentary of the insurance, required facility prior to delive had a note on file the facility via telephone Resident #321's and AM, and then follow ADON/IDON, reque Interview with Physis 1:05 PM, revealed he available for resider facility and admission provide immediate of the recalled the nurse #321's antibiotic for to administer on 07/ he told the nurse the medication and he of However, he did not aware that Resident arrive for administration was resident. Interview with the AM 12:05 PM, revealed a new admission, the reviewed the case to meet the resident's Admission's Coordin handled any cost appre-admission proceed did recall anyone not antibiotic medication at the medication and he case to meet the resident's Admission proceed did recall anyone not antibiotic medication at the medication and he case to meet the resident's Admission proceed any cost appre-admission proceed any cost app	redication, which was nsive, or not approved by a cost approval from the ery. She stated the pharmacy at they attempted to reach the e for a cost approval for ibiotic on 07/16/2021 at 11:25 ed-up with an email to the sting the cost approval. cian #1, on 08/04/2021 at the expected medications to be its upon admission to the on orders to be followed to care to residents. He stated e notifying him that Resident Urosepsis was not available 17/2021. Physician #1 stated e resident needed the lid not change the order. recall the facility making him : #321's antibiotic did not tion on 07/18/2021, nor that never administered to the DON/IDON, on 08/11/2021 at that when the facility received e Admission Coordinator o ensure the facility could needs. The ADON/IDON the nator should have already	F 75		

Facility ID: 100599

If continuation sheet Page 275 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			0 NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
F 755	 1:50 PM, revealed the admissions to ensure needs prior to admise expected staff to follow medications to be avito admission to the far not aware Resident # available following his cost approval issue. Coordinator should herelated to the facility assesses the cognitively impaired. Review of Resident # Plan, dated 07/09/20 was at risk for declin Disabilities and Muse maintain the highest Further review revea potential for alteratio for pain related to Memuscle spasms with as comfortable as potential so redered, notifying pain, and if the pain the pain	ministrator, on 08/10/2021 at the facility reviewed new the facility could meet their sion. She stated she ow admission orders and ailable for the resident prior acility. She stated she was #321's antibiotic was not s/her admission due to a She stated the Admissions have resolved any issue val prior to Resident #321's wealed the facility admitted 1/2013 with diagnoses that erosis, Muscular Dystrophy, #9's Annual MDS 16/09/2021, revealed the resident to be severely #9's Comprehensive Care 120, revealed the resident e related to Intellectual cular Dystrophy with a goal to level of comfort possible. led Resident #9 had the n in comfort and was at risk uscular Dystrophy and a goal to keep the resident	F 755		

Facility ID: 100599

If continuation sheet Page 276 of 401

	OF DEFICIENCIES	X MEDICAID SERVICES	(X2) MULTIPLE C		OMB NO. 0938-03
ND PLAN O	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
			. 200	NURSING HOME LANE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		РІК	EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 755	10/13/2020, reveale resident Gabapentir daily and Norco by r Diazepam by mouth beginning on 06/17/ Multiple Sclerosis, M spasms, restlessness Review of Resident thru 08/04/2021, rev 06/24/2021, and 07/ administer Resident times daily as presc medication was not 08/02/2021, 08/03/2 facility failed to adm Gabapentin three (3 the medication had Further review of the 08/03/2021 the facil Resident #9's Norco times daily as presc the medication was Interview with Regis 08/05/2021 at 1:00 been out of Gabape days. She stated sh and Physician #1 m pharmacy had not d 08/04/2021. RN #1 medications sometir stated often had to r pharmacy multiple ti or refill for narcotics nurses notified the p there were three (3)	A d staff were to administer the a by mouth three (3) times mouth two (2) times daily, and a three (3) times daily 2021, for treatment of Auscular Dystrophy, muscle as and agitation. #9's MAR, from 06/23/2021 /ealed on 06/23/2021, /27/2021, the facility failed to a #9's Diazepam three (3) ribed and documented the available from pharmacy. On 2021 and 08/04/2021, the inister Resident #9's B) times daily and documented not arrived from pharmacy. MAR revealed, on ity also failed to administer o pain medication two (2) ribed and staff documented not in from pharmacy. stered Nurse (RN) #1, on PM, revealed Resident #9 had entin medication for several e had notified the pharmacy ultiple times, but the lelivered the medication until stated obtaining refills on me took a long time. RN #1 notify Physician #1 and the imes to obtain a prescription for a resident. RN #1 stated ohysician and pharmacy when	F 755		

Facility ID: 100599

If continuation sheet Page 277 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	N POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 755	Continued From pag or arrival of the medi		F 755		
	 #1, on 08/05/2021 at #9 had been out of G and she had notified documented the med 3. Review of Resider revealed the facility a 07/30/2021 with diag Respiratory Failure w Myocardial Infarction 	•••			
	assessment, dated 0 facility assessed the Interview for Mental 9	8/06/2021, revealed the resident to have a Brief Status score of nine (9), ht was moderately cognitively			
	Plan, dated 08/12/20 was care planned for	#326 Comprehensive Care 21, revealed the resident pain management and d administering medications			
	dated 07/31/2021, re				
	Record (E-Mar), date Resident #326 receiv mg (milligram), one (Medication Administration ed 08/05/2021, revealed /ed Percocet Tablet 5-325 1) tablet by mouth for head 4 PM, approximately six (6)			

Facility ID: 100599

If continuation sheet Page 278 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW	V POST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 755	Continued From pag	e 278	F 755		
	hours after requestin voicing severe pain t	g pain medication and o staff.			
	10:01 AM, revealed I head and back pain a (8) of ten (10) on the revealed no pain me resident, and staff re delivery of the medic Observation of Resid 11:09 AM, revealed t holding his/her head #326, on 08/05/2021 resident stated he/sh was waiting on pain stated he/she had be	Note, dated 08/05/2021 at Resident #326 complained of and rated the pain as eight pain scale. Further review dication was available for the quested a "STAT" (now) ation. dent #326 on 08/05/2021, at the resident was lying in bed . Interview with Resident at 11:09 AM, revealed the ne was "hurting all over" and medication. The resident een in pain "all morning" and an eight (8) on the pain			
	on 08/05/2021 at 11: #326 did not have pa awaiting the medicat	ed Practical Nurse (LPN) #4, 11 AM, revealed Resident ain medication and they were ion from pharmacy. LPN #4 e nurse assigned to the			
	revealed Resident #3 and they were attem	e, on 08/05/2021 at 11:57 AM, 326 had no pain medication pting to get the medication The RN stated she was gency medication kit.			
	1:42 PM, revealed he	ent #326, on 08/05/2021 at e/she had not yet received ion. Resident #326 stated, g me".			

If continuation sheet Page 279 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 755	revealed she had no with any medication nothing in the buildin needed something for she was unaware of medication any soon Interview with Resided 4:45 PM, revealed th received any pain mo pain. Interview with RN #8 revealed, she had sp they had instructed h emergency medication Resident #326's pain Observation of a mer at 5:15 PM, revealed Resident #326 a Per emergency kit. Interview with Physic 1:26 PM, revealed he issues with obtaining for residents at the fa physician stated he w including Resident # pain medications. Interview with ADON 12:00 PM, revealed a were going several of medications due to n available. The ADOI	8, on 08/05/2021 at 1:50 PM, t provided Resident #326 for pain because there was ig. However, the resident or pain. She further stated how to obtain the resident's ner. ent #326, on 08/05/2021 at he resident still had not edication and was still in 8, on 08/05/2021 at 4:47 PM, poken to the pharmacy and her on the facility's on kit and how to obtain in medication from the kit. dication pass, on 08/05/2021 d RN #5 administered recocet tablet from the cian #1, on 08/27/2021 at e was aware there were g narcotic pain medications	F 755		

Facility ID: 100599

If continuation sheet Page 280 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	12/08/2021 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/1	0/2021
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 755	Continued From pag	je 280	F 755			
	 1:50 PM, revealed the admissions to ensurneeds prior to admissions to ensurneeds prior to admission to ensurneeds prior to admission. Administrator stated #326's pain medicate following admission. Record review revealed the solution of the prior to admission. Record review revealed the solution of the pain due to the solution of the physician of the physician	Auadriplegia. #351's Quarterly MDS 05/26/2021 revealed the resident to have a BIMS dicating the resident was				

Facility ID: 100599

If continuation sheet Page 281 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	12/08/2021 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
- E		185256	B. WING		09/1	0/2021
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 755	thru 08/06/2021, reve administer Resident is prescribed on 04/01// 08/02/2021, 08/03/20 08/05/2021. Further if documented the med from pharmacy to ad Interview with Certifie (CMT) #1, on 08/05/2 Resident #351 had b several days. The CI and documented the She stated sometime available to administe and the nurse would pharmacy. She furthe out of narcotic medic or the facility did not available to administe Interview with RN #1 revealed she often has the pharmacy multipl prescription or refill for The RN stated the nu and pharmacy when remaining of medicat would go multiple da awaiting a refill or arr 5. Record review rev Resident #324 on 03 including Quadripleg Reflux Disease (GEF Syndrome.	4351's MAR from 04/01/2021 ealed the facility failed to #351's Oxycodone tablet as 2021, 04/02/2021, 021, 08/04/2021 and review revealed the facility dication was not available minister to the resident. ed Medication Technician 2021 at 1:00 PM, revealed een without Oxycodone for MT stated she notified RN #1 medication was unavailable. es medications were not er and she notified the nurse, notify the physician and the er stated residents often run tation when waiting for a refill have the medication er. , on 08/05/2021 at 1:55 PM, ad to notify Physician #1 and the times to obtain a or narcotics for a resident. urse notified the physician	F 755			

Facility ID: 100599

If continuation sheet Page 282 of 401

CENTER	S FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING	-EIN/	09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AND	REHABILITATION CENTER	200 NURSING HOME LANE		
		PIP	KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 755	Continued From p	bage 282	F 755		
	-	d 07/06/2021, revealed the			
		the resident to have a BIMS			
		(14), indicating the resident was			
	cognitively intact.				
	Review of Resident #324's Comprehensive Care				
		2021, revealed Resident #324			
		with a goal to remain free of			
		discomfort. Further review			
		tions included administering the			
	resident medication	ons as ordered and pain			
	management as r	needed.			
	Review of Reside	nt #324's admitting Physician			
		24/2021, revealed Resident			
		bed Sertraline HCI daily,			
	Lactulose Solution	n two (2) times daily,			
	Gabapentin three	(3) times daily, and Baclofen			
		ily. Further review of Physician			
		on 03/28/2021, an order for			
	,	imes a day and on 07/03/2021,			
		for Fentanyl via transdermal			
	hours.	nged every seventy-two (72)			
		nt #324's MAR revealed that on			
		cility failed to administer			
		Sertraline, Lactulose,			
		Baclofen as ordered. The			
	-	ed the medications were not hister to the resident.			
		3/29/2021, 06/04/2021,			
	-	6/2021 and 06/07/2021, the			
		Iminister the resident's			
	-	documented the medication			
		from pharmacy. Further, the			
		Iminister Resident #324's			
		/02/2021-07/03/2021 and staff			
	failed to change t	he resident's Fentanyl patch on			

Facility ID: 100599

If continuation sheet Page 283 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
					OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				200 NURSING HOME LANE	
PARKVIEV	V POST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 755	both the Baclofen ar not available from p Interview with Certiff 08/05/2021 at 1:00 I medications were no She stated she notifi called the physician interview revealed th residents' narcotic n waiting on a refill or medication available when medications w administer she notifi called the physician stated the facility ran medications and the pain medicine for se refill. Interview with RN #' revealed it had been prescription refills fo when there was a th medication remainin physician and the pl pharmacy's "cut off orders for prescription to fill anything rece next day. In addition admitted a resident resident's medication RN #10 stated there residents not getting stated staff could rei emergency kit on the for the medication.	12/2021. Staff documented and Fentanyl medications were harmacy. Ted Medication Aide #1, on PM, revealed sometimes of available to administer. Ted the nurse, and the nurse and the pharmacy. Further the facility often ran out of nedications when they were they did not have the e to administer. She stated were not available to ed the nurse, and the nurse and pharmacy. She further no out of residents' narcotic residents had to go without weral days while waiting for a 10, on 08/25/2021 at 4:28 PM, nore difficult to get r narcotics. The RN stated ree (3) day supply of g; the nurse would notify the harmacy. RN #10 stated the time" was 4:00 PM to fax ons, and the pharmacy would ived after 4:00 PM until the n, RN #10 stated if the facility on the weekend, none of the ns might be available. were frequent issues with g narcotic refills on time. She move medication from the e floor if there was an order however, RN #10 stated if the	F 755		
	for the medication. I				

Facility ID: 100599

If continuation sheet Page 284 of 401

CENTERS FOR MEDICARE & MEDICAID SERVICES ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDPLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
D PLAN OF	CORRECTION		A. BUILDING	_	COMPLETED	
		185256	B. WING		09/10/2021	
AME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
			. 2	00 NURSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIO	
F 755	Continued From page	ge 284	F 755			
		10 stated to obtain a				
		emergency kit, staff faxed an				
		ation to the pharmacy along				
		nt information, and then a				
	pharmacist would c	all the nurse at the facility and				
	5	code to enter into the				
	• •	obtain the narcotic. RN #10				
		ure how the facility maintained				
	• •	to ensure medications were				
		tated she had never received				
	training on the eme "figured it out".	rgency kit, stating she just				
	Interview with RN #	7, on 08/24/2021 at 4:28 PM,				
	revealed there were	e issues with medications not				
	being available to re	esidents. She stated if a				
		available, the nurse should				
		cy kit first and call the				
		lication was not in the kit. She				
		otic medication needed, then				
		e pharmacy to find out if the				
		available due to needing a on did require a refill, the				
		e physician and get an order				
		e medication from the facility's				
	•	the medication arrived from				
		urther stated the nurse was				
	responsible to pull t					
	medication's contain	ner when there was				
	seventy-two (72) ho	ours of medication remaining				
		e staff then faxed the sticker to				
		tain a refill of the medication.				
		ker available, because the				
	-	l a refill, they would contact				
	-	e and she notified the				
		e medication. RN #7 stated				
	-	rained her on utilizing the kits, om other staff. RN #7 stated to				
		om the emergency kit, the				

Facility ID: 100599

If continuation sheet Page 285 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 755	Continued From pag	je 285	F 755		
		nysician's order to the the pharmacy would call and e to open the box.			
	resident needed a m would notify the phys enter the medication medication record (E electronically authori medication. She furth specific process in p were refilled, but if a the facility or the resi medication, the facili stated there have be and having to resence medications because	AM, revealed when a nedication refill, facility staff sician's office, and she would into the electronic EMAR) for Physician #1 to ize the pharmacy to refill the her stated the office had no lace to ensure medications medication did not arrive to ident was completely out of a ity would call the office. She een issues with the pharmacy			
	1:05 PM, revealed he available to residents	cian #1, on 08/04/2021 at e expected medications to be s upon admission to the I staff to follow the admission nt care to residents			
	08/27/2021 at 1:26 F there were issues wi medications for resid he requested the fac when the resident's s down to a ten (10) da stated he was not av several days without	with the physician #1, on PM, revealed he was aware ith obtaining narcotic pain dents at the facility. He stated cility send him a refill request supply of medication was ay supply. The physician ware residents were going t pain medications. Continued cian #1, revealed he was			

Facility ID: 100599

If continuation sheet Page 286 of 401

	S FOR MEDICARI	E & MEDICAID SERVICES		r c	MB NO. 0938-03
TATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	03/10/2021
				NURSING HOME LANE	
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER		EVILLE, KY 41501	
(X4) ID	SUMMAR	RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFIC	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETIC
F 755	Continued From p	bage 286	F 755		
	aware there were	issues with obtaining narcotic for residents at the facility.			
		vsician stated he was unaware			
		bing several days without pain			
		physician stated residents in			
		their needs addressed and			
	treated as soon a	s possible.			
	Interview with the	ADON/IDON, on 08/27/2021 at			
		ed she expected nursing staff to			
		an when a resident's narcotic			
		vas down to a three (3) day			
	supply. The ADC	N/IDON stated the facility did			
		nated back-up pharmacy to			
		medications. She stated she			
		ents were going several days			
		pain medications due to			
		being available and stated this			
		le. She stated Physician #1 was an issue with narcotic pain			
		ng to the facility timely. Further			
	•	d that staff notified the physician			
		advance for refills. The			
	ADON/IDON state	ed it was not standard practice			
		t to be in pain for several hours			
		ing a prescribed pain			
	medication.				
	Interview with the	Administrator, on 08/10/2021 at			
		d she expected resident			
		e filled, available and			
		ordered. She stated the facility			
		missions to ensure the facility			
		needs prior to admission. The			
		ted it was not acceptable for several hours for pain			
	medication.				
F 802		Support Personnel	F 802		
SS=F		11			

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		NURSING HOME LANE EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 802	Continued From pag CFR(s): 483.60(a)(3)		F 802		
	 §483.60(a) Staffing The facility must emp appropriate compete out the functions of the taking into consideral individual plans of ca and diagnoses of the in accordance with the required at §483.70(c) §483.60(a)(3) Support personnel to safely a functions of the food §483.60(b) A member Services staff must pro- personnel to safely a functions of the food §483.60(b) A member Services staff must pro- interdisciplinary team (2)(ii). This REQUIREMENT by: Based on observation and review of the facilities staff with the appropri- sets to carry out the nutrition service. Observation of the reformation of the staff failed to serve for increased content of been added to impro- recommended by the for forty-two (42) of formation. 	ploy sufficient staff with the encies and skills sets to carry the food and nutrition service, ation resident assessments, are and the number, acuity e facility's resident population the facility assessment e). ort staff. vide sufficient support and effectively carry out the and nutrition service. er of the Food and Nutrition participate on the in as required in § 483.21(b) T is not met as evidenced on, interview, record review cility's policies, it was ty failed to employ sufficient riate competencies and skills functions of the food and			

Facility ID: 100599

If continuation sheet Page 288 of 401

		ND HUMAN SERVICES			FORM APPROVED
CENTER	RS FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF F	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
D (2	00 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND F	REHABILITATION CENTER	P	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 802	received fortified for they had not been ef foods. During the lunch me staff failed to utilize plating the food; and portion of the meal size. In addition, resident served late due to in kitchen. The findings include Review of the facilit Nutrition Services," revealed staff would nourishing, palatabl the resident's daily in needs, with preferent into consideration. would be provided with the scheduled meal Review of the facilit Control," undated, determined by the r residents, and portion according to the facilit Servers guidance u undated, revealed a	 bds. Staff interviews revealed educated on how to fortify balanced on how to fortify balanced diet that met nutritional/special dietary nees of each resident taken The policy also stated meals within forty-five (45) minutes of time. by's policy titled, "Portion revealed portion size was nutritional needs of the on sizes must be served ility's menu and staff should ngredients as applicable. by's Scoops/Ladles and Portion tilized in the facility's kitchen, a #10 scoop was equal to 3/8 equal to ½ cup and a #12 	F 802		

Facility ID: 100599

If continuation sheet Page 289 of 401

PRINTED: 12/08/2021

CENTERS FOR MEDICARE & MEDICAID SERVICES OM	1B NO. 0938-0391
	B) DATE SURVEY COMPLETED
185256 B. WING	09/10/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER 200 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 802 Continued From page 289 F 802 Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed the facility had no policy related to fortified foods. However, she stated residents that were assessed to require fortified foods should be provided them, as well as any interventions the physician and/or the Registered Dietican (RD) had determined the resident needed to maintain their nutritional status. 1. Review of the menu for the lunch meal on 08/05/2021, revealed the residents were being served their meal of choice. Further review of the menu revealed the residents should receive three (3) ounces of protein for the lunch meal. According to the menu, ar& (12 cup) serving of green beans or other vegetables should be provided to the residents. Review of the, "Diet Roster" provided by the facility indicated forty-two (42) residents had been assessed to need fortified foods with all three meals, to assist in ensuring their nutritional needs were met. Observations of the tray line for the lunch meal service, on 08/05/2021 at 1:15 PM, revealed staff were serving beef fritters with gravy, corn or green beans, mashed potatoes, chocolate pudding and a roll. Further observations of the tray line revealed no fortified foods. The facility assessed 42 residents to receive fortified foods. Further observations of the tray line revealed cork and been arse serving beef fritters with gravy, corn or green beans, mashed potatoes, chocolate pudding and a roll. Further observations of the tray line revealed cork #2 residents to receive fortified foods. Further observations of the tray line revealed Cock #2 used a #10 scoop (3% cup) to serve the residents. The facility assessed 42 residents to receive	

Facility ID: 100599

If continuation sheet Page 290 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE 8	MEDICAID SERVICES		(DMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
				200 NURSING HOME LANE	
PARKVIE	N POST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501	
	1		I •		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D ATE
F 802	for the lunch meal. (the protein (meat) p however, the kitcher Observations of the staffs use, on 08/05. PM, revealed the sc chipped paint, was of appearance. Contin the scale was a mar calibrated at zero (0 Further observations 08/05/2021, and rev Roster" revealed die resident tray cards t preferences were ho Interview with Cook PM, revealed she had facility for approxima employment, the coo trained or directed to also stated she had facility, to provide ar foods and she had r for the residents. Po trained on scoop siz appropriate portions acknowledged she u during the lunch me residents should har mashed potatoes ar the facility had not tr weigh meat/protein	sidents corn or green beans Cook #2 was asked to weigh ortion of the lunch meal; in had no functioning scale. kitchen scale available for /2021 at approximately 3:00 ale was metal, dusty with dated and rusty in ued observations revealed hual scale and was visibly not). s of the tray line, on iew of the facility's "Diet etary staff failed to review o ensure their food	F 802		
		lid not review tray cards "like I ay line for resident meals			

Facility ID: 100599

If continuation sheet Page 291 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER			
				IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 802	Continued From pag	ge 291	F 802		
	because there was would be even more	not "enough of us and meals e off schedule."			
	PM, revealed the fa	ok #2, on 08/05/2021 at 12:00 cility was serving lunch to irteen residents (113).			
	indicated breakfast	y's mealtime schedule was served at 7:00 AM, lunch) PM and the evening meal PM.			
	08/05/2021, reveale was scheduled for 1 tray carts hadn't exit to go to the third floo revealed the last tra	tray line for the lunch meal on d even though the meal time 2:00 PM, the first of three (3) ted the kitchen until 1:30 PM or. Further observation y cart exited the kitchen at PM (almost 3 hours late) h floor residents.			
	on 08/05/2021, reversion on 08/05/2021, reversion on the second staff did nit start the first of three (3) tray kitchen to be served PM. Continued obs did not left the kitchen the second staff of the second	tray line for the supper meal ealed even though the supper d to be served at 5:00 PM, tray line until 6:15 PM. The carts did not leave the d to the residents until 6:50 ervation revealed the last cart en until 8:00 PM (three hours sidents on the 5th floor.			
	department had bee meals were always adequate time to re- residents' preferenc there should be three	ry Aide (DA) #1, on PM, revealed the dietary en short staffed for months, late and there was not view tray cards to ensure es were honored because ee (3) dietary aides, but staff y two (2) for months.			

Facility ID: 100599

If continuation sheet Page 292 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		-	0 NURSING HOME LANE KEVILLE, KY 41501		
	SLIMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 802	Continued From pag	e 292	F 802		
	revealed the dietary and they should be v aides. However, the (2) aides for approximal Interview with Cook a PM, revealed she hat facility for approximal she worked five (5) of three (3) meals on the stated she had work short staffing. She all of overtime and had overtime during the l the meal services we short staffed in the k facility had no Dietary months, which make on time, "impossible does not review tray tray line for resident enough of us and me schedule."	#2, on 08/05/2021 at 5:20 ad worked full-time at the ately one (1) year. She stated days a week and cooked all he days she worked. She is this way for months due to lso stated she worked "a lot" approximately 15-20 hours of ast pay period. She stated ere late because they were itchen. Per the cook, the y Manager and they were aide and had been for is getting meals to residents ." She acknowledged she cards "like I should" during meals "because there is not eals would be even more off			
	08/17/2021 at 3:00 F employed at another and had been asked weeks ago, to come and retrain dietary st because the facility f been identified in the she had visited the fa- times. According to t visited the facility sho	y Manager (DM) #2, on PM, revealed she was facility the company owned, approximately three (3) provide assistance/oversight taff on dietary processes, had no DM and concerns had e kitchen. The DM stated acility approximately three (3) the DM, when she initially e identified that staff had not d to fortify foods for the			

Facility ID: 100599

If continuation sheet Page 293 of 401

OMB NO. 093 (X3) DATE SURVE COMPLETED 09/10/20	'EY
09/10/20	
	021
D BE COM	(X5) MPLETIC DATE
1	

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		NURSING HOME LANE EVILLE, KY 41501	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION
F 803	Continued From pag	ge 294	F 803		
	CFR(s): 483.60(c)(1)-(7)			
	§483.60(c) Menus a Menus must-	nd nutritional adequacy.			
		the nutritional needs of ance with established national			
	§483.60(c)(2) Be pr	epared in advance;			
	§483.60(c)(3) Be fol	llowed;			
	reasonable efforts, t ethnic needs of the	ct, based on a facility's the religious, cultural and resident population, as well as residents and resident			
	§483.60(c)(5) Be up	dated periodically;			
	dietitian or other clin	viewed by the facility's nically qualified nutrition itional adequacy; and			
		ng in this paragraph should be e resident's right to make bices.			
	by: Based on observati and review of the fa determined the facil were followed for or	IT is not met as evidenced ion, interview, record review, cility's policies, it was ity failed to ensure menus he hundred eight (108) out of 109) residents who received a			

Facility ID: 100599

If continuation sheet Page 295 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	REHABILITATION CENTER) NURSING HOME LANE KEVILLE, KY 41501	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	E COMPLETION
F 803	Continued From page	je 295	F 803		
	Observation of the tr 06/15/2021, reveale green beans with sn them, pinto beans w ham in them, fried p white cake with mars menu for the lunch r residents were to re- pinto beans, buttere and cornbread. The findings include Review of the facility Substitutions and Ali the food substitute w usual and ordinary for Review of the facility Nutrition Services," I revealed staff would nourishing, palatable the resident's daily r needs, with preferent into consideration. 1. Review of the me 06/15/2021, reveale country ham slice, p Texas sheet cake, a Observation of the tr service, on 06/15/20 residents were serve pieces of country ham	y's policy titled, "Menu ternatives", undated, revealed would be consistent with the food items. y's policy titled, "Food and last revised October 2017, I provide residents with a e, well-balanced diet that met nutritional/special dietary nees of each resident taken enu for the lunch meal, on ed residents were to receive a binto beans, buttered carrots, and cornbread. ray line for the lunch meal 021 at 1:14 PM, revealed the ed green beans with small am in them, pinto beans with ntry ham in them, fried potato			

Facility ID: 100599

If continuation sheet Page 296 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2 FORM APPROV OMB NO. 0938-03	/ED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		ON
F 803	Continued From pag marshmallows in it.	e 296	F 803			
	Group interview cond (Residents #3, #16, 3) 06/16/2021 at 10:13 meal on 06/15/2021 stated they did not lif pinto beans served to they rarely got cake revealed menus wer Observation and inter 06/16/2021 at 9:27 A eating club crackers not know what was of day. The resident st for the alternate and usually they did not. stated that they aske facility served myste Interview with Reside 1:16 PM, revealed th tray from lunch on the resident stated, "I wo give me". The reside butter crackers beside Interview with Reside 10:25 AM, revealed for interview, the milk we too tough. The reside would go hungry if it from the outside. Interview with Cook a PM, revealed she co- carrots because she	erview with Resident #27, on M, revealed the resident was and stated that he/she did on the menu for lunch that ated sometimes they asked sometimes they got it, but The resident laughed and ed for the alternate when the ry meat. ent #307, on 06/16/2021 at he resident lying in bed with a e overbed table. The build not feed a dog what they ent had a soda and peanut				

Facility ID: 100599

If continuation sheet Page 297 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LIST MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 803	Continued From pag	e 297	F 803		
		lanager had instructed her to			
	-	n up and put it in the beans.			
		did not have chocolate cake			
		ite cake mix, so she had h marshmallows instead of			
		he Cook stated she had only			
	worked at the facility				
	Interview conducted	with the former Dietary			
		6/16/2021 at 1:30 PM,			
		it on 06/15/2021. The DM			
		he Cook to put the country			
		n beans and the pinto beans ot enough country ham. The			
		esponsible for ordering and			
	•	enough food to prepare the			
		he DM revealed she had not			
	could not prepare the	stered Dietician (RD) that she e menu as directed.			
	Interview conducted	with the RD, on 06/18/2021			
		I she had been aware the			
		ving the menus she had tated she had previously			
		regarding her concerns of			
	-	e menu and had been			
	-	he situation had been			
		tated not following the menus			
		ition, weight loss, and other e RD stated staff were			
		anytime they changed the			
		not done so on 06/15/2021.			
	The RD stated, "I wo have no authority ov	rk closely with the DM but I er her. "			
		with the Administrator, on M, revealed she had only			
		or at the facility for two (2)			
		trator stated she had spoken			

Facility ID: 100599

If continuation sheet Page 298 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 803 F 804 SS=E	aware of the problem Administrator stated the kitchen and foun food to be prepared Administrator stated and had purchased t Administrator stated realized the DM was needed to prepare th kitchen. Nutritive Value/Appe CFR(s): 483.60(d)(1) §483.60(d) Food and Each resident receiv §483.60(d)(1) Food p conserve nutritive value	d the DM and had not been ns in the kitchen. The on 06/14/2021, she went into d the DM had not ordered the for 06/15/2021. The she went to the grocery store he needed food. The it was not until then that she not ordering what was ne meals needed in the ar, Palatable/Prefer Temp)(2) d drink es and the facility provides- prepared by methods that ilue, flavor, and appearance;	F 803		
	attractive, and at a sitemperature. This REQUIREMEN by: Based on observation policy review, it was to provide food at pattemperatures for the and the lunch meal of on two (2) of the three Observations on 08/0 the food temperatures pureed meat at ninef (F), potatoes ninety-f	T is not met as evidenced on, interview, and facility determined the facility failed			

If continuation sheet Page 299 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2027 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-\L
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BATE
F 804	 (60) degrees F. The findings include: Review of the facility and Palpability", und prepared by methods value, flavor, and app policy, food would be appetizing temperatu Observation of the ev at 6:05 PM, revealed was obtained. The tra- sandwich which tasted hundred nine (109) di coleslaw at sixty (60) was cool, but tasted Interview with the Ac on 06/16/2021 at 6:0 should be less than fi DM stated she did rat the food taste good at temperature. The DN out because the form The DM stated she v owned by the compa Observation on 08/02 fourth floor lunch me 	F and chocolate pudding sixty 's policy titled,"Food: Quality ated, revealed food would be s which conserve nutritive bearance. According to the e served at a safe and ure. vening meal, on 06/16/2021 a test tray on the third floor ay contained a chicken ed cool and bland at one legrees Fahrenheit, and o degrees Fahrenheit, and o degrees Fahrenheit which bland. ting Dietary Manager (DM), 5 PM, revealed cold foods orty-one (41) degrees. The ndom tray checks to ensure and was at the appropriate A stated she was only helping her DM quit on 06/15/2021. vorked at another facility ny and was only filling in. 5/2021 revealed the first al cart arrived on the unit at	F 804	DEFICIENCY)	
	Further observation r (RN) #8 was the only from 1:59 PM until 2: Observation of the la	(20) trays on the cart. evealed Registered Nurse y staff passing meal trays 04 PM. st tray (test tray) passed 5/2021 at 2:16 PM, with the			

Facility ID: 100599

If continuation sheet Page 300 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	REHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 804	on the test tray were degrees Fahrenheit degrees F, pureed g degrees F, pureed g and chocolate puddi Interview with the R 08/05/2021 at 2:16 I should be at or belo and hot foods should and thirty-five (135) temperatures of the in acceptable param Observation on 08/0 fourth floor lunch me 2:10 PM with fifteen revealed only one (1 trays until 2:30 PM. delivered at 2:35 PM	evealed the food temperatures e: pureed meat at ninety (90) (F), potatoes ninety-two (92) green beans ninety (90) oread eighty (80) degrees F ing sixty (60) degrees F. egional Dietitian, on PM, revealed that cold foods w forty-one (41) degrees F d be at or above one hundred degrees F. She stated the food on the test tray were not neters. 05/2021 revealed the second eal cart arrived on the unit at (15) trays. Observation 1) staff person was passing The last tray passed was <i>M</i> .	F 804		
	08/05/2021 at 2:35 I temperatures as foll gravy one hundred a whole kernel corn of degrees F, mashed twenty-four (124) de (58) degrees F, coff degrees F and choc degrees F. Interview with Resid 11:00 AM, revealed Interview with Resid 1:20 PM, revealed h	est tray delivered, on PM, revealed food lows: chicken fried steak with and four (104) degrees F, ne hundred twelve (112) potatoes one hundred egrees F, 2% milk fifty-eight ee one hundred eight (108) colate pudding sixty-eight (68) dent, #332 on 07/27/2021 at the food was always cold. dent #39, on 08/17/2021 at ne/she had "lost a lot of weight cause the facility's food was			

Facility ID: 100599

If continuation sheet Page 301 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501	
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(¥5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 804	Continued From pag	e 301	F 804		
	always late and the f				
	revealed residents of informed her they we had failed to supply s "about a year." The interview and stated, facility kitchen was c stated she, as well as informed the Adminis complaints and reque department to send u for the residents; how yet." Interview with State H (SRNA) #16, on 07/2 the facility was short The SRNA stated the for night shift; howev worked short staffed almost forty (40) resi service was always H 8:00 PM before the t floor. The SRNA stated that require assistants stated residents freq "because it's cold be There's not enough H Interview with Dietart 08/17/2021 at 3:00 P should be one-hundr when it reaches the n coffee should be served.	re "hungry" and the facility snacks on the floors for RN became tearful in the food that came from the old and late. RN #6 also is other co-workers, had strator of the resident's ested she direct the dietary up snacks to have available vever, "that hasn't happened Registered Nurse Aide (7/2021 at 8:10 PM, revealed staffed, "especially at night." ere should be two (2) SRNAs er, for months they had with only one (1) SRNA to dents. She stated meal ate and sometimes it was rays were delivered to the ted, "There's no way one ys and feed the residents ce and do it right." She also uently complain of cold food fore they're getting it. help." y Manager (DM) #2, on M, revealed all hot foods ed, forty degrees (140) F resident. She also stated yed at one hundred (120) be served between thirty-six			

Facility ID: 100599

If continuation sheet Page 302 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/08/2021 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE S COMPL	SURVEY
		185256	B. WING		09/1	0/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		00 NURSING HOME LANE		
	CLIMMA DV C			,		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From pag	e 302	F 804			
	(RD), on 06/18/2021 completed a test tray stated she had not h temperature, but foor RD stated cold food (41) degrees Fahren palatability concerns and malnutrition. Interview with the As (ADON)/Interim Direct 08/18/2021 at 9:50 F at the facility for appu- the facility had been nurses and aides dur she was aware resid food. However, she could with the number ADON stated she was were consistently late stated when the food floor until 7:00 PM or was difficult to serve because there was on nurses were busy ad during that time and completed timely. Pe expected resident me and at the appropriate Interview with the Ad 6:00 PM, revealed si short staffed, there w nurse aides. She sta- nurses and four (4) r	d had very little taste. The should be served at forty one heit or less. The RD stated could lead to weight loss sistant Director of Nursing ctor of Nursing (DON), on PM, revealed she had worked roximately one (1) year and inadequately staffed with ring that time. She stated ents complained of cold stated staff did the best they er of staff at the facility. The as also aware meal times e, which made it difficult for uring the evening meal. She cart did not come to the 8:00 PM in the evening, it and assist residents inly one (1) aide. She stated iministering medications not everything could be er the ADON/IDON, she eals to be delivered timely				

Facility ID: 100599

If continuation sheet Page 303 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/08/2021 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE S COMPL	
		185256	B. WING		09/1	0/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From pag	e 303	F 804			
F 806 SS=F	and three (3) aides for PM-7:00 AM). Howe the facility had not m since she had been interview with the Ad aware of residents' of meals were served la stated there should b least four (4) other s the kitchen had work three (3) staff since s Administrator at the aware there was not ensure meals were t on it." Resident Allergies, F CFR(s): 483.60(d)(4 §483.60(d) Food and Each resident receiv §483.60(d)(4) Food a allergies, intolerance §483.60(d)(5) Appea nutritive value to resi food that is initially si different meal choice This REQUIREMENt by: Based on observation review, it was determ ensure one hundred hundred nine (109) m trays were offered ap	or the night shift (7:00 ever, the Administrator stated net those staffing numbers at the facility. Continued ministrator revealed she was cold food complaints and ate to the residents. She be a Dietary Manager and at taff in the kitchen; however, ted with no manager and only she had been the facility. She stated she was enough staff in the kitchen to imely, and was she "working Preferences, Substitutes)(5) d drink es and the facility provides- that accommodates resident es, and preferences; aling options of similar idents who choose not to eat erved or who request a	F 806			

If continuation sheet Page 304 of 401

		D HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/08/2021 APPROVED . 0938-0391
STATEMENT OF D AND PLAN OF CC	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE S COMPL	SURVEY
		185256	B. WING		09/1	0/2021
NAME OF PROV	IDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	- 1	
PARKVIEW P	OST-ACUTE AND RE	HABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
re se fo in (5 #' 0 la th in of TI RS re na al fo va pr na w se R N re na th na in (1 5 #') 0 la th in of TI RS re na al fo va se re na la th in of TI RS re na la th in of th in of th th in of th th in of th th in of th th in of th th th th th th th th th th th th th	erved. In addition, the bod served accomme- tolerance, and prefe 57) sampled residem 332) who were serve 8/05/2021. Also, Re- actose free milk; how re lactose free milk; how re lactose free milk in terviews revealed the f the milk. he findings include: eview of the facility's ubstitutions and Alter evealed staff should eeds were met and re- lergies, dislikes or w bod were served a sta- alue. According to the reference would be alue. According to the reference, and food ould be placed on the erving line. eview of the facility's utrition Services," la evealed staff would p pourishing, palatable, he resident's daily nu- eeds, with preference to consideration. . Review of the men 6/15/2021, revealed pountry ham slice, pir	e 304 b eat food that was initially e facility failed to ensure odated residents' allergies, erences for (3) of fifty-seven ts (Resident #350, #39 and ed food from the kitchen on esident #350 was to receive rever, the facility was out of on 08/05/2021 and staff he facility was frequently out s policy titled, "Menu ernatives" (not dated), ensure residents' nutritional residents with known who expressed a refusal of ubstitute of similar nutritive he policy, the resident's followed to the extent possible to encourage food preference information he tray card for use on the s policy titled, "Food and st revised October 2017, provide residents with a well-balanced diet that met tritional/special dietary tes of each resident taken u for the lunch meal, on residents were to receive a no beans, buttered carrots, d cornbread. In addition to	F 806			

Facility ID: 100599

If continuation sheet Page 305 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND F	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 806	alternate menu was Observation of the t service, on 06/15/20 residents were serv pieces of country ha pieces of country ha chunks, cornbread, marshmallows in it. Group interview corr (Resident #3, #16, # 06/16/2021 at 10:13 meal on 06/15/2021 the residents stated an alternate menu it served to them. Interview with Cook PM, revealed she w prepare an alternate	is listed on the menu, no listed or prepared. ray line for the lunch meal 021 at 1:14 PM, revealed the ed green beans with small am, pinto beans with small am in them, fried potato	F 80	06	
	(DM), on 06/16/202 had quit on 06/15/20 not directed the Coor menu but, she (the menu was required. know why she did n alternate foods. Co residents could hav served meals they w Interview with the R 06/18/2021 at 4:18 the facility was not f	revious Dietary Manager 1 at 1:30 PM, revealed she 021. The DM stated she had bk to prepare an alternate DM) was aware an alternate The DM stated she did not ot ask the cook to prepare ntinued interview revealed the e weight loss if they were vould not eat. egistered Dietitian (RD), on PM, revealed she was aware ollowing the menus and was ative menus. The RD stated			

Facility ID: 100599

If continuation sheet Page 306 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039	ΞD
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	4
F 806	her concerns of staff not providing an alter the DM had assured corrected. The RD st alternative to a reside served could cause r other health concern closely with the DM the her." Interview with the Ad 1:30 PM, revealed st Administrator at the f Administrator at the f Administrator stated Tuesday (06/15/2021 had been prepared of spoken with both the been made aware of The Administrator stated 06/15/2021. The Administrator stated 06/15/2022. The Administrator stated 06/15/2022. The Administrator stated 06/15/2021. The Administrator stated 06/15/2022. The Administrator stated 06/15/2021. The Administrator stated 06/15/2022. The Administrator stated 07/15/2022. The Administrated 07/15/2022. The Administrato	poken with the DM regarding not following the menu and mative menu. The RD stated her the situation had been ated not providing an ent who refused what was malnutrition, weight loss, and s. The RD stated, " I work but I have no authority over ministrator, on 06/19/2021 at he had only been the facility for two (2) weeks. The she had identified on I) that no alternative menus or served. She stated she had RD and the DM, but had not the problems in the kitchen. ated that on 06/14/2021, he kitchen she found that the the food to be prepared for ministrator stated she did not 21 that the DM was not eeded to prepare the meals	F 80	6		

Facility ID: 100599

If continuation sheet Page 307 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AND R	EHABILITATION CENTER		VIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 806	not have lactose free indicated on the dieta Interview with Dietar 08/17/2021 at 5:30 F enough food purchas food preferences. Th "always" out of multij wanted and it had be to work at the facility According to the DA, preference, "it was a milk was rarely availat Interview with Certifie 08/05/2021 at 2:45 F the kitchen and requisent to the floor for F was unavailable. She Administrator and the for the resident. Interview with Dietar 08/17/2021 at 3:00 F facility on three (3) d facility had been out occasion. She stated lactose free milk, she times to assist in ensi- were met. 3. Review of Reside revealed the facility a 03/12/2021 with diag 2 Diabetes, Chronic	evealed Resident #350 did e milk on his/her tray as ary tray card. y Aide (DA) #1, on PM, revealed there was not sed and available to honor he aide stated the facility was oble items the residents een this way since she started , a few months ago. lactose free milk wasn't a need," however lactose free able for the resident. ed Medication Aide #1, on PM, revealed she contacted ested lactose free milk be Resident #350 and was told it e stated she contacted the e kitchen sent a supplement y Manager (DM) #2, on PM, revealed she visited the ifferent occasions, and the of lactose free milk on each I residents that required buld have that available at all suring their dietary needs admitted the resident on moses, which included Type Kidney Disease, Reflux Disease, Hypertension	F 806		

Facility ID: 100599

If continuation sheet Page 308 of 401

STATE DEAN OF DEPORENCIES AND FLAN OF CORRECTION (20) DATE SURVEY COMPLETED (20) DATE SURVEY COMPLETED IMME OF RECVIDER OF REVOLUER 185256 IN WING (9/10/2021) STREET ADDRESS, CITY, STATE, JP CODE 200 NURSING HOME LANE 09/10/2021 PARKVIEW POST-ACUTE AND REHABILITATION CENTER 09/10/2021 STREET ADDRESS, CITY, STATE, JP CODE 200 NURSING HOME LANE 09/10/2021 PREVIEW POST-ACUTE AND REHABILITATION CENTER 010 IN WING (EACH CORRECTION) 021 PREVIEW POST-ACUTE AND REHABILITATION CENTER 010 IN WING 02.000 02.000 PREVIEW POST-ACUTE AND REHABILITATION CENTER 010 IN WING 02.000 02.000 PREVIEW POST-ACUTE AND REHABILITATION CENTER 010 IN WING 02.000 02.000 02.000 PREVIEW POST-ACUTE AND REHABILITATION CENTER 010 IN WING 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000 02.000			ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039	ED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE. 2P CODE PARKVIEW POST_ACUTE AND REHABILITATION CENTER STREET ADDRESS. CITY, STATE. 2P CODE 200 NURSING HOME LANE 200 NURSING HOME LANE PREFX REACH DEPICIENCY MUST BE PRECEDED BY FULL PREVIEW FOR ACUTE AND REHABILITATION CENTER 1746 REACH DEPICIENCY MUST BE PRECEDED BY FULL PREVIEW ACTION SHOULD BE COMPRETING INFORMATION) F 806 Continued From page 308 F 806 Review of Resident #332's Quarterly MDS assessment diated 06/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15), indicating intact cognition. Further review revealed the resident to have a Brief Interview for Resident #332's plan of care, dated 06/16/2021, revealed the resident dut in terventions to provide the resident with his/her ordered diet and to offer substitutions as requested or indicated. Review of Resident #332's blan of care, dated 06/16/2021, revealed the resident was to receive a no added satt diet, regular texture, thin liquids consistency, with one (1) ounce extra protein with meals. Review of Resident #332's Dietary-Nutrition Data Collection assessment, stated the resident's neargy needs. Review of Resident #332's Dietary-Nutrition Data Collection substitutions as requested or indicated. Review of Resident #332's Dietary-Nutrition Data Collection assessment, stated the resident's needed. Further review revealed ta recommendation to ad fortified foods with meals to be ther meet the resident's needy assessment stated the resident's better meet the	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		(X3) DATE SURVEY	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER Description (mit) (mit) Too SUMMARY STATEMENT OF DEFICIENCIES (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (model) (mode			185256	B. WING		09/10/202 <u>1</u>	
PARKYLEW POST-ACUTE AND RELABILITATION CENTER PIKEVILLE, KY 41501 (M) 10 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST REPRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) D PREFIX TAG PRODUCENS FLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY 00 00 00 00 00 00 00 00 00 00 00 00 00	NAME OF PI	ROVIDER OR SUPPLIER					
PREPIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIS IDENTIFYING INFORMATION) PREPX TAG CROSHERETWE ACTION SHOULD BE CROSHEREDUCE TO THE APROPRIATE COMMETTION INTERPRETED TO THE ACTION SHOULD BE CROSHEREDUCE TO THE APROPRIATE F 806 Continued From page 308 Review of Resident #332's Quarterly MDS assessment, dated 06/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15), indicating intact cognition. Further review revealed the resident was independent with eating and weighed one hundred eighty-four (184) pounds. F 806 Review of Resident #332's plan of care, dated 06/16/2021, revealed area related to the resident's therapeutic diet with interventions to provide the resident with his/her ordered diet and to offer substitutions as requested or indicated. Review of Resident #332's physician ordered diet, dated 06/16/2021, revealed the resident was to receive a no added salt diet, regular texture, thin liquids consistency, with one (1) ounce extra protein with meals. Review of Resident 332's Dietary-Nutrition Data Collection assessment, completed on 03/16/2021 at 5:39 PM, revealed the resident's needs. Further review revealed a recommendation to add fortified foods with meals to better meet the resident's energy needs. The dietary assessment stated the resident's ideal body weight was one hundred and ninety (190) pounds; however, the	PARKVIEV	W POST-ACUTE AND R	EHABILITATION CENTER				
Review of Resident #332's Quarterly MDS assessment, dated 06/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15), indicating intact cognition. Further review revealed the resident was independent with eating and weighed one hundred eighty-four (184) pounds. Review of Resident #332's plan of care, dated 06/16/2021, revealed a focused area related to the resident with his/her ordered diet and to offer substitutions as requested or indicated. Review of Resident #332's physician ordered diet, dated 06/16/2021, revealed the resident was to receive a no added salt diet, regular texture, thin liquids consistency, with one (1) ounce extra protein with meals. Review of Resident 332's Dietary-Nutrition Data Collection assessment, completed on 03/16/2021 at 5:39 PM, revealed the resident's needs. Further review revealed a recommendation to add fortified foods with meals to better meet the resident's ideal body weight was one hundred and ninety (190) pounds; however, the	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E COMPLETION	N
usual body weight was two hundred and one (201) pounds. Review of Resident #332's Nutrition Progress Note, dated 04/11/2021 at 2:26 PM, revealed the resident had a nine (9) percent weight loss in thirty days. Further review revealed the resident's current intake was inadequate to meet the	F 806	Review of Resident i assessment, dated 0 facility assessed the Interview for Mental fourteen (14) out of f cognition. Further re- was independent with hundred eighty-four Review of Resident i 06/16/2021, revealed the resident's therap to provide the reside and to offer substitut indicated. Review of Resident i diet, dated 06/16/202 to receive a no adde thin liquids consister protein with meals. Review of Resident i Collection assessme at 5:39 PM, revealed was inadequate to m Further review reveal add fortified foods w resident's energy ne stated the resident's hundred and ninety (usual body weight w (201) pounds. Review of Resident i Note, dated 04/11/20 resident had a nine (thirty days. Further review reveal in the review for the resident is note, dated 04/11/20	 #332's Quarterly MDS 06/19/2021, revealed the resident to have a Brief Status (BIMS) score of ifteen (15), indicating intact view revealed the resident h eating and weighed one (184) pounds. #332's plan of care, dated d a focused area related to eutic diet with interventions nt with his/her ordered diet ions as requested or #332's physician ordered 21, revealed the resident was d salt diet, regular texture, ney, with one (1) ounce extra 332's Dietary-Nutrition Data ent, completed on 03/16/2021 d the resident's needs. Ided a recommendation to ith meals to better meet the eds. The dietary assessment ideal body weight was one (190) pounds; however, the as two hundred and one #332's Nutrition Progress 021 at 2:26 PM, revealed the 9) percent weight loss in eview revealed the resident's 	F 806			

Facility ID: 100599

If continuation sheet Page 309 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
	1		P	VIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 806	Continued From pag	e 309	F 806		
		e Progress Notes stated the			
		ere made to liberalize the			
		egular diet, add large protein d add a snack at bedtime.			
		ent #332, on 07/27/2021 at the food was always cold,.			
		ealed the resident had lost			
	-	as supposed to get a			
		h his/her tray for lunch and			
		e facility did not send the ident stated that he/she had			
		andwiches and the facility			
		of bologna. Resident #332			
		/er had snacks, especially at			
	-	as hungry. The resident im/her that he/she must wait			
	until morning when t				
	Observation of Resid	dent #332's tray, on PM, revealed the resident did			
		sandwich or a large protein			
	portion.	en a le ge protent			
		#2, on 08/05/2021 at 5:20			
		ility was out of bologna, ice se free milk, tomato juice and			
		se items for weeks at a time.			
		I the dietary department			
	should prepare and				
		those that have or have the			
		ce weight loss. However,			
		haven't sent out snacks in " She stated there was not			
	-	t of food items purchased to			
	fulfill the menu, and				
		ility to provide snacks to			
	those that needed ar	nd wanted them. She also			

Facility ID: 100599

If continuation sheet Page 310 of 401

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-03	ED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	<u></u>
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER		S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE AND R	EHABILITATION CENTER				
	CLIMMA DV C	TATEMENT OF DEFICIENCIES		IKEVILLE, KY 41501	0(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		N
F 806	Continued From pag	e 310	F 806			
		ned the Administrator on				
	tray cards. However, ensure foods were p	s which were included on the , the Administrator failed to urchased and available to preferences/requests.				
	revealed the facility a	ent #39's medical record admitted the resident on gnoses which included Type 2				
	07/10/2021, revealed resident to have a Bl of fifteen (15), and w independent with me indicated it was unkr experienced a signifi to the MDS the resid	#39's Quarterly MDS, dated d the facility assessed the IMS score of fifteen (15) out ras interviewable, was eals and the assessment nown if he/she had icant weight loss. According lents most recent weight undred and fifty three (253)				
	plan, dated 06/17/20 identified the residen nutrition related to re diet and the diagnos implemented on 06/7 honoring the residen requests/preferences	#39's comprehensive care 21, revealed the facility at was at risk for impaired eceiving a mechanical soft is of Diabetes. Interventions 17/2021 included staff t's food s, monitoring the residents the resident with "ordered				
	revealed documenta	sident #39's weight record tion that the resident refused n weight in July 2021.				
	Observation of staff	weighing Resident #39, on				

Facility ID: 100599

If continuation sheet Page 311 of 401

CENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
		REHABILITATION CENTER	200	NURSING HOME LANE	
	V POST-ACUTE AND	REPADILITATION CENTER	РІК	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 806	Continued From pa	ana 311	F 806		
1 000	-	-	F 000		
		led the resident weighed two			
	hundred sixty-one pounds.	and seven tenths (261.7)			
	Review of Residen	at #39's weight record and			
		an (RD) documentation			
		eighed two hundred ninety-four			
		1/04/2021 and two hundred fifty			
		s on 06/22/2021, which the RD			
		elve and eight tenths (12.8)			
		weight loss in the past one			
		80) days. Recommendations			
		or his/her dietary preferences			
		dent's foods at meals.			
	Interview with Resi	ident #39, on 08/17/2021 at			
	1:20 PM, revealed	the resident preferred salads			
	for lunch, and he/s	he liked "Fruit Loops" (type of			
	cereal). However,	a salad had not been provided			
	to the resident for I	lunch as requested. The			
		she had "lost a lot of weight in			
		ause the facility's food was			
	-	e food was cold. Resident #39			
		n he/she had requested salads			
	-	me ago" he/she had never			
		The resident stated he/she had			
	· ·	bast, why he/she never			
		nd he/she stated, "It's always a			
		ney forgot, or they're out of			
		#39 stated he/she had also			
	· ·	ops cereal, as that was his/her			
		ore admission into the facility.			
		t #39 stated "They won't give			
		r." He/she also stated, "Why			
		sk me what I liked or wanted to			
		onna give it to me, makes no			
	-	to the resident, breakfast was			
		d sometimes the resident was			
	nungry unui iunch.	Resident #39 stated, If I could			

Facility ID: 100599

If continuation sheet Page 312 of 401

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/08/2021 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING _		-FINZ	09/	10/202 <u>1</u>
NAME OF PF	NAME OF PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	PARKVIEW POST-ACUTE AND REHABILITATION CENTER						
			PIKE	VILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 806	Continued From pag	e 312	F 8	06			
	get me cereal I could myself."	l eat that, I could make it					
	meal on 08/05/2021, had requested bolog dinner, and three (3) requested salads for the facility was out of other sandwiches or the residents. Review indicated two (2) resi- cereal for breakfast; Loops in the facility. Observations of the of facility at 4:30 PM on was one (1), nine (9) corn flakes available Interview with Cook # PM, revealed she had facility for approxima stated the facility was items. The cook stat continuously asked ff breakfast. However, order the food items residents' nutritional also stated she had i multiple occasions of requests/preferences tray cards. Continue Administrator failed t	the lunch meal. However, f bologna and lettuce, and no substitutes were provided to v of the diet roster also dents preferred Fruit Loops however, there was no Fruit cold cereal available in the 0.8/05/2021 revealed there ounce bag of unsweetened for the residents. #2, on 08/05/2021 at 5:20 d worked full-time at the tely one (1) year. She is frequently out of food ted two (2) residents or Fruit Loops cereal for the Administrator refused to timely, or at all, to meet the request and needs. She nformed the Administrator on f the residents is which were included on the d interview revealed the o ensure the foods were able to honor the residents'					
	Interview with Dietar 08/17/2021 at 5:30 P	y Aide (DA) #1, on M, revealed there wasn't					

If continuation sheet Page 313 of 401

TATEMENT (DF DEFICIENCIES CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		MB NO. 0938-039 X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
		D REHABILITATION CENTER	200	NURSING HOME LANE	
FARRAIE	V POST-ACOTE AN	D REMADILITATION CENTER	РІКІ	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE
F 806	Continued From	page 313	F 806		
	food preferences lettuce, ice cream	chased and available to honor . The aide also stated bologna, n and other food items the facility than it was available for the			
	and 08/18/2021 a been contracted for approximately she had identified the residents. Per recommendations at all, and resider honored. The RI been discussed of Administrator. He to correct the pro that even though informed of reside for Fruit Loops, to that required lact continued to not I She stated if reside honored and on-s	RD, on 08/11/2021 at 4:10 PM at 10:30 AM, revealed she had to provide services at the facility one (1) year. The RD stated d concerns with weight loss for er interview, concerns of her s not being addressed timely or ht choice/preference not 0 stated these concerns had on multiple occasions with the owever, nothing had been done blem. Further interview revealed the Administrator had been ents that had ongoing requests omato juice, bologna and one (1) ose free milk, those items be available for the residents. dent food preferences were going interventions implemented, vented Resident #39's significant			
	08/18/2021 at 11 DM at another far and placed some DM #1 stated she when she placed stated she was n weren't being hor always followed a	etary Manager (DM) #1, on 40 AM, revealed she was the cility and had assisted the facility food orders for the building. e looked at the menu "best I can" orders for the facility. She also ot aware resident preferences nored or the menu was not at the facility. The DM stated, if red/preferred specific food/drink			

Facility ID: 100599

If continuation sheet Page 314 of 401

		E & MEDICAID SERVICES			DMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		200 N	IURSING HOME LANE		
PARRVIEW POST-ACOTE AND REHABILITATION CENTER		PIKE	VILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F 806	Continued From	page 314	F 806		
	are "required to."	The DM stated if the menu was			
		ghts were not monitored, RD			
		s were not implemented and			
		ces was not honored that could			
		eight loss, resident decline and blems" for the residents.			
		bients for the residents.			
	Interview with the	Administrator, on 08/11/2021 at			
	6:00 PM and 08/	18/2021 at 3:30 PM, revealed			
	-	ed residents had requested Fruit			
		multiple occasions. She stated,			
	-	o kinds of cereal here, Corn			
		rios". She stated she planned "RD about all the stuff that's on			
		" The Administrator declined to			
	· ·	ne need to talk with the RD			
	related to honorir	ng the residents' preference and			
		e only offer two kinds of cereal			
		she acknowledged the facility's			
	· ·	onor the residents' food			
		also stated, " as long as I feel" s "are within reason." According			
		tor, she as well as a DM from			
		aced the facility's food orders.			
		r stated she had been notified of			
		e kitchen had been out of and			
		provided everything staff had			
F 809	requested for the	als/Snacks at Bedtime	F 809		
SS=E			1 009		
	§483.60(f) Frequ	encv of Meals			
		ch resident must receive and the			
	,	ide at least three meals daily, at			
		nparable to normal mealtimes in			
		r in accordance with resident			
	needs, preferenc	es, requests, and plan of care.			

Facility ID: 100599

If continuation sheet Page 315 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	\mathbf{D}	185256	B. WING		09/10/202 <u>1</u>	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	PARKVIEW POST-ACUTE AND REHABILITATION CENTER			PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 809	hours between a sub breakfast the followir nourishing snack is s hours may elapse be meal and breakfast ti group agrees to this §483.60(f)(3) Suitabl meals and snacks m who want to eat at no of scheduled meal se the resident plan of of This REQUIREMENT by: Based on observation and review of the facilit resident received me comparable to norma community or in accon needs, preferences, In addition, the facilit alternative meals and wanted to eat at non- of scheduled meal set the resident's plan of 07/27/2021 on two (2 floors/units revealed storage area contain and resident interview frequently did not red were later than sched The findings include:	 nust be no more than 14 astantial evening meal and ng day, except when a served at bedtime, up to 16 atween a substantial evening he following day if a resident meal span. e, nourishing alternative ust be provided to residents contraditional times or outside ervice times, consistent with eare. T is not met as evidenced on, interview, record review ility's policy it was the gular times al mealtimes in the prodance with the residents' requests, and facility policy. If a successful to provide nourishing d snacks for residents who etraditional times or outside ervice times, consistent with face. T is not met as evidenced on, interview, record review ility's policy it was the policy it was the face of the three sidents' requests, and facility policy. If alled to provide nourishing d snacks for residents who etraditional times or outside ervice times, consistent with face of the three (3) resident the refrigerator and snack end no resident snacks. Staff we revealed residents evice snacks and, meals duled for most meals. 	F 809			
	I VENEW OF THE ISCHILLY					

Facility ID: 100599

If continuation sheet Page 316 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 809	revealed staff would nourishing, palatable the resident's daily n needs, with preferen into consideration. T would be provided w the scheduled mealti reasonable efforts w accommodate reside nourishing snacks sh resident's twenty-fou policy, residents cou or snacks could be s accommodate the re patterns. 1. Observation of th snack storage on 07, revealed no snacks of residents on the unit five (5) cartons of ex and one (1) half gallo 07/21/2021. Addition (2) pudding cups lab additional snacks we Observation of the 55 snack storage on 07, revealed no snacks of residents on the floo three (3) cartons of ex 07/25/2021 and one thickened dairy date observation revealed (2) of which were un	ast revised October 2017 provide residents with a a, well-balanced diet that met nutritional/special dietary nees of each resident taken the policy also stated meals within forty-five (45) minutes of ime. The policy stated rould be made to ent choices/preferences and hould be available to ar (24) hours a day. Per the and request snacks as desired scheduled between meals to esident's typical eating the 3rd floor refrigerator and t/27/2021 at 11:30 AM or drinks were available for the refrigerator contained typired milk dated 07/25/2021 on of expired buttermilk dated hal observation revealed two beled for medication pass. No ere observed on the unit/floor. Ath floor refrigerator and t/27/2021 at 12:05 PM or drinks were available for the refrigerator contained expired milk dated	F 809		

Facility ID: 100599

If continuation sheet Page 317 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 809	on 07/27/2021 at 11 Additional observation and snack storage of revealed the refriger of milk and one (1) of snacks available. Interview with Resid 10:45 AM, revealed residents and the sa nights a week. The resid not provide him/her the hungry. Interview with Resid 11:00 AM, revealed the hungry snacks were the facility being out Interviews with Resid 07/27/2021 and Resis 11:10 AM, revealed the available. Resident requested "a snack of one occasion since I facility, and staff had was available to give stated he/she would discharged and "go able to assist him/he stated, "I have to stat choice."	ge 317 th floor resident refrigerator :30 AM revealed no snacks. on of the 5th floor refrigerator in 08/05/2021 at 1:50 PM ator contained one (1) carton carton of med pass with no ent #39, on 07/27/2021 at no snacks were available for ime food was served multiple resident stated the facility did with snacks when he/she was ent #3, on 07/27/2021 at when he/she would get not always available due to of snacks a lot of the time. dent #332, at 11:00 AM on ident #308 on 07/27/2021 at snacks were not always #308 stated he/she had of some kind" on more than he/she was admitted to the d informed him/her nothing e him/her. The resident also have requested to be home"; however, no one was er at home. Resident #308 by here for now, I have no 2021 with Resident #45 at dent #309 at 11:40 AM, re not available, especially at	F 80		
		re not available, especially at e hungry and requested			

Facility ID: 100599

If continuation sheet Page 318 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER) NURSING HOME LANE KEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE	
F 809	informed them they w morning when dietary would be able to get Observations and int on 07/27/2021 at 11: items, which included crackers and snack of resident's bedside. T were always late, foo not been available to Resident #343 stated to keep so I don't go for me I would have so long time ago." Interview with State F 07/27/2021 at 4:40 P enough snacks for th times. The SRNA sta staff had to call the k the unit/floor. In addi "When residents say times the facility is co Interview with SRNA PM, revealed when r hungry there were not the residents on the o issues with getting ju frequently not available Interview with SRNA PM, revealed staff was snacks to give to the often the kitchen only	cording to the residents, staff would have to wait until the y staff arrived before they something to eat. terview with Resident #343 45 AM, revealed various food d microwaveable soups, cakes were observed at the The resident stated the meals of was cold and snacks had o residents "for a long time." d, "My sister brings me food hungry, if she didn't do that starved to death in here a Registered Nurse Aide #1, on PM, revealed there were not he residents and no juice at ated if juice was available, itchen to get it delivered to ition, the SRNA stated, they are hungry there are completely out of snacks."	F 809	DEFICIENCY)		
		dents on the unit. She further				

Facility ID: 100599

If continuation sheet Page 319 of 401

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED
	$2 \cap$	185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 809	and the kitchen si enough snacks at facility was out of residents were be (2) to three nights staff often bought to give to the resi available for them Interview with Ce #1, on 08/05/202 facility did not hav residents. She sta snacks. CMA #1 would buy the resi	page 319 tion was aware of the situation, taff said they did not have vailable. SRNA #4 stated the juice for a while and the eing served cold sandwiches two sout of the week. She stated t snacks out of their own pocket dents due to not having any n when they were hungry. rtified Medication Aide (CMA) 1 at 1:30 PM, revealed the ve snacks available for ated usually there were no stated that she and other staff sidents snacks and drinks with when they told them that they	F 809		
	07/28/2021 at 100 her floor frequent "hungry" and the snacks on the floo became tearful in that came from th and if staff didn't the residents "the also stated that si had informed the complaints and re department send the residents. Ho yet."	gistered Nurse #6, on :00 AM, revealed residents on ly informed her they were facility had failed to supply ors for "about a year." The RN interview and stated, the food he facility kitchen was cold, late purchase and provide snacks to by wouldn't have any." RN #6 he, as well as other co-workers, Administrator of the residents' equested she direct the dietary up snacks to have available for powever, "that hasn't happened			
	revealed the resid hungry to staff an	dents complained of being d stated, "That's been going on s pitiful." The RN stated she had			

Facility ID: 100599

If continuation sheet Page 320 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE NKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E COMPLETION	
F 809	complaints. The RN shift, and no access food for the residents stated she had purch food/snacks from hei into the facility for sta the RN, she bought t food/snacks to provid stated "someone told and she then informe wouldn't allow me to made me take it back Interview with State I (SRNA) #19, on 08/1 she was also a resto She stated the facility provided/prepared by which was given to fa AM, 2:00 PM and at there has not been s residents "for months Interview with SRNA AM, revealed there w She further revealed to snacks unless the them to the unit. Interview with SRNA AM, revealed there a units. She stated tha bring up four (4) to fir entire unit and staff for the snacks. She stated	strator of the residents' stated she worked the night or no one here to ask for s when "I am here." She hased \$84.00 worth of personal funds and brought aff to keep on her floor. Per he snack so staff would have de to the residents; however the Administrator I did that ed me it was illegal and keep the food here, she c home." Registered Nurse Aide 7/2021 at 1:50 PM, revealed rative aide at the facility. y "use to have snacks" y the dietary department, acility residents daily at 10:00 night. However, she stated nacks available/provided to s" at the facility. #1, on 07/27/2021 at 11:35 yas no snacks on the unit. the staff did not have access dietary department send #13, on 07/28/2021 at 6:28 re not enough snacks on the t the dietary department will ye (5) sandwiches for the nave to determine who gets es that residents state they aff cannot get into the	F 809			

Facility ID: 100599

If continuation sheet Page 321 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE		
			F	PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 809	Continued From pag Interview with Dietary 08/17/2021 at 2:30 P at 2:15 PM revealed cream, tomato juice, bologna "constantly." (2) residents request also on their tray car that type of cereal wa available for the resid Administrator has be occasions of the resid Administrator has be occasions of the resid Interview with Cook a PM, revealed she has facility for approxima also stated the dietar and send out snacks those that have or has experience weight lo sent out snacks in sid stated there is not ar items purchased to fin not enough purchase snacks to those that Interview with Dietary 08/17/2021 at 3:00 P employed at another and had been asked weeks ago, to come	e 321 y Aide (DA) #1, on 'M, and DA #2 on 08/17/2021 the facility was out of ice lactose free milk and ' The aides also stated two fruit loop cereal, which is ds, "all the time"; however, as not purchased and dents, even though the en informed on multiple dents' request. #2, on 08/05/2021 at 5:20 d worked full-time at the tely one (1) year. The cook ry department should prepare for residents, especially ave the potential to ss; however, "we haven't x months or longer." She a dequate amount of food ulfill the menu, and definitely ed at the facility to provide need and want them. y Manager (DM) #2, on M, revealed she was facility the company owns, approximately three (3) provide assistance/oversight	F 809			
	because the facility h been identified in the facility approximately time the facility had b tomato juice, lactose other things she was stated resident prefe	aff on dietary processes, nad no DM and concerns had kitchen. She has visited the three (3) times, and each been out of ice cream, free milk and bologna and unable to recall. She also rence was not honored at the to (2) residents request fruit				

Facility ID: 100599

If continuation sheet Page 322 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2 FORM APPROV OMB NO. 0938-03	/ED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PF	NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			20	00 NURSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		P	IKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		ЛС
F 809	personally went throu and made a list of nei- the nutritional needs, were met in the facili the Administrator. H informed the DM, she items and the resider She also stated since assistance to the fac grocery store on two purchased food item own pocket, because purchase what the re She also she had pu because "I couldn't w resident's weren't ge Interview with the Ad 6:00 PM and 08/18/2 she had been the fac 06/07/2021 and she not being provided. residents had reques multiple occasions at kinds of cereal here, and stated she plann about all the stuff tha When asked to elabor needed to occur with attempting to honor to stated "we only offer however, acknowled to honor the resident	as other items and she had ugh the residents tray cards reded food items to ensure (preferences of the residents ty, and provided the list to owever, the Administrator e "wasn't buying all those ints could eat what was here." e she had been providing ility, she had went to the (2) separate occasions and s for the residents, out of her e the Administrator refused to esidents needed to eat/drink. rchased items on her own, valk out of here knowing tting what they needed." ministrator, on 08/11/2021 at 2021 at 3:30 PM, revealed cility Administrator since was not aware snacks were She also acknowledged sted fruit loop cereal on and stated "we only offer two corn flakes and cheerios" red on talking to the "RD it's on these tray cards." orate on why discussions the RD, when the RD was he residents preference she two kinds of cereal here" ged the facilities requirement 's food preferences and also	F 809	DEFICIENCY)		
	within reason." According to the solution within the food orders for the food orders food orders for the food orders food	eel" those preferences "are ording to the Administrator, from another facility placed he facility, and stated she had hus things the kitchen had				

Facility ID: 100599

If continuation sheet Page 323 of 401

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 809	Continued From pag	ge 323	F 809			
		ted she felt like she provided requested for the residents.				
	12:00 PM, revealed	ook #2, on 08/05/2021 at the facility was serving lunch I thirteen residents (113).				
	breakfast was serve	y mealtime schedule indicated ed at 7:00 AM, lunch was and the evening meal was				
	08/05/2021, revealed served the residents Observations of the service on 08/05/20 were serving beef fr	a for the lunch meal on ed the residents were being s meal of choice. I tray line for the lunch meal 21 at 1:15 PM, revealed staff ritters with gravy, corn or ed potatoes, chocolate				
	even though the me 12:00 PM the first o exited the kitchen u floor, and the last tra	Iunch meal also revealed eal time was scheduled for f three (3) tray carts hadn't ntil 1:30 PM to go to the third ay cart exited the kitchen at PM (almost 3 hours late) th floor residents.				
	conducted of tray lir 08/05/2021, revealed barbeque riblett san salad and two (2) go Continued observat supper meal was so PM, staff was not ob 6:15 PM. The first of	y menu and Observations ne for the supper meal on ed the facility was serving a ndwich, tater tots, three bean ooey butter cookies. ions revealed even though the cheduled to be served at 5:00 bserved to start tray line until of three (3) tray carts had not e served to the residents until				

Facility ID: 100599

If continuation sheet Page 324 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 809	until 8:00 PM (three residents on the 5th Interviews on 07/27/ 11:00 AM, and Resid indicated meals were residents at the sche Interviews on 07/27/ 11:30 AM, and Resid revealed meals were facility. Interview with Family at 5:30 PM revealed 10:45 AM on 07/18/2 Resident #321. She approximately 3:00 F received the lunch m Interview with State (SRNA) #16, on 07/2 the facility was short She stated meal sen sometimes 8:00 PM to the floor. The SR one aide can pass th residents that require She also stated resid cold food "because i it. There's not enoug Interview with LPN # revealed meal trays times it has been 8:00	t cart had not left the kitchen hours late) going to the floor. 2021 with Resident #332 at dent #308 at 11:10 AM e never provided to the eduled time in the facility. 2021 with Resident #45 at dent #309 at 11:40 AM, e always served late in the 2021 with Resident #45 at dent #309 at 11:40 AM, e always served late in the 2021 for a scheduled visit with stated when she left at 2021 for a scheduled visit with stated when she left at 2021 for a scheduled visit with stated when she left at 2021 at 8:10 PM, revealed staffed, "especially at night." vice was always late and was before trays were delivered NA stated, "There's no way he trays and feed the e assistance and do it right." dents frequently complain of t's cold before they're getting gh help." 52, on 07/28/2021 at 6:52 AM, were often late. She stated at 00 PM before the supper o the unit. She stated late giving residents their	F 809		

If continuation sheet Page 325 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE	
		-	P	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 809	Continued From pag	e 325	F 809		
	PM, revealed she pri She stated the support the floors as late as 9 enough staff to pass Interview with SRNA PM, revealed meal tra- at 8:00 PM. Interview with RN #7 revealed meal trays of times it has been 8:0 trays have made it to messed with giving re- like insulin. Interview with RN #6 revealed residents of informed her they we had failed to supply s "about a year." The interview and stated, facility kitchen was co Interview with RN #9 revealed she worked sometimes supper tra- floor until 7:30 PM - 8 most of the time, the pass trays and assiss it "impossible for the meal service like that assisted the aide with	#18, on 07/28/2021 at 9:54 ays came to the unit at times , on 08/01/2021 at 11:40 AM, were often late. She stated at 0 PM before the supper the unit. She stated it esidents their medications , on 07/28/2021 at 10:00 AM, her floor frequently ere "hungry" and the facility snacks on the floors for RN became tearful in the food that came from the			
	approximately 40 res	idents, and that was also a ation time and the residents			

If continuation sheet Page 326 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROV OMB NO. 0938-03	ED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER				
				IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		Ņ
F 809	Continued From pag	e 326	F 809			
	PM, revealed she had facility for approximal she works five (5) dat three (3) meals on th for months due to sh also stated she work had approximately 19 the last pay period. So were late because th kitchen. Per the coor manager and were shad been for months to residents on time, acknowledged she d "like I should" during because there is not would be even more stated the facility was items. She also state bologna, ice cream, I tomato juice and hav weeks at a time. Interview with the RE and 08/18/2021 at 10 been contracted to p for approximately on- meals are always se enough food purchas residents. Interview with the As (ADON)/Interim Direct 08/18/2021 at 9:50 F	bes not review tray cards tray line for resident meals enough of us and meals off schedule. She also is frequently out of food ed the facility was out of ettuce, lactose free milk, e been out of those items for 0, on 08/11/2021 at 4:10 PM 0:30 AM, revealed she had rovide services at the facility e (1) year. The RD stated roved late, and there is not sed to provide snacks to the sistant Director of Nursing				
	the facility had been	inadequately staffed with ce during that time. The				

Facility ID: 100599

If continuation sheet Page 327 of 401

		HAND HUMAN SERVICES			PRINTED: 12/08/20 FORM APPROVI
TATEMENT (S FOR MEDICAR OF DEFICIENCIES CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		MB NO. 0938-03 X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER	R	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE AN	D REHABILITATION CENTER		NURSING HOME LANE	
	CUMMAR			•	0/5)
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE
F 809	Continued From	page 327	F 809		
	-	e was also aware that meal times / late, which made it difficult for			
	•	ts during the evening meal. She			
		food cart did not come to the			
		PM in the evening, it was and assist residents because			
		ne (1) aide. She stated nurses			
		istering medications during that			
		rything could be completed			
	timely.				
	Interview with the	Administrator, on 08/11/2021 at			
		d she was aware the facility was			
		n not enough nurses and nurse			
		nistrator stated she was aware food complaints and that meals			
		to the residents. She stated			
		a Dietary Manager and at least			
		ff in the kitchen; however, the			
		ed with no Manager and only			
		ce she had been Administrator			
	•	e stated she was aware that was in the kitchen to ensure meals			
	•	was "working on it."			
F 812 SS=F	-	nt,Store/Prepare/Serve-Sanitary	F 812		
	8483 60(i) Eard	safety requirements.			
	The facility must				
	§483.60(i)(1) - Pr	ocure food from sources			
		sidered satisfactory by federal,			
		de food items obtained directly			
	• •	cers, subject to applicable State			
	and local laws or	regulations.			
		does not prohibit or prevent			
	facilities from usi	ng produce grown in facility			

Facility ID: 100599

If continuation sheet Page 328 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
- E		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 812	safe growing and foo (iii) This provision do from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food set This REQUIREMENT by: Based on observation policy review, it was to prepare and serve conditions. Observation of 15/2021, revealed on the residents' mea addition, approximate food was observed a fryer. The deep fryer brown. Observation on 07/21 (3) resident units/floo refrigerators revealed expired milk, which we use. The findings include: Review of the facility Sanitation of Dining a undated, revealed the staff would maintain sanitation of the dining comprehensive clear	ompliance with applicable d-handling practices. es not preclude residents is not procured by the facility. prepare, distribute and ance with professional ervice safety. T is not met as evidenced on, interview, and facility determined the facility failed food under sanitary tion of the lunch tray line on I uncovered cake was sent al trays to the units. In ely two (2) inches of dried round the inside of the deep oil was observed to be dark 7/2021 of two (2) of the three ors (3rd and 5th floor) d each refrigerator contained vas available for resident s policy titled, "Cleaning and and Food Service Areas," e food and nutrition services the cleanliness and ng room and food service iance with a written,	F 812		

Facility ID: 100599

If continuation sheet Page 329 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE	
F 812	would prepare food in Interview with the Ad 1:50 PM revealed the policy/process in place stored in the refrigera for resident use were 1. Observation of the service on 06/15/202 was observed to place resident meal trays a units/floors. In additi inches of dried food v inside of the deep fry deep fry potato chun deep fryer oil was ob in need of changing. Review of the facility the deep fryer was ne schedule. Interview with Cook a PM, revealed she ke kitchen to cut off the inside of the deep fry only worked at the fa stated she had only of time since she had w interview revealed sh should be cleaned af stated she was also have been covered p residents.	lated, revealed the Cook in a sanitary manner. ministrator on 08/10/2021 at e facility had no ce to ensure foods/fluids ators, which were available e safe for consumption. e tray line for the lunch meal c1 at 1:14 PM, revealed staff ce uncovered cake on	F 812			

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		NURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 812	Cook. The DM state cleaned after every u been covered. The D should have been or Interview with the Re 06/18/2021 at 4:18 F the deep fryer once i was dirty. The RD st prior to leaving the ki residents. The RD st cleaning schedule di stated it should have Interview conducted 06/19/2021 at 1:30 F been the Administrat weeks. She stated th covered previously w The Administrator sta both the RD and the aware of the problem 06/15/2021. 2 Observation of the snack storage on 07, revealed the refrigera cartons of expired m (1) half gallon of exp 07/21/2021. Observation of the 50 snack storage on 07, revealed the refrigera cartons of expired m container of expired m	stated she had trained the d the deep fryer should be use and the cake should have M stated the deep fryer the cleaning scheduled. Agistered Dietitian (RD), on M, revealed she had cleaned in the past month because it ated cake should be covered tchen and being delivered to ated she was not aware the d not list the deep fryer and with the Administrator, on M, revealed she had only or at the facility for two (2) the deep fryer had been when she was in the kitchen ated she had spoken with DM and had not been made the in the kitchen, until ated floor refrigerator and (27/2021 at 11:30 AM ator contained five (5) lik dated 07/25/2021 and one	F 812		

Facility ID: 100599

If continuation sheet Page 331 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE	
PARKVIE	N POST-ACUTE AND R	EHABILITATION CENTER		KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 812	Continued From pag two (2) dated 07/27/	-	F 812		
F 835 SS=K	Interview with Dietar 08/17/2021 at 2:15 F at 2:30 PM, revealed trained/instructed to in the refrigerators lo to ensure they were consumption. Interview with the Ao 1:50 PM, revealed fo for resident consump safe for residents. S sure who was respo- items stored in the re Administration CFR(s): 483.70 §483.70 Administrat A facility must be ad enables it to use its efficiently to attain out	ry Aide (DA) #2, on PM and DA #1 on 08/17/2021 d neither aide had been stock or monitor food/fluids ocated on all three (3) floors in date and safe for resident dministrator, on 08/10/2021 at ood/fluids that were available ption should be in date and She also stated she was not onsible to monitor food/fluid efrigerators on the units. tion. Iministered in a manner that resources effectively and or maintain the highest , mental, and psychosocial	F 835		
	by: Based on interview, the Administrator's a (DON) Job Descripti administered in a ma use of its resources highest practicable p	IT is not met as evidenced , record review, and review of and the Director of Nursing ion, the facility failed to be anner that enabled effective to attain and maintain the physical, mental and eing for each resident, and to			

Facility ID: 100599

If continuation sheet Page 332 of 401

		E & MEDICAID SERVICES					RM APPROVE 0. 0938-039
TATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			(X3) DAT	E SURVEY
		185256	B. WING			0	9/10/2021
NAME OF PI	ROVIDER OR SUPPLIER	ł		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
				200 N	URSING HOME LANE		
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER		PIKE	VILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 835	Continued From	page 332	F 83	5			
		re and services were provided					
	· · ·	Is of the residents (Refer to					
		5, F656, F657, F684, F686,					
	F692, F725, F744	4, F755, F867 and F880).					
	Record review an	nd staff interviews revealed the					
		ave systems in place to ensure					
		ent changes in condition were					
		; failed to ensure residents were					
		failed to ensure baseline and					
	comprehensive c	are plans were developed and					
	implemented; fail	ed to ensure resident care was					
		rdance with professional					
		ctice; failed to ensure residents					
		prevent/treat and promote					
	, , ,	ure sores; failed to ensure					
		ned acceptable parameters of					
		and/or body weight; and failed to					
		/ had adequate numbers of ietary staff. Staff interviews					
		ninistrator was aware of the					
		taken no action to correct the					
	·	ditions were worse.					
	The facility's failu	re to be administered in a					
	-	bled effective use of its					
	resources to attai	in and maintain the highest					
		cal, mental and psychosocial					
		ch resident, and to ensure quality					
		s were provided that met the					
		dents, has caused or is likely to					
		ury, harm, impairment or death					
		mediate Jeopardy was					
		11/2021, and was determined to					
		21, at 42 CFR 483.10 Resident CFR 483.12 Freedom from					
		2 CFR 483.12 Comprehensive					
	, ,	Care Plans (F655) (F656), 42					
		lity of Care (F684) (F686)					

Facility ID: 100599

If continuation sheet Page 333 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
- E		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER			
				IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 835	(F755) and 42 CFR 4	45 Pharmacy Services 183.80 Infection Control	F 835		
	(F880). The facility w Jeopardy on 08/11/2	vas notified of Immediate 021.			
	was received on 09/0 removal of the Imme 09/02/2021. Howeve verified based on obs and review of facility Immediate Jeopardy 483.35 Nursing Serv Administration (F835 Quality Assurance ar Improvement (F867)	er, the AOC could not be servations, staff interviews, documentation. Additional was identified at 42 CFR ices (F725), 42 CFR 483.70) (F837), 42 CFR 483.75 nd Performance . The facility was notified of ardy on 09/10/2021. The			
	2021 revealed the fa committed to serving members and would atmosphere, where t were of utmost impor stated the facility offe the individual needs evaluated and servic accordingly. Accordin Administrator's prima day-to-day functions with current federal, s guidelines and regula facilities to ensure th care was provided at The Administrator was	nistrators Manual" dated May cility corporation was residents and their family strive to create a homelike he needs of the residents rtance. The manual also ered dynamic services and of each resident would be es would be provided			

Facility ID: 100599

If continuation sheet Page 334 of 401

	-				PRINTED: 12/08/20 FORM APPROV
TATEMENT (S FOR MEDICAR	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
_0		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER	R	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AN	D REHABILITATION CENTER		00 NURSING HOME LANE	
	010000	RY STATEMENT OF DEFICIENCIES			1011
(X4) ID PREFIX TAG	(EACH DEFIC	(OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTIC
F 835	Continued From	page 334	F 835		
		cility/equipment, evaluate care esidents, and evaluate			
	stated the Admini	atisfaction. The manual also istrator's duties included			
	policies/procedur	naintaining written es and professional standards of			
		overn the operation of the facility.			
	duties included e	vealed the Administrator's daily nsuring the Interdisciplinary IDT) were occurring;			
	review/manage s	taffing; observe facility systems, ining; and ensure personal			
	assistance was p	rovided to the residents. The reekly duties included monitoring			
	residents, which	had identified problems, and and pressure ulcer reports for			
	facility residents.	Monthly Administrator duties follow up had occurred for			
	consultant report	s, which included dietary reports; API meetings were conducted			
	monthly as requir	red. The manual also stated the uld review all incident reports,			
	would coordinate	all investigations in the facility, e compliance for reporting of all			
	events to State a	nd Federal agencies. The public terms of term			
	residents were m	sure the individual needs of the et. According to the manual, the			
		ould ensure menus were posted urishments were offered to the			
	#82's ongoing be	dent Reports revealed Resident haviors resulted in			
	05/18/2021, Resi	ent abuse incidents. On dent #82 grabbed Resident kin tear. On 06/04/2021,			
		bbed Resident #64's wrist and			

Facility ID: 100599

If continuation sheet Page 335 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/ FORM APPRC OMB NO. 0938-(VED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TION
F 835	held Resident #82's wandered into his/he On 07/15/2021, Resi with a shoe causing a resident's upper arm #82 hit Resident #64 with Resident #86 or was afraid when he/s Resident #82 still can facility had taken no Interview with the Ad 6:00 PM, revealed sh Coordinator and was afraid of Resident #82 residents' rooms, trig abuse incidents. Ho evidence the Adminis to protect residents fi 2. Review of the facili indicated breakfast w was served at 12:00 was served at 5:00 F Review of Resident # revealed the resident and required staff to glucose. Review of I Notes dated 07/18/20 approximately 7:30 A #321's blood glucose per deciliter) (less tha blood glucose result) Interview with LPN #	06/30/2021, Resident #317 wrist because Resident #82 r room and would not leave. dent #82 hit Resident #86 a large bruise to the . On 07/31/2021, Resident on the left wrist. Interview 07/27/2021 revealed he/she she went to sleep because me in his/her room and the action to protect the resident. ministrator, on 08/11/2021 at he was the Abuse aware Resident #86 was 2. She stated she was also wandered into other gering resident-to-resident wever, there was no strator had taken any action rom abuse. ity's mealtime schedule //as served at 7:00 AM, lunch PM and the evening meal PM. #321's medical record t had a diagnosis of Diabetes monitor the resident's blood Resident #321's Nursing 021 at 3:20 PM, revealed at M on 07/18/2021, Resident e was 67 mg/dL (milligrams an 70 is considered a low	F 835			

If continuation sheet Page 336 of 401

					FORM APPROVED
STATEMENT	S FOR MEDICARE 8 OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		185256	B. WING	- ETNI/	09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
F 835	07/18/2021. She st hypoglycemic episo 7:30 AM as noted in second episode was 07/18/2021 (exact ti she found the resided glucose level "arour Continued review of Notes revealed on O found the resident u The resident's docu was 32 mg/dL. Staff raise the resident's resident remained u experienced labored of the Nursing Note Emergency Medical Resident #321 to th hospital record reve diagnosed with hypo sustain life), Pneum Encephalopathy, an secondary to prolon sugar). Interview with Admin 1:50 PM, revealed to monitor to ensure re receiving basic and resident's blood glu acceptable paramet system to ensure re were identified/addr Administrator furthe be two (2) nurses an at night.	ated the resident had two (2) des, once at approximately in the nursing notes. The is late afternoon on me unknown). She stated ent unresponsive, with a blood and 40 mg/dL". The Resident #321's Nursing 07/19/2021 at 12:23 AM, staff in-responsive and clammy. mented blood glucose and it of administered medication to blood glucose; however, the in-responsive and d breathing. Continued review is revealed at 1:00 AM, Services (EMS) transported e hospital. Review of the aled the resident was oxemia (not enough oxygen to onia, Acute Metabolic id acute respiratory failure, ged hypoglycemia (low blood instrator, on 08/10/2021 at he facility had no system to esidents with Diabetes were consistent care to ensure the cose levels remained within ers and did not have a sident changes in condition	F 835		

Facility ID: 100599

If continuation sheet Page 337 of 401

PRINTED: 12/08/2021

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	V POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE	
			P	PIKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 835	Continued From pag	le 337	F 835		
	Resident #65 on 03/	23/2021 without pressure			
		eview of the record revealed			
		at risk for pressure ulcers			
		nce of staff for turning and			
		continent care. However, the and reposition the resident.			
		and reposition the resident.			
	On 05/02/2021, Res	ident #65 developed a deep			
		occyx. The facility failed to			
	assess the pressure	ulcer (measurements,			
		je, odor, etc.). Subsequently,			
	-	to identify the pressure ulcer			
)5/28/2021, Resident #65			
		e Emergency Department			
		ng of the pressure ulcer.			
	Resident #65 was ad	dmitted to the hospital related			
		e ulcer that had worsened			
		eptic with large decubitis			
	[pressure] ulcer with	associated infection			
	•	d possible abscess".			
		went debridement on			
	05/30/2021, when al				
		on was down to the bone".			
	Resident #65 was re	admitted to the facility.			
		continued to fail to turn and			
		#65; and, failed to conduct			
		ressure ulcer assessments.			
		ped five (5) more pressure			
	ulcers: a Stage I (on				
		leep tissue injury) to the right			
	l heel on 06/26/2021; ulcer to the back of t	an unstageable pressure			
		o (2) Stage II (2) pressure			
		on 08/26/2021. Further			
	review revealed a w				
		#65's sacral pressure ulcer on			
	08/26/2021 at 9:00 A	AM, and documented the			

Facility ID: 100599

If continuation sheet Page 338 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185256 NAME OF PROVIDER OR SUPPLIER		B. WING		09/10/2021
NAME OF PI			STE	REET ADDRESS, CITY, STATE, ZIP CODE	
	PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200	NURSING HOME LANE	
	ARKVIEW POST-ACUTE AND REHABILITATION CENTER		Pił	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 835	Continued From pag		F 835		
		1.			
	PM, SRNA #1 on 8/5 on 08/27/2021 at 11: 08/27/2021 at 3:00 P enough staff to turn a provide incontinence SRNA #10 stated the Administrator knew " hours turns and repo changes in" and "the anything". SRNA #1 one (1) or two (2) nu over 40 residents and every two (2) to three "It can't be done by c	1 stated there were usually rse aides to provide care for d residents were only turned e (3) hours. SRNA #4 stated, ne person".			
	6:00 PM, revealed sł staffing daily. She sł was not enough staff related services to m practicable physical, well-being for resider	ministrator on 08/11/2021 at ne was required to review ated she was aware there to provide nursing and aintain the highest mental, and psychosocial nts; however, stated she was sidents at the facility, even			
	though she knew the staffed to meet the re Administrator stated ensure resident care with professional stat the facility operated of guidelines. However Administrator she ha monitor the care delif facility. She also stat any oversight meetin weekly or monthly Q	facility was not adequately esident's needs. The was also responsible to was provided in accordance ndards of practice and that within the regulatory			

Facility ID: 100599

If continuation sheet Page 339 of 401

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES				1 APPROVE 0. 0938-039
ATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	
185256		B. WING		09/	10/202 <u>1</u>	
NAME OF PF	ROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		1.1	200 NURSING HOME LANE			
ARAVIEV	POST-ACUTE AND	D REHABILITATION CENTER		PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 835	Continued From	page 339	F 835			
	to ensure care pla	ans were developed and				
		I care delivered to residents with				
		nd at risk for pressure sores met				
		dards of practice.				
	1 Observation of	f the lunch meal on 08/05/2021,				
		e menu for the lunch meal on				
		aled the residents should have				
) ounces of protein, 1/2 cup of				
	•	s, and $\frac{1}{2}$ cup of vegetable.				
		ations revealed staff served the				
		of mashed potatoes and 3/8				
		In addition, when staff was				
		ne protein to ensure it was				
		was no functioning scale in the				
		the meat. The "Diet Roster"				
	provided by the fa	acility indicated forty-two (42)				
		d fortified foods, including				
	Residents #90, #	327, #82, #39, #332, #81, and				
	#65. However, th	nere was no food prepared and				
	designated as "fo	ortified". Continued observation				
	revealed three (3) residents were supposed to get				
	sandwiches with	meals including Residents #332				
		ee (3) other residents were				
	•••	salads for the lunch meal				
	-	nt #39. However, continued				
		interview with dietary staff				
		lity did not have lunchmeat,				
		sandwich ingredients available.				
		rvations revealed that although				
		be served to residents at 2:00 PM, the last food tray did not				
	exit the kitchen u	-				
		ent #65, Resident #90, Resident				
		82, Resident #330, Resident				
		32, and Resident #81's medical				
		each of the residents sustained t loss as a result of the facility's				

Facility ID: 100599

If continuation sheet Page 340 of 401

ENTER	S FOR MEDICARE	ND HUMAN SERVICES & MEDICAID SERVICES		(PRINTED: 12/08/20 FORM APPROV DMB NO: 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/202 <u>1</u>	
AME OF PI	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
	N POST-ACUTE AND P	REHABILITATION CENTER	200	NURSING HOME LANE	
			PIK	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 835	Continued From as	na 240	F 005		
F 000	Continued From pa		F 835		
		stemic procedure in place to			
		ight loss. The facility failed to			
		hts according to policy, failed			
		ered Dietitian (RD) when a			
		veight loss, failed to provide			
		ations to prevent further o honor resident food			
	.				
		ent weight loss, and/or failed were served adequate			
	portions to prevent	•			
		weight 1033.			
	Interview with the R	D on 08/11/2021 at 4:10 PM			
		I0:30 AM, revealed she had			
		provide services at the facility			
		ne (1) year and had never			
		of resident to evaluate for			
		use the resident had a			
		e RD stated she had identified			
	concerns with weig	nt loss for the residents,			
	concerns that her re	ecommendations were not			
	being implemented	resident choice/preference			
		ommunication with nursing			
		d she had discussed the			
	-	e occasions with the			
		ever, she stated the facility			
		to correct the problems. The			
		ere always late and there was			
		rchased to provide snacks to RD stated she was not aware			
	staff did not know h				
		fying foods. The RD stated			
		not utilizing the correct scoop			
		esidents servings, failing to			
		weighing protein portions, not			
		ents she had recommended			
		and not serving residents their			
		all lead to weight loss and			
	malnutrition for the	-			

If continuation sheet Page 341 of 401

TATEMENT (OF DEFICIENCIES CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/202 <u>1</u>	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AN	D REHABILITATION CENTER		IURSING HOME LANE	
	CUMMAN				0(5)
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 835	Continued From	page 341	F 835		
	6:00 PM and on 0 she had been the 06/07/2021. The had no systems i weight loss or nu facility "was work The Administrato conducted NAR (since she had be she was working The Administrato or tracking she di doing everything weight loss. Furt Administrator rev department was not enough kitche provided timely a available to ensu addition, the Adm preferences were were not available	Administrator on 08/11/2021 at 08/18/2021 at 3:30 PM, revealed a facility's Administrator since Administrator stated the facility n place to monitor resident tritional needs, but stated the ing on getting one in place". r confirmed the facility had not Nutritional at Risk) meetings en the Administrator, but stated on getting those established. r could not voice any monitoring id to ensure the facility was possible to prevent resident her interview with the ealed she was aware the dietary "a mess". She stated there was en staff to ensure meals were nd was aware food was not re menus were followed. In inistrator was aware food e not met/followed and snacks e for residents and stated she a plan to correct the problems			
F 837 SS=K	Governing Body CFR(s): 483.70(c		F 837		
	body, or designat governing body, t establishing and	rning body. e facility must have a governing ted persons functioning as a that is legally responsible for implementing policies regarding and operation of the facility; and			
	administrator who	e governing body appoints the o is- e State, where licensing is			

If continuation sheet Page 342 of 401

		E & MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER	2	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
		D REHABILITATION CENTER	200 N	NURSING HOME LANE	
FARAVIE	N POST-ACOTE AN	D REHABILITATION CENTER	PIKE	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 837	Continued From	page 342	F 837		
		or management of the facility;			
	and (iii) Reports to an governing body.	id is accountable to the			
		ENT is not met as evidenced			
	policies were dev	Body failed to ensure facility veloped and implemented ement and operation of the			
	with 42 CFR 483	ody failed to ensure compliance .80 Infection Control during			
	11/13/2020, and Jeopardy (IJ) was)7/14/2020, 09/24/2020, 12/10/2020. Immediate s identified on 11/20/2020 and			
	483.80 Infection	ist on 11/17/2020, at 42 CFR Control, F-880 at a S/S of an "L" 's failure to prevent the spread of			
	COVID-19. Imme identified 11/25/2	ediate Jeopardy (IJ) was 020 and determined to exist on e area of 42 CFR 483.12			
	· · ·	ouse, F-600 related to failure to			
	achieved complia	itted a Plan of Correction and ance effective 01/20/2021.			
	facility had an ac	verning Body failed to ensure the tive Quality Assurance provement program to ensure			
	compliance was i Jeopardy was ide	maintained. Immediate entified again on 08/11/2021, at nfection Control (F880) and at 42			
	CFR 483.12 Free	nfection Control (F880) and at 42 edom from Abuse, F-600. The olate residents who were			

Facility ID: 100599

If continuation sheet Page 343 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	03/10/202
	PARKVIEW POST-ACUTE AND REHABILITATION CENTER		20	0 NURSING HOME LANE	
			PI	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 837	Continued From pag	e 343	F 837		
	positive for COVID-1 residents. Two (2) re COVID-19. Further,	9 to prevent spread to other esidents died due to the facility failed to protect as Resident #21 on the			
	were enough staff at residents, turn and re	further failed to ensure there the facility to monitor/assess eposition residents, provide pare and distribute meals, with eating.			
	were developed and management and op ensure compliance a free from abuse has serious injury, harm, resident. Immediate 08/11/2021, and was 03/06/2021, at 42 CF (F580), 42 CFR 483. (F600), 42 CFR 483. Person-Centered Ca CFR 483.25 Quality (F692), 42 CFR 483. (F755) and 42 CFR 4	re Plans (F655) (F656), 42 of Care (F684) (F686) 45 Pharmacy Services 483.80 Infection Control /as notified of Immediate			
	was received on 09/0 removal of the Imme 09/02/2021. Howeve verified based on ob- and review of facility Immediate Jeopardy 483.35 Nursing Serv	ation of Compliance (AOC) D3/2021, which alleged diate Jeopardy on er, the AOC could not be servations, staff interviews, documentation. Additional was identified at 42 CFR ices (F725), 42 CFR 483.70 b) (F837), 42 CFR 483.75			

Facility ID: 100599

If continuation sheet Page 344 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 837	the Immediate Jeopardy Immediate Jeopardy The findings include: Interview by email w Consultant on 08/18, the facility did not ha Governing Body. Sh Officer, Regional Vic Regional Nurse Con- the facility. Review of Statement survey visits on 07/1 11/13/2020, and 12/2 was found to be out 483.80 Infection Cor Centers for Medicare (CMS) and the Cente Prevention (CDC) re prepare for COVID-1 Review of the SOD i abbreviated survey of Agency on 12/12/20 Jeopardy (IJ) was idd determined to exist of 483.80 Infection Cor 42 CFR 483.21 Care F-657 at a S/S of an Administration, F-833 facility was notified of	And Performance The facility was notified of ardy on 09/10/2021. The is ongoing. The facility was notified of ardy on 09/10/2021. The is ongoing. The facility was notified of ardy on 09/10/2021. The is ongoing. The facility for the the stated the Regional Nurse (2021 at 2:20 PM, revealed ve a specific policy for the the stated the Chief Nursing e President, and the sultant provided oversight at the sof Deficiencies (SOD) for 4/2020, 09/24/2020, 10/2020, revealed the facility of compliance with 42 CFR and Medicaid Services ers for Disease Control and commended practices to 9. Initial comments for an completed by the State 20, revealed Immediate entified on 11/20/2020 and on 11/17/2020, at 42 CFR atrol, F-880 at a S/S of an "L", a Plan Timing and Revision, "L", and 42 CFR 483.70 5 at a S/S of an "L". The of the IJ on 11/20/2020. 12/2020 Statement of ation and interviews revealed	F 837		

Facility ID: 100599

If continuation sheet Page 345 of 401

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES					0. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		STRUCTION	(X3) DAT	E SURVEY IPLETED
185256		B. WING		EIN/	09	9/10/202 <u>1</u>	
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				200 NU	JRSING HOME LANE		
PARAVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER		PIKEV	/ILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES FIENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 837	Continued From	page 345	F 83	37			
	implement their C	COVID-19 Action Plan (AP),					
	· ·	(IC) policies and the Health					
) recommendations; failed to					
	place IC/isolation	signage on residents' door that					
	were under preca	autions; failed to ensure					
		al protective equipment					
	(PPE)/supplies w	ere available for use; and failed					
	to ensure staff wo	ore the PPE according to					
	guidelines and po	olicies. Facility staff from					
	housekeeping, la	undry, central supply and					
	nursing were obs	erved not following IC practices					
		contamination between units set					
	· ·	positive residents and units with					
		negative. Additionally, there					
		Administration consistently					
		yee infection control practices to					
		ad of COVID-19. Due to the					
	•	follow their COVID-19 AP, IC					
		DC guidelines, and the HD					
		s, residents were unnecessarily					
	· ·	D-19. On 10/13/2020, the					
	•	one (1) staff member as positive					
		d four (4) residents to be positive					
		10/17/2020 and 10/28/2020.					
		en (10) additional residents were					
		ositive for COVID-19. From					
		gh 11/13/2020 sixty-eight (68)					
		r COVID-19 and there was a					
		esident deaths. Six additional positive of on 11/20/2020.					
	Review of facility	COVID-19 testing revealed on					
	-	acility conducted routine testing					
		ents and all were negative. On					
	07/24/2021, two s	staff members tested positive for					
		outpatient clinic/hospital.					
		ility was aware the staff tested					
	positive, interviev	vs with staff revealed there was					
	no attempt by the	e facility to determine what					

Facility ID: 100599

If continuation sheet Page 346 of 401

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
DM	185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE IKEVILLE, KY 41501	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
effort to isolate the m spread of the virus. to immediately test m the facility policy after Further review of face residents were not to (4) days after the sta During the 07/28/202 #314 and Resident # COVID-19. However revealed the facility of prevent the spread of others. Interviews w unable to isolate Resident and others. Interviews w unable to isolate Resident and others. Interviews w unable to isolate Resident and others. Subsequer wander the hallways Observation and inter made no attempts to 08/05/2021, eight da positive, when a plas over the resident's d Further, continued resident's d Furthe	sed to the infected staff in an esidents to prevent further In addition, the facility failed esidents for COVID-19 per er the known exposure. cility testing, revealed ested until 07/28/2021, four aff members were positive. 21 resident testing, Resident #311 tested positive for er, observation and interviews did not isolate the residents to of COVID-19 infection to <i>v</i> ith staff revealed they were sident #311 due to wandering ntly, the resident continued to a without a mask. erviews revealed the facility o isolate the residents until ays after the residents tested stic zip barrier was placed	F 837		

If continuation sheet Page 347 of 401

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		OMB NO: 0938-039 (X3) DATE SURVEY COMPLETED	
IDENTIFICATION NOWBER.		A. BUILDING	TTNL	COMPLETED	
	185256		B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE ANI	D REHABILITATION CENTER		IURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 837	Prior to the barrie Resident #325, w COVID-19 positiv walking in the hal hallway adjacent Resident #325 w 08/08/2021, Resi COVID-19. On 0 developed respira transferred to the hospitalized. Res the hospital to the 08/19/2021, Resi distress, had a de back to the hospi One (1) additionat tested positive for was hospitalized 08/15/2021 at the Resident #329 ha COVID-19. Immediate Jeopa 08/11/2021, and CFR 483.80 Infect was notified of the 08/11/2021. Further review of additional IJ and (SQC) was identitid determined to exit 42 CFR 483.25 C Accident Hazards 42 CFR 483.21 C Centered Care P	page 347 er being placed on 08/05/2021, tho resided across the hall from re residents, was observed lways and sitting in a chair in the to COVID-19 positive rooms. as not wearing a mask. On dent #325 tested positive for 8/09/2021, Resident #325 atory distress and was emergency room and ident #325 was readmitted from e facility on 08/12/2021, and on dent #325 developed respiratory ecline in condition and was sent tal and expired on 08/26/2021. Il resident (Resident #327) r COVID-19 on 08/07/2021 and on 08/14/2021, and expired on e hospital. Resident #82 and ad also been hospitalized due to rdy was identified, on was determined to exist at 42 ction Control (F880). The facility e Immediate Jeopardy on the 12/12/2020 SOD revealed Substandard Quality of Care fied on 11/25/2020 and ist on 11/06/2020, in the areas of Quality of Care, F-689, Free from s/Supervision at a S/S of a "J", comprehensive Resident lans, F-656, Develop/Implement Care Plan, at a S/S of a "J", and	F 837		

Facility ID: 100599

If continuation sheet Page 348 of 401

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION (MB NO. 0938-039 X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER	185256	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200	NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIOI DATE
F 837	(SQC) was also ide determined to exist 42 CFR 483.12 Free Free from Abuse at and Implement Abus F-608, Reporting Re Crime at a S/S of a Violations at a S/S of Abuse at a S/S of a Administration, F-83 facility was notified Continued review of revealed additional identified at 42 CFR F-550, Resident Rig F-580, Notification of 42 CFR 483.25, Qu Management, at a S 483.60, Food and N Nutritive Value/Pala at a S/S of a "D". The According to the 12 failed to protect Res the 09/10/2021 surv implement the facility protecting and invest On 11/09/2020, the #21 to the hospital f behaviors. However Room (ER) records	ubstandard Quality of Care ntified on 11/25/2020 and on 11/09/2020, in the areas of edom from Abuse, F-600, a S/S of a "J", F-607, Develop se Policy at a S/S of a "J", easonable Suspicion of a "J", F-609, Reporting Alleged of a "J", F-610, Investigation of "J", and 42 CFR 483.70, 35 at a S/S of an "L". The of the IJ on 11/25/2020. If the 12/12/2020 SOD, deficient practice was a 483.10 Resident Rights, ghts, at a S/S of a "D" and of Change, at a S/S of a "G"; ality of Care, F-697, Pain S/S of a "G"; and 42 CFR lutrition Services, F-804, table/Preferred Temperature,	F 837		

Facility ID: 100599

If continuation sheet Page 349 of 401

PRINTED: 12/08/2021

	-	H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVI DMB NO. 0938-03
ATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING	-ETNIZ	09/10/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
	N DOOT A OUTE AN		200 N	NURSING HOME LANE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		PIKE	PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 837	Continued From	page 349	F 837		
		e (RN) #5 brutalized him/her;			
		sted his/her arm; and hit him/her			
	-	his/her hand and arm.			
		ne time of the interview revealed			
	bruising to the re	sident's right hand/thumb/wrist			
		RNA #19 and SRNA #20 stated			
		20, they found Resident #21 on			
		ne facility crying and scared. The			
		e resident reported to them that			
		en his/her hand, twisted his/her			
		her with the phone. SRNA #19			
		tated the resident's right thumb swollen. Further staff interviews			
		revealed that on 11/09/2020, they			
		being aggressive towards			
		reatening the resident with a			
		g at the resident. However,			
	•	SRNA #20 failed to follow the			
	facility's policy re	lated to abuse and failed to			
	report this to any	one. RN #5 continued to work			
	the remainder of	the shift and worked again on			
		rview with the Administrator on			
		aled he was not aware of			
		llegation of abuse. He stated this			
		he was hearing of the			
	0	ver, interview with Interim			
		ng (DON) on 11/17/2020 eived a text message from RN			
) stating Resident #21 was sent			
		al for behaviors. She further			
		t review the resident's record			
		the hospital, and had she done			
		ve seen the ER report with the			
	allegation of assa	ault.			
	Review of Reside	ent #86's (Resident #21 from the			
		ey) medical record revealed on			
		:15 AM, the resident called the			
		ause Resident #82 was coming			

Facility ID: 100599

If continuation sheet Page 350 of 401

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES				FORI	D: 12/08/20: MAPPROVE D. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		185256	B. WING			09/10/202 <u>1</u>	
NAME OF PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
				200	NURSING HOME LANE		
PARKVIE	V POST-ACUTE ANI	D REHABILITATION CENTER		PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 837	Continued From	page 350	F8	37			
	in his/her room ar	nd was exposing him/herself.					
		of the record revealed RN #1					
		ce that "95% of our residents					
		d some do wander". Per the					
	record, the RN int	formed the Police a resident had					
		g him/herself to Resident #86 or					
		also documented she informed					
	the Police Reside	ent #86 "has been known to					
	exaggerate."						
		Resident #86's medical record					
		eport dated 07/15/2021 revealed					
		5:50 PM Resident #82 had					
		esident #86's room again and					
		esident's shoes. According to					
	· ·	rt, Resident #86 pressed his/her					
		rovided by the facility (exact date					
	,	rew water on Resident #82.					
		lso indicated a stop sign had					
		d to prevent residents from					
		s/her room; however, the					
		tly takes it down." The incident					
		he investigation determined					
		s abused by Resident #86					
		hrew water on him/her when					
		ne resident's room and steps					
		further abuse was that the facility					
		Resident #86 to keep his/her n he/she was in her room.					
		n ne/sne was in ner 100m.					
	An interview with	Resident #86, on 07/27/2021 at					
		00 PM, revealed he/she felt like					
	the facility was no	ot trying to help him/her, and the					
	resident did not k	now what else to do. The					
		esident #82 entered his/her					
		p" and then "asked me how I					
		resident, Resident #82 had					
	· ·	self to the resident numerous					
	times since Resid	lent #82's admission to the					

Facility ID: 100599

If continuation sheet Page 351 of 401

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC		OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIEF	t i i i i i i i i i i i i i i i i i i i	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
			200	NURSING HOME LANE		
PARKVIEV	V POST-ACUTE AN	D REHABILITATION CENTER	РІКІ	EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 837	Continued From	page 351	F 837			
		lent stated he/she reported the				
	•	y staff; however, stated, "No one				
		e". Resident #86 stated he/she				
		ed the Police, but again, no				
	actions had been	taken to protect the resident.				
		stated he/she was "moved				
		e opposite end of the hall) to				
	· ·	32 away from him/her; however,				
		ntinued to come in/out of his/her				
		#86 stated on 07/15/2021,				
		in bed and Resident #82				
		oom again. Resident #82				
		self to the resident, picked up be and Resident #86 on the left,				
		resident stated he/she threw				
		dent to get him/her out of his/her				
		ed; however, no actions had				
	· ·	btect the resident from further				
	abuse from Resid					
	Immediate Jeona	rdy was identified, on				
		was determined to exist again at				
	· ·	Freedom from Abuse (F600).				
		notified of the Immediate				
	Jeopardy on 08/1	1/2021.				
	Interview with the	e Regional Vice President (RVP)				
	on 08/30/2021, a	t 3:30 PM revealed he had been				
		cility for 90 days, and was a				
		overning Body. He stated a				
		meeting had not been held since				
		VP. He stated he did not know				
		s previously. He stated he was				
		facility monitored to ensure care				
		e provided to residents, except				
		neetings and Quality rmance Improvement (QAPI)				
		ver, he stated since he had been				

Facility ID: 100599

If continuation sheet Page 352 of 401

	S FOR MEDICAR	E & MEDICAID SERVICES		(MB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION (X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
			NURSING HOME LANE		
	SLIMMAE	RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFIC	(OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETIO
F 837	Continued From	page 352	F 837		
	or clinical meetin	gs. He stated he was not aware			
		hough staff at the facility to turn			
		sidents every two (2) hours. He			
		with SRNAs and nursing, they			
	•	asks done that needed to be stated the facility was always			
		but had been "aggressively"			
	looking recently.	aggroonvory			
	Further interview	with the RVP revealed it was not			
	-	ention that the facility needed			
		ood, nor that residents were not			
	• •	He stated if it had been brought			
		tor's attention and it had not he should have been notified.			
	,	stated it "would have been ideal"			
		about the Infection Control			
	deviancies from I	December 2020; however, no			
		hing about any ongoing QAPI			
	-	he December 2020 survey. He			
		ard the facility had been cited for rdy in the past, but he did not			
	know the specific	• •			
F 842	•	s - Identifiable Information	F 842		
)(5), 483.70(i)(1)-(5)			
	§483.20(f)(5) Res	sident-identifiable information.			
	(i) A facility may r	not release information that is			
	resident-identifial				
		ay release information that is			
		ble to an agent only in a contract under which the agent			
		e or disclose the information			
	•	ent the facility itself is permitted			
	to do so.	- ,			
	§483.70(i) Medic				
	§483.70(i)(1) In a	ccordance with accepted			

If continuation sheet Page 353 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 842	professional standard must maintain medic that are- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically or §483.70(i)(2) The fac all information contai regardless of the forr records, except when (i) To the individual, or representative when (ii) Required by Law; (iii) For treatment, par operations, as permi with 45 CFR 164.500 (iv) For public health neglect, or domestic activities, judicial and law enforcement pur purposes, research p medical examiners, f a serious threat to he by and in compliance §483.70(i)(3) The fac record information ag unauthorized use. §483.70(i)(4) Medica for- (i) The period of time (ii) Five years from th there is no requirement	ds and practices, the facility cal records on each resident hented; de; and rganized cility must keep confidential ined in the resident's records, m or storage method of the n release is- or their resident e permitted by applicable law; dayment, or health care tted by and in compliance 5; activities, reporting of abuse, violence, health oversight d administrative proceedings, poses, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or al records must be retained e required by State law; or he date of discharge when ent in State law; or ears after a resident reaches	F 842		

Facility ID: 100599

If continuation sheet Page 354 of 401

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/08/2021 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTR G		(X3) DATE	
		185256	B. WING			09/	10/2021
NAME OF PI	NAME OF PROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE AND RE	EHABILITATION CENTER			ING HOME LANE .E, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 842	 (i) Sufficient informat (ii) A record of the re- (iii) The comprehens provided; (iv) The results of an and resident review of determinations condution (v) Physician's, nurse professional's progret (vi) Laboratory, radio services reports as results of an and resident review of the services reports as results and the services reports as results and the services reports as results of an and resident review of the services reports as results and the services reports as results are reported to a services reports as results are reported to obtain the results are reported to a services reports as results are reported to a service reports are reported to a service reports are reported to a service report report of the service reports are reported to a service report of the service reports are reported to a service report of the service reports are reported to a service report of the service reports are reported to a service report of the service reports are reported to a service report of the service reports are reported to a service report of the service reports are reported to a service report of the service reports are reported to a service report of the service reports are reported to a service report of the service reports are reported to a service report of the service reports are reported to a service report of the service reports are reported to service reports are reported t	edical record must contain- ion to identify the resident; sident's assessments; ive plan of care and services y preadmission screening evaluations and ucted by the State; e's, and other licensed ss notes; and logy and other diagnostic equired under §483.50. Γ is not met as evidenced and record review it was y failed to maintain two (2) of oled residents' (Residents dical records in accordance	F 84	42	DEFICIENCY)		
	failed to document th	ds (MAR) revealed staff at the resident's insulin ower blood glucose) was 3/2021.					

Facility ID: 100599

If continuation sheet Page 355 of 401

CENTER	MENT OF HEALTH	E & MEDICAID SERVICES		(FORM APPROVE 2005 OMB NO. 0938	
TATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			IURSING HOME LANE			
			•			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL / OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 842	Continued From	page 355	F 842			
	2020, revealed th well-controlled dia daily if the resider Continued review would monitor an therapy or sliding times a day. The indicated, if a res procedure, had res	ility's policy titled, I Protocol", dated November e facility would monitor a abetic's blood glucose level twice nt was receiving insulin. of the policy revealed the facility y resident on intensive insulin scale insulin three (3) to four (4) facility would also monitor as ident was fasting before a eturned to the facility after a ce, or had an acute illness or				
	Documentation", the resident's corr accidents involvin toward or change objective will be of record. Further re documentation w including assess findings obtained notification of fam	ility's policy titled "Charting and undated, revealed changes in adition, event, incidents or ag the resident and progress es in the care plan goals and documented in the medical eview revealed the ould include care-specific details ment date and/or any unusual during the procedure/treatment, hily, physician or other staff, if e signature and title of the enting.				
	revealed the facil 07/16/2021, with Diabetes Mellitus Review of Reside (MDS) assessme the facility assess Interview for Men	ident #321's medical record ity admitted the resident on diagnoses of Urosepsis, , and Invasive Bladder Cancer. ent #321's Minimum Data Set int dated 07/19/2021, revealed sed the resident to have a Brief tal Status (BIMS) score of cating the resident was				

Facility ID: 100599

If continuation sheet Page 356 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12 FORM APP OMB NO. 093	PROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURV COMPLETED	′EY
		185256	B. WING		09/10/20	021
NAME OF P	ROVIDER OR SUPPLIER		S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	V POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE		-
		-	P	IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) MPLETION DATE
F 842	Continued From pag	e 356	F 842			
	dated 07/16/2021, ref have the resident's d Further review revea interventions listed ref monitoring Resident Review of the Physic 07/16/2021, revealed order for staff to obta levels as required an Continued review of revealed staff was to Glargine Insulin (long blood sugar) every m Review of Resident # Administration Record documentation that se blood glucose level at on 07/16/2021, until 07/18/2021. Although staff to conduct diabe hypoglycemia/hyperg sugar), there was no staff completed the m resident's blood gluco of 07/16/2021, at 11 admitted Resident #2 care of the resident of until 7:00 PM. LPN # resident's blood gluco	egarding obtaining or #321's blood glucose levels. ian's Orders dated I Resident #321 received an in his/her blood glucose d as needed (PRN). the Physician's Orders administer the resident g acting medication to lower norning. 4321's Medication d (MAR) and Treatment ds (TAR) revealed no taff obtained the resident's after admission to the facility prior to breakfast on n the resident's MAR directed etic monitoring every shift for glycemia (low/high blood documented evidence the nonitoring or obtained the ose readings on the evening				

Facility ID: 100599

If continuation sheet Page 357 of 401

					FORM APPROVED
STATEMENT O	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF PF	ROVIDER OR SUPPLIER	185256	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>
PARKVIEV	W POST-ACUTE AND R	REHABILITATION CENTER		NURSING HOME LANE EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 842	07/28/2021 at 4:25 for Resident #321 o PM-7:00 AM on 07/ #7 stated she obtain glucose levels as or what they were. The documented the blo resident's medical re forgot. Continued in routinely her and on Aide (SRNA) workin struggled to get the Interview with Resid (Physician #1), on 0 revealed he expected document and monid diabetic residents at further stated his ex obtain blood glucost diabetic medications of diabetes. Interview with the As (ADON)/Interim Dire 08/11/2021 at 12:05 nursing staff to obtal levels on all diabetic every shift. Howeve residents might require The DON stated sho monitoring to ensure	stered Nurse (RN) #7 ,on PM, revealed that she cared n night shift from 7:00 16/2021 and 07/17/2021. RN hed the resident's blood dered, but could not recall e RN stated she should have od glucose results in the ecord, but she guessed she terview revealed that it was he State Registered Nurse ing the entire floor, and she	F 842		
	Interview with the A	dministrator, on 08/10/2021 at			

If continuation sheet Page 358 of 401

PRINTED: 12/08/2021

	LTH AND HUMAN SERVICES ARE & MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED
DM	185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPL	NAME OF PROVIDER OR SUPPLIER		REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			0 NURSING HOME LANE KEVILLE, KY 41501	
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
 were not docu resident's med unable to say if residents to er were staying w staff were not if 2. Review of Res revealed the fa 07/06/2021 with Metabolic Enc Failure, Autisti Mellitus, Dyspi Review of Res dated July 202 the resident Le Humulin-R ins Review of Res at 9:00 AM rev staff administe Further review 11:30 AM and evidence staff Humulin-R ins Interview with revealed she w on 07/13/2021 6:30 PM. She Resident #323 however, must medication on Interview with 12:05 PM, rev 	aled she was unaware that staff menting blood glucose levels in the lical record. The Administrator was how the facility was monitoring how the facility and the facility and how the facility and the facility and how the facility and the multin-R, thave failed to document the	F 842		

If continuation sheet Page 359 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE IKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 842	ADON/IDON stated	edication to a resident. The she had not identified a cumenting medication	F 842			
F 867 SS=K	1:50 PM, revealed sl were not documentir insulin on the resider QAPI/QAA Improven CFR(s): 483.75(g)(2) §483.75(g) Quality a §483.75(g)(2) The quassurance committee (ii) Develop and impl	nent Activities)(ii) ssessment and assurance. uality assessment and	F 867			
	by: Based on interview, facility's policy, and r Correction submitted was determined the effective performance which measured the performance of its pl were implemented, of and the facility maint The facility failed to e maintained at 42 CF Deficiencies were cit 09/24/2020, 11/13/20	T is not met as evidenced record review, review of the review of the facility's Plan of I for the 12/12/2020 survey, it facility failed to have an e improvement program success and tracked the ans to ensure interventions deficiencies were corrected ained substantial compliance ensure compliance was R 483.80 Infection Control. ed during the 07/14/2020, 020, and 12/12/2020 surveys. urvey, Immediate Jeopardy				

Facility ID: 100599

If continuation sheet Page 360 of 401

	-	I AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED
185256		B. WING	09/10/202 <u>1</u>		
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC
F 867	Continued From p	page 360	F 867		
		and cited at a Scope and e to the facility's failure to d of COVID-19.			
	achieved complia However, the faci Assurance Perfor plans to ensure co Immediate Jeopa 08/11/2021, at 42 (F880). The facili were positive for 0	tted a Plan of Correction and nce effective 01/20/2021. lity failed to implement Quality mance Improvement (QAPI) ompliance was maintained. rdy was identified again on CFR 483.80 Infection Control ty failed to isolate residents who COVID-19 to prevent the spread . Two (2) residents died due to to F880.			
	Assurance Perfor Program was in p cause serious inju to a resident. Imr on 08/11/2021, ar 03/06/2021, at 42 (F580), 42 CFR 4 (F600), 42 CFR 4 Person-Centered CFR 483.25 Qual (F692), 42 CFR 4 (F755) and 42 CF	re to ensure an effective Quality mance Improvement (QAPI) lace has caused or is likely to ury, harm, impairment or death nediate Jeopardy was identified, nd was determined to exist on CFR 483.10 Resident Rights 83.12 Freedom from Abuse 83.12 Comprehensive Care Plans (F655) (F656), 42 ity of Care (F684) (F686) 83.45 Pharmacy Services FR 483.80 Infection Control y was notified of Immediate 1/2021.			
	was received on (removal of the Im 09/02/2021. How verified based on and review of faci	egation of Compliance (AOC) 09/03/2021, which alleged mediate Jeopardy on rever, the AOC could not be observations, staff interviews, lity documentation. Additional rdy was identified at 42 CFR			

Facility ID: 100599

If continuation sheet Page 361 of 401

					FORM APPROVED
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	NAME OF PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND F	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 867	Administration (F83 Quality Assurance a Improvement (F867 the Immediate Jeop Immediate Jeopard The findings include Review of the facilit Performance Impro May 2021, and the 2014, revealed the implement and main QAPI plan designed quality and safety o methods to improve identified problems. data should be gath organized and mea be appropriate to m staff turnover and a and deficiencies, ca complaints, clinical ulcers, infections ar assessment and da input would be gath family members and involved in the care were encouraged to concerns as well as improvement. The p facility's leadership efforts and systems care and services a performance indicat action plans would	vices (F725), 42 CFR 483.70 5) (F837), 42 CFR 483.75 and Performance). The facility was notified of ardy on 09/10/2021. The y is ongoing. y's Quality Assurance and yement (QAPI) Plan, dated QAPI policy, last revised April facility should develop, ntain an ongoing, facility wide I to monitor and evaluate the f resident care, pursue care quality and resolve According to the policy, QAPI ered and used in an ningful way. Areas that might onitor and evaluate included: ssignments, State surveys re plans, resident/family butcomes such as pressure d MDS (Minimum Data Set) ta. The policy also indicated ered from staff, residents, d individuals who were of the residents, and staff i dentify/report quality opportunities for policy stated members of the was accountable for QAPI would be in place to monitor nd outcomes utilizing ors. The policy also stated	F 867		

Facility ID: 100599

If continuation sheet Page 362 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
	W POST-ACUTE AND RI	EHABILITATION CENTER	20	0 NURSING HOME LANE	
			PI	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 867	Continued From pag	e 362	F 867		
	May 2021, revealed to committed to serving members and would atmosphere, where to were of utmost impor- policy, the Administration direct the day-to-day accordance with curr standards, guidelines nursing facilities to en- quality care was prov- residents. The Admir make daily rounds of overall appearance of care provided to the resident/family satisfa- stated the Administration developing and main policies/procedures a practice which gover Further review reveal duties included ensu Team Meetings (IDT) review/manage staffi which included dining assistance was provi Administrator's week residents, identified p weight and pressure residents. Monthly A ensuring follow up ha reports, which include as required. The mar Administrator would in	and professional standards of in the operation of the facility. Iled the Administrator's daily ring the Interdisciplinary) were occurring; ing; observe facility systems, g; and ensure personal ided to the residents. The Idy duties included monitoring problems, and reviewing ulcer reports for the Administrator duties included ad occurred for consultant ed dietary reports; and to gs were conducted monthly			

Facility ID: 100599

If continuation sheet Page 363 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
	N POST-ACUTE AND R	REHABILITATION CENTER	2	200 NURSING HOME LANE	
	NT COTACCTE AND IN		F	PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 867	Continued From pag	ge 363	F 867		
		ompliance for reporting of all			
		Federal agencies. The			
		d listen to and know their			
		e the individual needs of the According to the manual, the			
		d ensure menus were posted			
		shments were offered to the			
	residents.				
	for the surveys, date	ment of Deficiencies (SOD) ed 07/14/2020, 09/24/2020			
		realed the facility had been			
	failure to prevent the	8.80, infection control, for			
	COVID-19. Review	• •			
	Deficiencies (SOD)	for the survey date,			
		ed the facility was cited			
		y at 42 CFR 483.80, Infection			
	Control at a Scope a prevent the spread	and Severity "L" for failure to			
	prevent the spread of	01 00 010-19.			
	Review of the facility	y's Plan of Correction (POC),			
		survey, revealed the facility			
		e facility's infection control			
		s, COVID emergency plan,			
		ce mask and PPE (personal nt) and handwashing. In			
		staff were required to complete			
		f the Nursing Home Infection			
		g on the Centers of Disease			
		tion (CDC) website and were			
		eos on "Keep COVID-19 Out",			
		bat COVID-19; and Use (PPE) Equipment Correctly".			
		uired to review the document			
	-	g to Coronavirus (COVID-19)			
		Continued review of the POC			
	-	would monitor to ensure			
	compliance with infe	ection control. The POC			

Facility ID: 100599

If continuation sheet Page 364 of 401

	-	HAND HUMAN SERVICES			PRINTED: 12/08/20 FORM APPROV OMB NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/202 <u>1</u>	
NAME OF PR	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW	ARKVIEW POST-ACUTE AND REHABILITATION CENTER				
				EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 867	Continued From	page 364	F 867		
		adhere to the facility's PPE,			
		and competency checks. The			
		ionist with oversite from the			
		ng (DON) or designee would			
		checks of four (4) random			
		d nursing staff to assure			
		the facility's policy and			
		oss contamination for four (4)			
	weeks or until zer	ro negative findings were			
	determined by the	e Quality Assurance (QA)			
		the plan, compliance would be			
	reviewed by the (QA Committee each month for			
	six (6) months to	determine if the POC had been			
	effective to preve	nt the violations from recurring.			
	The facility allege	ed and achieved compliance			
	effective 01/11/20)21.			
	However, the fac	ility failed to ensure they			
	continued to mon	itor and evaluate compliance			
	with infection con	trol per the Plan of Correction			
	and the facility's	QAPI plan/policy. Observation of			
	the facility's fifth f	loor on 08/05/2021 at 10:54 AM,			
		h two (2) residents (Resident			
		ested positive for COVID-19 on			
		wo (2) residents (Resident #329			
		positive on 08/02/21, the facility			
		nd segregate the residents as			
	• •	acility's policy. The fire doors			
		sident room doors were open,			
		re wandering the halls of the			
		ervation revealed no designated			
		separate residents. Additionally,			
		sted positive on 08/07/2021 and sted positive on 08/08/2021.			
	Review of the fac	ility's COVID-19 test records,			
	dated 07/28/2021	I, revealed both Resident #311			
		14 tested positive for COVID-19.			
	Continued review	of COVID-19 test records			

Facility ID: 100599

If continuation sheet Page 365 of 401

<u>CENTER</u>	S FOR MEDICARE	E & MEDICAID SERVICES		C	MB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION (X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			NURSING HOME LANE		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETIO DATE
F 867	Continued From p	page 365	F 867		
	revealed Residen for COVID-19 on	t #82 and #329 tested positive 08/02/2021.			
	maintenance staff	8/05/2021 at 10:54 AM, revealed f placed plastic zip barriers			
	Resident #311 an	ay of a room where both d Resident #314 resided. s eight (8) days following the			
	resident's positive	COVID-19 results. In addition, sident #325, on 08/05/2021 at			
		ed the resident was wandering ast the red biohazard waste			
		staff were doffing COVID E on the outside of the			
		who were COVID positive. ons, on 08/05/2021 at 11:00 AM,			
	revealed Residen	t #325 was sitting in a chair in			
		fifth floor with no facemask. seated adjacent to COVID			
	positive residents	rooms.			
		on on the fifth (5th) floor, on 54 AM, revealed large red			
		the hallway on each end of the			
		contained large amounts of			
		E, which had been used by staff ' rooms who were COVID			
	positive.				
		NA #19, on 08/05/2021 at 11:15			
	SRNA #3 on 08/0	n 08/09/2021 at 11:47 AM, and 5/2021 at 12:30 PM, revealed			
		(remove) contaminated PPE ositive rooms in a red			
	bio-hazard can in				
		ility's COVID-19 test records,			
	tested positive for	, revealed Resident #327			

Facility ID: 100599

If continuation sheet Page 366 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/202 <u>1</u>	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 867	Continued From pag	e 366	F 867			
	08/09/2021 at 5:19 P two (2) episodes of d notified and the resid increase oral fluid int Notes, dated 08/14/2 routine vital signs, st have a low blood pre low oxygen saturatio and Resident #327 w room via an ambular Review of Resident # summary, dated 08/1 resident expired at th The resident's admis Sepsis and COVID-1 discharge summary, likely due to the COV resident's diagnosis w Pneumonia. Review of the facility dated 08/08/2021, re positive for COVID-1 Review of the Nurse' 2:45 PM, revealed R in condition and had developed a fever of respiratory distress re emergency room for Review of a Nursing dated 08/12/2021 at	's COVID-19 test records, vealed Resident #325 tested 9 on 08/08/2021. s Notes, dated 08/09/2021 at esident #325 had a change cough, congestion and 100.2 F (Fahrenheit) and equiring transfer to the				

If continuation sheet Page 367 of 401

		ND HUMAN SERVICES			FORM APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
		REHABILITATION CENTER	2	00 NURSING HOME LANE	
PARKVIE	W POST-ACOTE AND P		P	IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 867	08/19/2021 at 1:30 developed a low ox physician and resid notified. The Physic and a Fentanyl pato related to the reside Do Not Resuscitate staff discussed the care, DNR status, a physician with resid resident's represent send Resident #325 physician and DON an ambulance trans emergency room fo Review of hospital of 08/26/2021, revealed the hospital on 08/2 diagnoses included Failure secondary to On 08/23/2021 at 2 conducted with a pr resigned effective 0 Administrator stated to monitor all deficie December 2020 sur continued to review Assurance (QA) and identified any conce He stated he lead O Administrator, the D Assistant Director o worked together on reviewing records.	i the Nurse's Notes, dated PM, revealed Resident #325 ygen saturation of 89% and ent representative were cian ordered palliative care h (pain medication skin patch) ent's declined condition and a (DNR) status. Per the note, resident's condition, palliative nd new orders from the ent representative. The ative requested the facility b back to the hospital. The were notified of request and ported the resident to the r evaluation. discharge summary, dated ed Resident #325 expired at 6/2021 and the resident's Acute Hypoxic Respiratory to COVID-19 Pneumonia. 10 PM, an interview was evious Administrator, who 6/01/2021. The former I prior to leaving, he continued encies cited during the vey. He stated they all monitoring through Quality d when he left, he had not erns with information gathered.	F 867		

If continuation sheet Page 368 of 401

		ND HUMAN SERVICES			FORM APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF P	ROVIDER OR SUPPLIER	185256	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 867	Nursing (IDON), on revealed she had be for approximately or she was also servin Nurse since Decem the role of Interim D was unable to recall interview. She state employed as the AD as a staff nurse mor an ADON, due to the facility. She also staff no QA Nurse since a She stated she reca being hired a few m after the first week of mandated to work the staffing problems in ADON, she was una conducted by the DU employment at the fi former DON) always short staffing." The currently and had no processes or gather processes in the fact revealed she had no weekly or monthly, the since her employment the ADON, she was infection control pro However, she stated she had worked the nights on the floor a the required monitor	DON/Interim Director of 08/18/2021 at 9:50 PM, een the ADON at the facility the (1) year. The ADON stated g as the Infection Control ber 2020, and had assumed ON around 07/23/2021, she the exact date during the ed since she had been ON, she had worked the floor e than she had functioned as e ongoing short staffing in the ted the facility had no Unit Development Coordinator and she had worked at the facility. Illed one (1) Unit Manager onths ago, but the nurse left or so, because she was ne floor due to the ongoing the facility. According to the aware of any monitoring ON, prior to her leaving acility. She stated, "She (the s worked the floor too, due to ADON stated she was not ever monitored any QA ed any data related to QA idity. Further interview ot attended any meetings, o discuss quality processes ent at the facility. According to also responsible to monitor cesses in the facility. d at the time of the interview, last six (6) out of seven (7) nd was unable to complete	F 867		

Facility ID: 100599

If continuation sheet Page 369 of 401

				~	
TATEMENT (S FOR MEDICAR OF DEFICIENCIES CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		MB NO. 0938-03 X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/2021	
NAME OF PI	AME OF PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	.
		D REHABILITATION CENTER	200 N	IURSING HOME LANE	
FARRAIE	VPOST-ACOTE AN	D REHABILITATION CENTER	PIKE	VILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE
F 867	Continued From	page 369	F 867		
		d she was not made aware of			
		its of quality processes that were			
	in place at the fac	cility when she became the			
		June 2021. She also stated			
		o QA meetings conducted since			
		ninistrator in June 2021. The ostated she was the QA			
		was responsible for the QA			
		ses in the facility. However, she			
	-	ot conducted any monitoring in			
	the facility related	d to infection control, because			
		ADON to complete infection			
		g. The Administrator also			
		e facility had no Unit Managers,			
		ment or QA Nurse. She stated vere posted and have been			
		nce she had been at the facility;			
	•	lified applicants had expressed			
		positions. She also			
	acknowledged th	e ADON worked the floor as a			
		ently. During the interview, when			
		DON could monitor, when she			
	was working the "Well I don't know	floor as a staff nurse , she stated v."			
F 880	Infection Prevent		F 880		
SS=K	CFR(s): 483.80(a	a)(1)(2)(4)(e)(f)			
	§483.80 Infectior	Control			
		establish and maintain an			
		ion and control program			
	designed to prov	ide a safe, sanitary and			
		ronment and to help prevent the			
		transmission of communicable			
	diseases and infe	ections.			
	§483,80(a) Infect	tion prevention and control			
	program.				
		establish an infection prevention			

Facility ID: 100599

If continuation sheet Page 370 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	N POST-ACUTE AND R	EHABILITATION CENTER		NURSING HOME LANE EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 880	15		F 880		
	and control program a minimum, the follow	(IPCP) that must include, at wing elements:			
	reporting, investigatin and communicable d staff, volunteers, visi providing services ur arrangement based	upon the facility assessment g to §483.70(e) and following			
	§483.80(a)(2) Written procedures for the pro- but are not limited to (i) A system of surve possible communical infections before the persons in the facility (ii) When and to who communicable disea reported; (iii) Standard and tra to be followed to pre- (iv)When and how is resident; including bu (A) The type and dur depending upon the involved, and (B) A requirement tha least restrictive poss circumstances. (v) The circumstances must prohibit employ disease or infected s contact with resident	n standards, policies, and rogram, which must include, billance designed to identify ble diseases or y can spread to other y; om possible incidents of ase or infections should be unsmission-based precautions vent spread of infections; tolation should be used for a ut not limited to: ration of the isolation, infectious agent or organism at the isolation should be the bible for the resident under the es under which the facility yees with a communicable skin lesions from direct ts or their food, if direct			

Facility ID: 100599

If continuation sheet Page 371 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	REHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	E COMPLETION
F 880	Continued From page	ge 371	F 880		
	by staff involved in c	direct resident contact.			
		tem for recording incidents facility's IPCP and the iken by the facility.			
		ndle, store, process, and as to prevent the spread of			
		eview. luct an annual review of its eir program, as necessary.			
	by: Based on observati and review of the facility determined the facility maintain an infection program to properly spread of COVID-19 residents (Resident	IT is not met as evidenced ion, interview, record review, cility's policies, it was ity failed to establish and n prevention and control prevent and contain the 9 for seven (7) of 57 sampled #325, #314, Resident #311, ident #82, Resident #328 and			
	COVID-19 testing of were all negative. members tested pos outpatient clinic/hos was aware the staff attempt by the facilit residents were expo	facility conducted routine f staff and residents and they On 07/24/2021, two (2) staff sitive for COVID-19 at an pital. Although, the facility tested positive, there was no ty to determine which osed to the infected staff in an residents to prevent further			

Facility ID: 100599

If continuation sheet Page 372 of 401

		ND HUMAN SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE NKEVILLE, KY 41501	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
F 880	residents for COVID Residents were not (4) days after the sta During the 07/28/202 #314 and Resident # COVID-19. However the residents to prevo others. Interviews we unable to isolate Rebehavior of wanderin continued to wander The facility made no residents until 08/05 residents until 08/05 residents tested pos Further, the facility of routinely tested for C However, State Reg #13 stated she was scheduled shift on 0 through 6:00 AM on at approximately 12: stated she started for residents. She state symptoms to the num COVID-19 test, which From 07/28/2021 the additional three (3 re COVID-19. Prior to the barrier b Resident #325, who COVID-19 positive r walking in the hallwar	ty failed to immediately test -19 per the facility's policy. tested until 07/28/2021, four aff members tested positive. 21 resident testing, Resident 4311 tested positive for er, the facility did not isolate tent the spread of infection to vith staff revealed they were sident #311 due to his/her ng; subsequently, the resident the hallways without a mask. attempts to isolate the /2021, eight (8) days after the itive. locumented staff were COVID-19 on 07/30/2021. istered Nurse Aide (SRNA) not tested prior to starting her 7/30/2021 from 6:00 PM 07/31/2021. During her shift, 00 AM on 07/31/2021, she teling sick while caring for ed she reported her rse who conducted a rapid th was positive. tough 08/05/2021, an tesidents) tested positive for eing placed on 08/05/2021, resided across the hall from tesidents, was observed ays and sitting in a chair in the COVID-19 positive rooms.	F 880		

Facility ID: 100599

If continuation sheet Page 373 of 401

STATEMENT (E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		MB NO. 0938-039 X3) DATE SURVEY COMPLETED
	185256		B. WING		09/10/202 <u>1</u>
		D REHABILITATION CENTER	200 N	ET ADDRESS, CITY, STATE, ZIP CODE IURSING HOME LANE EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE
F 880	Record review re #325 tested posit 08/09/2021, Resi distress and was room and hospita readmitted from t 08/12/2021. Furth 08/19/2021, Resi distress, had a de back to the hospi Interview with the Preventionist/ADU 08/11/2021 revea should have been first COVID-19 po stated she was a COVID-19 should stated not isolatin others at risk for of One (1) additionat tested positive for was hospitalized 08/15/2021 at the Resident #329 ha COVID-19. The facility's failu prevention and co likely to cause se death to a residen identified, on 08/2 exist on 03/06/20 Rights (F580), 42 Abuse (F600), 42 Person-Centered CFR 483.25 Qua	vealed on 08/08/2021, Resident ive for COVID-19. On dent #325 developed respiratory transferred to the emergency dized. Resident #325 was he hospital to the facility on her review revealed on dent #325 developed respiratory ecline in condition and was sent tal and expired on 08/26/2021. e Infection Control ON/Acting Interim DON on aled she was aware residents in tested immediately after the positive staff member. She also ware residents who had d have been isolated. She ng residents with COVID-19 put	F 880		

Facility ID: 100599

If continuation sheet Page 374 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AND RE	EHABILITATION CENTER		0 NURSING HOME LANE	
			PI	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 880	Continued From pag	e 374	F 880		
		483.80 Infection Control as notified of Immediate 021.			
	was received on 09/0 removal of the Imme 09/02/2021. Howeve verified based on obs and review of facility Immediate Jeopardy 483.35 Nursing Serv Administration (F835 Quality Assurance ar Improvement (F867) the Immediate Jeopardy	er, the AOC could not be servations, staff interviews, documentation. Additional was identified at 42 CFR ices (F725), 42 CFR 483.70) (F837), 42 CFR 483.75 nd Performance . The facility was notified of urdy on 09/10/2021. The is ongoing.			
	revealed staff will be Pandemic COVID-19 and procedures. Sta Hygiene and proper Equipment (PPE) inc residents exhibiting s COVID-19 will be iso the door closed and precautions (TBP) ba Disease Control and Review of the facility Emergency Operatio				
	positive residents wil the rest of the popula	l be segregated away from ation and the resident unit will d, Yellow, and Green zones.			

Facility ID: 100599

If continuation sheet Page 375 of 401

	-	ND HUMAN SERVICES			FORM APPROVED
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF P	ROVIDER OR SUPPLIER	185256	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	09/10/202 <u>1</u>
PARKVIE	W POST-ACUTE AND F	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 880	utilized to divide Re along with privacy of to act as a barrier a and remain closed. Yellow, and Green z members are not as policy revealed staff in a designated area Review of the facilit "CORONAVIRUS D TESTING RESIDEN residents were tester to detect the preser testing) and to help COVID-19 in the fac all residents were set symptoms of COVII residents will be cor in the facility. An ou new onset of SARS or a single case of i personnel and, testi as a new confirmed who test positive, in pre-symptomatic res- testing of all previou repeated every 3 to no new cases of SA residents or healtho days since the most 1. Review of the fac records revealed on Nurse (RN) #2 and (SRNA) #16 tested	aled zipper walls will be d, Yellow and Green Zones, urtains in semi-private rooms nd fire doors will be closed Assigned staff will work Red, cones, so multiple staff signed. Further review of the were to be dedicated to work a (e.g. red zone).	F 880		

Facility ID: 100599

If continuation sheet Page 376 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
	\mathbf{D}	185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE	
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 880	Continued From pag	e 376	F 880		
	AM, revealed she wo cared for residents to SRNA stated she test 07/24/2021. She state were being tested rest they had been off set stated her family men #13 tested positive we exposed to her. The was not tested prior to she became ill. Review of the facility the next scheduled to 07/30/2021. Howeve prior to starting her st 07/30/2021 while wo stated SRNA #16 wa coworker and had test Although the facility if and visitors prior to e stated the facility did related to contact tra SRNA #16. Per the S fifth floor and cared ff She further stated sh on 07/30/2021 and b of her shift. The SRI nurse that she felt ill. positive for COVID-1	#16, on 08/09/2021 at 11:47 orked on the fifth floor and hroughout the unit. The ted positive for COVID-19 on ted she did not think staff gularly or prior to working if veral days. SRNA #16 further mber and coworker SRNA while at work after being SRNA stated SRNA #13 to starting her shift the night 's testing schedule revealed esting for staff was on er, SRNA #13 was not tested hift at 6:00 PM on #13 on 08/01/2021 at 5:40 ted positive for COVID-19 on rking at the facility She is a family member and sted positive on 07/24/2021. reported screening all staff entry to the facility, the SRNA not ask her any questions cing or being exposed to SRNA, she worked on the or all residents on the floor. Ise began her shift at 6:00 PM egan feeling ill in the middle VA stated she reported to the She stated she tested 9 and was sent home. ered Nurse (RN) #9, on			
	08/09/2021 at 10:55	PM revealed she worked			

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	PARKVIEW POST-ACUTE AND REHABILITATION CENTER				
				KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 880	Continued From pag	e 377	F 880		
		n floor and cared for all			
		r. The RN stated the facility to be tested prior to coming			
		g off for several days. RN #9			
	-	s not testing staff on any			
	specific days.				
		orporate Nurse Consultant, on			
		AM, revealed the facility was			
	-	9 testing two (2) times and Thursdays for both staff			
	and residents. She s	tated the nurses on the floor			
	•	testing residents on their ection Control/ADON/Interim			
		She further stated staff used a			
		s the residents were tested			
		hecked off as staff came in r, the ADON was on leave on			
	u u u u u u u u u u u u u u u u u u u	as unclear who was providing			
	staff testing on night	shift.			
	2. Continued review	of the facility's COVID-19			
	testing records revea	aled the facility failed to			
		dents for COVID-19, and did esting until 07/28/2021, four			
		iff members tested positive.			
		vealed on 07/28/2021, resides on the fifth floor)			
	tested positive for CO	,			
	Record review revea	led the facility admitted			
		5/28/2021 with diagnoses of			
	Dementia, Alzheime	-			
		of the Minimum Data Set 2021, revealed the facility			
	· · ·	nt with a Brief Interview for			
		s) score of eight (8), which			
	indicated the residen	t was moderately cognitively			

Facility ID: 100599

If continuation sheet Page 378 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 880	Continued From pag impaired.	e 378	F 880			
	Review of the Nurse' revealed staff had to keep him/her in his/h resident became ups congestion was note Nurse's Notes revea #311 was doing well Interview with RN #9 revealed Resident #3 unit after testing post difficult to redirect an (b) Continued review testing records revea #314 (who resided in #311) tested positive Record review revea Resident #314 on 06 Dementia and Cereb Minimum Data Set (f revealed the facility a Brief Interview for Me ten (10), indicating th cognitively impaired. Review of Nurse's N revealed Resident #3 no cough or congest Nurse's notes dated Resident #314 was of with no cough or conf (c) Review of COVID Resident #329 tested	of the facility's COVID-19 aled on 07/28/2021, Resident to the same room as Resident for COVID-19. led the facility admitted //03/2021 with diagnoses of oral Infarction. Review of the MDS) dated 07/30/2021 assessed the resident with a ental Status (BIMS) score of the resident was moderately otes dated 07/29/2021, 314 had no complaints and ion noted. Further review of 08/10/2021, revealed but of isolation and doing well				

Facility ID: 100599

If continuation sheet Page 379 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PARKVIEV	V POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE		
			I	IKEVILLE, KY 41501		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		
F 880	Continued From pag	je 379	F 880			
	to Resident #311 an floor.	d #314's room on the fifth				
	Resident #329 on 05 Parkinson's Disease and Dementia. Revie (MDS) dated 05/14/2 assessed the reside of Mental Status (BII indicating the reside impaired. Review of Resident 1 08/07/2021 at 5:29 /2 developed at fever of to the emergency ro Continued review of 08/10/2021 at 9:01 F was readmitted to th hospitalization and to related to COVID-19 (d) Review of COVID Resident #82 also te on 08/02/2021. Res on the fifth floor, nex Record review revea Resident #82 on 05/ Parkinson Disease a Review of the Minim the facility assessed	reatment for Hypotension				
	(0), indicating the re- cognitively impaired. Review of Resident	-				

If continuation sheet Page 380 of 401

	-	AND HUMAN SERVICES		(FORM APPROVE DMB NO. 0938-039
STATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	V POST-ACUTE AND	REHABILITATION CENTER		IURSING HOME LANE	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
F 880	Continued From p	age 380	F 880		
	08/09/2021 at 12:: developed tachyp Resident #82 had 89-91% (95-100%	55 PM revealed the resident nea (rapid respirations). a low oxygen saturation rate of normal reference range. The sident to the emergency room			
	revealed the resid readmission to the	of Resident #82 clinical record ent did not return for e facility following discharge The resident was admitted to			
	at the local Health 10:40 AM, revealed facility approximate to newly diagnosed facility staff and re- not responsible to the facility for resid Control Coordinate responsible for co- inside the facility. staff was not contor residents and staff Infection Control C big problem that the tracing properly." Coordinator, the facility.	Infection Control Coordinator, Department on 08/09/2021 at ed she was in contact with the tely every other week in regards ad COVID-19 cases among esidents. She stated she was conduct contact tracing inside dents or staff. The Infection or stated the facility was nducting the contact tracing She stated she was not aware lucting contact tracing for f inside the facility. The Coordinator stated, "That is a ney're not conducting contact Per the Infection Control acility's failure to conduct residents and staff inside the to an outbreak of COVID-19 is and staff.			
	DON, on 08/11/20 thought the local h tracing in the facili	Infection Control/ADON/Interim 21 at 12:05 PM, revealed she nealth department did contact ity. She stated she was not was responsible to do their own			

Facility ID: 100599

If continuation sheet Page 381 of 401

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/08/2021 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN			(X3) DATE SURVEY COMPLETED	
- L		185256	B. WING _			09/	10/2021
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER			NURSING HOME LANE EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ľ.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	contact tracing within Infection Control Nur aware residents shor immediately for COV staff member testing no response as to wi four (4) days after st 2021. Interview with Admin 1:50 PM, revealed sl department did conta stated she was unaw responsible for comp tracing. 3. Observation of the 08/05/2021 at 10:54 (2) residents tested p 07/28/2021 and 08/0 isolate and segregat by the facility's policy all resident room doo were wandering the Further observation zones existed to sep Continued observation AM, revealed mainter barriers across the d both Resident #311 at However, this was effirst resident on the f COVID-19. Interview with Mainter 08/11/2021 at 11:30 plastic zip barriers across	a the facility. Per the rse/ADON/DON, she was uld have been tested 'ID-19 following the initial positive. However, she had ny testing was delayed for aff tested positive in July, istrator, on 08/10/2021 at ne thought the local health act tracing in the facility. She vare the facility was oleting their own contact e facility's fifth floor on AM, revealed although two positive for COVID-19 on 2/2021, the facility failed to e the residents as required v. The fire doors were open, ors were open, and residents halls of the unit at will. revealed no designated	F 8	80			

Facility ID: 100599

If continuation sheet Page 382 of 401

	-	ND HUMAN SERVICES			FORM APPROVED	
		MEDICAID SERVICES			OMB NO. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021	
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER	20	00 NURSING HOME LANE		
	POST-ACOTE AND N		P	IKEVILLE, KY 41501		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/	DATE	
				DEFICIENCY)		
F 880	Department to instat 08/05/2021, and that utilized the barriers. notify the Maintenar another room conver- place one of the play resident's doorway. Interview with SRNA PM, revealed she de training related to PI equipment) or COVI second wave of out The SRNA stated she floor caring for both negative residents s stated the floor had red for positive, yelle for negative resident Continued interview 08/09/2021 at 11:47 worked on the fifth finew residents becar were not isolated or stated they continue negative residents. for both COVID-19 p residents all at the s the floor was the "ur many of the residen wandered. She stat	ted the Maintenance II the barriers prior to at was the first day the facility MA #1 stated staff was to nee Department if a resident in arted to positive so they could stic zip barriers over the A #3, on 08/05/2021 at 12:30 enied having received any PE (personal protective ID-19 at the facility since the breaks began in late July. he routinely worked the fifth COVID -19 positive and simultaneously. SRNA #3 no designated zones such as ow for quarantined or green ts.	F 880			
	#1, on 08/05/2021 a	ied Medication Aide (CMA) It 11:45 AM, revealed staff fifth floor attempted to keep				

Facility ID: 100599

If continuation sheet Page 383 of 401

	-				FORM APPROVED
STATEMENT O	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING		
		185256	B. WING		09/10/2021
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	W POST-ACUTE AND F	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, KY 41501	
	SUMMARY	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(75)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 880	unable to do so, bed understand and war CMA stated mainter barriers over the do resident rooms, was knowledge the facili isolate residents sin COVID-19 infections Interview with RN # revealed COVID po zip covers on the do stated the only iden on the residents' do taped on the door s room. She stated th never been closed. residents on the ent COVID-19 and thos Interview with the In DON, on 08/11/202 facility had initially a positive residents in of residents who we wandering on the fif one area, were disc Control Nurse/ADO facility tried to keep on the floor. Howev Nurse/ADON/DON spread if positive re off unit (isolated). F Nurse/ADON/DON, redirect residents to unit if they were war wear a facemask if	their rooms, but they were cause the residents did not need to leave their rooms. The nance placing the plastic zip orways of COVID-19 positive a the first time to her ty had taken any action to ce the second wave of s began. 9, on 08/09/2021 at 10:55 PM, sitive rooms "now" had plastic porways, but not initially. She tifiers prior to the zip covers ors was a hand written paper aying if it was a red or yellow he fire doors on that hall had The RN stated she cared for ire unit, both positive for e who were not. fection Control/ADON/Interim 1 at 12:05 PM, revealed the their rooms. Observations, re positive for COVID th floor and not isolated in ussed with the Infection N/DON. She stated the positive residents in one area ver, the Infection Control stated the COVID virus could sidents were not in a closed ver the Infection Control she expected nursing staff to the closed off area on the ndering and to ask them to they were not wearing one.	F 880		
		they were not wearing one. ioned no further actions for			

Facility ID: 100599

If continuation sheet Page 384 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING	/	09/10/2021
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER) NURSING HOME LANE KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 880	Continued From pag	je 384	F 880		
	nursing staff to utilize effective.	e if redirection was not			
	08/09/2021 at 10:45 a red zone where CO resided, a yellow zor admits or residents w facility more than two stated when a reside both the resident and quarantined; a sign w identifying the room zip barrier curtain wa doorway of the room Nurse Consultant sta the 5th floor were de other rooms on the 5 zone. She stated she rooms were not desi	cility's Nurse Consultant, on AM, revealed the facility has OVID positive residents ne for non-vaccinated, new who had been out of the enty-four (24) hours. She ent was COVID-19 positive, d their roommate were was placed on the door as red zone; and, a plastic as immediately placed on the n to isolate the room. The ated the positive rooms on esignated as red zone and all 5th floor should be yellow e was not aware yellow zone ignated or staff had not e room barriers after the initial			
	Resident #42 was wa floor outside the roor	5/2021 at 6:02 PM revealed andering the hall on the fifth ms of residents who were The resident was not			
	biohazard cans in the floor containing large PPE, which had bee COVID positive resid was observed wande containers and staff COVID contaminated	e fifth (5th) floor on AM revealed large red e hallway on each end of the e amounts of contaminated en used by staff while in dents' rooms. Resident #325 ering the hall walking past the were observed doffing d PPE into the red biohazard ttside of the COVID positive			

Facility ID: 100599

If continuation sheet Page 385 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE DATE
F 880	Continued From pag	e 385	F 880		
	residents' rooms.				
		#19, on 08/05/2021 at 11:15 ere doffing contaminated			
	PPE from COVID-19	positive rooms in the red			
		e hallway. The SRNA stated staff were not doffing PPE			
	inside the resident's	room. She further stated			
		ns had cans inside the room led interview with SRNA #19,			
	on 08/05/2021 at 12:	25 PM, revealed she had not			
		ing on donning and doffing nce the outbreak began this			
	time. SRNA #19 sta	ted she did not routinely work			
		was pulled on 08/05/2021 to he SRNA stated she was a			
		worked with residents			
	throughout the buildi	ng.			
		#3, on 08/05/2021 at 12:30			
		d not received any training 9 since the outbreak began			
		staff doffed PPE in red			
	bio-hazard cans in th	ne hallway.			
	Continued interview				
		AM, revealed she worked on or residents who had the			
		those who did not have the			
		ated she had not received			
	u	PPE, handwashing, or er stated staff were doffing			
		d PPE in large red biohazard			
		way with no PPE receptacle			
	in the rooms. SRNA	#16 stated the only OVID positive resident rooms			
	were the small perso				
	Interview with Certifie	ed Medication Aide #1, on			

Facility ID: 100599

If continuation sheet Page 386 of 401

CENTER	<u>S FOR MEDICARI</u>	E & MEDICAID SERVICES		(DMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	DINSTRUCTION	(X3) DATE SURVEY COMPLETED
185256		B. WING		09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200 1	NURSING HOME LANE		
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER	PIKE	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 880	Continued From	page 386	F 880		
	received recent tr on PPE donning a began. She furthe whether to doff co outside of resider positive, or where	45 AM, revealed she had not raining on COVID-19 or training and doffing since this outbreak er stated she was unsure ontaminated PPE inside or ht rooms who were COVID to place contaminated PPE, so			
	hallway in the pro She stated the or	Iff had been placing it in the ovided red biohazard containers. aly containers in the COVID ere for soiled linens and small ceptacles.			
	revealed she had COVID-19 and ha donning and doffi containers with ba soiled linens and been doffing cont	I #1, on 08/05/2021 at 11:50 AM, not received training on ad not been re-trained on ng PPE. She stated there were ags in the COVID rooms for trash. RN #1 stated staff had caminated COVID PPE into the hallway. She further stated staff n the room.			
	10:55 PM, reveal training on donnin been inserviced s this time. She fun a large red bio-ha	ew with RN #9, on 08/09/2021 at ed she had not received any ng and doffing PPE, and had not since COVID-19 outbreak began rther stated the facility provided azard can in the hallway and that e for staff to doff COVID E.			
	08/09/2021 at 10: biohazard contair floor were not for PPE. The Nurse aware there were	a facility's Nurse Consultant, on 245 AM, revealed the red hers in the hallway on the fifth the disposal of contaminated Consultant stated she was not a no trash containers in the for staff to doff PPE. She stated			

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/08/2021 MAPPROVED). 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN			(X3) DATE	
		185256	B. WING			09/	10/2021
NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				NURSING HOME LANE			
(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 SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
s b li li li c s s s c v v s c v v s c v v s c v v s c v v s c v v s c v v s c v v s c v v s c v v s c v v s c v v s c v v s c v v s c v v s c v v s c v v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s c v s s c v s c v s c v s c v s c v s c v s c v s c v s s c v s c v s c v s c v s s c v s c v s s c v s s c v s s c v s s c v s s c v s s s s	biohazards containers interview with the Infe DON on 08/11/2021 a nad not received new education on PPE or putbreak began in the vere evaluated on do supervisory and visual competency. She sta vere doffing PPE in t biohazard containers. Noffing inside the resis- stated she had not be since the COVID-19 of interview revealed res- could touch contamin spread COVID-19. Interview with Admini- tics PM, revealed the competent in utilizing and trained using CD Control and Prevention the was unsure if any conducted with staff so putbreak began. Per also unaware staff we PPE in red biohazard where other residents stated there should b ooms to doff PPE. S no specific auditing o vas using to monitor observational monitor	the intended use of the red s in the hallway. action Control/ADON/Interim at 12:05 PM, revealed staff or recent training or COVID-19 since the a facility. She stated staff inning and doffing PPE by al observation of ted she was not aware staff he hallway in the red She stated staff should be dents' room. She further een up on the 5th floor much butbreak began. Continued sidents wandering in the hall ated PPE containers and strator, on 08/10/2021 at a facility ensured staff were PPE through observation C (Centers for Disease on) guidelines. She stated v retraining had been since this COVID-19 the Administrator, she was are doffing contaminated containers in the hallway is were wandering. She e containers in COVID he further stated there was r documentation the facility infection control other than	F 8	80			

If continuation sheet Page 388 of 401

CENTERS FOR MEDICARE & MED	JMAN SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
	185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABI	LITATION CENTER		00 NURSING HOME LANE NKEVILLE, KY 41501	
PREFIX (EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 880 Continued From page 388 tested positive for COVID- resided on the fifth floor or the unit from the other resi positive for COVID-19. Record review revealed th Resident #328 on 04/14/20 Transient Cerebral Ischem and Alzheimer Disease. Review of the Minimum Da 07/05/2021 revealed the fa resident to have a Brief Int Status (BIMS) score of zer resident was severely cogi Review of Resident #328 N 08/05/2021 at 8:15 AM rev stated to staff that he/she had a fever of 100.3 degre facility administered the re test. Resident #328 tested COVID-19. Further review revealed on 08/09/2021 at #328 stated to staff he/she ambulating in his/her room isolation. Continued review revealed on 08/07/2021 at #328 was awake and alert congestion noted. (b) Review of the facility's revealed on 08/07/2021, a (Resident #327) tested pos Resident #327's room was floor near Resident #82's r Re	 19. Resident #328 a the opposite end of dents who were e facility admitted 021 with diagnoses of ic Attack, Dementia ata Set (MDS) dated acility assessed the erview for Mental to (0), indicating the nitively impaired. Nurse's Notes dated realed the resident wasn't feeling well and tes Fahrenheit (F). The sident a COVID-19 d positive for of the Nurse's Notes 5:17 PM, Resident e was feeling better and the was feeling better and the of Nurse's Notes 7:52 AM, Resident with no cough or COVID-19 test records in additional resident sitive for COVID-19. clocated on the fifth to make the of the fifth the fifth the of the fifth the of the fifth the fifth the fifth the fifth the fifth t	F 880		

Facility ID: 100599

If continuation sheet Page 389 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
) NURSING HOME LANE (EVILLE, KY 41501		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 880	Continued From pag	e 389	F 880		
		nd Chronic Peptic Ulcers.			
	07/22/2021 revealed resident with a Brief I (BIMS) score of zero was severely cognitiv Review of Resident # 08/09/2021 at 5:19 P two (2) episodes of d notified and the resid increase oral fluid int Further review of the 08/14/2021 at 12:05 staff found Resident pressure, low heart r saturation. The physi Resident #327 was s via an ambulance for Review of Resident # 08/14/2021 revealed pressure of 75/44 (no rate of 46 (normal rai saturation of 80% (no five (5) liters of oxyge temperature was 100 98.6) prior to being s Review of Resident # summary reviewed th hospital on 08/15/202 diagnoses included S Pneumonia. Per the resident's Sepsis was	 #327's Nurse's Notes dated PM revealed the resident had diarrhea. The physician was dent was encouraged to take and was drinking well. Nurse's Notes revealed on AM during routine vital signs, #327 to have a low blood rate, and low oxygen ician was notified and sent to the emergency room r further evaluation. #327 vital signs dated the resident had a blood ormal range 120/80), heart nge 60-100), and oxygen ormal range 95-100%) on en. The resident's 0.1F (normal temperature sent to emergency room. #327 hospital discharge the resident expired at the 21. The resident's admission Sepsis and COVID-19 discharge summary, the s likely due to the COVID-19 sident's discharge diagnosis 			

Facility ID: 100599

If continuation sheet Page 390 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			200 NURSING HOME LANE PIKEVILLE, KY 41501		
()(())	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG		OULD BE COMPLETION
F 880	PM, revealed she wo all residents on the fl COVID positive and 3 She stated there was or green zone, only in as red zone rooms. Continued interview 9 08/09/2021 at 11:47 the fifth floor caring fc COVID-19 virus and virus. The SRNA sta wandered on the fifth redirected. However rooms and wandered Interview with RN #9 revealed the only ide on the resident doors taped on door saying room and the fire door been closed. The RN residents on the entit COVID-19 and those 6. Continued observa AM revealed Resident the fifth floor in a char resident was seated	#3, on 08/05/2021 at 12:30 orked the fifth floor caring for oor, both residents who were those who were negative. Is no designated yellow zone individual rooms designated with SRNA #16, on AM, revealed she worked on or residents who had the those who did not have the ated many residents in floor and had to be they did not stay in their d the hallways on the unit. , on 08/09/2021 at 10:55 PM, intifiers prior to the zip covers is was a hand written paper g if it was a red or yellow for son that hall had never I stated she cared for re unit, both positive for	F 88	80	
	plastic zip barrier to a resident was observe AM wandering the ha biohazard waste con doffing COVID conta Review of the facility	a doorway. In addition, the ed on 08/05/2021 at 10:54 all walking past the red tainers where staff were			

Facility ID: 100599

If continuation sheet Page 391 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 880	Continued From pag COVID-19 on 08/08/		F 880		
	Resident #325 on 09 Dementia, Polyostec Disorder. Review of dated 06/26/2021 ret the resident with a B Status (BIMS) score resident was modera An attempt to intervie 08/05/2021 at 11:05 Resident #325 was r conversation. Reside room to lie down. Review of the Nurse 2:45 PM, revealed R in condition and had	led the facility admitted /15/2017 with diagnoses of parthritis, and Psychotic Minimum Data Set (MDS) vealed the facility assessed rief Interview for Mental of ten (10), indicating the tely cognitively impaired. ew Resident #325 AM was unsuccessful. eluctant to engage in ent #325 went into his/her 's Note dated 08/09/2021 at esident #325 had a change a cough, congestion and 100.2 F. Further review			
	revealed the residen and required transfer evaluation. Review of the Nursin dated 08/12/2021 at #325 was readmitted hospital. Continued review of 08/19/2021 at 1:30 F developed a low oxy and the physician an were notified. The p	t was in respiratory distress t was in respiratory distress t to the emergency room for g Readmission Assessment 4:40 PM revealed Resident t to the facility from the the Nurse's Notes dated PM revealed Resident #325 gen saturation rate of 89% d resident's representative hysician ordered palliative atch (pain medication skin			
	"Do Not Resuscitate	dent's declined condition and ' (DNR) status. Per the note, esident's condition, palliative			

Facility ID: 100599

If continuation sheet Page 392 of 401

	-	AND HUMAN SERVICES			FORM APPROVED
		& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/2021
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/10/2021
				200 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND F	REHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 880	care, DNR status, a physician with the m resident's represent send Resident #325 physician and DON and an ambulance emergency room fo Review of the Hosp revealed Resident # 08/26/2021 and the Acute Hypoxic Resp COVID-19 Pneumo Continued interview 08/09/2021 at 11:47 on the fifth floor wor wandered the hallw stated Resident #32 covering on his/her out of the room. Continued interview 10:55 PM, revealed halls, and residents rooms and fire door positive residents to Interview with Phys Medical Director, or revealed he expector residents on the CO for decompensation COVID-19. He stat difficulties isolating dysfunction, lack of of wearing masks. H	ind new orders from the esident's representative. The tative requested the facility 5 back to the hospital. The were notified of the request transported the resident to the r evaluation. ital Discharge Summary #325 expired at the hospital on discharge diagnoses included piratory Failure secondary to	F 88		

Facility ID: 100599

If continuation sheet Page 393 of 401

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (PRINTED: 12/08/20 FORM APPROV <u>OMB NO. 0938-03</u> (X3) DATE SURVEY
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		185256	B. WING		09/10/2021
IAME OF PR	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE	
			200	NURSING HOME LANE	
PARKVIEV	V POST-ACUTE AND F	REHABILITATION CENTER	PI	KEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
-					
F 880	- 1,		F 880		
		ted to be isolated in an area			
		tive residents on the floor.			
		d he was not aware residents			
	to one area of the u	or COVID-19 were not isolated nit.			
		fection Control/ADON/Interim			
		1 at 12:05 PM, revealed staff w or recent training or			
		or COVID-19 since the			
		he facility. She stated staff			
		donning and doffing PPE by			
		ual observation of their			
		tated she was not aware staff			
	were doffing PPE in	the hallway in the red			
	biohazard container	s. She stated staff should be			
	doffing inside the re	sident's room. She further			
		been up on the 5th floor much			
		outbreak began. The ADON			
		o wandered in the hall could			
		PPE containers and spread			
		her stated she was aware			
		vere not on COVID-19 positive			
		til 08/05/2021. The Infection			
		I stated the facility had initially the positive residents in their			
		ns of residents, who were			
		wandering on the fifth floor			
		one area, were discussed with			
		I Nurse/ADON/DON. She			
		ed to keep COVID positive			
		a on the floor. However, the			
		irse/ADON/DON stated the			
	COVID virus could	spread if positive residents			
		off unit and she stated a			
	closed off area of th	e floor/unit could prevent the			
		9. Per the Infection Control			
		she expected nursing staff to			
	redirect residents to	the closed off area on the			

Facility ID: 100599

If continuation sheet Page 394 of 401

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/20: FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		09/10/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE
F 880	wear a facemask However, she me nursing staff to ut effective. Interview with the 1:50 PM, revealed competent in utiliz and trained using	bage 394 vandering and to ask them to if they were not wearing one. Intioned no further actions for ilize if redirection was not Administrator, on 08/10/2021 at d the facility ensured staff were zing PPE through observation CDC guidelines. She stated i any retraining had been	F 88	0	
	outbreak began. A residents were cu COVID-19, she re (4) residents hosp (2) of those reside She stated COVII on one end of the the Infection Cont responsible for m control practices of	aff since this COVID-19 When asked how many irrently hospitalized with esponded there were initially four bitalized with COVID-19, but two ents were back in the facility. D positive residents were kept e 5th floor in the red zone and trol/ADON/ Interim DON was onitoring to ensure infection were in place. The Administrator naware that all COVID 19			
	positive residents floor. Per the Ad unaware staff wer red biohazard cor other residents we there should be c doff PPE. She fur auditing or docum monitor infection monitoring. 7. Review of Resi	were not on one end of the 5th ministrator, she was also re doffing contaminated PPE in ntainers in the hallway where ere wandering. She stated ontainers in COVID rooms to ther stated there was no specific mentation the facility was using to control other than observation			
	diagnoses, which Hypertension. Ac Minimum Data Se	ne resident on 07/23/2020 with included Dementia and ccording to his/her Annual et Assessment (MDS) dated aled the resident was not			

Facility ID: 100599

If continuation sheet Page 395 of 401

	-	I AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
185256		B. WING	<u> </u>	09/10/202 <u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CON (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLETIC
F 880	Continued From p	page 395	F 880		
	Status (BIMS) sco assessment, the r	had a Brief Interview for Mental ore of four (4). Per the MDS resident required assistance of with transfers and toileting.			
	revealed on 07/27 was noted to requine normal, had whee had a non-product record revealed the change in his/her test the resident of nebulizer treatment days; obtain his/her hours for three (3) to his/her room for signs were noted temperature, hear	of Resident #317's record 7/2021 at 9:35 AM, the resident uire more assistance than ezes in his/her lung fields and tive cough. Review of his/her ne physician was notified of the condition and directed staff to laily for COVID-19; administer nts twice a day for seven (7) er vital signs every four (4)) days; and, isolate the resident r "now". Resident #317's vital to be 97.7 F (normal 98.6 F) rt rate was 86 (normal range ons were 20 (normal 12-20) and			
	120/80). Observations con 5th floor, at 11:25 resident was amb by other residents	as 150/77 (normal range ducted on 07/27/2021 on the AM and 3:50 PM revealed the ulating in the hallway, passing s with no mask in use or noted			
	staff were not obs mask and no staff isolate him/her to physician. Further 07/28/2021 at 11:: was ambulating a	Staff were close by; however, erved to offer Resident #317 a were observed to attempt to his/her room as ordered by the observations conducted on 20 AM revealed Resident #317 round the nurse's station,			
	person. Staff was offer/encourage h attempts to isolate	taff, with no mask on his/her s not observed to im/her to wear a mask and no e him/her to his/her room for potential COVID-19 infection			

Facility ID: 100599

If continuation sheet Page 396 of 401

CENTER	S FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-03	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		B. WING	09/10/202 <u>1</u>			
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE			
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		PIKEVILLE, KY 41501				
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL / OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC	
F 880	Continued From	page 396	F 880			
	-	bservations of Resident #317's				
	-)21 and 07/28/2021 revealed no				
		n placed on his/her door to				
		hould have been isolated due to				
	a potential COVI					
	Interview with Re	gistered Nurse (RN) #1, on				
		50 AM, revealed she contacted				
		ohysician on 07/27/2021 at 9:35				
		sident's change in condition and				
		D-19 infection. According to the				
	RN, the physician					
		ments for the resident, COVID				
	•	ed he/she be isolated to his/her				
		ated she tested him/her and				
	-	tive. However, she				
		e failed to place signage on				
		failed to take actions in				
		e him/her to his/her room as				
		ysician, but stated she should				
		stated she had not provided the				
		ask, because she did not think				
		ar it. RN #1 stated she informed				
		Physician's Orders to isolate the				
		ADON just stated, "OK". She				
		never directed any further				
	•	esidents to occur, and she gave				
		actions to take to protect the				
	other residents.					
	Interview with Ph	ysician #1, on 08/04/2021 at				
		ed he was Resident #317's				
		s notified of the resident's				
		on. Physician #1 had given				
	-	test and isolate the resident for				
	a potential COVI	D-19 infection. He stated he was				
		s difficulty in isolating residents,				
		with dementia. However, he				
		ed staff to isolate sick residents				

Facility ID: 100599

If continuation sheet Page 397 of 401

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03						
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE		(X3) DATE SURVEY COMPLETED 09/10/202 <u>1</u>							
									PI	KEVILLE, KY 41501	
						(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIC
						F 880	Continued From	page 397	F 880		
	away from the otl	her residents to decrease the									
		virus spreading in the facility and									
	should follow the	ir policy.									
	9 Observations	conducted in the dietary									
		3/05/2021 at approximately 4:00									
		tary Aide (DA) #1 was observed									
		tray cart from the 5th floor									
		positive residents resided.									
		ons revealed no one									
	cleaned/sanitized	I the cart before the cart was									
	taken from the 5t	h floor, onto the elevator and									
		en soiled dish area, where other									
	-	bserved. Continued									
		ealed the DA utilized a surgical									
		o other PPE in use while cleaning									
		ad been on the COVID-19 Unit in rvations also indicated the DA									
		er" to clean/sanitize the carts.									
	Interview with DA	√#1, on 08/05/2021 at 4:15 PM,									
		informed that facility residents									
	had tested positiv	e for COVID-19 on the fifth									
		ne had not been directed to do									
		t when carts were retrieved from									
		it in the facility. He stated he									
	•	e "Silver Power" degreaser to									
		rts in the facility, and had not change any dietary processes.									
	been directed to	change any dietary processes.									
	Review of the Sa	fety Data Sheet for Silver Power									
		ent was utilized as a "presoak"									
	-	w of the sheet provided no									
		n effective disinfectant for the									
	COVID-19 virus.										
	Interview with the	e Registered Dietician (RD), on									
) AM, revealed she would have									
		staff to sanitize the food carts,									

Facility ID: 100599

If continuation sheet Page 398 of 401

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		(X2) MULTIPLE CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 09/10/2021	
		A. BUILDING			
		B. WING			
		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE			
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC
F 880	Continued From	page 398	F 880		
	-	agent for COVID-19 before the			
	carts were brought back into the kitchen to				
	prevent the potential spread of COVID-19. She				
		ot conducted training with staff			
		-19 infection control processes a directed to do so.			
	Interview with the	-			
		erim DON, on 08/18/2021 at 9:50			
		e was not aware dietary staff had od carts with an effective agent			
		fore they were brought back in			
		being on the COVID-19.			
		ted she would have expected			
		he acknowledged reeducation			
	· ·	e conducted in the facility, when virus were identified for			
		outlined in the facility's policy.			
		ited she had not conducted			
	facility wide traini	ng because she had been			
	working the floor				
F 925 SS=E		ve Pest Control Program (4)	F 925		
		ntain an effective pest control			
	program so that t rodents.	he facility is free of pests and			
		ENT is not met as evidenced			
	by:				
		vation, interview, and a review of			
		y for pest control, it was			
		cility failed to have an effective ram to ensure the facility was			
		its were observed during the			
		2021 and 06/16/2021 in resident			

If continuation sheet Page 399 of 401

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		09/10/2021
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501		
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 925	Continued From pag	e 399	F 925		
	"Pest Control" with a revealed the facility s pest control program was kept free of pest revealed pest contro an outside company services assisted in p services. Observation during that 2:24 PM revealed resident room 414. Observation of the for 06/16/2021 at 9:18 A resident room 406. Observation of room PM revealed a gnat of Resident #92, who w Observation on 06/10 a gnat was observed #74, who was eating Observation of Resid 08/05/2021 at 2:08 F around the resident's An interview with Regist	M revealed a gnat near 414 on 06/16/2021 at 1:06 observed in the room of ras eating lunch. 6/2021 at 1:07 PM, revealed in room 416 near Resident lunch. ent #339's room, on M, revealed gnats and flies bed and the over bed table. empted with Resident #339; it declined. ered Nurse (RN) #8, on M, revealed Resident #339's			
	A group interview co	nducted on 06/16/2021 at			

Facility ID: 100599

If continuation sheet Page 400 of 401

		ND HUMAN SERVICES			FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		185256	B. WING	- ETN/	09/10/202 <u>1</u>	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			BTREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		PIKEVILLE, KY 41501		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 925	who resided on the t revealed the residen facility had a problem Interview with the Ma 06/19/2021 at 10:22 the facility monthly for the Invoices revealed facility for gnats on C 04/30/2021. Further Maintenance Director gnats he would try to treating the drains. J Director, if the gnats "real bad" he would control the gnats. Fo Maintenance Director was ineffective, gnat or wounds and caus Interview with Admin PM, revealed she ha facility the first of Jun had a discussion wit to gnats and a poten building/facility. The	5) alert and oriented residents hird, fourth, and fifth floors ts had complained that the n with gnats. aintenance Director, on AM, revealed the lab treated or pest control. Review of d the lab had treated the 16/17/2021, 05/27/2021, and interview with the or revealed if he observed o get rid of the gnats by According to the Maintenance is were in a resident's room place traps in the room to urther interview with the or revealed if the pest control is could get on residents' food	F 925			

Facility ID: 100599

If continuation sheet Page 401 of 401