STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	R-C 01/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance on 01/19/2022, as alleged.	{F 000}		

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

Electronically Signed | 02/08/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY00032822, KY00032923, KY00033536, KY00033596, KY00033707, KY00034170, KY00034610, and a COVID-19 Focused Infection Control Survey was conducted 11/30/2021 through 12/08/2021. There was no deficient practice identified at 42 CFR 483.80 Infection Control regulations and the facility had implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 160. KY00032822 was substantiated with related and unrelated deficiencies cited. KY00032923, KY00033536, KY00033596, KY00033707, KY00034170, KY00034610 were unsubstantiated.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		1/19/22

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

Electronically Signed | 01/14/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 656	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, and facility policy; it was determined the facility failed to implement fall interventions for Resident #5 in a sample size of (7) seven residents. Resident #5's fall mat was observed rolled up and tucked beside the closet away for the right side of residents bed, with Resident #5 occupying the bed at the time. The findings include: Review of facility policy, Resident Assessment Instrument & Care Plan, with review date of 05/10/2021, revealed; The facility should develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. The care plan should describe the following: the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being as required under 483.24, 483.25 or 483.40. The care plan includes measure objectives, timeframes to meet the patient's cultural, nursing, mental, and psychosocial needs including services being provided to meet those needs. Observation on 11/30/2021 at 3:40 PM and 4:30 PM, revealed one of the two fall mats for Resident #5 rolled up against the wall closet at foot of residents bed; and not on the right side of the resident's bed while bed was occupied by Resident #5.	F 656	1. On 11/30/2021, the DON placed bilateral fall mats to bedside of resident #5. 2. On 11/30/2021, the DON/ADON completed facility rounding to ensure all fall interventions were in place as per Care Plan. No further concerns were identified. 3. (a) Beginning on 1/11/2022 and completed on 1/14/2022, the Staff Development Coordinator provided education to nurses and certified nursing assistants on following the facility policy for Comprehensive Care Plans for fall interventions. The facility does not currently utilize agency or medication aides. (b) Beginning on 1/15/2022, all newly hired Nurses, Nursing Assistants, medication aides and agency nursing staff will receive training on comprehensive care plans and fall interventions prior to assignment to a units. (c) Beginning on January 17, 2022, Monday- Friday x 2 weeks, then weekly x 2, the Nursing Unit managers will complete rounding audits to ensure Care Planned fall interventions are in place. 4. Monthly, beginning in January 2022 x 2 months, the QAPI committee will review the audits to ensure compliance. If at any time non-compliance is identified the IDT may extend audits until compliance is achieved. The QAPI meeting consists of the ED, DON, ADON,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 656	Continued From page 3 Record review revealed the facility admitted Resident #5 on 03/09/2020 with the following diagnoses: Alzheimers Disease with Late Onset, Delusional Disorders, Difficulty in Walking and History of Falling. Quarterly Minimum Data Set (MDS), dated 09/28/2021, revealed the resident was assessed as requiring extensive assistance with activities of daily living (ADLs), and no fall history notated Review of Brief Interview Mental Status (BIMS) dated 11/29/2021 revealed Resident #5 had been assessed as having a BIMS of eight (08) signifying moderate cognitive impairment. Review of a Fall Investigation, dated 07/25/2020, revealed Resident #5 was found lying beside the bed, in the floor. Immediate interventions placed included floor mat to bedside for safety. Review of the fall care plan for Resident #5, dated 12/22/2021, revealed the interventions to included bilateral fall mat at bedside for safety. Interview with Licensed Practical Nurse (LPN) #1, on 11/30/2021 at 4:30 PM, revealed fall mat should have been in place and was for safety of the resident. Interview with MDS Nurse #1, on 12/07/2021 at 12:12 PM revealed residents care plans should be followed at all times by staff, and the purpose of the care plan is to provide individualized personalized care for the betterment of the resident. Additionally, MDS Nurse #1, revealed the outcome of not following the care plan, would be that it can cause harm to the resident. Interview with Director of Nursing (DON), on	F 656	MD, Pharmacy, Social Services Director, Dietary Manager, and Activities Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 656	Continued From page 4 12/08/2021 at 3:41 PM, revealed the purpose of fall mats was to prevent injuries if a resident falls out of bed, for safety, and is an intervention so the resident will not get injured if they fall.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure the resident's environment remained as free from accidents hazards as possible for two (2) of seven (7) sampled residents, Resident #5 and Resident #7. Observation revealed two (2) oxygen canisters present in Resident #7's room, not in use, leaning	F 689	1. On 11/30/2021, the DON removed two oxygen canisters from the room of resident # 7. On 11/30/2021, the DON ensured bilateral fall mats at the bedside of resident # 5. 2. On 11/30/2021, the Nursing unit managers completed facility rounding to ensure proper oxygen storage and all fall interventions were in place to prevent	1/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 689	Continued From page 5 against the wall, with one (1) canister not in a carrier. In addition, Resident #5 was observed lying on his/her bed with his/her fall mat not lying on the floor beside the bed as required. The fall mat was observed to be rolled up and tucked beside the closet not near the resident's bed. The findings include: Review of the facility's policy titled, "Event Management System Policy", with a review date of 05/05/2020 revealed it's purpose was to provide an environment that as free from accident hazards, over which the facility had control. Per interview, the facility was to provide the supervision and assistive devices that each resident required to prevent avoidable accidents. Continued review revealed the facility was to: identify potential hazard(s) and risk(s); evaluate and analyze the hazard(s) and risk(s); implement interventions to reduce the hazard(s) and risk(s); and monitor the interventions for effectiveness and modify the interventions as necessary. Review revealed all "patients" were to receive the supervision and assistance they required as per their care plan to help reduce the risk of an event (incident). Further review revealed if an event occurred the facility would assess, report, investigate, and determine the root cause of the event in an effort to minimize the potential for recurrence. In addition, the policy had been designed to assist the facility in identifying and reducing events for resident which included: falls, unwitnessed or witnessed; medication discrepancies; and wandering or other behaviors. 1. Review of the facility's policy titled, "Compressed Oxygen Cylinders", revised 08/26/2021, revealed the policy addressed	F 689	accidents. No further concerns were identified. 3. (a) Beginning on 1/11/2022 and completed on 1/14/2022, the Staff Development Coordinator educated all staff on Accident Management and proper oxygen storage to prevent accidents. (b) Beginning on 1/11/2022 and completed on 1/14/2022, the Staff Development Coordinator educated nurses and certified nursing assistants on the Accident/Incident policy including fall interventions. The facility does not currently utilize agency staff or medication techs. c) Beginning on 1/15/2022 all new hires to include all agency nurses and medication techs will be educated on their hire date concerning the Accident Policy which includes the proper storage of oxygen before assignment to a unit. (d) Beginning on January 17, 2022, Monday-Friday x 2 weeks, then weekly x 2, the Nursing Unit Managers will complete facility wide audit rounding to ensure proper Oxygen storage to prevent accidents. (e) Beginning on January 17, 2022, Monday-Friday x 2 weeks, then weekly x 2, the Nursing Unit Managers will complete facility wide audit rounding to ensure fall interventions are in place as Care planned to prevent accidents. 4. Monthly, beginning in January 2022 x 2 months, the QAPI committee will review the audit results to ensure compliance. If at any time non-compliance is identified, the IDT may extend audits until compliance is achieved. The QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 689	Continued From page 6 ensuring the safety of residents, associates, and visitors through the safe handling of compressed oxygen cylinders. Per review, portable oxygen cylinders were to be attached to an oxygen stand designed to hold the cylinders or a therapy apparatus when the oxygen was in use. Continued review revealed the medical gas (oxygen) cylinders were to be stored in a manner which protected the cylinders from mechanical shock that could damage the cylinder or valve. Review revealed the oxygen cylinders were also to be protected from tampering by any unauthorized individuals. Review of the facility's list of residents who wandered dated 12/08/2021 at 10:50 AM, provided by the Executive Director revealed the facility had identified (8) eight resident wanderers. Per review, the residents who wandered were located on the 100, 300, 500, 600, and 900 halls of the facility. Record review revealed the facility admitted Resident #7 on 09/16/2021, with the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD); Dependence on Supplemental Oxygen; Unspecified Dementia without Behavioral Disturbance; History of Falling; and Heart Failure. Review of Resident #7's Admission Minimum Data Set (MDS) Assessment dated 09/23/2021, revealed the facility had assessed the resident as cognitively intact. Continued review of the MDS Assessment revealed the facility had also assessed Resident #7 to have care needs related to his/her Dementia, Depression, COPD, Vision (due to diagnoses of Macular Degeneration, Glaucoma and Cataracts) and Oxygen therapy. Further interview revealed Resident #7 had additionally	F 689	meeting consists of the ED, DON, ADON, MD, Pharmacy, Social Services Director, Dietary Manager, and Activities Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 689	Continued From page 7 been assessed to require extensive assistance with his/her Activities of Daily Living (ADLs). Observation on 11/30/2021 at 9:20 AM, in Resident #7's room, revealed two (2) oxygen (O2) canisters lying against the wall of the room, with O2 Canister #1 located in an oxygen carrier which had been leaned against the wall, and O2 Canister #2 situated in a plastic sling lying against the corner of the wall near the adjoining wall closet. Interview on 11/30/2021 at 9:20 AM, with Resident #7, revealed the O2 canisters located in his/her room had probably been there for about a week. Interview on 11/30/2021 at 9:25 AM and 9:55 AM, with Licensed Practical Nurse (LPN) #2, revealed O2 canisters should not be stored on the floor, without being in a carrier or a rack. Per interview, the O2 canisters should not be stored in a resident's room. LPN #2 further stated that the O2 canister(s) should not be stored on the floor due to the danger of an explosion if turned over or fell over. In addition, LPN #2 revealed the O2 canisters should be stored on an oxygen transport carrier to decrease the risk of dropping them or having them fall over. Interview with the Nurse Practitioner (NP), on 12/08/2021 at 2:50 PM, revealed O2 canisters should not be located in resident's room unless the O2 was in use. Per interview, if O2 canisters were left in a resident's room all the time they could get knocked over. Further interview revealed if O2 canisters were in a sling and the attached straps of the sling were lying on the floor, there was the potential it could be a tripping	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 689	Continued From page 8 hazard for a resident or staff. Interview on 12/08/2021 at 3:41 PM, with the Director of Nursing (DON), revealed 02 canisters were brought to residents' rooms for placement to use when in their wheelchairs. Per interview, the O2 canisters were to be removed from a resident's room if empty, or not in use. The DON further stated if the O2 canisters were not attached to a carrier on the wheelchair there could be a negative outcome if the canister got knocked over as it was a compressed air cylinder. 2. Review of the facility's policy titled, "Fall Management", with review date of 08/02/2021, revealed it's purpose was for promoting "patient" safety, and to reduce falls for "patients" by proactively identifying, care planning, and monitoring of "patients" fall indicators. Per review, the facility was to assess the "patient", reassess with any fall event for fall risks; and identify appropriate interventions to minimize the risk of injury related to falls. Further review revealed the facility's definition of adequate supervision referred to an intervention and means of mitigating the risk of an accident for a "patient". In addition, the policy noted facilities were obligated to provide adequate supervision to prevent accidents. Review of the facility's policy titled, "Resident Assessment Instrument & Care Plan", with a review date of 05/10/2021, revealed the facility was to develop and implement a comprehensive person-centered care plan for each of its residents, which was consistent with the residents rights. Per review, the care plan should include measurable objectives and time frames to meet a	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 689	Continued From page 9 resident's medical, nursing, mental and psychosocial needs as identified in the comprehensive assessment. Continued review revealed the care plan was to contain the services to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being. Record review revealed the facility admitted Resident #5 on 03/09/2020, with the following diagnoses: Alzheimer's Disease with Late Onset; Delusional Disorders; Difficulty in Walking; and History of Falling. Review of Resident #5's Quarterly MDS Assessment dated 09/28/2021, revealed the facility had assessed the resident to have a BIMS score of eight (8) indicating moderate cognitive impairment. Further review of the MDS Assessment revealed as requiring extensive assistance with all ADL's. In addition, review of the MDS Assessment revealed no documented evidence of the resident's fall history had been noted. Review of the facility's 07/25/2020 Fall Investigation documentation revealed staff had found Resident #5 lying on the floor beside his/her bed. Further review revealed the immediate interventions the facility implemented was the placement of floor mats to Resident #5's bedside for safety. Review of Resident #5's Comprehensive Care Plan revealed the facility had care planned the resident for falls. Per review of the falls care plan, which had a target date of 12/22/2021, revealed the following intervention had been initiated on 07/25/2020: bilateral fall mats at the resident's bedside for safety.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 689	Continued From page 10 Observation on 11/30/2021 at 3:40 PM and 4:30 PM, revealed Resident #5 lying on his/her bed, with a fall mat located on the left side of the bed. Continued observation revealed one (1) of Resident #5's two (2) fall mats was lying rolled up against the wall closet at the foot of the resident's bed, and not located on the right side of his/her bed as required. Interview on 11/30/2021 at 4:30 PM, with Licensed Practical Nurse (LPN) #1, revealed both of Resident #5's fall mats, which were for his/her safety, should have been in place to his/her bedside as required. Interview with the Nurse Practitioner (NP), on 12/08/2021 at 2:50 PM, revealed the purpose of fall interventions for a resident was to decrease the chance of falls. Per interview, the NP stated having padding (floor mats) beside a resident's bed was for his/her safety, and mainly was to decrease the potential of injury related to a fall. The NP further stated injury could be the outcome if a resident's fall interventions were not in place as required. Interview on 12/08/2021 at 3:41 PM, with the Director of Nursing (DON), revealed a resident's fall mats were for his/her safety, and was an intervention placed to prevent injuries if a resident was to fall out of his/her bed.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		1/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 761	Continued From page 11 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and facility policy, it was determined the facility failed to ensure all drugs and biological's were stored in locked compartments for one resident (Resident #2) in a samples size of seven (7) residents. Staff placed Resident #2's medication on top of medication cart and walked away leaving two medications on top of the cart unsecured. Additionally, staff left Resident #2's	F 761	1. On 12/1/2021, the DON educated RN #1 on storage of medications. 2. On 12/1/2021, the Unit Managers completed facility rounding with no unsecured medications were identified in patient rooms. 3. (a) Beginning on 1/11/2022 and completed on 1/14/2022 , the Staff Development Coordinator provided	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 761	Continued From page 12 medication on sink, in residents room, and walked out of the room leaving the medication unsupervised and unsecured. The findings include: Review of facility policy, General Dose Preparation and Medication Administration, with revision date of 01/01/2013 revealed; Staff should take all measures by facility policy and applicable law to include: observe the resident's consumption of the medication(s). Review of facility policy, Administration of Medications, revised 07/14/202 revealed; all medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. Medication administration is the responsibility of those individuals who through certification and licensure are authorized in their state to administer medications in a skilled nursing facility. Letterhead facility documentation, provided by Executive Director on 12/08/2021, revealed facility did not have an accident policy on medication storage. However, facility did have the Event Management System policy. Review of facility policy, Event Management System Policy, with review date of 05/05/202 revealed; Purpose is to provide an environment that is free from accident hazards, over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents, that includes: identifying hazard(s) and risk(s), evaluating and analyzing hazard(s) and risk(s), implementing interventions to reduce hazard(s) and risk(s), and monitoring	F 761	education to all nurses on the following polices: • Event Management • Administration of Medication (b) Beginning on January 10, 2022 and completed by January 18, 2022 the ADON, SDC and Unit Managers completed a Med Pass Competency for all nurses. The facility currently does not utilize agency nurses or medication techs. (c) Beginning on January 19 2022, the ADON, SDC or Unit Managers will educate all newly hired nurses including agency nurses and medication techs on the Policies of Event Management and Administration of Medication prior to assignment to the floor. (d) Beginning on January 19, 2022, the ADON, SDC or Unit Managers will complete a Med Pass Competency on all newly hired nurses including agency nurses and medication techs prior to an assignment to a unit. (e) Beginning on January 17, 2022 Monday-Friday x 2 weeks, the SDC, ADON or Unit Managers will monitor 5 nurses during med pass to ensure proper administration of meds. These audits will include agency nurses and medication techs if utilized. Audits will then be reduced to 5 nurses monthly x 2 months. The facility does not utilize medication techs or agency nurses at this time. 4. Monthly, beginning in January 2022, x 2 months the QAPI committee will review the med pass audits. If any time non-compliance is identified the IDT may	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 761	Continued From page 13 for effectiveness and modifying interventions when necessary. Review of provided Executive Director's list of wanderers, dated 12/08/2021 at 10:50 AM, revealed (8) eight wanderers in the facility. Wanderers consisted of residents from unit's 100, 300, 500, 600, and 900. Record review revealed facility last admitted Resident #2 on 04/12/20219 with the following diagnoses: unspecified Dementia Without Behavioral Disturbance, Post-Traumatic-Disorder, Anxiety Disorder, and Major Depressive Disorder. Quarterly MDS, dated 09/30/2021, revealed Resident #2 had been assessed as requiring limited assistance for activities of daily living (ADLs) and assessed as having a Brief Interview Mental Status of (15) fifteen. However, Resident # 2 was assessed as having Dementia, but had not bee assessed as being able to self-administer medications. Review of Resident #2's Physician Order Summary Report, dated 11/30/2021, revealed Biotene Dry Mouth Liquid (Mouthwashes) give one application by mouth two (2) times a day for dry mouth with start date of 12/30/2019 and no end date notated. Additionally, order for Fluticasone Propionate Suspension 50 mcg/ACT (2) two sprays in each nostril as needed for allergies daily. with start date of 04/19/2021 and no end date notated. Review of Electronic Mediation Administration Record (EMAR), dated 11/01/2021-11/30/2021 and 12/01/2021-31/2021, revealed Biotene Dry Mouth Liquid (Mouthwashes), give (1) one application by mouth two times a day for dry	F 761	extend audits. The QAPI meeting consists of the ED, DON, ADON, MD, Pharmacy, Social Services Director, Dietary Manager, and Activities Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 761	Continued From page 14	F 761		

mouth, with order date 12/30/2019; and Fluticasone Propionate Suspension fifty (50) micrograms (mcg)/ACT (2) two sprays in each nostril as needed for allergies daily, with order date of 04/19/2021.

Review of Resident #2's care plan, target date of 12/22/2021, revealed; resident had impaired visual function relate to right eye blindness with history of retinal detachment and limited vision in his/her left eye. Additionally, care plans for: ADL self care performance deficit related to visual impairment, revealed: Administer dry mouth liquid as ordered for dry mouth, notify MD as needed (PRN) if ineffective. The resident has oral/dental health problems related to dry mouth with the following intervention: Administer Dry mouth Liquid mouthwash as ordered and observe for effects.

Observation on 12/01/2021 at 9:20 AM, revealed Registered Nurse (RN) #1 placing medication cup of Biotene Dry Mouth Liquid (Mouthwash--not intended to be swallowed, but to be swished for (30) seconds then spit out), and Fluticasone Propionate Suspension nose spray(a steroid to be used intranasal route only with maximum total daily dose to not exceed 2 sprays in each nostril) on top of the medication cart and walking off from the medication cart.

Observation on 12/01/2021 at 9:28 AM, revealed RN #1 entering double occupancy room and placing Resident #2's medication cup of Biotene Dry Mouth Liquid (Mouthwash) on sink and informing Resident #2 of this. After providing Resident #2 with his/her other medications, RN #2 left the room. Medication cup of Biotene Dry Mouth Liquid (Mouthwashes) was left on sink in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 761	Continued From page 15 the double occupancy room. Interview with RN #1, on 12/02/2021 at 10:36 AM, revealed Biotene Dry Mouth Liquid (Mouthwashes) was left on the sink and the resident does not take it right then during medication administration nor will he/she come ask for it. RN #1 stated she leaves it on the sink and resident takes it himself/herself and was told they say supposed to. RN #1 further stated, Resident #2 was pretty with it and does everything on his/her own. Interview with Director of Nursing (DON), on 12/08/2021 at 3:41 PM, revealed; Resident #2 was not authorized to self administer medication, and Biotene Dry Mouth Liquid (Mouthwashes) or any medication should not be left in room,and the outcome could be negative too much or too little medication(s). Additionally, DON stated that medications were to be placed in medications carts and locked if staff walk away from the carts, because a different resident could take the medications. DON stated the facility does have wanderers. Interview with Nurse Practitioner (NP) #1, on 12/08/2021 at 2:50 PM, revealed; that it was not preferable leave Biotene Dry Mouth Liquid (Mouthwashes) in resident's room because residents may stash it, not take it or take multiple doses at once. NP#1 further stated she did not see any standing orders for Resident #2 to self administer medication and documentation would be charted if a resident is to self administer medication. Additionally, NP #1 revealed medication should not be left on a medication care because someone could grab the medication and take it, a confused resident could	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 761	Continued From page 16 grab and take it.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		1/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 842	Continued From page 17 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy, the facility failed to ensure	F 842	F842 Resident Records –Identifiable information	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 842	Continued From page 18 resident information was kept confidential in one (1) residents record (Resident #3) in a sample size of seven (7) residents. Registered Nurse (RN) #1 walked away from medication cart in hallway leaving Resident #3's electronic medication (EMAR) record screen open and unlocked, allowing view of Resident #3's electronic chart. The findings include; Review of facility policy, Disclosure of Protected Health Information (PHI) Release of Information, reviewed date of 03/18/2021 revealed; The facility maintains the confidentiality of the residents medical information contained in the residents record, regardless of the form or storage method of the records. The resident is assured confidential treatment of his or her medical records. Review of facility policy, Notice of Privacy Practices, reviewed date of 03/18/2021 revealed, Facility Responsibilities: Facility is required to maintain the privacy of resident health record. Record review revealed facility admitted Resident #3 on 03/17/2021 with the following diagnoses: Traumatic Subarachnoid Hemorrhage with Loss of Consciousness of 30 Minutes or less Sequela, Cognitive Communications Deficit, Muscle Weakness, and Need for Assistance with Personal Care. Review of Annual MDS dated 10/26/2021 revealed resident was assessed as requiring extensive assistance with activities of Daily living(ADLs), a Brief Interview Mental Status (BIMS) of eleven (11)-signifying moderate cognitive impairment, and impaired vision.	F 842	1. On 12/1/2021 the DON educated RN # 1 on the need to maintain privacy of records during med passes. 2. On 12/1/2021, the DON, ADON and Nursing Unit Managers rounded the facility to ensure privacy of records were maintained. No issues were identified. 3. (a) Beginning on 1/11/2022 and completed on 1/14/2022, the SDC and Nursing Unit Managers educated all staff on the following policy: • Disclosure of Health Protected Information • Computer screens should be locked when staff not present. (b) Beginning on 1/15/2022 the Staff Development Coordinator, and Nursing Unit Managers will educate all new hires to include agency nurses and medication techs on the policy of Disclosure of Health Protected Information and Computer screens locked when staff are not present. (c) Beginning on January 17, 2022, Monday-Friday, x 2 weeks then weekly x 2 weeks, the SDC, ADON and Nursing Unit Managers will complete rounding audits to ensure privacy of medical records during med pass and throughout daily activities. 4. Monthly, beginning in January 2022 x 2 months the QAPI committee will review the med pass audits. If any time non-compliance is identified the IDT may extend audits. The QAPI meeting consists of the ED, DON, ADON, MD, Pharmacy, Social Services Director, Dietary Manager, and Activities Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK ROAD PADUCAH, KY 42003

(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)	(X5) COMPLETION DATE
F 842	Continued From page 19 Observation, on 12/01/2021 at 9:00 AM, revealed Registered Nurse (RN) #1 walking off from medication cart during medication pass with screen of Resident #3 EMAR's information on the screen and visible to individuals passing by in the hallway. Interview with Registered Nurse (RN) #1, on 12/02/2021 at 10:36 AM, revealed when staff walks off they should lock the screen and lock the cart of course. Additionally, she further stated one should always lock the screen, but she was nervous and failed to do so. Interview with Director of Nursing (DON). on 12/08/2021 at 3:41 PM, revealed the screen should be locked or shut off because that is information on the resident, and the outcome would be a HIPPA violation.	F 842		