					FORM APPROVED
CENTERS F	FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		185256	B. WING		12/16/2021
NAME OF PROV	/IDER 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 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 000} IN	VITIAL COMMENTS	3	{F 000}		
in inii 12 su Je Cl ar ar As (F id At Je Tr (I. OI Re gr th re to Re Si ar fo Ri Si ar to ca sta to ca ar ar ar ar ar ar ar ar ar ar ar ar ar	vestigating Compla itiated on 11/20/20 2/02/2021. Compla ubstantiated with de eopardy (IJ) was id FR 483.12 Freedo nd F610); 42 CFR 4 nd F837); and 42 C ssurance and Perfor 5867). Substandard lentified at 42 CFR buse (F600, F609, eopardy was deterr he facility was notif J) on 12/02/2021, a m 11/10/2021 at ap egistered Nursing / rabbed Resident #3 ne resident while at eposition him/her. F o the facility Social V egional Director of RNA #24 "hurt" him nd the facility's SW orm dated 11/10/20 DO and SW intervi as informed SRNA bok no action to rem are. The facility com tated the grievance noving SRNA #24 to here was no docum ompleted a thoroug	ormance Improvement d Quality of Care (SQC) was 483.12 Freedom from and F610). The Immediate nined to exist on 11/10/2021. ded of Immediate Jeopardy nd IJ is ongoing. proximately 4:30 PM, State Assistant (SRNA) #24 424 by the ankle and "jerked" empting to turn and esident #324 then reported Norker (SW) and to the Operations (RDO) that //her. Interview with the RDO and review of a grievance 21, revealed although the ewed Resident #324 and #24 hurt him/her, the facility nove the SRNA from resident apleted a "grievance" which would be resolved by another floor; however, ented evidence the facility h investigation of this determine if SRNA #24			
LABORATORY DIRI	ECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	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.

01/14/2022

PRINTED: 01/20/2022

TATEMENT (S FOR MEDICARI	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
185256		B. WING	EIN	R-C 12/16/2021	
NAME OF P	NAME OF PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIO
{F 000}	Continued From	page 1	{F 000}		
	5:00 PM, SRNA # room with SRNA provide care. Res care, yelling, and SRNA #24 proceet the left arm/shoul SRNA #24 and in However, the fac abuse Resident # investigating the documented evid (2) witnesses to t facility failed to re the alleged incide previous incident #324 alleged the him/her. The facil to work on 11/17/ Furthermore, SRI witnessed the incident but failed to report	a 11/10/2021 at approximately #24 entered Resident #358's #25 and SRNA #26 in order to sident #358 was resistive to refusing to change clothes. eded to strike Resident #358 on Ider. The facility suspended ititated an investigation. illity concluded SRNA #24 did not #358 prior to thoroughly allegation, as there was no ence of interviews with the two he incident. Additionally, the eview the events leading up to ent and failed to consider a on 11/10/2021, where Resident same staff (SRNA #24) "hurt" lity permitted SRNA #24 to return 2021, providing resident care. NA #25 and SRNA #26 cident, at approximately 5:00 PM, rt until approximately 6:00 PM, vestigation failed to identify this ately report.			
	received on 12/14 the Immediate Je State Survey Age Jeopardy was rer conducted on 12/ scope and severi Freedom from Ab CFR 483.70 Adm 42 CFR 483.75 G	egation of compliance was 4/2021, which alleged removal of copardy on 12/13/2021. The ency determined the Immediate moved as alleged during a revisit (16/2021, which lowered the ty to "D" at 42 CFR 483.12 puse (F600, F609, and F610); 42 ninistration (F835 and F837); and Quality Assurance and provement (F867), while the			

If continuation sheet Page 2 of 144

CENTER STATEMENT	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	FORM OMB NC (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED
- E					R	-C
		185256	B. WING		12/16/202 <u>1</u>	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE , 200 NURSING HOME LANE			
PARKVIE	N POST-ACUTE AND R	EHABILITATION CENTER	20	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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 600} SS=D	Free from Abuse and CFR(s): 483.12(a)(1		{F 600}			12/21/21
	Exploitation The resident has the neglect, misappropri and exploitation as of includes but is not lir corporal punishment any physical or chen treat the resident's m §483.12(a) The facili	ty must- se verbal, mental, sexual, or oral punishment, or				
	by: Based on interview, facility policy, it was to protect two (2) of t (Resident #324 and On 11/10/2021 at ap Registered Nursing A SRNA #26 witnessed #324 by the ankle ar attempting to turn an According to SRNA # #324 yelled out in par	T is not met as evidenced record review, and review of determined the facility failed three (3) sampled residents Resident #358) from abuse. proximately 4:30 PM, State Assistant (SRNA) #25 and d SRNA #24 grab Resident ad "jerk" the resident while d reposition the resident. #25 and SRNA #26, Resident in, and cursed at SRNA #24, her and that he/she wanted		F600- The Regional Director of Operations w re-educated on 12/2/2021 by the Divisional Vice President on Abuse Investigation Reporting, Abuse Prever Program, and Recognizing Signs of Abuse. A new Regional Director of Operations has been assigned to over the building as of 12/3/2021. SRNA# 24 was suspended on 11/21/2 and has not returned to work. She was reported to the nurse aide registry on 12/6/2021. SRNA #24 was terminated	ntion rsee 2021 s	

Facility ID: 100599

		& MEDICAID SERVICES			OMB NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
	185256		B. WING		12/16/2021
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	12/10/2021
		20	00 NURSING HOME LANE		
PARKVIEV	V POST-ACUTE AND	REHABILITATION CENTER	P	IKEVILLE, KY 41501	
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	•	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
{F 600}	Continued From p	age 3	{F 600}		
		against SRNA #24. Although ctor of Operations (RDO) and		12/9/2021	
		ker (SW) interviewed Resident		On 12/17/2021 The Staff Developmer	nt/
		m SRNA #24 hurt him/her, the		Infection Nurse re-educated LPN # 11	
		on to remove the SRNA from		concerning abuse, neglect and	
	resident care.			misappropriation specifically ensuring	
	Cubaaauaattu aa	11/10/2021 at an aviantaly		safety of the alleged victim, assistance	ein
		11/10/2021 at approximately 25 and SRNA #26 accompanied		removing the alleged perpetrator and immediately notify the nursing supervi	isor
		ident #358's room and		and/or the abuse coordinator for the	1301
		#24 strike the resident on the		facility.	
		after the resident refused to			
	change clothes ar			All staff working 12/2/2021 on the 6p-	6a
	Furthermore, after	r SRNA #25 and SRNA #26		shift were verbally re-educated by the	
		dent, they did not report the		Assistant Director of Nursing on the	
		nistration until approximately		definition of Abuse- Abuse is define	
		hour later, and SRNA #24		willful infliction of injury, unreasonable	
	time.	de resident care during that		confinement, intimidation, or punishm with resulting physical harm, pain, or	ent
	ume.			mental anguish and Abuse Investigati	on
	The facility's failur	e to have an effective system in		and Reporting - An alleged violation o	
	-	esidents were free from abuse,		abuse, neglect, exploitation or	
	•	ikely to cause serious injury,		mistreatment (including injuries of	
	· •	or death to a resident.		unknown source and misappropriation	n of
		dy was identified on		resident property) will be reported	
		vas determined to exist on		immediately to the department superv	
		CFR 483.12 Freedom from		who will then call the abuse coordinat	
		9, and F610); 42 CFR 483.70 335 and F837); and 42 CFR		If an employee suspects that either of above has happened, they are to	ule
		surance and Performance		immediately ensure the resident is sa	fe.
		67). Substandard Quality of		and immediately report to their superv	
		dentified at 42 CFR 483.12		who will immediately report to the abu	
		use (F600, F609, and F610).		coordinator, in accordance to the abu	
	-	otified of Immediate Jeopardy		policy.	
	(IJ) on 12/02/2021	I, and IJ is ongoing.		The supervisor will remove the allege	
				perpetrator from the building pending	
	Refer to F-609 an	a F-610		investigation. The Administrator will the	
		egation of compliance (AoC)		coordinate the investigation and repor all required agencies. Beginning	τιο

Event ID: COGB12

Facility ID: 100599

If continuation sheet Page 4 of 144

TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		185256	B. WING	ETN/	R-C 12/16/2021
NAME OF P	NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	12/10/202
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			00 NURSING HOME LANE		
		REHABILITATION CENTER	PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	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)	BE COMPLETIO
{F 600}	Continued From p	page 4	{F 600}		
{r 000}	was received on a removal of the Im 12/13/2021. The determined the In removed as allege 12/16/2021, which severity to "D" at A buse (F600, F60 Administration (F8 483.75 Quality As Improvement (F8 the effectiveness assurance activitie The findings inclue Review of the fac Prevention Progra revealed resident be free from abuse Review of the fac Signs and Symptor January 2011, rev condone any form 1. Review of Reside Data Set (MDS) A date of 11/11/202 the resident as ha Status (BIMS) score second	12/14/2021, which alleged mediate Jeopardy on State Survey Agency mediate Jeopardy was ed during a revisit conducted on n lowered the scope and 42 CFR 483.12 Freedom from 09, and F610); 42 CFR 483.70 335 and F837); and 42 CFR surance and Performance 67), while the facility monitors of systemic changes and quality es. de: ility's policy titled "Abuse am", revised December 2016, s of the facility had the right to	{F 600}	12/3/2021 staff not working on 12/2/20 including agency staff and new hires w be educated by the DON, ADON, IP, Regional Director of Nursing, regional nurse or consultant on their next scheduled shift. All employees who ha worked have been in-serviced and completed a post-test competency by 12/20/2021. The CMS hand in hand training modul Preventing and responding to Abuse h been added to the annual training program for all employees of Parkview Beginning 12/3/2021 residents with a BIMS of 8 or greater will be interviewe the Regional Nurse Consultant, Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Staff Development/ Infection Preventionist, Medical Recor Wound Nurse or staff nurse to ensure they feel safe in the facility, have not witnessed abuse and have not been subject to abuse, daily until the immed jeopardy has been removed then weel until substantial compliance has been achieved. Beginning 12/3/2021 residents with a BIMS of 7 or less will have their skin checked for any new bruise, redness, rash, blister, skin tears or open areas the Regional Nurse Consultant, Direct of Nursing, Assistant Director of Nursing Staff development/ infection preventio wound nurse, or staff nurse daily until immediate jeopardy has been removed then weekly until substantial compliance	ve e 5 as r. d by d, d, d, d, d, d, d, e iate kly by or ng, nist, the d

Facility ID: 100599

If continuation sheet Page 5 of 144

	-	H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		12/16/2021	
		S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
		20	00 NURSING HOME LANE		
PARKVIE	W POST-ACUTE AN	D REHABILITATION CENTER	Р	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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC
{F 600}	Continued From	page 5	{F 600}		
. ,		ility, and having limited range of	()	Administrator/Director of Nurses and/	or
		. Continued review revealed the		Assistant Director of Nursing will initia	
		the resident as having no		QAPI program related to review of an	
	-	avioral symptoms.		Abuse, Neglect, and Misappropriation	
				property that will include at a minimu	
		ent #324's Comprehensive Plan		" Review of education delivered to	all
		0/03/2021, revealed the resident		staff and confirm all staff have been	
	· ·	related to Quadriplegia,		educated, including contract staff. Sta	-
		Osteoarthritis. The goal stated		12/20/2021 the results of the review	
		Id verbalize adequate relief of		be presented to the QAPI Committee	
		to cope with incompletely re Plan interventions included:		weekly to determine if the issue has a resolved or if the initiative should be	been
		ent for pain every shift; provide		revised or continued.	
		I support, and additional pillows		" Review of Interviews conducted	with
		er review of this Care Plan		residents were completed to all	
		nt #324 had a Stage II pressure		interviewable residents. The results of	of the
	ulcer to the left o			review will be presented to the QAPI	
				Committee to determine if the issue h	las
	Review of the Co	mplaint/Grievance Report, dated		been resolved or if the initiative shoul	d be
	11/10/2021, reve	aled on 11/10/2021, Resident		revised or continued.	
	#324 reported St	ate Registered Nursing Assistant		" Education sign-in sheets will be	
		abbed" his/her bandaged ankle,		reviewed to ensure that all staff have	been
		egs, and stated that it had "hurt".		properly educated related to	
		e resolution to the grievance		Abuse/neglect policy. The results of t	he
	-	SRNA #24 to another unit and		review will be presented to the QAPI	
		RNA on positioning. Further		Committee to determine if the issue h	
	· ·	ort, revealed it was resolved on		been resolved or if the initiative shoul	a
	Social Worker (S	signed as completed by the		continue. Beginning 12/20/21 the Nursing	
		vv).		Consultants will audit the abuse educ	eation
	Review of the Nu	irse's Progress Note, dated		completion, resident abuse interviews	
		30 PM, revealed Resident #324's		ensure no abuse was identified or if it	
		sed, and there were no changes		identified it has been addressed and	
		t was present, and no redness or		reported, and that no new skin injurie	s are
	concerns were no	-		identified on the weekly skin integrity	
				review weekly for 4 weeks and then	
	Observation of R	esident #324, on 11/20/2021, at		monthly for 3 months to ensure	
		d the resident was in a specialty		compliance with the POC. The Nursi	ng
	bed with an air m	attress. The resident was		Consultants will also deliver educatio	n to

Facility ID: 100599

If continuation sheet Page 6 of 144

TATEMENT (OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					R-C
		185256	B. WING		12/16/2021
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
		20	00 NURSING HOME LANE		
PARAVIEN	V POST-ACUTE AND	REPABILITATION 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
{F 600}	Continued From p	page 6	{F 600}		
	covered with a sh The resident's had and the resident's position under the 9:02 AM, revealed incident that occu SRNA #24. Per in his/her leg and "g bandaged due to happened "around stated he/she yell away from and the room took over th he/she requested incident. Resider me", and voiced of worked at the fact someone else. Interview with SR PM and 12/01/202 11/10/2021, she v #26, and both SR facility by SRNA # first day on the jol went to Resident the resident includ SRNA #25 stated rush" and hurried ankle and turned #25 stated Reside contracted and im SRNA #24 to "get wanting to report	eet with his/her hands visible. nds were severely contracted, s legs appeared to be in a fetal		the administrative team as needed. The Nursing Consultants will report findings the abuse education completion, reside abuse interviews and weekly skin integ review to the full QAPI committee and the Chief Executive Officer of the company determine if the issues have been resolved or if the QAPI initiative should revised or continued. #4 Beginning the first week of December 2021 the Administrator/DON/ADON or Unit Manager will quiz 5 random staff monthly on the s/s of abuse and when report abuse. Results are reported to the QAPI committee to ensure staff have a continue understanding of the policy/regulations related to abuse and neglect. At the QAPI meetings the results of the monitoring by the DON, Social Services ADON, Administrator, and contract consultants will be reviewed by the Administrator, however any concerns identified will be addressed as discover including any needed education and/or progressive discipline. Beginning 12/20/21 the DON, ADON, Social Services Director, and the contrat Consultants will report monitoring outcomes of in-services, assessments/interviews, competencies staff, and test/checks, at the weekly and/or monthly QAPI Committee meeting.	of ent rity he to be er to he s, red, act of

Facility ID: 100599

If continuation sheet Page 7 of 144

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER		B. WING		R-C 12/16/2021		
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
		200 NURSING HOME LANE				
PARKVIE	V POST-ACUTE AN	D REHABILITATION CENTER	PIKE	VILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES HENCY 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 600}	Continued From	page 7	{F 600}			
. ,		equested to speak to the	[1 000]			
		r of Operations (RDO) to file a				
		ing SRNA #24. SRNA #25 stated				
	0 0	RDO, and Social Worker (SW)				
		#324's room after she (SRNA				
	-	#26 completed the resident's				
	· ·	stated she did not know how the				
		d to come to the resident's room.				
	Interview with SR	RNA #26, on 11/20/2021 at 1:47				
		21 at 9:51 AM, confirmed she				
		with SRNA #25 on 11/10/2021,				
		as orienting them. SRNA #26				
		nt between SRNA #24 and				
		ccurred at approximately 4:30				
		1. She stated they all three (3)				
		t #324's room to provide care,				
		as observed to pull Resident				
		er, the resident immediately				
		and was saying he/she wanted				
		e against SRNA #24. SRNA #26				
	stated SRNA #24	left the room and she and				
	SRNA #25 turned	and repositioned Resident				
		concerns. SRNA #26 stated				
	SRNA #24 left the	e room to tell the RDO that the				
		to file a grievance. SRNA #26				
		lid come to the resident's room				
	to talk to the resid	dent.				
		ate Registered Nursing Assistant				
		11/20/2021 at 7:08 PM, and on				
		5 PM, revealed she denied				
		nt #324's ankle. She stated she				
	-	of the pillows used for				
		sident when the resident starting				
		her to get out of the room.				
		when she went out into the				
		the RDO, she motioned for him				
	to come to the re	sident's room and informed him				

If continuation sheet Page 8 of 144

		AND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(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		R-C 12/16/2021	
		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		200	0 NURSING HOME LANE		
		PII	KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY 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 APPROPF DEFICIENCY)	BE COMPLETIC
{F 600}	Continued From p	age 8	{F 600}		
	the resident wante	ed to file a grievance.			
	11/21/2021 at 12:1 10:13 AM, revealed for the day on 11/7 Director of Operat told her Resident a She stated it was and 5:30 PM, but a time. The SW stat Resident #324's ro who reported SRN and had hurt him/f asked the resident grievance, and the did not want SRN/ anymore. The SW the RDO he/she w on how to care for Continued intervie was read to Resid signed it and was The SW stated wh room, SRNA #24 w desk and the RDC allowed to go back and she would rec again. However, th not removed from investigation was I	Social Worker (SW), on 12 PM and on 12/01/2021 at ad she was preparing to leave 10/2021, when the Regional ions (RDO) came to her and #324 wanted to file a grievance. sometime between 4:30 PM she was unsure of the exact ed she and the RDO went to boom to interview the resident 1A #24 moved him/her too fast her. The SW stated the RDO t what would resolve the the resident told the RDO he/she A #24 to care for him/her further stated the resident told vanted SRNA #24 re-educated residents with contractures. w revealed the grievance form ent #324 and the resolution. then she and the RDO left the was standing near the reception to told the SRNA, she was not is into Resident #324's room, there is wisted SRNA #24 was resident care and an not initiated by the RDO. Regional Director of Operations 021 at 10:54 AM and			
	informed Resident grievance on 11/1 remember the time	41 AM, revealed he was #324 wanted to file a 0/2021. He stated he did not e, but it was in the evening. The d he did not remember how he			

Facility ID: 100599

If continuation sheet Page 9 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	AL
PARKVIE	V POST-ACUTE AND RE	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
	SLIMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
{F 600}	Continued From pag	e 9	{F 600)}	
		ified the SW, and they went			
		lent. The RDO stated ay SRNA #24 had "hurt"			
		when he directly asked the			
		s abused, the resident O stated Resident #324 did			
	not report he/she wa				
	u	and therefore he did not			
	•	remove SRNA #24 from as not an allegation of abuse.			
		noving the SRNA from care			
		ncident was not necessary.			
		revealed the grievance was			
	agreeable to the reso	olution of reassigning the			
	staff person to anoth staff member about r	er unit and re-educating the repositioning.			
	2. Review of Resider	nt #358's medical record			
	-	admitted the resident on			
		gnoses including Cerebral bstructive Pulmonary			
	Disease, and Anxiety	-			
	Review of Resident #	#358's Quarterly Minimum			
		essment, with a reference			
		revealed the facility assessed ig a BIMS score of fifteen			
		5) indicating intact cognition			
	and assessed the rea	sident as displaying			
		s directed toward others. MDS Assessment, revealed			
	the facility assessed	I the resident as requiring			
	extensive assistance				
	frequently incontinen	ncontinent of bowel, and as it of urine.			
		#358's Comprehensive Plan /2021, revealed the resident			

If continuation sheet Page 10 of 144

OLIVILINO		E & MEDICAID SERVICES			OMB NO. 0938-039
TATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		12/16/202 <u>1</u>	
			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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
re h re pir re h ir fo R d A R S N # p Ir 1 re s e h s liii s h Y w Ir P	ygiene at times. esident would be ossible consequi- terventions inclu- esident regarding is/her decisions, formed choice a or the resident's of eview of the "Se ated 11/10/2021 dministrator, rev- egistered Nursir RNA #26 reporter ursing (ADON) to 358 on the left si- rovide care to the aterview with Res 2:05 PM, revealer ecollection of the tated if someoner nough to feel. The e/she "gets aggr taff at times. The ebeing botherer ometimes yell at im/her. Residen elled at staff, the thile and came b aterview with SR M and 12/01/202	The goal stated that the informed regarding the ences of his/her decisions. The uded: staff to educate the g possible consequences of document the resident's and attempt to find the reason choice. eff-Reported Incident Form", , untimed, completed by the realed on 11/10/2021, State ng Assistant (SRNA) #25 and ed to the Assistant Director of that SRNA #24 "struck" Resident houlder while attempting to	{F 600}		

Facility ID: 100599

If continuation sheet Page 11 of 144

	-	AND HUMAN SERVICES			FORM APPROV 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		R-C 12/16/202<u>1</u>	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		200 N	URSING 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
{F 600}	Continued From p	bage 11	{F 600}		
	-	n Resident #324 minutes prior.	(****)		
		sident #358 was lying in bed and			
		and was arguing with SRNA #24			
		lent did not want to change			
		aned up. SRNA #25 stated			
	-	as on his/her right side and			
		anding behind the resident and			
		t on the left upper arm/shoulder			
		e resident would not cooperate.			
		stated, when SRNA #24 struck			
		de an audible noise, and she			
		"shocked". Per interview, SRNA			
		ter striking the resident and the			
		ned down. SRNA #25 stated she			
		ompleted the resident's care and			
	left the resident p	-			
		NA #26, on 11/20/2021 at 1:47			
		21 at 9:51 AM, verified she was			
		s room on 11/10/2021, at			
		00 PM, with SRNA #25 and			
		#26 stated SRNA #24 was			
		dent #358 to change clothes and			
		e the resident was wet; however,			
		refusing to change clothes or do			
		equested. SRNA #26 stated			
		Resident #358 on the left			
		d enough that it made a sound			
		urred. SRNA #26 further stated and SRNA #25 immediately took			
		he resident after the incident			
		#26 stated she and SRNA #25			
		vince Resident #358 to get			
		aned up after SRNA #24 was out			
	-	longer arguing with the			
	-	interview with SRNA #26,			
		g the incident with SRNA #20,			
		e on the floor, so she and SRNA			
	#25 proceeded to				

If continuation sheet Page 12 of 144

CENTER	-	AND HUMAN SERVICES			FORM APPROVI OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	12/10/2021
PARKVIEW POST-ACUTE AND REHABILITATION CENTER			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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
{F 600}	therefore did not i	bage 12 immediately report what they SRNA #26 stated SRNA #24 was	{F 600}		
	also passing trays upset". SRNA #20 Practical Nurse (I passing trays and asked what she s #11 told her to rep administration, ar action. Per intervit the incident to the	SRNA #26 stated SRNA #24 was s to residents and "still seemed 6 stated she went to Licensed LPN) #11 after they finished I told her what happened and hould do. SRNA #26 stated LPN port what she saw to nd LPN #11 took no further ew, she and SRNA #25 reported e Assistant Director of Nursing pximately 6:00 PM at the end of			
	#11, on 11/21/202 at 9:29 AM, revea reported that she Resident #358 an do. LPN #11 state the incident imme #11 further stated incident was report the end of the shi aware she did no report it, but she f	ensed Practical Nurse (LPN) 21 at 10:14 AM and 11/30/2021 aled on 11/10/2021, SRNA #26 witnessed SRNA #24 hit of asked her what she should ed she told her she should report ediately to administration. LPN I she was unsure what time the orted to her, but it was "toward ft". LPN #11 stated she was t have to witness the abuse to shought it would be better for the essed the abuse to report it to			
	PM, revealed on 4:30 PM, she entry provide care and spilled juice on hi further stated the she was trying to change clothes. F encourage Reside	NA #24, on 11/20/2021 at 7:08 11/10/2021 at approximately ered Resident #358's room to it appeared the resident had s/her bed and clothing. She resident was refusing care and encourage the resident to Per interview, while trying to ent #358 to roll over so they /her sheets and shirt, she			

Facility ID: 100599

If continuation sheet Page 13 of 144

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/2021
NAME OF PI	ROVIDER OR SUPPLIEF	R		STREET ADDRESS, CITY, STATE, ZIP C	
			200 NURSING HOME LANE		
PARKVIE	W POST-ACUTE AN	D REHABILITATION CENTER		PIKEVILLE, 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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETIO HE APPROPRIATE DATE
{F 600}	Continued From	page 13	{F 600	n	
(,		dent on the shoulder. SRNA #24	1,000	L. L	
		it slap or strike the resident and			
		resident to encourage him/her			
		4 further stated after the			
		as provided, supper trays were			
		ney passed the supper trays and			
	then she clocked	out. She stated soon after she			
	clocked out and	went to her car, she received a			
	message to com	e back into the facility and give a			
	statement. She s	tated she was suspended for a			
	week, and then r	eturned to work at the facility.			
		e Assistant Director of Nursing			
		0/2021 at 6:20 PM and			
		08 PM, revealed at approximately			
		0/2021, SRNA #25 and SRNA			
		er, "they thought" they saw			
		sident #358. The ADON stated			
		Iready left because it was the so she called the SRNA, who			
		e facility to provide a written			
		er, she informed SRNA #24 that			
		led pending the investigation.			
		er stated she went to Resident			
		in five (5) to ten (10) minutes of			
		t was reported and conducted a			
		on Resident #358 and found no			
	redness or bruisi	ng. The ADON stated she asked			
		yone had hit him/her or had been			
		and the resident denied being			
	mistreated by an	yone.			
	Interview with the	Administrator, on 11/21/2021 at			
		n 12/01/2021 at 11:01 AM,			
		the Abuse Coordinator for the			
	facility and respo	nsible for investigating and			
		ons of abuse. He stated he was			
		ident with Resident #358 and			
	SRNA #24 on 11	/10/2021 after he had left for the			

Facility ID: 100599

If continuation sheet Page 14 of 144

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES					M APPROVI O. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		STRUCTION	(X3) DAT	E SURVEY
							२- С
		185256	B. WING			12	2/16/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PARKVIE	N POST-ACUTE AND	D REHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501				
	CLIMMAT	RY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX TAG	(EACH DEFIC	IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
{F 600}	Continued From p	page 14	{F 600	2}			
. ,	-	e ADON notified him they were	(.,			
		ts from the witnesses and had					
		A #24. He further stated he made					
	the required notifi	ications to the state agencies					
	after he got home	e. Further, he stated he was					
		25 and SRNA #26 waited					
		hour before reporting what they					
		volving Resident #358. He					
		at any allegations of abuse were					
		administration immediately.					
		ew with the Administrator,					
		aware of the previous grievance Resident #324 that same day					
		#24, but since Resident #324					
		she was not abused, he did not					
		rmation to be pertinent to the					
		on being conducted related to					
	Resident #358.						
		ew with the Administrator, on					
		:43 PM, and on 12/01/2021 at					
		ed he reviewed grievances					
		the grievance was complete					
		I that nothing was "missed". The					
		ted he did not feel there were h the grievance filed by Resident					
		no bearing on the abuse					
		ducted related to Resident #358.					
		with the Administrator, revealed					
		abuse involving Resident #358					
	-	ated because Resident #358					
		e occurred. Further, SRNA #24					
	-	return to work on 11/17/21.					
		Administrator, the facility					
	re-trained SRNA	#24 on abuse and "perception"					
	and instructed the	e SRNA she needed to be					
		reated residents, because some					
		her actions were abusive, even					
	though that was r	not her intention.					

Facility ID: 100599

If continuation sheet Page 15 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/2 FORM APPI OMB NO. 093	ROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVE COMPLETED	Y
		185256	B. WING		R-C 12/16/20 2	21
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	12/10/20	<u> </u>
PARKVIE	N POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE		1
				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)	E COMF	(X5) PLETION PATE
{F 600}	Continued From pag	e 15	{F 600}			
	Jeopardy Removal F	an acceptable Immediate Plan, on 12/14/2021, that ne Immediate Jeopardy (IJ)				
	The facility implemen actions:	nted the following corrective				
	Residents #324 and concerns with abuse voiced. On 12/02/20 Consultant (RNC) als ensure there was no	he Administrator interviewed #358 regarding any , and no concerns were 21, the Regional Nurse so assessed the residents to new bruises, redness, rash, open areas, and there were				
	Nursing Assistant (S was re-investigated s new Regional Directo SRNA #25 and #26 a	use by State Registered RNA) #24 to Resident #358 starting 12/03/2021 by the or of Operations (RDO). and Resident #358 were w RDO on 12/03/2021.				
	#358, was reported of reporting agencies, p resident's attending abuse involving Resi 11/21/2021, to the st department, and the physician. SRNA #2 11/21/2021 and has #24 was also reported on 12/06/2021.	4 was suspended on not returned to work. SRNA ed to the nurse aide registry				
		a brief interview for mental of eight (8) or greater were				

Facility ID: 100599

If continuation sheet Page 16 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 01/20/2022 1 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE COMP	SURVEY LETED
		185256	B. WING			-C 16/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	10/2021
			2	00 NURSING HOME LANE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION 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)		(X5) COMPLETION DATE
{F 600}	Continued From pag interviewed and resid (7) or less were asse Director of Nursing (/ on 12/02/2021. The r signs of abuse and w had witnessed, or we facility. There were r 3. The Regional Dire was re-educated on Vice President (DVP Reporting, Abuse Pre Signs of Abuse. A ne oversee the building 4. On 12/03/2021 th Operations (RDO) re interdisciplinary man Administrator, Direct Assistant Director of Service Director, Min coordinators, Human Manager, Medical Re Supply, Dietary Mana Coordinator, Wound Unit manager, House regarding the definiti defined as the willful unreasonable confine punishment with resu mental anguish. The Investigation and Re reporting an alleged exploitation, or mistre unknown source and	e 16 dents with a BIMS of seven issed by the RNC, Assistant ADON), and/or Administrator residents were assessed for vere asked if they felt safe, ere subjected to, abuse in the no concerns identified. ector of Operations (RDO) 12/02/2021 by the Divisional) on Abuse Investigation evention, and Recognizing w RDO was assigned to as of 12/03/2021. e new Regional Director of -educated the facility agement team, including the or of Nursing (DON), Nursing (ADON), Social imum Data Set (MDS) Resources, Business Office ecords, Maintenance, Central ager, Staff Development Nurse, Activities Director, ekeeping/Laundry Supervisor on of Abuse. "Abuse" was	{F 600}			
	that either of the abo to immediately ensur	ve had happened, they were e the residents were safe, y report the situation to the				

Facility ID: 100599

If continuation sheet Page 17 of 144

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/20/3 FORM APPRO OMB NO. 0938-0
TATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		185256	B. WING		12/16/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			ZIP CODE	
PARKVIE	W POST-ACUTE ANI	D REHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, 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 PLA (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLET D TO THE APPROPRIATE DATE CIENCY)
{F 600}	Continued From	page 17	{F 600	13	
(,	-	visor, who would immediately	(1 000	, i	
		coordinator, who was currently			
	the Administrator	. Training of the Immediate			
		done through the previously			
		training. The Staff			
		ordinator administered a written ning sessions. If staff did not			
		ing score of one hundred (100%)			
		al consultation was done until a			
	passing score wa	is obtained.			
	5. All staff working	g 12/02/2021 on the 6 PM to 6			
		oally re-educated by the ADON			
		of Abuse and Abuse Investigation			
		he training included reporting tion of abuse, neglect,			
		istreatment (including injuries of			
		and misappropriation of resident			
		ately. If an employee suspected			
		above had happened, they were			
		nsure the resident was safe, and rt to their supervisor who would			
		rt to the abuse coordinator, in			
		e abuse policy. Staff not working,			
		staff and new hires would be			
		next scheduled shift. Prior to			
	-	r next shift, the Staff			
		ordinator administered a written did not achieve the passing			
		dred (100%) percent, individual			
		done until a passing score was			
		indred (100%) percent of the			
	facility staff have	been educated.			
	On 12/03/2021. tl	he Director of Nursing (DON)			
		A #25 and SRNA #26 on the			
		nmediately report to the			
		rvisor any verbal allegation or			
	witnessed abuse	or neglect immediately upon			

Facility ID: 100599

If continuation sheet Page 18 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	01/20/2022 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE S COMPLI	ETED
		185256	B. WING		R-0	C 6/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		0/2021
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF 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	3E	(X5) COMPLETION DATE
				DEFICIENCY)		
{F 600}	provided that the alle removed from the bu- investigation. The A- coordinate the invest required agencies. 6. Beginning 12/03/2 Consultant (RNC), A Nursing (DON), Assi (ADON), Social Serv interview residents w or greater daily and a with a BIMS score of any signs of abuse o they feel safe in the f abuse, and have not the immediate jeopar	g it. Training was also ged perpetrator would be	{F 600}			
	 achieved. Results of reported to the Quali Improvement (QAPI) DON/ADON. 7. On 12/03/2021, the reviewed the grievand days to ensure no ab on the grievance log investigated. There we that alleged abuse of 8. Grievance forms we hallway and all grievan the grievance officer. Grievances/complain be investigated and of taken to resolve the grievance forms 	the interviews would be ty Assurance Performance committee by the ne New RDO and/or DVP ce log for the last thirty (30) puse allegations were noted and not reported or vere no logged grievances r neglect. were located on each ances would be reviewed by the Administrator. All the filed with the facility would corrective actions would be grievance(s). The grievance neglect or				

If continuation sheet Page 19 of 144

		H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROVI OMB NO. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C 12/16/2021	
NAME OF P	ROVIDER OR SUPPLIEF	2	STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
			200	NURSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		РІКІ	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)		
{F 600}	Continued From	page 19	{F 600}			
		or for investigation. Beginning				
		Administrator would also report				
		ances received each day with the				
		r of Operations (RDO) or				
		resident (DVP) daily until the				
		rdy was removed and then				
		stantial compliance was				
	achieved.					
	9. On 12/03/202	1 the Rytes Company (outside				
		ontracted to achieve compliance)				
		ody consisting of the Chief				
	-	Chief Strategy Officer, Divisional				
		lew Regional Vice President,				
		Consultant were re-educated on				
	-	buse, abuse reporting and				
		ng, Grievance and complaints				
		sibility. The Chief Operating				
		lealthcare Administration (MHA),				
		Administration and Geriatric				
), Licensed Nursing Home				
		NHA), and Certified Healthcare				
		cialist (CHC) of the Rytes				
		ed an in-depth review and				
		n on abuse investigation, abuse				
		izing signs and symptoms of				
		ct. They also reviewed the				
	-	irements, the self-reporting				
		d the Kentucky mandatory				
	reporting require					
	10 Reginning 1	2/03/2021 a member of the				
		2/03/2021 a member of the				
		vould be on site at the facility				
		nediate jeopardy was removed				
		compliance was achieved.				
		governing body included the New P, Regional Nurse Consultant				
		sing Officer. While a member of				
		dy was in the facility, they would				
	ine governing bo	uy was in the facility, they would				

Facility ID: 100599

If continuation sheet Page 20 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/202 FORM APPROVE OMB NO. 0938-039	ΞD
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C 12/16/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		200 NURSING HOME LANE		
	1			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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	N
{F 600}	abuse, and/or allegat investigated, and alle suspended. Informat would be provided to Assurance Performa program and the Adr governing body. The State Survey Ag implemented the follo 1. Review of facility Administrator intervie #358 and the Region assessed the resider allegation of complia and no concerns wer Review of facility doo the new Regional Dir interviewed Resident 12/03/2021 and the a residents was re-investigation	buse interviews and a day to ensure allegations of tions were reported, eged perpetrators ion gathered from audits the facility's Quality nce Improvement (QAPI) ninistrator would report to the ency verified the facility owing corrective actions: documentation revealed the ewed Residents #324 and hal Nurse Consultant (RNC) nts as outlined in the nce (AOC) on 12/02/2021, re identified.	{F 600	D}		
	the allegation of abus Resident #358 was r state agencies, the p resident's attending p regarding Resident # 11/21/2021, to the sta department, and the physician. Review of investigati	16/2021 at 4:40 PM revealed se regarding SRNA# 24 and eported on 11/10/2021 to the police department, and the physician and the allegation #324 was reported on ate agencies, the police				

If continuation sheet Page 21 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/2022 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		R-C 12/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
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 600}	Continued From pag	e 21	{F 600}			
		0 PM revealed the facility				
	suspended the SRN/ employment was terr	A #24 on 11/21/2021, and her				
		o the nurse aide abuse				
	with the DVP on 12/1 confirmed State Reg	istered Nurse Aide (SRNA)				
	#24 was suspended worked at the facility	on 11/21/2021 and had now since that date.				
	11:30 AM and intervi	ent #324 on 12/16/2021 at ew with Resident #358 on				
		AM revealed both residents , no complaints regarding				
	-	voiced and both residents				
		ws/skin assessments				
		gional Nurse Consultant ector of Nursing (ADON)				
		on 12/02/2021 revealed all				
		S with eight (8) or greater				
		It safe in the facility, had had been subject to abuse				
	and no concerns wer	e identified. Further reviews				
		e ADON on 12/16/2021 at 12/02/2021 residents with a				
		(7) or less were assessed				
		ny open areas, new bruising,				
	concerns were identi	s or skin tears and no fied.				
	3. Review of education	on provided to the Regional				
		is (RDO) revealed the				
	Administrator on 12/0	dent (DVP) re-educated the 02/2021 on facility's Abuse ng, Abuse Prevention				

Facility ID: 100599

If continuation sheet Page 22 of 144

		ND HUMAN SERVICES				FORM	D: 01/20/2022 A APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRU G		(X3) DATE COMP	SURVEY LETED
		185256	B. WING				-C 16/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE	12/	10/2021
	N POST-ACUTE AND R	EHABILITATION CENTER		200 NURSI	IG HOME LANE		
				PIKEVILLE	E, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	c	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	Continued From page	ge 22	{F 60	0}			
	Interview with the D	gnizing Signs of Abuse. VP on 12/16/2021 at 4:50 PM D was assigned to oversee 2/03/2021.					
	sheets revealed the Operations (RDO) r interdisciplinary tear abuse to include the Administrator, Direct Assistant Director of Service Director (SS (MDS) coordinators Business Office Man Maintenance, Centr Staff Development (Activities Director, L Housekeeping/Laur facility provided con revealed the facility completed a written score of one hundred Interview with the AI PM, the Social Serv at 4:20 PM, and the 12/16/2021 at 4:25 received training reg policy/procedures a following the educat 5. Interview with the 4:33 PM and review revealed all staff wo PM-6 AM shift were ADON regarding the	adry Supervisor. Review of hpetency testing documents interdisciplinary team post-test, with a passing ed (100%) percent. DON on 12/16/2021 at 4:33 ices Director on 12/16/2021 Director of Nursing (DON) on PM revealed they had garding the facility's abuse nd had taken a post-test					

If continuation sheet Page 23 of 144

		ND HUMAN SERVICES			FORM	: 01/20/2022 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE COMPI	LETED
		185256	B. WING		R- 12/*	-C 16/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	- 12	10/202
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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	Continued From pag	je 23	{F 600}			
	continued interview v at 4:33 PM. revealed	with the ADON on 12/16/2021				
	, ,	which included agency staff				
	and new hires were	educated and were required				
	•	ompetency before their next cord review and interview with				
	the ADON revealed	all staff had been educated				
	and completed a pos	st-test by 12/13/2021.				
	Interview with SRNA	#1 on 12/16/2021 at 3:00				
		cal Nurse (LPN) # 10 on				
		PM; and interview with N) #12 on 12/16/2021 at				
		training also included Abuse				
		ing and that any alleged				
		eglect, exploitation or ing injuries of unknown				
	source and misappro	opriation of resident property)				
		mmediately to the department ON and SRNA interview also				
	-	nstructed that if an employee				
	suspected that abus	e had occurred, they were to				
		the resident was safe. They n required to immediately				
		visor. Further, the supervisor				
		leged perpetrator from the				
	building pending the	investigation and differences of the sources of the				
	coordinator.					
		rector of Nursing (DON) on				
		PM and review of education ealed on 12/03/2021, the				
		tate Registered Nursing				
	Assistant (SRNA) #2					
		ny allegations of abuse to the or when the incident				
	occurred.					

Event ID: COGB12

Facility ID: 100599

If continuation sheet Page 24 of 144

		ND HUMAN SERVICES			PRINTED: 0 FORM A OMB NO. 0	PPROVED
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING		(X3) DATE SUI COMPLET	
		185256	B. WING		R-C 12/16 /	/2021
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER				
			I	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)	-	(X5) COMPLETION DATE
{F 600}	Continued From pag	ge 24	{F 600}			
	Interview with the A	dministrator on 12/16/2021 at				
		e would coordinate the ensure all allegations were				
	reported to state age	encies as required.				
	-	d incident of resident to /een Resident #322 and				
		h occurred on 12/14/2021 at				
		o concerns with the facility				
		g nor investigating. The ngoing; however, actions had				
	-	ct those and all other				
	residents and no co	ncerns were identified.				
	Interview with Resid	lent #322 on 12/16/2021 at				
		ew with Resident #361 on				
		PM revealed they felt safe in no concerns related to abuse.				
	6. Interview with the	e ADON on 12/16/2021 at				
		of Resident Abuse Interview				
		ealed beginning on 12/03/2021 acility with a BIMS of eight (8)				
	or greater were inter	rviewed daily by the DON,				
		l/or Social Worker to ensure fe, had not been subject to				
		witnessed abuse. No				
	concerns were ident	tified.				
	Interview with Resid	lent #362 on 12/16/2021 at				
		#361 at 3:30 PM and				
		40 PM confirmed staff were aily. The stated they had no				
	concerns of abuse of	or neglect and none had been				
	reported to facility st	taff during the interviews				
		ssments revealed beginning				
		RNC, DON and ADON				
		f residents with a BIMS of ily to ensure any new bruise,				

		ND HUMAN SERVICES			FORM	D: 01/20/2022 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING		<u> </u>	PLETED
		185256	B. WING			-C 16/2021
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		10/202
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
{F 600}	Continued From pag	je 25	{F 600}			
		r, skin tears or open areas lo concerns were identified.				
	(RVP) on 12/16/202 reviewed the grieval previous thirty (30) of of abuse was includ concerns were ident 8. Observations on grievance forms were the resident care un Interview with the Ad 4:40 PM revealed he and would oversee for grievances/complain be investigated and taken to resolve the Administrator also s process in the facilit guidelines regarding Interview with the Re on 12/16/2021 at 4:9 to review the grievan ensure the facility w grievance process. Interview with Licens #10 on 12/16/2021 at training provided to retrained and were for	12/16/2021 revealed re located on each hallway of its in the facility. dministrator on 12/16/2021 at e was the grievance officer the process to ensure any hts voiced at the facility would corrective actions would be				
		y. evance forms revealed a on 12/14/2021 by Resident				

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C 12/16/202<u>1</u>	
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER		IURSING HOME LANE VILLE, KY 41501		
	0.000		I			
(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 600}	Continued From	bage 26	{F 600}			
	#362 regarding hi	is/her bathroom appearance and				
		ew revealed the grievance was				
	•	resident was interviewed, and				
		evance was resolved on				
		re were no allegations of abuse,				
	log/grievance for	ted on the grievance n.				
	Interview with Re	sident #362 on 12/16/2021 at				
		ed he/she had voiced a				
		ng cleanliness of his/her				
		ility staff had resolved the				
	grievance. The rewith care/treatme	esident had no current concerns nt in the facility.				
		ning documentation, testing				
		nd sign-in sheets revealed on				
		Rytes Company, educated the				
		consisting of the Chief Nursing ategy Officer, Divisional Vice				
		Regional Vice President,				
		Consultant on the definition of				
	•	orting and abuse investigating,				
		omplaints and staff				
		e Governing body members				
		ed on conducting abuse				
	-	use reporting, recognizing signs				
		abuse and neglect, state ce requirement, a self-reporting				
		the Kentucky mandatory				
	reporting requirer					
	Interview with the	Administrator on 12/16/2021 at				
		2 on 12/16/2021 at 3:40 PM, and				
		Il Vice President (DVP) on				
		0 PM revealed they attended				
		led by the Rytes company ing and reporting abuse,				
	• • •	olicies, and completed a				

Facility ID: 100599

If continuation sheet Page 27 of 144

		ND HUMAN SERVICES	_		FORM	D: 01/20/2022 A APPROVED D: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING			LETED
		185256	B. WING			-C
NAME OF P	ROVIDER OR SUPPLIER	105250		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	16/202 <u>1</u>
				00 NURSING HOME LANE		
PARKVIE	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 R 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 600}	Continued From page post-test following the		{F 600}			
{F 609} SS=D	 Review of record Divisional Vice Press 4:50 PM revealed the member of the gove facility daily and would until the immediate j substantial compliant governing body men reviewed the resider grievances filed eace allegations of abuse investigated, and all suspended per the f guidelines. Continue information they gat was taken to QAPI. Review of the facility the team met on 12/ provided no evidence identified. Reporting of Alleged CFR(s): 483.12(c)(1) §483.12(c) In respont neglect, exploitation must: §483.12(c)(1) Ensur- involving abuse, neg- mistreatment, includ source and misappro- are reported immediant 	ds and interview with the ident (DVP) on 12/16/2021 at iat beginning 12/03/2021, a rrning body was onsite at the uld continue to be onsite daily eopardy was removed, and nee was achieved. The nber in the facility also nts' abuse interviews, and h day to ensure there were no that were not immediately eged perpetrators were acility policy and regulatory ed interviews revealed the hered, and audit information y's QAPI meetings revealed '13/2021 and documentation e any new concerns were any new concerns were to violations (4) mose to allegations of abuse, , or mistreatment, the facility re that all alleged violations	{F 609}			12/21/21

Facility ID: 100599

If continuation sheet Page 28 of 144

		ND HUMAN SERVICES			PRINTED: 01/20/2022 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		R-C 12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	12/16/2021
	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 609}	Continued From pag	je 28	{F 609}		
	abuse and do not rea	e the allegation do not involve sult in serious bodily injury, to			
	officials (including to adult protective serv	the facility and to other the State Survey Agency and rices where state law provides			
		g-term care facilities) in te law through established			
	§483.12(c)(4) Repor investigations to the	t the results of all administrator or his or her			
	designated represen accordance with Sta Survey Agency, with incident, and if the a	ntative and to other officials in the law, including to the State in 5 working days of the illeged violation is verified ve action must be taken.			
		T is not met as evidenced			
	by: Based on interview,	, record review, and facility		F609	
	policy review, it was to immediately repor	determined the facility failed rt allegations of abuse for two		The Allegation of abuse by SRNA# 24 resident # 324 was reported to OIG, All police department, attending physician	PS,
	and Resident #358).	bled residents (Resident #324		police department, attending physician 11/21/21. The Allegation of abuse by SRNA# 24	
	On 11/10/2021 at ap	proximately 4:30 PM, State		resident # 358 was reported to OIG, Al	

Facility ID: 100599

If continuation sheet Page 29 of 144

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/2021
NAME OF P	ROVIDER OR SUPPLIEF	2	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
				00 NURSING HOME LANE	
PARKVIE	V POST-ACUTE AN	D REHABILITATION CENTER		PIKEVILLE, 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 COMPLETIO
{F 609}	Continued From	page 29	{F 609}		
. ,	Registered Nursi	ng Assistant (SRNA) #24 It #324 by the ankle and "jerked"	[1 000]	police department, attending physicia 11/10/2021.	an on
		e turning and repositioning the nt #324 reported to the facility		All residents with a BIMS of 8 or great were interviewed by the Regional Nu	
		W) and to the Regional Director		Consultant, Assistant Director of Nur	
		DO) that SRNA #24 "hurt"		and/or Administrator on 12/2/2021. T	•
	· · ·	r, the facility failed to report the		residents were asked if they felt safe	in
	incident to the ap	propriate agencies according to		the facility, had witnessed abuse or h	ad
	the facility policy.			been subject to abuse. No residents	
				voiced any concerns.	
		nately thirty (30) minutes later,		All residents with a BIMS of 7 or less	had
		approximately 5:00 PM, SRNA		their skin checked for any new bruise	
		dent #358's room with SRNA		redness, rash, blister, skin tears or op	
		26 and struck Resident #358 on		areas by the regional nurse consulta	
		Ider. SRNA #25 and SRNA #26		and/or Assistant Director of Nursing of	
		cident, but failed to report the		12/2/2021. There were no new skin is	ssues
		tely and waited until		identified.	
		00 PM to report the incident to		SRNA# 24 was suspended on 11/21/	
	the Assistant Dire	ector of Nursing (ADON).		and has not returned to work. She wa	
				reported to the nurse aide registry on	
	•	ire to have an effective system in		12/6/2021. SRNA #24 was terminate	d on
		all allegations of abuse were		12/9/2021.	#00
		orted, has caused or is likely to		ON12/3/2021 SRNA #25 and SRNA	#20
		ury, harm, impairment or death		were -re-educated by the Director of	
		nediate Jeopardy (IJ) was 02/2021, and was determined to		Nursing on the requirement to immediately reporting to the departm	ont
		21, at 42 CFR 483.12 Freedom		supervisor any verbal allegation or	CIIL
		0, F-609 and F-610); 42 CFR		witnessed abuse or neglect immedia	telv
		ation (F-835, F-837); and 42		upon witnessing or hearing it.	lory
		lity Assurance and Performance		All staff working 12/2/2021 on the 6p	-6a
		867). Substandard Quality of		shift were verbally re-educated by the	
		identified at 42 CFR 483.12		Assistant Director of Nursing on the	-
		buse (F600, F609, and F610).		definition of Abuse- Abuse is defin	led as
		notified of Immediate Jeopardy		willful infliction of injury, unreasonable	
	on 12/02/2021, a			confinement, intimidation, or punishm	
	, -			with resulting physical harm, pain, or	
	Refer to F600 an	d F610		mental anguish and Abuse Investigat	
				and Reporting - An alleged violation	
	An accentable all	legation of compliance (AoC)		abuse, neglect, exploitation or	

Facility ID: 100599

If continuation sheet Page 30 of 144

	S FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
	185256		B. WING		12/16/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				200 NURSING HOME LANE	
PARKVIE	V POST-ACUTE ANI	OREHABILITATION CENTER		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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC
{F 609}	Continued From	20 0 - 20			
(i 000)	-	-	{F 609]		
		12/14/2021, which alleged		mistreatment (including injuries of	ion of
		mediate Jeopardy on		unknown source and misappropriati resident property) will be reported	
		State Survey Agency			nuicor
		nmediate Jeopardy was ed during a revisit conducted on		immediately to the department supe who will then call the abuse coordin	
	-	h lowered the scope and		If an employee suspects that either	
		42 CFR 483.12 Freedom from		above has happened, they are to	
	•	09, and F610); 42 CFR 483.70		immediately ensure the resident is s	afe
	•	835 and F837); and 42 CFR		and immediately report to their supe	
		surance and Performance		who will immediately report to the a	
	-	67), while the facility monitors		coordinator, in accordance to the at	
		of systemic changes and quality		policy. The supervisor will remove the	
	assurance activiti			alleged perpetrator from the building	
				pending the investigation. The	9
	The findings inclu	de:		Administrator will then coordinate th	ie.
				investigation and report to all require	
	1. Review of the	facility policy titled "Abuse		agencies. Beginning 12/3/2021 staf	
		Reporting", with a revision date		working on 12/2/2021 including age	
		ealed all reports of resident		staff and new hires will be educated	
		omptly reported to local, state		the DON, ADON, IP, Regional Direc	
		cies and thoroughly investigated		Nursing, regional nurse or consulta	
	by facility manage			their next scheduled shift. All emplo	
				who have worked have been in-service	-
	Review of the fac	ility policy titled		and completed a post-test compete	
		plaints, Filing", with a revision		12/20/2021. If staff did not achieve	
		, revealed grievances and		passing score of 100%, individual	
		be investigated, and the		consultation was done until a passir	ng
		would coordinate actions with		score was obtained. 100% of staff h	-
	the appropriate st	ate and federal agencies		been educate.	
	depending on the	nature of the allegation. The		The CMS hand in hand training mod	dule 5
	policy further stat	ed, all alleged violations of		Preventing and responding to Abuse	e has
	abuse or neglect	would be investigated under the		been added to the annual training	
	guidelines for rep	orting abuse and neglect.		program for all employees of Parkvi	
				Beginning 12/3/2021 residents with	
		plaint/Grievance Report, dated		BIMS of 8 or greater will be interview	wed by
		me on the form), revealed		the Regional Nurse Consultant,	
		ported to the facility's Social		Administrator, Director of Nursing,	
		a State Registered Nursing		Assistant Director of Nursing, Socia	
	Assistant (SRNA)	"grabbed" the resident's ankle		Service Director, Staff Developmen	t/

Event ID: COGB12

Facility ID: 100599

If continuation sheet Page 31 of 144

CENTER	S FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		185256	B. WING		12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	12/10/2021
				200 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND	REHABILITATION CENTER		PIKEVILLE, KY 41501	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{F 609}	Continued From p	bage 31	{F 609}		
	-	d, "jerked" the resident's legs,		Infection Preventionist, Medical Record	d.
		"hurt". The report was signed		Wound Nurse or staff nurse to ensure	
		11/10/2021 by the Social Worker		they feel safe in the facility, have not	
		esident and the plan to resolve		witnessed abuse and have not been	
	the grievance was	s to reassign the SRNA and		subject to abuse, daily until the immed	iate
	educate the SRNA	A on positioning.		jeopardy has been removed then weel	dy
				until substantial compliance has been	
	Interview with Res	sident #324, on 11/20/2021 at		achieved.	
		d the resident recalled the		Beginning 12/3/2021 residents with a	
		2021 with State Registered		BIMS of 7 or less will have their skin	
		(SRNA) #24. Resident #324		checked for any new bruise, redness,	
		came into his/her room and		rash, blister, skin tears or open areas b	-
	-	nkle and jerked his/her leg while		the Regional Nurse Consultant, Directo	
		itioning the resident. Resident		of Nursing, Assistant Director of Nursin	
		e reported to the Regional		Staff development/ infection prevention	
		tions (RDO) that SRNA #24 hurt		wound nurse, or staff nurse daily until	
		n she grabbed it. Further		immediate jeopardy has been removed	
		Resident #324 stated, "She did		then weekly until substantial compliance has been achieved.	ce
		nterview, the resident did not		has been achieved.	
		A still worked at the facility and		#4 Desting the first week of Desem	hor
		l hurt someone else."		#4 Beginning the first week of Decem 2021 the Administrator/DON/ADON or	
		NA #25, on 11/20/2021 at 7:29		Unit Manager quizzes 5 random staff	
		21 at 8:05 AM; and with SRNA		monthly on the s/s of abuse and when	
		1 at 1:47 PM and 11/21/2021 at		report abuse. Results are reported to t	
		they saw SRNA #24 grab the		QAPI committee to ensure staff have a	
		nd pull the resident "hard". They		continue understanding of the	
		seemed to be in a hurry or		policy/regulations related to abuse and	ı
		esident preferred staff to be slow		neglect.	
	-	he resident's contractures. They		At the QAPI meetings the results of the	e
	-	sident started yelling, telling		monitoring by the DON, Social Service	
		y from him/her and that she had		ADON, Administrator, and contract	
		SRNAs stated the resident		consultants will be reviewed by the	
	requested to talk t	to the RDO and was saying		Administrator, however any concerns	
	he/she wanted to	file a grievance. SRNA #26		identified will be addressed as discove	red,
	stated, SRNA #24	left the room and the RDO		including any needed education and/or	r
	came to the room	to talk to Resident #324.		progressive discipline.	
				Beginning 12/3/2021 the Administrator	will
	Interview with Lice	ensed Practical Nurse (LPN)		report, and review for timely reporting	and

Facility ID: 100599

If continuation sheet Page 32 of 144

	-	HAND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
					R-C
		185256	B. WING		12/16/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
	V POST-ACUTE AN	D REHABILITATION CENTER		00 NURSING HOME LANE	
			P	IKEVILLE, 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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC
{F 609}	Continued From	page 32	{F 609}		
{F 609}	#11, on 11/30/202 working on 11/10 #324 filed a griev RDO asked the L LPN #11 stated F #24 "grabbed" his LPN #11 stated th his/her ankle; how the wound and no #11, staff should by using the foot/ Continued review Complaint/Grieva and review of the investigations, re Resident #324's a "jerked" or "hurt" state agencies. Interview with the 11/21/2021 at 12: 10:13 AM, reveal Grievance Officer facility and did no until 11/15/2021 a The SW stated, s the complaint/grie she was still in tra occurred on 11/10	21 at 9:29 AM, revealed she was /2021. She stated Resident ance with the RDO and the PN to assess Resident #324. Resident #324 told her, SRNA s/her ankle and "hurt" him/her. he resident had a wound to wever, there were no changes to b new injuries. According to LPN never turn/reposition a resident fankle.	{F 609}	thorough investigation of grievance any allegation of abuse/neglect re- each day with the Regional Director Operations and/or Divisional Vice President daily until the immediate jeopardy is removed and then wee substantial compliance is achieved Beginning 12/20/21 the DON, ADO Social Services Director, and the of Consultants will report monitoring outcomes of in-services, assessments/interviews, competer staff, and test/checks, at the week and/or monthly QAPI Committee meetings.	ceived or of ekkly until d. DN, contract
	Resident #324 fil #24. The SW stat SRNA #24 hurt h	ed a grievance regarding SRNA ted Resident #324 reported im/her, but stated he/she was			
	grievances were Administrator to e appropriately as a	asked. She stated all reviewed with the RDO and the ensure they were investigated an abuse allegation or as a urther stated, because the			

If continuation sheet Page 33 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/20/2022 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE S COMPL	
		185256	B. WING		R-	C I 6/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		10/202
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)		(X5) COMPLETION DATE
{F 609}	Continued From pag	e 33	{F 609}			
	resident stated he/sh allegation was not re	e was not abused; the ported.				
	(RDO), on 11/21/202 11/23/2021 at 9:20 A filed a grievance on that was provided by stated Resident #324 him/her and had the hurt, the allegation w an abuse allegation. Complaint/Grievance Resident #324 was h Resident #324 repor him/her. The RDO st he/she was abused, "no". Therefore, the f was not reported as RDO, the resident wa resolution to reassign of the facility and to r repositioning.	e Form, which stated burt, the RDO acknowledged ted that SRNA #24 did hurt ated he asked the resident if and the resident responded, RDO stated the allegation abuse. According to the as satisfied with the in the SRNA to another area re-educate the SRNA on ministrator, on 11/21/2021 at				
	allegations of abuse. Resident #324 filed a #24 on 11/10/2021, b resident did not say b allegation was not re accordance with faci 2. Review of the fac Signs and Symptoms revision date of Janu	acility and investigated He stated he was aware a grievance against SRNA but stated because the ne/she was abused, the ported to state agencies in lity policy. ility policy titled, "Recognizing s of Abuse/Neglect", with a ary 2011, revealed the facility				
	would not condone a	ny form of resident abuse or urther stated, all personnel				

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	12/10/2021
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE	
			P	PIKEVILLE, KY 41501	1
(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 609}	Continued From pag	e 34	{F 609}		
		gns and symptoms of r supervisor or the Director ely.			
	11/10/2021, revealed documented), two (2 Assistants (SRNAs), reported that another Resident #358 on the performing activities	of daily living (ADL) care. t the reporting party was the			
	revealed she witness Resident #358 on the resident was refusing other aide "stepped i resident. Review of the Statement from SRN SRNA #24 strike Res	e left arm/shoulder while the g care. Further, she and the n" and provided care to the			
	PM and 12/01/2021 a #26, on 11/20/2021 a 9:51 AM; revealed or left Resident #324's i "upset" about the inc	A #25, on 11/20/2021 at 7:29 at 8:05 AM; and with SRNA at 1:47 PM and 11/21/2021 at n 11/10/2021 they had just room and SRNA #24 was ident with that resident. They Resident #358's room at PM to provide care.			
	was resisting care ar resident was on his/h	with SRNA #25, on M, revealed Resident #358 nd was yelling. She stated the ner right side and SRNA #24 ent when she (SRNA #24)			

Facility ID: 100599

If continuation sheet Page 35 of 144

	-	H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/2021
NAME OF P	ROVIDER OR SUPPLIEF	र	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
			200 M	NURSING HOME LANE	
PARKVIE	W POST-ACUTE AN	D REHABILITATION CENTER		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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIC
{F 609}	Continued From	page 35	{F 609}		
		nt on the left upper arm/shoulder			
		stated, it made an audible noise			
		resident and it "shocked" her.			
		they immediately reported the			
		Irse on duty (Licensed Practical			
		after the incident occurred, who			
	, , ,	to Administration. She stated			
		e on the floor and they did not			
		tion to the Assistant Director of			
		until the end of the shift at			
	approximately 6:	00 PM.			
	Continued intervi				
		iew with SRNA #26, on			
		47 PM, and 11/21/2021 at 9:51			
		NA #24 was trying to get			
		change clothes and clean up			
		dent had spilled something on			
		resident was wet. She stated the			
		using to change. She further			
		4 struck Resident #358 on the left			
		d it made an audible noise. Per			
		id SRNA #25 reported the			
		ssistant Director of Nursing			
		oximately 6:00 PM at the end of			
		26 stated they did not			
		ort the incident because supper			
		e floor when they finished care for			
		o they passed the supper trays.			
		d SRNA #24 passed trays to the			
		s well and still "seemed upset".			
	SRNA #26 stated	she went to LPN #11 after they			
	finished passing	trays and the nurse told her it			
	needed to be rep	oorted immediately to			
	administration.				
		censed Practical Nurse (LPN)			
	#11, on 11/21/20	21 at 10:14 AM, and 11/30/2021			
	9:29 AM, reveale	ed she was working on			
	11/10/2021 and §	SRNA #26 told her she witnessed			
	57(02-99) Previous Versior	ns Obsolete Event ID:CC		ID: 100599 If cor	ntinuation sheet Page 36 of

Facility ID: 100599

If continuation sheet Page 36 of 144

	-	AND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROVE OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C 12/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
			200 NURSING HOME LANE			
PARKVIEV	V POST-ACUTE AND	D 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO	
{F 609}	she was unsure w the abuse allegati the end of the shi SRNA to report th LPN #11 stated sh approximately five the SRNA had rep further action. LPI abuse allegations immediately to ad the allegation bed to report. Interview with the (ADON), on 11/20 11/21/2021 at 1:0 remember the exa #26 reported the a Resident #358, bu PM", at the end o reported they "tho Resident #358. Th already left the fa- but she was called statement, and was stated she also no was the Abuse Co she was unaware	page 36 Resident #358. LPN #11 stated what time SRNA #26 told her of ion, but stated it was "around ft." She stated she told the ne allegation to Administration. he confirmed with the ADON e (5) to ten (10) minutes later, borted the allegation and took no N #11 stated she was aware were required to be reported liministration, but did not report cause she instructed SRNA #26 Assistant Director of Nursing D/2021 at 6:20 PM, and 8 PM, revealed she did not act time SRNA #25 and SRNA abuse allegation involving ut stated it was "around 6:00 f the shift. She stated they bught" they saw SRNA #24 hit he ADON stated SRNA #24 hit he ADON stated SRNA #24 had cility because her shift was over, d back to the facility, gave a as suspended. She further bordinator. The ADON stated the incident had occurred at 00 PM, and was not reported	{F 609}	DEFICIENCY)		
	Interview with the 12:43 PM, and 11 he believed he be SRNA #24 and Re immediately after ADON called him	Administrator, on 11/21/2021 at /22/2021 at 8:58 AM, revealed ecame aware of the incident with esident #358 "almost it happened". He stated the on 11/10/2021 after he had left ild him about the incident. The				

Facility ID: 100599

If continuation sheet Page 37 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/2022 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		R-C 12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		s	STREET 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)	
{F 609}	Continued From pag	e 37	{F 609}		
		when he got home, he made			
		e state agencies according ministrator stated that he			
		ff who witnessed the incident			
	I	incident to administration			
		he Administrator was asked ly" and the expectation for			
	reporting, he stated s	staff was expected to report			
	when the resident's shad been provided.	safety was assured, and care			
		an acceptable Immediate			
		Plan, on 12/14/2021, that ne Immediate Jeopardy (IJ)			
	on 12/13/2021.	ie inineulale seopardy (is)			
	The facility implement actions:	nted the following corrective			
		ne Administrator interviewed			
	Residents #324 and	#358 regarding any , and no concerns were			
		21, the Regional Nurse			
		so assessed the residents to			
		new bruises, redness, rash, open areas, and there were			
	no concerns.				
		use by State Registered			
		RNA) #24 to Resident #358 starting 12/03/2021 by the			
		or of Operations (RDO).			
	SRNA #25 and #26 a	and Resident #358 were			
	re-interviewed by ne	w RDO on 12/03/2021.			
		use by SRNA #24 to Resident			
	-	on 11/10/2021 to the state police department, and the			
		physician. The allegation of			

If continuation sheet Page 38 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/20/2022 APPROVED . 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING	ETN/	R-	C I 6/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	10/202
		EHABILITATION CENTER	2	00 NURSING HOME LANE		
	W POST-ACOTE AND R		Р	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)		(X5) COMPLETION DATE
{F 609}	Continued From pag abuse involving Resi	e 38 dent #324 was reported on	{F 609}			
	11/21/2021, to the st department, and the physician. SRNA #2 11/21/2021 and has	ate reporting agencies, police				
	status (BIMS) score interviewed and resid (7) or less were asse Director of Nursing (<i>i</i> on 12/02/2021. The signs of abuse and w had witnessed, or we	a brief interview for mental of eight (8) or greater were dents with a BIMS of seven essed by the RNC, Assistant ADON), and/or Administrator residents were assessed for vere asked if they felt safe, ere subjected to, abuse in the no concerns identified.				
	was re-educated on Vice President (DVP Reporting, Abuse Pre	ector of Operations (RDO) 12/02/2021 by the Divisional) on Abuse Investigation evention, and Recognizing w RDO was assigned to as of 12/03/2021.				
	Operations (RDO) re interdisciplinary man Administrator, Direct Assistant Director of Service Director, Min coordinators, Human Manager, Medical Re Supply, Dietary Man Coordinator, Wound Unit manager, House regarding the definiti defined as the willful	Nursing (ADON), Social nimum Data Set (MDS) n Resources, Business Office ecords, Maintenance, Central ager, Staff Development Nurse, Activities Director, ekeeping/Laundry Supervisor on of Abuse. "Abuse" was				

Facility ID: 100599

If continuation sheet Page 39 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 01/20/2022 1 APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			-C
NAME OF P	ROVIDER OR SUPPLIER	100200		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	16/202 <u>1</u>
				00 NURSING HOME LANE		
PARKVIE	N POST-ACUTE AND RE	EHABILITATION CENTER	P	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)		(X5) COMPLETION DATE
{F 609}	mental anguish. The Investigation and Re- reporting an alleged exploitation, or mistre unknown source and property) immediately that either of the abor to immediately ensur and then immediately immediate superviso notify the abuse coor the Administrator. Tr Supervisors was don mentioned abuse tra Development coordin test following training achieve the passing percent, individual co passing score was of 5. All staff working 12 AM shift was verbally on the definition of Al and Reporting. The any alleged violation exploitation, or mistre unknown source and property) immediately that either of the abor to immediately report to accordance to the ab including agency staff educated on their ne- staff working their ne- Development Coordin	ulting physical harm, pain, or e training also included Abuse porting, which included violation of abuse, neglect, eatment (including injuries of misappropriation of resident y. If an employee suspected ve had happened, they were the residents were safe, y report the situation to the r, who would immediately rdinator, who was currently raining of the Immediate through the previously ining. The Staff hator administered a written y sessions. If staff did not score of one hundred (100%) onsultation was done until a btained. 2/02/2021 on the 6 PM to 6 (re-educated by the ADON buse and Abuse Investigation training included reporting of abuse, neglect, eatment (including injuries of misappropriation of resident y. If an employee suspected ve had happened, they were the the resident was safe, and o their supervisor who would o the abuse coordinator, in ouse policy. Staff not working, ff and new hires would be xt scheduled shift. Prior to xt shift, the Staff nator administered a written	{F 609}			
	-	not achieve the passing				

If continuation sheet Page 40 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 0 FORM AF OMB NO. 09	PROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY
		185256	B. WING		R-C	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/16/2	2021
			20	00 NURSING HOME LANE		
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER	Р	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)		(X5) DMPLETION DATE
{F 609}	consultation was dor	d (100%) percent, individual ne until a passing score was ed (100%) percent of the	{F 609}			
	On 12/03/2021, the I reeducated SRNA #2 requirement to imme department supervis witnessed abuse or r witnessing or hearing provided that the aller removed from the bu- investigation. The A coordinate the invest required agencies. 6. Beginning 12/03/2 Consultant (RNC), A Nursing (DON), Assi (ADON), Social Serv interview residents w or greater daily and a with a BIMS score of any signs of abuse of they feel safe in the f abuse, and have not the immediate jeopal weekly until substant achieved. Results of reported to the Quali Improvement (QAPI) DON/ADON. 7. On 12/03/2021, th reviewed the grievant days to ensure no at on the grievance log	Director of Nursing (DON) 25 and SRNA #26 on the or any verbal allegation or neglect immediately upon g it. Training was also eged perpetrator would be hilding pending the dministrator would then tigation and report to all 2021 the Regional Nurse dministrator, Director of stant Director of Nursing rice Director (SSD) would with a BIMS score of eight (8) assess the skin of residents if seven (7) or less daily for or any unidentified to ensure facility, have not witnessed been subject to abuse, until rdy has been removed then tial compliance has been if the interviews would be ty Assurance Performance o committee by the				

Facility ID: 100599

If continuation sheet Page 41 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/2022 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		R-C 12/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	N 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 609}	Continued From pag	e 41	{F 609}			
	that alleged abuse or	neglect.				
	hallway and all grieva the grievance officer. Grievances/complain be investigated and of taken to resolve the g officer would either in assign the grievance director/supervisor for 12/03/2021, the Adm and review grievance Regional Director of Divisional Vice Presid	or investigation. Beginning inistrator would also report es received each day with the Operations (RDO) or dent (DVP) daily until the was removed and then				
	consulting firm contra the Governing Body Nursing Officer, Chie Vice President, New Regional Nurse Cons the definition of abus abuse investigating, and staff responsibili Officer, Master Healt Master of Public Adm Healthcare (MPA), Li Administrator (LNHA Compliance Specialis Company provided a education session or reporting, recognizing abuse and neglect. compliance requirem	e Rytes Company (outside acted to achieve compliance) consisting of the Chief of Strategy Officer, Divisional Regional Vice President, sultant were re-educated on the, abuse reporting and Grievance and complaints ty. The Chief Operating hcare Administration (MHA), ninistration and Geriatric censed Nursing Home), and Certified Healthcare st (CHC) of the Rytes n in-depth review and n abuse investigation, abuse g signs and symptoms of They also reviewed the tents, the self-reporting e Kentucky mandatory				

Facility ID: 100599

If continuation sheet Page 42 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	01/20/2022 APPROVED 0.0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R- 12/*	-C 16/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		10/202
PARKVIE	W POST-ACUTE AND R	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)	3E	(X5) COMPLETION DATE
{F 609}	Continued From page	ge 42	{F 609}			
	reporting requireme	nt.				
	governing body wou daily until the immed and substantial com Members of the gov RDO and/or DVP, R and/or Chief Nursing the governing body review the resident a grievances filed eac abuse, and/or allega investigated, and all suspended. Informa would be provided to Assurance Performa	3/2021 a member of the uld be on site at the facility diate jeopardy was removed apliance was achieved. verning body included the New Regional Nurse Consultant g Officer. While a member of was in the facility, they would abuse interviews and ch day to ensure allegations of ations were reported, leged perpetrators ation gathered from audits o the facility's Quality ance Improvement (QAPI) Iministrator would report to the				
		gency verified the facility lowing corrective actions:				
	Administrator intervi #358 and the Region assessed the reside	v documentation revealed the iewed Residents #324 and anal Nurse Consultant (RNC) ents as outlined in the ance (AOC) on 12/02/2021, ere identified.				
	the new Regional D interviewed Resider 12/03/2021 and the residents was re-inv AOC by the new RD documentation and Administrator on 12/	ocumentation also revealed irector of Operations (RDO) nt #324 and #358 on allegation regarding both vestigated as stated in the DO. Further review of facility interview with the /16/2021 at 4:40 PM revealed use regarding SRNA# 24 and				

Facility ID: 100599

If continuation sheet Page 43 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/20/2022 APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-	·C 16/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	121	10/2021
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		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)		(X5) COMPLETION DATE
{F 609}	Continued From pag	e 43	{F 609}			
		reported on 11/10/2021 to the				
		oolice department, and the physician and the allegation				
	regarding Resident #	#324 was reported on				
	11/21/2021, to the st department, and the	ate agencies, the police				
	physician.	resident's attending				
	Peview of investigati	on findings after re-opening				
		terview with the Administrator				
		0 PM revealed the facility				
	suspended the SRN/ employment was terr	A #24 on 11/21/2021, and her minated The facility				
		o the nurse aide abuse				
	registry on 12/06/202	21.				
	Review of SRNA# 24	4's timecard and interview				
	with the DVP on 12/					
		istered Nurse Aide (SRNA) on 11/21/2021 and had now				
	worked at the facility					
	Interview with Reside	ent #324 on 12/16/2021 at				
		ew with Resident #358 on				
		AM revealed both residents				
		, no complaints regarding voiced and both residents				
	stated they were free					
	2 Review of intervie	ews/skin assessments				
		gional Nurse Consultant				
		ector of Nursing (ADON)				
		on 12/02/2021 revealed all S with eight (8) or greater				
	were asked if they fe	elt safe in the facility, had				
		had been subject to abuse re identified. Further reviews				
		e ADON on 12/16/2021 at				
		12/02/2021 residents with a				

Facility ID: 100599

If continuation sheet Page 44 of 144

	-	AND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING	ETN/	R-C 12/16/202<u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
{F 609}	BIMS score of sev for signs of abuse	age 44 ven (7) or less were assessed , any open areas, new bruising, sters or skin tears and no	{F 609}		
	concerns were ide 3. Review of educ				
	Divisional Vice Pro Administrator on 1 Investigation Repo Program, and Rec	esident (DVP) re-educated the 2/02/2021 on facility's Abuse orting, Abuse Prevention cognizing Signs of Abuse. DVP on 12/16/2021 at 4:50 PM			
	revealed a new RI the building as of	DO was assigned to oversee 12/03/2021.			
	sheets revealed th Operations (RDO) interdisciplinary te	raining materials and sign in ne Regional Director of ne-educated the facility am on 12/03/2021 regarding he following staff members: the			
	Administrator, Dire Assistant Director Service Director ((MDS) coordinator	ector of Nursing (DON), of Nursing (ADON), Social SSD), Minimum Data Set rs, Human Resources,			
	Maintenance, Cer Staff Developmen Activities Director,	lanager, Medical Records, htral Supply, Dietary Manager, t Coordinator, Wound Nurse, Unit manager and			
	facility provided co revealed the facilit completed a writte	undry Supervisor. Review of ompetency testing documents ty interdisciplinary team on post-test, with a passing			
	Interview with the PM, the Social Se	red (100%) percent. ADON on 12/16/2021 at 4:33 rvices Director on 12/16/2021			
	12/16/2021 at 4:2	ne Director of Nursing (DON) on 5 PM revealed they had egarding the facility's abuse			

Facility ID: 100599

If continuation sheet Page 45 of 144

		ND HUMAN SERVICES			FORM	: 01/20/2022 APPROVED . 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-	-C 16/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/	10/2021
				200 NURSING HOME LANE		
PARAVIEN	WPOST-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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 609}	Continued From page	ge 45	{F 609			
		nd had taken a post-test				
	4:33 PM and review revealed all staff wo PM-6 AM shift were ADON regarding the Further review of on continued interview at 4:33 PM, revealed scheduled to work, and new hires were to take a post-test c scheduled shift. Re the ADON revealed and completed a po Interview with SRNA PM; Licensed Practi 12/16/2021 at 3:20 Registered Nurse (F 3:15 PM; confirmed Investigation/Report violation of abuse, n mistreatment (includ source and misappr should be reported i supervisor. The ADO revealed staff were suspected that abus immediately ensure	going education provided and with the ADON on 12/16/2021				
	would remove the a building pending the immediately reporte	visor. Further, the supervisor lleged perpetrator from the investigation and d the allegation to the abuse				
	coordinator.					

If continuation sheet Page 46 of 144

	-	ND HUMAN SERVICES				FORM	0: 01/20/2022 APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				-C 16/2021	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		10/202	
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER			NURSING HOME LANE			
				PIR	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)		(X5) COMPLETION DATE	
{F 609}	Continued From pag	ge 46	{F 60)9}				
	12/16/2021 at 4:25 I provided to staff rev facility reeducated S Assistant (SRNA) #2 immediately report a department supervise occurred. Interview with the Ad 4:40 PM revealed he investigations and e reported to state ag Review of an allege resident abuse betw Resident #361 whic 3:10 PM revealed ne practices of reportin investigation was or been taken to protect residents and no co Interview with Resid 3:40 PM and intervie 12/16/2021 at 3:30 I the facility and had no 6. Interview with the 4:33 PM and review Questionnaires reve all residents in the fa or greater were inter RNC #2, ADON and the residents felt sa abuse, and had not concerns were ident	d incident of resident to veen Resident #322 and h occurred on 12/14/2021 at o concerns with the facility g nor investigating. The ngoing; however, actions had ct those and all other ncerns were identified. lent #322 on 12/16/2021 at ew with Resident #361 on PM revealed they felt safe in no concerns related to abuse. e ADON on 12/16/2021 at of Resident Abuse Interview saled beginning on 12/03/2021 acility with a BIMS of eight (8) rviewed daily by the DON, d/or Social Worker to ensure fe, had not been subject to witnessed abuse. No						

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/20/2022 APPROVED . 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-	
NAME OF P	ROVIDER OR SUPPLIER	100200		TREET ADDRESS, CITY, STATE, ZIP CODE	12/1	16/202 <u>1</u>
				00 NURSING HOME LANE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION 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)		(X5) COMPLETION DATE
{F 609}	interviewing them da	#361 at 3:30 PM and 0 PM confirmed staff were ily. The stated they had no	{F 609}			
	reported to facility sta Review of skin asses on 12/03/2021, the R assessed the skin of seven (7) or less dail redness, rash, blister had not occurred. No 7. Interview with the (RVP) on 12/16/2021 reviewed the grievan previous thirty (30) d of abuse was include concerns were identi 8. Observations on grievance forms were the resident care unit Interview with the Ad 4:40 PM revealed he	fied. 12/16/2021 revealed e located on each hallway of ts in the facility. ministrator on 12/16/2021 at was the grievance officer				
	grievances/complain be investigated and of taken to resolve the of Administrator also sta process in the facility guidelines regarding Interview with the Re on 12/16/2021 at 4:5 to review the grievan	ne process to ensure any ts voiced at the facility would corrective actions would be grievance(s). The ated he would oversee the r to ensure the regulatory grievances were followed. egional Vice President (RVP) 0 PM revealed she continued ce log daily and oversee to is in compliance with the				

Facility ID: 100599

If continuation sheet Page 48 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	01/20/2022 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-0	
		105250		TREET ADDRESS, CITY, STATE, ZIP CODE	12/1	6/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER			00 NURSING HOME LANE			
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)		(X5) COMPLETION DATE
{F 609}	Continued From pag	e 48	{F 609}			
	 #10 on 12/16/2021 at training provided to a retrained and were refollowing the training process in the facility. Review of facility grie grievance was filed of #362 regarding his/h odor. Further review investigated, the resident's grievance to cumented log/grievance form. Interview with Reside 12:00 PM revealed h grievance regarding bathroom and facility grievance. The resident is grievance. The resident is grievance. The resident is grievance form. 9. Review of training documentation, and 12/03/2021, the Ryte Governing Body con Officer, Chief Strateg President, New Regi Regional Nurse Con abuse, abuse reportigrievances and com responsibility. The Gwere also educated of the strateg of the strateg	evance forms revealed a on 12/14/2021 by Resident ier bathroom appearance and revealed the grievance was ident was interviewed, and nce was resolved on vere no allegations of abuse, on the grievance ent #362 on 12/16/2021 at ne/she had voiced a cleanliness of his/her v staff had resolved the dent had no current concerns n the facility. g documentation, testing sign-in sheets revealed on es Company, educated the sisting of the Chief Nursing gy Officer, Divisional Vice ional Vice President, sultant on the definition of ing and abuse investigating,				
		use and neglect, state requirement, a self-reporting				

If continuation sheet Page 49 of 144

	-	H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/20/202 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED	
185256		B. WING		R-C 12/16/2021		
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	_		
		200 1	NURSING HOME LANE			
PARAVIEN	V PUST-ACUTE 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
{F 609}	Continued From	page 49	{F 609}			
	incident form and reporting require	the Kentucky mandatory ment.				
	4:40 PM, RNC # with the Divisiona 12/16/2021 at 4: the training provi regarding identify	e Administrator on 12/16/2021 at 2 on 12/16/2021 at 3:40 PM, and al Vice President (DVP) on 50 PM revealed they attended ded by the Rytes company ying and reporting abuse, policies, and completed a g the training.				
	Divisional Vice P 4:50 PM revealed member of the gr facility daily and until the immedia substantial comp governing body r reviewed the res grievances filed of allegations of ab investigated, and suspended per th guidelines. Conti	cords and interview with the resident (DVP) on 12/16/2021 at d that beginning 12/03/2021, a overning body was onsite at the would continue to be onsite daily ate jeopardy was removed, and diance was achieved. The member in the facility also idents' abuse interviews, and each day to ensure there were no use that were not immediately I alleged perpetrators were he facility policy and regulatory nued interviews revealed the gathered, and audit information PI.				
{F 610}	the team met on provided no evid identified.	cility's QAPI meetings revealed 12/13/2021 and documentation ence any new concerns were ent/Correct Alleged Violation	{F 610}		12/21/21	
• •	CFR(s): 483.12(c) §483.12(c) In res					

If continuation sheet Page 50 of 144

		ND HUMAN SERVICES			PRINTED: 01/20/202 FORM APPROVEI OMB NO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C	
NAME OF P	ROVIDER OR SUPPLIER	100200		TREET ADDRESS, CITY, STATE, ZIP CODE	12/16/202 <u>1</u>	
				00 NURSING HOME LANE		
PARAVIE	WPOST-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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
{F 610}	Continued From pag must:	je 50	{F 610}			
	§483.12(c)(2) Have violations are thorou	evidence that all alleged ghly investigated.				
		nt further potential abuse, , or mistreatment while the ogress.				
	designated represer accordance with Sta Survey Agency, with incident, and if the a	t the results of all administrator or his or her itative and to other officials in te law, including to the State in 5 working days of the lleged violation is verified <i>v</i> e action must be taken.				
	by: Based on interview, policy review, it was to ensure allegations investigated for two residents (Resident	T is not met as evidenced record review, and facility determined the facility failed s of abuse were thoroughly (2) of three (3) sampled #324 and Resident #358).		F610 The Allegation of abuse by SRNA# 24 resident # 324 was re-investigated sta 12/3/2021 by the new Regional Direct Operations. SRNA #25 and # 26 were re-interviewed by new Regional Direct of Operations on 12/3/2021&& Reside	irting or of or	

Facility ID: 100599

If continuation sheet Page 51 of 144

		I AND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
185256		B. WING	R-C 12/16/2021		
	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	12/10/202
NAME OF PROVIDER OR SUPPLIER			00 NURSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC
{F 610}	Continued From r	page 51	/F 610\		
{F 610}	grabbed Resident the resident during the resident. Resi Social Worker (SW of Operations (RD him/her. Interview SW and review of 11/10/2021, revea Resident #324's re them SRNA #24 h facility took no act resident care. Th "grievance" which resolved by movin however, and then the facility complet the allegation in o abused Resident = Furthermore, appl later, on 11/10/202 SRNA #25 and SF resistive to care a proceeded to strik arm/shoulder. The and initiated an in facility concluded	a Assistant (SRNA) #24 #324 by the ankle and "jerked" g turning and repositioning of dent #324 reported to the facility W) and to the Regional Director DO) that SRNA #24 "hurt" w with the RDO and the facility's a grievance form dated aled the RDO and SW went to oom and the resident informed hurt him/her; however, the tion to remove the SRNA from e facility completed a stated the grievance would be ng SRNA #24 to another floor; re was no documented evidence ted a thorough investigation of rder to determine if SRNA #24	{F 610}	324 was re-interviewed by new Regio Director of Operations on 12/3/2021. The Allegation of abuse by SRNA# 2- resident # 358 was re-investigated st 12/3/2021 by the new Regional Direct Operations. SRNA #25 and # 26 were re-interviewed by new Regional Direct of Operations on 12/3/2021&& Resid 358 was re-interviewed by new Regio Director of Operations on 12/3/2021. SRNA #24 was terminated on 12/9/20 All residents with a BIMS of 8 or great were interviewed by the Regional Nu Consultant, Assistant Director of Nurs and/or Administrator on 12/2/2021. T residents were asked if they felt safe the facility, had witnessed abuse or h been subject to abuse. No residents voiced any concerns. All residents with a BIMS of 7 or less their skin checked for any new bruise redness, rash, blister, skin tears or op areas by the regional nurse consulta and/or Assistant Director of Nursing of 12/2/2021. There were no new skin is identified All staff working 12/2/2021 on the 6p- shift were verbally re-educated by the Assistant Director of Nursing on the definition of Abuse- Abuse is defin	4 to arting tor of ector ent # onal 021. ter rse sing he in ad had , oen ant on ssues 6a
	witnesses to the in to review the ever incident and failed on 11/10/2021, wh the same staff (SF	considering there were two (2) ncident. The facility also failed nts leading up to the alleged t to consider a previous incident here another resident alleged RNA #24) "hurt" him/her. The		willful infliction of injury, unreasonable confinement, intimidation, or punishm with resulting physical harm, pain, or mental anguish and Abuse Investigat and Reporting - An alleged violation of abuse, neglect, exploitation or	ion
	11/17/2021, provid	SRNA #24 to return to work on ding resident care. Additionally, RNA #26 witnessed the incident,		mistreatment (including injuries of unknown source and misappropriatio resident property) will be reported	n of

Facility ID: 100599

If continuation sheet Page 52 of 144

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI F	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					R-C
	185256		B. WING		
		105200			12/16/202 <u>1</u>
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER			TREET ADDRESS, CITY, STATE, ZIP CODE		
			00 NURSING HOME LANE		
	SUMMARY	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J (X5)
(X4) ID PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
{F 610}	Continued From p	age 52	{F 610}		
	at approximately 5	5:00 PM, but failed to report until		immediately to the department superv	visor
		0 PM, and the facility		who will then call the abuse coordinat	
		to identify this failure to		If an employee suspects that either of	-
	immediately repor	-		above has happened, they are to	
				immediately ensure the resident is sa	fe,
	The facility's failur	e to have an effective system in		and immediately report to their superv	visor
	place to ensure al	l allegations of abuse were		who will immediately report to the abu	ise
	thoroughly investig	gated has caused or is likely to		coordinator, in accordance to the abu	se
	cause serious inju	ry, harm, impairment or death		policy. The supervisor will remove the	•
	to a resident. Imm	ediate Jeopardy (IJ) was		alleged perpetrator from the building	
		2/2021, and was determined to		pending the investigation. The	
		21, at 42 CFR 483.12 Freedom		Administrator will then coordinate the	
		, F609, and F610), 42 CFR		investigation and report to all required	
		tion (F835 and F837), and 42		agencies. Beginning 12/3/2021 staff r	
		ty Assurance and Performance		working on 12/2/2021 including agend	-
		67). Substandard Quality of		staff and new hires will be educated b	•
		dentified at 42 CFR 483.12		the DON, ADON, IP, Regional Directo	
		use (F600, F609, and F610).		Nursing, regional nurse or consultant	
	on 12/02/2021 and	otified of Immediate Jeopardy		their next scheduled shift. All employe who have worked have been in-servic	
		a is ongoing.		and completed a post-test competence	
	Refer to F600 and	1 E600		12/20/2021.	,y Dy
		11003		The CMS hand in hand training modu	le 5
	An acceptable alle	egation of compliance (AoC)		Preventing and responding to Abuse I	
		2/14/2021, which alleged		been added to the annual training	
		mediate Jeopardy on		program for all employees of Parkview	v.
		State Survey Agency		All Grievances/complaints filed with th	
		mediate Jeopardy was		facility will be investigated and correct	
		ed during a revisit conducted on		actions will be taken to resolve the	
	-	lowered the scope and		grievance(s). Grievance forms are loc	ated
	severity to "D" at 4	12 CFR 483.12 Freedom from		on each hallway, all grievances will be	e
		9, and F610); 42 CFR 483.70		reviewed grievance officer who is the	
		335 and F837); and 42 CFR		Administrator. The Social Service	
	-	surance and Performance		Director will serve as a backup grieva	
		67), while the facility monitors		officer to the Administrator. Grievance	
		of systemic changes and quality		officer will either investigate grievance	
	assurance activitie	es.		assign the grievance to the manager	of
				the department it relates to for	
	The findings inclue	de:		investigation. The grievance officer with	

Facility ID: 100599

If continuation sheet Page 53 of 144

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256		(X2) MULTIPLE A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		B. WING	R-C		
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/16/202 <u>1</u>
			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
{F 610}	Continued From	page 53	{F 610}		
	Review of the fac Investigating and of July 2017, reve abuse shall be pr and federal agend by facility manage the individual con interview any witr all staff members with the resident of incident, and revie alleged incident. Review of the fac "Grievances/Com date of April 2017 complaints would Grievance officer the appropriate st depending on the policy further stat or neglect would I guidelines for rep 1. Review of Res revealed the facili 03/24/2021 with c	ility policy titled "Abuse Reporting", with a revision date ealed all reports of resident omptly reported to local, state, cies and thoroughly investigated ement. The policy further stated ducting the investigation would nesses to the incident, interview (on all shifts) who had contact during the period of the alleged ew all events leading up to the		follow up on grievances to ensure a thorough investigation has been conducted and the grievance has been resolved. Beginning 12/3/2021 staff no working on 12/2/2021 including agence staff and new hires will be educated by the DON, ADON, IP, Regional Directo Nursing, regional nurse or consultant of their next scheduled shift. All employed who have worked have been in-service and completed a post-test competency 12/20/2021. The New Regional Director of Operation and/or Divisional VP reviewed the grievance log for the last 30 days on December 3, 2021 to ensure no abuse allegations were noted on the grievance log and not reported or investigated. There were no logged grievances that alleged abuse or neglect. #4 Beginning the first week of December 2021 the Administrator/DON/ADON or Unit Manager quizzes 5 random staff monthly on the s/s of abuse and when report abuse. Results are reported to to QAPI committee to ensure staff have a continue understanding of the policy/regulations related to abuse and neglect. Beginning 12/3/2021 residents with a	ot y y r of on es ed y by ons ons e ce per to he a
	11/10/2021, untim reported to the fa SRNA "grabbed" bandaged and "je resident informed	plaint/Grievance Report, dated ned, revealed Resident #324 cility Social Worker (SW), a his/her ankle, which was erked" the resident's legs. The the SW, it "hurt". The report mpleted on 11/10/2021 and the		BIMS of 8 or greater will be interviewe the Regional Nurse Consultant, Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Staff Development/ Infection Preventionist, Medical Recorr Wound Nurse or staff nurse to ensure they feel safe in the facility, have not	d,

Facility ID: 100599

If continuation sheet Page 54 of 144

-				PRINTED: 01/20/20 FORM APPROVE OMB NO. 0938-039
IENCIES CTION	(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		R-C 12/16/202<u>1</u>
		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
		20		
-ACUTE AND F		P	KEVILLE, KY 41501	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
nued From pag	ge 54	{F 610}		
to work anoth on positionin nentation reve ucated on 11/2 eporting as w itioning of resi w of the Nurse 2021 at 5:30 was assessed wound that w rns were note w of the Quar) Assessment cility assessed nterview for M (15) out of fif ent was cognition (15) out of fif ent was cognition (15) out of fif ent was cognition and with Resid M, revealed h occurred on 2 ent #324 state of further state a burt someone iew with State A) #25, on 11/ (2021 at 8:05 (2021 at 1:47) evealed they w ent #324 and	her floor and educate the g. Review of training ealed SRNA #24 was 17/2021 on Abuse Prevention ell as turning and dents. b's Progress Note, dated PM, revealed Resident #324's d, and there was no changes as present, and no redness or d. terly Minimum Data Set , dated 11/11/2021, revealed d the resident as having a lental Status (BIMS) score of teen (15) indicating the ively intact. terl #324, on 11/20/2021 at he/she did recall the incident 11/10/2021 with SRNA #24. ed, "She did abuse me". The ed, he/she did not like that the tt the facility because, "She e else". Registered Nursing Assistant 20/2021 at 7:29 PM and AM, and with SRNA #26, on PM and 11/21/2021 at 9:51 vitnessed the incident with SRNA #24 on 11/10/2021	{r o i u}	subject to abuse, daily until the immedieopardy has been removed then week until substantial compliance has been achieved. Beginning 12/3/2021 residents with a BIMS of 7 or less will have their skin checked for any new bruise, redness, rash, blister, skin tears or open areas the Regional Nurse Consultant, Direct of Nursing, Assistant Director of Nursi Staff development/ infection prevention wound nurse, or staff nurse daily until immediate jeopardy has been removed then weekly until substantial compliant has been achieved. Beginning 12/3/2021 the Administrato report, and review for timely reporting thorough investigation of grievances a any allegation of abuse/neglect receiv each day with the Regional Director o Operations and/or Divisional Vice President daily until the immediate jeopardy is removed and then weekly substantial compliance is achieved.	by tor ing, onist, the ed ice ir will and and yed f
	MEDICARE & MEDICARE & IENCIES CTION OR SUPPLIER -ACUTE AND F -ACUTE AND F -ACUTE AND F -ACUTE AND F -ACUTE AND F -ACUTE AND F -C-C-C-C-C-C-C-C-C-C-C-C-C-C-C-C-C-C-C	CTION IDENTIFICATION NUMBER: 185256 OR SUPPLIER	MEDICARE & MEDICAID SERVICES VENCIES VENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING 185256 OR SUPPLIER -ACUTE AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Aude From page 54 At work another floor and educate the to on positioning. Review of training nentation revealed SRNA #24 was ucated on 11/17/2021 on Abuse Prevention eporting as well as turning and tioning of residents. w of the Nurse's Progress Note, dated 2021 at 5:30 PM, revealed Resident #324's was assessed, and there was no changes wound that was present, and no redness or rns were noted. w of the Quarterly Minimum Data Set (15) out of fifteen (15) indicating the nt was cognitively intact. ew with Resident #324, on 11/20/2021 at M, revealed he/she did recall the incident occurred on 11/10/2021 with SRNA #24. ent #324 stated, "She did abuse me". The nt further stated, he/she did not like that the still worked at the facility because, "She hurt someone else". ew with State Registered Nursing Assistant A) #25, on 11/20/2021 at 7:29 PM and 2021 at 8:05 AM, and with SRNA #26, on 2021 at 1:47 PM and 11/21/2021 at 9:51 evealed they witnessed the incident with ent #324 and SRNA #24 on 11/10/2021 d 4:30 PM. Both SRNAs stated SRNA #24	MEDICARE & MEDICAID SERVICES LENCIES (X1) PROVIDERSUPPLERCULA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BULDING

If continuation sheet Page 55 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/202 FORM APPROVE OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C	
NAME OF P	ROVIDER OR SUPPLIER	100200		TREET ADDRESS, CITY, STATE, ZIP CODE	12/16/202 <u>1</u>	
			00 NURSING HOME LANE			
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER	Р	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 610}	Continued From pag statement regarding		{F 610}			
	Interview with the Ref (RDO), on 11/21/202 11/23/2021 at 9:20 A filed a grievance on provided by SRNA # Resident #324 did no Per interview, if the r hurt him/her, then the investigated as an at the interview, the RD reported SRNA #24 do when he (RDO) aske abused, the resident RDO, therefore, the a investigated or repor interview revealed ar completed because to with the resolution to another area of the fa SRNA on repositionin grievance was satisfit therefore an investig. The RDO confirmed from patient care imr Interview with the So 11/21/2021 at 12:12 10:13 AM, revealed as Officer for the facility worker in the facility at the time the incide she was still in trainin training at a sister fac Grievance Officer on The SW stated she v 11/10/2021 when Re	egional Director of Operations 1 at 10:54 AM, and again on M, revealed Resident #324 11/10/2021 related to care 24. The RDO initially stated ot say the SRNA hurt him/her. esident had stated the SRNA e allegation would have been ouse allegation. Later during 00 stated Resident #324 did hurt him/her; however, ed the resident if he/she was responded, "no". Per the allegation was not ted as abuse. Continued investigation was not the resident was satisfied reassign SRNA #24 to acility and to re-educate the ng. The RDO stated the led immediately and ation was not completed. SRNA #24 was not removed mediately after this incident. cial Worker (SW), on PM and on 12/01/2021 at she was the Grievance and just started as the social on 11/03/2021. Per interview, nt occurred on 11/10/2021, ng. Further, she received cility on her role as the 11/15/2021 and 11/16/2021. vas present with the RDO on				

Facility ID: 100599

If continuation sheet Page 56 of 144

	-	HAND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED
185256		B. WING		R-C 12/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		200 N	URSING HOME LANE		
		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)	BE COMPLÉTIC
{F 610}	Continued From	page 56	{F 610}		
		ported SRNA #24 hurt him/her,			
		ned further, the resident stated			
		bused. The SW further stated all			
		reviewed with the RDO and the			
		ensure they were investigated			
		abuse if necessary. She stated			
		t #324 stated he/she was not			
		plaint was not investigated as an			
	abuse allegation.				
	Interview with the	Administrator, on 11/21/2021 at			
		ed he was the Abuse			
		ne facility and investigated any			
		use. He stated he was aware			
	Resident #324 file	ed a grievance against SRNA			
		21; however, the resident did not			
		bused. Further interview			
		gation was not investigated as			
		ore, there was no documentation			
		stigation nor was SRNA #24 oved from resident care due to			
	this incident.				
	2. Review of Res	sident #358's clinical record			
		ity admitted the resident on			
		diagnoses including Cerebral			
		c Obstructive Pulmonary			
		kiety. Review of the Quarterly			
		t with a reference date of			
		aled the facility assessed the g a Brief Interview for Mental			
		bre of fifteen (15) out of fifteen			
		e resident was cognitively intact.			
	Review of a "Self	-Reported Incident Form" dated			
		aled on 11/10/2021, SRNA #25			
		eported SRNA #24 struck			
	Resident #358 or	the left shoulder while			
	performing activit	ies of daily living (ADL) care.			

If continuation sheet Page 57 of 144

	-	ND HUMAN SERVICES			PRINTED: 01/20/202 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		R-C 12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				00 NURSING HOME LANE PIKEVILLE, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
{F 610}	Continued From page	ge 57	{F 610}		
		the Administrator was the			
	Note, dated 11/10/2	#358's Nurse's Progress 021, revealed there was no noted to the left shoulder.			
	(SRNA) #25's writte 11/10/2021, reveale strike Resident #356 while the resident w	gistered Nursing Assistant n Witness Statement, dated d she witnessed SRNA #24 3 on the left arm/shoulder as refusing care. Further e and the other aide "stepped re to the resident.			
	strike Resident #358	6's written Witness , revealed she saw SRNA #24 8 on the left arm and she and e of the resident after the			
	undated, revealed w	4's Witness Statement, /hile providing care to "tapped" the resident's hand sident to turn.			
	12:05 PM, revealed with staff at times an The resident stated to be bothered. Per at the staff, they wo alone for a while "lik back later. The resid not recall an incider	lent #358, on 11/21/2021 at he/she would get aggravated nd would "get loud" with them. sometimes he/she did not like interview, when he/she yelled uld usually leave him/her te they should" and come dent further stated he/she did at where staff hit him/her.			
	(SRNA) #25, on 11/	Registered Nursing Assistant 20/2021 at 7:29 PM and AM, revealed she provided			

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES	(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		R-C	
			ET ADDRESS, CITY, STATE, ZIP CODE	12/16/202 <u>1</u>	
			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 610}	Continued From	page 58	{F 610}		
. ,	-	#358 on 11/10/2021 at			
		00 PM, with SRNA #24 and			
		stated Resident #358 was			
	resisting care and	d yelling. She further stated the			
	resident was on h	nis/her right side and SRNA #24			
		esident when SRNA #24 struck			
		e left upper arm/shoulder area.			
		she heard an audible noise			
		hit the resident and it "shocked"			
		terview revealed SRNA #25 and			
		ed the incident at the end of the ant Director of Nursing (ADON)			
		6:00 PM and was asked to			
		statement as to what happened			
		irector of Operations. Per			
	-	ovided a written statement, but			
	was not interview	ed again about the incident nor			
	asked to provide	any further information.			
		NA #26, on 11/20/2021 at 1:47			
		21 at 9:51 AM, revealed the			
		/2021 with Resident #358			
		roximately 5:00 PM. She stated			
		A #25, and she (SRNA #26) went 's room to provide care for the			
		rview, SRNA #24 was trying to			
		8 to change clothes and clean			
		esident had spilled something on			
		26 stated the resident was wet			
	and was refusing	to change. She further stated			
		Resident #358 on the left			
		l it made an audible noise.			
		ew revealed she and SRNA #25			
		lent to the Assistant Director of			
		at approximately 6:00 PM, at the nd was asked to provide a			
		at that time. SRNA #26 stated			
		viewed again by facility staff nor			
		questions regarding the			

Facility ID: 100599

If continuation sheet Page 59 of 144

SERVICES ER/SUPPLIER/CLIA CATION NUMBER:			OMB NO. 0938-039	
	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
185256		B. WING		
		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
PARKVIEW POST-ACLITE AND REHABILITATION CENTER		200 NURSING HOME LANE		
PARKVIEW POST-ACUTE AND REHABILITATION CENTER				
EFICIENCIES ECEDED BY FULL NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE	
	{F 610	0}		
20/2021 at 7:08 M, revealed she ankle. Per f the pillows used the resident get out of the e went out into e RDO to come ed him that the e. Further at red Resident it appeared er bed and trying to over so they t, she "tapped" NA #24 stated dent and only ge him/her to t was changed, r, so they n she clocked e she clocked she clocked out a message to a statement. or a week and				
	it appeared r bed and trying to over so they t, she "tapped" VA #24 stated dent and only te him/her to t was changed, r, so they a she clocked she clocked out message to a statement. or a week and	it appeared r bed and trying to over so they t, she "tapped" NA #24 stated dent and only he him/her to t was changed, r, so they she clocked she clocked she clocked out message to a statement. or a week and	it appeared r bed and trying to over so they t, she "tapped" NA #24 stated dent and only le him/her to t was changed, r, so they le she clocked she clocked out message to a statement. or a week and tor of Nursing	

Facility ID: 100599

If continuation sheet Page 60 of 144

		I AND HUMAN SERVICES <u> E & MEDICAID SERVICES</u>			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING	ETN/	R-C 12/16/202<u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER		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 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)	
{F 610}	Continued From	page 60	{F 610}		
. ,	-	the facility to provide a written	(****)		
		In the rated at that point SRNA			
		bending the investigation.			
		ew revealed the ADON went to			
		room within five to ten (5-10)			
		the incident was reported and			
		assessment on the resident and			
		or bruising. Per interview, she			
		sident if anyone had hit him/her			
		im/her, and the resident denied			
	being hit by anyo				
		ensed Practical Nurse (LPN) 21 at 10:14 AM and 11/30/2021			
		d she was working on			
		SRNA #26 reported to her that			
		RNA #24 abuse Resident #358.			
		he was assigned to care for			
		11/10/2021 and was working at			
		cident, but was not asked to			
		ent and was not interviewed			
	regarding the inci	dent.			
	Review of the fac	ility's Investigation, revealed a			
	completion date of	of 11/16/2021. The summary of			
	the investigation	revealed residents with a BIMS			
		n eight (8) were interviewed and			
	asked if they felt	safe, if they were being treated			
	well, and if they h	ad any concerns. Further			
	review of the inve	stigation revealed skin			
		residents with BIMS scores of			
) were completed. The summary			
		staff and the resident involved			
		However, there was no			
		ence of interviews with staff in			
	-	only written statements from			
		A #25, and SRNA #26. The			
	-	stated, based on Resident			
	#358's statement	, the allegation of abuse was			

If continuation sheet Page 61 of 144

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/20/20 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	ETN/	R-C 12/16/202<u>1</u>
NAME OF PF	ROVIDER OR SUPPLIER		STRE	ET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
{F 610}	Continued From	bage 61	{F 610}		
. ,	-	There was no documented			
		vestigation that the previous			
		ident #324 and SRNA #24 was			
		at the events leading up to the			
		IA #24 and Resident #358 were			
		more, there was no			
		ence the facility identified during			
		that SRNA #25 and SRNA #26			
		tely report an allegation of			
	abuse.				
	Interview with the	Regional Director of Operations			
	(RDO), on 11/21/2	2021 at 10:54 AM, revealed on			
	11/10/2021, two (2) SRNAs (SRNA #25 and			
	SRNA #26) repor	ted an allegation of abuse to the			
		stated the witnesses wrote out			
		and a statement was obtained			
		SRNA #24) that the allegation			
		she was suspended. The RDO			
		rmation was given to the			
		ause he was the abuse			
	coordinator and to	ook over the investigation.			
		Administrator, on 11/21/2021 at			
		/22/2021 at 8:58 AM, revealed			
		ng on the abuse policy upon hire			
		tor. Per interview, he was the			
	•	ordinator and was responsible			
		use investigations. The			
		ted he became aware of the			
		IA #24 and Resident #358			
		ely after it happened". He stated			
		him on 11/10/2021, after he had			
	•	d told him about the incident ON and the RDO) had			
		A #24 and were getting			
		the staff. The Administrator			
		ot home, he made the			
	•	e state agencies, according to			

If continuation sheet Page 62 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO. (PPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SU COMPLE	RVEY
- E		185256	B. WING		R-C 12/16	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	12,10	
PARKVIE	W POST-ACUTE AND R	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 APPROPRIA DEFICIENCY)	- 1	(X5) COMPLETION DATE
{F 610}	the policy. However, Administrator was ur #26 witnessed the in PM, but failed to report PM, as this had not be investigation of the ir stated he completed 11/16/2021 and unsu- abuse based on Reso- he/she was not abus- revealed he was awa 11/10/2021, which out provided care for Re- stated he did not cor- making the determin Resident #358 was un Administrator stated #324 was "a care isse abuse. The facility provided Jeopardy Removal Fe alleged removal of the on 12/13/2021. The facility implement actions: 1. On 12/02/2021, the Residents #324 and concerns with abuse voiced. On 12/02/2020 Consultant (RNC) alse ensure there was no blister, skin tears or of no concerns. The allegation of abu	per interview, the haware SRNA #25 and SRNA cident, at approximately 5:00 ort until approximately 6:00 been identified during the holdent. The Administrator the investigation on ubstantiated the allegation of ident #358's statement that ed. Further interview, are of the incident on courred when SRNA #24 sident #324. However, he hasider this incident when ation that the allegation with unsubstantiated. The the incident with Resident oue" and not an allegation of an acceptable Immediate Plan, on 12/14/2021, that he Immediate Jeopardy (IJ) hted the following corrective	{F 610}			

If continuation sheet Page 63 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 01/20/2022 A APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _			LETED
		185256	B. WING			-C 16/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/16/202 <u>1</u> E, ZIP CODE	
		EHABILITATION CENTER	20	00 NURSING HOME LANE		
FARAVIE	W POST-ACOTE AND R	ENABILITATION 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 610}	Continued From pag	e 63 starting 12/03/2021 by the	{F 610}			
	new Regional Direct SRNA #25 and #26 a	or of Operations (RDO). and Resident #358 were w RDO on 12/03/2021.				
	 #358, was reported of reporting agencies, president's attending abuse involving Rest 11/21/2021, to the st department, and the physician. SRNA #211/21/2021 and has #24 was also reported on 12/06/2021. 2. All residents with status (BIMS) score interviewed and resident (7) or less were assed Director of Nursing (0 on 12/02/2021. The signs of abuse and whad witnessed, or we had witnessed, or we had witnessed, or we see the status of the status o	use by SRNA #24 to Resident on 11/10/2021 to the state police department, and the physician. The allegation of ident #324 was reported on ate reporting agencies, police resident's attending 44 was suspended on not returned to work. SRNA ed to the nurse aide registry a brief interview for mental of eight (8) or greater were dents with a BIMS of seven essed by the RNC, Assistant ADON), and/or Administrator residents were assessed for vere asked if they felt safe, ere subjected to, abuse in the no concerns identified.				
	 was re-educated on Vice President (DVP Reporting, Abuse Pr Signs of Abuse. A ne oversee the building 4. On 12/03/2021 th Operations (RDO) re interdisciplinary man Administrator, Direct 	ector of Operations (RDO) 12/02/2021 by the Divisional on Abuse Investigation evention, and Recognizing ew RDO was assigned to as of 12/03/2021. The new Regional Director of e-educated the facility agement team, including the or of Nursing (DON), Nursing (ADON), Social				

Facility ID: 100599

If continuation sheet Page 64 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/20/2022 APPROVED . 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE S COMPL	LETED
		185256	B. WING		R-	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	12/16/202<u>1</u> , 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 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)	3E	(X5) COMPLETION DATE
{F 610}	Continued From pag	e 64	{F 610}			
		imum Data Set (MDS) Resources, Business Office				
	Supply, Dietary Man	ecords, Maintenance, Central ager, Staff Development				
		Nurse, Activities Director, ekeeping/Laundry Supervisor				
	regarding the definiti defined as the willful	on of Abuse. "Abuse" was infliction of injury,				
		ement, intimidation, or Ilting physical harm, pain, or				
	mental anguish. The	e training also included Abuse				
	-	porting, which included violation of abuse, neglect,				
		eatment (including injuries of misappropriation of resident				
	property) immediatel	y. If an employee suspected				
		ve had happened, they were the residents were safe,				
	and then immediatel	y report the situation to the				
		r, who would immediately dinator, who was currently				
		aining of the Immediate through the previously				
	mentioned abuse tra	ining. The Staff				
		nator administered a written sessions. If staff did not				
	achieve the passing	score of one hundred (100%)				
	passing score was o	onsultation was done until a btained.				
	-	2/02/2021 on the 6 PM to 6				
	-	/ re-educated by the ADON buse and Abuse Investigation				
	and Reporting. The any alleged violation	training included reporting				
	exploitation, or mistre	eatment (including injuries of				
		misappropriation of resident y. If an employee suspected				
		ve had happened, they were				

Facility ID: 100599

If continuation sheet Page 65 of 144

	-	HAND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	85256 B. WING		R-C 12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
			200 N	IURSING HOME LANE	
PARKVIE	N 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
{F 610}	Continued From	page 65	{F 610}		
. ,		sure the resident was safe, and			
		rt to their supervisor who would			
		rt to the abuse coordinator, in			
		e abuse policy. Staff not working,			
		staff and new hires would be			
		next scheduled shift. Prior to			
		r next shift, the Staff			
		ordinator administered a written			
		did not achieve the passing			
		dred (100%) percent, individual			
		done until a passing score was			
		ndred (100%) percent of the			
	facility staff have				
		he Director of Nursing (DON)			
		A #25 and SRNA #26 on the			
		mediately report to the			
		rvisor any verbal allegation or			
		or neglect immediately upon			
		aring it. Training was also			
		alleged perpetrator would be			
		e building pending the			
		e Administrator would then			
		vestigation and report to all			
	required agencies	5.			
	6. Beginning 12/	03/2021 the Regional Nurse			
), Administrator, Director of			
		Assistant Director of Nursing			
		Service Director (SSD) would			
		ts with a BIMS score of eight (8)			
		nd assess the skin of residents			
		e of seven (7) or less daily for			
		se or any unidentified to ensure			
		he facility, have not witnessed			
		not been subject to abuse, until			
	-	ppardy has been removed then			
	-	tantial compliance has been			
	achieved. Result	s of the interviews would be			

Facility ID: 100599

If continuation sheet Page 66 of 144

STATEMENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		185256 B. WING			R-C 12/16/202<u>1</u>
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
PARKVIE	W POST-ACUTE AND	REHABILITATION CENTER			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTIO
{F 610}	Improvement (QA DON/ADON. 7. On 12/03/2021 reviewed the griev days to ensure not on the grievance of investigated. Then that alleged abuse 8. Grievance form hallway and all gri the grievance offic Grievances/comp be investigated an taken to resolve the officer would eithe assign the grievan director/supervise 12/03/2021, the A and review grievan Regional Director Divisional Vice Pri immediate jeopan weekly until subst achieved. 9. On 12/03/2021 consulting firm co the Governing Bo Nursing Officer, C Vice President, N Regional Nurse C the definition of all abuse investigatir	uality Assurance Performance PI) committee by the I, the New RDO and/or DVP vance log for the last thirty (30) o abuse allegations were noted log and not reported or re were no logged grievances	{F 610}		

Facility ID: 100599

If continuation sheet Page 67 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	0: 01/20/2022 APPROVED 0: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE COMP	LETED
		185256	B. WING		R- 12/'	-C 16/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	STATE, ZIP CODE	
PARKVIE	W 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 610}	Administrator (LNHA Compliance Speciali Company provided a education session or reporting, recognizin abuse and neglect. compliance requiremen incident form, and th reporting requiremen 10. Beginning 12/03 governing body woul daily until the immed and substantial comp Members of the gove RDO and/or DVP, Re and/or Chief Nursing the governing body w review the resident a grievances filed each abuse, and/or allega investigated, and alle suspended. Informat would be provided to Assurance Performa program and the Adr governing body. The State Survey Ag implemented the follo 1. Review of facility Administrator intervie #358 and the Region assessed the residen	censed Nursing Home), and Certified Healthcare st (CHC) of the Rytes in in-depth review and in abuse investigation, abuse g signs and symptoms of They also reviewed the inents, the self-reporting e Kentucky mandatory it. /2021 a member of the d be on site at the facility iate jeopardy was removed bliance was achieved. erning body included the New egional Nurse Consultant Officer. While a member of vas in the facility, they would buse interviews and in day to ensure allegations of tions were reported, eged perpetrators ion gathered from audits the facility's Quality nce Improvement (QAPI) ninistrator would report to the ency verified the facility pwing corrective actions: documentation revealed the ewed Residents #324 and nal Nurse Consultant (RNC) nts as outlined in the nce (AOC) on 12/02/2021,	{F 610}			

Facility ID: 100599

If continuation sheet Page 68 of 144

<u>CENT</u> ER	<u>S FOR MED</u> ICARE	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	R WING		R-C
	AME OF PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE , 200 NURSING HOME LANE		12/16/202 <u>1</u>
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETIC
{F 610}	Continued From p	bage 68	{F 610}		
. ,	-	documentation also revealed	[1 0 10]		
	•	Director of Operations (RDO)			
		lent #324 and #358 on			
		ne allegation regarding both			
	residents was re-investigated as stated in the AOC by the new RDO. Further review of facility				
		nd interview with the			
		12/16/2021 at 4:40 PM revealed			
		buse regarding SRNA# 24 and			
		as reported on 11/10/2021 to the			
		e police department, and the			
		ng physician and the allegation nt #324 was reported on			
	• •	e state agencies, the police			
		the resident's attending			
	physician.				
		pation findings after re-opening			
	-	I interview with the Administrator			
		4:40 PM revealed the facility			
	•	RNA #24 on 11/21/2021, and her terminated. The facility			
		A to the nurse aide abuse			
	registry on 12/06/2				
	Review of SRNA#	# 24's timecard and interview			
		12/16/2021 at 4:50 PM			
		Registered Nurse Aide (SRNA)			
		ed on 11/21/2021 and had now			
	worked at the faci	ility since that date.			
	Interview with Res	sident #324 on 12/16/2021 at			
		erview with Resident #358 on			
		40 AM revealed both residents			
		ility, no complaints regarding			
		ere voiced and both residents			
	stated they were f				
	2. Review of inter				

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		R-C
		185256	B. WING		12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	12/10/2021
			. 200 NURSING HOME LANE		
PARKVIE	W POST-ACUTE ANI	D REHABILITATION CENTER		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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
{F 610}	Continued From	nade 69	{F 610}		
[1 0 10]		-	{F 0 10}		
		Regional Nurse Consultant Director of Nursing (ADON)			
		ator on 12/02/2021 revealed all			
		BIMS with eight (8) or greater			
		y felt safe in the facility, had			
	witnessed abuse,	, or had been subject to abuse			
	and no concerns	were identified. Further reviews			
	and interview with	n the ADON on 12/16/2021 at			
		d on 12/02/2021 residents with a			
		ven (7) or less were assessed			
	-	e, any open areas, new bruising,			
		sters or skin tears and no			
	concerns were id	entified.			
	3. Review of edu	cation provided to the Regional			
		tions (RDO) revealed the			
	Divisional Vice Pi	resident (DVP) re-educated the			
		12/02/2021 on facility's Abuse			
		oorting, Abuse Prevention			
		cognizing Signs of Abuse.			
		DVP on 12/16/2021 at 4:50 PM			
		RDO was assigned to oversee			
	the building as of	12/03/2021.			
	4. Review of the	training materials and sign in			
	sheets revealed t	he Regional Director of			
	Operations (RDO) re-educated the facility			
		eam on 12/03/2021 regarding			
		the following staff members: the			
		rector of Nursing (DON),			
		r of Nursing (ADON), Social			
		(SSD), Minimum Data Set			
		ors, Human Resources, ⁄Ianager, Medical Records,			
		ntral Supply, Dietary Manager,			
		nt Coordinator, Wound Nurse,			
		r, Unit manager and			
		aundry Supervisor. Review of			
		competency testing documents			

Facility ID: 100599

If continuation sheet Page 70 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING	ETN/	R-C 12/16/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	12/10/2021
		EHABILITATION CENTER	200	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 610}	Continued From pag	je 70	{F 610}		
		interdisciplinary team post-test, with a passing d (100%) percent.			
	PM, the Social Service at 4:20 PM, and the 12/16/2021 at 4:25 F received training reg	DON on 12/16/2021 at 4:33 ces Director on 12/16/2021 Director of Nursing (DON) on PM revealed they had arding the facility's abuse and had taken a post-test ion training.			
	4:33 PM and review revealed all staff wor	ADON on 12/16/2021 at of education provided to staff rking on 12/02/2021 on the 6 verbally re-educated by the e definition of abuse.			
	continued interview of at 4:33 PM, revealed scheduled to work, w and new hires were of to take a post-test co scheduled shift. Red the ADON revealed a	going education provided and with the ADON on 12/16/2021 d staff that were not which included agency staff educated and were required ompetency before their next cord review and interview with all staff had been educated st-test by 12/13/2021.			
	PM; Licensed Practic 12/16/2021 at 3:20 F Registered Nurse (R 3:15 PM; confirmed t Investigation/Reporti violation of abuse, ne mistreatment (includi source and misappro should be reported in	A #1 on 12/16/2021 at 3:00 cal Nurse (LPN) # 10 on PM; and interview with RN) #12 on 12/16/2021 at training also included Abuse ing and that any alleged eglect, exploitation or ing injuries of unknown opriation of resident property) mmediately to the department DN and SRNA interview also			

If continuation sheet Page 71 of 144

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	A. BUILDING B. WING		R-C 12/16/2021
NAME OF P	AME OF PROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	12/10/2021
				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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
{F 610}	Continued From	-	{F 610}		
	suspected that at	re instructed that if an employee buse had occurred, they were to ire the resident was safe. They			
	report to their sup	then required to immediately pervisor. Further, the supervisor e alleged perpetrator from the			
	building pending	the investigation and rted the allegation to the abuse			
	12/16/2021 at 4:2 provided to staff r facility reeducated	Director of Nursing (DON) on P PM and review of education revealed on 12/03/2021, the d State Registered Nursing) #25 and SRNA #26 to			
	immediately repo	rt any allegations of abuse to the rvisor when the incident			
	4:40 PM revealed	Administrator on 12/16/2021 at he would coordinate the d ensure all allegations were			
	reported to state a Review of an alle resident abuse be Resident #361 wh	agencies as required. ged incident of resident to etween Resident #322 and hich occurred on 12/14/2021 at			
	practices of repor investigation was been taken to pro	I no concerns with the facility ting nor investigating. The ongoing; however, actions had btect those and all other concerns were identified.			
	3:40 PM and inter 12/16/2021 at 3:3	sident #322 on 12/16/2021 at rview with Resident #361 on 30 PM revealed they felt safe in ad no concerns related to abuse.			

Facility ID: 100599

If continuation sheet Page 72 of 144

		ND HUMAN SERVICES			FORM	D: 01/20/2022 A APPROVED D: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		<u> </u>	LETED
		185256	B. WING			-C 16/2021
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 R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
{F 610}	Continued From pag	ge 72	{F 610}			
	Questionnaires reve all residents in the fa or greater were inte RNC #2, ADON and the residents felt sa abuse, and had not concerns were idem Interview with Resident Resident #322 at 3: interviewing them da concerns of abuse of reported to facility s Review of skin asse on 12/03/2021, the assessed the skin of seven (7) or less da redness, rash, bliste had not occurred. N 7. Interview with the (RVP) on 12/16/202 reviewed the grieva previous thirty (30) of abuse was includ concerns were idem 8. Observations on grievance forms we the resident care un Interview with the A	aaled beginning on 12/03/2021 acility with a BIMS of eight (8) rviewed daily by the DON, l/or Social Worker to ensure fe, had not been subject to witnessed abuse. No tified. lent #362 on 12/16/2021 at #361 at 3:30 PM and 40 PM confirmed staff were aily. The stated they had no or neglect and none had been taff during the interviews ssments revealed beginning RNC, DON and ADON f residents with a BIMS of ily to ensure any new bruise, er, skin tears or open areas to concerns were identified. e Regional Vice President 1 at 4:50 PM revealed she nce log on 12/03/2021 for the days to ensure no allegations ed on the log and no tified. 12/16/2021 revealed re located on each hallway of				
	and would oversee grievances/complain	the process to ensure any nts voiced at the facility would corrective actions would be				

Facility ID: 100599

If continuation sheet Page 73 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 01/20/2022 1 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	<u> </u>	LETED
		185256	B. WING	ETN/		-C 16/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	10/2021
PARKVIEV	V POST-ACUTE AND RE	EHABILITATION CENTER	200 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)		(X5) COMPLETION DATE
{F 610}	process in the facility	ated he would oversee the v to ensure the regulatory	{F 610}			
	guidelines regarding Interview with the Re on 12/16/2021 at 4:5 to review the grievan ensure the facility wa grievance process. Interview with Licens #10 on 12/16/2021 a training provided to s retrained and were re following the training process in the facility Review of facility grie grievance was filed of #362 regarding his/h odor. Further review investigated, the resi the resident's grievan 12/16/2021. There w neglect documented log/grievance form. Interview with Reside 12:00 PM revealed h grievance. The resid with care/treatment in 9. Review of training	grievances were followed. gional Vice President (RVP) 0 PM revealed she continued ce log daily and oversee to as in compliance with the ed Practical Nurse (LPN) t 3:20 PM and review of taff confirmed staff were equired to take a post-test , regarding the grievance r. evance forms revealed a on 12/14/2021 by Resident er bathroom appearance and revealed the grievance was dent was interviewed, and nce was resolved on vere no allegations of abuse, on the grievance ent #362 on 12/16/2021 at e/she had voiced a cleanliness of his/her r staff had resolved the lent had no current concerns				
	12/03/2021, the Ryte Governing Body cons	es Company, educated the sisting of the Chief Nursing y Officer, Divisional Vice				

If continuation sheet Page 74 of 144

		E & MEDICAID SERVICES			OMB NO. 0938-03		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING				
		195356	B. WING		R-C		
		185256			12/16/202 <u>1</u>		
NAME OF PI	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE			
PARKVIE	V POST-ACUTE AND	D REHABILITATION CENTER		IURSING HOME LANE			
(X4) ID	SUMMAR	RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	(EACH DEFIC	OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETIC		
{F 610}	Continued From	page 74	{F 610}				
(* • • • • • •		Regional Vice President,					
		Consultant on the definition of					
	-	porting and abuse investigating,					
		omplaints and staff					
		e Governing body members					
	were also educate	ed on conducting abuse					
		ouse reporting, recognizing signs					
		abuse and neglect, state					
		ce requirement, a self-reporting					
		the Kentucky mandatory					
	reporting requirer	nent.					
	Interview with the	Administrator on 12/16/2021 at					
		2 on 12/16/2021 at 3:40 PM, and					
	with the Divisiona	al Vice President (DVP) on					
	12/16/2021 at 4:5	50 PM revealed they attended					
		ded by the Rytes company					
		ring and reporting abuse,					
		olicies, and completed a					
	post-test following	g the training.					
		cords and interview with the					
		resident (DVP) on 12/16/2021 at					
		that beginning 12/03/2021, a					
	-	overning body was onsite at the					
		would continue to be onsite daily					
		te jeopardy was removed, and					
		liance was achieved. The					
		nember in the facility also dents' abuse interviews, and					
		each day to ensure there were no					
	•	use that were not immediately					
		alleged perpetrators were					
	-	he facility policy and regulatory					
		nued interviews revealed the					
	-	gathered, and audit information					
	was taken to QAF	-					
	Povious of the fee	ilitu's OADI mostings revealed					
-		ility's QAPI meetings revealed					

If continuation sheet Page 75 of 144

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		185256	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		12/16/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIEF				
PARKVIE	V POST-ACUTE AN	D REHABILITATION CENTER		00 NURSING HOME LANE	
(X4) ID		RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
{F 610}	Continued From	page 75	{F 610}		
		12/13/2021 and documentation ence any new concerns were			
{F 835} SS=D	Administration CFR(s): 483.70		{F 835}		12/21/21
	enables it to use efficiently to attai	administered in a manner that its resources effectively and n or maintain the highest cal, mental, and psychosocial			
	by: Based on intervi Administrator's Jo facility's policies a determined the fa	ENT is not met as evidenced ew, record review, review of the ob Description, and review of the and procedures, it was acility failed to be administered in otected the residents from		F835 Residents #324 and #358 had their ski checked for any new bruises, redness, rash, blister, skin tears or open areas b the RN regional nurse consultant on 12/2/2021. There were no new skin iss identified.	ру
	Resident #324 re him/her by the ar while turning and incident was with #26. Resident #3 SRNA #24, statin he/she wanted to SRNA. This alleg	approximately 4:30 PM, ported that SRNA #24 grabbed ikle and "jerked" the resident repositioning him/her. This essed by SRNA #25 and SRNA 24 yelled out and cursed at g the SRNA hurt him/her and file a grievance against the gation was not reported to cies, nor was there an ated.		Residents #324 and #358 were interviewed on 12/2/2021 by the Administrator, they were asked if they is safe in the facility, had witnessed abus had been subject to abuse, Both reside # 324 and #358 stated they felt safe in facility and both resident #324 and # 38 stated they had not witnessed abuse n were they subject to abuse. All residents with a BIMS of 8 or greate were interviewed by the Regional Nurs	e or ents the 58 or er e
	Approximately th	irty (30) minutes later, on		Consultant, Assistant Director of Nursin and/or Administrator on 12/2/2021. The	-

Facility ID: 100599

If continuation sheet Page 76 of 144

		H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		185256	B. WING		12/16/2021
NAME OF PI	ROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE		
			. 2	00 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC
{F 835}	Continued From	nage 76	{F 835}		
(,			[1 000]	residents were asked if they felt safe	in
		IA #24 entered Resident #358's care with SRNA #25 and SRNA		residents were asked if they felt safe	
		425 and SRNA #25 and SRNA		the facility, had witnessed abuse or h	iau
		sident #358 on the left		been subject to abuse. No residents voiced any concerns.	
		icility Administration failed to		All residents with a BIMS of 7 or less	had
		-			
		tigate the allegation of abuse and		their skin checked for any new bruise	
	-	staff did not immediately report		redness, rash, blister, skin tears or o	
	this allegation.			areas by the regional nurse consult	
		the large starting		and/or Assistant Director of Nursing of	
		ire to have an effective		12/2/2021. There were no new skin is	
		ensure the facility's policies		identified. On 12/12/21 The Administ	
		ed and failure to ensure its		conducted in-services with Director o	
		tilized effectively and efficiently		Nursing, and Social Services Directo	
		likely to cause serious injury,		concerning Significant Event Call (SE	EC)
		t, or death to a resident.		policy, Abuse, Neglect, and	
		ardy (IJ) was identified on		Misappropriation especially reporting	and
		determined to exist on		investigating and the Concerns,	
		2 CFR 483.12 Freedom from		Complaint, and Grievance policy.	
		09, and F610); 42 CFR 483.70			
	Administration (F	835 and F837); and 42 CFR		The Regional Director of Operations	was
	483.75 Quality As	ssurance and Performance		re-educated on 12/2/2021 by the	
	Improvement (F8	867). Substandard Quality of		Divisional Vice President on Abuse	
	· · ·	identified at 42 CFR 483.12		Investigation Reporting, Abuse Preve	ention
		ouse (F600, F609, and F610).		Program, and Recognizing Signs of	
	The facility was r	notified of Immediate Jeopardy		Abuse. A new Regional Director of	
	on 12/02/2021 ar	nd IJ is ongoing.		Operations has been assigned to over	ersee
				the building as of 12/3/2021.	
	Refer to F600, F6	609, F610, and F867		On 12/3/2021 the new Regional Dire	ctor
				of Operations re-educated the facility	,
	An acceptable al	legation of compliance (AoC)		interdisciplinary management team,	
	was received on	12/14/2021, which alleged		including the Administrator, Director	of
	removal of the Im	nmediate Jeopardy on		Nursing, Assistant Director of Nursing	g,
	12/13/2021. The	e State Survey Agency		Social Service Director, MDS	
	determined the Ir	mmediate Jeopardy was		coordinators, Human Resources,	
	removed as alleg	ed during a revisit conducted on		Business Office Manager, Medical	
		h lowered the scope and		Records, Maintenance, Central Supp	ly,
	severity to "D" at	42 CFR 483.12 Freedom from		Dietary Manager, Staff Development	
	-	09, and F610); 42 CFR 483.70		Coordinator, Wound Nurse, Activitie	
		835 and F837); and 42 CFR		Director, Unit manager,	

Facility ID: 100599

If continuation sheet Page 77 of 144

	S FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				R-C	
		185256	B. WING		12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		s	<u> </u>	
			STREET ADDRESS, CITY, STATE, ZIP CODE , 200 NURSING HOME LANE		
PARKVIE	W POST-ACUTE ANI	D REHABILITATION CENTER	Р		
(X4) ID		RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	IENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
{F 835}	Continued From	page 77	{F 835}		
	483.75 Quality As	ssurance and Performance		Housekeeping/Laundry Supervisor wer	e
		67), while the facility monitors		verbally re-educated on the definition o	
		of systemic changes and quality		Abuse- Abuse is defined as willful	
	assurance activiti			infliction of injury, unreasonable	
				confinement, intimidation, or punishme	nt
	The findings inclu	ıde:		with resulting physical harm, pain, or	
				mental anguish and Abuse Investigation	n
		s the Job Description for		and Reporting - An alleged violation of	
		ith a revision date of January		abuse, neglect, exploitation or	
		e primary purpose of the		mistreatment (including injuries of	
		rect day-to-day functions of the		unknown source and misappropriation	of
	-	nce with current federal, state,		resident property) will be reported	
		ds, guidelines, and regulations		immediately to the department supervis	
		highest degree of quality care		who will then call the abuse coordinator	
		o residents at all times. If the Administrator included to		If an employee suspects that either of t above has happened, they are to	ne
		ntain written policies and		immediately ensure the resident is safe	
		professional standards of		and then immediately report situation to	
		ern the operation of the facility.		immediate supervisor who will	,
		and the operation of the facility.		immediately notify the abuse coordinate	or
	Review of the fac	ility's "Abuse Investigating and		which is currently the Administrator. The	
		, with a revision date of July		Staff Development coordinator	
		I reports of resident abuse shall		administered a written test following	
		rted to local, state, and federal		training sessions. If staff did not achiev	e
		roughly investigated by facility		the passing score of 100%, individual	
	management. The	e policy further stated the		consultation was done until a passing	
	individual conduc	ting the investigation would		score was obtained	
		nesses to the incident, interview		The supervisor will remove the alleged	
		(on all shifts) who had contact		perpetrator from the building pending the	
		during the period of the alleged		investigation. The Administrator will the	
		ew all events leading up to the		coordinate the investigation and report	to
	alleged incident.			all required agencies. Beginning	
				12/3/2021 staff not working on 12/2/202	
		ility's "Recognizing Signs and		including agency staff and new hires wi	11
	• •	use/Neglect" Policy, with a		be educated by the DON, ADON, IP,	
		anuary 2011, revealed the facility		Regional Director of Nursing, regional	
		he any form of resident abuse or		nurse or consultant on their next	
		cy further stated all personnel		scheduled shift. All employees who have	/e
	were to report an	y signs and symptoms of		worked have been in-serviced and	

Facility ID: 100599

If continuation sheet Page 78 of 144

CENTER	S FOR MEDICARI	E & MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		185256	B. WING		12/16/2021
	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	12/10/2021
				00 NURSING HOME LANE	
PARKVIE	V POST-ACUTE ANI	D REHABILITATION CENTER		IKEVILLE, KY 41501	
(X4) ID	SUMMAR	RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETIC
{F 835}	Continued From	page 78	{F 835}		
	abuse/neglect to of Nursing immed	their supervisor or the Director Jiately.		completed a post-test competency by 12/20/2021	
				All Grievances/complaints filed with the	
		omplaint/Grievance Report,		facility will be investigated and correcting	ve
		, untimed, revealed Resident		actions will be taken to resolve the	4
		the facility Social Worker, that a the resident's ankle which was		grievance(s). Grievance forms are loca on each hallway, all grievances will be	ited
	-	erked" the resident's legs. The		reviewed grievance officer who is the	
		"hurt". The plan to resolve the		Administrator. The Social Service	
		reassign the SRNA to another		Director will serve as a backup grievan	ce
	-	icate the SRNA on positioning.		officer to the Administrator. Grievance	
		the report revealed the		officer will either investigate grievance	or
		nce was resolved and the results		assign the grievance to the manager o	
	of the grievance v	were communicated to Resident		the department it relates to for	
	#324 and the resi	ident signed the report on		investigation. The grievance officer will	
		report was signed as completed		follow up on grievances to ensure a	
	-	y the Social Worker (SW).		thorough investigation has been	
		vas no documented evidence the		conducted and the grievance has been	
		a thorough investigation of the		resolved. Beginning 12/3/2021 staff no	
	-	r to determine if SRNA #24		working on 12/2/2021 including agency	
		#324. In addition, the facility		staff and new hires will be educated by	
		e incident to the appropriate ng to the facility policy.		the DON, ADON, IP, Regional Director Nursing, regional nurse or consultant of	
		ng to the facility policy.		their next scheduled shift. All employee	
	The facility asses	sed Resident #324 in the		who have worked have been in-service	
	-	m Data Set (MDS) Assessment,		and completed a post-test competency	
	, , , , , , , , , , , , , , , , , , ,	date of 11/11/2021, as having a		12/20/2021.	- ,
		r Mental Status (BIMS) score of		Beginning 12/3/2021 residents with a	
		fifteen (15) indicating intact		BIMS of 8 or greater will be interviewed	d by
	cognition. Intervi	ew with Resident #324 on		the Regional Nurse Consultant, Directo	
	11/20/2021 at 9:0	2 AM revealed he remembered		of Nursing, Assistant Director of Nursir	ng,
		n occurred on 11/10/2021 with		Social Service Director or designee to	
		dent #324 stated "She did abuse		ensure they feel safe in the facility, hav	
		nt complained he/she did not like		not witnessed abuse and have not bee	
		Il worked at the facility because		subject to abuse, daily until the immed	
	"She could hurt s			jeopardy has been removed then week until substantial compliance has been	(ly
		"Self-Reported Incident Form"		achieved.	
	aated 11/10/2021	, revealed on 11/10/2021, two		Beginning 12/3/2021 residents with a	

Facility ID: 100599

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
		EHABILITATION CENTER	20	0 NURSING HOME LANE	
PARKVIE	V POST-ACUTE AND R	ERABILITATION CENTER	PI	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
{F 835}	(2) SRNAs (SRNA # another SRNA (SRN on the left shoulder daily living (ADL). F Witness Statement, SRNA #24 strike Re arm/shoulder while f care. Review of SR revealed she saw S #358 on the left arm The facility assesse Quarterly MDS Asse of 09/01/2021, as ha (15) out of fifteen (11) Interview with Resid 12:05 PM, revealed incident where staff Although the facility initiated an investigat documented evidem #25 and SRNA #26 approximately 5:00 incident until approx there was no docum were reviewed leadi or that the previous where another resid (SRNA #24) "hurt" h Additionally, there w of interviews with SF SRNA #26. The faci allegation of abuse o on Resident #358's were two (2) witness	 425 and SRNA #26) reported NA #24) struck Resident #358 while performing activities of Review of SRNA #25's revealed she did witness usident #358 on the left the resident was refusing NA #26's Witness Statement, RNA #24 strike Resident d Resident #358 in the essment with a reference date aving a BIMS score of fifteen 5) indicating intact cognition. lent #358, on 11/21/2021 at he/she did not recall an hit him/her. suspended SRNA #24 and ation, there was no ce the facility identified SRNA witnessed the incident at PM, but failed to report the timately 6:00 PM. Further, nented evidence the events ng up to the alleged incident incident on 11/10/2021, ent alleged the same staff im/her was considered. vas no documented evidence RNA #24, SRNA #25, and lity's investigation found the was unsubstantiated based statement, even though there eses to the incident. The NA #24 to return to work on 	{F 835}	BIMS of 7 or less will have their skin checked for any new bruise, redness, rash, blister, skin tears or open areas b the Regional Nurse Consultant, Directo of Nursing, Assistant Director of Nursin or Designee daily until the immediate jeopardy has been removed then week until substantial compliance has been achieved. Beginning 12/3/2021 the Administrator report, and review for timely reporting a thorough investigation of grievances ar any allegation of abuse/neglect receive each day with the Regional Director of Operations and/or Divisional Vice President daily until the immediate jeopardy is removed and then weekly u substantial compliance is achieved.	y g ly will and ad ad

If continuation sheet Page 80 of 144

PRINTED: 01/20/2022

		AND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE		R-C 12/16/202<u>1</u>
NAME OF PR	ROVIDER OR SUPPLIER				
	POST-ACUTE AND	REHABILITATION CENTER			
			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
{F 835}	Continued From p	page 80	{F 835}		
	Interview with the	Regional Director of Operations			
		2021 at 10:54 AM and on			
		6 PM, revealed all information			
		ons of abuse were given to the			
	Administrator who	o was the Abuse Coordinator			
	and he took over	the investigations. The RDO			
	further stated all a	abuse investigations were			
	reviewed with the	Administrator to ensure the			
	investigations wer	re complete.			
	Interview with the	Administrator, on 11/21/2021 at			
		2021 at 8:58 AM, and			
	12/01/2021 at 11:	01 AM, revealed he took on the			
	role as Administra	ator of the facility on 10/01/2021.			
	He confirmed he	was the Abuse Coordinator and			
		o thoroughly investigate and			
		of abuse to the state agencies			
		ew, he reviewed all grievances			
		they were complete, to ensure			
		vas satisfied with the resolution,			
	and to ensure not	hing was missed.			
	Further interview	with the Administrator, on			
	11/21/2021 at 12:4	43 PM, 11/22/2021 at 8:58 AM,			
	and 12/01/2021 a	t 11:01 AM, revealed the			
	incident with Resi	dent #324 was "a care issue"			
	-	tion of abuse. The Administrator			
	•	resident reported a staff			
		n, it would be reported and			
	-	buse, but since Resident #324			
		nen asked if he/she was abused,			
		not reported to appropriate			
	•	tigated as an allegation of			
		d interview revealed he became			
		lent with SRNA #24 and			
		Imost immediately after it			
	••	nterview, the Administrator was 25 and SRNA #26 witnessed the			
		timately 5:00 PM, but failed to			

If continuation sheet Page 81 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 01/20/2022 A APPROVED). 0938-0391
STATEMENT OF AND PLAN OF 0	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		<u> </u>	LETED
		185256	B. WING			-C 16/2021
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			10/2021
PARKVIEW	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 B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
	the Assistant Directo Administrator stated investigation involvin 11/16/2021 and unsu abuse based on the he/she was not abus Administrator stated incident with Resider determination. The facility provided Jeopardy Removal F alleged removal of th on 12/13/2021. The facility implement actions: 1. On 12/02/2021, th Residents #324 and concerns with abuse voiced. On 12/02/200 Consultant (RNC) al- ensure there was no blister, skin tears or no concerns. The allegation of abu Nursing Assistant (S was re-investigated a new Regional Direct SRNA #25 and #26 a re-interviewed by ne The Allegation of abu #358, was reported o reporting agencies, p	htil approximately 6:00 PM to r of Nursing (ADON). The he completed the g Resident #358 on ubstantiated the allegation of resident's statement saying ed. However, the he did not consider the ht #324 when making the an acceptable Immediate Plan, on 12/14/2021, that he Immediate Jeopardy (IJ) hted the following corrective	{F 835}			

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/2022 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		R-C 12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	N POST-ACUTE AND R	EHABILITATION CENTER	200 NURSING HOME LANE		
				PIKEVILLE, KY 41501	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{F 835}	Continued From pag	e 82	{F 835}		
		ident #324 was reported on			
		ate reporting agencies, police			
	department, and the physician. SRNA #2	4 was suspended on			
	11/21/2021 and has	not returned to work. SRNA			
	#24 was also reporte on 12/06/2021.	ed to the nurse aide registry			
	2. All residents with	a brief interview for mental			
		of eight (8) or greater were			
		dents with a BIMS of seven essed by the RNC, Assistant			
		ADON), and/or Administrator			
		residents were assessed for			
	-	vere asked if they felt safe, ere subjected to, abuse in the			
		no concerns identified.			
		ector of Operations (RDO)			
		12/02/2021 by the Divisional			
	,) on Abuse Investigation evention, and Recognizing			
		ew RDO was assigned to			
	oversee the building	-			
	4. On 12/03/2021 th	e new Regional Director of			
		e-educated the facility			
		agement team, including the			
	Administrator, Direct	or of Nursing (DON), Nursing (ADON), Social			
		nimum Data Set (MDS)			
	coordinators, Humar	Resources, Business Office			
		ecords, Maintenance, Central			
		ager, Staff Development Nurse, Activities Director,			
		ekeeping/Laundry Supervisor			
	regarding the definiti	on of Abuse. "Abuse" was			
	defined as the willful				
	unreasonable confin	ement, intimidation, or			

Facility ID: 100599

If continuation sheet Page 83 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 01/20/2022 1 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		<u> </u>	LETED
		185256	B. WING			-C
	ROVIDER OR SUPPLIER	105250		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	16/202 <u>1</u>
				00 NURSING HOME LANE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION 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)		(X5) COMPLETION DATE
{F 835}	mental anguish. The Investigation and Re- reporting an alleged exploitation, or mistre unknown source and property) immediately that either of the abo to immediately ensur and then immediately immediate superviso notify the abuse coor the Administrator. Tr Supervisors was don mentioned abuse tra Development coordin test following training achieve the passing percent, individual co passing score was of 5. All staff working 12 AM shift was verbally on the definition of Al and Reporting. The any alleged violation exploitation, or mistre unknown source and property) immediately that either of the abo to immediately report to accordance to the ab including agency staff educated on their ne- staff working their ne-	ulting physical harm, pain, or e training also included Abuse porting, which included violation of abuse, neglect, eatment (including injuries of misappropriation of resident y. If an employee suspected ve had happened, they were e the residents were safe, y report the situation to the r, who would immediately rdinator, who was currently raining of the Immediate through the previously ining. The Staff nator administered a written y sessions. If staff did not score of one hundred (100%) onsultation was done until a btained. 2/02/2021 on the 6 PM to 6 (re-educated by the ADON buse and Abuse Investigation training included reporting of abuse, neglect, eatment (including injuries of misappropriation of resident y. If an employee suspected ve had happened, they were the resident was safe, and o their supervisor who would o the abuse coordinator, in ouse policy. Staff not working, ff and new hires would be xt scheduled shift. Prior to	{F 835}			
	Development Coordi					

Facility ID: 100599

If continuation sheet Page 84 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	0: 01/20/2022 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE	
- F		185256	B. WING			-C
NAME OF P	ROVIDER OR SUPPLIER	100200		IREET ADDRESS, CITY, STATE, ZIP CODE	12/	16/202 <u>1</u>
				00 NURSING HOME LANE		
PARKVIE	W POST-ACUTE AND RI	EHABILITATION 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
TAG {F 835}	Continued From pag score of one hundred consultation was dor obtained. One hundr facility staff have bee On 12/03/2021, the II reeducated SRNA #2 requirement to imme department supervis witnessed abuse or n witnessing or hearing provided that the alle removed from the bui investigation. The A coordinate the invest required agencies. 6. Beginning 12/03/2 Consultant (RNC), A Nursing (DON), Assi (ADON), Social Serv interview residents w or greater daily and a with a BIMS score of any signs of abuse of	e 84 d (100%) percent, individual ne until a passing score was red (100%) percent of the en educated. Director of Nursing (DON) 25 and SRNA #26 on the rediately report to the or any verbal allegation or neglect immediately upon g it. Training was also reged perpetrator would be	TAG {F 835}		ATE	DATE
	 abuse, and have not the immediate jeopar weekly until substant achieved. Results of reported to the Quali Improvement (QAPI) DON/ADON. 7. On 12/03/2021, the reviewed the grievant days to ensure no at on the grievance log 	been subject to abuse, until rdy has been removed then tial compliance has been f the interviews would be ty Assurance Performance committee by the ne New RDO and/or DVP fice log for the last thirty (30) buse allegations were noted				

Facility ID: 100599

If continuation sheet Page 85 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03	/ED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED	
- E		185256	B. WING		R-C 12/16/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/10/202	
		EHABILITATION CENTER		200 NURSING HOME LANE		
PARAVIEN	W POST-ACUTE AND RE	ENABLITATION 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC	ЛС
{F 835}	Continued From pag that alleged abuse or		{F 835	5}		
	 8. Grievance forms of hallway and all grieva the grievance officer. Grievances/complain be investigated and of taken to resolve the go officer would either in assign the grievance director/supervisor for 12/03/2021, the Adm and review grievance Regional Director of Divisional Vice Preside immediate jeopardy of weekly until substant achieved. 9. On 12/03/2021 th consulting firm contrat the Governing Body Nursing Officer, Chiev Vice President, New Regional Nurse Const the definition of abus abuse investigating, and staff responsibili Officer, Master Healtt Master of Public Adm Healthcare (MPA), Li Administrator (LNHA Compliance Specialis Company provided a education session or reporting, recognizing abuse and neglect. compliance requirem 	were located on each ances would be reviewed by , the Administrator. All hts filed with the facility would corrective actions would be grievance(s). The grievance nvestigate the grievance or to the department or investigation. Beginning hinistrator would also report es received each day with the Operations (RDO) or dent (DVP) daily until the was removed and then				

Facility ID: 100599

If continuation sheet Page 86 of 144

		ND HUMAN SERVICES			FORM	0: 01/20/2022 APPROVED 0: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE COMP	LETED
		185256	B. WING		R- 12/*	-C 16/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		10/202
PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID	SUMMARY S	STATEMENT 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{F 835}	Continued From pag	je 86	{F 835}			
	reporting requirement	nt.				
	governing body wou daily until the immed and substantial com Members of the gov RDO and/or DVP, R and/or Chief Nursing the governing body review the resident a grievances filed eac abuse, and/or allega investigated, and all suspended. Informa would be provided to Assurance Performa	3/2021 a member of the ald be on site at the facility diate jeopardy was removed apliance was achieved. reming body included the New Regional Nurse Consultant g Officer. While a member of was in the facility, they would abuse interviews and th day to ensure allegations of ations were reported, leged perpetrators tion gathered from audits to the facility's Quality ance Improvement (QAPI) ministrator would report to the				
		gency verified the facility lowing corrective actions:				
	Administrator intervi #358 and the Region assessed the reside	documentation revealed the iewed Residents #324 and nal Nurse Consultant (RNC) ents as outlined in the ance (AOC) on 12/02/2021, ere identified.				
	the new Regional Di interviewed Residen 12/03/2021 and the residents was re-inv AOC by the new RD documentation and Administrator on 12/	allegation regarding both restigated as stated in the DO. Further review of facility				

Facility ID: 100599

If continuation sheet Page 87 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	01/20/2022 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE S COMPL	ETED
		185256	B. WING		R-0 12/1	C 6/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		0/202
PARKVIE	N POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE		
			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)		(X5) COMPLETION DATE
{F 835}	Continued From pag	e 87	{F 835}			
		reported on 11/10/2021 to the				
		oolice department, and the physician and the allegation				
	regarding Resident #	#324 was reported on				
	11/21/2021, to the standard department, and the	ate agencies, the police				
	physician.	resident's attending				
	Peview of investigati	on findings after re-opening				
		terview with the Administrator				
		0 PM revealed the facility				
	suspended the SRN/ employment was terr	A #24 on 11/21/2021, and her minated The facility				
		o the nurse aide abuse				
	registry on 12/06/202	21.				
	Review of SRNA# 24	4's timecard and interview				
	with the DVP on 12/1					
		istered Nurse Aide (SRNA) on 11/21/2021 and had now				
	worked at the facility					
	Interview with Reside	ent #324 on 12/16/2021 at				
		ew with Resident #358 on				
		AM revealed both residents				
		, no complaints regarding voiced and both residents				
	stated they were free					
	2 Review of intervie	ews/skin assessments				
		gional Nurse Consultant				
		ector of Nursing (ADON)				
		on 12/02/2021 revealed all S with eight (8) or greater				
	were asked if they fe	elt safe in the facility, had				
		had been subject to abuse re identified. Further reviews				
		e ADON on 12/16/2021 at				
		12/02/2021 residents with a				

Facility ID: 100599

If continuation sheet Page 88 of 144

	-	AND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIO
{F 835}		age 88 /en (7) or less were assessed	{F 835}		
	for signs of abuse	, any open areas, new bruising, sters or skin tears and no			
	Director of Operat Divisional Vice Pre	ation provided to the Regional ions (RDO) revealed the esident (DVP) re-educated the			
	Investigation Report Program, and Record	2/02/2021 on facility's Abuse orting, Abuse Prevention cognizing Signs of Abuse. DVP on 12/16/2021 at 4:50 PM			
	revealed a new RI the building as of	DO was assigned to oversee 12/03/2021.			
	sheets revealed th	raining materials and sign in ne Regional Director of) re-educated the facility			
	abuse to include to Administrator, Dire	am on 12/03/2021 regarding he following staff members: the ector of Nursing (DON),			
	Service Director ((MDS) coordinator	of Nursing (ADON), Social SSD), Minimum Data Set rs, Human Resources,			
	Maintenance, Cer Staff Developmen	lanager, Medical Records, htral Supply, Dietary Manager, t Coordinator, Wound Nurse,			
	Housekeeping/La facility provided co	Unit manager and undry Supervisor. Review of ompetency testing documents			
	completed a writte	ty interdisciplinary team en post-test, with a passing red (100%) percent.			
	PM, the Social Se at 4:20 PM, and th	ADON on 12/16/2021 at 4:33 rvices Director on 12/16/2021 ne Director of Nursing (DON) on 5 PM revealed they had			
		egarding the facility's abuse			

Facility ID: 100599

If continuation sheet Page 89 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/ FORM APPRC OMB NO. 0938-0	OVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C 12/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	12, 10,202	
		EHABILITATION CENTER	2	00 NURSING HOME LANE		
	N POST-ACOTE AND IN		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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		TION
TAG {F 835}	Continued From pag policy/procedures an following the education 5. Interview with the 4:33 PM and review revealed all staff wor PM-6 AM shift were ADON regarding the Further review of ong continued interview of at 4:33 PM, revealed scheduled to work, w and new hires were of to take a post-test co scheduled shift. Red the ADON revealed a and completed a post Interview with SRNA PM; Licensed Practic 12/16/2021 at 3:20 P Registered Nurse (R 3:15 PM; confirmed t Investigation/Reporti violation of abuse, ne mistreatment (includi	e 89 d had taken a post-test on training. ADON on 12/16/2021 at of education provided to staff king on 12/02/2021 on the 6 verbally re-educated by the definition of abuse. going education provided and with the ADON on 12/16/2021 staff that were not which included agency staff educated and were required impetency before their next cord review and interview with all staff had been educated tt-test by 12/13/2021. #1 on 12/16/2021 at 3:00 cal Nurse (LPN) # 10 on M; and interview with N) #12 on 12/16/2021 at raining also included Abuse ng and that any alleged	TAG {F 835}			
	supervisor. The ADO revealed staff were in suspected that abuse immediately ensure t stated they were then report to their superv would remove the all building pending the	nmediately to the department N and SRNA interview also instructed that if an employee e had occurred, they were to he resident was safe. They in required to immediately isor. Further, the supervisor eged perpetrator from the investigation and I the allegation to the abuse				

If continuation sheet Page 90 of 144

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01 FORM API OMB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURV COMPLETE	VEY
		185256	B. WING		R-C 12/16/2	021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		02_1
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
	STIMMARX S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE CO	MPLETION DATE
{F 835}	Continued From pag	e 90	{F 83	5}		
	12/16/2021 at 4:25 F provided to staff rever facility reeducated Si Assistant (SRNA) #2 immediately report a department supervision occurred. Interview with the Ad 4:40 PM revealed hei investigations and er reported to state age Review of an alleged resident abuse betwo Resident #361 which 3:10 PM revealed no practices of reporting investigation was on been taken to protect residents and no cor Interview with Reside 3:40 PM and intervie 12/16/2021 at 3:30 F the facility and had no 6. Interview with the 4:33 PM and review Questionnaires revea all residents in the fac or greater were intern RNC #2, ADON and/ the residents felt safe abuse, and had not view concerns were identified	ny allegations of abuse to the or when the incident ministrator on 12/16/2021 at a would coordinate the nsure all allegations were encies as required. I incident of resident to een Resident #322 and n occurred on 12/14/2021 at o concerns with the facility g nor investigating. The going; however, actions had t those and all other neerns were identified. ent #322 on 12/16/2021 at wwith Resident #361 on PM revealed they felt safe in to concerns related to abuse. ADON on 12/16/2021 at of Resident Abuse Interview aled beginning on 12/03/2021 icility with a BIMS of eight (8) viewed daily by the DON, for Social Worker to ensure e, had not been subject to witnessed abuse. No				

If continuation sheet Page 91 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 01/20/2022 1 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		<u> </u>	LETED
		185256	B. WING			-C
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	16/202 <u>1</u>
			2	00 NURSING HOME LANE		
PARKVIEN	W POST-ACUTE AND RE	EHABILITATION CENTER	F	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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 835}	Continued From pag		{F 835}			
	12:00 PM, Resident	PM and 0 PM and 0 PM and 0 PM confirmed staff were				
	interviewing them da concerns of abuse or	ily. The stated they had no neglect and none had been aff during the interviews				
	on 12/03/2021, the R assessed the skin of seven (7) or less dail redness, rash, blister	sments revealed beginning NC, DON and ADON residents with a BIMS of y to ensure any new bruise, c, skin tears or open areas o concerns were identified.				
	(RVP) on 12/16/2021 reviewed the grievan	-				
	8. Observations on 7 grievance forms were the resident care unit	e located on each hallway of				
	4:40 PM revealed he and would oversee th grievances/complain be investigated and o taken to resolve the Administrator also st process in the facility	ministrator on 12/16/2021 at was the grievance officer he process to ensure any ts voiced at the facility would corrective actions would be grievance(s). The ated he would oversee the to ensure the regulatory grievances were followed.				
	on 12/16/2021 at 4:5 to review the grievan	gional Vice President (RVP) 0 PM revealed she continued ce log daily and oversee to is in compliance with the				

If continuation sheet Page 92 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/20/2022 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE COMP	
		185256	B. WING		R-	
	ROVIDER OR SUPPLIER	165250		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	16/202 <u>1</u>
	NOWDER OR GOT LIER			00 NURSING HOME LANE		
PARKVIE	W 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 835}	Continued From pag	e 92	{F 835}			
	 #10 on 12/16/2021 at training provided to a retrained and were refollowing the training process in the facility. Review of facility grie grievance was filed of #362 regarding his/h odor. Further review investigated, the resident's grievance to cumented log/grievance form. Interview with Reside 12:00 PM revealed h grievance regarding bathroom and facility grievance. The resident is grievance. The resident is grievance. The resident is grievance form. 9. Review of training documentation, and 12/03/2021, the Ryte Governing Body con Officer, Chief Strateg President, New Regi Regional Nurse Con abuse, abuse reportigrievances and com responsibility. The Gwere also educated or the stratege of the	evance forms revealed a on 12/14/2021 by Resident ier bathroom appearance and revealed the grievance was ident was interviewed, and nce was resolved on vere no allegations of abuse, on the grievance ent #362 on 12/16/2021 at ne/she had voiced a cleanliness of his/her v staff had resolved the dent had no current concerns n the facility. g documentation, testing sign-in sheets revealed on es Company, educated the sisting of the Chief Nursing gy Officer, Divisional Vice ional Vice President, sultant on the definition of ing and abuse investigating,				
		use and neglect, state requirement, a self-reporting				

If continuation sheet Page 93 of 144

-	AND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03
F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
	185256	B. WING		R-C 12/16/202<u>1</u>
ROVIDER OR SUPPLIEF		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
POST-ACUTE AN	D REHABILITATION CENTER			
(EACH DEFIC	IENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG		
Continued From	page 93	{F 835}		
4:40 PM, RNC #2 with the Divisiona 12/16/2021 at 4:5 the training provis regarding identify grievances and p	2 on 12/16/2021 at 3:40 PM, and al Vice President (DVP) on 50 PM revealed they attended ded by the Rytes company ing and reporting abuse, olicies, and completed a			
Divisional Vice P 4:50 PM revealed member of the go facility daily and y until the immedia substantial comp governing body n reviewed the resi grievances filed e allegations of abu investigated, and suspended per th guidelines. Conti information they g	resident (DVP) on 12/16/2021 at d that beginning 12/03/2021, a overning body was onsite at the would continue to be onsite daily te jeopardy was removed, and liance was achieved. The nember in the facility also dents' abuse interviews, and each day to ensure there were no use that were not immediately alleged perpetrators were he facility policy and regulatory nued interviews revealed the gathered, and audit information			
Review of the fac the team met on provided no evide identified.	ility's QAPI meetings revealed 12/13/2021 and documentation	{F 837\		12/21/21
CFR(s): 483.70(d) §483.70(d) Gove	rning body.			
	S FOR MEDICARI F DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER / POST-ACUTE ANI SUMMAF (EACH DEFIC REGULATORY Continued From (incident form and reporting requirer Interview with the 4:40 PM, RNC #2 with the Divisional 12/16/2021 at 4:5 the training provid regarding identify grievances and p post-test following 10. Review of re- Divisional Vice Pr 4:50 PM revealed member of the go facility daily and v until the immedia substantial compl governing body n reviewed the resi grievances filed e allegations of abu investigated, and suspended per th guidelines. Contir information they go was taken to QAF Review of the fac the team met on provided no evide identified. Governing Body CFR(s): 483.70(d) Gove	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256 OVIDER OR SUPPLIER V POST-ACUTE AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 93 incident form and the Kentucky mandatory reporting requirement. Interview with the Administrator on 12/16/2021 at 4:40 PM, RNC #2 on 12/16/2021 at 3:40 PM, and with the Divisional Vice President (DVP) on 12/16/2021 at 4:50 PM revealed they attended the training provided by the Rytes company regarding identifying and reporting abuse, grievances and policies, and completed a post-test following the training. 10. Review of records and interview with the Divisional Vice President (DVP) on 12/16/2021 at 4:50 PM revealed that beginning 12/03/2021, a member of the governing body was onsite at the facility daily and would continue to be onsite daily until the immediate jeopardy was removed, and substantial compliance was achieved. The governing body member in the facility also reviewed the residents' abuse interviews, and grievances filed each day to ensure there were no allegations of abuse that were not immediately investigated, and alleged perpetrators were suspended per the facility policy and regulatory guidelines. Continued interviews revealed the information they gathered, and audit information was taken to QAPI. Review of the facility's QAPI meetings revealed the team met on 12/13/2021 and documentation provided no evidence any new concerns were identified. <td>S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER. (X2) MULTIPLE CO A BUILDING 185256 B. WING COVIDER OR SUPPLIER 185256 Y POST-ACUTE AND REHABILITATION CENTER D PREF Y POST-ACUTE AND REHABILITATION OF DEFICIENCIES (EACH DEFICIENCY WOST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREF Continued From page 93 incident form and the Kentucky mandatory reporting requirement. D ID PREFIX (F 835) Interview with the Administrator on 12/16/2021 at 4:40 PM, RNC #2 on 12/16/2021 at 3:40 PM, and with the Divisional Vice President (DVP) on 12/16/2021 at 4:50 PM revealed they attended the training provided by the Rytes company regarding identifying and reporting abuse, grievances and policies, and completed a post-test following the training. 10. Review of records and interview with the Divisional Vice President (DVP) on 12/16/2021 at 4:50 PM revealed that beginning 12/03/2021, a member of the governing body was onsite at the facility daily and would continue to be onsite daily until the immediate jeopardy was removed, and substantial compliance was achieved. The governing body member in the facility also reviewed the residents' abuse interviews, and grievances filed each day to ensure there were no allegations of abuse that were not immediately investigated, and alleged perpetrators were suspended per the facility policy and regulatory guidelines. Continued interviews revealed the information they gathered, and audit information was taken to QAPI. {F 837} Review of the facility's QAPI meetings revealed the team met</td> <td>S FOR MEDICARE & MEDICAID SERVICES IP DEFICIENCIES CORRECTION (X1) PROVIDERUSUPLENCIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILING IBS256 Image: Construction of the con</td>	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER. (X2) MULTIPLE CO A BUILDING 185256 B. WING COVIDER OR SUPPLIER 185256 Y POST-ACUTE AND REHABILITATION CENTER D PREF Y POST-ACUTE AND REHABILITATION OF DEFICIENCIES (EACH DEFICIENCY WOST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREF Continued From page 93 incident form and the Kentucky mandatory reporting requirement. D ID PREFIX (F 835) Interview with the Administrator on 12/16/2021 at 4:40 PM, RNC #2 on 12/16/2021 at 3:40 PM, and with the Divisional Vice President (DVP) on 12/16/2021 at 4:50 PM revealed they attended the training provided by the Rytes company regarding identifying and reporting abuse, grievances and policies, and completed a post-test following the training. 10. Review of records and interview with the Divisional Vice President (DVP) on 12/16/2021 at 4:50 PM revealed that beginning 12/03/2021, a member of the governing body was onsite at the facility daily and would continue to be onsite daily until the immediate jeopardy was removed, and substantial compliance was achieved. The governing body member in the facility also reviewed the residents' abuse interviews, and grievances filed each day to ensure there were no allegations of abuse that were not immediately investigated, and alleged perpetrators were suspended per the facility policy and regulatory guidelines. Continued interviews revealed the information they gathered, and audit information was taken to QAPI. {F 837} Review of the facility's QAPI meetings revealed the team met	S FOR MEDICARE & MEDICAID SERVICES IP DEFICIENCIES CORRECTION (X1) PROVIDERUSUPLENCIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILING IBS256 Image: Construction of the con

Facility ID: 100599

If continuation sheet Page 94 of 144

		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					R-C
		185256	B. WING		12/16/202 <u>1</u>
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER		00 NURSING HOME LANE	
			P	IKEVILLE, KY 41501	1
(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)	BE COMPLETION
{F 837}	Continued From	page 94	{F 837}		
	body, or designat	ted persons functioning as a			
	• • •	hat is legally responsible for			
		implementing policies regarding			
	the management	and operation of the facility; and			
	•	e governing body appoints the			
	•••	e State, where licensing is			
	required; (ii) Responsible f	or management of the facility;			
	and	or management of the facility,			
		d is accountable to the			
	governing body.				
	This REQUIREM	ENT is not met as evidenced			
		ew, record review, and facility		F837	
	· ·	vas determined the facility's		Residents #324 and #358 had their sk	
	• •	failed to ensure facility policies		checked for any new bruises, redness	
	•	d regarding management and acility. The Governing Body		rash, blister, skin tears or open areas the RN regional nurse consultant on	by
		compliance with 42 CFR 483.12		12/2/2021. There were no new skin is	sues
		ouse, Neglect, and Exploitation		identified.	
		ated 09/24/2020, 12/12/2020,		Residents #324 and #358 were	
		Continued non-compliance was		interviewed on 12/2/2021 by the	
		survey at 42 CFR 483.12 Abuse,		Administrator, they were asked if they	
		loitation (F600, F609 and F610).		safe in the facility, had witnessed abus	
	•	rdy and Substandard Quality of cited at F600, F609, and F610		had been subject to abuse, Both resid # 324 and #358 stated they felt safe in	
	• •	J". Additionally, 42 CFR 483.70		facility and both resident #324 and # 3	
		835 and F837 was cited at a S/S		stated they had not witnessed abuse r	
		FR 483.75 Quality Assurance		were they subject to abuse.	
	•	ovement, F867 was cited at a		All residents with a BIMS of 8 or great	
	S/S of a "J".			were interviewed by the Regional Nurs	
	The feeling to feel	to to have an affective mercini		Consultant, Assistant Director of Nursi	-
		re to have an effective governing ted persons functioning as a		and/or Administrator on 12/2/2021. Th residents were asked if they felt safe in	

Facility ID: 100599

If continuation sheet Page 95 of 144

TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
	00111.2011011		A. BUILDING		
		185256	B. WING		R-C
					12/16/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AN	D REHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501	
(X4) ID	SUMMAR	RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	ON (X5)
PREFIX TAG		HENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIC
{F 837}	Continued From	page 95	{F 837]		
		that that is legally responsible for		the facility, had witnessed abuse or I	nad
		implementing policies regarding		been subject to abuse. No residents	
	-	of the facility, has caused or is		voiced any new concerns at the time	
		prious injury, harm, impairment or		the interview.	
		nt. Immediate Jeopardy (IJ)was		All residents with a BIMS of 7 or less	had
		2/2021, and was determined to		their skin checked for any new bruise	e,
	exist on 11/10/20	21, at 42 CFR 483.12 Freedom		redness, rash, blister, skin tears or o	
	from Abuse (F60	0, F609, and F610), 42 CFR		areas by the regional nurse consulta	nt
	483.70 Administr	ation (F835 and F837), and 42		and/or Assistant Director of Nursing	on
	CFR 483.75 Qua	lity Assurance and Performance		12/2/2021. There were no new skin i	ssues
		67). Substandard Quality of		identified.	
		identified at 42 CFR 483.12		On 12/3/2021 the Governing Body	
		ouse (F600, F609, and F610).		consisting of the Chief Nursing Office	
		otified of Immediate Jeopardy		Chief Strategy Officer, Divisional Vic	
	(IJ) on 12/02/202	1, and IJ is ongoing.		President, New Regional Vice President	lent,
				Regional Nurse Consultant were	
	Refer to F600, F6	609, F610 and F867		re-educated on abuse definition, abu	ISE
	A	in a standard line of (A = O)		reporting and abuse investigating,	
		legation of compliance (AoC)		Grievance and complaints and staff	
		12/14/2021, which alleged		responsibility by Rytes Company. Th	le
		mediate Jeopardy on State Survey Agency		Chief Operating Officer, MHA, MPA, LNHA, CHC. of the Rytes Company,	who
		nmediate Jeopardy was		provides corporate compliance for	UTIU
		ed during a revisit conducted on		Plainview provided an in-depth revie	w and
		h lowered the scope and		education session on abuse investig	
		42 CFR 483.12 Freedom from		abuse reporting, recognizing signs a	
		09, and F610); 42 CFR 483.70		symptoms of abuse and neglect, rev	
		835 and F837); and 42 CFR		compliance requirement of Office of	
		ssurance and Performance		Inspection General, self-reporting inc	cident
	-	67), while the facility monitors		form and Kentucky mandatory report	
		of systemic changes and quality		requirement.	-
	assurance activit			Beginning 12/3/2021 the Administrat	or will
				report, and review grievances receiv	ed
	The findings inclu	ıde:		each day with the New Regional Dire	
				of Operations or Divisional Vice Pres	sident
		ility policy titled "Quality		daily until the immediate jeopardy is	
		erformance Improvement		removed and weekly until substantia	I
		- Governance and Leadership"		compliance is achieved.	
	with a revision da	ate of March 2020, revealed the		On 12/2/21 the Divisional Vice Presi	dent

Event ID: COGB12

Facility ID: 100599

If continuation sheet Page 96 of 144

		HAND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C
	OVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	12/16/202 <u>1</u>
	CONDERVOR SOFT EIER				
PARKVIEW POST-ACUTE AND REHABILITATION CENTER		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLÉTIC
				DEFICIENCY)	
{F 837}	Continued From p	bage 96	{F 837}		
		was responsible for ensuring that n was implemented and based		of Operation conducted a Teachable Moment with the Regional Director of	
		at measures performance and		Operation (RDO) concerning failure to)
	focuses on proble	ems and opportunities that		follow Significant Event Call (SEC) Pc	licy
	•	, functions, and services		and failed to report and/or investigate	
	provided to the re	esidents.		abuse for Resident #324 and #358. La	ater,
				12/2/21 the RDO resigned.	
		nents of Deficiencies (SOD) for		A new Regional Director of Operation	
		1 09/24/2020, revealed the		has been assigned to oversee the bui	-
		at 42 CFR 483.12 Abuse,		as of 12/3/2021. The new regional dire	ector
		loitation (F610) at a Scope and		of operations attended the corporate	
	• • •	a "D" for failure to investigate an		training conducted by the Rytes comp	any
	-	se. However, the Governing		for corporate compliance.	
	maintained.	sure compliance was		On 12/12/21 the Divisional Vice President	uent
	maintaineu.			of Operation conducted a Teachable	ning
	Poviow of Statom	ents of Deficiencies (SOD) for		Moment with the Administrator concer Significant Event Call (SEC) Policy,	ming
		1 12/12/2020, revealed the		Abuse, Neglect and Misappropriation	and
		at 42 CFR 483.12 Abuse,		Concerns, Complaint, and Grievance	anu
		loitation (F600, F607, F608,		policy.	
	•	Immediate Jeopardy and		On 12/12/21 The Administrator condu	cted
		ality of Care (SQC) was identified		in-services with Director of Nursing, a	
		d determined to exist on		Social Services Director concerning	
		e areas of 42 CFR 483.12		Significant Event Call (SEC) policy,	
		use, F-600, at a Scope and		Abuse, Neglect, and Misappropriation	
		a "J"; Develop and Implement		especially reporting and investigating	
	• • •	07 at a S/S of a "J"; Reporting		the Concerns, Complaint, and Grievar	
	-	bicion of a Crime, F608, at a S/S		policy.	
	•	g Alleged Violations, F609 at a			
		Investigate/Prevent Abuse,		Beginning 12/3/2021 a member of the	.
	F610, at a S/S of	a "J". Additionally, 42 CFR		governing body will be on site at the	
	483.70, Administr	ation, F835 was cited at a S/S		facility daily until the immediate jeopa	
		cility submitted a Plan of		is removed and substantial complianc	
		chieved compliance effective		achieved. Members of the governing I	
		ever, the Governing Body failed		include New RDO and/or DVP, Regio	
	to ensure complia	ance was maintained.		Nurse Consultant and/or Chief Nursin	
				Officer. All members are responsible.	
		atements of Deficiencies (SOD)		Information gather will be QAPI d and	d
	for the Survey de	ated 09/10/2021, revealed the		reported to full governing body by	

		HAND HUMAN SERVICES			FORM OMB NO	APPROVI . 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	ETED
		185256	B. WING		R- 12 /1	C I 6/2021
NAME OF PR	ROVIDER OR SUPPLIEF	R	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
		D REHABILITATION CENTER	20	00 NURSING HOME LANE		
		PIKEVILLE, KY 41501				
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES SIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
{F 837}	Continued From	page 97	{F 837}			
	Neglect, and Exp Immediate Jeopa Care (SQC) was related to failure from abuse. The Immediate Jeopa 09/25/2021, alleg Jeopardy on 09/2 verified the Imme 09/26/2021, as a Body failed to en maintained. During this Surve CFR 483.12 Abu (F600, F609 and Substandard Qua F600, F609, and Additionally, 42 C F-835 and F837 f 42 CFR 483.75 C Improvement, F8 Record review ar on 11/10/2021 at Resident #324 re him/her by the ar while turning and incident was with #26. Although Re cursed at SRNA against the SRNA	at 42 CFR 483.12 Abuse, bloitation (F600 and -609). ardy and Substandard Quality of cited at F600 at a S/S of a "K", to ensure residents were free facility submitted an acceptable ardy Removal Plan on ging removal of the Immediate 26/2021. The State Agency ediate Jeopardy was removed on lleged. However, the Governing sure compliance was ey, the facility was cited at 42 se, Neglect, and Exploitation F610). Immediate Jeopardy and ality of Care (SQC) was cited at F610 all at a S/S of a "J". CFR 483.70, Administration, was cited at a S/S of a "J"; and Quality Assurance and Quality 67 was cited at a S/S of a "J". nd staff interviews, revealed that approximately 4:30 PM, eported that SRNA #24 grabbed takle and "jerked" the resident repositioning him/her. The sessed by SRNA #25 and SRNA esident #324 yelled out and #24, stating the SRNA hurt he wanted to file a grievance A, this allegation was not opriate agencies, nor was there nitiated. SRNA #24 was not sident care.		Administrator. The Medical Director attends QAPI. While the member is facility they will review the resident interviews, and grievances filed ear to ensure that there are no allegating abuse, and/or allegations are immer investigated, and alleged perpetrate suspended. Two outside Nurse Consultant (Key Management) and (Healthcare Adv Associates) will provide additional oversight with this POC beginning 12/12/21 weekly for 4 months and no often if necessary to ensure compli with the POC. The Nurse Consultant also deliver education to the administrative team as needed. The Nurse Consultants will report findin the Governing Body, the QAPI committee, and the Chief Executive Officer of the company to determine issues have been resolved or if the initiative should continue.	s in abuse ch day ons of ediately ors y rocate more ance nts will e gs to e e if the	
	Subsequently, ap	oproximately thirty (30) minutes				

If continuation sheet Page 98 of 144

FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
				R-C
185256 NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		B. WING		12/16/202 <u>1</u>
		200 NURSING HOME LANE		
(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIO
Continued From r	page 98	(F 837)		
later, on 11/10/20. #358's room to pr SRNA #26. Both witnessed SRNA arm/shoulder. Hor failed to thorough abuse and failed to immediately report Interview with the (RDO) on 11/21/2 11/23/2021 at 9:20 filed a grievance of that was provided stated Resident # hurt him/her, but f was hurt, the alleg as an abuse alleg Complaint/Grieva #324 was hurt, the Resident #324 rej him/her. Further i asked the residen resident responde stated the allegati According to the F satisfied with the #24 to another are re-educate SRNA Continued intervie at 10:54 AM and a regarding the incir revealed two (2) S	21, SRNA #24 entered Resident ovide care with SRNA #25 and SRNA #25 and SRNA #26 #24 hit Resident #358 on the left wever, facility Administration ly investigate the allegation of to identify staff did not rt this allegation. Regional Director of Operations 021 at 10:54 AM and again on 0 AM, revealed Resident #324 on 11/10/2021 related to care by SRNA #24. The RDO initially 324 did not report the SRNA had the resident stated he/she gation would have been reported ation. After discussing the nce form that stated Resident e RDO then acknowledged ported SRNA #24 did hurt interview revealed the RDO tt if he/she was abused, and the ed "no". Therefore, the RDO on was not reported as abuse. RDO, Resident #324 was resolution to reassign SRNA ea of the facility and to . #24 on repositioning.			
	S FOR MEDICARE F DEFICIENCIES CORRECTION OVIDER OR SUPPLIER POST-ACUTE AND SUMMAR (EACH DEFICI REGULATORY Continued From p later, on 11/10/20 #358's room to pr SRNA #26. Both witnessed SRNA arm/shoulder. Hoy failed to thorough abuse and failed to immediately repord Interview with the (RDO) on 11/21/2 11/23/2021 at 9:2 filed a grievance of that was provided stated Resident # hurt him/her, but I was hurt, the alleg as an abuse alleg Complaint/Grieva #324 was hurt, the Resident #324 re him/her. Further asked the resident resident respondent stated the allegati According to the F satisfied with the #24 to another ard re-educate SRNA Continued intervie at 10:54 AM and a regarding the inci- revealed two (2) S #26) reported an	CORRECTION IDENTIFICATION NUMBER: 185256 OVIDER 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 98 later, on 11/10/2021, SRNA #24 entered Resident #358's room to provide care with SRNA #25 and SRNA #26. Both SRNA #25 and SRNA #26 witnessed SRNA #24 hit Resident #358 on the left arm/shoulder. However, facility Administration failed to thoroughly investigate the allegation of abuse and failed to identify staff did not immediately report this allegation. Interview with the Regional Director of Operations (RDO) on 11/21/2021 at 10:54 AM and again on 11/23/2021 at 9:20 AM, revealed Resident #324 filed a grievance on 11/10/2021 related to care that was provided by SRNA #24. The RDO initially stated Resident #324 did not report the SRNA hurt him/her, but had the resident stated he/she was hurt, the allegation. After discussing the Complaint/Grievance form that stated Resident #324 was hurt, the RDO then acknowledged Resident #324 reported SRNA #24 did hurt him/her. Further interview revealed the RDO asked the resident if he/she was abused, and the resident #324 reported SRNA #24 did hurt him/her. Further interview revealed the RDO asked the allegation was not reported as abuse. According to the RDO, Resident #324 was satisfied with the resolution to reassign SRNA #24 to another area of the facility and to re-educate SRNA #24 on repositioning. Continued interview with the RDO, on 11/21/2021 at 10:54 AM and again on 11/23/2021 at 9:20 AM, regarding the incident with Resident #358, revealed two (2) SRNAs (SRNA #25 and SRNA #26) reported an allegation of abuse to the	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CL A BUILDING IDENTIFICATION NUMBER: A BUILDING IDENTIFICATION NUMBER: B. WING IDENTIFICATION CENTER ID PRESTACUTE AND REHABILITATION CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 98 [F 837] later, on 11/10/2021, SRNA #24 entered Resident #358's room to provide care with SRNA #25 and SRNA #26. Both SRNA #25 and SRNA #26 witnessed SRNA #24 hit Resident #358 on the left arm/shoulder. However, facility Administration failed to thoroughly investigate the allegation of abuse and failed to identify staff did not immediately report this allegation. [F 837] Interview with the Regional Director of Operations (RDO) on 11/21/2021 at 10:54 AM and again on 11/23/2021 at 9:20 AM, revealed Resident #324 filed a grievance on 11/10/2021 related to care that was provided by SRNA #24. The RDO initially stated Resident #324 did not report the SRNA hurt him/her, but had the resident stated he/she was hurt, the allegation. After discussing the Complaint/Grievance form that stated Resident #324 was hurt, the RDO then acknowledged Resident #324 reported SRNA #24 did hurt him/hrer. Further interview revealed the RDO asked the resident if he/she was abused, and the resident #324 reported SRNA #24 was satisfied with the resolution to reassign SRNA #24 to onother area of the facility and to re-educate SRNA #24 on repositioning. <	SPOR MEDICARE & MEDICAID SERVICES PERFICIENCIES (11) PROVIDERSUPPLIER/CLIA (22) MULTIPLE CONSTRUCTION ORDERGTION (12) BUTHFICATION NUMBER A. BUILDING OWDER OR SUPPLIER 185256 STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE 200 NURSING HOME LANE PREFIX POST-ACUTE AND REHABILITATION CENTER ID PREFIX Continued From page 98 ID PREFIX REGULATORY OR LSC. IDENTIFYING INFORMATION) Continued From page 98 IET, on 11/10/2021, SRNA #24 entered Resident #358 strom to provide care with SRNA #25 and SRNA #26 witnessed SRNA #24 hit Resident #358 on the left armshoulder. However, facility Administration failed to identify staff did not immediately report this allegation. [F 837] Interview with the Regional Director of Operations (RDO) on 11/21/2021 at 10:54 AM and again on 11/12/2021 at 9:20 AM, revealed Resident #324 [S and scale and failed to identify staff did not immediately report this allegation. Interview with the Regional Director of Operations (RDO) on 11/21/2021 at 10:54 AM and again on 11/23/2021 at 9:20 AM, revealed Resident #324 [S and scale and there the scale and the resident the scale and the resident theorem action would be as abuse. According to the addresion as abuse. According to the resident if he/she was abused, and the resident theresident theresident the resident the 20 0.0 M, revealed

Facility ID: 100599

If continuation sheet Page 99 of 144

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					R-C	
185256		185256	B. WING		12/16/2021	
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	A^{-}		
		200 M	URSING HOME LANE			
PARNVIEV	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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETI	
{F 837}	Continued From	page 99	{F 837}			
(,		all the information was given to	[1 007]			
		as he was the Abuse				
		completed the investigation. The				
		ed all abuse investigations were				
		Administrator to ensure the				
		re complete and no concerns				
	were identified wi	ith the investigation.				
	Further interview	with the Regional Director of				
), on 12/02/2021 at 6:56 PM,				
		the Governing Body				
		r the facility and had been since				
		tated he was present at the				
		RDO stated he was the Interim the facility from 09/13/2021 -				
		RDO further stated the				
		met the week of 09/15/2021 to				
		iencies cited from the				
		ey and there were regional				
		riday. He stated he was not				
		cility when the other jeopardies nd cited, but had been involved				
		Correction and monitoring to				
		encies. He stated he was				
		cility abuse policy when he				
		im Administrator on 09/13/2021,				
		ified there were continuing				
	abuse reporting.	use, abuse investigations, or				
	• •	led an acceptable Immediate				
		al Plan, on 12/14/2021, that				
	alleged removal on 12/13/2021.	of the Immediate Jeopardy (IJ)				
	The facility imple actions:	mented the following corrective				

If continuation sheet Page 100 of 144

STATEMENT OF DEGRETION AND FLAY OF CORRECTION (N) DATE BUNCH UBENTROLING.NUMBER: (N) DATE BUNCH (DURLE NOT DEGRETION (N) DATE (DURLE NOT DEGRETION (N) DATE (DURL			ND HUMAN SERVICES MEDICAID SERVICES			FORM): 01/20/2022 APPROVED 0. 0938-0391
Investige B: Wind STREET ADDRESS, CITY, STATE, 28 CODE PARKVIEW POST-ACUTE AND REHABILITATION CENTER ISTREET ADDRESS, CITY, STATE, 28 CODE 200 MRSING HOBE LANE PARKVIEW POST-ACUTE AND REHABILITATION CENTER ISTREET ADDRESS, CITY, STATE, 28 CODE 200 MRSING HOBE LANE 200 MRSIN	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		(X3) DATE	SURVEY
NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, 212 CODE PARKVIEW POST-ACUTE AND REHABILITATION CENTER Dimension of the control			185256	B. WING			
PARKVIEW POST-ACUTE AND REHABILITATION CENTR PIKEVILLE, KY 41601 (P4) ID PREFIX TAG SUMMARY STATEMENT OF DEPICIENCIES (eACH DEPICIENCY MUST ET MENCEDDE BY FULL REGULATORY OR LSC DEPITITIVIE INFORMATION) ID PREFIX PREFIX PROVIDERS PLAN OF CORRECTION (eACH DEPICIENCY MUST ET MENCEDDE BY FULL REGULATORY OR LSC DEPITITIVIE INFORMATION) ID PREFIX PREFIX PROVIDERS PLAN OF CORRECTION (eACH DEPICED VIELS ET MENCEDDE BY FULL REGULATORY OR LSC DEPITITIVIE INFORMATION) IP PREFIX PREFIX PROVIDERS PLAN OF CORRECTION (eACH DEPICED VIELS ET MENCEDDE BY FULL REGULATORY OR LSC DEPITITIVIE INFORMATION) IP PREFIX PREFIX {F 837} Confinued From page 100 Residents #324 and #358 regarding any concerns with abuse, and no concerns were voiced. On 12/02/2021, the Regional Nurse Consultant (RNC) also assessed the residents #358 was re-investigated starting 12/03/2021 by the new Regional Director of Operations (RDO). SRNA #25 and #26 and Resident #358 was re-investigated starting 12/03/2021 by the safet reporting agencies, police department, and the resident's attending physician. The allegation of abuse involving Resident #324 was reported on 11/21/2021 in the state reporting agencies, police department, and the resident's attending physician. SRNA #24 was used on the 11/21/2021. The rule allow of the nurse aide registry on 12/06/2021. 2. All residents with a brief interview for mental status (BIMS) score of eight (8) or greater were interviewed and residents with a BIMS of seven (7) or less were assessed by the RNC, Assistant Director of Nursing (ADON), and/or Administrator on 12/02/2021. The residents were assessed for signs of abuse and were asked if they felt safe, had witnessed, or were subjected to, abuse in the facility. There were no	NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
(W) ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EXPL DEFICIENCY MUST & PRECEDED BY FULL TAG ID PRETX (EXPL OPPRECIDENCY MUST & PRECEDED BY FULL (EXPL OPPRECIDENT OF DIM SHOULD BY ECOLORISET AT DIM SHOULD BY (EXPL OPPRECIDENT OF DIM SHOULD BY (EXPL OPPRECIDENT) (EXPL OPPRECIDENT OF DIM SHOULD BY (EXPL OPPRECIDENT) (EXPL OPPRECIDENT OF DIM SHOULD BY (EXPL OPPRECIDENT) (EXPL OPPRECIDENT	PARKVIE	PARKVIEW POST-ACUTE AND REHABILITATION CENTER					
Residents #324 and #358 regarding any concerns with abuse, and no concerns were voiced. On 12/02/201, the Regional Nurse Consultant (RNC) also assessed the residents to ensure there was no new bruises, redness, rash, bilster, skin tears or open areas, and there were no concerns. The allegation of abuse by State Registered Nursing Assistant (SRNA) #24 to Resident #358 was re-investigated starting 12/03/2021 by the new Regional Director of Operations (RDO), SRNA#25 and #26 and Resident #358 were re-interviewed by new RDO on 12/03/2021. The Allegation of abuse by SRNA #24 to Resident #358, was reported on 11/10/2021 to the state reporting agencies, police department, and the resident's attending physician. The allegation of abuse involving Resident #324 was reported on 11/21/2021, to the state reporting agencies, police department, and the resident's attending physician. SRNA#24 was suspended on 11/21/2021 to the state reporting agencies, police department, and the resident's attending physician. SRNA#24 was suspended on 11/21/2021 and has not returned to work. SRNA #24 was also reported to the nurse aide registry on 12/06/2021. 2. All residents with a brief interview for mental status (BIMS) score of eight (8) or greater were interviewed and residents with a BMS of seven (7) or less were assessed by the RNC, Assistant Director of Nursing (ADON), and/or Administrator on 12/02/2021. The residents were assessed for signs of abuse and were asked if they felt safe, had witnessed, or were subjected to, abuse in the facility. There were no concerns identified.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION
3. The Regional Director of Operations (RDO) was re-educated on 12/02/2021 by the Divisional	{F 837}	Residents #324 and concerns with abuse voiced. On 12/02/202 Consultant (RNC) als ensure there was no blister, skin tears or of no concerns. The allegation of abu Nursing Assistant (SI was re-investigated s new Regional Directo SRNA #25 and #26 a re-interviewed by new The Allegation of abu #358, was reported of reporting agencies, p resident's attending p abuse involving Resi 11/21/2021, to the sta department, and the physician. SRNA #2 11/21/2021 and has n #24 was also reporte on 12/06/2021. 2. All residents with status (BIMS) score of interviewed and resid (7) or less were asse Director of Nursing (/ on 12/02/2021. The r signs of abuse and w had witnessed, or we facility. There were r	#358 regarding any , and no concerns were 21, the Regional Nurse so assessed the residents to new bruises, redness, rash, open areas, and there were asse by State Registered RNA) #24 to Resident #358 starting 12/03/2021 by the or of Operations (RDO). and Resident #358 were w RDO on 12/03/2021. Use by SRNA #24 to Resident on 11/10/2021 to the state bolice department, and the obysician. The allegation of dent #324 was reported on ate reporting agencies, police resident's attending 4 was suspended on not returned to work. SRNA ed to the nurse aide registry a brief interview for mental of eight (8) or greater were dents with a BIMS of seven assed by the RNC, Assistant ADON), and/or Administrator residents were assessed for vere asked if they felt safe, ere subjected to, abuse in the no concerns identified.	{F 837}			

		HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/202<u>1</u>
NAME OF PI	ROVIDER OR SUPPLIEF		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
PARKINEW ROOT AQUITE AND RELIABILITATION CENTER		200 N	URSING HOME LANE		
PARKVIEV	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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
{F 837}	Continued From	page 101	{F 837}		
		VVP) on Abuse Investigation			
	· ·	Prevention, and Recognizing			
		A new RDO was assigned to			
	U U	ing as of 12/03/2021.			
	4. On 12/03/202	1 the new Regional Director of			
) re-educated the facility			
		nanagement team, including the			
	Administrator, Di	rector of Nursing (DON),			
	Assistant Directo	r of Nursing (ADON), Social			
	Service Director,	Minimum Data Set (MDS)			
	coordinators, Hui	man Resources, Business Office			
	Manager, Medica	I Records, Maintenance, Central			
	Supply, Dietary N	lanager, Staff Development			
	Coordinator, Wou	und Nurse, Activities Director,			
		busekeeping/Laundry Supervisor			
		inition of Abuse. "Abuse" was			
		llful infliction of injury,			
		nfinement, intimidation, or			
		resulting physical harm, pain, or			
		The training also included Abuse			
		Reporting, which included			
		jed violation of abuse, neglect,			
		istreatment (including injuries of			
		and misappropriation of resident			
		ately. If an employee suspected			
		above had happened, they were			
	· ·	nsure the residents were safe,			
		ately report the situation to the visor, who would immediately			
		coordinator, who was currently			
		. Training of the Immediate			
		done through the previously			
		training. The Staff			
		ordinator administered a written			
		ning sessions. If staff did not			
		ing score of one hundred (100%)			
		al consultation was done until a			
	passing score wa				

If continuation sheet Page 102 of 144

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED: 01/20/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185256	B. WING		R-C 12/16/2021
NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	<u></u>
PARKVIEW POST-ACUTE AND	REHABILITATION CENTER		NURSING HOME LANE	
PREFIX (EACH DEFICIE	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
{F 837} Continued From pa	age 102	{F 837}		
AM shift was verba on the definition of and Reporting. The any alleged violation exploitation, or miss unknown source a property) immediat that either of the a to immediately report immediately report accordance to the including agency s educated on their staff working their Development Coor post-test. If staff d score of one hund consultation was d obtained. One hund facility staff have b On 12/03/2021, the reeducated SRNA requirement to immediately super- witnessed abuse of witnessing or hear provided that the a removed from the investigation. The coordinate the inve- required agencies. 6. Beginning 12/0 Consultant (RNC),	e Director of Nursing (DON) #25 and SRNA #26 on the mediately report to the visor any verbal allegation or or neglect immediately upon ring it. Training was also alleged perpetrator would be building pending the e Administrator would then estigation and report to all			

If continuation sheet Page 103 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 01/20/2022 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		185256	B. WING		R- 12/*	-C 16/2021
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		10/2021
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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 837}	interview residents v or greater daily and with a BIMS score o any signs of abuse o they feel safe in the abuse, and have not the immediate jeopa weekly until substan achieved. Results o reported to the Qual Improvement (QAPI DON/ADON. 7. On 12/03/2021, th reviewed the grievar days to ensure no al on the grievance log investigated. There that alleged abuse o 8. Grievance forms hallway and all griev the grievance officer Grievances/complain be investigated and taken to resolve the officer would either i assign the grievance director/supervisor ff 12/03/2021, the Adm and review grievance Regional Director of Divisional Vice Presi immediate jeopardy weekly until substan	vice Director (SSD) would vith a BIMS score of eight (8) assess the skin of residents f seven (7) or less daily for or any unidentified to ensure facility, have not witnessed t been subject to abuse, until rdy has been removed then tial compliance has been f the interviews would be ity Assurance Performance) committee by the he New RDO and/or DVP nee log for the last thirty (30) buse allegations were noted and not reported or were no logged grievances r neglect. were located on each fances would be reviewed by r, the Administrator. All nts filed with the facility would corrective actions would be grievance(s). The grievance nvestigate the grievance or e to the department or investigation. Beginning ninistrator would also report es received each day with the Operations (RDO) or ident (DVP) daily until the was removed and then	{F 837}			
	achieved. 9. On 12/03/2021 th	e Rytes Company (outside				

	S FOR MEDICAR	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					R-C
185256 NAME OF PROVIDER OR SUPPLIER		B. WING		12/16/202 <u>1</u>	
			EET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AN	D REHABILITATION CENTER		NURSING HOME LANE EVILLE, KY 41501	
(X4) ID	SUMMAR	RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TON (X5)
PREFIX TAG	(EACH DEFIC	CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
{F 837}	Continued From	page 104	{F 837}		
,		ontracted to achieve compliance)	[1 007]		
		bdy consisting of the Chief			
	Nursing Officer, 0	Chief Strategy Officer, Divisional			
		lew Regional Vice President,			
		Consultant were re-educated on			
		buse, abuse reporting and ng, Grievance and complaints			
		sibility. The Chief Operating			
		ealthcare Administration (MHA),			
		Administration and Geriatric			
		.), Licensed Nursing Home			
		IHA), and Certified Healthcare			
		cialist (CHC) of the Rytes ed an in-depth review and			
		n on abuse investigation, abuse			
		izing signs and symptoms of			
		ct. They also reviewed the			
		rements, the self-reporting			
	reporting require	d the Kentucky mandatory ment.			
	10. Beginning 12	2/03/2021 a member of the			
	governing body v	vould be on site at the facility			
		nediate jeopardy was removed			
		ompliance was achieved.			
		governing body included the New P, Regional Nurse Consultant			
		sing Officer. While a member of			
		dy was in the facility, they would			
		nt abuse interviews and			
	-	each day to ensure allegations of			
		egations were reported,			
		alleged perpetrators mation gathered from audits			
		to the facility's Quality			
		rmance Improvement (QAPI)			
		Administrator would report to the			

If continuation sheet Page 105 of 144

		AND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/202 1
NAME OF PI	NAME OF PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
	N DOCT ACUTE AND	D REHABILITATION CENTER	200 N	URSING HOME LANE	
PARKVIE	POST-ACUTE AND	REPABILITATION 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO
{F 837}	Continued From p	page 105	{F 837}		
		Agency verified the facility following corrective actions:			
	Administrator inte #358 and the Reg assessed the resi	lity documentation revealed the rviewed Residents #324 and gional Nurse Consultant (RNC) idents as outlined in the pliance (AOC) on 12/02/2021, were identified.			
	the new Regional interviewed Resid 12/03/2021 and the residents was re-id AOC by the new Resident and Administrator on the allegation of a Resident #358 was state agencies, the resident's attending regarding Residen 11/21/2021, to the	documentation also revealed Director of Operations (RDO) lent #324 and #358 on the allegation regarding both investigated as stated in the RDO. Further review of facility and interview with the 12/16/2021 at 4:40 PM revealed abuse regarding SRNA# 24 and as reported on 11/10/2021 to the the police department, and the ang physician and the allegation at #324 was reported on the state agencies, the police the resident's attending			
	the allegation and on 12/16/2021 at suspended the SF employment was	gation findings after re-opening d interview with the Administrator 4:40 PM revealed the facility RNA #24 on 11/21/2021, and her terminated. The facility A to the nurse aide abuse 2021.			
	with the DVP on 1 confirmed State F	# 24's timecard and interview 12/16/2021 at 4:50 PM Registered Nurse Aide (SRNA) led on 11/21/2021 and had now			

Facility ID: 100599

If continuation sheet Page 106 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 01/20/2022 A APPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		LETED
		185256	B. WING			-C 16/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		10/2021
PARKVIE	PARKVIEW POST-ACUTE AND REHABILITATION CENTER					
				PIKEVILLE, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
{F 837}	Continued From pag	e 106	{F 837}			
	worked at the facility	since that date.				
	11:30 AM and intervi 12/16/2021 at 11:40 felt safe in the facility care/treatment were stated they were free 2. Review of intervie conducted by the Re (RNC), Assistant Din and/or Administrator residents with a BIM were asked if they fe witnessed abuse, or and no concerns were and interview with th 4:33 PM revealed on BIMS score of seven for signs of abuse, at	ews/skin assessments gional Nurse Consultant ector of Nursing (ADON) on 12/02/2021 revealed all S with eight (8) or greater It safe in the facility, had had been subject to abuse re identified. Further reviews e ADON on 12/16/2021 at 12/02/2021 residents with a (7) or less were assessed ny open areas, new bruising, rs or skin tears and no				
	Director of Operation Divisional Vice Presi Administrator on 12/0 Investigation Reporti Program, and Recog Interview with the DV revealed a new RDC the building as of 12/0 4. Review of the trai sheets revealed the Operations (RDO) re interdisciplinary team	ning materials and sign in				

Facility ID: 100599

If continuation sheet Page 107 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/2022 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/10/202
PARKVIE	N 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)	
{F 837}	Assistant Director of Service Director (SS (MDS) coordinators, Business Office Mar Maintenance, Centra Staff Development O Activities Director, U Housekeeping/Laun facility provided com revealed the facility completed a written score of one hundre Interview with the AD PM, the Social Servi at 4:20 PM, and the 12/16/2021 at 4:25 F received training reg	tor of Nursing (DON), Nursing (ADON), Social D), Minimum Data Set Human Resources, hager, Medical Records, al Supply, Dietary Manager, Coordinator, Wound Nurse, nit manager and dry Supervisor. Review of opetency testing documents interdisciplinary team post-test, with a passing d (100%) percent. DON on 12/16/2021 at 4:33 ces Director on 12/16/2021 Director of Nursing (DON) on PM revealed they had parding the facility's abuse	{F 837	}	
	following the education 5. Interview with the 4:33 PM and review revealed all staff wor PM-6 AM shift were ADON regarding the Further review of on continued interview of at 4:33 PM, revealed scheduled to work, w and new hires were to take a post-test co scheduled shift. Real the ADON revealed and completed a post	ADON on 12/16/2021 at of education provided to staff rking on 12/02/2021 on the 6 verbally re-educated by the e definition of abuse. going education provided and with the ADON on 12/16/2021			

STATEMENT	DF DEFICIENCIES CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	OMB NO. 0938-030 (X3) DATE SURVEY COMPLETED R-C	
_		185256	B. WING		12/16/202 <u>1</u>	
NAME OF P	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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIO	
{F 837}	12/16/2021 at 3:2 Registered Nurse 3:15 PM; confirm Investigation/Rep violation of abuse mistreatment (inc source and misag should be reporte supervisor. The A revealed staff we suspected that at immediately ensu- stated they were report to their sup would remove the building pending immediately repo coordinator. Interview with the 12/16/2021 at 4:2 provided to staff r facility reeducate Assistant (SRNA) immediately repo department super occurred. Interview with the 4:40 PM revealed investigations and reported to state Review of an alle resident #361 wi 3:10 PM revealed	page 108 actical Nurse (LPN) # 10 on 20 PM; and interview with a (RN) #12 on 12/16/2021 at ed training also included Abuse porting and that any alleged a, neglect, exploitation or cluding injuries of unknown opropriation of resident property) ed immediately to the department ADON and SRNA interview also re instructed that if an employee puse had occurred, they were to ure the resident was safe. They then required to immediately pervisor. Further, the supervisor e alleged perpetrator from the the investigation and rted the allegation to the abuse e Director of Nursing (DON) on 25 PM and review of education revealed on 12/03/2021, the d State Registered Nursing) #25 and SRNA #26 to rt any allegations of abuse to the rvisor when the incident e Administrator on 12/16/2021 at d he would coordinate the d ensure all allegations were agencies as required. ged incident of resident to etween Resident #322 and hich occurred on 12/14/2021 at d no concerns with the facility rting nor investigating. The	{F 837}			

Facility ID: 100599

If continuation sheet Page 109 of 144

					OVED
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	COMPLETED	
	185256	B. WING			1
ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	12, 10,202	<u>•</u>
N POST-ACUTE AND RE	EHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501			
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG		E COMPL	ETION
Continued From pag been taken to protect residents and no con Interview with Reside 3:40 PM and intervie 12/16/2021 at 3:30 P the facility and had n 6. Interview with the 4:33 PM and review Questionnaires revea all residents in the fa or greater were interv RNC #2, ADON and/ the residents felt safe abuse, and had not v concerns were identi Interview with Reside 12:00 PM, Resident a Resident #322 at 3:4 interviewing them da concerns of abuse on reported to facility sta Review of skin asses on 12/03/2021, the R	e 109 t those and all other neerns were identified. ent #322 on 12/16/2021 at w with Resident #361 on PM revealed they felt safe in to concerns related to abuse. ADON on 12/16/2021 at of Resident Abuse Interview aled beginning on 12/03/2021 tocility with a BIMS of eight (8) viewed daily by the DON, for Social Worker to ensure e, had not been subject to witnessed abuse. No fied. ent #362 on 12/16/2021 at #361 at 3:30 PM and to PM confirmed staff were illy. The stated they had no r neglect and none had been aff during the interviews essments revealed beginning RNC, DON and ADON	{F 837}		ATE	
seven (7) or less dail redness, rash, blister had not occurred. No 7. Interview with the (RVP) on 12/16/2021 reviewed the grievan previous thirty (30) d of abuse was include	ly to ensure any new bruise, r, skin tears or open areas o concerns were identified. Regional Vice President 1 at 4:50 PM revealed she ice log on 12/03/2021 for the ays to ensure no allegations ed on the log and no				
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER W POST-ACUTE AND RE SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag been taken to protect residents and no cond Interview with Resided 3:40 PM and intervie 12/16/2021 at 3:30 P the facility and had n 6. Interview with the 4:33 PM and review of Questionnaires revea all residents in the fa or greater were intervient RNC #2, ADON and/ the residents felt safe abuse, and had not w concerns were identi Interview with Resided 12:00 PM, Resident 3 Resident #322 at 3:4 interviewing them da concerns of abuse or reported to facility stat Review of skin assess on 12/03/2021, the R assessed the skin of seven (7) or less dail redness, rash, blister had not occurred. No 7. Interview with the (RVP) on 12/16/2021 reviewed the grievan previous thirty (30) d of abuse was include	CORRECTION IDENTIFICATION NUMBER:	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING IB5256 B. WING ROVIDER OR SUPPLIER IB5256 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX FAGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 109 {F 837} been taken to protect those and all other residents and no concerns were identified. Interview with Resident #322 on 12/16/2021 at 3:40 PM and interview with Resident #361 on 12/16/2021 at 3:30 PM revealed they felt safe in the facility and had no concerns related to abuse. 6. Interview with the ADON on 12/16/2021 at 4:33 PM and review of Resident Abuse Interview Questionnaires revealed beginning on 12/03/2021 all residents in the facility with a BIMS of eight (8) or greater were interviewed daily by the DON, RNC #2, ADON and/or Social Worker to ensure the resident felt safe, had not been subject to abuse, and had not witnessed abuse. No concerns were identified. Interview with Resident #362 on 12/16/2021 at 12:00 PM, Resident #363 on 12/16/2021 at 12:00 PM, Resident #361 on 12/16/2021 at 12:00 PM, Resident #362 on 12/16/2021 at 12:00 PM, Resident #361 on 12/16/2021 at 12:00 PM, Resident #360 on 12/16/2021 at 12:00 PM, Reside	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDEROUPPLIER/CLIA A. BUILDING IDENTIFICATION NUMBER: A. BUILDING IDENTIFICATION NUMBER: A. BUILDING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PREFX REGULATORY OR SUPPLIER D NOTOTACUTE AND REHABILITATION CENTER D REGULATORY OR SUPPLIER D REGULATORY OR SUPPLIER D SUMMARY STATEMENT OF DEFICIENCIES D REGULATORY OR SUPPLIER D Continued From page 109 CROSS-REFERENCED TO THE APPROPRI Deen taken to protect those and all other CROSS-REFERENCED TO THE APPROPRI residents and no concerns were identified. FIGURATION 12/16/2021 at 3:30 PM revealed they felt safe in in the facility with a BIMS of eight (8) or greater were interviewed daily by the DON, RNC #2, ADON and/or Social Worker to ensure the resident #362 on 12/16/2021 at 13:30 PM and Resident #362 on 12/16/2021 at 13:30 PM and Resident #362 on 12/16/2021 at 12:00 PM, Resident #362 on 12/16/2021 at 12:00 PM, Resident #362 on 12/16/2021 at 12:00 PM, Resident #362 on 12/03/2021 (he RNC, ON and ADON assessed the skin of residents who a BIMS of seven (7) or less daily to ensure any new bruise, redness, rish, bilster, skin tears or open areas had not oc	MENT OF HEALTH AND FUMAN SERVICES CMB NO. 0938 SFOR MEDICARE & MEDICALD SERVICES CMB NO. 0938 CREMENTION INFORMATION NUMBER: A BUILDING CONSTRUCTION CONTRECTOR DEVENTION INFORMATION NUMBER: A BUILDING CREME Rec 1216/202 The Contract of the Construction of the Constr

If continuation sheet Page 110 of 144

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/20/2022 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING			(X3) DATE	
		185256	B. WING				-C 16/2021
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		10/202
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER			NURSING HOME LANE EVILLE, KY 41501		
	SUMMA DV S	TATEMENT OF DEFICIENCIES			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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 837}	Continued From pag		{F 83	37}			
	8. Observations on a	12/16/2021 revealed e located on each hallway of					
	the resident care unit	-					
		ministrator on 12/16/2021 at					
		e was the grievance officer he process to ensure any					
		ts voiced at the facility would					
	taken to resolve the	corrective actions would be grievance(s). The					
	Administrator also st	ated he would oversee the					
		to ensure the regulatory grievances were followed.					
		egional Vice President (RVP) 0 PM revealed she continued					
	to review the grievan	ice log daily and oversee to as in compliance with the					
	grievance process.						
		ed Practical Nurse (LPN)					
		t 3:20 PM and review of staff confirmed staff were					
	retrained and were re	equired to take a post-test					
	following the training process in the facility	, regarding the grievance /.					
		evance forms revealed a on 12/14/2021 by Resident					
	#362 regarding his/h	er bathroom appearance and					
		revealed the grievance was dent was interviewed, and					
	the resident's grievar	nce was resolved on					
		vere no allegations of abuse,					
	neglect documented log/grievance form.	on the grievance					
	Interview with Reside 12:00 PM revealed h	ent #362 on 12/16/2021 at ie/she had voiced a					

If continuation sheet Page 111 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		STI	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 APPROPRIA DEFICIENCY)	
{F 837}	grievance regarding bathroom and facility	cleanliness of his/her / staff had resolved the dent had no current concerns	{F 837}		
	 Review of training documentation, and 12/03/2021, the Ryte Governing Body con Officer, Chief Strateg President, New Regi Regional Nurse Con- abuse, abuse reporti grievances and comp responsibility. The G were also educated of investigations, abuse and symptoms of ab- agency compliance r incident form and the reporting requirement Interview with the Ad 4:40 PM, RNC #2 on with the Divisional Vi 12/16/2021 at 4:50 F the training provided regarding identifying grievances and polic post-test following th 10. Review of record Divisional Vice Presi 4:50 PM revealed that member of the gover facility daily and wou until the immediate je substantial compliantice 	g documentation, testing sign-in sheets revealed on es Company, educated the sisting of the Chief Nursing gy Officer, Divisional Vice ional Vice President, sultant on the definition of ing and abuse investigating, plaints and staff overning body members on conducting abuse e reporting, recognizing signs use and neglect, state requirement, a self-reporting e Kentucky mandatory nt. ministrator on 12/16/2021 at n 12/16/2021 at 3:40 PM, and ice President (DVP) on PM revealed they attended I by the Rytes company and reporting abuse, sies, and completed a			

If continuation sheet Page 112 of 144

	DF DEFICIENCIES CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C 12/16/202<u>1</u>	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE ANI	REHABILITATION CENTER		00 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 837} {F 867}	grievances filed e allegations of abu investigated, and suspended per th guidelines. Contir information they g was taken to QAF Review of the fac the team met on provided no evide identified. QAPI/QAA Impro	dents' abuse interviews, and bach day to ensure there were no ise that were not immediately alleged perpetrators were e facility policy and regulatory nued interviews revealed the gathered, and audit information Pl. ility's QAPI meetings revealed 12/13/2021 and documentation ence any new concerns were wement Activities	{F 837} {F 867}		12/21/21	
SS=D	§483.75(g) Qualit §483.75(g)(2) The assurance comm (ii) Develop and in	y assessment and assurance. e quality assessment and				
	by: Based on intervie review, and revie (SOD) from the 0 09/10/2021 Surve facility's Quality A develop and impl action to correct i Review of the fac 483.12 Freedom Exploitation was	ENT is not met as evidenced ew, record review, facility policy w of Statements of Deficiencies 9/24/2020, 12/12/2020 and eys, it was determined the ssurance Committee failed to ement appropriate plans of dentified quality deficiencies. ility's history revealed 42 CFR from Abuse, Neglect, and cited during Surveys dated 2/2020, and 09/10/2021.		F867 On 12/3/2021 the New Regional Director of Operations re-educated the facility interdisciplinary management team whi includes the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, MDS coordinators, Human Resources, Business Office Manager, Medical Records, Maintenance, Central Supply,	ch	

Event ID: COGB12

Facility ID: 100599

If continuation sheet Page 113 of 144

		AND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		185256	B. WING		12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/10/202
				00 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND	REHABILITATION CENTER		PIKEVILLE, KY 41501	
(X4) ID	SUMMAR'	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J (X5)
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
{F 867}	Continued From p	age 113	{F 867}		
	Continued non-co	mpliance was cited during this		Dietary Manager, Staff Development	
		483.12 Abuse, Neglect, and		Coordinator, Wound Nurse, Activities	;
), F609 and F610). Immediate		Director, Unit manager,	
		ostandard Quality of Care (SQC)		Housekeeping/Laundry Supervisor we	ere
	was cited at F600	, F609, and F610 all at a S/S of		verbally re-educated on the definition	of
	a "J". Additionally,	, 42 CFR 483.70 Administration,		Abuse- Abuse is defined as willful	
	F835 and F837 w	as cited at a S/S of a "J"; and 42		infliction of injury, unreasonable	
	CFR 483.75 Qual	ity Assurance and Quality		confinement, intimidation, or punishm	ent
	Improvement, F86	67 was cited at a S/S of a "J".		with resulting physical harm, pain, or	
				mental anguish and Abuse Investigati	on
		e to have an effective Quality		and Reporting - An alleged violation of	of
		erformance Improvement		abuse, neglect, exploitation or	
		ensure appropriate action		mistreatment (including injuries of	
		compliance has caused or is		unknown source and misappropriation	n of
	-	ious injury, harm, impairment or		resident property) will be reported	
		t. Immediate Jeopardy (IJ)was		immediately to the department superv	
		2/2021, and was determined to		who will then call the abuse coordinat	
		21, at 42 CFR 483.12 Freedom		If an employee suspects that either of	the
		, F609, and F610), 42 CFR		above has happened, they are to	
		ation (F835 and F837), and 42		immediately ensure the resident is sa	
		ity Assurance and Performance		and immediately report to their superv	
		67). Substandard Quality of		who will immediately report to the abu	ISE
		dentified at 42 CFR 483.12		coordinator who is currently the	
		use (F600, F609, and F610).		Administrator. The supervisor will ren	
	on 12/02/2021. IJ	otified of Immediate Jeopardy		the alleged perpetrator from the build pending the investigation. The	ng
	011 12/02/2021. 13	is ongoing.		Administrator will then coordinate the	
	Refer to F600, F6	00 and E610		investigation and report to all required	
		09, and F010		agencies. staff have been educated.:	
	An accentable alle	egation of compliance (AoC)		supervisor will then immediately notify	
	-	2/14/2021, which alleged		Administrator will immediately begin to	
		mediate Jeopardy on		coordinate the investigation. If abuse	
		State Survey Agency		happens while the Administrator is off	
		mediate Jeopardy was		Administrator would be expected to st	
		ed during a revisit conducted on		immediately begin coordinating the	-
	-	lowered the scope and		investigation., this also includes off	
		42 CFR 483.12 Freedom from		hours/weekends/holidays etc. The	
	-	9, and F610); 42 CFR 483.70		Administrator is also responsible to	
		335 and F837); and 42 CFR		reporting to all state agencies. Prior to	

Facility ID: 100599

If continuation sheet Page 114 of 144

CENTER	-	AND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/2021
	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE	12/10/2021
	to the little to the off of the little to			00 NURSING HOME LANE	
PARKVIE	W POST-ACUTE AND	REHABILITATION CENTER		IKEVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIE	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 B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	DATE
{F 867}	Continued From p	age 114	{F 867}		
. ,	-	surance and Performance		working their next shift all staff were	
		67), while the facility monitors		retrained on recognizing and reporting	
		of systemic changes and quality		abuse and the Staff Development	
	assurance activitie			Coordinator administered a written	
				post-test. If staff did not achieve the	
	The findings includ	de:		passing score of 100%, individual	
	_			consultation was done until a passing	
	Review of the facil	lity "Quality Assurance and		score was obtained. 100% of staff hav	e
	Performance Impr	ovement (QAPI) Program"		been educated.	
	Policy, with a revis	sion date of April 2014, revealed		All Grievances/complaints filed with the	e
		se of the QAPI program was to		facility will be investigated and correcti	ve
		en, facility-wide processes that		actions will be taken to resolve the	
		y of care, quality of life and		grievance(s). Grievance forms are loca	ated
		of the residents. The policy		on each hallway, all grievances will be	
		on plans were implemented to		reviewed grievance officer who is the	
	prevent recurrence	e of adverse events.		Administrator. The Social Service	
		cipietostada Jak Daganistian		Director will serve as a backup grievan	ice
		ninistrator's Job Description,		officer to the Administrator. Grievance	o.r.
		015, revealed the administrator assist the Quality Assurance		officer will either investigate grievance assign the grievance to the manager o	
		nent committee in developing		the department it relates to for	•
		appropriate plans of action to		investigation. The grievance officer wil	
		juality deficiencies.		follow up on grievances to ensure a	
		duality deficiencies.		thorough investigation has been	
	Review of Stateme	ents of Deficiencies (SOD) for		conducted and the grievance has been	1
		09/24/2020, revealed the facility		resolved. Beginning 12/3/2021 staff no	
	· ·	-R 483.12 Abuse, Neglect, and		working on 12/2/2021 including agency	
		at a Scope and Severity (S/S)		staff and new hires will be educated by	
		to investigate an allegation of		the DON, ADON, IP, Regional Director	
		he QA Committee failed to		Nursing, regional nurse or consultant o	
	ensure substantial			their next scheduled shift. All employee	
				who have worked have been in-service	
	Review of Stateme	ents of Deficiencies (SOD) for		and completed a post-test competency	/ by
		12/12/2020, revealed		12/20/2021.	
		at 42 CFR 483.12 Abuse,		Beginning 12/3/2021 the Administrator	
		oitation (F600, F607, F608,		report, and review grievances received	
		Immediate Jeopardy (IJ) and		each day with the New Regional Direc	
		ity of Care (SQC) was identified		of Operations or Divisional Vice Presid	ent
	on 11/25/2020 and	d determined to exist on		daily until the immediate jeopardy is	

Facility ID: 100599

If continuation sheet Page 115 of 144

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		185256	B. WING		12/16/2021
NAME OF P	ROVIDER OR SUPPLIEF	2	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
			20	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 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)	
{F 867}	Continued From	nage 115	{F 867}		
[1 007]			{[007]	removed and weakly until substantial	
		e areas of 42 CFR 483.12 ouse, F-600, at a Scope and		removed and weekly until substantial compliance is achieved.	
		•			
		a "J"; Develop and Implement 07 at a S/S of a "J"; Reporting		Beginning 12/3/2021 a member of the governing body will be on site at the	
		picion of a Crime, F608, at a S/S		facility daily until the immediate jeopar	dv
		g Alleged Violations, F609 at a		is removed and substantial compliance	-
		Investigate/Prevent Abuse,		achieved. Members of the governing	
		a "J". In addition, 42 CFR		body include New RDO and/or DVP,	
		ration, F835 was cited at a S/S		Regional Nurse Consultant and/or Chi	ef
		cility submitted an acceptable		Nursing Officer. The key members of t	
		n with a compliance date of		QAPI committee consist of Administrat	
		plan of correction for the		Director of Nursing, Medical Director,	,
		ey stated any new hires or		Infection Preventionist. Information gat	her
		Id be in-serviced on abuse prior		will be QAPI d and reported to full	
		t resident care; and the facility		governing body by Administrator. The	
		audits which included staff		Medical Director attends QAPI. While i	
		esident interviews, and resident		facility the member of governing body	
		s. However, the corrective		present will review the resident abuse	
		effective in maintaining		interviews, and grievances filed each o	lay
		liance at 42 CFR 483.12 Abuse,		to ensure that there are no allegations	
	Neglect and Expl			abuse, and/or allegations are immedia	tely
				investigated, and alleged perpetrators	-
	Review of the Sta	atements of Deficiencies (SOD)		suspended.	
		ated 09/10/2021, revealed		Beginning 12/20/2021 the Administrate	or or
		l at 42 CFR 483.12 Abuse,		designee will ensure the Monitoring an	
		loitation (F600 and -609).		Trending Reports for Incident/Accident	ts,
		ardy (IJ) and Substandard Quality		Infection Control, Pressure Wound	
		as cited at F600 at a S/S of a		reports, Reportable Events, resident	
	-	submitted an acceptable		dignity, and staffing levels are provided	
		ardy Removal Plan on		the QAPI Committee. All monitoring to	
	-	jing removal of the Immediate		developed for the survey deficiencies	
		26/2021. The State Agency		be reviewed to ensure that compliance	
		diate Jeopardy was removed on		expectations are met by the Administra	ator
		lleged. However, the Governing		prior to submitting at each QAPI	
	-	sure compliance was		Committee meetings. If compliance	
	maintained.			expectations are not met staff the QAF	
	During this C			committee members will complete a ro	
	-	ey, record review and staff		cause analysis and then a performanc	e
	interviews, revea	led that on 11/10/2021 at		improvement plan will be initiated to	

Facility ID: 100599

If continuation sheet Page 116 of 144

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/202<u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
	N POST-ACUTE AND R	EHABILITATION CENTER	- 1 ²	200 NURSING HOME LANE	
			1	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 867}	Continued From pag	ge 116	{F 867}		
	State Registered Nu	PM, Resident #324 reported irsing Assistant (SRNA) #24		correct and not deficient practice.	
	turning and reposition yelled out and curse	the ankle and "jerked" while oning him/her. Resident #324 d at SRNA #24, stating the and he/she wanted to file a		Beginning 12/20/2021 all PI Projects w be monitored, and results provided to t QAPI Committee meeting.	
	SRNA #25 and SRN allegation was not re agencies, nor was th	e SRNA, as witnessed by IA #26. However, this eported to appropriate here an investigation initiated.		Two outside Nurse Consultant (Key Management) and (Healthcare Advoca Associates) will provide additional oversight with this POC beginning	
	11/10/2021, SRNA # room with SRNA #2 care. Although both witnessed SRNA #2 arm/shoulder, and p the facility failed to th	t thirty (30) minutes later, on 424 entered Resident #358's 5 and SRNA #26 to provide 1 SRNA #25 and SRNA #26 4 hit Resident #358 on the left rovided Witness Statements, horoughly investigate the		12/12/21 weekly for 4 months and mor often if necessary to ensure compliance with the POC. The Nurse Consultants also deliver education to the administrative team as needed. The Nurse Consultants will report findings to the Governing Body, the QAPI commit and the Chief Executive Officer of the company to determine if the issues have	e will o tee,
	unsubstantiated. In a	and found the allegation to be addition, the failed to identify ately report this allegation.		been resolved or if the QAPI initiative should continue.	
	12:43 PM, 11/22/202 11:01 AM, and 12/2/ had been in the role facility since 10/01/2	dministrator, on 11/21/2021 at 21 at 8:58 AM, 12/01/2021 at 2021 at 6:42 PM, revealed he of administrator of the 2021, and was over the			
	(QAPI) committee. T also served as the A facility. Further inter	Performance Improvement The Administrator stated he buse Coordinator at the view, revealed usually if a			
	would be reported a since Resident #324	staff member hurt them, it nd investigated as abuse, but l answered "no" when asked d, the incident was not			
	as an allegation of a	ate agencies or investigated buse. Per interview, he ent involving Resident #324 a			

Facility ID: 100599

If continuation sheet Page 117 of 144

PRINTED: 01/20/2022

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 01/20/2022 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		1. A 1.	LETED
		185256	B. WING			-C
NAME OF P	ROVIDER OR SUPPLIER	100200		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	16/202 <u>1</u>
		EHABILITATION CENTER	²	00 NURSING HOME LANE		
FARRAIEN	FOST-ACOTE AND RI		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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	Continued From pag		{F 867}			
	care issue and not a	n allegation of abuse.				
	11/21/2021 at 12:43 12/01/2021 at 11:01 PM, revealed he com involving Resident #3 unsubstantiated the at the resident's statem abused. The Admini was aware of the inc occurred when SRM Resident #324, he di when making the det involving Resident #3 Further, after discuss Resident #358, the A unaware SRNA #25 incident at approxima report the incident un the Assistant Director Additional interview of 12/2/2021 at 6:42 PM deficiencies for the 0 reviewed through the being monitored thro done as part of the F survey. The Administ committee had not ic the monitoring of abu concerns that abuse corrected. The facility provided Jeopardy Removal F	with the Administrator, on PM, 11/22/2021 at 8:58 AM, AM, and 12/2/2021 at 6:42 appleted the investigation 358 on 11/16/2021, and allegation of abuse based on ent saying he/she was not strator stated, although he ident on 11/10/2021, which A #24 provided care for d not consider this incident termination the allegation 358 was unsubstantiated. sion of the incident involving administrator revealed he was and SRNA #26 witnessed the ately 5:00 PM, but failed to ntil approximately 6:00 PM to r of Nursing (ADON). with the Administrator, on <i>A</i> , revealed the abuse 9/10/2021 Survey had been e QAPI program and were ugh audits that were being Plan of Correction for the trator stated the QAPI lentified any concerns with use and he did not have citations had not been an acceptable Immediate Plan, on 12/14/2021, that he Immediate Jeopardy (IJ)				

If continuation sheet Page 118 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03	/ED
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C	
NAME OF PI	ROVIDER OR SUPPLIER	100200		IREET ADDRESS, CITY, STATE, ZIP CODE	12/16/202 <u>1</u>	
		EHABILITATION CENTER	20	00 NURSING HOME LANE		
PARKVIEV	POST-ACUTE AND RE	ENABILITATION CENTER	PI	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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		NC
{F 867}	Continued From pag	e 118	{F 867}			
		ted the following corrective				
	Residents #324 and concerns with abuse voiced. On 12/02/202 Consultant (RNC) als ensure there was no blister, skin tears or o no concerns. The allegation of abu Nursing Assistant (Si was re-investigated s new Regional Directo SRNA #25 and #26 a re-interviewed by new The Allegation of abu #358, was reported o reporting agencies, p resident's attending p abuse involving Resi 11/21/2021, to the sta department, and the physician. SRNA #2 11/21/2021 and has #24 was also reported on 12/06/2021. 2. All residents with status (BIMS) score o interviewed and resid (7) or less were asse	and no concerns were 21, the Regional Nurse 30 assessed the residents to new bruises, redness, rash, open areas, and there were ase by State Registered RNA) #24 to Resident #358 starting 12/03/2021 by the or of Operations (RDO). and Resident #358 were w RDO on 12/03/2021. ase by SRNA #24 to Resident on 11/10/2021 to the state bolice department, and the obysician. The allegation of dent #324 was reported on ate reporting agencies, police resident's attending 4 was suspended on not returned to work. SRNA id to the nurse aide registry a brief interview for mental of eight (8) or greater were lents with a BIMS of seven assed by the RNC, Assistant				
	on 12/02/2021. The r signs of abuse and w	ADON), and/or Administrator residents were assessed for vere asked if they felt safe, ere subjected to, abuse in the				

Facility ID: 100599

If continuation sheet Page 119 of 144

CENTER		AND HUMAN SERVICES			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	CIN	R-C 12/16/2021
	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COD	
	CONDERVOIR ON OUT FIELD			00 NURSING HOME LANE	
PARKVIEW	V POST-ACUTE AND	REHABILITATION CENTER		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
{F 867}	Continued From p	age 119	{F 867}		
	facility. There we	re no concerns identified.			
	was re-educated of Vice President (D' Reporting, Abuse Signs of Abuse. A	Director of Operations (RDO) on 12/02/2021 by the Divisional VP) on Abuse Investigation Prevention, and Recognizing new RDO was assigned to ng as of 12/03/2021.			
	Operations (RDO) interdisciplinary m Administrator, Dire Assistant Director Service Director, I coordinators, Hum Manager, Medical	the new Regional Director of re-educated the facility anagement team, including the ector of Nursing (DON), of Nursing (ADON), Social Minimum Data Set (MDS) nan Resources, Business Office Records, Maintenance, Central anager, Staff Development			
	Coordinator, Wou Unit manager, Ho regarding the defin defined as the will unreasonable con	nd Survey, Activities Director, usekeeping/Laundry Supervisor nition of Abuse. "Abuse" was ful infliction of injury, finement, intimidation, or esulting physical harm, pain, or			
	Investigation and reporting an allege exploitation, or mi unknown source a	The training also included Abuse Reporting, which included ed violation of abuse, neglect, streatment (including injuries of and misappropriation of resident			
	that either of the a to immediately en and then immedia	tely. If an employee suspected bove had happened, they were sure the residents were safe, tely report the situation to the isor, who would immediately			
	notify the abuse c the Administrator. Supervisors was c	oordinator, who was currently Training of the Immediate lone through the previously training. The Staff			

Facility ID: 100599

If continuation sheet Page 120 of 144

		AND HUMAN SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C 12/16/2021
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE
			200 NURSING HOME LANE		
PARKVIEV	/ POST-ACUTE AND	D REHABILITATION CENTER		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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE
{F 867}	Continued From p	page 120	{F 867	}	
	-	ning sessions. If staff did not			
		ng score of one hundred (100%)			
		Il consultation was done until a			
	passing score wa				
		g 12/02/2021 on the 6 PM to 6			
		ally re-educated by the ADON			
		of Abuse and Abuse Investigation			
		he training included reporting ion of abuse, neglect,			
		istreatment (including injuries of			
		and misappropriation of resident			
		ately. If an employee suspected			
		above had happened, they were			
		sure the resident was safe, and			
		rt to their supervisor who would			
		rt to the abuse coordinator, in			
	accordance to the	e abuse policy. Staff not working,			
	including agency	staff and new hires would be			
		next scheduled shift. Prior to			
	•	next shift, the Staff			
	•	ordinator administered a written			
	•	did not achieve the passing			
		dred (100%) percent, individual			
		done until a passing score was ndred (100%) percent of the			
	facility staff have				
	lacinty stan nave				
	On 12/03/2021, th	ne Director of Nursing (DON)			
		A #25 and SRNA #26 on the			
	requirement to im	mediately report to the			
		visor any verbal allegation or			
		or neglect immediately upon			
		ring it. Training was also			
	•	alleged perpetrator would be			
		building pending the			
	-	e Administrator would then			
	coordinate the inv required agencies	vestigation and report to all			

Facility ID: 100599

If continuation sheet Page 121 of 144

		ND HUMAN SERVICES MEDICAID SERVICES				01/20/2022 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SU COMPLE	JRVEY
		185256	B. WING		R-C	
NAME OF P	ROVIDER OR SUPPLIER	100200		TREET ADDRESS, CITY, STATE, ZIP CODE	12/16	5/202 <u>1</u>
				00 NURSING HOME LANE		
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER	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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) COMPLETION DATE
{F 867}	Continued From pag	e 121	{F 867}			
	Consultant (RNC), A Nursing (DON), Assis (ADON), Social Serv interview residents w or greater daily and a with a BIMS score of any signs of abuse o they feel safe in the f abuse, and have not the immediate jeopar weekly until substant achieved. Results of reported to the Quali Improvement (QAPI) DON/ADON. 7. On 12/03/2021, th reviewed the grievan days to ensure no ab on the grievance log investigated. There w that alleged abuse or 8. Grievance forms w hallway and all grieva the grievance officer, Grievances/complain be investigated and o taken to resolve the g officer would either in assign the grievance Regional Director of Divisional Vice Presid	he New RDO and/or DVP ce log for the last thirty (30) buse allegations were noted and not reported or vere no logged grievances neglect. were located on each ances would be reviewed by the Administrator. All the filed with the facility would corrective actions would be grievance(s). The grievance to the department or investigation. Beginning inistrator would also report as received each day with the				

Facility ID: 100599

If continuation sheet Page 122 of 144

CENTER	S FOR MEDICARE	E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		185256	B. WING		12/16/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{F 867}	Continued From p	page 122	{F 867}		
	-	antial compliance was			
	consulting firm co the Governing Bo Nursing Officer, C Vice President, N Regional Nurse C the definition of al abuse investigatin and staff respons Officer, Master He Master of Public A Healthcare (MPA) Administrator (LN Compliance Spec Company provide education session reporting, recogni abuse and neglec compliance require incident form, and reporting requirem				
	governing body w daily until the imm and substantial co Members of the g RDO and/or DVP and/or Chief Nurs the governing boo review the residen grievances filed e abuse, and/or alle investigated, and	/03/2021 a member of the rould be on site at the facility nediate jeopardy was removed ompliance was achieved. overning body included the New , Regional Nurse Consultant sing Officer. While a member of dy was in the facility, they would nt abuse interviews and ach day to ensure allegations of egations were reported, alleged perpetrators mation gathered from audits			

If continuation sheet Page 123 of 144

		ND HUMAN SERVICES MEDICAID SERVICES				01/20/2022 APPROVED 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SU COMPLE	TED
		185256	B. WING		R-C 12/16	; 5/2021
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V 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 APPROPRI/ DEFICIENCY)	-	(X5) COMPLETION DATE
TAG {F 867}	Continued From page Assurance Performan program and the Adm governing body. The State Survey Ag implemented the follo 1. Review of facility of Administrator intervie #358 and the Region assessed the resider allegation of complian and no concerns wer Review of facility doo the new Regional Dir interviewed Resident 12/03/2021 and the a residents was re-inve AOC by the new RDO documentation and in Administrator on 12/7 the allegation of abus Resident #358 was re- state agencies, the p resident's attending p regarding Resident # 11/21/2021, to the state department, and the physician. Review of investigation the allegation and int on 12/16/2021 at 4:4 suspended the SRNA	e 123 nce Improvement (QAPI) ministrator would report to the ency verified the facility owing corrective actions: documentation revealed the ewed Residents #324 and hal Nurse Consultant (RNC) nts as outlined in the nce (AOC) on 12/02/2021, re identified. cumentation also revealed rector of Operations (RDO) t #324 and #358 on allegation regarding both estigated as stated in the O. Further review of facility nterview with the 16/2021 at 4:40 PM revealed se regarding SRNA# 24 and eported on 11/10/2021 to the police department, and the oblice department the allegation #324 was reported on ate agencies, the police resident's attending	TAG {F 867}		ATE	DATE
	registry on 12/06/202					

Facility ID: 100599

If continuation sheet Page 124 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/20 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		R-C 12/16/2021	
NAME OF PI	ROVIDER 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 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 867}	with the DVP on 12/1 confirmed State Reg #24 was suspended worked at the facility Interview with Reside 11:30 AM and intervie 12/16/2021 at 11:40 felt safe in the facility care/treatment were stated they were free 2. Review of intervie conducted by the Re (RNC), Assistant Dire and/or Administrator residents with a BIMS were asked if they fe witnessed abuse, or and no concerns wer and interview with the 4:33 PM revealed on BIMS score of seven for signs of abuse, ar redness, rash, blister concerns were identi 3. Review of education Divisional Vice Presid Administrator on 12/0 Investigation Reporti Program, and Recog Interview with the DV revealed a new RDO the building as of 12/0	I's timecard and interview 16/2021 at 4:50 PM istered Nurse Aide (SRNA) on 11/21/2021 and had now since that date. ent #324 on 12/16/2021 at ew with Resident #358 on AM revealed both residents on complaints regarding voiced and both residents e from abuse. ews/skin assessments gional Nurse Consultant ector of Nursing (ADON) on 12/02/2021 revealed all S with eight (8) or greater It safe in the facility, had had been subject to abuse re identified. Further reviews the ADON on 12/16/2021 at 12/02/2021 residents with a (7) or less were assessed my open areas, new bruising, s or skin tears and no fied. on provided to the Regional s (RDO) revealed the dent (DVP) re-educated the 02/2021 on facility's Abuse mg, Abuse Prevention nizing Signs of Abuse. (P on 12/16/2021 at 4:50 PM was assigned to oversee 03/2021.	{F 867}			
	4. Review of the trai	ning materials and sign in				

Facility ID: 100599

If continuation sheet Page 125 of 144

STATEMENT	DF DEFICIENCIES CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED R-C
		185256	B. WING		12/16/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	W POST-ACUTE AN	D REHABILITATION CENTER	PIKE		
(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 COMPLETIO
{F 867}	Operations (RDC interdisciplinary te abuse to include Administrator, Din Assistant Director Service Director (MDS) coordinate Business Office M Maintenance, Ce Staff Developmen Activities Director Housekeeping/La facility provided of revealed the facil completed a writt score of one hum Interview with the PM, the Social So at 4:20 PM, and te 12/16/2021 at 4:2 received training policy/procedures following the edu 5. Interview with 4:33 PM and revi revealed all staff PM-6 AM shift we ADON regarding Further review of continued intervie at 4:33 PM, revea scheduled to wor and new hires we	he Regional Director of b) re-educated the facility eam on 12/03/2021 regarding the following staff members: the rector of Nursing (DON), r of Nursing (ADON), Social (SSD), Minimum Data Set ors, Human Resources, Manager, Medical Records, ntral Supply, Dietary Manager, nt Coordinator, Wound Nurse, r, Unit manager and aundry Supervisor. Review of competency testing documents ity interdisciplinary team en post-test, with a passing dred (100%) percent. ADON on 12/16/2021 at 4:33 ervices Director on 12/16/2021 the Director of Nursing (DON) on 25 PM revealed they had regarding the facility's abuse s and had taken a post-test	{F 867}		

Facility ID: 100599

If continuation sheet Page 126 of 144

	-	AND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING	TTNI	R-C
		185256	B. WING		12/16/202 <u>1</u>
NAME OF PI	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIEV	V POST-ACUTE AND	REHABILITATION CENTER		URSING 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 867}	Continued From p	-	{F 867}		
		d all staff had been educated post-test by 12/13/2021.			
	PM; Licensed Pra	NA #1 on 12/16/2021 at 3:00 ctical Nurse (LPN) # 10 on			
	Registered Nurse	0 PM; and interview with (RN) #12 on 12/16/2021 at d training also included Abuse			
	violation of abuse,	orting and that any alleged neglect, exploitation or uding injuries of unknown			
	source and misap should be reported	propriation of resident property) d immediately to the department DON and SRNA interview also			
	revealed staff were suspected that ab	e instructed that if an employee use had occurred, they were to re the resident was safe. They			
	stated they were t report to their sup would remove the	hen required to immediately ervisor. Further, the supervisor alleged perpetrator from the			
		he investigation and ted the allegation to the abuse			
	12/16/2021 at 4:28 provided to staff re	Director of Nursing (DON) on 5 PM and review of education evealed on 12/03/2021, the State Registered Nursing			
	immediately repor	#25 and SRNA #26 to t any allegations of abuse to the visor when the incident			
	4:40 PM revealed investigations and	Administrator on 12/16/2021 at he would coordinate the ensure all allegations were			
	Review of an alleg	igencies as required. Jed incident of resident to tween Resident #322 and			

If continuation sheet Page 127 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03	ΈD
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C 12/16/2021	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	12, 10,202	
PARKVIE	W POST-ACUTE AND RE	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
	SUMMARY ST	TATEMENT OF DEFICIENCIES		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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIC	N
{F 867}	Continued From page	e 127	{F 867}			
		occurred on 12/14/2021 at				
		concerns with the facility nor investigating. The				
	investigation was one	going; however, actions had				
	been taken to protect	t those and all other cerns were identified.				
		identis were identified.				
		ent #322 on 12/16/2021 at				
		w with Resident #361 on M revealed they felt safe in				
		o concerns related to abuse.				
		ADON on 12/16/2021 at of Resident Abuse Interview				
		aled beginning on 12/03/2021				
		cility with a BIMS of eight (8)				
		viewed daily by the DON, or Social Worker to ensure				
	the residents felt safe	e, had not been subject to				
	abuse, and had not v concerns were identi					
		neu.				
		ent #362 on 12/16/2021 at #261 at 2:20 DM and				
	12:00 PM, Resident Resident #322 at 3:4	0 PM confirmed staff were				
		ily. The stated they had no				
		r neglect and none had been aff during the interviews				
		-				
		ssments revealed beginning RNC, DON and ADON				
		residents with a BIMS of				
		y to ensure any new bruise,				
		, skin tears or open areas o concerns were identified.				
	7. Interview with the	Regional Vice President				
	(RVP) on 12/16/2021	at 4:50 PM revealed she ce log on 12/03/2021 for the				

Facility ID: 100599

If continuation sheet Page 128 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/20/2022 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE S COMPL	ETED
		185256	B. WING		R- 12/1	C 16/2021
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		0/202
PARKVIEV	N POST-ACUTE AND RI	EHABILITATION CENTER		0 NURSING HOME LANE KEVILLE, 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)		COMPLETION DATE
{F 867}	Continued From pag	e 128	{F 867}			
	previous thirty (30) d of abuse was include concerns were identi	5				
	8. Observations on 7 grievance forms were the resident care unit	e located on each hallway of				
	4:40 PM revealed he and would oversee th grievances/complain be investigated and o taken to resolve the Administrator also st process in the facility	Iministrator on 12/16/2021 at e was the grievance officer he process to ensure any ts voiced at the facility would corrective actions would be grievance(s). The ated he would oversee the / to ensure the regulatory grievances were followed.				
	on 12/16/2021 at 4:5 to review the grievan	egional Vice President (RVP) i0 PM revealed she continued ace log daily and oversee to as in compliance with the				
	#10 on 12/16/2021 a training provided to s retrained and were re	ed Practical Nurse (LPN) at 3:20 PM and review of staff confirmed staff were equired to take a post-test r, regarding the grievance /.				
	grievance was filed of #362 regarding his/h odor. Further review investigated, the resi the resident's grievar	vere no allegations of abuse,				

If continuation sheet Page 129 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/20 FORM APPROV OMB NO. 0938-03	/ED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C 12/16/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/10/2021	
PARKVIE	W 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETIC	NC
{F 867}	Continued From pag	e 129	{F 867	}		
	log/grievance form.					
	12:00 PM revealed h grievance regarding bathroom and facility grievance. The reside with care/treatment in 9. Review of training documentation, and 12/03/2021, the Ryte Governing Body con Officer, Chief Strateg President, New Regi Regional Nurse Cons abuse, abuse reporti grievances and comp responsibility. The G were also educated of investigations, abuse and symptoms of abu agency compliance r	cleanliness of his/her staff had resolved the lent had no current concerns in the facility. g documentation, testing sign-in sheets revealed on is Company, educated the sisting of the Chief Nursing gy Officer, Divisional Vice onal Vice President, sultant on the definition of ing and abuse investigating, blaints and staff overning body members on conducting abuse e reporting, recognizing signs use and neglect, state equirement, a self-reporting e Kentucky mandatory				
	4:40 PM, RNC #2 on with the Divisional Vi 12/16/2021 at 4:50 F the training provided regarding identifying grievances and polic post-test following th 10. Review of record Divisional Vice Presi 4:50 PM revealed that	ies, and completed a				

Facility ID: 100599

If continuation sheet Page 130 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/20/2022 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	ETED
		185256	B. WING		R- 12/1	C I 6/2021
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		0/202
PARKVIE	W POST-ACUTE AND RI	EHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501		
				PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 867}	Continued From pag	e 130	{F 867}			
		ld continue to be onsite daily				
		eopardy was removed, and				
		ce was achieved. The ber in the facility also				
	reviewed the residen	ts' abuse interviews, and				
		h day to ensure there were no				
		that were not immediately eged perpetrators were				
	U .	acility policy and regulatory				
	-	d interviews revealed the				
	was taken to QAPI.	nered, and audit information				
	Review of the facility	's QAPI meetings revealed				
		13/2021 and documentation				
	provided no evidence identified.	e any new concerns were				
	The facility provided	an acceptable Immediate				
		Plan, on 12/14/2021, that				
	alleged removal of th on 12/13/2021.	e Immediate Jeopardy (IJ)				
	The facility implemer actions:	nted the following corrective				
		ne Administrator interviewed				
	Residents #324 and	#358 regarding any , and no concerns were				
		21, the Regional Nurse				
	Consultant (RNC) als	so assessed the residents to				
		new bruises, redness, rash,				
	no concerns.	open areas, and there were				
	The allegation of abu	use by State Registered				
		RNA) #24 to Resident #358				
	Ū	starting 12/03/2021 by the or of Operations (RDO).				

		ND HUMAN SERVICES			FORM	: 01/20/2022 APPROVED . 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE COMPI	LETED
		185256	B. WING		R- 12/*	·C 16/2021
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 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)	BE	COMPLETION DATE
{F 867}	Continued From page	ge 131	{F 867}			
		and Resident #358 were w RDO on 12/03/2021.				
	 #358, was reported reporting agencies, resident's attending abuse involving Res 11/21/2021, to the s department, and the physician. SRNA #2 11/21/2021 and has #24 was also report on 12/06/2021. All residents with status (BIMS) score 	use by SRNA #24 to Resident on 11/10/2021 to the state police department, and the physician. The allegation of ident #324 was reported on tate reporting agencies, police e resident's attending 24 was suspended on not returned to work. SRNA ed to the nurse aide registry				
	(7) or less were ass Director of Nursing (on 12/02/2021. The signs of abuse and	dents with a BIMS of seven essed by the RNC, Assistant (ADON), and/or Administrator residents were assessed for were asked if they felt safe, ere subjected to, abuse in the				
	facility. There were	no concerns identified.				
	was re-educated on Vice President (DVF Reporting, Abuse Pr	rector of Operations (RDO) 12/02/2021 by the Divisional P) on Abuse Investigation revention, and Recognizing ew RDO was assigned to as of 12/03/2021.				
	Operations (RDO) ru interdisciplinary mar Administrator, Direc Assistant Director of Service Director, Mi	ne new Regional Director of e-educated the facility nagement team, including the tor of Nursing (DON), f Nursing (ADON), Social nimum Data Set (MDS) n Resources, Business Office				

If continuation sheet Page 132 of 144

	F DEFICIENCIES CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
185256 NAME OF PROVIDER OR SUPPLIER		B. WING		12/16/2021	
		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	12/10/202	
			200 N	URSING HOME LANE	
PARKVIEW	POST-ACUTE AND	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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
{F 867}	Continued From	bage 132	{F 867}		
(,	-	I Records, Maintenance, Central	[, 007]		
	•	lanager, Staff Development			
		Ind Nurse, Activities Director,			
		busekeeping/Laundry Supervisor			
		inition of Abuse. "Abuse" was			
	defined as the wil	Iful infliction of injury,			
		nfinement, intimidation, or			
	•	resulting physical harm, pain, or			
		The training also included Abuse			
	-	Reporting, which included			
		ed violation of abuse, neglect,			
		istreatment (including injuries of			
		and misappropriation of resident ately. If an employee suspected			
		above had happened, they were			
		isure the residents were safe,			
		ately report the situation to the			
		visor, who would immediately			
	•	coordinator, who was currently			
		Training of the Immediate			
	Supervisors was	done through the previously			
	mentioned abuse	training. The Staff			
		ordinator administered a written			
	•	ning sessions. If staff did not			
		ing score of one hundred (100%)			
	•	al consultation was done until a			
	passing score wa	is obtained.			
	5. All staff working	g 12/02/2021 on the 6 PM to 6			
		ally re-educated by the ADON			
		of Abuse and Abuse Investigation			
		he training included reporting			
	any alleged violat	ion of abuse, neglect,			
		istreatment (including injuries of			
		and misappropriation of resident			
		ately. If an employee suspected			
		above had happened, they were			
	to immediately en	sure the resident was safe, and			

If continuation sheet Page 133 of 144

CENTER	S FOR MEDICARI	E & MEDICAID SERVICES		(OMB NO. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-C	
		185256	B. WING		12/16/2021	
NAME OF PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
		200 N	URSING HOME LANE			
PARKVIEV	V POST-ACUTE ANI	D REHABILITATION CENTER	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 APPROPRIA DEFICIENCY)	DATE	
{F 867}	Continued From	nage 133	{F 867}			
[1 007]		-				
		rt to the abuse coordinator, in e abuse policy. Staff not working,				
		staff and new hires would be				
		next scheduled shift. Prior to				
		next shift, the Staff				
	-	ordinator administered a written				
	•	did not achieve the passing				
		dred (100%) percent, individual				
	consultation was	done until a passing score was				
	obtained. One hu	ndred (100%) percent of the				
	facility staff have	been educated.				
		ne Director of Nursing (DON)				
		A #25 and SRNA #26 on the				
		mediately report to the				
		rvisor any verbal allegation or				
		or neglect immediately upon				
		rring it. Training was also				
		alleged perpetrator would be building pending the				
		e Administrator would then				
		estigation and report to all				
	required agencies					
	6. Beginning 12/	03/2021 the Regional Nurse				
), Administrator, Director of				
		ssistant Director of Nursing				
		Service Director (SSD) would				
		ts with a BIMS score of eight (8)				
		nd assess the skin of residents				
		e of seven (7) or less daily for				
		e or any unidentified to ensure				
		he facility, have not witnessed				
		not been subject to abuse, until				
		ppardy has been removed then tantial compliance has been				
	•	s of the interviews would be				
		uality Assurance Performance				
		API) committee by the				

Facility ID: 100599

If continuation sheet Page 134 of 144

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES		(DMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
			1		R-C	
185256		B. WING		12/16/202 <u>1</u>		
NAME OF PF	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AN	D REHABILITATION CENTER		IURSING HOME LANE		
0(0)15	CLIMMAT	RY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(72)	
(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 APPROPRIA DEFICIENCY)	DATE	
{F 867}	Continued From	page 134	{F 867}			
	DON/ADON.					
	7. On 12/03/202	1, the New RDO and/or DVP				
		vance log for the last thirty (30)				
	•	o abuse allegations were noted log and not reported or				
	•	re were no logged grievances				
	that alleged abus					
		ms were located on each				
		rievances would be reviewed by cer, the Administrator. All				
	-	plaints filed with the facility would				
	-	nd corrective actions would be				
		he grievance(s). The grievance				
		er investigate the grievance or nee to the department				
	• •	or for investigation. Beginning				
	•	Administrator would also report				
	and review grieva	ances received each day with the				
		of Operations (RDO) or				
		resident (DVP) daily until the				
		dy was removed and then tantial compliance was				
	achieved.					
	9. On 12/03/202	1 the Rytes Company (outside				
	0	ontracted to achieve compliance)				
		bdy consisting of the Chief				
	•	Chief Strategy Officer, Divisional lew Regional Vice President,				
		Consultant were re-educated on				
	-	buse, abuse reporting and				
	abuse investigati	ng, Grievance and complaints				
		ibility. The Chief Operating				
		ealthcare Administration (MHA),				
		Administration and Geriatric), Licensed Nursing Home				
	•	IHA), and Certified Healthcare				

If continuation sheet Page 135 of 144

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 01/20/2022 1 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE	
		185256	B. WING	ETN/		-C 16/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	- 12/	10/2021
PARKVIEV	V POST-ACUTE AND R	EHABILITATION CENTER		00 NURSING HOME LANE		
				PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT 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 867}	Continued From pag	e 135	{F 867}			
		st (CHC) of the Rytes in in-depth review and				
	education session or reporting, recognizin abuse and neglect. compliance requirem	n abuse investigation, abuse g signs and symptoms of They also reviewed the nents, the self-reporting e Kentucky mandatory				
	governing body would daily until the immed and substantial comp Members of the gove RDO and/or DVP, Re and/or Chief Nursing the governing body w review the resident a grievances filed each abuse, and/or allega investigated, and alle suspended. Informat would be provided to Assurance Performa program and the Adr governing body. The State Survey Ag implemented the follo 1. Review of facility Administrator intervie #358 and the Region assessed the resider	an day to ensure allegations of tions were reported, eged perpetrators ion gathered from audits the facility's Quality nce Improvement (QAPI) ninistrator would report to the ency verified the facility powing corrective actions: documentation revealed the ewed Residents #324 and hal Nurse Consultant (RNC) nts as outlined in the nce (AOC) on 12/02/2021,				
		cumentation also revealed rector of Operations (RDO)				

		E & MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	R-C	
185256		B. WING		12/16/2021	
NAME OF PI	ROVIDER OR SUPPLIEF	R	STR	EET ADDRESS, CITY, STATE, ZIP CODE	
		D REHABILITATION CENTER	200	NURSING HOME LANE	
PARAVIEV	POST-ACUTE AN	D REHABILITATION CENTER	РІК	EVILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES HENCY 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 COMPLETIC
{F 867}	Continued From	page 136	{F 867}		
		dent #324 and #358 on			
	12/03/2021 and t	he allegation regarding both			
		investigated as stated in the			
	•	RDO. Further review of facility nd interview with the			
		12/16/2021 at 4:40 PM revealed			
		abuse regarding SRNA# 24 and			
	-	as reported on 11/10/2021 to the			
	-	ne police department, and the			
		ng physician and the allegation			
		ent #324 was reported on estate agencies, the police			
		the resident's attending			
	physician.	5			
	.				
		gation findings after re-opening dinterview with the Administrator			
	-	4:40 PM revealed the facility			
		RNA #24 on 11/21/2021, and her			
	employment was	terminated. The facility			
	•	IA to the nurse aide abuse			
	registry on 12/06	/2021.			
	Review of SRNA	# 24's timecard and interview			
		12/16/2021 at 4:50 PM			
		Registered Nurse Aide (SRNA)			
		ded on 11/21/2021 and had now			
	worked at the fac	cility since that date.			
	Interview with Re	sident #324 on 12/16/2021 at			
	11:30 AM and int	erview with Resident #358 on			
		:40 AM revealed both residents			
		cility, no complaints regarding			
	stated they were	ere voiced and both residents free from abuse.			
	2. Review of inte	erviews/skin assessments			
		Regional Nurse Consultant			
	(RNC), Assistant	Director of Nursing (ADON)			

If continuation sheet Page 137 of 144

		AND HUMAN SERVICES			PRINTED: 01/20/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
185256		B. WING		R-C 12/16/202<u>1</u>	
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
54 51 <i>0</i> (15)			200 N	IURSING HOME LANE	
PARKVIE	W POST-ACUTE AND	REHABILITATION CENTER	PIKE	VILLE, KY 41501	
(X4) ID PREFIX TAG	(EACH DEFICIE	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)	
{F 867}	Continued From p	age 137	{F 867}		
	residents with a B were asked if they witnessed abuse, and no concerns v and interview with 4:33 PM revealed BIMS score of sev for signs of abuse redness, rash, blis concerns were ide 3. Review of educ Director of Operat Divisional Vice Pre Administrator on 1 Investigation Repo Program, and Rec	ation provided to the Regional ions (RDO) revealed the esident (DVP) re-educated the 2/02/2021 on facility's Abuse orting, Abuse Prevention cognizing Signs of Abuse. DVP on 12/16/2021 at 4:50 PM DO was assigned to oversee			
	sheets revealed th Operations (RDO) interdisciplinary te abuse to include th Administrator, Dire Assistant Director Service Director (S (MDS) coordinator Business Office M Maintenance, Cen Staff Development Activities Director, Housekeeping/Lau facility provided co revealed the facilit	raining materials and sign in the Regional Director of or re-educated the facility am on 12/03/2021 regarding the following staff members: the ector of Nursing (DON), of Nursing (ADON), Social SSD), Minimum Data Set rs, Human Resources, anager, Medical Records, thral Supply, Dietary Manager, t Coordinator, Wound Nurse, Unit manager and undry Supervisor. Review of ompetency testing documents by interdisciplinary team an post-test, with a passing			

Facility ID: 100599

If continuation sheet Page 138 of 144

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETE A. BUILDING COMPLETE A. BUILDING COMPLETE A. BUILDING COMPLETE B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION			ND HUMAN SERVICES			PRINTED: 01/20/2 FORM APPROV OMB NO. 0938-0	VED
182256 IN WING 12/16/2 VAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STREE _ 20 CODE 20 NURSING HOME LANE PARKVIEW POST-ACUTE AND REHABILITATION CENTER 20 NURSING HOME LANE 20 NURSING HOME LANE (d) ID TKS SUMMARY SWIEMENT OF DEFICIENCES PREX PREX PREX PREX CONCOMPRET: ACUTOR NOR CORRECTION (CONCOMPRETIVE ACTION SHOLD SE CROSS-REPRESENCE FOR ACTION SHOLD SE CROSS-REPRESENC				· /		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLER STREET ADDRESS. CITY, STATE, ZP CODE PARKVIEW POST-ACUTE AND REHABILITATION CENTER STREET ADDRESS. CITY, STATE, ZP CODE Image: Comparison of the state of the comparison of the state of the s			185256	B. WING			
PARKWIEW POST-ACUTE AND REHABILITATION CENTER PIKEVILLE, KY 41501 Majin TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OERFICIENCY MUST EXPECTEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) D D RECKY TAG PREVX (EACH OERFICIENCY MUST EXPECTEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) D CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 000000000000000000000000000000000000	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/10/2021	
Date 10 PREPRY Txg SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) p. PREPRX Txg PROVIDERS FUN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) column (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 867} Continued From page 138 score of one hundred (100%) percent. (F 867) (F 867) Interview with the ADON on 12/16/2021 at 4:33 PM, the Social Services Director on 12/16/2021 at 4:20 PM, and the Director of Nursing (DON) on 12/16/2021 at 4:25 PM revealed they had received training regarding the facility's abuse policy/procedures and had taken a post-test following the education training. 5. Interview with the ADON on 12/16/2021 at 4:33 PM and review of education provided to staff revealed all staff working on 12/02/2021 on the 6 PM-6 AM shift were verbally re-educated by the ADON regarding the definition of abuse. Further review of ongoing education provided and continued interview with the ADON on 12/16/2021 at 4:33 PM, revealed all that were not scheduled to work, which included agency staff and new hires were educated and were required to take a post-test by 12/13/2021. Interview with SRNA#1 on 12/16/2021 at 3:00 PM; Licensed Practical Nurse (LPN)# 10 on 12/16/2021 at 3:20 PM, and interview with Registered Nurse (RN) #12 on 12/16/2021 at 3:15 PM; confirmed training also included Abuse Investigation/Reporting and that any alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misspropristion of resident property)	DA DIG (1 2	200 NURSING HOME LANE		
PREFIX TAG (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGULATORY OR USC IDENTFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSSREPTENCED TO THE APPROPRIATE DEFICIENCY) [F 867] Continued From page 138 score of one hundred (100%) percent. (F 867] Interview with the ADON on 12/16/2021 at 4:33 PM, the Social Services Director on 12/16/2021 at 4:20 PM, and the Director of Nursing (DON) on 12/16/2021 at 4:25 PM revealed they had received training regarding the facility's abuse policy/procedures and had taken a post-test following the education training. 5. Interview with the ADON on 12/16/2021 at 4:33 PM, and review of education provided to staff revealed all staff working on 12/22/201 on the 6 PM-6 AM shift were verbally re-educated by the ADON regarding the definition of abuse. Further review of ngoing education provided and continued interview with the ADON on 12/16/2021 at 4:33 PM, revealed staff that were not scheduled to with, which included agency staff and new hires were educated and were required to take a post-test by 12/13/2021. Interview with SRNA #1 on 12/16/2021 at 3:15 PM, confirmed training also included Abuse Investigation/Reporting and that any alleged violation of abuse, neglect, exploitation or mistreatment (including injunes of unknown source and misappropriation of resident property)	PARKVIE	W POST-ACUTE AND R	EHABILITATION CENTER	F	PIKEVILLE, KY 41501		
score of one hundred (100%) percent. Interview with the ADON on 12/16/2021 at 4:33 PM, the Social Services Director on 12/16/2021 at 4:20 PM, and the Director of Nursing (DON) on 12/16/2021 4t 4:25 PM revealed they had received training regarding the facility's abuse policy/procedures and had taken a post-test following the education training. 5. Interview with the ADON on 12/16/2021 at 4:33 PM and review of education provided to staff revealed all staff working on 12/02/2021 on the 6 PM-6 AM shift were verbally re-educated by the ADON regarding the definition of abuse. Further review of ongoing education provided and continued interview with the ADON on 12/16/2021 at 4:33 PM, revealed staff that were not scheduled thir. Record review and interview with the ADON revealed all staff had been educated and new hires were educated and were required to take a post-test competency before their next scheduled shift. Record review and interview with the ADON revealed all staff had been educated and completed a post-test by 12/13/2021. Interview with SRNA #1 on 12/16/2021 at 3:00 PM; confirmed training also included Abuse Investigation/Reporting and that an	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR	BE COMPLET	ION
score of one hundred (100%) percent. Interview with the ADON on 12/16/2021 at 4:33 PM, the Social Services Director of Nursing (DON) on 12/16/2021 at 4:25 PM revealed they had received training regarding the facility's abuse policy/procedures and had taken a post-test following the education training. 5. Interview with the ADON on 12/16/2021 at 4:33 PM and review of education provided to staff revealed all staff working on 12/02/2021 on the 6 PM-6 AM shift were verbally re-educated by the ADON regarding the definition of abuse. Further review of ongoing education provided and continued interview with the ADON on 12/16/2021 at 4:33 PM, revealed staff that were not scheduled to work, which included agency staff and new hires were educated and were required to take a post-test ompletney before their next scheduled shift. Record review and interview with the ADON revealed all staff had been educated and completed a post-test y 12/13/2021. Interview with SRNA #1 on 12/16/2021 at 3:00 PM; Licensed Practical Nurse (LPN) # 10 on 12/16/2021 at 3:20 PM; and interview with Registered Nurse (RN) #12 on 12/16/2021 at 3:15 PM; confirmed training also included Abuse Investigation/Reporting and that any alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misapropriation of resident property)	{F 867}	Continued From pag	je 138	{F 867}			
PM, the Social Services Director on 12/16/2021 at 4:20 PM, and the Director of Nursing (DON) on 12/16/2021 at 4:25 PM revealed they had received training regarding the facility's abuse policy/procedures and had taken a post-test following the education training. 5. Interview with the ADON on 12/16/2021 at 4:33 PM and review of education provided to staff revealed all staff working on 12/02/2021 on the 6 PM-6 AM shift were verbally re-educated by the ADON regarding the definition of abuse. Further review of ongoing education provided and continued interview with the ADON on 12/16/2021 at 4:33 PM, revealed staff that were not scheduled to work, which included agency staff and new hires were educated and were required to take a post-test competency before their next scheduled shift. Record review and interview with the ADON revealed all staff had been educated and completed a post-test by 12/13/2021. Interview with SRNA #1 on 12/16/2021 at 3:00 PW: Licensed Practical Nurse (LPN) # 10 on 12/16/2021 at 3:20 PM; and interview with Registered Nurse (RN) #12 on 12/16/2021 at 3:15 PM; confirmed training also included Abuse Investigation/Reporting and that		score of one hundre	d (100%) percent.				
3:15 PM; confirmed training also included Abuse Investigation/Reporting and that any alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property)		PM, the Social Serv at 4:20 PM, and the 12/16/2021 at 4:25 F received training reg policy/procedures an following the educat 5. Interview with the 4:33 PM and review revealed all staff wo PM-6 AM shift were ADON regarding the Further review of on continued interview at 4:33 PM, revealed scheduled to work, v and new hires were to take a post-test co scheduled shift. Re the ADON revealed and completed a post Interview with SRNA	ces Director on 12/16/2021 Director of Nursing (DON) on PM revealed they had parding the facility's abuse and had taken a post-test ion training. ADON on 12/16/2021 at of education provided to staff rking on 12/02/2021 on the 6 verbally re-educated by the e definition of abuse. going education provided and with the ADON on 12/16/2021 d staff that were not which included agency staff educated and were required ompetency before their next cord review and interview with all staff had been educated st-test by 12/13/2021. A#1 on 12/16/2021 at 3:00 cal Nurse (LPN) # 10 on				
violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property)		Registered Nurse (F 3:15 PM; confirmed	N) #12 on 12/16/2021 at training also included Abuse				
supervisor. The ADON and SRNA interview also revealed staff were instructed that if an employee suspected that abuse had occurred, they were to		violation of abuse, n mistreatment (includ source and misappr should be reported i supervisor. The ADC revealed staff were i	eglect, exploitation or ing injuries of unknown opriation of resident property) mmediately to the department DN and SRNA interview also nstructed that if an employee				

Facility ID: 100599

If continuation sheet Page 139 of 144

TATEMENT (S FOR MEDICAR	E & MEDICAID SERVICES	· ,	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	R-C	
NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	12/16/202 <u>1</u>	
				0 NURSING HOME LANE	
PARKVIE	V POST-ACUTE ANI	D REHABILITATION CENTER	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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO
{F 867}	stated they were report to their sup would remove the building pending immediately repo coordinator. Interview with the 12/16/2021 at 4:2 provided to staff facility reeducate Assistant (SRNA) immediately repo department supe occurred. Interview with the 4:40 PM revealed investigations and reported to state Review of an alle resident abuse be Resident #361 wil 3:10 PM revealed practices of repor investigation was been taken to pro- residents and no Interview with Re 3:40 PM and inte 12/16/2021 at 3:3 the facility and ha 6. Interview with 4:33 PM and revi	page 139 are the resident was safe. They then required to immediately pervisor. Further, the supervisor a alleged perpetrator from the the investigation and rted the allegation to the abuse a Director of Nursing (DON) on 25 PM and review of education revealed on 12/03/2021, the d State Registered Nursing) #25 and SRNA #26 to rt any allegations of abuse to the rvisor when the incident addininistrator on 12/16/2021 at d he would coordinate the d ensure all allegations were agencies as required. ged incident of resident to etween Resident #322 and hich occurred on 12/14/2021 at d no concerns with the facility ting nor investigating. The ongoing; however, actions had otect those and all other concerns were identified. sident #322 on 12/16/2021 at rview with Resident #361 on 30 PM revealed they felt safe in ad no concerns related to abuse. the ADON on 12/16/2021 at ew of Resident Abuse Interview evealed beginning on 12/03/2021	{F 867}		

Facility ID: 100599

If continuation sheet Page 140 of 144

		ND HUMAN SERVICES			PRINTED: 01/20/2022 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		R-C 12/16/2021
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	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 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 867}	Continued From page	ge 140	{F 867}		
	RNC #2, ADON and the residents felt sat	rviewed daily by the DON, l/or Social Worker to ensure fe, had not been subject to witnessed abuse. No tified.			
	12:00 PM, Resident Resident #322 at 3: interviewing them da concerns of abuse of	lent #362 on 12/16/2021 at #361 at 3:30 PM and 40 PM confirmed staff were aily. The stated they had no or neglect and none had been taff during the interviews			
	on 12/03/2021, the l assessed the skin o seven (7) or less da redness, rash, bliste	ssments revealed beginning RNC, DON and ADON f residents with a BIMS of ily to ensure any new bruise, er, skin tears or open areas to concerns were identified.			
	(RVP) on 12/16/202 reviewed the grieval previous thirty (30) o	e Regional Vice President 1 at 4:50 PM revealed she nce log on 12/03/2021 for the days to ensure no allegations ed on the log and no tified.			
		12/16/2021 revealed re located on each hallway of its in the facility.			
	4:40 PM revealed h and would oversee t grievances/complain be investigated and taken to resolve the Administrator also s	dministrator on 12/16/2021 at e was the grievance officer the process to ensure any hts voiced at the facility would corrective actions would be grievance(s). The tated he would oversee the y to ensure the regulatory			

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/20/2022 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		R-C 12/16/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
PARKVIE	N POST-ACUTE AND RE	EHABILITATION CENTER		00 NURSING HOME LANE PIKEVILLE, KY 41501	
040.15	CUMMADY C			PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{F 867}	Continued From pag	e 141	{F 867}		
	guidelines regarding	grievances were followed.			
	on 12/16/2021 at 4:5 to review the grievan	gional Vice President (RVP) 0 PM revealed she continued ce log daily and oversee to as in compliance with the			
	#10 on 12/16/2021 a training provided to s retrained and were re	ed Practical Nurse (LPN) t 3:20 PM and review of taff confirmed staff were equired to take a post-test , regarding the grievance			
	grievance was filed of #362 regarding his/h odor. Further review investigated, the resi the resident's grievar	vere no allegations of abuse,			
	12:00 PM revealed h grievance regarding bathroom and facility	cleanliness of his/her staff had resolved the lent had no current concerns			
	documentation, and 12/03/2021, the Ryte Governing Body con Officer, Chief Strateg President, New Regi	documentation, testing sign-in sheets revealed on s Company, educated the sisting of the Chief Nursing y Officer, Divisional Vice onal Vice President, sultant on the definition of			

Facility ID: 100599

If continuation sheet Page 142 of 144

CENTER	-	HAND HUMAN SERVICES			FORM APPROVI OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING		R-C 12/16/2021	
NAME OF P	NAME OF PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
	N DOCT ACUTE AN	D REHABILITATION CENTER	200 1	NURSING HOME LANE		
PARAVIEN	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLETIO	
{F 867}	Continued From	page 142	{F 867}			
		oorting and abuse investigating, omplaints and staff				
	responsibility. The were also educate	e Governing body members ed on conducting abuse				
	and symptoms of	use reporting, recognizing signs abuse and neglect, state				
		ce requirement, a self-reporting I the Kentucky mandatory ment.				
	4:40 PM, RNC #2	Administrator on 12/16/2021 at 2 on 12/16/2021 at 3:40 PM, and al Vice President (DVP) on				
	12/16/2021 at 4:5 the training provid	50 PM revealed they attended ded by the Rytes company				
		ring and reporting abuse, olicies, and completed a g the training.				
	Divisional Vice Pr	cords and interview with the resident (DVP) on 12/16/2021 at				
	member of the go facility daily and v	that beginning 12/03/2021, a overning body was onsite at the would continue to be onsite daily				
	substantial compl	te jeopardy was removed, and liance was achieved. The nember in the facility also				
	grievances filed e	dents' abuse interviews, and each day to ensure there were no use that were not immediately				
	investigated, and suspended per th	alleged perpetrators were ne facility policy and regulatory nued interviews revealed the				
		gathered, and audit information				
	the team met on	ility's QAPI meetings revealed 12/13/2021 and documentation ence any new concerns were				

Facility ID: 100599

If continuation sheet Page 143 of 144

		ND HUMAN SERVICES			PRINTED: 01/20/2022 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		185256	B. WING		R-C
NAME OF P	ROVIDER OR SUPPLIER	100200		EET ADDRESS, CITY, STATE, ZIP CODE	12/16/202 <u>1</u>
		EHABILITATION CENTER	200	NURSING HOME LANE	
PARAVIEN	WPOST-ACUTE AND R		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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
{F 867}	Continued From pag	ge 143	{F 867}	DEFICIENCY)	

Event ID: COGB12

Facility ID: 100599

If continuation sheet Page 144 of 144