STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing & Rehabilitation Center	544 Lone Oak Road Paducah, KY 42003

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 47798 Based on observation, interview, record review, and facility policy review, the facility failed to promote residents' personal privacy for 1 of 5 residents sampled for wound care, out of the total sampled residents of 33, (Resident (R)87). During observation of wound care for R87 on 03/20/2025, the wound care nurse failed to close the window blind, exposing R87 to view by anyone outside within sight of the resident's window. The findings include: Review of the facility policy titled, Resident Rights, reviewed 11/19/2024, revealed the resident had a right to be treated with respect and dignity. Review of the Admission Record for R87 revealed the facility admitted the resident on 09/28/2022, with diagnoses to include: paraplegia, limitation of activities due to disability, and neuromuscular dysfunction of bladder. Record review revealed R87 had wounds requiring treatment to her buttock and foot. Review of the Quarterly Minimum Data Set (MDS) Assessment with a Assessment Reference Date (ARD) of 02/01/2025, revealed the facility assessed R87 to have a Brief Interview for Mental Status (BIMS) score of a 14 out of 15, indicating the resident was cognitively intact. During observation of R87's wound care on 03/20/2025 at 9:20 AM, the wound care (WC) nurse failed to close the resident's window blinds which exposed her to view of anyone near the window while in the facility's main entrance parking lot. During interview with the WC nurse on 03/20/2025 at 9:50 AM, she stated she should have pulled the window blind closed to protect R87's privacy. She further stated R87 often refused to have the window blind closed; however, she failed to ask the resident if it was okay to close it. During interview with R87 on 03/20/2025 at 11:00 AM, she stated it did not make her feel very good knowing the window blind was left open. R87 stated anyone could look through her window and see her (exposed). She further stated there was a lot of people walking by and they could have seen her (exposed). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the Director of Nursing (DON) on 03/20/2025 at 4:49 PM, she stated she expected staff to provide privacy for residents all the way around. The DON reported staff should knock before entering a resident's room, close the privacy curtain and close the window blinds prior to performance of care. She further stated it was a dignity issue because someone could have walked by (R87's window) and observed the resident exposed. During interview with the Administrator on 03/20/2025 at 5:02 PM, he stated R87's window blind should have been pulled closed. He stated it was a big dignity issue with the nurse exposing her (R87) to the public.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 52040 Based on observation, interview, record review, and facility policy review, the facility failed to ensure treatment and care in accordance with professional standards of practice for 1 of 7 residents sampled during medication pass out of the total sample of 33, (Resident (R)4). Observation revealed medication observed under R4's bed, lying on her bedside table, and lying in her hand while she was lying on her bed with eyes closed. The findings include: Review of the facility policy, Administration of Medications, reviewed 09/16/2024, revealed the facility was to ensure medications were administered safely and appropriately. Review revealed the definition of a medication error was noted as the observed or identified preparation or administration of medications or biologicals which were not in accordance with . 3. Accepted professional standards and principles which applied to professionals providing services. Per review , the facility procedure included medication administration was the responsibility of individuals, who through certification and licensure, were authorized to administer medications in a skilled nursing facility. Continued policy review revealed staff responsible for medication administration were to adhere to the 10 Rights of Medication Administration, which included ensuring: right drug; right resident; right dose; right route; right time and frequency; right documentation; right assessment; right to refuse; right evaluation/response; and right education and information. Review of R4's electronic medical record (EMR) revealed the facility admitted the resident on 07/26/2019, with diagnoses which included: multiple sclerosis, attention-deficit hyperactivity disorder, and Parkinson's Disease. Review of the Minimum Data Set (MDS) Assessment for R4, with an Assessment Reference Date (ARD) of 12/27/2024, revealed the facility assessed with a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident was cognitively intact. Review of R4's comprehensive care plan (CCP) documentation revealed the facility had not identified an intervention for the resident being able to take her medications unsupervised. Observation on 03/17/2025 at 1:03 PM, revealed a circular white tablet lying under R4's bed. During interview with R4, at the time of observation, she stated the nurse set her medication cup on her bedside table that morning, told her There they are, and walked away. R4 stated she accidentally knocked the medication cup over. The resident reported an aide came into her room later, and picked the medication up off the floor. She said the aide returned the medication (from off the floor) back into the medication cup, and placed the cup on her bedside table. R4 reported she took the medication at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility' Electronic Medication Administration Record (eMAR) for R4, located in the EMR, under the Reports tab, revealed the resident's ordered medications listed. Continued review revealed the following medications were documented as administered as AM meds, with no specific time, to R4: Buspirone HCl (used to treat anxiety) 5 milligram (mg); Bupropion HCl (an antidepressant) 150 mg; Duloxetine HCl (used to treat anxiety, depression and nerve damage from diabetes) 60 mg; Duloxetine HCl 30 mg; Dapagliflozin Propanediol (to treat diabetes) 5 mg; Aldactone (diuretic to treat high blood pressure and heart failure) 25 mg; Folic Acid (B vitamin supplement) 800 micrograms (mcg); Furosemide (diuretic) 40 mg; Metformin (to treat diabetes) HCl 500 mg; Aspirin (blood thinner) 81 mg; Docusate Sodium (stool softner) 250 mg; Ferrous Sulfate (iron supplement) 325 mg; Omeprazole (to treat gastrointestinal reflux disease [GERD] and heartburn) 20 mg; Potassium Chloride (to treat low potassium levels) 20 milliequivalents (meq); Pramipexole Dihydrocholride (to treat Parkinson's disease) 0.5 mg; and Vitamin B-12 1000 mcg. In interview on 03/17/2025 at 1:10 PM, Registered Nurse (RN) 2 stated the nurse who had completed the morning medication pass for R4 was at lunch. The State Survey Agency (SSA) Surveyor notified RN 2 of there being a white tablet under R4's bed, and he retrieved the tablet. The RN identified the tablet as Metformin 500 mg and then disposed of the tablet. In interview on 3/17/2025 at 3:39 PM, Licensed Practical Nurse (LPN) 2 she stated she was responsible for that morning's med pass which included R4's medications. LPN 2 further stated R4 took all the medication in the medication cup and implied it was while she (the LPN) was present in the room. She further stated she was unaware of one of the medications dropping (on the floor. In interview on 03/17/2025 at 3:43 PM, Certified Nursing Assistant (CNA) 3 stated he entered the room of R4 at about 11:00 AM to assist her, and noticed several pills lying on the floor. He stated he picked the pills up, put them in a medicine cup, and then placed the cup on the resident's bedside table. The CNA reported he witnessed R4 consume the pills after he put the cup on the bedside table. He stated, I must have missed one if there was one under the bed. CNA 3 said he did not notify anyone of the medication being on the floor. When the SSA Surveyor asked him what he should have done when he saw the medication on the floor, he stated I should have told the nurse. Continued review of R4's medical record revealed LPN 2 had placed an Alert Note in the Progress Notes section of the EMR. Per review, at 4:03 PM on 03/17/2025, LPN 2 documented this nurse went into residents [sic] room to give medication, medication placed in residents [sic] hand. This nurse was unaware that resident did not take medication. This nurse was alerted that resident spilled medication and did not take medication, alerted aprn [sic] and alerted POA about change in condition. Further review revealed the LPN noted no new orders at this time, and R4 was assessed for pain and denied having any pain. In addition, review revealed LPN 2 noted No adverse reactions noted at this time. Will continue plan of care. Observation on 03/20/2025 at 9:41 AM, revealed R4 lying on her bed with eyes closed with a medicine cup containing multiple medications in her left hand and a white tablet lying on the overbed table. The SSA Surveyor was joined in observation by another SSA Surveyor. Observation revealed R4 woke up and said she was very sleepy that morning, then proceeded to close her eyes again and fell back to sleep. The SSA Surveyors asked LPN 9, who completed the morning medication pass, and LPN 10, the Unit Coordinator, to join their observation of R4 and the medications located in the resident's hand. Observation further revealed LPN 9 woke R4 up and witnessed the resident take all the medications located in the medication cup and from the overbed table. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 03/20/2025 at 9:50 AM, LPN 9 stated she was normally very cautious when passing residents' medication; however, might have gotten busy and failed to watch R4 take her medication. Review of R4's eMAR, in conjunction with LPN 9 and LPN 10, revealed the following medications had been documented as administered to the resident that morning: Buspirone HCl 5 mg; Bupropion HCl 150 mg; Duloxetine HCl 60 mg; Duloxetine HCl 30 mg; Dapagliflozin Propanediol 5 mg; Aldactone 25 mg; Folic Acid 800 mcg; Furosemide 40 mg; Metformin HCl 500 mg; Aspirin 81 mg; Docusate Sodium 250 mg; Ferrous Sulfate 325 mg; Omeprazole 20 mg; Potassium Chloride 20 meq; Pramipexole Dihydrochloride 0.5 mg; and Vitamin B-12 1000 mcg. In interview on 03/20/2025 at 9:52 AM, LPN 10/Unit Coordinator stated LPN 9 was a young nurse. She reported she would educate LPN 9 (on proper medication administration). In interview on 03/20/2025 at 4:40 PM, the Assistant Infection Prevention (IP) Nurse stated residents ingesting medication off the floor was unacceptable. In interview on 03/20/2025 at 4:50 PM, the Director of Nursing (DON) stated she expected nurses to observe residents taking their medications. She said the nurses were trained during their orientation on how to properly pass (residents') medication. The DON reported if a CNA found medication on the floor they should give it to the nurse immediately. She further stated she did not condone residents consuming medications off the floor. In interview on 03/20/2025 at 5:13 PM, the facility's Administrator stated he expected the nurses to watch residents taking their medications. He stated it would have been possible for anyone to have taken the medication when it was lying on the floor if it was not witnessed as being taken during the medication pass.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 52041 Based on observation, interview, and facility policy review, the facility failed to assure the nutritive value of food was not compromised and destroyed because of prolonged holding on a steam table. The deficient practice had the potential to affect 163 of the facility's 163 residents who consumed food from the kitchen. Observation on 03/17/2025 at 3:20 PM, revealed macaroni and cheese and greens were placed on the steam table an hour and ten minutes prior to the evening meal being served. The findings include: Review of the facility policy titled, Food Temperature Control, revised 06/28/2024, revealed the food temperatures were to be maintained during mealtimes to ensure residents received safe food served at acceptable temperatures. Continued review revealed food was to be prepared by methods that conserved the nutritive value, flavor, and appearance. Review of the facility policy titled, Cleaning Schedule, reviewed on 04/30/2024, revealed food was not to be placed on the steam table more than 30 minutes before a meal service began. Observation on 03/17/2025 at 3:20 PM, during the initial tour of the kitchen, revealed macaroni and cheese and greens stored on the steam table for that evening's dinner meal. In interview on 03/17/2025 at 3:21 PM, the Dietary Manager (DM) stated she was not aware food had already been stored on the steam table for that evening's meal. In interview on 03/17/2025 at 3:30 PM, the Dietary [NAME] confirmed placing the macaroni and cheese and greens on the steam table at approximately 3:10 PM. He stated however, the evening dinner meal was not scheduled to be initiated until 4:30 PM (an hour and 20 minutes after the macaroni and cheese and greens were placed on the steam table).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50153 Based on observation, interview, record review, and review of the facility policy, it was determined the facility failed to ensure infection control procedures to prevent the spread of infection were followed for 1 of 33 sampled residents, (Resident (R)139); and for all residents residing on the 900 hall/unit who used ice from the ice cooler. 1. Observation on 03/19/2025 revealed staff failed to use appropriate Personal Protective Equipment (PPE) when providing care for R139 who required Enhanced Barrier Precautions (EBP). 2. Observation on 03/18/2025 revealed staff, after overfilling a resident's used cup with ice, and then to proceed to pour the excess ice, off the top of the cup, back into the clean cooler of ice. The findings include: 1. Review of the facility policy titled, Enhanced Barrier Precautions, revised 06/03/2024, revealed the facility should use Enhanced Barrier Precautions (EBP) during high-contact resident care activities. Per review, the high-contact resident care activities included: wound and/or indwelling medical devices even if the resident was not known to be infected or colonized with a Multidrug Resistant Organism (MDRO). Record review revealed the facility admitted R139 initially on 01/22/2024, with diagnosis which included: hemiplegia and hemiparesis affecting the left non-dominant side following cerebral infarction; Type 2 diabetes mellitus; and peripheral vascular disease. Further review of the record revealed R139 was admitted with a gastrostomy tube (g-tube) in place at the time of admission due to dysphagia following cerebral infarction. Additionally, review of R139's record revealed the resident had a foley catheter (indwelling catheter), a stage 4 pressure wound to the coccyx: and the g-tube. Review of R139's comprehensive care plan dated 11/25/2024, revealed the facility developed a care plan for urinary catheter which noted enhanced precautions were indicated. Observation of foley catheter care for R139 on 03/19/2025 at 10:39 AM, revealed Certified Nursing Assistant (CNA) 8 and CNA 9 failed to don necessary PPE (a gown) while providing the resident's catheter care. Observation of wound care for R139 on 03/19/2025 at 2:19 PM, revealed Registered Nurse (RN) 3 and CNA 10 entered the resident's room to complete wound care without donning necessary PPE (gowns). Continued observation revealed RN 3 and CNA 10 proceeded with performance of R139's wound care without donning a gown prior to completion of the procedure. Observation of g-tube site care for R139 on 03/19/2025 at 2:40 PM, revealed RN 3 failed to don the necessary PPE (a gown) prior to or when performing the g-tube site care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In interview on 03/19/2025 at 11:52 AM, CNA 9 stated she had been nervous and failed to put a gown on. The CNA said the signage was above R139's bed indicated EBP were necessary, and the PPE was kept in the bottom drawer of the resident's dresser. CNA 9 further stated PPE was used to prevent the spread of infection. In interview on 03/19/2025 at 11:25 AM, CNA 8 assigned to R139's care, stated he was from another state and had not been trained to wear gowns. He said he had worked here (at the facility) for six months. The CNA reported being trained on EBP at the facility; however, did not recall being trained that a gown was needed when performing catheter care. CNA 8 stated he would wear a gown when residents had Contact / Barriers precautions. He said he was not aware of anything being in the room that communicate EBP was needed for R139. The CNA further stated he received information through shift report or from the CNA care plan that said he needed to wear a gown with catheter care. In interview on 03/19/2025 at 11:30 AM, Licensed Practical Nurse (LPN) 8 regarding EBP, stated EBP was used for residents who had a catheter, tracheostomy, wounds and/or a feeding tube. She said she was to use gowns and gloves when providing care for residents with any of those. The LPN reported the PPE was kept in all the residents' rooms in the drawers, which were labeled EBP. She further stated there was a sign over those residents' beds to communicate the necessity of EBP for staff. In interview on 03/19/2025 at 2:53 PM, RN 3 stated she observed EBP (when providing resident care), which included handwashing and use of gloves. She reported she did not know if gowns were included in EBP and said EBP was new to her. The RN said she had been employed (at the facility) approximately two weeks and had just gotten out of orientation. She further stated the purpose of EBP was to decrease contamination and the spread of infection. In interview on 03/20/2025 at 4:33 PM, Infection Prevention (IP) Nurse 4 stated high contact tasks included g-tube, wound, and foley catheter care. She said it was her expectation that staff wear PPE during those high contact tasks to prevent the spread of infection. IP 4 reported the PPE was checked daily by the IP Nurses, who also noted the levels of gowns to reflect usage of the gowns. She stated the IP's rounded daily and observed staff for compliance with PPE. The IP Nurse explained staff were educated in mandatory monthly in-services and through video presentation with explanation during new hire orientation. She said everyone sees the video and the IP Nurses reviewed, signed, and went into depth with explaining infection control to new hires. IP Nurse 4 stated staff were also educated by the IP Nurses on where the PPE was located in the resident's room. She reported additional PPE was available in the designated stock room on the 200 hall that could be accessed by all nurses at any time. The IP Nurse further stated the audit findings were reported in the facility's Quality Assurance Performance Improvement (QAPI) Committee meetings. In interview on 03/20/2025 at 4:53 PM, the Director of Nursing (DON) stated the high contact tasks included g-tube, wound, and foley catheter care. She said it was her expectation staff wear PPE during those high contact tasks to prevent the spread of infection. The DON further stated the IP Nurses shared the findings of their audits and if a systemic problem was identified, a focused education would be completed. In interview with the Administrator on 03/20/2025 at 5:13 PM, he stated he expected staff to follow the facility's policy for EBP to prevent the spread of infection. 52040 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility policy, Ice Chests, reviewed on 06/03/2024, revealed all ice handlers were educated to not return unused iced to an ice storage chest. However, observation on 03/18/2025 at 9:39 AM, revealed CNA 5 was delivering fresh ice to residents on the 900 hall/unit. Per observation, CNA 5 filled a used resident's cup (R29's) over the opened cooler of clean ice. Further observation revealed after overfilling the used cup she then poured the excess ice from the top of the cup back into the clean ice in the cooler. In interview on 03/18/2025 at 9:40 AM, CNA 5 stated she should been more cautious. RN 3, who was also present during the interview with CNA 5, immediately removed the cooler with ice from use to empty it and clean it. In interview on 03/20/2025 at 4:40 PM, the Assistant IP Nurse stated ice should never be dumped back into a cooler of clean ice. In interview on 03/20/2025 at 4:50 PM, the DON stated she expected the facility's, Ice Chest policy to be followed by staff. In interview on 03/20/2025 at 5:13 PM, the Administrator stated he expected the facility's, Ice Chest policy to be followed by staff.