

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Parkview Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 128 North Hardesty Kansas City, MO 64123	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45403</p> <p>Based on interview and record review, the facility failed to ensure one sampled resident's (Resident #3) dignity was maintained when on 9/30/24 Certified Nursing Aide (CNA) B pulled the resident's pants down exposing his/her buttocks to other bystanders out of four sampled residents. The facility census was 105 residents.</p> <p>Review of the facility's Dignity policy dated 2/2021 showed:</p> <ul style="list-style-type: none"> -Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. -Residents are treated with dignity and respect at all times. -The facility culture support dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. -This begins with the initial admission and continues throughout the resident's facility stay. -Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. -Demearing practices and standards of care that compromise dignity are prohibited. -Staff are expected to treat cognitively impaired residents with dignity and sensitivity. <p>1. Review of Resident #3's Admission Record showed the resident was admitted on [DATE], readmitted on [DATE] with diagnoses including residual schizophrenia and repeated falls.</p> <p>Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 7/10/24 showed the resident was cognitively intact.</p> <p>Review of the resident's undated Care Plan showed:</p> <ul style="list-style-type: none"> -The resident was physically aggressive related to poor impulse control and poor coping skills. <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident had been verbally aggressive to staff and residents.</p> <p>-When the resident becomes agitated, staff should intervene before agitation escalates.</p> <p>-Staff should guide the resident away from source of distress and engage the resident calmly in conversation; if the resident response was aggressive, staff were to walk calmly away and approach later.</p> <p>Review of the Facility Investigation dated 10/7/24 showed:</p> <p>-The Regional Director and Director of Nursing (DON) were made aware on 10/3/24 at 8:30 A.M. that on 9/30/24 CNA B pulled the resident's pants down when he/she was trying to leave the facility during an episode of aggression.</p> <p>-Investigation conducted by interviews with all potentially involved parties and review of facility cameras.</p> <p>-It was determined CNA B was observed on the facility camera pulling the resident's pants down and CNA C witnessed the event.</p> <p>-CNA B was terminated due to pulling the resident's pants down as alleged.</p> <p>-CNA C was terminated due to witnessing the event and failed to report to supervisors.</p> <p>During an interview on 10/3/24 at 10:38 A.M., the DON said:</p> <p>-He/she was made aware on 10/3/24 that CNA B pulled the resident's pants down while the resident was trying to leave the facility during an episode of aggression.</p> <p>-He/She was initiating the investigation and prepared to report the allegations per regulatory guidelines.</p> <p>-The investigation had just begun, however, the plan was to terminate the CNA once he/she came in for an interview with him/her and the Regional Director.</p> <p>During an interview on 10/3/24 at 11:19 A.M., the Regional Director said:</p> <p>-He/She was made aware on 10/3/24 that CNA B pulled the resident's pants down.</p> <p>-He/She expected staff to respect the dignity of the residents at all times.</p> <p>During an interview on 10/3/24 at 12:00 P.M., the resident said:</p> <p>-He/She tried to leave the facility by the front entrance and had his/her back to the staff.</p> <p>-While trying to get out the doors, someone pulled his/her pants down exposed his/her buttocks.</p> <p>-He/She heard someone laughing when his/her pants were pulled down.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She could not see who pulled down his/her pants, but could name all staff that were in the area at the time.</p> <p>-He/She felt uncomfortable and embarrassed during the incident.</p> <p>-He/She said pulling down his/her pants was uncalled for.</p> <p>During an interview on 10/3/24 at 3:04 P.M., the DON said:</p> <p>-The facility video footage showed CNA B pulled the resident's pants down.</p> <p>-The resident was at the front door of the facility trying to exit.</p> <p>-CNA B is seen on the video standing up from a chair and then pulling the resident's pants down, exposing the resident's buttocks.</p> <p>During an interview on 10/3/24 at 3:50 P.M. with DON, CNA C said:</p> <p>-He/She observed the resident attempting to get out of the facility on 9/30/24.</p> <p>-He/She did not attempt to engage with the resident or any other the staff.</p> <p>-He/She observed CNA B coming in contact with the resident.</p> <p>-The DON said the camera showed he/she was as a witness to CNA B pulling the resident's pants down, exposing the resident's buttocks.</p> <p>-He/She did not intervene or report the incident to anyone.</p> <p>During an interview on 10/3/24 at 4:31 P.M. with DON, CNA B said:</p> <p>-He/She was assigned to the resident for one on one monitoring (one person assigned to monitor) due to self-harming behaviors earlier on 9/30/24.</p> <p>-He/She observed the resident trying to get out the front door.</p> <p>-He/she denied pulling the resident's pants down purposefully.</p> <p>-He/She pulled on the resident's pants while the resident was standing at the front door to move the resident back and in the process the resident's buttocks was exposed.</p> <p>-The DON stated he/she was observed on camera him/her pulling the resident's pants down, exposing the residents buttocks.</p> <p>MO00242964</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45403</p> <p>Based on observation, interview and record review, the facility failed to maintain the call light system which resulted in one sampled resident's (Resident #2) call light not being answered for approximately 20 minutes out of four sampled residents. The facility census was 105 residents.</p> <p>Review of the facility Supporting Activities of Daily Living policy dated 3/2018 showed:</p> <ul style="list-style-type: none"> -Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. <p>Review of the facility Answering the Call Light policy dated 3/2021 showed:</p> <ul style="list-style-type: none"> -The purpose of this procedure is to ensure timely responses to the resident's requests and needs. -When answering from the call light station, turn off the signal light. -Identify yourself and politely respond to the resident by his/her name, Mr./Mrs. Name, how may I help you? --If the resident needs assistance, indicate the approximate time it will take for you to respond. --If the resident's request requires another staff member, notify the individual. --If the resident's request is something you can fulfill, complete the task within five minutes if possible. --If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the resident's request, as the nurse supervisor for assistance. -If assistance is needed when you enter the room, summon help by using the call signal. <p>1. Review of the facility call light company's maintenance invoice dated 7/8/24 showed:</p> <ul style="list-style-type: none"> -On 7/2/24 CAT (a communication system used along with a call light system to notify staff that a light is on) phones not connecting to the server, technician came onsite and was able to correct the settings. -On 7/3/24 keyboard/mouse combo was purchased and installed onsite. <p>Review of the facility's Call Light Log dated 10/1/24 showed:</p> <ul style="list-style-type: none"> -Seven out of 48 activated call lights went unanswered for 20 to 30 minutes. <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Four out of 48 activated call lights went unanswered for 30 to 60 minutes.</p> <p>-Five out of 48 activated call lights went unanswered for 60 to 706 minutes.</p> <p>Review of the facility's Call Light Log dated 10/2/24 showed:</p> <p>-Three out of 35 activated call lights went unanswered for 20 to 30 minutes.</p> <p>-Seven out of 35 activated call lights went unanswered for 30 to 60 minutes.</p> <p>-Six out of 35 activated call lights went unanswered for 60 to 260 minutes.</p> <p>Review of the facility's Call Light Log dated 10/3/24 showed:</p> <p>-Three out of 59 activated call lights went unanswered for 20 to 30 minutes.</p> <p>-Three out of 59 activated call lights went unanswered for 30 to 60 minutes.</p> <p>-Six out of 59 activated call lights went unanswered for 60 to 237 minutes.</p> <p>2. Review of Resident #2's Admission Record showed the resident was admitted on [DATE] with diagnoses including ventricular tachycardia (rapid heart rate), chronic obstructive pulmonary disease (chronic lung disease) and repeated falls.</p> <p>Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 8/18/24 showed the resident was cognitively intact.</p> <p>Review of the resident's undated Care Plan showed:</p> <p>-The resident had an ADL self-care performance deficit related to alcohol abuse, anxiety, asthma, chronic back pain, depression, repeated falls, personality disorder, and cardiac disease.</p> <p>-The resident required supervision for ADLs.</p> <p>-The resident was at risk for falls related to psychotropic medications.</p> <p>--The resident will be free of falls.</p> <p>---Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.</p> <p>---Follow facility protocol.</p> <p>During an interview and observation on 10/3/24 from 1:32 P.M., to 1:58 P.M. the resident said:</p> <p>-The call lights don't work.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident's call light was activated.</p> <p>-The Activities Director came to the resident's room to invite him/her to an activity and was not aware the call light was activated.</p> <p>-Licensed Practical Nurse (LPN) A came to the resident's door, but was unaware the resident's call light was activated.</p> <p>-The resident felt ignored and like his/her needs were not important to the staff and they don't care about him/her.</p> <p>During an interview on 10/3/24 at 1:57 P.M., the Activity Director said:</p> <p>-He/She was unaware the resident's call light was activated when she stopped by.</p> <p>-He/She was unable to see the activated light because it was hidden behind the divider curtain in the room from the doorway, the light above the door was not working and there was no sound.</p> <p>-He/She did not have a CAT phone.</p> <p>During an interview on 10/3/24 at 1:58 P.M., LPN A said:</p> <p>-He/She was unaware of the resident's call light being on when he/she stopped by.</p> <p>-The only place the call lights alert was at the nurses station.</p> <p>-He/She was not able to tell when call light was activated even while at the resident's doorway.</p> <p>-There was no sound, or light over the door and the activated light in the room was behind the divider curtain.</p> <p>-He/She did not have a CAT phone.</p> <p>-He/She did not know why the call light had not been answered for the last 20 minutes.</p> <p>-He/She expected the call light should have been answered.</p> <p>During an interview on 10/3/24 at 2:34 P.M., the Maintenance Director said:</p> <p>-He/She was not aware the call system was down.</p> <p>-The call lights alert only at the nurse's station.</p> <p>-The indicator lights on the outside of the rooms do not work.</p> <p>-The system will alert on the CAT phone when the system was working.</p> <p>-He/She was not sure if the CAT phones were working.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The nurses and Certified Nurse's Aides (CNA) were responsible for ensuring the CAT phones were charged and working.</p> <p>-He/She was not responsible for the repair or maintenance of the CAT phones.</p> <p>-If the CAT phones were not working then staff were supposed to go to the Staffing Coordinator or the Director of Nursing (DON).</p> <p>-The CAT phones were unavailable and not in use at this time.</p> <p>During an interview on 10/3/24 at 2:40 P.M., the DON said:</p> <p>-The CAT phones were not in use.</p> <p>-He/she requested the Maintenance Director to locate and test the three CAT phones for the building.</p> <p>During an interview on 10/3/24 at 3:04 P.M., the Regional Director said:</p> <p>-He/She was unaware of the current call light system was not being used.</p> <p>-He/she expected call lights to be answered according to policy and regulatory guidelines.</p> <p>During an interview on 10/8/24 at 3:43 P.M., the DON said:</p> <p>-The CAT phones were not in use prior to 10/3/24.</p> <p>-He/She expected call lights to be answered within five to 10 minutes, but no longer than 20 minutes.</p> <p>-He/She was not aware call lights were being left unanswered more than 20 minutes.</p> <p>-All call lights not answered in 20 minutes or less was outside the expectation.</p> <p>-Staff were expected to carry CAT phones to respond to call lights.</p> <p>-All staff were expected to answer call lights.</p> <p>MO00242992</p>