STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265519	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed ensure the dignity of all residents was maintained at all times when staff failed to ensure one resident's (Resident #23) catheter (a sterile tube inserted into the bladder to drain urine) bag was covered with a dignity bag when visible to others. A sample of 17 residents was reviewed in a facility with a census of 65. Review of the facility's policy titled, Resident Rights, Rules, and Regulations, updated 10/01/21, showed the following information: -Residents have the right to be treated with dignity and respect; -Residents have the right to privacy and respect regarding accommodations, personal care, medical treatment, written and telephone communications, and visits with other individuals. 1. Review of the resident's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses included acute metabolic acidosis (a condition in which too much acid accumulates in the body). Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 10/31/24, showed the following information: -Indwelling catheter use; -Diagnoses included benign prostatic hyperplasia (BPH - an age associated prostate enlargement that can cause urination difficulty) and kidney failure. Review of the resident's care plan, last reviewed on 11/24/24, showed the following information: -Monitor resident for complications of indwelling urinary catheter and report to charge nurse; -Position the drainage bag to facilitate flow of urine; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265519	A. Building B. Wing	11/22/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Change catheter and provide catheter care per orders; -Use leg bag when ambulating per residents choice. Observation on 11/19/24, at 9:48 A.M., showed the resident's room door open with catheter bag draining pale yellow urine hung on the right side of his/her bed visible from the hallway. Observation on 11/20/24, at 9:21 A.M., showed the resident's room door open with catheter bag draining pale yellow urine hung on the right side of his/her bed visible from the hallway. Observation on 11/20/24, at 12:09 P.M., showed the resident's room door open, catheter bag draining pale yellow urine hung on the right side of his/her bed visible from the hallway. Observation on 11/21/24, at 8:20 A.M., showed the resident's room door open, catheter bag draining pale yellow urine hung on the right side of his/her bed visible from the hallway. During an interview on 11/21/24, at 1:10 P.M., Certified Nursing Assistant/ Registered Medication Technician (CNA/RMT) A said catheter bags should be in dignity bags at all times. During an interview on 11/21/24, at 2:29 P.M., Registered Medication Technician (RMT) B said no one should be able to see urine in catheter bags from the hall. Catheter bags should be in dignity bags at all times. During an interview on 11/22/24, at 9:55 A.M., Licensed Practical Nurse (LPN) C said no one should be able to see urine in catheter bags from the hall. Catheter bags should be in dignity bags at all times, unless the staff can position the bag in a way that it is not visible from the hall. During an interview on 11/22/24, at 12:34 P.M., the Director of Nursing (DON) said she expected staff to have catheter bags covered with dignity bags at all times. During an interview on 11/22/24, at 1:19 P.M., the Administrator said he expected staff to have catheter bags covered at all times.

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	265519	A. Building B. Wing	11/22/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36974 Based on observation, interview, and record review, the facility failed to provide care to all residents per standards of practice when staff failed to transcribe a physician order change in breathing treatments and failed to administer the breathing treatments as order for one resident (Resident #1). The facility census was 70. Review of facility policy, Physician Orders, reviewed November 2024, showed the following: -In most circumstances, orders should be entered electronically by the practitioner; -Verbal or telephone orders may be given to providers (for example, a nursing facility) only if there is an emergency situation when the electronic entry may delay care, or if computer access is not available to the practitioner; -Upon receipt of a written or faxed order, staff will scan the order into the resident's electronic medical records (EMR). The orders will be entered into the EMR as applicable. 1. Review of Resident #1's face sheet showed the following: -admitted [DATE]; -Diagnoses included high blood pressure, anxiety, heart disease, and recent history of pneumonia. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/08/24, showed the following: -Cognitively intact; -No rejection of care; -Diagnoses included asthma (A condition in which the airways narrow and swell and may produce extra mucus. This can make breathing difficult and trigger coughing, a whistling sound (wheezing) when breathing out and shortness of breath.), chronic obstructive pulmonary disease (COPD - An ongoing lung condition caused by damage to the lungs. The damage results in swelling and irritation, also called inflammation, inside the airways that limit airflow into and out of the lungs.), or another chronic lung problem. Review of the resident's care plan, last reviewed 12/10/24, showed the following: -Respiratory treatment as ordered; -Supplemental oxygen use as ordered. Review of the resident's December 2024 Treatment Administration Record (TAR) showed the following : (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

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Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 12/02/24, for albuterol 2.5 milligrams (mg) every 8 hours as needed (PRN); -Staff did not administer the medication on 12/02/24; -Staff did not administer the medication on 12/03/24. Review of the resident's nursing notes, dated 12/04/24, showed the resident reported to staff that he/she had breathing treatments at home twice a day. The resident told staff he/she had not had any treatments since being admitted to the facility and was starting to feel congested. The nurse requested breathing treatments twice a day (scheduled). The doctor replied for staff to go ahead and schedule the albuterol (used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease (COPD - An ongoing lung condition caused by damage to the lungs. The damage results in swelling and irritation, also called inflammation, inside the airways that limit airflow into and out of the lungs.)) breathing treatments twice a day, per resident request. Review of the resident's December 2024 TAR showed the following: -An order, dated 12/02/24, for albuterol 2.5 mg every 8 hours PRN. (Staff did not update the order to reflect the new order from the physician for treatments scheduled twice a day.); -Staff did not administer the medication on 12/04/24; -Staff did not administer the medication on 12/05/24; -Staff did not administer the medication on 12/06/24; -Staff did not administer the medication on 12/07/24; -Staff administered the medication twice on 12/08/24; -Staff administered the medication once on 12/09/24; -Staff did not administer the medication on 12/10/24; -Staff administered the medication once on 12/11/24. Review of resident's physician's note, dated 12/12/24, showed the resident reported to the doctor a recent cough, and difficulty catching breath upon exertion. Review of the resident's December 2024 TAR showed the following: -An order, dated 12/02/24, for albuterol 2.5 mg every 8 hours PRN. (Staff did not update the order to reflect the new order from the physician for treatments scheduled twice a day.); -Staff administered the medication once on 12/12/24; -Staff administered the medication once on 12/13/24; (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff did not administer the medication on 12/14/24; -Staff administered the medication once on 12/15/24. Review of the resident's chest x-ray, completed on 12/16/24, showed findings related to pulmonary vascular congestion (PVC - an excessive accumulation of fluid in the blood vessels of the lungs, which can make breathing more difficult). Review of the resident's physician's notes showed, dated 12/16/24, showed diagnosis of PVC. Review of the resident's December 2024 TAR showed the following: -An order, dated 12/02/24, for albuterol 2.5 mg every 8 hours PRN. (Staff did not update the order to reflect the new order from the physician for treatments scheduled twice a day.); -Staff did not administer the medication on 12/16/24; -Staff did not administer the medication on 12/17/24; -Staff did not administer the medication on 12/18/24; -Staff did not administer the medication on 12/19/24; -Staff did not administer the medication on 12/20/24; -Staff did not administer the medication on 12/21/24; -Staff did not administer the medication on 12/22/24; -Staff did not administer the medication on 12/23/24; -Staff did not administer the medication on 12/24/24; -Staff did not administer the medication on 12/25/24; -Staff administered the medication once on 12/26/24; -Staff administered the medication once on 12/27/24; -Staff did not administer the medication on 12/28/24. Review of the resident's nursing note, dated 12/28/24, showed the resident requested breathing treatments to be scheduled twice a day, instead of as needed. A nurse practitioner replied on 12/29/24 that it was okay to schedule the breathing treatment twice a day for one week on a trial basis. Review of the resident's December 2024 TAR showed the following: -An order, dated 12/02/24, for albuterol 2.5 mg every 8 hours PRN; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265519	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024

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Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 12/29/24, for albuterol 2.5 mg scheduled twice a day, on a trial basis, with a stop date of 01/05/25; -Staff administered the medication twice on 12/29/24; -Staff administered the medication twice on 12/30/24; -Staff administered the medication twice on 12/30/24. Review of the resident's January 2025 TAR showed the following: -An order, dated 12/02/24, for albuterol 2.5 mg every 8 hours PRN; -An order, dated 12/29/24, for albuterol 2.5 mg scheduled twice a day, on a trial basis, with a stop date of 01/05/25; -Staff administered the medication once on 01/01/25 and did not administer any additional PRN doses; -Staff administered the medication twice on 01/02/25; -Staff administered the medication twice on 01/03/25; -Staff administered the medication twice on 01/04/25; -Staff administered the medication twice on 01/05/25. Review of the resident's January 2025 TAR showed the following: -An order, dated 12/02/24, for albuterol 2.5 mg every 8 hours PRN; -The order for scheduled albuterol was was discontinued on 01/05/25; -Staff administered the medication twice on 01/06/25; -Staff did not administer the medication on 01/07/25; -Staff administered the medication twice on 01/08/25; -Staff administered the medication once on 01/09/25; -Staff administered the medication twice on 01/10/25. Review of the resident's January 2025 TAR showed the following: -An order, dated 01/10/25, for albuterol 2.5 mg scheduled twice a day; -Staff administered the medication twice on 01/10/25; (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff administered the medication twice on 01/11/25; -Staff administered the medication twice on 01/12/25; -Staff administered the medication twice on 01/13/25; -Staff administered the medication twice on 01/14/25; -Staff administered the medication once on 01/15/25. Observation and resident interview on 01/16/25, at 1:20 P.M., showed the following: -The resident had contracted pneumonia before being admitted to the facility and had some breathing difficulties since that time; -He/She had breathing treatments twice a day at home, immediately prior to being admitted to the facility; -The resident had an oxygen concentrator in his/her room; -The resident said if he/she goes too long between breathing treatments, he/she will start to feel congested. The breathing treatments help him/her cough up liquid, which relieves congestion and he/she feels better. During an interview on 01/16/25, at 1:03 P.M., Certified Medication Tech (CMT) A said when a resident requested a change in medication, he/she notified the nurse and the nurse notified the doctor or other provider. During an interview on 01/16/25, at 3:30 P.M., Licensed Practical Nurse (LPN) B said he/she put in the change from albuterol as needed to albuterol twice daily on 12/04/24 after the resident requested the change. However, the facility was having computer problems that day, and the change in order must not have been saved. For requests of medication changes, the usual facility process is for the charge nurse to discontinue the as needed medication, then put in the new order. To make sure orders and messages are completed, the night shift charge nurse prints off and double-checks if the new order is in the system. During an interview on 01/16/25, at 2:05 P.M., the Director of Nursing (DON) said staff sent a message to the resident's physician on 12/04/24 about changing the albuterol breathing treatments from as needed to scheduled twice daily. Although the nursing note says the task was completed, no staff updated the doctor order. She did not know why the change was accepted by the doctor, but no staff put in any new orders until the second request was made by the resident on 12/29/24 (25 days after the first request was made). (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/25, at 4:00 P.M., the Administrator said doctors usually put orders into the facility records themselves. If not, then the charge nurses should put the new order in the EMR. The charge nurse or nurse manager should double check to make sure any new orders have been completed. He did not know why staff failed to completely put in the order for albuterol twice a day when first requested on 12/04/24. He said he did not know why different staff failed to double-check to assure orders were fully completed. MO00247213

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to provide pressure ulcer care consistent with standards of practice when the facility failed to consistently document regarding all wounds and failed to care plan regarding new wounds in a timely fashion for one one resident (Resident #23) withe multiple pressure wounds. A sample of 17 residents was reviewed in a home with a census of 65. Review of the facility's policy titled Pressure Ulcer/Wound Assessment and Treatment, last revised on 11/24, showed the following information: -Basic prevention includes to encourage hydration, offer moisturizing cream, provide incontinence care, reposition in bed or chart according to the individual patient needs, care goals, tissue tolerance, and response to treatment, avoid positioning on current pressure ulcer/wound. Review of the National Library of Medicines article, titled Review of Current Management of Pressure Ulcers, dated 2/1/2018, showed the following information: -Each dressing change should be accompanied by concurrent wound reassessment; -Foam dressings are ideal for stage I wounds. 1. Review of Resident #23's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included acute metabolic acidosis (too much acid in the blood). Review of the resident's nurse's note, dated 10/28/24, showed the nurse was notified of an area of concern to resident's back. Three spots of stage II (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) nature observed along the spine. Staff notified the Nurse Practitioner (NP) in person and verbal received to cover with Optifoam (absorbent foam dressing) and change every three days. Review of the resident's physician's progress note, dated 10/28/24, showed the following information: -Pressure injury of back, stage I (intact skin with a localized area of non-blanchable erythema (redness)), apply Optifoam for cushioning and protection, and change every three days. Staff to reposition in bed often and offload pressure from back. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 10/31/24, showed the following information: (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At risk for pressure ulcers; -Did not have one or more unhealed pressure ulcers at stage I or higher on admission; -Pressure reducing device for chair and bed. Review of the resident's physician's progress note, dated 11/06/24, showed the following information: -Pressure injury had worsened and was unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured) on thoracic spine. -Staff to cleanse area and cover with mepilex ag (antimicrobial foam that absorbs drainage) and apply Optifoam over it for cushioning. Review of the resident's nurse's note, dated 11/07/24, showed the nurse performed a skin assessment on resident. The resident did not have any skin discoloration on either heels. (The nurse did not document related to the resident's wound on his/her back.) Review of the resident's bath sheet, dated 11/07/24, showed staff noted an abrasion, decub (ulcer), and incision present. Staff did not indicate the location on the shower sheet. Review of the nurse's note, dated 11/11/24, showed an aide notified nurse of resident's heel. The heel assessed and showed blackened area to left heel. Staff notified the Director of Nursing (DON) and NP. Staff placed Optifoam placed on left heel. Review of the resident's physician's progress note, dated 11/11/24, showed the following information: -Pressure injury has worsened and unstageable on thoracic spine. Three circular areas of pressure, surrounded with erythema wound surface is slough (non-viable yellow, tan, gray, green or brown tissue) and kyphoscoliosis (abnormal curvature of the spine) present. -Staff to cleanse and cover with Mepilex Ag and apply Optifoam over it for cushioning. Staff to reposition frequently and offload from back. -Pressure injury to left heel unstageable has developed and right heel without redness or injury. -Staff to offload heels from bed surface, frequent repositioning in bed, and Optifoam for protection. Review of the resident's wound assessments, dated 11/12/24, showed the following information: -On 11/12/24, one acquired stage II pressure ulcer to the resident's right heel measuring 2 centimeters (cm) by 2.5 cm with a 0.1 cm depth. The appearance was dusky red and the surrounding tissue was peeling and pink, no odor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-One acquired unstageable pressure ulcer to the resident's left heel measuring 4 cm by 4.4 cm with a 0.1 cm depth. The appearance was necrotic (dead-black) the surrounding tissue was peeling. (Staff did not document an assessment of the wounds on the resident's back.) Review of the resident's care plan, revised on 11/13/24, showed the following information: -One pressure wound to left heel and one pressure wound to right heel; -Considerations included heel elevation, pressure relieving device implementation, hydration management, incontinence management, nutrition promotion, and position change; -Care included Braden scale (assessment tool to assess a patient's risk of developing pressure ulcers) as needed, float heels using pillows or offloading boots as needed, keep skin clean and dry, treatment as ordered, and weekly as needed skin monitoring by a professional nurse. (Staff did not care plan regarding the wounds on the resident's back.) Review of the resident's shower sheet, dated 11/14/24, showed staff documented abrasion, decub, and incision present. The shower sheet does not indicate location. Review of the resident's nurse's note, dated 11/15/24, showed the following information: -Per wound nurse, resident's back to remain open to air for the next few days as the area is very macerated. -Wounds cleansed, skin prep applied, and the resident repositioned on his/her right side with heel protectors on both feet and a pillow under the residents' calves to float feet. -Resident should be re-positioned as much as possible with bilateral heels always floating, and heel protectors on when up. Review of the resident's wound assessment, dated 11/15/24, showed the following information: -One acquired stage I pressure ulcer to the resident's distal (bottom) back measured 0.5 centimeters (cm) by 1 cm with a 0.1 cm depth. The appearance was reddened with no odor. -One acquired stage II pressure ulcer to the resident's medial (middle) back measured 1 cm by 1.4 cm with a 0.1 cm depth. The appearance was gray/white, surrounding tissue was red and macerated with no odor. -One acquired stage II pressure ulcer to the proximal (nearer to the center) back measured 1.5 cm by 1.8 cm with a 0.1 cm depth. The appearance was gray/white and the surrounding skin was red and macerated with no odor. (The first documented assessment for wounds staff originally identified on 10/28/24.) Review of the resident's physician progress note, dated 11/16/24, showed the following information: (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pressure injury to left heel now soft and fluid filled and continued to be black in color. -Unstageable pressure injury on thoracic lumbar spine. Staff to cleanse area and cover with Mepilex Ag, apply Optifoam over it for cushioning, and offload from back. -Right heel continued without redness or pressure. Offload heels from bed, frequent repositioning, and Optifoam to left heel. -Plans to admit resident to hospice. Review of the resident's wound assessment, dated 11/19/24, showed following information: -One acquired stage I pressure ulcer to the resident's distal back measured 0.5 centimeters (cm) by 1 cm with a 0.1 cm depth. The appearance was reddened with no odor. -One acquired stage II pressure ulcer to the resident's medial measured 1 cm by 1.2 cm with a 0.1 cm depth. The appearance was gray/white, surrounding tissue was red and macerated, with no odor. -One acquired stage II pressure ulcer to the proximal back measured 1.5 cm by 1.5 cm with a 0.1 cm depth. The appearance was gray/yellow, the surrounding skin was red and macerated with no odor. -One acquired stage II pressure ulcer to the resident's right heel measuring 3 cm by 2.4 cm with a 0.1 depth. The appearance was dusky red, and the surrounding tissue was peeling and pink, with no odor. -One acquired unstageable pressure ulcer to the residents left heel measuring 3.5 cm by 5 cm with a 0.1 depth. The appearance was necrotic the surrounding tissue was peeling. Review of the resident's physician progress note, dated 11/20/24, showed the resident on hospice services and continued with slow decline. Observation on 11/21/24, at 9:52 A.M., Licensed Practical Nurse (LPN) C, and the Wound Care/Infection Preventionist Nurse were in the resident's room performing wound care. The Wound Care/Infection Preventionist Nurse took off the resident's heel protectors and removed protective dressing to the resident's right heel. The resident had a quarter sized opening with erythema to the right heel. LPN C removed protective dressing to the resident's left heel. The resident had an area of eschar (dead or devitalized tissue), bigger than a half dollar in size. The resident rolled onto his/her left side, toward the Wound Care/Infection Preventionist nurse. At this time, a strong wound odor was present. LPN C removed the Mepilex dressing to the resident's back wounds. Two bigger than quarter size areas observed with 95 percent slough and 5 percent eschar to each wound. The tissue surrounding the wounds were dark red/purple coloring. A third wound on the back, approximately quarter size, minimally observed, with non-blanchable redness. During an interview on 11/21/24, at 1:10 P.M., Certified Nursing Assistant/ Registered Medication Technician (CNA/CMT) A said the following: -He/she noticed the resident's wounds shortly after the resident came back from the hospital; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265519	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If he/she noticed a change on the resident's skin, it was reported to the charge nurse; -Aides complete the showers and should document any skin issues on the bath sheets. Those sheets are then turned into the charge nurse, who signs and assesses any issues. After the charge nurse makes their assessment, the bath sheet is turned into the DON; -Wounds and wound care would be found on the care plan. During an interview on 11/21/24, at 2:49 P.M., Registered Mediation Technician (RMT) B said the following: -Bath sheets should be completed by the CNA completing the shower. After that's completed, it's turned into the nurse. From there, the nurse would sign it and assess any issues. After the charge nurse makes their assessment, the bath sheet is turned into the DON; -Aides should always report any new skin concerns and or worsening of skin to the charge nurse immediately; -He/she liked to follow up with the nurse after the nurse assesses the concerns to inquire about any new interventions for the resident. During an interview on 11/22/24, at 9:55 A.M., LPN C said the following: -Floor nurses are responsible for providing daily wound care; -He/she was not sure how often the Wound Care Nurse performed assessments/measurements; -If he/she noticed a wound to be deteriorating and/or not improvement, he/she would report it to the Wound Care Nurse, DON, or NP. One of them would observe the wound and maybe change the treatment; -He/she was not sure if the resident's treatment had ever been more than Mepilex Ag. He/she did not feel he/she had enough experience to say whether or not the treatment should be upgraded; -He/she was not sure if wounds and wound care should be included on the care plan. During an interview on 11/22/24, at 12:07 P.M., the Wound Care/Infection Preventionist Nurse said the following: -She was made aware of the resident's wounds the following day after discovery; -She does weekly wound rounds to include measurements and assessments for changes; -When she learned of the resident's wounds the treatment was just Optifoam dressings. It has since been changed to mepilex foam; -She feels the wounds declined quickly, but they are some better now; -If she didn't see much improvement in a wound within a week, she would let the NP know. (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24, at 12:34 P.M., the DON said the following: -The resident is also on hospice as of this date and they will get involved in the wound treatment; -She agrees that if there is no improvement in a wound within a week, the NP needs to be reached out to for a change in treatment; -The resident should be wearing heel protectors and be repositioned frequently. During an interview on 11/22/24, at 1:19 P.M., the Administrator said the following: -If a wound is not improving, there needs to be a communication with the provider to see what course of action needs to be taken next; -Pressure to the affected area needs to be limited; -Weekly wound documentation and measurements are expected.

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	265519	A. Building B. Wing	11/22/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to ensure an environment as free from accident hazards as possible when staff continued to transfer one resident (Resident #14) with a lift that required resident participation after to two prior falls using the same lift and after the resident showed a decline in his/her ability to bear weight. A sample of 17 residents was reviewed in a facility with a census of 65. Review of the facility's policy titled Resident Handling, revised on 04/22, showed the following information: -Mobility and transfer decision flow chart is utilized when selecting appropriate assistive equipment and devices during assessment of resident capabilities for care planning and prior to patient handling activity. When indicated on the patient care plan, the required assistive devices may be varied according to the decision flow chart. -Because resident conditions and physician or mental status may be continually changing throughout the day, staff members are encouraged and empowered to make an updated assessment with individual handling activities. -Staff members should be familiar with the resident's current status and be able to verbalize the reason(s) a particular device was selected for the activity. -Charge nurses are responsible for routinely observing resident handling activities and verifying the appropriate selection and use of safety devices. -Injury incidents, near miss incidents, or early signs and symptoms of muscle strains or other musculoskeletal injury resulting from resident handling activities are reported per policy. -Resident handling incidents are analyzed for trends or patterns and appropriate follow up, changes in policy, staff education, or equipment maintenance initiated as required. Review of the facility's Mobility and Transfer Decision Flow Chart, dated 08/05/19, showed the following information: -Team members are empowered to use the Limited Lift Flow Chart in real time when determining the proper way to lift, transfer, reposition, or ambulate a resident; -When/if there is uncertainty in answering a question on the flow chart, the next level down in the chart higher level of safety should be utilized until the next question is answered. The charge nurse or care plan team should be consulted for clarification; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-One person assisting using the sit-to-stand (a mechanical device that helps people with limited mobility move from a seated position to a standing position) or full lifts (Hoyer- a mechanical device that helps move people with limited mobility by placing the resident in a sling and suspending the resident in the air with the lift, and then lowering the resident on/in the destination) are authorized unless the resident's clinical needs, risks, or behaviors indicate otherwise, such as a resident who becomes very frightened or agitated during a transfer may require additional staff to ensure safety; -Partial or non-weight bearing residents that are unable to bear weight, are dependent on staff, and/or uncooperative or resistive to care require a maximum assist and a total lift device, such as a Hoyer. 1. Review of the Resident #14's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses included fracture of the left pubis (a bone in the pelvis that protects the bladder, intestines, and internal sex organs), and subsequent encounter for fracture. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 10/26/24, showed the following information: -Severely impaired cognition with inattention and disorganized thinking; -Substantial to maximal assist from staff for all activities of daily living (basic tasks that people need to perform to live independently in a household, such as bathing, dressing, toileting, and mobility) -No falls since admission; -Diagnoses included heart disease, kidney failure, and Alzheimer's disease. Review of the resident's care plan, revised on 03/13/24, showed the following information: -Staff to assist with ADL's as needed. Staff will need to use the decision flow chart to help with transfers; -Substantial assistance from staff, sit-to-stand, and wheelchair required; -Fall risk assessments to be completed every 90 days; -Interventions for falls included call light within reach, proper use of sit-to-stand, reeducate staff in the use of the sit-to-stand, low bed, fall mat, and non-skid footwear. Review of the resident's nurses note, dated 09/06/24, showed the following information: (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Will ask therapy to see resident for possible downgrade to a Hoyer lift. Resident is not able to bear weight at times for the sit-to-stand. Director of Nursing (DON), and Nurse Practitioner(NP) notified. Review of the resident's nurses notes, dated 09/07/24 to 10/06/24, showed no follow-up note regarding lift concerns. recorded. Review of the resident's nurse note, dated 10/07/24, of a fall communication form, showed the following information: -The resident was being transferred to bed via sit-to-stand when the resident unhooked his/herself. Staff member lowered the resident to the ground as resident slid out of the lift onto the floor; -Interventions included change in transfer mechanism via transfer tree protocol. Review of the resident's fall team meeting, dated 10/21/24, showed the following information: -The resident fell out of the sit-to-stand on 10/07/24; -The resident was a high fall risk; -New interventions included education on the use of a sit to stand. Review of the resident's nurses note, dated 11/07/24, of a fall communication form, showed the following information: -The certified nurses aide (CNA) was using the sit-to-stand to lift the resident from the recliner to the wheelchair. As the CNA lifted the resident, the resident slid his/her arm out of the sling and then fell on to the floor landing on his/her right side. The resident was assessed and assisted back to the wheelchair with a Hoyer lift; -New interventions include education on proper sling to use for the sit-to-stand transfer for this resident. Review of the resident's fall team meeting, dated 11/11/24, showed the following information: -The resident fell out of the sit-to-stand on 11/07/24; -No new interventions put into place; -The resident was reeducated on the use of the sit-to-stand. Review of the resident's care plan showed staff did not update the care plan regarding the need for a transfer method change to prevent future falls. During an interview on 11/20/24, at 10:32 A.M., Registered Nurse (RN) D said the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265519	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had been a sit-to-stand transfer, but he/she is now on hospice services due to a decline; -There has been mention of switching the resident to a Hoyer lift; -He/She plans to speak with the nurse practitioner (NP) about the transfer downgrade today and get that updated in the resident's chart. Observation on 11/20/24, at 1:25 P.M., showed the following: - Registered Medication Technician (RMT) I and Certified Nurse's Aide (CNA) J prepared to transfer the resident with the sit-to-stand lift from the wheelchair to the recliner. CNA J put a sit-to-stand sling around the resident and secured the sling around the resident. -CNA J began operating the sit-to-stand lift and the sit-to-stand lift started to rise. The resident's upper body lifted and resident was unable to come to a standing position. CNA J lowered the resident back into the wheelchair. -On the second attempt, CNA J began operating the sit-to stand lift. The sit-to-stand lift started to rise and the resident's upper body lifted and resident was unable to come to a standing position. CNA J lowered the resident back into the wheelchair. -On the third attempt, CNA J began operating the sit-to stand lift and the sit-to-stand started to rise. The resident's upper body lifted and resident was unable to come to a standing position. CNA J lowered the resident back into the wheelchair. -RMT J said morning transfers are usually a struggle for the resident. Nothing was passed in report regarding a decline and/or need to transfer the resident any other way. -CNA J said the resident should probably have non-slip socks on to assist with this transfer. (CNA J did not don non-slip socks onto the resident.) -On the fourth attempt, CNA J began operating the sit-to stand lift. The sit-to-stand started to rise, the resident's upper body lifted and resident was unable to come to a standing position. CNA J lowered the resident back into the wheelchair; The resident said he/she was tired. -On the fifth attempt, CNA J began operating the sit-to stand lift, the sit-to-stand started to rise and the resident's upper body lifted. The resident was unable to come to a standing position. CNA J lowered the resident back into the wheelchair. -RMT I said it might just be better to switch the resident to a Hoyer lift. He/she will fill out a stop and watch and the nurse will take care of it. -CNA J removed the sling from around the resident, and the resident continued to sit in his/her wheelchair. During an interview on 11/21/24, at 8:16 A.M., CNA/RMT E said the following: (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff are expected to transfer the residents with one staff; -There are several residents on the hall that are high fall risks that are either sit-to-stand or Hoyer transfers; -He/She knows from previous jobs that mechanical lifts should be done with two staff members, however this facility only lets one staff complete the task, due to staffing and cost; -Often times the transfers are not safe due to the staffing ratio and the needs of the residents. During an interview on 11/21/24, at 1:10 P.M., CNA/RMT A said the following: -If a resident is a frequent faller the aides are told to keep a closer eye on them. Other fall interventions include fall mats and low beds; -The resident is transferred with a sit-to-stand. He/she has not had any issues doing so other than with holding on at times. -He/she is aware that the resident has fallen out of the sit-to-stand before. -If a staff member doesn't feel safe, or notices that the resident is unable to bear weight, they should use the decision flow chart and downgrade the residents transfer for that occurrence. -Staff should be able to see how a resident is transferred in the care plan. During an interview on 11/21/24, at 2:49 P.M., RMT B said the following: -The resident's transfer status depends on his/her mood for the day. -Most of the time the sit-to-stand is used. Staff operate the sit-to-stand with one staff member. -He/she was aware that the resident had fallen out of the sit-to stand before. The resident chicken wings his/her arms and slides right out of it due to not being able to bear total weight; -If he/she noticed the resident was unable to bear weight, he/she would downgrade the resident's transfer status to a Hoyer lift for that occurrence; -He/she has never seen the resident attempt to unhook themselves from the lift. He/she is unsure if the resident is capable of that. During an interview on 11/22/24, at 9:55 A.M., Licensed Practical Nurse (LPN) C said the following: -The resident has been a sit-to-stand transfer; -Staff can use the sit-to-stand for transfers if the resident is able to bear weight on at least one leg and has the ability to hold on; (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If a resident seemed to be having trouble coming to a standing position, he/she would expect the staff to use the decision flow chart and downgrade the residents transfer status for that occurrence; -He/She was not aware if therapy had given any input on how the resident should be transferred; -He/she has not been made aware of any changes in the residents condition lately. During an interview on 11/22/24, at 10:26 A.M., Physical Therapist (PT) K said the following: -He/she had been asked to evaluate the resident before. He/she always recommended that the staff follow the decision flow chart, which means the staff should decide how much assistance the resident needs; -Knowing the resident, he/she would say that a decline will continue due to his/her mental and physical limitations; -A nurse did come to him/her this week and asked his/her thoughts on the resident's transfer status. At that time, he/she recommended the status be downgraded and care planned to a Hoyer lift. -When a transfer status is care planned, then that is what the staff should use at all times instead of the decision flow chart. -If the resident were to fall out a sit-to-stand, an intervention of education would not be appropriate, due to the resident's mental limitations. During an interview on 11/22/24, at 12:34 P.M., The Director of Nursing (DON) said the following: -She expected the staff to use the decision flow chart for determination of transfer status. -A resident must be able to bear weight if they are going to use the sit-to-stand. -A sit-to-stand can be operated with one staff member. She does encourage two staff members as it is safer. -The resident has sustained falls out of the sit-to-stand and the Hoyer lift potential has been discussed. -Transfer status should be care planned in this case. During an interview on 11/22/24, at 1:19 P.M., The Administrator said the following: -Staff are expected to use the sit to stand with one staff member. They are able to obtain help if it is needed; -Residents should be able to bear weight if they are using a sit-to-stand; -He was not aware of any current issues with the resident's transfer status; (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Transfer status as well as any fall interventions should be care planned.

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	265519	A. Building B. Wing	11/22/2024

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Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on observation, interview, and record review, the facility failed to provide respiratory care per standard of practice when staff failed to obtain physician orders for care of a continuous positive airway pressure machine (CPAP - a treatment for sleep apnea (sleep disorder that causes people to stop breathing or breathe shallowly while they sleep)) and failed to consistently clean the CPAP canister, tubing, and face mask for one resident (Resident #53) with a CPAP. The facility census was 65. 1. Review of Resident #53's face sheet showed: -admitted [DATE]; -Diagnosis included chronic respiratory failure with hypoxia (inadequate oxygen in the body tissues). Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 10/31/24, showed the following: -Cognitively intact; -No rejection of care; -Required substantial/maximum assistance of staff with showers and toileting hygiene; -Required partial/moderate assistance of staff with dressing and personal hygiene; -On oxygen therapy and non-invasive mechanical ventilation (CPAP). Review of the resident's care plan, dated 10/25/24, showed the following: -Ineffective breathing pattern: Resident has hypoxemia and chronic respiratory failure. Resident used a CPAP at hour of sleep (HS) and have a pleural drain. Vital signs as ordered, including oxygen saturation, physical assessment, and document any teaching regarding airway; -Oxygen use: Resident to use use oxygen at all times. Oxygen as ordered, instruct resident in pursed lip breathing, elevate the head of bed if requested, and minimize activities to short periods and one at a time. Review of the resident's physician orders an order, dated 11/04/24, for CPAP every HS and remove in the morning. (The orders did not include care and cleaning of the CPAP machine, CPAP tubing, or CPAP mask.) Observation and resident interview on 11/21/24, at 8:15 A.M., showed the following: -The resident lay on his/her bed with oxygen on via nasal cannula; (continued on next page)

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	265519	A. Building B. Wing	11/22/2024

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Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's CPAP mask and attached tubing lay on his/her bed connected to a CPAP machine located on his/her bedside table; -The resident said he/she had sleep apnea and used the CPAP machine every night; -Prior to admission to the facility, while at home, the resident cleaned his/her machine, the tubing, and the mask every week; -Since admission to the facility, on 10/25/24, nearly one month ago, no one had cleaned his/her CPAP machine, tubing, or mask. During an interview on 11/21/24, at 12:10 P.M., Registered Nurse (RN) F said the following: -He/she rinsed the resident's CPAP tubing with water and hung it up to dry in the resident's room; -He/she was unsure if the facility had specific physician orders to care for the resident's CPAP; -The nurse then checked the resident's electronic health record and said the resident had a physician's order for CPAP use, but no specific order to clean the CPAP machine, mask, or tubing. During an interview on 11/21/24 at 12:15 P.M., Licensed Practical Nurse (LPN) G said the following: -The nurses should obtain physician orders for care/cleaning of the resident's CPAP equipment; -Nurses generally clean the CPAP canister, mask, and tubing with a cleaning solution kept in the clean utility room and then allow to air dry; -He/she was unsure specifically what the cleaning solution consisted of. During an interview on 11/22/24, at 1:00 P.M. LPN H said the following: -The facility did not have any physician orders for care of the resident's CPAP machine; -The night shift should rinse out the CPAP canister with sterile water and change the oxygen tubing running from the oxygen machine to the CPAP every week; -He/she had not cleaned or changed out the resident's CPAP mask or tubing; -He/she had rinsed out the canister with sterile water. During an interview on 11/22/24 at 1:20 P.M., the Director of Nursing (DON) said the nurses should have orders to clean the CPAP machine canister, tubing, and mask daily.

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	265519	A. Building B. Wing	11/22/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to document assessment for risk for entrapment and obtain informed consent prior to bed rail use for one resident (Resident #23) out of 17 sampled residents. The facility census was 65. Review showed the facility did not provide a policy regarding bed rail use. 1. Review of Resident #23's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses included acute metabolic acidosis (too much acid in the blood). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 10/31/24, showed the resident required supervision for rolling from left to right and required substantial to maximum assistance from staff for moving from lying on the back to sitting on the side of the bed. Review of the resident's care plan, revised on 11/13/24, showed the resident used bed rails to assist in turning and repositioning. Review of the resident's medical record showed staff did not document assessment for risk of entrapment and informed consent for bed rails for the resident. Observation on 11/18/24, at 9:30 A.M., showed the resident lay in bed on his/her back with one half bed rail on each side of the bed, in the upright position. Observation on 11/19/24, at 9:48 A.M., showed the resident lay in bed on his/her back with one half bed rail on each side of the bed, in upright position. Observation on 11/20/24, at 12:11 P.M., showed the resident lay in bed on his/her back with one half bed rail on each side of the bed, in upright position. Observation on 11/21/24, at 9:52 A.M., showed the resident lay in bed on his/her back with one half bed rail on each side of the bed, in upright position. During an interview on 11/21/24, at 1:10 P.M., Certified Nursing Assistant/Registered Medication Technician (CNA/RMT) A said the following; -Residents need bed rails if they have an air mattress, so they don't roll out of bed; -There is an assessment that has to be completed by the nurses; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265519	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There has to be a physician's order; -Bed rail use should be seen in the care plan; -The Maintenance Director is who is responsible for installing and measuring the bed rails; -He/she believed the bed rails were monitored/reassessed quarterly; -The resident used side rails because he/she used to try to get out of bed a lot and would fall. The bed rails were used as a precaution to keep the resident from falling. During an interview on 11/21/24, at 2:49 P.M., RMT B said the following: -Residents use bed rails for mobility, as well as prevention for falling out of bed; -He/she was not sure if the nurses have to fill out any kind of assessment or informed consent; -He/she was not sure who measured the bed rails; -Some beds come with bed rails already on them. During an interview on 11/22/24, at 9:55 A.M., Licensed Practical Nurse (LPN) C said the following: -The nurses have to get a physician's order for a resident to use the side rails; -The Maintenance Director installs and measures them; -He/she was not sure if there was any required assessment and/or informed consent; -Residents use them for mobility, however some hospice patients are using them so they don't roll out of bed; -The resident has them for mobility. During an interview on 11/22/24, at 9:49 A.M., The Maintenance Director said the following: -He received a work order of when to add and remove bed rails; -He was responsible for installing the bed rails and doing an assessment along with measurements at the time of installation; -He checked the bed rails and re-measures quarterly; -He completed the resident's assessment and measurements on 11/21/24, after being told the rails were already installed. During an interview on 11/22/24, at 12:34 P.M., the Director of Nursing said the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nursing staff will put in a request for the Maintenance Director to install the bed rails; -The nursing staff will fill out an assessment and obtain an informed consent; -Bed rails should be care planned; -The Maintenance Director will install the bed rails and measure them; -The bed rails are re-assessed and monitored quarterly by both nursing and the Maintenance Director. During an interview on 11/22/24, at 1:19 P.M., the Administrator said the following: -He expected the Maintenance Director to install and obtain bed rail measurements; -The Maintenance Director was to assess/monitor the bed rails quarterly; -Bed rails should be care planned; -An assessment and informed consent should be completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to maintain a complete and effective infection control program when staff failed to follow hand hygiene procedures and handle equipment in a manner to prevent transmission of infections agents per standards of practice for one resident (Resident #23) out of 17 sampled residents. The facility census was 65. Review of the facility's policy titled, Infection Prevention Annual Plan and Program Evaluation, dated 05/24, showed the following information: -Maintain a sanitary environment to minimize, reduce, or eliminate the risk of infection and communicable disease; -Ensure safe practices for cleaning and disinfecting environmental surfaces; -Ensure proper handling, storage, and disinfection of multi-patient use medical equipment; -Provide education to new coworkers upon hire and annually for all coworkers to prevent exposure to and transmission of infections and communicable diseases, hand hygiene, and standard precautions. Review of the facility's policy titled, Hand Hygiene, dated 11/24, showed the following information: -Perform hand hygiene on ungloved hands with approved alcohol based hand rub (ABHR) or soap and water; -Five moments for hand hygiene from the World Health Organization (WHO) are as follows: before touching a resident, before a clean or aseptic technique, after body fluid exposure risk, after touching a resident, and after touching a resident's surroundings; -Change gloves during resident care if moving from a contaminated body site to a different body site of the same resident; -Perform hand hygiene and change gloves if you suspect your gloves have been contaminated. 1. Review of Resident #23's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses included acute metabolic acidosis (too much acid in the blood). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 10/31/24, showed the following information: -At risk for pressure ulcers; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Indwelling catheter (a sterile tube inserted into the bladder to drain urine) use. Review of the resident's care plan, last revised on 11/13/24, showed the following information: -Pressure ulcers to bilateral (both) heels. Staff to keep skin clean and dry, provide treatment as ordered, and follow enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes.); -Foley catheter used. Staff to keep clean, change catheter per orders, dignity, position drainage bag to facilitate flow of urine, and follow enhanced barrier precautions. Observation on 11/19/24, at 2:55 P.M., showed the following: -Registered Medication Technician (RMT) L and Licensed Practical Nurse (LPN) M enter the resident's room without performing hand hygiene. Both staff donned gowns and gloves. -RMT L removed the resident's catheter drainage bag and placed it onto the floor near the right side of the toilet. -RMT assisted the resident to a standing position and then pivoted to the toilet. The LPN noticed the catheter drainage bag on the floor, obtained the catheter bag, and placed it back under the resident's wheelchair. Staff did not perform had hygiene or change gloves. -RMT L assisted the resident to a standing position and LPN M obtained wipes and cleansed the resident's bottom. Staff did not perform hand hygiene or glove change. -RMT L assisted the resident back into sitting position on the toilet. LPN M obtained wipes and cleansed the residents front side. RMT L assisted the resident to a standing position. LPN M obtained additional wipes and cleansed the resident's bottom once more. Staff did not complete hand hygiene or change gloves. -LPN M pulled the resident's pants up and RMT L pivoted the resident back into a seated position in his/her wheelchair. -LPN M took off gloves and without performing hand hygiene donned new gloves. -RMT L and LPN M both placed wheelchair pedals onto the resident's wheelchair. -Both staff removed gloves. LPN M sanitized his/her hands. RMT L washed his/her hands in the bathroom sink. -LPN M then obtained the resident's oxygen tubing and assisted placing it inside the resident's nostrils before exiting the room. Observation on 11/21/24, at 9:52 A.M., showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN C stood outside the resident's room with the treatment cart. LPN C had gloves donned and sanitized scissors with disinfectant wipes. Supplies for wound care were gathered and placed on top of the treatment cart. LPN C took off gloves, obtained a gown, and donned the gown prior to entering the resident's room. -The Wound/Infection Preventionist (IP) Nurse was in the resident's room with gown and gloves donned. -LPN C laid the wound care supplies down onto the resident's bedside table, including the previously disinfected scissors, with no clean barrier or re-sanitization. -LPN C sanitized his/her hands, donned gloves, obtained the resident's bed adjusting dial, lowered the resident's bed, removed the resident's heel protectors, and removed the resident's sock to the right foot. -Without performing hand hygiene or changing gloves. LPN C obtained gauze and wound cleanser spray. LPN C moistened the gauze with the wound cleanser and cleansed the residents wound to the right heel. -LPN C removed gloves, sanitized hands, and donned new gloves. LPN C applied the treatment to the resident's right heel wound. LPN C did not sanitize his/her hands or change gloves and moved onto removing the resident's left heel wound previous treatment. The heel protectors and sock were preciously removed by the Wound/IP Nurse. -LPN C cleansed the resident's left heel wound. LPN removed gloves, sanitized hands, donned new gloves, and performed the treatment to the resident's left heel. The Wound/IP Nurse placed the resident's sock and heel protector back on. -Without removing gloves or sanitizing hands, the LPN touched the resident's bed blankets, the bed, the bed adjustor dial, and the resident's oxygen tubing. -The resident rolled toward the Wound/IP Nurse, onto his/her left side. LPN C adjusted the bed pad underneath the resident and removed the resident's pants and brief. -Without performing hand hygiene or changing gloves, the LPN obtained the contaminated scissors and cut the dressing material and laid the scissors back down onto the resident's bedside table with no clean barrier. The LPN touched the resident's bedside table and then removed the previous treatment dressing from the resident'' bottom. The LPN obtained gauze and wound cleanser and moistened the gauze with the wound cleanser. -While cleansing the resident's wound, bowel was seen on the gauze pad. The LPN obtained wipes and cleansed the resident's bottom with the swipe and fold method. -The LPN removed gloves, sanitized hands, and donned new gloves. LPN C obtained the treatment supplies and applied the treatment to the resident's bottom, placed on the resident's brief and pants and allowed the resident to roll onto his/her back to rest. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The LPN did not change gloves or perform hand hygiene. The resident rolled back onto his/her left side toward the Wound/IP Nurse. LPN C removed the dressings to the resident's back wounds and obtained wound cleanser and gauze. LPN C cleaned the wounds with moistened gauze. LPN C removed gloves, sanitized hands, and applied treatment to the resident's back wounds. -The resident rolled back onto his/her back. LPN C covered the resident with his/her blanket, obtained the residents bed pad, along with the Wound/IP Nurse and pulled the resident up into bed. LPN C removed gloves, sanitized hands, and donned new gloves. LPN C obtained the wound cleanser, picked trash up off the floor, obtained his/her scissors from the resident's bed side table, obtained the trash, a box of opened gloves, and then touched the residents nebulizer tubing without performing hand hygiene. During an interview on 11/21/24, at 1:10 P.M., Certified Nurses Aide/ Registered Medication Technician (CNA/RMT) A said the following: -Hand hygiene should be performed before and after care and if going from a dirty surface to a clean surface; -Catheter drainage bags should not be placed on the floor. During an interview on 11/21/24, at 2:49 P.M., RMT B said the following: -Hand hygiene should be performed before and after care and if going from a dirty surface to a clean surface; -Catheter drainage bags should not be placed on the floor. During an interview on 11/22/24, at 9:55 A.M., LPN C said the following: -Hand hygiene should be performed before and after care and if going from a dirty surface to a clean surface; -Catheter drainage bags should not be placed on the floor; -Equipment should be sanitized before and after each use and should be laid on a clean barrier During an interview on 11/22/24, at 12:07 P.M., the Wound/IP Nurse said the following: -Hand hygiene should be performed before and after care and if going from a dirty surface to a clean surface; -Catheter drainage bags should not touch the floor; -She expected staff to change gloves and perform hand hygiene prior to moving onto the next wound treatment; -She expected staff to have a clean barrier laid down for supplies; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Placing supplies on a dirty surface, then using the supplies would be considered cross contamination. During an interview on 11/22/24, at 12:34 P.M., the Director of Nursing (DON) said the following: -She expected hand hygiene to be performed before and after care and if going from a dirty surface to a clean surface; -Catheter drainage bags should not touch the floor; -She expected staff to change gloves and perform hand hygiene prior to moving onto the next wound treatment; -She expected equipment to be sanitized before it enters or leaves a residents room, and to have a clean barrier laid down. During an interview on 11/22/24, at 1:19 P.M., the Administrator said the following: -Hand hygiene should be performed before any task, when hands are soiled, and before and after cares; -He expected staff to have clean equipment and clean barriers; -Catheter drainage bags should not touch the floor.