STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175409	A. Building B. Wing	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health and Rehabilitation Center	811 N 1st Street Osborne, KS 67473

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 50 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to report Resident (R) 43's allegation of physical and verbal abuse to the State Agency (SA). This placed the resident at risk for unidentified and/or ongoing abuse. Findings included: - R43's Electronic Medical Record (EMR) documented R43 had diagnoses of acute and chronic respiratory failure, hemiplegia/hemiparesis (weakness and paralysis on one side of the body) following cerebral infarction (stroke/CVA- the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting left non-dominant side, heart failure, chronic kidney disease, unspecific complication of kidney transplant, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), major depressive disorder (major mood disorder which causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. The Quarterly Minimum Data Set (MDS), dated [DATE], documented that R43 had intact cognition and no behavioral symptoms. R43 had a functional range of motion impairment of one side both upper and lower extremities. The MDS further documented that R43 was dependent for toileting, lower body dressing, and putting on and off footwear. R43 required supervision or touch assistance with sit-to-stand and chair/bed-to-chair transfers. R43 had shortness of breath with exertion, weight loss with a prescribed weight loss regimen, and received a therapeutic diet. R43 received insulin (used to regulate blood sugar) injections, an antidepressant (a class of medications used to treat mood disorders), antiplatelet (a group of medications that stop blood cells from forming blood clots), and oxygen therapy. The Activity of Daily Living (ADL) Care Area Assessment (CAA), dated 05/25/23, documented that R43 required assistance with ADLs due to a recent CVA and left-sided paralysis. R43 worked with physical and occupational therapy and used a wheelchair as a main mode of transportation. R43's Care Plan, dated 10/12/23, documented that R43 needed assistance with ADL due to CVA. The care plan further documented that R43 required one to two people to assist with transfers using a cane and to pivot transfers to the right. (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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	175409	A. Building B. Wing	12/19/2023

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order, dated 11/07/23, documented that R43 may transfer independently from wheelchair to recliner but required the assistance of one person for all other transfers. The facility's Grievance Log dated 11/20/23 documented that R43 reported a Certified Nurse Aide (CNA) O had abused her. The log resolution date was 11/29/23. On 12/13/23 at 12:48 PM, R43 reported verbal and physical abuse during the resident interview. R43 stated the incident occurred on 11/20/23 when CNA O called her a liar. R43 reported CNA O told R43 she would have to wait until everyone was assisted to the dining room before being assisted with transferring to her recliner. CNA O grabbed R43's left leg and caused it to hurt. R43 reported she informed another CNA who brought a grievance form and assisted R43 in filling it out. On 12/19/23 at 08:45 AM, Administrative Nurse D reported on 11/20/23 during the morning meeting with department heads, the Social Worker reported R43 reported a grievance, regarding an interaction with CNA O. Administrative Nurse D stated she spoke to R43 regarding the complaint of CNA O's care. Administrative Nurse D verified she had not documented the conversation with R43 but felt, after talking to R43, there was no abuse or neglect due to R43 said CNA O was not in a good mood, and R43 was not fearful. Administrative Nurse D verified the facility did not report the incident to the SA. Administrative Nurse D reported she addressed the incident with CNA O on 11/21/23 with a review of the Abuse, Neglect, and Exploitation policy. The facility's Residents Right to Freedom from Abuse, Neglect, and Exploitation policy, dated 07/2017, documented that associates must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion against any resident. Report the results of all investigations to the administrator or his or her designated representative and other officials in accordance with State law, including to the state Survey Agency, within five working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken. The facility failed to report R43's allegation of physical and verbal abuse to the SA as required. This placed R43 at risk for unidentified and/or ongoing abuse.

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	175409	A. Building B. Wing	12/19/2023

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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. 37450 The facility had a census of 50 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to apply compression hose to Resident (R) 4, as ordered by the physician. This placed the resident at risk for ongoing complications related to edema (swelling resulting from an excessive accumulation of fluid in the body tissues). Findings included: - R4's Electronic Medical Record (EMR) documented R4 had diagnoses of generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear disorder, chronic bronchitis (inflammation of the tubes that let air in and out of lungs), major depressive disorder (major mood disorder which causes persistent feelings of sadness), polyneuropathy (malfunction of nerves throughout the body), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) with acute exacerbation, heart failure, atrial fibrillation (rapid, irregular heart beat), abnormal weight loss, and edema. The Quarterly Minimum Data Set (MDS), date 10/14/23, documented R4 had moderately impaired cognition, and inattention behavior which fluctuated. R4 had an indwelling urinary catheter (tube placed into the bladder to drain urine), and had shortness of breath wit exertion, sitting at rest and lying flat. R43 had no swallowing disorder, was 69 inches tall, and weighed 198 pounds (lbs.). R4 received a therapeutic mechanically altered diet. The MDS further documented R4 received an antidepressant (class of medications used to treat mood disorders), anticoagulant (a group of medication that decreases blood ability to clot), diuretic (medication to promote the formation and excretion of urine), opioid (a class of medication used to treat pain), had respiratory therapy treatments and used oxygen. R4's Care Plan, initiated 10/18/22, documented R4 had atrial fibrillation and hypertensive (elevated blood pressure) disease and took medication for that. The care plan further documented R4 wore knee high hose, which were placed on in the morning (AM) and off in the evening (PM). The Physician Order, dated 07/21/23, documented knee-high thromboembolic compression stockings (TED-stocking designed to treat disorders such as edema) hose on in the am, off in the pm. May use ACE (stretchable bandage) wrap, if desired, related to heart disease with heart failure. On 12/14/23 at 08:00 AM, observation revealed Certified Nurse Aide (CNA) O assisted R4 with the morning routine. CNA O took R4 to the dining room in a wheelchair. R4 had yellow gripper socks on and lacked compression hose or ACE wrap to the legs. On 12/18/23 at 09:20 AM, observation revealed R4 sat in his recliner. R4 reported he was tired. R4's feet were elevated and R4 lacked compression hose or ACE wrap to his legs. On 12/18/23 at 01:07 PM, CNA N reported staff look in the computerized chart to locate information regarding resident cares. CNA N reported they recently started working the hall R4 resided on. CNA N was not able to locate information related to R4's need of compression hose. (continued on next page)

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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	On 12/18/23 at 01:29 PM, Licensed Nurse (LN) G verified R4 should have compression hose, and said she thought the CNA was applying the compression hose, so she signed the treatment as completed in the electronic record. LN G stated she thought the CNA had applied them, when in fact staff had not placed compression hose on the resident. On 12/18/23 at 02:35 PM, Administrative Nurse D verified the physician order for compression hose and said the nurses should not sign the electronic record if the resident was not wearing the hose. The facility's Edema Management policy, dated 12/01/19, documented the facility provided inpatient care and at a minimum included physician, skilled nursing, dietary, pharmaceutical services and an activity program. The purpose to ensure that resident with edema have adequate assessment and services to manage edema. Edema management is comprised of elevation, exercise, modalities, medication and compression. The facility failed to apply compression hose to R4 as directed by the physician. This placed the resident at risk for ongoing complications related to edema.

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	175409	A. Building B. Wing	12/19/2023

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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** 27168 The facility had a census of 30 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to provide a safe environment for the three cognitively impaired independently mobile residents who resided on the [NAME] and the West/East halls. The facility further failed to ensure an environment free from accident hazards for Resident (R)2. This placed the affected resident at risk for injury. Findings included: - On 12/13/23 at 08:40 AM, observation during initial facility tour revealed an unlocked soiled utility room door on the West/East Hall. Further observation revealed the door contained a keypad to open the door that was unlocked. The soiled utility room contained the following: 1- one-quart Bio-Enzymatic Spotter spray-with the warning keep out of reach of children, may cause serious eye irritation, if swallowed call a poison control center. 1- 32-ounce (oz) spray bottle of Clorox clean-up disinfectant spray with the warning keep out of reach of children, may cause serious eye irritation. 1- 750 milliliter (ml) spray bottle of Re-Juv-Nal spray disinfectant with the warning keep out of reach of children, may be corrosive to skin and eyes. 1- aerosol can of Spartan Sparsan Q disinfectant deodorant with the warning keep out of reach of children, may cause respiratory irritation and eye irritation. On 12/13/23 at 08:50 AM, Licensed Nurse G verified the chemicals in the unlocked soiled utility room, stated the shower room door should have been locked, and chemicals were to be stored in a locked secure location. On 12/13/23 at 08:55 AM, Administrative Nurse D verified the soiled utility room door was to remain locked at all times and chemicals needed to be kept behind a locked door. Administrative Nurse D stated the facility had three cognitively impaired independently mobile residents. The facility's Accident and Supervision policy, undated, documented the resident environment would remain as free of accident hazards as is possible, and each resident would receive adequate supervision and assistive devices to prevent accidents that included identifying, evaluating and analyzing hazards and risks, implementing interventions to reduce hazards and risks, and monitoring the effectiveness and modifying interventions when necessary. The facility would establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. The facility failed to store hazardous chemicals in a safe environment, placing the three cognitively impaired independently mobile residents on the [NAME] and West/East Hall at risk for injury. (continued on next page)

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	175409	A. Building B. Wing	12/19/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R2's diagnoses included diabetes mellitus (when the body cannot use glucose), morbid obesity (being 100 pounds or more above ideal body weight), dementia (progressive mental disorder characterized by failing memory, confusion), and tremors. R2's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented R2 was independent with bed mobility and transfers. The MDS lacked documentation the resident had siderails. R2's medical record recorded a Device Assessment was completed on 11/30/23 for assist rails used by the resident as an enabling devise to provide the opportunity for safe self-positioning. Devices were reassessed quarterly and as indicated with a change in resident condition. Risk/benefits of the device were reviewed with the resident and/or responsible party. The resident and /or responsible party verbalized understanding and agreed with the use of the device and understood the potential risks of using the device including, but not limited to, bruising, skin tear, falls, feeling isolated, pressure injury, entrapment, strangulation, suffocation, and death. On 12/13/23 at 03:10 PM, observation revealed a one-half side rail on the right side of R2's bed. The side rail on the top right side and the bottom left foot of the bed with openings approximately 16.5 inches by 32 inches. On 12/13/23 at 04:00 PM, Administrative Staff A and Administrative Nurse E verified the bed rails on R2's bed had too large of openings. The facility's Proper Use of Side Rails policy, dated 2020, documented it is the policy of the facility to utilize a person-centered approach when determining the use of side rails. Alternative approaches are attempted prior to installing a side or bed rail, however if used, the facility would ensure correct installation, use, and maintenance of the rails. As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether the use of side rails meet those needs. The facility would attempt to use alternatives prior to using side/bed rails. The alternatives provided shall be appropriate for the intended use of the rail. Alternatives included, but are not limited to roll guards, foam bumpers, lowering of the bed and concave mattresses. The facility will assure the correct installation and maintenance of bed rails, prior to use. The facility will provide ongoing monitoring and supervision of side/bed rail use for effectiveness, assessment of need and determination when the side/bed rail will be discontinued. The nurse would complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail. The interdisciplinary team would make decisions when the side/bed rail would be used or discontinued, or when to revise the care plan to address any residual effects of the rail. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and rails. The facility failed ensure R2's environment was free from accident hazards relayed to a side rail in use which exceeded safe opening and created risk for entrapment. This placed her at risk for accident or injury.

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	175409	A. Building B. Wing	12/19/2023

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 50 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to implement the Registered Dietician (RD) recommendation for Resident (R) 4's weight loss which placed R4 at risk for further weight loss. The facility further failed to monitor R14 and R43's physician ordered fluid restriction which placed R13 and R43 at risk of complication related to hydration status. Findings included: - R4's Electronic Medical Record (EMR) documented R4 had diagnoses of generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear disorder, chronic bronchitis (inflammation of the tubes that let air in and out of lungs), major depressive disorder (major mood disorder which causes persistent feelings of sadness), polyneuropathy (malfunction of nerves throughout the body), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) with acute exacerbation, heart failure, atrial fibrillation (rapid, irregular heart beat), abnormal weight loss, and edema. The Quarterly Minimum Data Set (MDS), date 10/14/23, documented R4 had moderately impaired cognition, and inattention behavior which fluctuated. R4 had an indwelling urinary catheter (tube placed into the bladder to drain urine), and had shortness of breath wit exertion, sitting at rest and lying flat. R43 had no swallowing disorder, was 69 inches tall, and weighed 198 pounds (lbs.). R4 received a therapeutic mechanically altered diet. The MDS further documented R4 received an antidepressant (class of medications used to treat mood disorders), anticoagulant (a group of medication that decreases blood ability to clot), diuretic (medication to promote the formation and excretion of urine), opioid (a class of medication used to treat pain), had respiratory therapy treatments and used oxygen. The Nutritional Care Area Assessment (CAA), dated 04/19/23, documented R4 was overweight but had COPD and depression and had potential for weight loss. R4's Care Plan dated 07/16/23 documented R4 had weight loss. The care plan directed staff to consult the RD and encourage R4 to eat in the dining room. R4 had orders for a mechanical soft diet and staff were directed to monitor meal intake and record, offer milk shakes and weigh weekly. On 11/10/23 at 01:07 PM, and Interdisciplinary Team Progress Note documented R4 had a weight loss of five percent (%) in 30 days. R4 had a change in the diuretic on 10/14/23, which could have resulted in weight loss. (continued on next page)

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	175409	A. Building B. Wing	12/19/2023

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/17/23 at 02:23 PM, a RD Progress Note, documented the RD was notified of weight loss. R4 current weight was 169 lbs. showing a 29 lb. loss in one month for greater than 5% loss and a 34 lbs. loss in six months for a greater than 10% significant loss. R4 had started Lasix (a diuretic) on 10/14/23. R4 received a regular mechanical soft diet with ground meats and regular liquids, had a good appetite, and needed supervision at meals. The note further documented the RD recommended a house supplement twice a day (4 ounce (oz) shake in the afternoon and a magic cup at lunch) to prevent further weight loss. The note directed to continue to check for edema, shortness of air with weight gain and history of heart failure. R4's clinical record lacked evidence the RD recommendation was acted upon. On 12/14/23 at 08:21 AM, observation revealed R4 sat in the dining room and ate ground sausage and scrambled eggs; he drank a small glass of orange juice. Further observation revealed the resident ate and drank all food served. On 12/18/23 at 11:18 AM, Certified Nurse Aide (CNA) M stated the nurses were responsible for passing supplements and said the e CNAs documented the resident's intake. 12/18/23 at 11:21 AM, Licensed Nurse (LN) G reported the nurses were responsible for giving ordered supplements. She stated she was not aware of the supplement need for R4. On 12/18/23 at 11:18 AM Dietary Staff (DS) BB reported the Director of Nursing monitored weights. DS BB said if the dietician made recommendations, she forwarded it to the nursing department, and the Director of Nursing forwarded the recommendation to the physician. On 12/18/23 at 02:35 PM Administrative Nurse D reported she tracked the weights weekly. The RD made recommendations on a Dietary Recommendation form and gave it to medical records to be sent to the physician for an order. Administrative Nurse D said, when the physician order was received, the nursing staff placed the information in the EMR for implementation of the order. Administrative Nurse D stated R4 had fluid issues and had been on diuretics. She notified the RD of weight loss but had not followed up on the RD recommendation. Administrative Nurse D verified R4 continued to lose weight. The facility's Weight Monitoring policy, dated 01/02/2020, documented based on the resident's comprehensive assessment, the facility will ensure that residents maintain acceptable parameters of nutritional status, such as usual body weight or desired body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicated otherwise. Intervention will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. Residents with weight loss monitor weight weekly. The physician should be informed of a significant change in weight and may order nutritional interventions. The Registered Dietician or Dietary Manager should be consulted to assist with interventions: actions are recorded in the nutrition progress notes. The facility failed to implement the RD intervention related to R4's weight loss, which placed the resident at risk for complications of continued weight loss. (continued on next page)

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	175409	A. Building B. Wing	12/19/2023

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R13's Electronic Medical Record (EMR) documented diagnoses of hypertensive (elevated blood pressure) heart disease with heart failure, major depressive disorder (major mood disorder which causes persistent feelings of sadness), dementia (progressive mental disorder characterized by failing memory, confusion), hyponatremia (greater than normal concentration of sodium in the blood), chronic respiratory failure, chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), pain, and obesity (over weight). The Quarterly Minimum Data Sheet (MDS), dated [DATE], documented R13 had intact cognition, had not exhibited no behaviors, was independent to supervision with activities of daily living. The Care Plan, dated 08/09/23, documented R13 had an altered cardiovascular status due to hypertension and coronary artery disease (CAD-a condition that affects the heart). On 11/03/23 initiated a fluid restriction of 2200 cubic centimeter (cc). The Physician Order dated 08/16/23 directed staff to implement a fluid restriction of 2000 cc per day related to chronic respiratory failure and COPD. The Physician Order dated 11/02/23 directed staff to implement a fluid restriction of 2200 cc per 24 hours. The October 2023 Follow Up Question report for estimated amount of fluid intake lacked completed documentation 14 days of 31-day opportunities. The November 2023 Follow Up Question report for estimated amount of fluid intake lacked completed documentation 11 days of 30-day opportunities. The December 2023 Follow Up Question report for estimated amount of fluid intake lacked completed documentation eight days of 17-day opportunities. On 12/18/23 at 09:16 AM R13 reported she does not keep track of her fluid intake, R13 thought the staff looked at what she drank at mealtimes. R13 stated staff know when she is drinking bottled water which is kept in her room, and staff provide fresh ice water two times a day, once on day shift and once on evening shift. On 12/18/23 at 10:05 AM Certified Nurse Aide (CNA) M stated she thought two residents on the hall was on fluid restrictions but could not remember who the residents were. Observation at that time revealed CNA M providing a fresh cup of ice water to R13. On 12/18/23 at 01:56 PM Licensed Nurse (LN) G reported the CNAs kept track of the fluid and food intake. LN G did not know who monitors the fluid restriction amounts for totals remaining in parameters of the physician orders. On 12/18/23 at 02:35 PM Administrative Nurse D verified R13 had a fluid restriction, and it should be recorded in the EMR. Administrative Nurse D stated the facility did not have a procedure or follow up in place to ensure the fluid parameters were being met. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Fluid Restriction policy, dated 2021, documented it is the policy of this facility to ensure fluid restrictions will be followed in accordance with physician's orders. Fluid restriction are basically the restriction of fluid intake. This may be due to underlying medical conditions that may cause fluid buildup such as congestive heart failure or end state renal disease (ESRD), in addition to electrolyte imbalance disorders such as hyponatremia. Fluid restriction amounts can vary according to the resident condition and physician judgement. The fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes. The food and nutrition department will be notified by facility communication methods of the fluid restriction. Water will not be provided at bedside unless calculated into the daily total of fluid restriction. The resident has the right to refuse the fluid restriction, and if refused, documentation should support the reason for the refusal, the education of the risk and benefits, and supporting documentation of the residents continued refusal, assessment for any changes in condition related to refusal, and the notification of the physician about the resident's refusal. The facility failed to monitor R14's physician ordered fluid restriction which placed R14 at risk of complication related to hydration status. - R43's Electronic Medical Record (EMR) documented R43 had diagnoses of acute and chronic respiratory failure, hemiplegia/hemiparesis (weakness and paralysis on one side of the body) following cerebral infarction (stroke/CVA- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting left non-dominant side, heart failure, chronic kidney disease, unspecific complication of kidney transplant, diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), major depressive disorder (major mood disorder which causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R43 had intact cognition, and no behavioral symptoms. R43had functional range of motion impairment of one side both upper and lower extremities. The MDS further documented R43 was dependent for toileting, lower body dressing, and putting on and off footwear. R43 required supervision or touch assistance with sit to stand and chair/bed to chair transfers. R43 had shortness of breath with exertion, weight loss with prescribed weight loss regimen, and received a therapeutic diet. R43 received insulin (used to regulate blood sugar) injections, an antidepressant (class of medications used to treat mood disorders), antiplatelet (a group of medications that stop blood cells from forming blood clots), and oxygen therapy. The Care Plan dated 07/27/23, documented R43 had an actual weight loss due to heart conditions and CVA. The Care Plan directed staff administer heart medications, monitor cardiac status, notify the physician of weight changes and edema, provide ordered diet, monitor intake and record each meal. The Physician Order dated 09/29/23 directed staff to a fluid restriction of 1500 milliliters (ml) per day, 500 ml day shift, 500 ml evening shift and 500 ml night shift. The October 2023 Follow Up Question report for estimated amount of fluid intake lacked completed documentation 20 days of 31-day opportunities. The November 2023 Follow Up Question report for estimated amount of fluid intake lacked completed documentation 10 days of 30-day opportunities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175409	A. Building B. Wing	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health and Rehabilitation Center	811 N 1st Street Osborne, KS 67473

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The December 2023 Follow Up Question report for estimated amount of fluid intake lacked completed documentation eight days of 17-day opportunities. On 12/18/23 at 09:47 AM, R43 reported she was aware she was on a fluid restriction and the amount of 1500 ml per day. Observation revealed a paper attached to the wall above her bed that read R43 was allowed 500 ml of fluid each shift. R43 stated she keeps track of her intake and nursing does not ask her about her intake of fluids. On 12/18/23 at 10:05 AM Certified Nurse Aide (CNA) M stated she thought two residents on the hall was on fluid restrictions but could not remember who the residents were. On 12/18/23 at 01:56 PM Licensed Nurse (LN) G reported the CNAs kept track of the fluid and food intake. LN G did not know who monitors the fluid restriction amounts for totals remaining in parameters of the physician orders. On 12/18/23 at 02:35 PM Administrative Nurse D verified R43 had a fluid restriction, and it should be recorded in the EMR. Administrative Nurse D stated the facility did not have a procedure or follow up in place to ensure the fluid parameters were being met. The facility's Fluid Restriction policy, dated 2021, documented it is the policy of this facility to ensure fluid restrictions will be followed in accordance with physician's orders. Fluid restriction are basically the restriction of fluid intake. This may be due to underlying medical conditions that may cause fluid buildup such as congestive heart failure or end state renal disease (ESRD), in addition to electrolyte imbalance disorders such as hyponatremia. Fluid restriction amounts can vary according to the resident condition and physician judgement. The fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes. The food and nutrition department will be notified by facility communication methods of the fluid restriction. Water will not be provided at bedside unless calculated into the daily total of fluid restriction. The resident has the right to refuse the fluid restriction, and if refused, documentation should support the reason for the refusal, the education of the risk and benefits, and supporting documentation of the residents continued refusal, assessment for any changes in condition related to refusal, and the notification of the physician about the resident's refusal. The facility failed to monitor R43's physician ordered fluid restriction which placed R43 at risk of complication related to hydration status.

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	175409	A. Building B. Wing	12/19/2023

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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** 27168 The facility had a census of 50 residents. The sample included 13 residents, with one reviewed for side rails. Based on observation, record review, and interview, the facility failed to assess the actual rail being used to assure safety for Resident (R)2. This placed the affected resident at risk for injury. Findings included: - R2's diagnoses included diabetes mellitus (when the body cannot use glucose), morbid obesity (being 100 pounds or more above ideal body weight), dementia (progressive mental disorder characterized by failing memory, confusion), and tremors. R2's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented R2 was independent with bed mobility and transfers. The MDS lacked documentation the resident had siderails. R2's medical record recorded a Device Assessment was completed on 11/30/23 for assist rails used by the resident as an enabling devise to provide the opportunity for safe self-positioning. Devices were reassessed quarterly and as indicated with a change in resident condition. Risk/benefits of the device were reviewed with the resident and/or responsible party. The resident and /or responsible party verbalized understanding and agreed with the use of the device and understood the potential risks of using the device including, but not limited to, bruising, skin tear, falls, feeling isolated, pressure injury, entrapment, strangulation, suffocation, and death. On 12/13/23 at 03:10 PM, observation revealed a one-half side rail on the right side of R2's bed. The side rail on the top right side and the bottom left foot of the bed with openings approximately 16.5 inches by 32 inches. On 12/13/23 at 04:00 PM, Administrative Staff A and Administrative Nurse E verified the bed rails on R2's bed had too large of openings. (continued on next page)

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	175409	A. Building B. Wing	12/19/2023

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Proper Use of Side Rails policy, dated 2020, documented it is the policy of the facility to utilize a person-centered approach when determining the use of side rails. Alternative approaches are attempted prior to installing a side or bed rail, however if used, the facility would ensure correct installation, use, and maintenance of the rails. As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether the use of side rails meet those needs. The facility would attempt to use alternatives prior to using side/bed rails. The alternatives provided shall be appropriate for the intended use of the rail. Alternatives included, but are not limited to roll guards, foam bumpers, lowering of the bed and concave mattresses. The facility will assure the correct installation and maintenance of bed rails, prior to use. The facility will provide ongoing monitoring and supervision of side/bed rail use for effectiveness, assessment of need and determination when the side/bed rail will be discontinued. The nurse would complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail. The interdisciplinary team would make decisions when the side/bed rail would be used or discontinued, or when to revise the care plan to address any residual effects of the rail. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and rails. The facility failed to assess the actual rail being used to assure safety for R2. This placed the affected resident at risk for injury.

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	175409	A. Building B. Wing	12/19/2023

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 26768 The facility had a census of 50 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility's pharmacy services failed to provide medication in the specific dosage prescribed when they packaged the pills for the facility. This deficient practice placed Resident (R) 3 at risk for an incorrect dose of medication. Findings included: - On 12/19/23 at 08:19 AM, observation revealed Certified Medication Aide (CMA) R administered a 25 milligram (mg) metoprolol (medication that lowers blood pressure and heart rate) pill to R3. The pills in the medication bubble card were not cut in half and the card stated 25 mg, give one-half tab. On 12/19/23 at 08:36 AM, Licensed Nurse (LN) H verified the order and stated the pills should have been cut in half. LN H stated the pharmacy failed to cut the pills when packaging the morning dose, however, the evening dose was correctly packaged. The facility's Provider Pharmacy Requirements policy, dated April 2020, stated the provider pharmacy would dispense prescriptions based on the authorized prescriber orders and provide medications packaged in accordance with the facility's needs and equipment. The facility's pharmacy services failed to provide medication in the specific dosage prescribed when they packaged the pills for the facility, placing R3 at risk for an incorrect dose of medication.

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	175409	A. Building B. Wing	12/19/2023

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 26768 The facility had a census of 50 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to prevent a significant medication error for Resident (R)3. This placed the resident at risk for adverse medication effects. Findings included: - On 12/19/23 at 08:19 AM, observation revealed Certified Medication Aide (CMA) R administered a 25 milligram (mg) metoprolol (medication that lowers blood pressure and heart rate) pill to R3. The pills in the medication bubble card were not cut in half and the card stated 25 mg, give one-half tab (12.5 mg) On 12/19/23 at 08:36 AM, Licensed Nurse (LN) H verified the order and said R3 should only have received 12.5 mg and stated the pill should have been cut in half to give the correct dose. The facility's Medication Administration policy, dated 2022, directed staff to compare the medication source (bubble pack) with the order, check expiration date, and administer the medication as ordered. The facility's Medication Errors policy, dated 01/01/20, stated the facility would ensure medications were administered according to the physician orders. Nurses should verify the right resident, medication, dose, route, and time of administration. The facility failed to prevent a significant medication error when R3 received twice the ordered dose of metoprolol. This placed R3 at risk for adverse medication effects.

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	175409	A. Building B. Wing	12/19/2023

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Parkview Health and Rehabilitation Center	811 N 1st Street Osborne, KS 67473

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 26768 The facility had a census of 50 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to label and store drugs and biological medications appropriately. This deficient practice placed the affatced residents at risk to receive ineffective or inappropriate medication. Findings included: - On 12/13/23 at 08:55 AM, observation in the East Hall medication room revealed the medication refrigerator temperature logs were not assessed and recorded daily. The medication refrigerator had a vial of Levemir insulin (hormone that lowers the level of glucose in the blood) without an open or expiration date. The vial of Levemir was used and contained less than half. On 12/13/23 at 08:55 AM, Licensed Nurse (LN) H verified the insulin was not dated and had not been used since the resident had gone to the hospital a couple of months ago and should have been disposed of. She verified the temperature log was not completed daily and said it should have been. The facility's Medication Storage policy, dated 01/01/20, stated medication requiring refrigeration were stored in refrigerators in the medication room and maintained within 36-46 degrees F. Refrigerator temperatures were to be recorded daily. The policy stated the medications rooms would be routinely inspected for discontinued, outdated, or deteriorated medications with illegible or missing labels and those would be destroyed according to policy. The facility's Labeling of Medications and Biologicals policy, dated 2023, stated all medications and biologicals would be labeled in accordance with federal and state requirements and current accepted pharmaceutical practices. Labels for multi-use vials must include the date the vial was initially opened or accessed and should be discarded within 28 days unless the manufacturer specifies a different date for that opened vial. The facility failed to label and store drugs and biological medications appropriately, placing residents who received refrigerated medications at risk to receive ineffective medication. 37450 - On 12/13/23 at 08:55 AM, during initial tour of facility, observation of the medication cart for the south hall with Licensed Nurse (LN) G revealed a plastic medication cup with numerous pills labeled with a B in the top drawer. LN G retrieved the medication cup and placed it on the top of the medication cart, then unlocked the lock box and pulled a medication card, popped a pill and added it the cup on the top of the cart labeled with a B. LN G then took it into Resident (R) 251's room. LN G stated medication should not be preset. On 12/19/23 at 10:12 AM, Administrative Nurse D stated the medication should not be preset. (continued on next page)

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	175409	A. Building B. Wing	12/19/2023

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Medication Administration policy, dated 11/2017, documented medications were administered by licensed nurse or other staff who are legally authorized to do so in this state, as ordered by physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review MAR to identify medication to be administered, compare medication with MAR to verify resident name, medication name, form, dose, route, and time. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. If medication is a controlled substance, sign narcotic book. The facility failed to store medication in accordance with professional standards of practice. This placed the residents at risk for incorrect or ineffective medication administration.

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	175409	A. Building B. Wing	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 29183 The facility had a census of 50 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to provide the services of a full time certified dietary manager for the 49 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 12/13/23 at 8:30 AM, observation revealed dietary staff in the kitchen prepared the breakfast meal. On 12/13/23 at 09:10 AM, Dietary Staff BB verified she was not a certified Dietary Manager. Dietary Staff BB stated the facility had four residents who required a pureed texture diet. On 12/13/23 at 2:00 PM, Administrative Staff A verified Dietary Staff BB was not certified. The Facility's Director of Food and Nutrition Services dated 2021 documented the director of food and nutrition services is responsible for all aspects of the food and nutrition services department including but not limited to food safety, cost management, and meeting nutritional need of the residents served. The director of food and nutrition services would be qualified according to the position's job description and guidelines put forth by the agency that regulates the facility. A facility that does not have a full-time dietician (registered dietician nutritionist or RDN) or clinically qualified nutritional professional must designate a person to serve as director of food and nutrition services. The director of food and nutrition services would be a certified dietary manager (CDM) or is a certified food service manager or has similar national certification for food service management and safety from an national certifying body or has an associate's or higher degree in food service management or in hospitality, if the course study includes food services or restraint management from an accredited intuition of higher learning and states that have established standards for food service managers or dietary managers, must meet state requirements for food service managers or dietary managers. The director of food and nutrition services would carry out his/her daily activities according to the job description, work schedule, and list of duties. The facility failed to employ a full time certified dietary manager to evaluate residents' nutritional concerns and oversee the ordering, preparing, and storage of food for the 49 residents in the facility, placing the residents at risk for inadequate nutrition.

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	175409	A. Building B. Wing	12/19/2023

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 29183 The facility had a census of 50 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to meet the nutritional needs of residents in accordance with established national guidelines, placing the residents at risk for unmet nutritional needs. Findings included: - On 12/13/23 at 11:30AM, observation of the lunch meal revealed the kitchen served lasagna and strawberry short cake for dessert. On 12/13/23 at 11:40AM, review of the menu for the meal to be served at lunch stated, Resident Choice Meal, lasagna, garlic bread and a vegetable to be served. On 12/13/23 at 11:50AM, Dietary Staff (DS) CC verified he did not prepare a vegetable or garlic bread to serve with the meal. On 12/14/23 at 12:30PM, DS BB verified the menu for the lunch meal on 12/13/23 was to include a vegetable and garlic bread. The facility's Meal Service policy dated 12/21, documented a menu is to be approved each month by a registered dietician. The facility failed to serve the menu items, placing the residents at risk for unmet nutritional needs.

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	175409	A. Building B. Wing	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 29183 The facility had a census of 50 residents. Based on observation, record review, and interview the facility kitchen staff failed to provide food prepared by methods that conserve nutritive value, flavor and appearance, when dietary staff failed to follow a recipe while preparing four residents' pureed diets. This placed the residents at risk for impaired nutrition. Findings included: - On 12/14/23 at 11:15 AM, Dietary Staff (DS) CC stated the facility had four residents with pureed diets. DS CC placed four pieces of roast beef into the blender container with one cup beef broth. DS CC placed it in a metal pan, covered, and placed on the steam table. Further observation revealed DS CC placed four scoops of au gratin potatoes into the blender then poured milk from the gallon jug into the blender, DS CC then placed four scoops of carrots into the blender and poured milk from the gallon jug into the blender, without following a recipe. On 12/14/23 at 11:30AM, DS CC verified he had not followed a recipe and stated he was unsure if there was a pureed recipe. On 12/14/23 at 12:30PM, DS BB stated staff should follow a recipe when preparing residents pureed diet. The facility's Texture and Consistency Diets policy, dated 2021, documented the food and nutrition services department will be responsible for preparing and serving the correct consistency of food following a recipe for desired texture. The facility kitchen staff failed to follow a recipe when preparing four residents' pureed diet. This placed the residents at risk for impaired nutrition.

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	175409	A. Building B. Wing	12/19/2023

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29183 The facility had a census of 50 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to prepare food in accordance with professional standards for food service safety when staff failed to check temperatures of food items prior to serving, failed to ensure clean and sanitary refrigerators and food preparation areas, failed to check sanitation for the dishwasher, and failed to keep food items off the floor in the food storage room. This placed the residents at risk for foodborne illness. Findings included: - On [DATE] at 08:30AM, observation of the kitchen revealed #8 freezer had food particles of yellow and orange chunks smeared on freezer surface, an open and uncovered three-gallon tub of vanilla ice cream with ice particles on top. The large upright refrigerator had a four-quart clear plastic container with white substance and brown particles in container, not labeled or dated, and a four-quart clear plastic container of shredded cheese, not labeled or dated. On [DATE] at 08:40AM, observation revealed a 12-quart uncovered metal bowl which contained a red substance in the corner of the cabinet. On [DATE] at 08:45AM, observation in the food storage stock room revealed numerous boxes on the floor. Further observation revealed one box of opened paper napkins, opened box of salt containers. On [DATE] at 09:00AM, observation revealed a three-compartment sink. Above the sink on the counter were two packages of sanitation test strips. Further observation revealed one package of test strips with an expiration date of ,d+[DATE], the other package of sanitation test strips with an expiration date of ,d+[DATE]. Dietary Staff (DS) CC stated the facility had more test strips but was unable to find them. Review of the sanitation log hanging on a clip by the sink revealed a blank document with no documentation. On [DATE] at 11:40AM, observation of the kitchen revealed a steam table with food prepared for the lunch meal. Further observation revealed a black, three-ring notebook with food temperature logs. Further observation revealed no documentation of food temperatures since [DATE] for all three meals. DS CC stated staff took food temperatures before serving but just forgot to write them in the notebook. On [DATE] at 12:40PM, observation revealed a certified nurse aide pushed a cart from the kitchen. The cart contained five resident lunchroom trays. Further observation revealed slices of uncovered pie on small plates were pushed down the north hallway. (continued on next page)

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	175409	A. Building B. Wing	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health and Rehabilitation Center	811 N 1st Street Osborne, KS 67473

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[DATE] 12:30PM, Dietary Staff BB verified the kitchen refrigerator items were to be marked and dated. Food storage room items were not to be stored on the floor and should be placed on the shelves. DS BB verified the three-compartment sink sanitation strips were expired, and the facility needed to order new strips for sanitation. DS BB stated the cook should check food temperatures before serving meals and document the temperatures on the log. DS BB said food items transported through the halls should be covered. The facility's undated Food-Supply Storage-Food and Nutrition Services Policy, documented to ensure food is stored properly products should be consumed on or before the date listed on the package of food items. Items kept in the refrigerator are to be marked and dated when opened, food items are to be kept six inches above the floor and placed on shelves, dishwashing areas and sink sanitation is to be tested daily and recorded, resident room trays are to be delivered timely and are to be covered. The facility failed to prepare food in accordance with professional standards for food service safety. This placed the residents at risk for foodborne illness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health and Rehabilitation Center	811 N 1st Street Osborne, KS 67473

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 29183 The facility had a census of 50 residents. Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal year (FY) 2023 Quarter 1, 2,3 and 4 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple days. (Quarter 1: 36 dates, Quarter 2: 27 dates, Quarter 3: 20 dates, Quarter 4: 17 dates) Review of the facility licensed nurse payroll data for the dates listed on the PBJ revealed a licensed nurse was on duty for 24 hours a day seven days a week. On 12/13/23 at 08:30AM, observation revealed a registered nurse on duty in the facility. On 12/14/23 at 01:00PM, Administrative Staff A verified the facility did not send in the correct data to CMS for payroll-based data. The facility's Reporting Payroll Based Data Journal policy, dated 12/01/2019, documented complete, and accurate direct care staffing information is to be reported electronically and, in the uniform, specified by CMS. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.

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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. 29183 The facility had a census of 50 residents. The sample included 13 residents. Based on observation, record review and interview the facility failed to provide ice water in a sanitary manner. The facility further failed to ensure appropriate infection control principles related to the use of an indwelling catheter (tube inserted directly in the bladder to drain urine) for Resident (R) 14. These deficient practices placed the residents at risk for infection. Findings included: - On 12/13/23 at 11:30AM, observation revealed Dietary Staff (DS) DD with a cart by the facility ice machine in the dining room. Further observation revealed the cart contained clear water glasses. Observation revealed DS DD used her bare hands to grab ice out of the ice machine and place in the glasses. On 12/13 23 at 11:40AM, DS DD verified she should use an ice scoop to place ice in the glasses but said the scoop holder was broken on the side of the ice machine and she did not know where the scoop was. On 12/13/23 at 11:42AM, per request, DS DD emptied the glasses and obtained new water glasses to fill with the ice using the ice scoop. On 12/13/23 at 02:30PM, Administrative Nurse D verified the dietary staff were to use an ice scoop to obtain ice for residents. The facility's policy for Passing Ice Water dated 11/01/19, documented staff are to use an ice scoop to place ice in water pitchers and glasses for residents. The facility failed to provide ice in a sanitary manner, placing the residents at risk for infection. 26768 - On 12/13/23 at 02:32 PM, observation revealed R14 sat in a wheelchair in the commons area with approximately five inches of urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) tubing sliding along the floor as she self-propelled her wheelchair around the area. On 12/14/23 at 10:21 AM, observation revealed R14 self-propelled her wheelchair to the living room with the urinary catheter tubing touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/18/23 at 01:18 PM, observation revealed Certified Nurse Aide (CNA) MM took R14 to her room, set a container on the floor, and then laid the urinary catheter collection bag on the floor to drain the tubing. CNA MM wiped the port with alcohol before and after emptying the bag of urine. She placed collection bag back into the privacy bag and hung it under the wheelchair with the tubing touching the floor. CNA MM verified it was touching the floor and stated she did not like to put too much of the tubing into the bag as another resident's catheter tubing had kinked in the bag. On 12/19/23 at 09:15 AM, CNA P stated staff should not allow the catheter tubing to drag on the floor. On 12/19/23 at 09:39 AM, Licensed Nurse (LN) H verified staff should not allow the catheter tubing to drag on the floor. She stated staff were educated regarding catheter care and tubing. On 12/18/23 at 10:00 AM, Administrative Nurse D verified staff should not allow urinary catheter tubing to drag on the floor and staff should not lay the bag on the floor. The facility's Catheter Care policy, dated 10/01/19, stated the facility would provide catheter care in an effort to reduce bladder and kidney infections. The facility failed to implement adequate infection control practices related to R14's urinary catheter. This placed the resident at risk for increased transmission of infectious disease.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 29183 The facility had a census of 50 residents. Based on record review and interview, the facility failed to ensure the staff person designated as the Infection Preventionist, who was responsible for the facility's Infection Prevention and Control Program, completed the specialized training and possessed the required certification in infection prevention and control. This placed the residents at risk for lack of identification and treatment of infections. Findings included: - On 12/13/23 at 11:00 AM, Administrative Nurse D stated she was responsible for the Infection Prevention and Control Program and verified she lacked certification as an Infection Preventionist. Administrative Nurse D stated she had not completed the training modules and had not taken the test for certification. The facility's Infection Preventionist policy, dated August 15, 2022, documented the Infection Control Preventionist is responsible for implementing the infection prevention and control program. The facility would designate a qualified individual as Infection Preventionist (IP) whose primary role is to coordinate and be actively accountable for the facility's infection prevention and control program to include the antibiotic stewardship program. The facility would ensure the IP is qualified by education, training, experience or certification. The IP would be professionally trained in nursing, medical technology, microbiology, epidemiology, or other related fields. The IP must have time necessary to properly assess, develop. Implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as Quality Assessment and Assurance. The facility failed to ensure the person designated as the Infection Preventionist possessed the required certification, placing the residents at risk for lack of identification and treatment of infections.