

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/15/2014
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 644 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A Recertification and an Abbreviated Survey investigating Complaint #KY21690 was conducted on 05/13/14 through 05/15/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E." #KY21690 was unsubstantiated with no deficiencies cited.	F 000	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan or correction is prepared and /or executed solely because it is required by law the provision of Federal and State laws."		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to provide an environment that was free from accident hazards and provide supervision to prevent avoidable accidents for one (1) of eighteen (18) sampled residents (Resident #6). The facility failed to implement and document interventions, including adequate supervision consistent with Resident #6's needs, goals, and plan of care. Staff interviews revealed Resident #6 had a history of wandering into other residents' rooms, taking personal items, and eating other residents' food.  Additionally, observation on 05/14/14 at 9:00 AM,	F 323	1. The bottle of Cid-A L11 was removed from the whirlpool room and the Virex TB disinfectant was removed by the housekeeping supervisor by 5/16/14. Resident's #6 careguide was updated on 5/16/14 to include the resident's behavior and interventions to redirect the resident during periods of wandering. Resident #6 was added to the wander list on 5/16/14.  2. An audit of the facility was completed by the Housekeeping supervisor on 5/16/14 to ensure the proper storage of chemicals. All wander's had their careplan and careguides updated to include their behaviors and interventions to address their behaviors by the Unit Managers by 5/16/14.  3. Nursing staff were educated by the DON on 6/3/14 regarding identifying wanders, ensuring behaviors are assessed, careplanned, and careguides		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*L. M. M... Director*

TITLE

(X6) DATE

6-9-14

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.

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F 323	<p>Continued From page 1</p> <p>revealed a partially used bottle of Cid-A-L II located in the unlocked whirlpool room on Wing 1, and a spray bottle approximately one-third full of Virex TB disinfectant cleaner, located in the unlocked clean linen room, on Wing 1.</p> <p>The findings include:</p> <p>1. Review of the facility's policy and procedure titled, "Behavior Management", last revised 06/17/08, revealed the facility's behavior management system addressed residents with behavior patterns that interfere with their functional capacity and ensuring these patterns were reduced or eliminated to maximize the resident's dignity, independence, and self-determination. The plan included a specific description of the behavior and interdisciplinary behavioral interventions with a monitoring system to document the specific behavioral problem and the resident's response to the intervention.</p> <p>Observation during the initial tour revealed Resident #6 resided in Room 206-1; however, on 05/14/14 at 10:05 AM through 10:15 AM, an observation revealed the resident was in [his/her] wheelchair in Room 205, and the residents who occupied that room were not in their room at the time. [He/she] was observed going through another resident's (Room 205-1) personal belongings. Further observation, on 05/14/14 at 2:40 PM, revealed Resident #6 self-propelled into another resident's room, but was redirected by staff.</p> <p>Record review revealed the facility admitted Resident #6 on 06/13/12 with diagnoses which included Mental Retardation, Aphasia, Anxiety, Depression, and Seizure Disorder.</p>	F 323	<p>are updated to include their interventions for those behaviors. All staff were also educated on properly storing chemicals behind locked doors by the ED on 6/13/14. This will also be added to our general orientation and discussed yearly at staff our staff meeting. Any staff not in attendance will be educated through a mailout of the meeting by 6/14/14.</p> <p>4. Social Workers will audit new admissions to ensure they have been assessed by nursing for wandering /behaviors and have been careplanned. They will also ensure careguides have interventions in place to address their behaviors (weekly for 4 weeks then monthly for 2 months). The housekeeping supervisor will randomly audit housekeeping staff 3 times per weeks for 4 weeks to ensure all chemicals are secured properly. The ADONs will audit 50 rooms per week times 4 weeks then monthly times 2 to ensure no chemicals are at the bedside and are all secured. The results of the audits will be presented to the QA committee to determine the need for further monitoring.</p> <p>5. Date completed:</p>	6/15/14	

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F 323	<p>Continued From page 2</p> <p>Review of Resident #6's Plan of Care, dated 05/07/14, revealed behaviors to include socially inappropriate behavior, resistant to care, and wandered at times. Approaches included redirecting from inappropriate areas, engaging in diversional activity, remove from the situation, and taking to another location as needed. Additional review revealed Resident #6 was at risk for wandering/elopement. Approaches included to redirect from all inappropriate areas, attempt to keep him/her occupied, document all wandering or exit-seeking behaviors, and be mindful of placement and the resident's needs.</p> <p>Review of Resident #6's Care Guide, dated 05/15/14, revealed no information regarding the resident's behavior, or interventions listed for redirection related to him/her wandering into other residents' rooms. Review of the facility's list of wandering residents revealed Resident #6 was not identified as a wanderer.</p> <p>Review of Residents #6's Behavior Monthly Flow Sheets for March, April, and May 2014, revealed four (4) documented episodes of socially inappropriate or disruptive behavior for the three month time frame. There was no documented evidence related to episodes of wandering for March, April, or May 2014.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1, on 05/14/14 at 2:30 PM, revealed "[he/she] goes into other residents' rooms, goes through people's drawers, and tries to eat other residents' snacks. We catch [him/her] most of the time and we redirect [him/her] back to [his/her] room or up front to the lobby".</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>Interview with SRNA #2, on 05/14/14 at 2:40 PM, revealed "[Resident #6] wandered, went into other residents' rooms, got peoples' snacks, opened doors, and wandered on a daily basis." SRNA #2 stated, "I report this behavior to the nurse".</p> <p>Interview with SRNA #3, on 05/15/14 at 9:00 AM, revealed she has seen [him/her] wandering, usually looking for something to eat or drink and stated, "some of the other residents complained about [his/her] behavior. They came to the nurse's desk or out in the hallway complaining about [Resident #6] going in their room".</p> <p>Interview with Housekeeping Aide #1, on 05/15/14 at 10:30 AM, revealed "[Resident #6]wandered into other residents' rooms all the time, especially Room 207, ate other residents' food and snacks. [He/she] was in Room 210 last week and ate the cookies out of that room". He stated, "when I observe this behavior, I report it to the nurse".</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 05/15/14 at 9:50 AM, revealed [Resident #6]'s behavior had calmed down, wandering had increased, and [he/she] went in other residents' rooms to look for their snacks. She stated, "I called the Primary Medical Doctor and received an order to increase [his/her] Ativan (anxiety medication) due to the resident's increase in wandering. Additionally, she stated, "one intervention used was to give [him/her] a magazine".</p> <p>Interview with the Dietician, on 05/15/14 at 9:10 AM, revealed "[Resident #6] liked to eat". She did not feel the resident was hungry. Review of a dietary note, dated 02/05/14, revealed the</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>resident had a significant weight gain greater than five (5) percent in one (1) month due to the appropriate intake, and the physician and guardian were notified about this weight gain on 02/05/14.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 05/15/14 at 11:55 AM, revealed he expected the staff to document Resident #8's wandering, and the resident going into other residents' rooms. He revealed he would not expect them to document daily unless there was an altercation. In regard to monitoring to ensure the resident was not going into others' rooms, he revealed, "only if the other residents complained". He revealed the plan of care should be specific to the resident's behavior with specific interventions listed, and in regard to the resident taking other residents' snacks, he stated, "I have heard about it; however, it does not happen every day".</p> <p>Interview with the Executive Director (ED), on 05/15/14 at 12:10 PM, revealed she considered wandering part of the elopement assessment. She stated there should be a plan of care in place, a care guide for SRNAs, an area in the behavior book, and staff documentation. The ED revealed she was unaware [he/she] ate other residents' snacks, and had concerns about the resident's behavior not being addressed on [his/her] plan of care.</p> <p>2. Review of the Material Safety Data Sheet (MSDS) for Cid-A-L II, dated 03/01/11, revealed Cid-A-L II was a severe skin/eye irritant. The hazardous rating was high toxicity and reactivity.</p> <p>Review of the MSDS for Virex TB, dated</p>	F 323			

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F 323	Continued From page 5 01/23/07, revealed Virex TB was moderately irritating to the eyes and mildly irritating to the skin.  Observation, on 05/14/14 at 9:00 AM, revealed the following:  a). A partially used bottle of Cid-A-L II (disinfectant/cleaner/detergent/fungicide/deodorizer/virucide), was located in the unlocked whirlpool room on Wing 1. b). A spray bottle approximately one-third full of Virex TB disinfectant cleaner, was located in the unlocked clean linen room on Wing 1.  Interview with the Executive Director, on 05/15/14 at 12:15 PM, revealed she expected staff to store chemicals behind closed doors.	F 323			
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the manufacturer's instructions, and the facility's policy/procedure, it was determined the facility failed to store food under sanitary conditions. The	F 371	1. All thickened liquids were dated by the Dietary Manager by 5/16/14.		

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F 371	<p>Continued From page 6</p> <p>facility's census was two-hundred three (203) residents with twenty-three (23) residents receiving thickened liquids.</p> <p>The findings include:</p> <p>Review of the manufacturer's instructions on the carton for honey thick lemon flavored water, nectar thick lemon flavor water, nectar thick orange juice, honey thick cranberry cocktail, nectar thick apple juice, and honey thick sweet tea, revealed to refrigerate the products after opening for up to five (5) days.</p> <p>Observation, on 05/13/14 at 9:15 AM, revealed the following cartons opened, but undated in the refrigerator:</p> <p>(1) honey thick lemon flavored water (1) nectar thick lemon flavored water (1) nectar thick orange juice (1) honey thick dairy drink</p> <p>Observation, on 05/15/14 at 9:50 AM, revealed the following cartons opened, but undated in the refrigerator:</p> <p>(6) honey thick cranberry cocktail (2) nectar thick lemon flavored water (2) nectar thick apple juice (2) honey thick sweet tea</p> <p>Interview with the Dietary Manager, on 05/15/14 at 10:00 AM, revealed she expected staff to date refrigerated items when opened.</p> <p>Interview with the Executive Director, on 05/15/14 at 12:15 PM, revealed she expected staff to date thickened liquids when opened.</p>	F 371	<ol style="list-style-type: none"> <li>2. All other thickened liquids in the facility were audited by the Dietary Manager to ensure they were dated by 5/16/14.</li> <li>3. Dietary staff were inserviced by the Dietary Manager on 5/22/14 to date any products that require refrigeration after opening. The DON educated nursing staff on the need to date any opened item that requires refrigeration by 6/13/14. This requirement will also be added to our general orientation. Any staff not in attendance will receive a copy of the staff meeting via mail by 6/14/14.</li> <li>4. The Dietary Manager will audit the kitchen refrigerators, nutrition rooms and med room refrigerators to ensure all products are dated after opened weekly for 4 weeks then monthly for 2 months. The results of the audits will be presented to the QA committee to determine the need for further monitoring.</li> <li>5. Date completed:</li> </ol>	6/15/14	

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F 490 SS-D	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's job description for the Executive Director, it was determined the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident related to one (1) repeat Life Safety Code (LSC) deficiency.</p> <p>The findings include: (Refer to K-0025)</p> <p>Review of the job description for the Executive Director, revised 04/18/13, revealed the Executive Director would provide leadership and direction for overall facility operations to provide quality resident care in accordance with all laws, regulations, and LCCA standards.</p> <p>Interview, on 05/14/14 at 8:00 AM with the Executive Director, revealed she was unaware how often the walls were being checked at the smoke barriers. She stated the walls are at the cross-corridor doors of the facility but was unaware of the walls required to extend from</p>	F 490	<ol style="list-style-type: none"> <li>The ED was shown each smoke barrier to ensure that it was sealed properly to the exterior wall on 6/3/14.</li> <li>All other smoke barriers were assessed and sealed properly as of 6/3/14 by the maint dept.</li> <li>The maintenance department was educated by the ED to monitor all smoke barrier areas from exterior wall to exterior wall during their monthly rounds on 6/2/14. The safety committee will spot check areas through an audit quarterly from this date forward.</li> <li>The Asst ED will monitor the smoke barriers monthly times 3 months to ensure they are sealed properly. The results of the audits will be presented to the QA committee to determine the need for further monitoring.</li> <li>Date completed:</li> </ol>	6/15/14	

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F 490	Continued From page 8 exterior wall to exterior wall. Further interview revealed she relied on the maintenance staff to ensure the smoke barriers were properly sealed in the facility.	F 490			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1968.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (222).</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1968 and upgraded March 2012, with 102 smoke detectors and 09 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1968.</p> <p>GENERATOR: Type II generator installed in 1996. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 05-13-14 to 05-14-14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Two-Hundred Twenty-Eight (228) beds with a census of Two-Hundred Three (203) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Edw. M. M... Dir. Director* TITLE: \_\_\_\_\_ (X8) DATE: 6-9-14

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	<p>"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan or correction is prepared and /or executed solely because it is required by law the provision of Federal and State laws."</p> <ol style="list-style-type: none"> <li>The following areas were sealed with fire retardant calk or mineral wool: ceiling at room #102, ceiling near therapy area (nutrition room), ceiling at rooms #201 and 202, ceiling at room #301, ceiling at kitchen , ceiling at #401, ceiling next to dining room, ceiling at #601and #602 around the conduits and junction box, ceiling at room #501, and the ceiling located at the room #512 was sprayed with fire-rated mastic to ensure the barriers would resist the passage of smoke between smoke compartments by the maintenance department by 6/11/14.</li> <li>All other smoke compartments were reassessed by the maintenance department on 5/16/14 to determine the need for repairs to ensure proper resistance of smoke.</li> </ol>		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect eleven (11) of twelve (12) smoke compartments, all residents, staff and visitors. The facility has the capacity for two-hundred twenty-eight (228) beds and at the time of the survey, the census was two-hundred three (203). This is a repeat deficiency from the previous survey conducted on 05/15/13.</p> <p>The findings include:</p>	K 025			

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NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
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K 025	Continued From page 2  Observation, on 05/13/14 at 9:00 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at room #102 was penetrated at the top of the block next to the roof decking.  Interview, on 05/13/14 at 9:01 AM with the Maintenance Supervisor, revealed he was unaware of the penetrations at the top of the wall.  Observation, on 05/13/14 at 9:10 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at the therapy area had a large penetration around the pipes and the heating and air unit.  Interview, on 05/13/14 at 9:11 AM with the Maintenance Supervisor, revealed he was unaware of the penetrations located in the wall.  Observation, on 05/13/14 at 9:15 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at room #201 and 202 had penetrations around conduits passing through the wall.  Interview, on 05/13/14 at 9:16 AM with the Maintenance Supervisor, revealed he was unaware of the penetrations located in the wall.  Observation, on 05/13/14 at 9:20 AM with the Maintenance Supervisor, the smoke partition, extending above the ceiling located next room #301 was not completed to the roof decking.  Interview, on 05/13/14 at 9:21 AM with the Maintenance Supervisor, revealed he was unaware the wall was not constructed completely.	K 025	3. The maintenance department was re-educated on need to increase the audits of the smoke compartments to monthly to assess for proper resistance to smoke by the Executive Director on 6/2/14. The safety committee will also spot check smoke barrier areas on a monthly basis.  4. The Asst ED will monitor the smoke barriers monthly times 3 months to ensure they are sealed properly. The results of the audits will be presented to the QA committee to determine the need for further monitoring.  5. Date completed:	6/15/14	

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K 025	Continued From page 3  Observation, on 05/13/14 at 9:30 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at the kitchen had penetrations at the top of the wall due to the sealant material being removed.  Interview, on 05/13/14 at 9:31 AM with the Maintenance Supervisor, revealed he was unaware the wall was not correctly sealed at the top of the wall.  Observation, on 05/13/14 at 9:35 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at the office next to room #401 was not complete on the side of the office.  Interview, on 05/13/14 at 9:36 AM with the Maintenance Supervisor, revealed he was unaware the wall did not extend to the exterior wall of the building.  Observation, on 05/13/14 at 9:45 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at the dining room had penetrations at the top of the wall due to the sealant material being removed.  Interview, on 05/13/14 at 9:46 AM with the Maintenance Supervisor, revealed he was unaware the sealant was removed from the top of the wall.  Observation, on 05/13/14 at 9:55 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at room #601 and 602 had penetrations around conduits and a junction box passing through the	K 025			

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K 025	<p>Continued From page 4 wall.</p> <p>Interview, on 05/13/14 at 9:56 AM with the Maintenance Supervisor, revealed he was unaware of the penetrations located in the wall.</p> <p>Observation, on 05/13/14 at 10:05 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at room #512 was a two (2) hour fire wall constructed with wood exposed at the top of the barrier..</p> <p>Interview, on 05/13/14 at 10:06 AM with the Maintenance Supervisor, revealed he was unaware the wall was not constructed properly to meet the 2 hour fire wall specifications.</p> <p>Observation, on 05/13/14 at 10:10 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located next to room #501 was penetrated at the top of the block next to the roof decking.</p> <p>Interview, on 05/13/14 at 10:11 AM with the Maintenance Supervisor, revealed he was unaware of the penetrations at the top of the wall.</p> <p>Interview, on 05/14/14 at 7:47 AM with the Maintenance Supervisor, revealed the facility has a procedure in place to leave ceiling tiles out until inspected by the maintenance staff if a contractor does work in the attic. The smoke barriers are also audited every six (6) months by the maintenance staff with the last audit completed 1/04/14. The walls are examined for any penetrations during these audits.</p> <p>Interview, on 05/14/14 at 8:00 AM with the</p>	K 025			

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K 025	<p>Continued From page 5</p> <p>Administrator, revealed she was unaware how often the walls were being checked at the smoke barriers. She stated the walls are at the cross-corridor doors of the facility but was unaware of the walls required to extend from exterior wall to exterior wall. Further interview revealed she relied on the maintenance staff to ensure the smoke barriers were properly sealed in the facility.</p> <p>The census of two-hundred three (203) was verified by the Administrator on 05/14/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/14/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration</p>	K 025		

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K 025	Continued From page 6 into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.  8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would	K 027	1. The coordinating device was replaced on smoke doors located at room #101, #301, and 501 by the maintenance department on 6/11/14. 2. The other smoke doors were assessed on 5/16/14 to ensure proper closure by the maintenance dept. 3. The Maintenance dept was educated on the need for the smoke doors to close properly to prevent smoke passage on 6/2/14 by the ED. The safety committee will add this to their spot check audits on a monthly basis. 4. The Maintenance Supervisor will monitor all smoke doors weekly times 4 weeks then monthly thereafter. The results of the audits will be presented to the QA committee to determine the need for further monitoring. 5. Date completed:	6/15/14

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K 027	<p>Continued From page 7</p> <p>resist the passage of smoke in accordance with NFPA standards. The deficient practice has the potential to affect six (6) of twelve (12) smoke compartments, seventy-two (72) residents, staff and visitors. The facility has the capacity for two-hundred twenty-eight (228) beds and at the time of the survey, the census was two-hundred three (203).</p> <p>The findings include:</p> <p>Observation, on 05/13/14 at 1:16 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at room #101 would not close completely when tested. The doors were equipped with a coordinating device that would not function properly after the initial closure.</p> <p>Interview, on 05/13/14 at 1:17 PM with the Maintenance Supervisor, revealed he was unaware the doors were supposed to close correctly after each time the doors were opened and closed.</p> <p>Observation, on 05/13/14 at 3:10 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at room #301 would not close completely when tested. The doors were equipped with a coordinating device that would not function properly after the initial closure.</p> <p>Interview, on 05/13/14 at 3:11 PM with the Maintenance Supervisor, revealed he was unaware the doors were supposed to close correctly after each time the doors were opened and closed.</p>	K 027			

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K 027	Continued From page 8 Observation, on 05/13/14 at 4:15 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at room #501 would not close completely when tested. The doors were equipped with a coordinating device that would not function properly after the initial closure.  Interview, on 05/13/14 at 4:16 PM with the Maintenance Supervisor, revealed he was unaware the doors were supposed to close correctly after each time the doors were opened and closed.  The census of two-hundred three (203) was verified by the Administrator on 05/14/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/14/14.  Actual NFPA Standard:  NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.  NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027			
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free	K 072			

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K 072	<p>Continued From page 9</p> <p>of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficient practice has the potential to affect one (1) of twelve (12) smoke compartments, twenty-four (24) residents, staff and visitors. The facility has the capacity for two-hundred twenty-eight (228) beds and at the time of the survey, the census was two-hundred three (203).</p> <p>The findings include:</p> <p>Observation, on 05/13/14 at 9:58 AM with the Maintenance Supervisor, revealed twenty-two (22) biohazard trash cans stored in the egress path at the laundry exit. The trash cans were stored on the sidewalk from 9:58 AM to 4:00 PM</p> <p>Interview, on 05/13/14 at 9:59 AM with the Maintenance Supervisor, revealed the trash cans were placed on the sidewalk because there was a delivery of them earlier in the day.</p> <p>The census of two-hundred three (203) was verified by the Administrator on 05/14/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/14/14.</p>	K 072	<ol style="list-style-type: none"> <li>The red trashcans were removed from the sidewalk and properly stored on 5/28/14 by the Maintenance supervisor to clear the sidewalk.</li> <li>All other egress pathways were assessed by maintenance to ensure they were clear on 5/16/14.</li> <li>The maintenance department was educated on 6/2/14 on the importance of keeping exit pathways clear and other staff were educated between 5/16/14 and 6/13/14 by the DON or ED. The Maintenance Director will add this standard to his general orientation for new hires.</li> <li>The housekeeping supervisor will audit 10 pathways daily (Monday – Friday) for 2 weeks then 10 pathways weekly for 2 weeks then monthly times 2 months to ensure compliance. The results of the audits will be presented to the QA committee to determine the need for further monitoring.</li> <li>Completion date:</li> </ol>	6/15/14

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K 072	Continued From page 10	K 072			
K 147 SS=E	<p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficient practice has the potential to affect eight (8) of twelve (12) smoke compartments, one-hundred thirty-two (132) residents, staff and visitors. The facility has the capacity for two-hundred twenty-eight (228) beds and at the time of the survey, the census was two-hundred three (203).</p> <p>The findings include:</p> <p>Observation, on 05/13/14 at 2:36 PM with the Maintenance Supervisor, revealed an extension cord plugged into a desk lamp in the dietician office.</p> <p>Interview, on 05/13/14 at 2:37 PM with the</p>	K 147	<ol style="list-style-type: none"> <li>1. The extension cord was removed on 5/16/14 by the Maint. Supervisor and the desk lamp was plugged into a standard receptacle. The bed in room #402 was unplugged from the power strip and plugged into a standard receptacle on 5/16/14 by the Maint. Dept. The nebulizer in room #308 was unplugged from the power strip and plugged into a standard receptacle on 5/16/14 by the maint. Dept. The microwave was unplugged from the power strip and plugged into a standard receptacle on 5/16/14 by the Maint. Dept.</li> <li>2. An audit was completed of the facility on 6/2/14 to ensure proper electrical wiring was maintained removing any extension cords and ensuring no medical equipment was plugged into power strips.</li> <li>3. The maintenance department was educated on the proper use of power strips and removing all extension cords when found immediately by the ED on 6/2/14. All other staff were educated by the ED on 6/13/14. Any associate not in attendance was sent a a mailout of the staff meeting.</li> </ol>		

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NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
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K 147	<p>Continued From page 11</p> <p>Maintenance Supervisor, revealed he was unaware of the extension cord being used for the lamp. The facility does daily audits to ensure proper electric connections in the facility.</p> <p>Observation, on 05/13/14 at 3:03 PM with the Maintenance Supervisor, revealed a resident bed in room #402 was plugged into a power strip.</p> <p>Interview, on 05/13/14 at 3:04 PM with the Maintenance Supervisor, revealed he was unaware the bed was plugged into a power strip. The facility does daily audits to ensure proper electric connections in the facility.</p> <p>Observation, on 05/13/14 at 3:33 PM with the Maintenance Supervisor, revealed a mini nebulizer in room #308 was plugged into a power strip.</p> <p>Interview, on 05/13/14 at 3:34 PM with the Maintenance Supervisor, revealed he was unaware the mini nebulizer was plugged into a power strip. The facility does daily audits to ensure proper electric connections in the facility.</p> <p>Observation, on 05/13/14 at 3:45 PM with the Maintenance Supervisor, revealed a microwave in the kitchen hall was plugged into a power strip.</p> <p>Interview, on 05/13/14 at 3:46 PM with the Maintenance Supervisor, revealed he was unaware the microwave was plugged into a power strip. The facility does daily audits to ensure proper electric connections in the facility.</p> <p>Observation, on 05/13/14 at 1:00 PM with the Maintenance Supervisor, revealed an extension cord plugged into a desk lamp located in room</p>	K 147	<p>4. The maint. Dept will audit 5 rooms down each hallway for the proper use of power strips and ensuring no medical equipment is plugged into a power strip weekly for 4 weeks then monthly for 2 months. The results of the audits will be presented to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by:</p>	6/15/14	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186171	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  05/14/2014
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	<p>Continued From page 12 #111.</p> <p>Interview, on 05/13/14 at 1:01 PM with the Maintenance Supervisor, revealed he was unaware of the extension cord being used for the lamp. The facility does daily audits to ensure proper electric connections in the facility.</p> <p>Observation, on 05/13/14 at 1:50 PM with the Maintenance Supervisor, revealed a mini nebulizer in room #911 was plugged into a power strip.</p> <p>Interview, on 05/13/14 at 1:51 PM with the Maintenance Supervisor, revealed he was unaware the mini nebulizer was plugged into a power strip. The facility does daily audits to ensure proper electric connections in the facility.</p> <p>Observation, on 05/13/14 at 2:07 PM with the Maintenance Supervisor, revealed a O2 concentrator in room #205 was plugged into a power strip.</p> <p>Interview, on 05/13/14 at 2:08 PM with the Maintenance Supervisor, revealed he was unaware the O2 concentrator was plugged into a power strip. The facility does daily audits to ensure proper electric connections in the facility.</p> <p>Observation, on 05/13/14 at 4:05 PM with the Maintenance Supervisor, revealed a resident bed in room #510 was plugged into a power strip.</p> <p>Interview, on 05/13/14 at 4:06 PM with the Maintenance Supervisor, revealed he was unaware the bed was plugged into a power strip. The facility does daily audits to ensure proper electric connections in the facility.</p>	K 147			

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NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 644 LONE OAK RD. PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 13  The census of two-hundred three (203) was verified by the Administrator on 05/14/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/14/14.  Actual NFPA Standard:  Reference: NFPA 99 (1999 edition)3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.  Reference: NFPA 70 (1999 Edition). 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147		

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NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1968.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (222).</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1968 and upgraded March 2012, with 102 smoke detectors and 09 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1968.</p> <p>GENERATOR Type II generator installed in 1996. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 05-13-14 to 05-14-14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Two-Hundred Twenty-Eight (228) beds with a census of Two-Hundred Three (203) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE			TITLE	