

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

R E C E I V E

FEB 25 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 02/03/2011
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS Division of Health Care 200 NURSING HOME Placement Branch PIKEVILLE, KY 41501
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F 000	INITIAL COMMENTS	F 000		
F 167 SS=C	<p>A standard health survey was conducted on February 1-3, 2011. Deficient practice was identified with the highest scope and severity being at "F" level.</p> <p>An abbreviated standard survey (KY15771, KY15772, KY15777) was also conducted at this time. All three allegations were substantiated with deficient practice identified.</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p>	F 167	<p>F167</p> <p>Criteria #1 Results of most recent survey placed in plain sight on 3rd floor nurses station immediately upon notification from surveyor on 2/3/11.</p> <p>Criteria #2 Any resident wanting to look at survey results would have to have asked for them on 2/3/11.</p> <p>Criteria #3 A) Survey book is now kept in wall bracket near facility entrance. B.) A sign regarding the location of the survey book was placed at facility entrance on 2/4/11. C.) Staff re-educated on importance of location of survey book by ADON on 3/4/11.</p>	3/18/2011
	<p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the results of the most recent survey and the plan of correction were readily accessible, available for examination, and a notice posted of their availability.</p> <p>The findings include: Observation of the facility from February 1-3, 2011, revealed the most recent survey results and plans of correction were in a cubicle behind</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2/25/11
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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.

Received Time Feb. 25, 2011 2:35PM No. 6564

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F 167	Continued From page 1 the third floor nurses' desk and were not readily accessible, nor were they available for examination without having to ask to see them. Observation further revealed no notice had been posted regarding the location of the previous survey results and the availability of the results to be viewed without the individual having to ask to see the results. An interview conducted with the Administrator of the facility on February 3, 2011, at 4:35 p.m., revealed the book with the survey results was usually located on the top of the third floor nurses' desk. The Administrator stated the facility had been decorating for Valentine's Day and he/she felt the book had been behind the desk at that time and should not have been. The Administrator further revealed he/she was unaware a notice had not been posted regarding the location of the survey results and the availability to be examined without individuals having to ask to see them.	F 167	D.) A letter was sent to all residents and their responsible parties informing them of the location of the survey book. E.) Admissions Coordinator will observe and log the location of the survey book daily, 5 times a week for 2 weeks, then weekly for 1 month, then monthly for 6 months. Criteria #4 Findings will be brought to the Quality Assurance meeting monthly for 6 months for review and development of action plan if indicated to ensure most recent survey results are easily accessible.	
F 204 SS-D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG	F 204	F204	3/18/2011
	A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide sufficient preparation and orientation to ensure a safe and orderly discharge from the facility for one of nineteen sampled residents. Resident #18 was discharged from the facility on January 3, 2011, without preparation or referral to ensure a safe and orderly transition.		Criteria #1 Resident # 18 was discharged from the facility on 01/03/2011.	

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F 204	Continued From page 2 The findings include: A review of the medical record for resident #18 revealed the resident was admitted to the facility on December 18, 2010, with diagnoses that included Dementia, Anxiety, Cerebral Atrophy, Coronary Artery Disease, Depression, Hypertension, Urinary Incontinence, Atrial Fibrillation, Gastroesophageal Reflux Disease, Rheumatoid Arthritis, and Hypothyroidism. A comprehensive admission Minimum Data Set (MDS) assessment with an assessment reference date of December 31, 2010, was completed by the facility. Resident #18 was assessed to exhibit short and long-term memory problems and to have moderately impaired cognitive skills for daily decision-making. The resident was further assessed to exhibit disorganized thinking and difficulty focusing attention at times, however, these patterns fluctuated according to the MDS. Resident #18 was also assessed to exhibit verbal behavioral symptoms directed at others one to three days a week. None of the identified symptoms put the resident or others at significant risk for physical injury, or significantly interfered with the resident's care, participation in activities, or significantly intruded on the privacy or activity of others. A review of the nurse's notes dated January 1, 2011, at 8:30 a.m., revealed resident #18's roommate was yelling for help. When staff arrived resident #18 was over in her/his roommate's area and the roommate had red marks on the forehead, the bridge of the nose, and the chin with no open areas noted. The nurse's notes further revealed the resident was assisted back to bed and the physician,	F 204	Criteria # 2 Clinical records of all residents discharged to home from 09/01/2010 through 02/22/2011 reviewed by the interdisciplinary team for discharge planning. Review consisted of Physician's order for discharge, referrals to community services, Pharmacy notification, education/instructions, and physical assessment prior to discharge. Criteria #3 A) Social Services Director re-educated on discharge planning to home, both planned and immediate by Regional Quality Specialist on 2/23/11. B) Licensed staff re-educated by Director of Nursing/Assistant Director of Nursing on resident discharge preparation and orientation to ensure a safe and orderly discharge to home on 3/4/11.		

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F 204	<p>Continued From page 3</p> <p>responsible party, Adult Protective Services, and the Director of Nursing (DON) were notified. There was no evidence any additional incidents occurred.</p> <p>A review of the Social Service notes dated Monday, January 3, 2011, revealed the Social Worker (SW) called resident #18's son to inform him the resident was being discharged immediately due to the incident that occurred on Saturday, January 1, 2011. Further review of the SS note revealed the resident's son asked the SW if he could make some calls before resident #18 was released. The resident's son called the SW back with telephone numbers of facilities near his home. The resident's son called back again and told the SW to go ahead and send resident #18 to his home.</p> <p>A review of the facility's Transfer/Discharge-Outside the Facility, revised July 2009, revealed transfers or discharges initiated by the facility and not by the resident may require the completion of a state specific process and documentation. Federal regulation required that a facility may only transfer or discharge a resident in the following circumstances: Transfer of discharge is necessary to meet the needs of the resident and cannot be met in the facility; Transfer or discharge is appropriate because the health of the resident has improved sufficiently that the resident no longer requires services of the facility; Health and/or safety of individuals in the facility would be endangered; The resident has failed to pay for services or the facility ceases to operate.</p> <p>A review of the physician's progress note dated January 3, 2011, revealed the physician wrote,</p>	F 204	<p>C.) Prior to discharge home, resident records will be reviewed by Inter Disciplinary Team to ensure appropriate documentation is present and referrals are made as needed for 6 months.</p> <p>D.) DON/ADON will review records of residents discharged home monthly for 6 months to ensure appropriate documentation and referrals have been made.</p> <p>Criteria #4</p> <p>Findings will be brought to the Quality Assurance meeting monthly for 6 months for review and development of action plan if indicated to ensure a safe and orderly discharge from the facility occurs.</p>	

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F 204	<p>Continued From page 4</p> <p>"[Resident #18] has had combative behavior. The resident has assaulted two staff members and a resident. Due to this combative behavior the resident's needs will be better served in a behavior unit."</p> <p>An interview with the Administrator conducted on February 3, 2011, at 11:00 a.m., revealed the Administrator and the Interdisciplinary Team met on Monday, January 3, 2011, and based on the resident's "violent" behavior on January 1, 2011, decided to discharge resident #18 immediately. According to the Administrator, the facility did not implement any interventions following the behavior displayed by resident #18 on Saturday, January 1, 2011, until Monday, January 3, 2011, when the IDT met. The Administrator stated either every 15-minute checks or one-to-one observations should have been done, however, there was no evidence any special precautions were initiated. According to the Administrator, other residents in the facility had combative behaviors, but not to the extent of resident #18's combative behaviors. The Administrator stated the resident who was hit by resident #18 did not require evaluation by a physician or emergency treatment. The Administrator further stated the IDT did not consider referring the resident to a behavior unit as recommended by the physician.</p> <p>An interview conducted with the DON on February 3, 2011, at 1:00 p.m., revealed the DON was not present in the facility, but was notified of the incident by staff on January 1, 2011, between resident #18 and the roommate. The DON stated she gave instructions to separate the residents, but did not direct staff to initiate every 15-minute checks or one-to-one observations. The DON did not believe resident #18 was a threat to other</p>	F 204			

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F 204	<p>Continued From page 5</p> <p>residents for the two days without special supervision. The DON further stated the roommate's yelling may have caused resident #18 to be agitated that day. The DON stated she was unable to remember if the IDT discussed sending a "violent" resident home, or if a home health referral was made, or if the physician's recommendation was discussed. The DON stated the IDT should have attempted to refer resident #18 to a behavior unit as suggested by the physician.</p> <p>An interview with the facility's Social Worker (SW) conducted on February 3, 2011, at 10:45 a.m. and 1:35 p.m., revealed the SW was informed by the Administrator on Monday morning, January 3, 2011, to issue an immediate discharge order for resident #18 due to the incident that occurred on Saturday, January 1, 2011. The SW stated she called the resident's son to inform him of the immediate discharge and he asked for some time to find a place for the resident. The SW stated she did not ask the son if he was able to care for the resident or if he was able to purchase the resident's medications or if he knew how to administer medications. The SW further stated she "just assumed" he could care for the resident. The SW also stated she did not attempt to assist the resident to find placement even after the resident's son provided telephone numbers of local facilities.</p> <p>An interview with the resident's son conducted on February 2, 2011, at 3:00 p.m., and February 3, 2011, at 3:15 p.m., revealed the facility called him on Monday morning, January 3, 2011, to inform him that resident #18 was being immediately discharged from the facility due to violent behavior which occurred on January 1, 2011.</p>	F 204		

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F 204	Continued From page 6 The son stated he told the facility staff neither he nor his wife was physically able to care for the resident. The resident's son stated he asked the facility staff to allow him some time to attempt to find placement for the resident, which they agreed to do as long as the discharge was January 3, 2011. The resident's son was unable to find a place on such short notice. The son stated he finally called the facility back and told them to send the resident to his home. The facility agreed to call the resident's medications to the pharmacy near the son's home. According to the resident's son, the resident arrived at his home at 11:00 p.m. on January 3, 2011, and was extremely anxious and frightened. According to the son, the resident arrived home without the resident's coat or eyeglasses. The son was not able to obtain the resident's medications until the following day, January 4, 2011, as the pharmacy had not received the prescriptions the previous evening until 15 minutes prior to closing. The resident's son further stated no one had mentioned referral to a behavior unit to him and that he would have been agreeable if it would have helped the resident. According to the son, he was able to keep resident #18 at home until January 5, 2011, when the resident was admitted to the hospital with a diagnosis of pneumonia.	F 204		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a	F 225	F225 Criteria #1 Resident #18 was discharged from facility on 01/03/2011.	3/18/2011

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F 225	<p>Continued From page 7</p> <p>court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to report an allegation of abuse to the appropriate state agency timely. Resident #18 was involved in a resident-to-resident altercation on January 1, 2011, however, this was not reported to the State Survey and Certification Agency immediately.</p>	F 225	<p>Criteria # 2</p> <p>All self reported incidents to the State Survey and Certification Agency from 09/01/2010 through the present audited by the Administrator to ensure there was an initial notification of the incident and a 5 day follow up report of the facility investigation.</p> <p>Criteria #3</p> <p>A) Administrator, Director of Nursing and Assistant Director of Nursing re-educated on policy of self reporting by Regional Quality Specialist on 2/23/11.</p> <p>B) Licensed staff re-educated on the abuse policy by the Director of Nursing./ Assistant Director of Nursing on 3/4/11.</p> <p>C) Self reported incidents will be reviewed by the Administrator within 24 hours of initial report for timely notification of appropriate state agencies for 6 months.</p>	

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F 225	<p>Continued From page 8</p> <p>The findings include:</p> <p>A review of an investigation regarding a resident-to-resident altercation which occurred on January 1, 2011, revealed the incident was reported to Adult Protective Services but not to the State Survey and Certification Agency immediately as required.</p> <p>According to the investigation, on January 1, 2011, a staff nurse heard a resident call for help and found resident #18 standing over the bed of another resident. The other resident had reddened areas on the face, however, no open areas were identified. The staff separated the residents and no further incidents occurred. The investigation further revealed the resident with the reddened areas developed discolored/bruised areas. According to the investigation both residents were alert and oriented to name only and no history of physical violence had been known for either resident.</p> <p>An interview conducted with the staff nurse on February 3, 2011, at 11:25 a.m., revealed the staff nurse notified the Director of Nursing (DON) when the incident occurred on January 1, 2011, and was instructed to notify the physician, responsible party, and Adult Protective Services. The staff nurse stated he/she was not instructed to call the State Survey and Certification Agency.</p> <p>An interview with the DON conducted on February 3, 2011, at 1:00 p.m., revealed the DON was not present in the facility when the incident occurred. The DON stated she was notified by telephone of the incident by staff and instructed the staff member to notify Adult Protective Services. The DON stated she called the State</p>	F 225	<p>Criteria #4</p> <p>Findings will be brought to the Quality Assurance meeting for review and development of action plan to ensure that self reported incidents are called to the State Survey and Certification Agency in a timely manner, monthly for 6 months.</p>	

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F 225	Continued From page 9 Survey and Certification Agency and left a message on the voice mail of one of the surveyors. The DON stated she did not follow up on Monday, January 3, 2011, to ensure the message was delivered and there was no evidence the call was made. An interview with the State Surveyor on February 3, 2011, at 1:30 p.m., revealed the Surveyor did not have a voice mail regarding this incident. An interview with the Medical Records (MR) staff conducted on February 3, 2011, at 12:55 p.m., revealed the MR staff faxed a summary of the investigation to the State Survey Agency on January 6, 2011, five days after the incident occurred. The MR stated he/she did not initially report the incident because the incident occurred over a weekend and the MR was not on duty.	F 225			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide medically related social services for one of nineteen sampled residents. Resident #18 was discharged from the facility with no evidence that Social Services assisted the resident/family with discharge planning and/or making referrals from outside entities.	F 250	F250 Criteria #1 Resident #18 was discharged from the facility 01/03/2011	3/18/2011	

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F 250	<p>Continued From page 10</p> <p>The findings include:</p> <p>A review of the medical record for resident #18 revealed the resident was admitted to the facility on December 18, 2010, with diagnoses that included Dementia, Anxiety, Cerebral Atrophy, Coronary Artery Disease, Depression, Hypertension, Urinary Incontinence, Atrial Fibrillation, Gastroesophageal Reflux Disease, Rheumatoid Arthritis, and Hypothyroidism. A comprehensive admission Minimum Data Set (MDS) assessment with an assessment reference date of December 31, 2010, was completed by the facility. Resident #18 was assessed to exhibit short and long-term memory problems and to have moderately impaired cognitive skills for daily decision-making. Resident #18 was also assessed to exhibit verbal behavioral symptoms directed at others one to three days a week. The resident was further assessed to be frequently incontinent of bowel and bladder, to be unsteady and require human assistance with transitions and walking. In addition resident #18 had a Stage IV pressure sore, was totally dependent on staff for bathing and hygiene, and required a pureed diet.</p> <p>A review of the physician's progress note dated January 3, 2011, revealed the physician wrote, "[Resident #18] has had combative behavior. The resident has assaulted two staff members and a resident. Due to this combative behavior the resident's needs will be better served in a behavior unit."</p> <p>A review of the Social Service notes dated Monday, January 3, 2011, revealed the Social Worker (SW) called resident #18's son to inform him the resident was being discharged</p>	F 250	<p>Criteria #2</p> <p>Clinical records of all residents discharged to home from 09/01/2010 through 02/22/2011 reviewed by the interdisciplinary team for discharge planning. Review consisted of presence of documentation that the Social Services Director assisted resident/family with discharge planning and/or making referrals to outside entities.</p> <p>Criteria #3</p> <p>A) Social Services Director re-educated by Regional Quality Specialist on discharge planning on 2/23/11.</p> <p>B) Licensed staff re-educated on policy for discharge planning and discharge instructions by Director of Nursing/Assistant Director of Nursing on 3/4/11.</p> <p>C) Prior to discharge home, resident records will be reviewed by the Inter</p>		

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F 250	<p>Continued From page 11</p> <p>immediately due to the incident that occurred on Saturday, January 1, 2011. Further review of the SS note revealed the resident's son asked the SW if he could make some calls before resident #18 was released. The resident's son called the SW back with telephone numbers of facilities near his home. According to the note, the resident's son called back again and told the SW to go ahead and send resident #18 to his home.</p> <p>According to the nurse's notes, resident #18 was discharged from the facility on January 3, 2011, at 7:00 p.m.</p> <p>A review of the Post-Discharge Plan of Care revealed the resident was given the name and phone number of the district ombudsman and instructions to "follow up with your primary Dr. as soon as possible." The "Community Resources and Services Planning" section of the Plan of Care was blank with a line marked through it. Further instructions included to blenderize foods, avoid salt, and apply diaper rash cream to the buttocks three times a day. A list of 24 medications to be given daily was included. There was no signature on the form to indicate who had prepared or who had received these instructions.</p> <p>An interview with the Administrator conducted on February 3, 2011, at 11:00 a.m., revealed the Administrator and the Interdisciplinary Team (IDT) met on Monday, January 3, 2011, and based on the resident's behavior on January 1, 2011, decided to discharge resident #18 immediately. The Administrator further stated the IDT did not consider referring the resident to a behavior unit as recommended by the physician or obtaining any other services for resident #18.</p>	F 250	<p>Disciplinary Team to ensure appropriate documentation is present and referrals are made as needed for 6 months.</p> <p>D.) DON/ADON will review records of residents discharged to home monthly for 6 months to ensure appropriate documentation and referrals have been made.</p> <p>Criteria #4</p> <p>A.) Findings will be brought to the Quality Assurance meeting monthly for 6 months for review and development of action plan if indicated to ensure a safe and orderly discharge from the facility occurs</p>	

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F 250	<p>Continued From page 12</p> <p>An interview conducted with the Director of Nursing (DON) on February 3, 2011, at 1:00 p.m., revealed the DON was unable to remember if the IDT discussed sending a "violent" resident home, or if a home health referral was made, or if the physician's recommendation was discussed. The DON stated the IDT should have attempted to refer resident #18 to a behavior unit as suggested by the physician.</p> <p>An interview with the resident's son conducted on February 2, 2011, at 3:00 p.m., and February 3, 2011, at 3:15 p.m., revealed the facility called him on Monday morning, January 3, 2011, to inform him that resident #18 was being immediately discharged from the facility due to violent behavior which had occurred on January 1, 2011. The son stated he told the facility staff neither he nor his wife was physically able to care for the resident. The resident's son stated he asked the facility staff to allow him some time to attempt to find placement for the resident. The resident's son was unable to find a place on such short notice and stated he finally called the facility back and told them to send the resident to his home. The facility agreed to call the resident's medications to the pharmacy near the son's home. According to the resident's son, the resident arrived at his home at 11:00 p.m. on January 3, 2011, and was extremely anxious and frightened. According to the son, the resident arrived home without the resident's coat or eyeglasses. The son was not able to obtain the resident's medications until the following day, January 4, 2011, as the pharmacy had not received the prescriptions the previous evening until 15 minutes prior to closing. The resident's son further stated no one had mentioned a</p>	F 250		

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F 250	Continued From page 13 referral to a behavior unit to him and that he would have been agreeable if it would have helped the resident. The resident was admitted to the hospital with a diagnosis of pneumonia on January 5, 2011. An interview with the facility's Social Worker (SW) conducted on February 3, 2011, at 10:45 a.m. and 1:35 p.m., revealed the SW was informed by the Administrator on Monday morning, January 3, 2011, to issue an immediate discharge order for resident #18 due to the incident that occurred on Saturday, January 1, 2011. The SW stated he/she called the resident's son to inform him of the immediate discharge and he asked for some time to find a place for the resident. The SW stated she did not ask the son if he was able to care for the resident, if he was able to purchase the resident's medications, or if he knew how to administer medications and care for the resident. The SW further stated she "just assumed" he could care for the resident. The SW also stated she did not attempt to assist the resident to find placement in another facility or with obtaining follow-up care.	F 250			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to follow physician's orders for three of nineteen sampled residents. Resident #1 was not provided with a personal alarm which had been ordered by	F 281	F281 Criteria #1 A) Resident #1 had Physician order review on 2/2/11 with personal alarm administered per order. B) Resident #4 had Physician order review on 2/2/2011 with Oxygen administered per order.	3/18/2011	

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F 281	<p>Continued From page 14</p> <p>the resident's physician. Resident #4 was not administered oxygen therapy as ordered by the physician. Resident #9 had a physician's order to be provided a Magic Cup with the dinner meal, and this was not provided.</p> <p>The findings include:</p> <p>1. A review of the medical record revealed resident #1 was admitted to the facility on February 20, 2010, with diagnoses of Immobility, Seizure Disorder, Anxiety, Hypertension, and Constipation. A review of the physician's orders dated February 20, 2010, revealed a physician's order for resident #1 to have a bed alarm and personal alarm at all times. Further review of monthly physician's orders from the admission date to current (February 1, 2011) revealed resident #1 was ordered a bed alarm and a personal alarm at all times.</p> <p>Observation on February 2, 2011, at 9:00 a.m., revealed resident #1 was sitting up in a padded wheelchair. Further observation revealed resident #1 did not have a personal alarm attached and no personal alarm was observed in resident #1's room. Registered Nurse (RN) #2 conducted an observation with the surveyor on February 2, 2011, at 9:05 a.m. RN #2 confirmed resident #1 did not have a personal alarm. RN #2 revealed he/she was aware the resident required a bed alarm, however, was unaware a personal alarm was ordered for resident #1.</p> <p>An interview conducted on February 2, 2011, at 10:00 a.m., with the Administrator revealed the Minimum Data Set (MDS) Coordinator documents any intervention/physician's order on the care plan. The MDS Coordinator then completed a</p>	F 281	<p>C) Resident #9 had Physician's order reviewed on 2/2/2011 with Magic Cup placed on tray.</p> <p>Criteria #2</p> <p>A) Clinical records reviewed for safety alarms, oxygen settings and supplements to include Magic Cup to be provided on trays. B) Physician notified for clarifications of orders if indicated C) Care plans reviewed and revised.</p> <p>Criteria #3</p> <p>A) Licensed staff re-educated by the Director of Nursing /Assistant Director of Nursing on importance of following physician orders on 3/4/11. B) Unit Managers will monitor and log safety alarms placement and function, oxygen settings, and supplements on trays once daily 5 times a week for 4 weeks, then weekly for 6 months. Discrepancies will be reported to the Director of Nursing for development of action plan if needed.</p>		

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F 281	<p>Continued From page 15</p> <p>communication sheet with the care plan interventions and sent the communication sheet to all relevant staff. The Administrator further stated the CNA Preceptor should have received a communication sheet with orders for resident #1 to have a bed alarm and personal alarm at all times. The Administrator stated the CNA Preceptor should have documented this information on the Certified Nurse Aides' (CNA) daily assignment sheet. During this interview with the Administrator, the CNA Preceptor entered the room, and revealed he/she was unaware resident #1 had a physician's order for a personal alarm. The CNA Preceptor could not provide daily assignment sheets, she/he stated the assignment sheets were shredded at the end of a 24-hour shift, and then the CNAs received a new assignment sheet.</p> <p>2. A review of the medical record for resident #4 revealed resident #4 was admitted to the facility with diagnoses to include Generalized Muscle Weakness, Alzheimer's Disease, Hypertension, Diabetes Mellitus, Gastroesophageal Reflux, Atrial Fibrillation, Depression, and Anxiety.</p> <p>A review of the physician's orders revealed resident #4 had an order for oxygen to be administered at two liters per minute. Observation of resident #4 at 4:00 p.m., 4:25 p.m., 5:45 p.m., and 6:25 p.m. on February 1, 2011, and further observations at 8:40 a.m., 9:38 a.m., 10:30 a.m., and 11:37 a.m. on February 2, 2011, revealed oxygen was administered to resident #4 at three liters per minute.</p> <p>An interview was conducted with a Licensed Practical Nurse (LPN) at 4:50 p.m. on February 2, 2011. The LPN reviewed the physician's orders</p>	F 281	<p>Criteria #4</p> <p>Findings will be brought to the Quality Assurance meeting monthly for 6 months for review and development of action plan if indicated to ensure Physician orders are followed.</p>	
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F 281	<p>Continued From page 16 for resident #4, and the LPN confirmed the physician's order for oxygen for resident #4 was to be administered at two liters per minute. However, the LPN was unable to explain why the oxygen had been administered to resident #4 at three liters per minute.</p> <p>3. A review of the medical record for resident #9 revealed the resident had been admitted to the facility on February 8, 2005, with diagnoses to include Mental Retardation, Gastroesophageal Reflux, Malaise, and Fatigue. A review of resident #9's physician's orders dated January 14, 2011, revealed an order to provide a Magic Cup with the dinner meal.</p> <p>Observation of the dinner meal on February 1, 2011 and February 2, 2011, revealed the resident was not provided a Magic Cup on his/her tray.</p> <p>An interview conducted with the Dietary Manager (DM) for the facility on February 2, 2011, at 6:00 p.m., revealed the Dietary Department had not been notified of the physician's order dated January 14, 2011, to provide a Magic Cup with the dinner meal. The DM stated the nurse taking the order was responsible to ensure the diet order change was communicated to the Dietary Department by filling out a communication sheet and placing the sheet in the box provided outside the Dietary Department.</p> <p>An interview conducted on February 2, 2011, at 6:10 p.m., with the Registered Nurse (RN) responsible for taking the physician's order for the Magic Cup to be provided to resident #9, revealed the RN did not remember taking the physician's order. The RN further stated he/she should have written the diet order change on a communication</p>	F 281		

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F 281	Continued From page 17 slip and ensured the slip was placed in the box outside the Dietary Department. The RN stated it was his/her responsibility to ensure the order was sent to the Dietary Department and was unsure why the order had not been sent.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide the necessary care and services to attain/maintain the highest practicable physical, mental, and psychosocial well-being for one of nineteen sampled residents. Resident #4 was observed on February 2, 2011, lying in bed for more than two hours with the roommate's bedside commode (uncovered) containing feces within four feet of resident #4's head. The findings include: A review of the medical record for resident #4 revealed resident #4 was admitted to the facility with diagnoses to include Generalized Muscle Weakness, Alzheimer's Disease, Hypertension, Depression, and Anxiety. Further record review revealed resident #4 responded to verbal stimuli with eye movement.	F 309	F309 Criteria #1 Bedside commode cleaned at time of surveyor notification on 2/2/11. Criteria #2 A) All bedside commodes assessed for cleanliness and disinfection and cleaned/disinfected if needed on 2/2/11. Criteria #3 A) Nursing staff re-educated on use and cleaning of bedside commodes ADON on 3/4/11.	3/18/2011

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F 309	<p>Continued From page 18</p> <p>Observation of resident #4 at 9:30 a.m. on February 2, 2011, revealed the resident was awake, lying in bed, and responded to verbal stimuli by moving the resident's eyes toward the speaker. Further observation revealed resident #4's roommate had a bowel movement and urinated prior to 9:30 a.m. on February 2, 2011, in a bedside commode (BSC) which was located approximately four feet from resident #4's head.</p> <p>Further observation at 11:05 a.m. on February 2, 2011, revealed feces and urine remained in the roommate's BSC. However, a pillow had been placed on the BSC top.</p> <p>An interview was conducted with the roommate of resident #4 at 11:30 a.m. on February 2, 2011. The roommate stated that he/she had urinated and had a bowel movement in the BSC prior to going to the group interview at 9:30 a.m. on February 2, 2011.</p> <p>An interview was conducted with the certified nurse assistant (CNA) responsible for resident #4 at 11:37 a.m. on February 2, 2011. The CNA stated he/she had just cleaned the BSC for the roommate of resident #4. The CNA stated he/she thought another CNA had already cleaned the BSC and that was the reason it had not been cleaned earlier.</p>	F 309	<p>B) Unit Managers will observe cleanliness of bedside commodes randomly, daily 5 times a week for 1 month, then weekly for 3 months. Any issues will be addressed immediately with education. Results of observation will be brought to DON for development of action plan as needed.</p> <p>Criteria #4</p> <p>A) Findings will be brought to the Quality Assurance meeting monthly for 6 months for review and development of action plan if indicated to ensure necessary care and services are provided.</p>	
F 364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p>	F 364	<p>F364</p> <p>Criteria #1</p> <p>A) Replacement trays were offered immediately.</p> <p>B) Coffee replacement offered.</p>	3/18/2011

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F 364	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide foods/liquids that were palatable and at the proper temperature during the noon meal on February 2, 2011. The findings include: Observation of the noon meal service on February 2, 2011, revealed the food cart was delivered from the kitchen to the Long Hall on the fifth floor at 11:45 a.m. The last tray was removed from the cart at 12:15 p.m., 30 minutes after the cart was delivered to the floor. A food temperature and palatability test was conducted of the food items from the last tray with facility staff. The food temperatures revealed the baked potato was 110 degrees Fahrenheit, the mixed vegetables were 118 degrees Fahrenheit, the baked chicken drumstick was 98 degrees Fahrenheit, and the roll was 102 degrees Fahrenheit. The palatability test revealed the baked potato tasted warm, the mixed vegetables tasted warm but bland, the baked chicken drumstick tasted tepid, and the roll tasted warm on the inside but cold on the outside. In addition, coffee temperatures observed on February 3, 2011, at 8:15 a.m., revealed the coffee temperature on the third floor was 135.6 and was cool to taste. An interview conducted with resident #3 on February 3, 2011, at 11:55 a.m., revealed the resident stated foods were frequently cold to taste and frequently tasted bland. Resident #3 also	F 364	Criteria #2 A) Any resident that received a tray on 3 rd , 4 th , and 5 th floors from the dietary department food carts had the potential to receive a tray with food at improper temperature, impacting flavor, appearance, and nutritive value. Criteria #3 A) Nursing staff re-educated on tray pass and importance of timeliness to ensure proper food temperatures by the Assistant Director of Nursing on 3/4/11. B) Dietary staff was re-educated on importance of menu/ tray seasoning by the dietary manager on 3/4/11. C.) Replaced facility plate low rater on 2/8/11. D.) Dietary Manager will observe tray delivery 2 meals daily for 5 days, then 5 meals per week randomly for 3 months to ensure timeliness of tray pass, correct food/coffee temperatures, following of menu seasoning and palatability of food. Trays will be replaced as needed. Re-education of staff will be provided by Dietary Manager as needed immediately.	

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F 364	Continued From page 20 verbalized concerns related to cold coffee. A group interview was conducted on February 2, 2011, at 10:00 a.m., with 15 alert/oriented residents. These residents reported that foods were frequently cold for all meals and had little seasoning. These residents also stated coffee was frequently served cold. An interview conducted with the DM on February 3, 2011, at 5:30 p.m., revealed the food trays should be distributed to the residents within 15 minutes after the food cart has been delivered to the floor. The DM stated test trays were conducted weekly to evaluate/monitor food temperatures and/or palatability. The DM stated the facility had identified that tray delivery exceeded the 15-minute timeframe; however, no problems had been identified with cold food temperatures and palatability. The DM also stated the facility did not have a specific policy/procedure related to meal service. In addition, the DM stated the coffee brewed at 160-165 degrees Fahrenheit; however, a review of the coffee temperature logs revealed the temperatures ranged from 146-154 degrees Fahrenheit.	F 364	E.) Administrator/Assistant Administrator will taste tray for palatability and appropriate coffee temperatures 3 times a week randomly on an ongoing basis. F.) Administrator will review resident council minutes once monthly for three months to monitor resident food/coffee concerns. Criteria #4 Results of Dietary Manager meal observation and Administrator/Assistant Administrator test tray will be presented monthly to QA committee for development of action plan as indicated.	
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.	F 372	Criteria #1 Garbage removed from trash compactor by maintenance Director and disposed of in County Garbage Dump on 02/07/2011	3/18/2011

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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F 372	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store garbage and refuse properly to prevent the harborage of insects, rodents, roaches, and other insects. Observation of the facility dumpsters on February 1, 2011, revealed the large dumpster was completely full, and was not covered. The trash compactor had multiple bags of garbage stacked on top of it. The findings include: During an initial tour of the facility on February 1, 2011, at 2:30 p.m., the dumpster was observed to be completely full of garbage, uncovered, and with multiple bags of trash lying on top of the trash compactor. An interview conducted with the facility's Maintenance Supervisor (MS) on February 3, 2011, at 4:30 p.m., revealed the facility did not have a policy regarding trash. The MS stated the facility's trash compactor had been in need of repair for approximately two weeks. The MS further stated the trash compactor required additional hydraulic fluid; however, the temperature outside had been too cold to pour the fluid in the trash compactor. The MS further stated the dumpster should have been covered, and no trash should have been placed on top of the trash compactor. The MS further revealed the facility calls the garbage company when the dumpster requires emptying.	F 372	All residents have potential to be affected. Criteria #3 A) Staff re-educated by ADON on appropriate placement of trash in dumpster and ensuring the lid is closed on 3/4/11. B) Maintenance Department re-educated on trash compactor maintenance and reporting of maintenance issues timely by Administrator on 2/3/11. C) Maintenance Department to monitor proper function of trash compactor and appropriate placement of trash in dumpster daily, 5 times a week for 6 months. Any problems will be reported to Administrator immediately for development of action plan if needed. D.) Administrator to tour outside of building weekly to ensure trash is in compactor and lid is closed. Criteria #4 A) Administrator to tour outside of building weekly to ensure trash is in compactor and lid is closed B) Findings will be brought to the Quality Assurance meeting monthly for 6 months for development of action plan if indicated to ensure appropriate disposal of garbage.		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			

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F 431	<p>Continued From page 22</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule-II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to assure all drugs and biologicals are stored under</p>	F 431	<p>F431</p> <p>Criteria #1</p> <p>A) Temperature was adjusted in medication room on 3rd floor on 2/3/11. B.) Albuterol sulfate was discarded and reordered from pharmacy on 2/3/11.</p> <p>Criteria #2</p> <p>A) Temperature assessed in all rooms containing the storage of medications and biologicals and all met guidelines on 2/3/11.</p> <p>Criteria #3</p> <p>A) Licensed staff re-educated by Director of Nursing/Assistant Director of Nursing on correct temperature range for med rooms and the importance of temperature maintenance regarding the storage of drugs and biologicals on 3/4/11.</p>	3/18/2011
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F 431	Continued From page 23 proper temperature controls. The medication room contained two boxes of Albuterol Sulfate for nebulizer treatments, which were being stored at improper temperature levels. The findings include: Observation of the facility's medication room on the third floor of the facility on February 3, 2011, at 1:00 p.m., revealed two boxes of Albuterol Sulfate 0.083% for nebulizer treatments were being stored in the medication cart. The manufacturer's labels for the drugs stated to store the medications at a temperature of 36-77 degrees Fahrenheit. Observation on February 3, 2011, at 1:00 p.m., further revealed the temperature of the medication room was 83.5 degrees Fahrenheit. An interview with the Unit Manager (UM) for the third floor of the facility conducted on February 3, 2011, at 1:25 p.m., revealed temperatures were routinely monitored in the medication room, however, the UM was unable to provide documentation that the medication room temperatures had been checked, nor a policy regarding the checking of the medication room temperatures. According to the UM, the midnight shift nurse was responsible for checking the temperature of the medication room. The UM further revealed the staff was required to fill out a maintenance request form if the room temperature was greater than 77 degrees Fahrenheit. The maintenance request form was then placed on the maintenance bulletin board. According to the UM the Maintenance Department checked several times daily for communication slips.	F 431	B) The night shift nurse will log the medication room temperatures nightly, and complete Maintenance requests as indicated for incorrect temperatures. C) Unit Managers will monitor temperature logs weekly for 4 weeks, then monthly for 3 months. Any discrepancies will be addressed immediately by education and/or maintenance notification Criteria #4 A) Findings will be brought to the Quality Assurance meeting monthly for 6 months for review and development of action plan if indicated to ensure medications and biologicals are stored under the proper temperature controls.		
F 465	483.70(h)	F 465			

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F 465 SS=E	Continued From page 24 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Cracked tiles were observed in five resident rooms, cracked tile in one hallway, one loose sink, three stained bathtubs, one hard to close door to a Central Bath, four resident rooms with stained ceiling tiles, seven chipped doors to resident rooms, one chipped bathroom door, one shower with no curtain, eight resident rooms with torn drywall, one bathroom with torn linoleum, three chipped closet doors in resident rooms, one loose sink baseboard, loose tile under one resident sink, one resident room with rough and cracked windowsill, three ice dispensers in need of cleaning, one ice dispenser in which the water did not flow freely, one nurses' station with sharp edges on the countertop, one resident room with a hole in the wall, one toilet with loose handrails, and one hallway with dirty walls along both sides of entire hallway. The findings include: During the environmental tour of the facility on February 1-3, 2011, the following items were observed to be in need of repair:	F 465	F465 Criteria #1 A) Cracked tiles in room 312-2, 316 bathroom, 404 bathroom, and sink in room 409 will be repaired by 3/4/2011. B) Cracked tile in hallway between resident rooms 315-317 will be repaired by 3/4/2011 C) Loose sink in Central Bath 3 rd floor was replaced on 2/14/2011. D) Shower Central Bath 3 rd floor had shower curtain replaced on 2/12/2011. E) Tubs in Central Bath 3 rd , 4 th , and 5 th floors were cleaned on 2/3/2011. F) Door to Central Bath 3 rd floor was repaired on 2/3/2011. G) Handrails, Central Bath 5 th floor will be repaired by 3/4/2011. H) Stained ceiling tiles in bathroom 312 above bathroom door and above window in room 309 and 320 repaired on 2/25/2011.	3/18/2011
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F 465	Continued From page 25 -Cracked tiles were observed in resident rooms 312 under bed 2, 316 in the bathroom, 404 in the bathroom, 405 in the bathroom, and 409 under the sink. -Cracked tile was observed in the hallway between resident rooms 315 and 317. -A loose sink was observed in the Central Bath on the third floor of the facility. -A shower in the Central Bath on the third floor of the facility had no shower curtain. -The tubs in the Central Baths on the third, fourth, and fifth floors were all observed to be stained and in need of cleaning. -The door leading to the Central Bath on the third floor of the facility was hard to close. -The Central Bath on the fifth floor was observed with loose handrails on the toilet. -Stained ceiling tiles were observed in the bathroom of resident room 312, above the bathroom door and above the window in resident room 309, and above the window in resident room 320. -Chipped doors were observed on resident room doors in rooms 314, 316, 320, 403, 405, 407, and 416, and the bathroom door of resident room 316. -Torn drywall was observed in resident room 308 on the wall by the window, in resident room 309 at the head of the bed to bed 1, resident room 314 under the sink, resident room 316 on the bathroom wall, resident room 318 on the wall beside the sink, resident room 401 in the bathroom by the baseboard, resident room 409 under the sink, and resident room 519 behind the head of bed of bed 1. -Torn linoleum was observed in the bathroom of resident room 308. -Chipped closet doors were observed in resident rooms 309, 405, and 415. -The baseboard and tile under the sink in resident	F 465	I) Chipped doors in rooms 314, 316, 320, 403, 405, 407 and 416 as well as bathroom door in resident room 316 will be repaired by 3/4/2011. J) Drywall on wall by the window in room 308, head of bed, room 309-under sink, 314 bathroom, wall in room 316, wall by sink in room 318, baseboard in bathroom of room 401, under sink in room 409 and behind head of bed in room 519 repaired by 3/11/2011. K) Torn linoleum in bathroom of room 308 will be replaced by 3/18/2011. L) Chipped closet door in rooms 308, 405, 415 will be repaired by 3/4/2011. M) Loose baseboard and tile under sink in room 314 repaired 2/16/2011. N) Cracked and rough window sill in room 315 will be repaired 3/4/2011. O) Ice dispenser on 4 th and 5 th floors were cleaned on 2/3/2011. There is no ice dispenser on 3 rd floor. P) Rough, sharp edges on counter top on 4 th floor nurses station will be repaired by 3/18/2011. Q) hole in wall at head of bed in room 410 was repaired on 2/23/2011. R) sink in resident room 506 repaired 2/3/2011. S) Walls in hallway on 5 th floor cleaned on 2/3/2011.		

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F 465	Continued From page 26 room 314 were loose. -The windowsill in resident room 315 was observed to be cracked and rough. -The ice dispensers on the third, fourth, and fifth floors of the facility were in need of cleaning and were observed to have a white substance on them. The water did not flow freely from the ice dispenser on the fifth floor. -The fourth floor nurses' station was observed to have rough sharp edges to the countertop. -A hole in the wall was noted in resident room 410 at the head of the bed of bed 2. -The sink in resident room 506 was observed to be continuously dripping. -The walls of the hallway on the fifth floor of the facility were observed to be dirty and in need of cleaning along both sides of the entire hallway. Interview on February 3, 2011, at 4:30 p.m., with the Maintenance Supervisor (MS) revealed maintenance request forms were kept at every nurses' station and staff finding problems was required to fill out a request form and place it on the Maintenance bulletin board on the second floor of the facility. The MS stated he/she checked for request forms frequently throughout the day. The MS was not aware of identified areas in need of repair.	F 465	Criteria #2 A) All residents residing in facility on 02/03/2011 have the potential to be affected B) The Maintenance Director and Administrator will make rounds of the facility to list all needed repairs by 3/4/11. They will develop a quarterly plan to address any repairs noted that do not require immediate action by 3/4/11. Criteria #3 A) Maintenance staff re-educated on completion of maintenance repair request by the Administrator on 2/3/11. B) Staff re-educated on completion of maintenance repair requests by ADON on 3/4/11. C) The Maintenance Director and the Administrator will tour the facility weekly for 1 month and then monthly thereafter to note any needed repairs Criteria #4		
F 468 SS-E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 468	Findings of Administrators tour will be brought to the Quality Assurance meeting monthly for 6 months for development of action plan if indicated to ensure effective maintenance services are provided.		

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F 468	<p>Continued From page 27</p> <p>equip corridors with firmly secured handrails. The handrail on the second floor was loose on both sides with a portion below the fire extinguisher being broken. The handrail on the fifth floor of the facility across from the nurses' station was loose.</p> <p>The findings include:</p> <p>Observations conducted during an environmental tour of the facility on February 3, 2011, at 12:15 p.m., revealed the handrails on both sides of the hall on the second floor of the facility were loose, with a portion of the handrail below the fire extinguisher being broken. The observation further revealed the handrail on the fifth floor of the facility, across from the nurses' station, was loose.</p> <p>An interview conducted on February 3, 2011, at 4:30 p.m., with the facility's Maintenance Supervisor (MS) revealed the MS made daily rounds in the facility to identify problems requiring maintenance. However, there was no evidence the MS identified the handrails required repairs. The MS further revealed staff was required to fill out a repair request form when a problem was found requiring maintenance. However, the MS stated no requests had been made for repairs to be made to the handrails.</p> <p>A review of the policy titled Maintenance Repair Requests with no date revealed when issues arose staff was required to fill out a repair request form and place it on the second floor repair request board. The MS was required to check the board daily. The policy further revealed repair requests are addressed five days a week and a Maintenance employee was on call seven days a</p>	F 468	<p>F468</p> <p>Criteria #1</p> <p>A) Hand rails on 5th floor were tightened and repaired by the maintenance department on 02/03/2011</p> <p>B) Hand rails on 2nd floor were repaired by the maintenance department on 02/03/2011 A new handrail to replace broken one was ordered on 02/04/2011 and to be delivered on 03/16/2011.</p> <p>Criteria # 2</p> <p>All residents, have the potential to be affected. An assessment of all handrails in facility was completed by Maintenance Director on 2/3/11.</p> <p>Criteria #3</p> <p>A) Staff re-educated on identification of need for maintenance repair request by the ADON on 3/4/11.</p> <p>B.) Maintenance Department will test 5 random handrails daily, 5 times a week and report results to Administrator weekly.</p> <p>Criteria #4</p> <p>Findings of handrail audits will be brought monthly for 6 months Quality Assurance meeting for review and development of action plan as indicated to ensure handrails are secured firmly on each side in all resident accessible areas.</p>	3/18/2011

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F 468 F 469 SS=D	<p>Continued From page 28 week.</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an effective pest control program to ensure the facility was free of pests. Ladybugs were observed throughout the fourth floor of the facility during the survey conducted on February 1-3, 2011.</p> <p>The findings include:</p> <p>During the initial tour of the facility on February 1, 2011, at 3:00 p.m., 24 ladybugs were observed on the windowsill at the end of the fourth floor hallway.</p> <p>An environmental tour conducted on February 2, 2011, at 3:15 p.m., revealed two ladybugs in the windowsill of room 408, and two ladybugs in the windowsill of room 420, both on the fourth floor of the facility.</p> <p>Interview on February 3, 2011, at 8:45 a.m., with the Maintenance Assistant (MA) revealed the MA was not aware of any ladybug problem in the facility.</p>	F 468 F 469	<p>Criteria #1</p> <p>A) Window at end of 4th floor hallway vacuumed on 02/02/2011</p> <p>B) Ladybugs removed from windows in rooms 408 and 420 on 02/02/2011</p> <p>C) Housekeeping vacuumed window sills throughout building on 02/02/2011</p> <p>Criteria #2</p> <p>All residents have the potential to be affected. On 2/4/11 pest control was contacted and the only recourse is to vacuum the ladybugs when found.</p> <p>Criteria #3</p> <p>A) Housekeeping staff re-educated by the Housekeeping Supervisor on importance of pest control on 3/4/11.</p> <p>B.) Each resident floor will have their own vacuum cleaner. The housekeepers will observe each resident room daily as they clean them for the presence of ladybugs and vacuum them as needed. They will check the resident common areas daily to vacuum any ladybugs present. They will report number and location of ladybugs to Housekeeping Supervisor weekly.</p> <p>C.) Room rounds will be conducted randomly throughout the day 5 times a week by department heads to monitor</p>	3/18/2011
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F 469	Continued From page 29 An interview conducted on February 3, 2011, at 4:35 p.m., with the facility's Administrator revealed Housekeeping had been sweeping up ladybugs every day. The Administrator further stated this has been an ongoing problem. Review of a service agreement from the pest control company dated August 23, 2010, revealed the pest control company would be treating for roaches, ants, flies, and mice. However, there was no evidence the facility was being treated for ladybugs.	F 469	for presence of lady bugs. Any insects observed will be reported to Environmental Services for disposal. D.)Housekeeping Supervisor will maintain a log of noting location and number of ladybugs noted for 6 months. Criteria #4 Findings will be brought to the Quality Assurance meeting monthly for development of action plan if indicated to ensure maintenance of pest control.	
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure laboratory (lab) tests were conducted as ordered for one of nineteen sampled residents. Resident #14 had a physician's order for a Complete (CBC) and a Basic Metabolic Panel (BMP) test to be obtained on December 21, 2010, for resident #14. However, there was no evidence the facility obtained the laboratory tests for the resident. The findings include: A review of the medical record revealed resident #14 was admitted to the facility on April 29, 2010, with diagnoses to include Hypertension, Alzheimer's Disease, Anemia, and	F 502	F502 Criteria #1 Resident #14 had a Complete Blood Count and a Basil Metabolic Profile and Pre-albumin drawn on 02/04/2011 following Physician notification of missed lab work. Criteria #2 A) Chart review of all residents in building conducted by the Director of Nursing to review Physician orders for lab work and labs drawn. Physician notification of results with new orders received if indicated. Criteria #3 A) Licensed staff re-educated on documentation and transcription of Physician orders and lab policy by ADON on 3/4/11.	3/18/2011

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	
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F 502	Continued From page 30 Gastroesophageal Reflux. A review of a physician's order dated December 21, 2010, revealed the physician ordered a CBC and BMP lab test to be obtained. However, there was no documented evidence the lab tests were obtained. Interview with a Licensed Practical Nurse (LPN) at 1:00 p.m. on February 3, 2011, revealed the CBC and BMP labs were not obtained. The LPN stated another staff member took the physician's order but failed to transcribe the order over to the record for the labs to be obtained. The LPN further stated the labs should have been obtained the day the physician's order was written.	F 502	B.) Licensed staff re-educated on the 24 hour chart check which includes ensuring Physician orders for lab work has been transcribed to the correct forms by the Director of Nursing/Assistant Director of Nursing on 3/4/11. C) Unit Managers to monitor labs daily 5 times a week, to ensure order transcribed, lab obtained, and physician notification of results. Any discrepancies will be addressed immediately and reported to DON for re-education and/or development of an action plan as indicated.	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520	D.) Director of Nursing/Assistant Director of Nursing to monitor lab-logs weekly for 4 weeks then monthly for 3 months. Criteria #4 Findings of lab audits will be brought to the Quality Assurance meeting monthly for 6 months for development of action plan if indicated to ensure lab services meet the needs of the resident.	

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F 520	<p>Continued From page 31</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement appropriate plans of action to correct identified quality deficiencies which were identified during a previous standard health survey. Deficient practice was identified in September 2010 related to the facility's failure to utilize personal alarms per physician's orders. According to the facility's plan of correction an audit was conducted to ensure all residents' physician's orders were being followed. According to the facility, the audit was conducted; however, there was no evidence the facility identified resident #1 was not utilizing a personal alarm per physician's orders during the audit. Observations of resident #1 on February 1, 2011, revealed the resident did not have a personal alarm (refer to F281).</p>	F 520	<p>F 520</p> <p>Criteria #1</p> <p>Resident #1 was reassessed for need of personal alarm on 02/02/2011</p> <p>Criteria #2</p> <p>The Director of Nursing conducted a records review on 02/9/2011, for all current residents from 09/01/2010 to present to ensure Physician orders are being followed. Discrepancies were corrected as needed.</p> <p>Criteria # 3</p> <p>A) A root cause analysis was conducted by the Director of Nursing to determine the reason that Physician order for an alarm was not implemented and the reason an audit that was done in September 2010 did not identify this. It</p>	3/18/2011
	<p>The findings include:</p> <p>A record review conducted for resident #1 revealed the resident was admitted to the facility on February 20, 2010, with physician's orders for a personal alarm to be applied to the resident's wheelchair. There was no evidence the resident was provided a personal alarm as ordered until February 2, 2011, during the standard survey.</p> <p>Deficient practice was identified on the previous health survey completed on September 1, 2010, related to not following physician's orders for personal alarms. According to the facility plan of</p>		<p>was determined that the error was related to the monthly change over process and a lack of follow through by one particular nurse. This nurse is no longer employed by the facility.</p> <p>B) A change over team was created consisting of the Director of Nursing, the House Supervisor and Minimum Data Assessment Coordinator. This team will conduct the monthly changeover with Physician's orders being compared to the medication</p>	

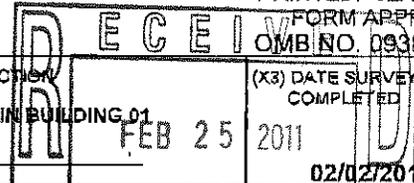
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F 520	Continued From page 32 correction dated October 8, 2010, a 100 percent audit was completed for all residents to determine if physician's orders were being followed and any negative findings were addressed immediately on September 27-30, 2010. An interview conducted with the Administrator on February 3, 2011, at 3:30 p.m., revealed that an audit had been completed; however, the paperwork was discarded when the facility was placed back in compliance due to an acceptable plan of correction. Further interview revealed the unit manager had completed the audit of all residents and had indicated that all physician's orders were being followed. According to the Administrator, the facility failed to identify that resident #1's physician's orders for a personal alarm were not being implemented during the audit.	F 520	administration records and the treatment administration records to ensure Physician orders are carried over from month to month. Any discrepancies will be corrected immediately. The Director of Nursing will track and trend any discrepancies monthly for 6 months. The Director of Nursing will provide re-education as needed. C) Re-education to licensed staff on follow through concerning Physician orders was provided by the Assistant Director of Nursing on 3/4/11. D) The Director of Nursing will observe 10 residents per week for 4 weeks, then 10 residents per month for 6 months to determine if specific Physician ordered interventions are being performed. Discrepancies will be corrected immediately and education provided as needed. Criteria #4 Findings of the tracking and trending and the resident observations by the Director of Nursing will be presented to the Quality Assurance Committee monthly meeting for 6 months for development of an action plan as needed.		

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on February 2, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, interview, and records, the facility failed to ensure that the building fire alarm system functioned and was maintained as required by NFPA standards. This deficient practice affected thirteen of smoke compartments, staff, and all the residents. The facility has the capacity for 120 beds with a census of 93 on the day of the survey.	K 052	K025 Criteria #1 The repair company was called immediately, and the fire alarm was repaired on 2/4/2011. Criteria #2 A test was ran to determine if there were any other issues or problems with the fire alarm trouble signals. Criteria #3 A.) A new contract was signed with a new fire alarm company on 2/24/2011. B.) Maintenance staff were in serviced by the Administrator on testing and ensuring correct function of the fire alarm panels weekly. Criteria #4 Maintenance Director will report findings of fire alarm panel audits monthly to Quality Assurance committee to review and develop action plans as needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *2/25/11*

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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K 052	Continued From page 1 The findings include: During the Life Safety Code survey on February 2, 2011, at 12:30 p.m., with the Director of Maintenance (DOM), a test of the fire alarm automatic dialer panel revealed when placed in trouble from phone line failure, the unit did not send a trouble signal to a continuously occupied location within the facility. The fire alarm monitoring company notified the facility of this phone line failure; however, observation revealed fire alarm panels that were located in continuously occupied locations in the facility showed all systems were normal. An interview with the DOM on February 2, 2011, at 12:45 p.m., revealed the DOM was not aware a phone line trouble signal should be located in a continuously occupied location in the facility. The facility was cited for the same deficient practice on August 19, 2008. Reference: NFPA 72 (1999 Edition).	K 052		
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	1-5.4.4 Distinctive Signals. Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated. 1-5.4.6 Trouble Signals. Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. If an intermittent signal is used, it shall sound at least once every 10 seconds, with a minimum			
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K 052	<p>Continued From page 2</p> <p>duration of 1/2 second. An audible trouble signal shall be permitted to be common to several supervised circuits. The trouble signal(s) shall be located in an area where it is likely to be heard.</p> <p>3-8.1* Fire Alarm Control Units. Fire alarm systems shall be permitted to be either integrated systems combining all detection, notification, and auxiliary functions in a single system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as stand alone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system performance.</p> <p>5-5.3.2.1.6.2 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1: (1) Both channels shall be supervised in a manner approved for the means of transmission employed. (3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes. (8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.</p> <p>5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions: (1) *Communicate immediately with persons</p>	K 052		
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K 052	Continued From page 3 designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone.	K 052		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by. Based on observation and interview, the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice affected three of thirteen smoke compartments, staff, and three residents. The facility has the capacity for 120 beds with a census of 93 on the day of the survey.	K 147	Criteria #1 Medical equipment was removed from the multi-outlet adapters in rooms 317, 402, and 515. Criteria #2 A 100% audit of all rooms was done on 02/03/2011 to determine if any other rooms had multi-outlet adapters in use for medical equipment, and removed if indicated by maintenance department.	3/18/2011
	The findings include: A review of the facility's compliance history revealed the facility was cited for the same deficient practice on September 1, 2010. Resident room 317 was also cited on this survey as well. According to the facility's plan of correction effective October 13, 2010, the multi-outlet adapters were removed from resident rooms, including room 317. The plan of correction stated the DOM would monitor monthly to ensure multi-outlet adapters were not in use and would report findings in the monthly Quality		Criteria #3 A) Additional receptacles will be placed in the residents room requiring extra receptacles by 3/18/11. B) Staff inserviced on the inappropriate use of multi outlet adapters for non-medical equipment by maintenance department by 3/4/11. C) Residents and families will receive education in the form of a letter to ensure they understand proper use of multi outlet adapters by 2/24/11.	

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K 147	Continued From page 4 Assurance meeting for review and development of action plans as needed. During the Life Safety Code tour on February 2, 2011, at 12:10 p.m., with the Director of Maintenance (DOM), an electric bed, oxygen concentrator, and nebulizer were observed to be plugged into a multi-outlet adapter (power strip) in resident room 317. In addition, power strips or adapters were observed to be in use with medical equipment in resident rooms 402 and 515. Generally, multiple-outlet adapters with surge protection may be used for resident TV's, computers, radios etc., on an as-needed basis but not to be used with medical equipment to help prevent against electrical shock. An interview with the DOM on February 2, 2011, at 12:10 p.m., revealed the DOM was not aware of the proper use of multiple-outlet adapters. Reference: NFPA 99 (1999 Edition). 3-3.2.1.2 D	K 147	D) Maintenance Department will tour facility weekly for one month then monthly for 6 months to ensure there are sufficient receptacles in each room, and medical equipment is not plugged into multi outlet adapters. E) Department Managers will tour resident rooms 5 times a week to ensure there is sufficient receptacles for medical equipment. Need for more receptacles will be reported to Administrator as indicated. Criteria #4 Maintenance Director will report findings monthly for 6 months in Quality Assurance meeting to review and develop action plans as needed.	
	2. 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.			