



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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185256</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 NURSING HOME LANE PIKEVILLE, KY 41501</b>		
(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 253	<p>Continued From page 1</p> <p>For Maintenance/Repair Requisitions," undated, revealed any staff member noting or sighting problems was to complete a maintenance repair requisition and the requisition was to be placed on the repair board on the second floor. According to the policy, Maintenance staff was to remove the requisitions from the board five days a week and complete any needed repairs.</p> <p>A review of the facility's policy titled, "General Hospitality Services Policies" (March 2003) revealed, "handwashing facilities are to be cleaned daily with a germicidal disinfectant. Bathroom tubs, tile and shower stalls are to be cleaned daily with a germicidal disinfectant spray."</p> <p>Observations made during the environmental tour of the resident rooms on 07/31/13, at 4:00 PM, the shower rooms on 07/31/13, at 4:15 PM, and the medication rooms on 08/01/13, at 3:20 PM revealed:</p> <ol style="list-style-type: none"> <li>The sink in the medication room of the fifth floor was observed to have a buildup of dirt and was stained. A shower chair and shower table in the shower room of the fifth floor were observed to have a buildup of dirt and the bathtub and surrounding tile were observed to have a buildup of dirt and scuffs. Resident rooms 501, 505, and 507 were observed to have chipped and rough edges on entry doors.</li> <li>The sink in the medication room of the fourth floor was observed to have a buildup of dirt and was stained. A shower chair and shower table in the shower room of the fourth floor were observed to have a buildup of dirt and the padded covering on the shower room table was observed</li> </ol>	F 253	<p>F 253</p> <ol style="list-style-type: none"> <li> <ol style="list-style-type: none"> <li>A new sink for the medication room on the fifth floor was ordered on 8/20/13.</li> <li>The shower chair and shower table in the fifth floor shower room were cleaned on 8/1/13.</li> <li>The bathtub in the fifth floor shower room was cleaned and resurfaced on 8/22/13.</li> <li>Entry doors to rooms 501, 505, and 507 were repaired on 8/21/13.</li> <li>A new sink for the medication room on fourth floor was ordered on 8/20/13.</li> <li>The shower chair and shower table in the fourth floor shower room was cleaned on 8/1/13.</li> <li>A new covering for the shower room table was ordered on 8/20/13.</li> <li>Entry door to room 414 was repaired on 8/21/13.</li> <li>The sink in the shower room on third floor was cleaned 8/20/13.</li> <li>The trash can and shower chair were cleaned on 8/1/13.</li> </ol> </li> </ol>	9/4/13

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185256</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 NURSING HOME LANE PIKEVILLE, KY 41501</b>		
(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 253	<p>Continued From page 2</p> <p>to have open/orn, cracked areas. Resident room 414 was observed to have a chipped and rough edge on the entry door.</p> <p>3. A sink in the shower room on the third floor was observed to have a buildup of dirt and was stained. A trash can, shower chair, and bathtub in the third floor shower room were dirty and the bathtub was scuffed. In addition, a bag of dark soiled washcloths was observed lying on the floor of the third floor shower room and there were multiple dried paint spots on the shower room floor.</p> <p>Interview with the Maintenance Supervisor on 08/01/13, at 5:20 PM, revealed staff was to fill out repair requisitions for areas identified to be in need of repair and place them on the repair board on the second floor. The Maintenance Supervisor said he checked the requisition repair board three times a day. He said the repairs were completed when he obtained the work order. The Maintenance Supervisor stated he conducted environmental rounds on a monthly basis to identify environmental concerns and had not observed the areas identified to be in need of repair.</p> <p>Interview with the Housekeeping Manager on 08/01/13, at 5:23 PM, revealed housekeeping staff was to clean areas after personal care had been completed. The Housekeeping Manager stated he made rounds three to four times daily to identify areas in need of cleaning and had failed to identify the reported areas of concern, and had not received any requests from staff related to housekeeping concerns.</p> <p>Interview with the Administrator on 08/01/13, at</p>	F 253	<p>k. The bathtub in the third floor shower was cleaned and resurfaced on 8/21/13.</p> <p>l. The bag of soiled washcloths were removed upon notification.</p> <p>m. The dried paint spots were removed on 8/21/13.</p> <p>2. All residents have the potential to be affected by the facility's failure to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. On 8/20/13, the Maintenance Director and the District Manager of Housekeeping made rounds of the facility interior to note any need for repairs or sanitation. Areas in need of sanitation were cleaned immediately. A calendar for repairs has been developed.</p> <p>3. a. On 8/23/13, the Administrator reeducated the Maintenance Director, maintenance staff, and the District Manager of Housekeeping that the facility must provide housekeeping and maintenance services necessary</p>		

- to maintain a sanitary, orderly, and comfortable interior.
- b. On 7/31/13 and/or 8/20/13, the Assistant Director of Nursing reeducated the line staff and the management staff on the procedure to request needed repairs.
  - c. On 8/20/13, the District Manager of Housekeeping reeducated housekeeping staff that the facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior including cleaning sinks, showers, and bathtubs.
  - d. On 7/31/13 and/or 8/1/13 the Assistant Director of Nursing reeducated the nursing assistants that soiled linen is to be taken to the facility laundry not left in the shower rooms.
  - e. The Maintenance Director will make rounds of the facility interior weekly for 4 weeks, then monthly to determine the need for repairs.
  - f. The District Manager of Housekeeping (or Housekeeping Supervisor when hired) will make weekly rounds of the facility interior for 4 weeks, then monthly to observe for cleanliness.
4. Findings of the tours will be brought monthly to the Quality Assurance Committee for 3 months for development of an action plan as needed.



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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185256</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>08/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 NURSING HOME LANE PIKEVILLE, KY 41501</b>		
(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 279	<p>Continued From page 4</p> <p>twenty sampled residents (Resident #18). Resident #18 was admitted to the facility with a diagnosis of Status Post Craniotomy Secondary to an Intercerebral Hemorrhage and a history of seizure activity. Facility staff failed to develop a plan of care that identified the risk factors related to the resident's diagnoses. Resident #18 experienced a fall from the bed on 07/31/13, and sustained an acute compression fracture of the thoracic spine.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Care Plan," dated 09/01/11, revealed a comprehensive plan of care would be developed for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. The policy noted an interim care plan would be developed within 24 hours of admission to ensure the resident's needs were met appropriately.</p> <p>Review of the closed medical record revealed the facility admitted Resident #18 on 07/26/13, with diagnoses that included Intercerebral Hemorrhage with Craniotomy, history of seizure activity, and status post Cerebral Vascular Accident (CVA). A review of Resident #18's admission assessment conducted by facility staff on 07/26/13, revealed the resident was assessed to be unable to communicate his/her needs, had right-sided hemiplegia, and had a scar on the posterior scalp secondary to clot evacuation. Based on the assessment, the resident was able to squeeze staff's hand with his/her left hand. Review of the fall risk assessment conducted on 07/26/13, revealed facility staff assessed</p>	F 279	<p>psychosocial well-being. Any discrepancy was corrected during the review.</p> <p>3. a. On 8/8/13 and/or 8/20/13, the Assistant Director of Nursing reeducated licensed nurses to develop a care plan for active diagnoses taking into consideration medical risk factors and development of a care plan based on the results of facility assessments.</p> <p>b. The Nurse Unit Managers or Minimum Data Set Coordinator will review the records of new admissions the next business day after admission to ensure a care plan has been developed for active diagnosis taking into consideration medical risk factors and based on the results of facility assessments. Discrepancies will be addressed immediately and reported to the Director of Nursing for reeducation as needed.</p> <p>4. The results of the Nurse Unit Mangers' and Minimum Data Set Coordinator's reviews will be reported monthly for 3 months to the Quality Assurance Committee for development of an action plan as needed.</p>		

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185256</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 NURSING HOME LANE PIKEVILLE, KY 41501</b>		
(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 279	<p>Continued From page 5</p> <p>Resident #18 to have a score of 9 which indicated the resident was not a fall risk. However, staff failed to consider the risks associated with possible head trauma for the resident and failed to develop a plan of care to include interventions to prevent possible falls/injury for Resident #18. On 07/31/13, at 2:40 PM, facility staff found the resident lying on the floor beside the resident's bed. The resident was assessed to have a small laceration above the left eye and was transferred to a hospital Emergency Room for further evaluation and treatment. According to the hospital history and physical dated 07/31/13, Resident #18 was found to have an acute compression fracture of the thoracic spine.</p> <p>Interview conducted with Emergency Room (ER) Physician #1 on 08/01/13, at 12:50 PM, revealed he had assessed/treated Resident #18 on 07/31/13. ER Physician #1 stated the resident was assessed to have an acute fracture of the thoracic spine as a result of the fall at the facility. According to the physician, Resident #18 had not experienced any worsening or changes in the resident's brain as a result of the fall on 07/31/13.</p> <p>Interview with Unit Coordinator (UC) #4 on 08/01/13, at 2:45 PM, revealed UC #4 had conducted the initial admission assessment and fall risk assessment for Resident #18 when the resident was admitted to the facility on 07/26/13. UC #4 stated the nurse completing the admission was responsible to develop the interim/admission care plan for residents upon admission. UC #4 stated she had not considered Resident #18 to be at risk for falls/injury since the resident was hemiplegic on the right side and she had not observed the resident move about in bed. UC #4 further stated she had considered the resident's</p>	F 279			

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

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 08/01/2013
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	
(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 279	Continued From page 6 diagnoses of CVA and seizures when conducting the fall risk assessment, but had not considered the resident's diagnosis of craniotomy as a risk for trauma/injury if the resident sustained a fall from the bed.  Interview with the Director of Nurses (DON) on 08/01/13, at 5:35 PM, revealed she had reviewed the resident's care plan on 07/30/13, and acknowledged staff had failed to develop a plan of care to address fall risks for Resident #18. The DON stated a care plan to address falls would not have routinely been developed since the resident's fall risk assessment did not indicate the resident to be a fall risk. The DON stated she developed a falls care plan on 07/30/13 for Resident #18 after "short side rails" were added to the resident's bed; however, no other interventions were included to protect the resident from injury in the event the resident sustained a fall.	F 279		
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 interview, record review, and review of the facility policy it was determined the facility failed to ensure services provided by the facility met professional standards of quality for three of twenty sampled residents (Residents #2, #9, and #14). A review of the medical records for Residents #2, #9, and #14 revealed the pharmacist had made recommendations to the	F 281	1. Physician approved pharmacy recommendations for residents # 2, #9, and #14 were implemented on 8/1/13.	9/4/13

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

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 08/01/2013
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 281	<p>Continued From page 7</p> <p>physician related to medications received by the residents. Interviews revealed the physician had signed and approved the pharmacist recommendations on 07/30/13; however, facility staff failed to provide services approved by the physician until 08/01/13, two days after the physician had signed the recommendations.</p> <p>The findings include:</p> <p>A review of the facility policy titled, "Physician Orders," with a revision date of 01/04/13, revealed a clinical nurse shall transcribe and review all physician orders in order to effect their implementation.</p> <p>An interview with the Director of Nursing (DON) on 08/01/13 revealed the facility did not have a specific policy related to the acknowledgment by the physician to accept the recommendations made by the pharmacist as a result of the Drug Regimen Review or how the physician would order the recommendations to be followed. However, according to the DON, a signed recommendation by the physician on the pharmacy reviews was considered a physician's order.</p> <p>1. A review of the medical record for Resident #2 revealed the facility admitted the resident on 12/31/08, with diagnoses that included Schizophrenia, Anxiety, and Depression. A review of a pharmacy recommendation dated 07/18/13 revealed the pharmacist had recommended a gradual dose reduction of Seroquel (antidepressant) from 400 milligrams down to 350 milligrams every night at bedtime. In addition, on 07/18/13 the pharmacist recommended a gradual dose reduction of Paxil</p>	F 281	<p>2. All residents have the potential to be affected by the facility's failure to provide or arrange services that meet professional standards of quality. On 8/19/13 and 8/20/13, the Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, and Nurse Unit Managers reviewed the last thirty days of physician approved pharmacy recommendations for current residents to ensure services approved by the physician met professional standards of quality. No discrepancies were noted.</p> <p>3. a. RN#1 is no longer employed by the facility. b. On 8/20/13, the Assistant Director of Nursing reeducated Licensed Nurses that the services provided by the facility must meet professional standards of quality including but not limited to the procedure for receiving, noting, and carrying out a physician order including approved pharmacy recommendations.</p>		

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

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 08/01/2013
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 281	Continued From page 8 (antidepressant) from 40 milligrams down to 20 milligrams every night at bedtime. Based on documentation and staff interview, the physician signed the recommendation form on 07/30/13. However, a review of the Medication Administration Records (MARs) for Resident #2 revealed the medication dosages were not changed until 08/01/13, two days after the physician approved the pharmacist's recommendations.  2. A review of the medical record for Resident #9 revealed the facility admitted the resident on 05/19/07, with diagnoses that included Depression. A review of a pharmacy recommendation, dated 07/18/13, revealed the pharmacist recommended a gradual dose reduction of Wellbutrin (antidepressant) from 200 milligrams to 100 milligrams every night at bedtime. Based on documentation and staff interview, the physician approved the pharmacist's recommendation on 07/30/13. However, a review of the Medication Administration Records (MARs) for Resident #2 revealed the medication dosage was not changed until 08/01/13, two days after the physician approved the reduction.  3. A review of the medical record for Resident #14 revealed on 07/18/13 the pharmacist had made a recommendation to the physician to discontinue the use of Risperdal (antipsychotic) for the resident. Based on documentation and staff interview the physician had signed the recommendation on 07/30/13. However, a review of the Medication Administration Record for Resident #14 revealed facility staff continued to administer the medication to the resident until 08/01/13, two days after the physician had signed	F 281	c. The pharmacy recommendation sheet will no longer be used as a physician order but will be transcribed onto a telephone order. The nurse transcribing the recommendation will date and initial the recommendation sheet to show that it has been transcribed and carried out returning the sheet to the Director of Nursing for reconciliation. d. The Nurse Unit Managers will QA monitor physician orders including physician approved pharmacy recommendations 5 x weekly for one month then monthly for 3 months to ensure they are carried out correctly and meet professional standards. Any discrepancies will be corrected immediately and reported to the Director of Nursing for reeducation as needed.  4. The results of the Unit Managers' QA monitoring will be reported monthly for 4 months to the Quality Assurance Committee for development of an action plan as needed.		

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185256</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 NURSING HOME LANE PIKEVILLE, KY 41501</b>		
(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 281	<p>Continued From page 9</p> <p>the pharmacist's recommendation to discontinue the medication.</p> <p>An interview conducted with Registered Nurse (RN) #1 on 08/01/13 at 2:45 PM revealed the recommendations to discontinue Resident #14's Risperdal, a gradual dosage reduction for Resident #2's Seroquel and Paxil, and Resident #9's gradual dosage reduction for Wellbutrin, had all been signed by the physician on 07/30/13. However, according to RN #1, she was not aware of what to do with the pharmacy recommendations after the recommendations had been signed by the physician. RN #1 stated she worked at the facility part-time and was unfamiliar with the facility's process related to signed pharmacy recommendations. RN #1 stated the Unit Manager usually addressed pharmacy recommendations signed by the physician and acknowledged the medication was not discontinued until 08/01/13.</p> <p>An interview with the Director of Nursing (DON) on 08/01/13 revealed the facility consultant pharmacist conducted medication reviews in the facility on a monthly basis and stated the pharmacist's recommendations were entered by the pharmacist on the computer two to three days after the pharmacist completed a visit for the DON to review. According to the DON, she monitors the computer daily for new recommendations. After the recommendations are reviewed by the DON, they are sent to each nursing unit for the Unit Manager to give to the physician for review during weekly rounds. Further interview with the DON revealed she was not aware why RN #1 had not changed the dosage of medications for Resident #2 and Resident #9, or discontinued the medication for</p>	F 281			

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

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 08/01/2013
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 281	Continued From page 10 Resident #14, after the physician had signed the pharmacy reviews because a signed recommendation was considered a physician's order.	F 281			
F 323 SS=D	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 interview, record review, and review of facility policy it was determined the facility failed to ensure the resident environment remained as free from accident hazards as possible for one of twenty sampled residents (Resident #18). Resident #18 was admitted to the facility with a diagnosis of status post craniotomy secondary to an intercerebral hemorrhage. Facility staff failed to identify risk factors associated with the resident's medical history and potential injury/trauma and failed to ensure the resident's environment was free from accident/fall hazards in an effort to prevent and/or lessen the resident's potential for falls/injury. Resident #18 experienced a fall from the bed on 07/31/13, and sustained an acute compression fracture of the thoracic spine.  The findings include:	F 323 F 323	1. Resident #18 was discharged from the facility before corrective action could be taken. 2. All residents have the potential to be affected by the facility's failure to ensure the resident environment remains as free of accident hazards as is possible. On 8/19/13 and 8/20/13, the Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, and Nurse Unit Managers reviewed current residents' active diagnosis lists and plans of care to ensure medical risk factors for potential injury/trauma have been considered in the care plan so the residents' environment remains as free of accident hazards as is possible.	9/4/13	

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185256</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 NURSING HOME LANE PIKEVILLE, KY 41501</b>		
(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 323	<p>Continued From page 11</p> <p>A review of the facility policy titled, "Falling Star Program," dated 09/01/11, revealed a fall risk assessment would be completed upon admission, quarterly, and as needed, and would be addressed on the care plan for all residents. The policy further noted residents would be placed on the Falling Star Program if the fall risk assessment score was 10 or more, and/or the resident has had a fall, or if the interdisciplinary care plan team determined the resident should be placed on the fall program.</p> <p>Review of the closed medical record revealed the facility admitted Resident #18 on 07/26/13, with diagnoses that included Intercerebral Hemorrhage with craniotomy, status post Cerebral Vascular Accident (CVA), Hypertension, History of Glioblastoma, and Atrial Fibrillation. A review of Resident #18's admission assessment conducted by facility staff on 07/26/13, revealed the resident was assessed to be unable to communicate his/her needs, to have right-sided hemiplegia, and to have a scar on the posterior scalp secondary to clot evacuation. The resident was assessed to be able to squeeze staff's hand with the resident's left hand. Review of the fall risk assessment conducted on 07/26/13, revealed facility staff assessed Resident #18 to have a score of 9 which indicated the resident was not a fall risk. However, staff failed to consider the risks associated with Resident #18's diagnoses and potential injury related to head trauma for the resident and failed to ensure the resident's environment was free of accident hazards.</p> <p>Review of the facility's falls investigation report dated 07/31/13, at 2:40 PM, revealed Resident #18 was found by facility staff to be lying on the floor next to the resident's bed. A small laceration</p>	F 323	<p>3. a. On 8/8/13 and/or 8/20/13, the Assistant Director of Nursing reeducated the licensed nurses to develop a care plan for active diagnoses taking into consideration risk factors for potential injury/trauma so that the environment remains as free of accident hazards as is possible.</p> <p>b. The Nurse Unit Managers or Minimum Data Set Coordinator will review the records of new admissions the next business day after admission to ensure a care plan has been developed for active diagnoses taking into consideration medical risk factors for potential injury/trauma have been addressed to ensure that the environment remains as free of accident hazards as is possible. Any discrepancies will be addressed immediately and reported to the Director of Nursing for reeducation as needed.</p> <p>4. The results of the Nurse Unit Manager QA will be reported to the Quality Assurance Committee monthly for three months for development of an action plan as needed.</p>	

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185256</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 NURSING HOME LANE PIKEVILLE, KY 41501</b>		
(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 323	<p>Continued From page 12</p> <p>was identified above the resident's left eye. The investigation determined the resident fell out of bed; however, no definite conclusion could be determined for the exact cause of the fall. The report noted fall mats and a therapy screen would be implemented to prevent further falls. Resident #18 was transferred to a hospital Emergency Room for further evaluation/treatment on 07/31/13. Review of the hospital history and physical dated 07/31/13, revealed the resident sustained an acute compression fracture of the thoracic spine.</p> <p>Interview conducted with Certified Nurse Aide (CNA) #1 on 08/01/13, at 3:50 PM, revealed she had provided care for Resident #18 on 07/29/13. CNA #1 stated she had observed the resident move his arm and leg on one side, but could not recall which side.</p> <p>CNA #4 stated in interview on 08/01/13, at 4:45 PM, she had cared for Resident #18 on the day the resident was admitted to the facility. CNA #4 stated she had observed the resident move his/her left hand and foot but had made no attempts to get out of bed.</p> <p>Interview with Unit Coordinator (UC) #4 on 08/01/13, at 2:45 PM, revealed UC #4 had conducted the admission assessment and fall risk assessment for Resident #18 when the resident was admitted to the facility on 07/26/13. UC #4 stated she had not considered the resident to be at risk for falls/injury since the resident was hemiplegic on the right side and she had not observed the resident to move in bed. UC #4 further stated she had considered the resident's diagnoses of CVA and seizures when conducting the fall risk assessment and did not consider the</p>	F 323			

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185256</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 NURSING HOME LANE PIKEVILLE, KY 41501</b>		
(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 323	Continued From page 13 diagnoses of craniotomy to place Resident #18 at risk for trauma/injury if a fall should occur. UC #4 stated no fall/safety interventions had been implemented for Resident #18 except for the short side rails which were used primarily for bed mobility/positioning.  Interview conducted with the Director of Nurses (DON) on 08/01/13, at 5:35 PM, revealed staff had not determined Resident #18 was at risk for falls. The DON stated the fall risk assessment should "cue" the nurses to evaluate for potential risks associated with falls/injury. The DON stated she believed the fall risk assessment completed on 07/26/13 was accurate at that time for Resident #18.	F 323			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  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.  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.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	F 431  1. The four vials of insulin and the vial of eye drops for residents B,C,D, and E were disposed of and replaced. The labels on the Pro-Stat were cleaned upon notification making the labels discernible.  2. All residents have the potential to be affected by the facility's failure to date vials of medication when opened and/or allow substances to cover labels.	9/4/13	

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

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 08/01/2013	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 431	<p>Continued From page 14</p> <p>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 facility policy review, it was determined the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional principles. On 08/01/13, at 4:13 PM, observation of two medication carts on the third floor revealed four multi-dose vials of insulin and one multi-dose vial of eye drops for Residents B, C, D, and E that had been opened and were available for use; however, facility staff failed to document the date as to when the vials had been opened. Further observations revealed six multi-dose bottles of "Pro-Stat" (protein supplement) that was opened and available for use; however, the bottles were observed to have a spillage of liquid down the sides of bottles making it difficult to read the medication labels.</p> <p>The findings include:</p> <p>A review of the facility policy titled, "House Stock Medications," dated 05/01/10, revealed facility</p>	F 431	<p>On 8/1/13, licensed nurses observed medication containers available for resident use to determine if they were labeled correctly and/or the label on the containers were discernible. Any discrepancies were corrected immediately.</p> <p>3. a. On 7/31/13, 8/1/13, 8/8/13, and/or 8/20/13, the Assistant Director of Nursing reeducated the licensed nurses on correctly labeling medication containers available for resident use in accordance with currently accepted professional principles and to ensure the labels on medications are discernible. The reeducation included to discard any medication that was labeled incorrectly, not dated when opened, or whose label was not discernible.</p>	

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

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 08/01/2013
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 431	<p>Continued From page 15</p> <p>staff was responsible to record the date medication containers were opened on the medication container. The policy also stated that the facility staff should destroy and reorder medications with soiled labels.</p> <p>Observations on 08/01/13, at 4:13 PM, of two medications carts on the third floor revealed four opened multi-dose vials of insulin and one opened multi-dose vial of eye drops for Residents B, C, D, and E that were open, available for use, and contained no date as to when the vials had been opened. Further observations revealed six multi-dose bottles of Pro-Stat that had been opened, available for use, and had spillage down the sides of the bottles and the labels of the medication were difficult to read.</p> <p>Interview with Registered Nurse (RN) #3 on 08/01/13, at 4:25 PM, revealed she was responsible to clean her medication cart every shift. RN #3 stated, "I hadn't seen the Pro-Stat spilled down the sides of the bottles or the undated vials of insulin and eye drops." She went on to say if she found undated medications, she was to discard the medication and reorder it from the pharmacy.</p> <p>An interview with the Director of Nursing (DON) on 08/01/13, at 4:37 PM, revealed staff was required to date multiple-dose vials of medication when they were opened. The DON stated she randomly checked medication carts and had checked all the medication carts in the facility on 07/31/13. The DON stated she had not identified any undated multi-dose medications or spillage on any medication bottles. Further interview with the DON revealed it was the nurses' responsibility to clean the medication carts.</p>	F 431	<p>b. The Nurse Unit Managers will QA monitor medications available for resident use 5 x weekly for one month then monthly for two months to ensure they are labeled in accordance with currently accepted professional principles and that all labels are discernible. Any discrepancies will be addressed immediately and reported to the Director of Nursing for reeducation as needed.</p> <p>4. The results of the Nurse Unit Managers' QA will be reported monthly for three months to the Quality Assurance Committee for development of an action plan as needed.</p>		

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

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 08/01/2013
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441</p> <ol style="list-style-type: none"> <li>1. Resident #9's and Resident A's glucose monitoring device was cleaned with a disinfectant wipe upon notification.</li> <li>2. All residents have the potential to be affected by the facility's failure to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection.</li> <li>3. a. On 7/31/13, 8/1/13, 8/8/13, and/or 8/20/13, the Assistant Director of Nursing reeducated the licensed nurses on infection control standards including but not limited to the procedure for cleaning the blood glucose monitoring devices after each use.</li> </ol>	9/4/13	

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

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185256</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 NURSING HOME LANE PIKEVILLE, KY 41501</b>		
(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 441	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and facility policy review, it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection for one of twenty sampled residents (Resident #9) and one of six unsampled residents (Resident A). Observation during medication administration on 07/30/13, revealed staff failed to clean/sanitize each resident's individual glucose monitoring device after checking Resident #9's and Resident A's blood glucose.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Blood Glucose Monitoring," with a revision date of 01/01/11, revealed the glucose monitoring device would be cleansed after each resident use with an approved disinfectant wipe.</p> <p>A review of an in-service titled, "Blood Glucose Monitoring," dated 09/10/12, revealed nurses were required to cleanse every blood glucose monitoring device after each use. The in-service roster revealed Registered Nurse (RN) #2 had attended the in-service.</p> <p>Observation of blood glucose monitoring for Resident A on 07/30/13, at 4:53 PM, revealed RN #2 performed the test using Resident A's own personal blood glucose monitoring device. The RN was then observed to place Resident A's blood glucose monitoring device back in a plastic bag labeled with Resident A's name without cleansing the blood glucose monitoring device.</p>	F 441	<p>b. The Nurse Unit Mangers will QA monitor in cleaning of the glucose monitoring devices 5 x weekly for one month then monthly for 2 months. Reeducation will be provided immediately as needed.</p> <p>4. Results of the Nurse Unit Managers' QA monitoring will be reported monthly for 3 months to the Quality Assurance Committee for development of an action plan as needed.</p>		

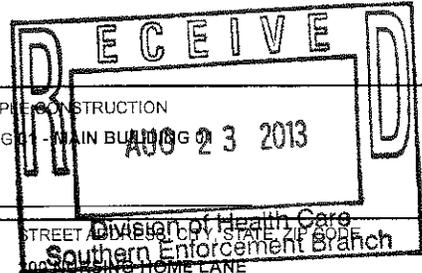
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185256</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/01/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 NURSING HOME LANE</b> <b>PIKEVILLE, KY 41501</b>		
(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 441	Continued From page 18  Observation of blood glucose monitoring for Resident #9 on 07/30/13, at 5:00 PM, revealed RN #2 performed the test using Resident #9's own personal blood glucose monitoring device. The RN then placed Resident 9's blood glucose monitoring device back in a plastic bag labeled with the resident's name, without first cleansing the blood glucose monitoring device.  An interview conducted with RN #2 on 08/01/13, at 2:12 PM, revealed she was required to cleanse blood glucose monitoring devices with a bleach wipe after each use. The RN stated she forgot to clean the devices prior to placing them back in the plastic bags.  An interview conducted with the Director of Nursing (DON) on 08/01/13, at 2:15 PM, revealed staff was required to clean all blood glucose monitoring devices with a bleach wipe after each use and prior to placing the devices back in the plastic bags. The DON revealed all residents requiring blood glucose monitoring have their own devices. The DON stated she randomly monitored nursing staff to ensure blood glucose monitoring devices were being cleaned appropriately and had not identified any concerns.	F 441			

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

PRINTED: 08/15/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NURSING HOME LANE PIKEVILLE, KY 41501
--	---

(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 000	INITIAL COMMENTS  CFR: 42 CFR §483.70 (a)  BUILDING: 01  PLAN APPROVAL: 1989  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: Five story, Type II (222)  SMOKE COMPARTMENTS: 13  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLED, SUPERVISED (WET SYSTEM)  EMERGENCY POWER: Type II diesel generator  A life safety code survey was initiated and concluded on 07/31/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Parkview Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction, to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care and safety of the residents. The plan of correction is submitted as a written allegation of compliance. Parkview Nursing and Rehabilitation Center's response to this State of Deficiencies and Plan of Correction does not denote agreement with the statement of deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Parkview Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the state deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal, and/or any other administrative or legal proceedings.	
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	K 052		

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

*Ronald Tamson*

TITLE

*Administrator*

(X9) DATE

08-23-13

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.

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

PRINTED: 08/15/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501
--	---

(X4) IO 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 052	<p>Continued From page 1</p> <p>72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system functioned as required by NFPA standards. This deficient practice affected thirteen of thirteen smoke compartments, staff, and all the residents. The facility has the capacity for 120 beds with a census of 98 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 07/31/13, at 2:30 PM with the Director of Maintenance (DOM), a test of the facility fire alarm system revealed the fire/smoke barrier doors would close when the alarm was activated but could be reset while in the silent mode to the open position on the third and fourth floors while the system was still showing fire conditions. The doors should not reset to the open position until the fire alarm is reset and showing normal conditions.</p> <p>The first and second floor alarms could not be silenced. The fire alarm reactivated twice during</p>	K 052	<p>K 052</p> <ol style="list-style-type: none"> <li>1. No residents were identified.</li> <li>2. All residents have the potential to be affected.</li> <li>3. a. On 8/5/13 Hazard Fire and Safety Equipment Company provided a service call on the fire alarm system reporting that bells are now silencing appropriately and door holders are now holding appropriately.</li> <li>b. On 8/23/13 the Administrator reeducated the Director of Maintenance that a fire alarm system required for life safety is installed, tested, and maintained and should have an approved maintenance and testing program complying with applicable requirements.</li> <li>c. The Director of Maintenance will QA monitor the fire alarm system and the fire doors weekly for one month, then monthly for 2 months. If any problems are identified the Director of Maintenance will contact Hazard Fire and Safety Equipment Company for a service call. Hazard Fire and Safety Company will test the fire alarm system quarterly.</li> </ol>	9/4/13
-------	---	-------	--	--------

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

PRINTED: 08/15/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2013
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	
(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 052	Continued From page 2 testing while in the silent mode for no obvious reason.  An interview with the DOM on 07/31/13, at 2:40 PM revealed he was not aware of the problems associated with the fire alarm system.  The findings were revealed to the Administrator upon exit.  Reference: NFPA.72 (1999 Edition).  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.  3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.	K 052	4. The results of the QA will be reported to the Quality Assurance Committee monthly for 3 months for development of an action plan as needed.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062		

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

PRINTED: 08/15/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2013	
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 062	<p>Continued From page 3 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the sprinkler system was maintained by NFPA standards. This deficient practice affected thirteen of thirteen smoke compartments, staff, and all the residents. The facility has the capacity for 120 beds with a census of 98 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour conducted on 07/31/13 at 12:40 PM, an interview with the Director of Maintenance (DOM) revealed the pump for the facility's sprinkler system was exercised for 15 to 20 seconds on a weekly basis. The pump is required to run for 10 minutes or as recommended by the manufacturer to ensure the pump operates as intended. The DOM stated he was not aware how long the pump should be exercised on a weekly basis.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>5-3.2.1 A weekly test of electric motor-driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes. Exception: A valve installed to open as a safety feature shall be permitted to discharge water.</p>	K 062	<p>K. 062</p> <ol style="list-style-type: none"> <li>1. No residents were identified.</li> <li>2. All residents have the potential to be affected.</li> <li>3.             <ol style="list-style-type: none"> <li>a. On 8/5/13 Hazard Fire and Safety Equipment Company provided a service call, testing the pump for 15 minutes and report that it is functioning appropriately.</li> <li>b. On 8/23/13 the Administrator reeducated the Director of Maintenance that the required automatic sprinkler systems are to be continuously maintained in reliable operating condition and are to be inspected and tested periodically to include weekly testing of the pump for at least 10 minutes.</li> <li>c. The Director of Maintenance will maintain records of the weekly pump testing and if any problems are identified will contact Hazard Fire and Safety Equipment Company for a service call.</li> </ol> </li> </ol>	9/4/13

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

PRINTED: 08/15/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2013
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	
(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 062	Continued From page 4 5-5.1* A preventive maintenance program shall be established on all components of the pump assembly in accordance with the manufacturer's recommendations. Records shall be maintained on all work performed on the pump, driver, controller, and auxiliary equipment. In the absence of manufacturer's recommendations for preventive maintenance, Table 5-5.1 provides alternative requirements.	K 062	4. The results of the pump testing will be reported to the Quality Assurance Committee monthly for 3 months for development of an action plan as needed.	