

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

DECEIVED
 JUL 20 2012
 Division of Health Care
 System Enforcement Branch
 07/27/2012
 OMB NO. 0938-0391
 DATE SURVEY COMPLETED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS 200 NURSING HOME LANE PIKEVILLE, KY 41501
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(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
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F 000	INITIAL COMMENTS An abbreviated standard survey (KY18588) was conducted on June 27, 2012. The complaint was unsubstantiated with deficient practice identified at 'D' level.	F 000		
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 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	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 the Statement 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 stated deficiencies through informal dispute resolution, formal appeal, and/or any other administrative or legal proceedings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angeladell Owens TITLE: ADMINISTRATOR (X6) DATE: 7-20-2012

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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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 225	<p>Continued From page 1</p> <p>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 interview, record review, review of the facility policy, and a review of the facility's investigations, it was determined the facility failed to ensure an allegation of abuse was immediately reported to the state survey and certification agency and failed to have evidence that an allegation of abuse had been thoroughly investigated for one of three sampled residents (Resident #1). On 06/18/12, the facility's Administrator was made aware of an allegation of abuse, date unknown, that involved Resident #1. However, the facility did not report the allegation immediately to the appropriate state agencies or thoroughly investigate the allegation.</p> <p>The findings include:</p> <p>A review of the facility's Resident Abuse policy (effective date: March 2012) revealed the Abuse Coordinator would investigate all reports of suspected abuse and would refer any or all incidents and reports of resident abuse to the appropriate state agencies.</p> <p>A review of the facility investigation revealed the facility Administrator and Abuse Coordinator were made aware on 06/18/12, of an allegation of physical abuse that involved facility staff and Resident #1. The facility's investigation revealed</p>	F 225	<p>F 225</p> <ol style="list-style-type: none"> 1. At the time the facility was made aware of the abuse allegation, nurse #1 was suspended and an investigation was completed. 2. Residents that nurse #1 had cared for prior to the allegation had the potential to be affected. Alert and oriented residents living on nurse #1's floor were interviewed and skin sweeps were performed on the other residents of that floor. No concerns were identified. 3. a. Staff and management were reeducated on the abuse policy on 7/3/12, 7/9/12, or 7/11/12 by the Assistant Director of Nursing. This reeducation included immediately reporting all allegations to the appropriate state agencies and completing a thorough investigation. 	07/23/12

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F 225	<p>Continued From page 2</p> <p>the Administrator was notified by the Admissions Director by telephone on 06/18/12, that when the Admissions Director was visiting Resident #1 in the hospital on 06/18/12, Resident #1 reported to her that Registered Nurse (RN) #1 had "tossed" the phone to Resident #1 and "hit" him/her in the stomach. Based on review of the facility's investigation the facility failed to ensure a thorough investigation of the incident was conducted.</p> <p>A review of Resident #1's medical record revealed the facility assessed the resident on 05/15/12, to be alert and oriented. An interview with Resident #1 on 06/27/12, at 3:45 PM, revealed Resident #1 told "a lady" from the facility that came to visit him/her in the hospital about an incident that occurred with facility staff and "a phone" and later that day the facility's Administrator and another lady came to talk to him/her about the incident. In addition, continued interview with the resident revealed RN #1 had an argument with Resident #1's daughter on the phone and then tossed the phone to Resident #1, hitting Resident #1 in the stomach. Resident #1 denied that RN #1 hit him/her intentionally or had hurt/abused him/her.</p> <p>An interview with the Admission Director on 06/27/12, at 2:08 PM, revealed she visited Resident #1 in the hospital on 06/18/12, and he/she reported the head nurse had brought the phone to the resident's room, had "tossed" the telephone to him/her and, as a result, the telephone had hit him/her in the stomach. The interview further revealed the Admission Director immediately reported the information to the Director of Nursing.</p>	F 225	<p>b. Staff and management will be queried by department managers or Regional Nurse Consultant about the abuse policy randomly for a month. Reeducation will be provided immediately by the department manager or Regional Nurse Consultant if needed.</p> <p>4. The Regional Nurse Consultant will review documentation obtained during the investigations of abuse allegations monthly for three months. Reeducation will be provided by the Regional Nurse Consultant immediately if needed on abuse allegation reporting and thoroughly investigating any allegation.</p>	
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F 225	<p>Continued From page 3</p> <p>An interview with RN #1 on 06/27/12, at 2:28 PM, revealed RN #1 took Resident #1 the telephone many times but denied ever tossing the telephone to the resident causing the telephone to hit him/her in the stomach.</p> <p>A review of the personnel record for RN #1 revealed the facility had conducted the required criminal background checks prior to her employment at the facility and there were no findings reported. A review of RN #1's personnel record also revealed the facility had provided the employee with training related to the facility's policies/procedure of abuse/neglect/exploitation of residents.</p> <p>An interview with the Administrator on 06/27/12, at 12:17 PM, confirmed she had been notified of the incident involving Resident #1 by phone on the morning of 06/18/12. The Administrator stated RN #1 was removed from resident care and interviewed about the incident but denied tossing the phone to Resident #1. According to the Administrator, she and the Abuse Coordinator went to the hospital to interview Resident #1, at which time Resident #1 described the incident but denied that he/she was harmed or abused. The Administrator stated the facility documented the incident on a resident concern form and acknowledged the incident had not been reported to the state agencies because the facility did not feel the incident was abuse. The interview went on to reveal that RN #1 was returned to resident care after the interview with Resident #1. Based on the interview, even though the facility interviewed Resident #1 about the incident, there were no other interviews/observations conducted</p>	F 225		

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F 225	Continued From page 4 with other staff and/or other residents related to the incident and/or resident care and services. An interview with the facility's Regional Director of Clinical Services on 06/27/12, at 12:36 PM, revealed that even though she did not feel there was willful intent to harm the resident, facility staff should have thoroughly investigated and reported the incident to the state agencies.	F 225			