

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

PRINTED: 01/24/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/12/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{F 000}	INITIAL COMMENTS An annual survey and abbreviated survey (KY #15350 and KY #15591) was conducted on 11/30/10 through 12/03/10 to determine the facility's compliance with Federal requirements. The facility is not in compliance with Federal requirements with deficiencies cited at the highest S&S of a "G". KY #15350 was unsubstantiated with no deficiencies cited and KY #15591 was substantiated with no deficiencies cited. An on-site revisit was conducted on 01/11-12/11. The facility is not in compliance with Federal requirements with deficiencies re-cited at F282 and F323 at a S/S of a "D".	{F 000}	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan or correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws." F 282	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to implement care guide interventions for one resident (#65), not in the selected sample. The facility assessed Resident #65 and determined the resident required the assistance of two staff members for transfers as indicated on the nurse aide care guide. on 01/12/11, Certified Nurse Aide (CNA) #1 was observed transferring Resident #65 alone using the mechanical lift. Findings include: A review of the "Mechanical Lift Policy", undated,	F 282	1. Resident #65 had their careplan and careguide reviewed and revised by the CCC (Clinical Compliance Coordinator, RN) so that interventions may be carried out correctly on 1/12/11. 2. Resident's who required a mechanical lift were reviewed and revised by the Unit Manager (to include whether a mechanical lift is required and how many person assist under the interventions of the careguide) as needed to ensure accuracy by 1/16/11 so that interventions may be carried out correctly. Transfer assessments of those residents who are to be transferred with a lift were reviewed and revised by the Unit Manager as of 1/16/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shirley Mowbray, R Exec. Director</i>	TITLE Exec. Director	(X6) DATE 1-25-11
---	-------------------------	----------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/12/2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 1</p> <p>revealed lifts may be operated by one trained associate, unless the care plan and/or care guide revealed a need for a two staff member assistance.</p> <p>A record review revealed Resident #65 was admitted to the facility with diagnoses to include Cerebrovascular Accident (CVA), History of Falls, and Bone Fracture. A review of the Minimum Data Set (MDS), dated 12/16/10, revealed the facility assessed the resident as cognitively intact and required extensive assistance of two persons for transfers. The MDS revealed the facility addressed the resident's limitations on one side for upper and lower range of motion.</p> <p>A review of the "Daily Care Guide", dated 01/11/11, revealed the resident used the sit-to-stand lift and required a two staff member assistance with transfers, indicated by a code "3".</p> <p>An observation, on 01/12/11 at 7:45 AM, revealed Certified Nurse Aide (CNA) #1 transferred Resident #65 from the bed to wheelchair with the sit-to-stand lift, without assistance.</p> <p>An interview with CNA #1, on 01/12/11 at 11:35 AM, revealed he referred to and followed the care guide to determine the number of staff needed for transfers. Upon review of Resident #65's care guide, CNA #1 revealed the resident was to have "two assist" with transfers. CNA #1 revealed the care guide for Resident #65 specified "two assist" with transfers, however, he usually transferred the resident by himself.</p> <p>An interview with the Unit Manager, on 01/12/11 at 12:25 PM, revealed if the care guide specified two assist, it should be followed.</p>	F 282	<ol style="list-style-type: none"> 3. Clinical Staff (therapy and nursing) were inserviced by the DON and/or SDC on assessing, initiating a careplan and implementing and following interventions for the careplans/careguides on 1/14/11. DON/SDC also discussed bringing any discrepancies to the attention of a Unit Manager. These areas are also included in our general orientation with the nursing staff. 4. The Unit Managers will complete weekly audits for 4 weeks to ensure proper careplanning is initiated and implemented on mechanical lifts then monthly times two months. Findings of these audits will be presented to the QA committee to determine the need for further monitoring. 5. Completion date: 	1/16/11

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

PRINTED: 01/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/12/2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure the resident's environment remained as free of accident hazards as possible and failed to ensure adequate supervision was provided to prevent accidents for one resident (#65), not in the selected sample. The facility failed to ensure staff was following the mechanical lift manufacturer's guidelines, the facility's, "Mechanical Lift policy" and Resident #65's daily care guide. On 01/12/11, CNA #1 failed to secure Resident #65 in the mechanical lift prior to transferring the resident from the bed to the wheelchair. Findings include:</p> <p>A review of the facility's "Mechanical Lift Policy", undated, revealed lifts may be operated by one trained associate, unless that associate felt more comfortable using a "two assist" or it was indicated on the care plan and/or care guide the resident needed a "two assist" transfer.</p> <p>A review of the facility's policy "Incident Management", dated 11/2008, revealed each resident received adequate assistance and</p>	F 323	<p>F323</p> <ol style="list-style-type: none"> 1. This C.N.A. was inserviced instructing him to buckle the belt clip and competency checked on 12/10/10. He was suspended on 1/12/11 and terminated on 1/17/11. The resident will be transferred using manufacturer guidelines as of 1/16/11 to include buckling the belt clip. 2. Residents who require the use of a mechanical lift will be transferred using manufacturer guidelines including buckling the belt clip as of 1/16/11. 3. Therapy and nursing staff were inserviced by the SDC and/or DON on 1/14/11 on the policy and procedure of using sit to stand lifts. Associates also received via mail the staff meeting notes on 1/14/11, which included a step by step procedure of using a sit to stand lift (including the use of a belt clip). Competency checks have been increased to twice a year and during orientation to therapy and nursing staff to be completed by the SDC, RSM or Nursing Admin. 4. Unit Managers will audit 10 nurse aides or therapy personnel lifting techniques to ensure safety 	

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

PRINTED: 01/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/12/2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 3</p> <p>oversight as defined in an individualized plan of care that reduced the risks for incidents.</p> <p>A review of the lift manufacturer's "Training Checklist", dated 2009, revealed the "Support Vest" must be applied with the resident in a seated position and should be connected using the "belt clip".</p> <p>A record review revealed Resident #65 was readmitted to the facility, on 09/06/10, with diagnoses to include Cerebrovascular Accident (CVA), History of Falls, and Bone Fracture. A review of an annual Minimum Data Set (MDS), dated 12/16/10, revealed the facility assessed the resident as cognitively intact and required extensive assistance of two persons for transfers. The MDS revealed the resident had limitations on one side of the body affecting the upper and lower range of motion. A review of the "Daily Care Guide", dated 01/11/11, revealed Resident #65 used the sit-to-stand lift with transfers. The care guide specified transfers as a "3", as referenced by the key at the bottom of the care guide as a "two assist" for transfers.</p> <p>An observation, on 01/12/11 at 7:45 AM, revealed Certified Nurse Aide (CNA) #1 transferred Resident #65 from the bed to the wheelchair utilizing the sit-to-stand lift. The accessory for upper torso support, referred to as a "Support Vest", had a "belt clip" which was not secured around the waist of the resident.</p> <p>An interview with CNA #1, on 01/12/11 at 7:45 AM, revealed he did not secure the "belt clip" because the resident was not in the lift for a long period of time. He revealed the resident could be transferred with "one assist".</p>	F 323	<p>per week for four weeks then 10 per month times two months. Findings of these audits will be presented to the QA committee to determine the need for further monitoring.</p> <p>5. Completion date:</p>	1/16/11	

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

PRINTED: 01/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/12/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 4</p> <p>An interview with CNA #1, on 01/12/11 at 11:35 AM, revealed he was trained to use the "belt clip" while using the sit-to-stand lift, but was distracted during the observation. He revealed the purpose of the "belt clip" was to help support the resident's upper trunk while in the "Support Vest". CNA #1 revealed he used the care guide to determine how much assistance a resident needed with transfers. The care guide for Resident #65 specified a "two assist" with transfers, however, CNA #1 stated, "I usually transfer the resident by myself."</p> <p>An interview with the Staff Development Coordinator (SDC), on 01/12/11 at 11:30 AM, revealed she was responsible for ensuring staff were trained on the proper use of the sit-to-stand lift. Training and competency checks was completed on 12/28/10. She stated the staff were told, "If there is a strap, buckle it." The purpose of the "belt clip" was to prevent a resident from falling in the event the resident's arms fell inside the "Support Vest".</p>	F 323		
-------	---	-------	--	--

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/12/2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	INITIAL COMMENTS An annual survey and two complaint surveys (KY #15350 and KY #15591) were conducted on 11/30/10 through 12/03/10 to determine the facility's compliance with state requirements. The facility failed to meet state licensure requirements with deficiencies cited. KY #15350 was unsubstantiated with no deficiencies cited and KY #15591 was substantiated with no deficiencies cited. An on-site revisit was conducted on 01/11-12/11. The facility failed to meet state licensure requirements with deficiencies re-cited.	{N 000}	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan or correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws." N 194	
N 194	902 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment (4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 2. Be provided by qualified persons in accordance with each resident's written plan of care. This requirement is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to implement care guide interventions for one resident (#65), not in the selected sample. The facility assessed Resident #65 and determined the resident required the assistance of two staff members for transfers as indicated on the nurse aide care guide. on 01/12/11, Certified Nurse Aide (CNA) #1 was observed transferring Resident #65 alone using the mechanical lift. Findings include: A review of the "Mechanical Lift Policy", undated, revealed lifts may be operated by one trained	N 194	1. Resident #65 had their careplan and careguide reviewed and revised by the CCC (Clinical Compliance Coordinator, RN) so that interventions may be carried out correctly on 1/12/11. 2. Resident's who required a mechanical lift were reviewed and revised by the Unit Manager (to include whether a mechanical lift is required and how many person assist under the interventions of the careguide) as needed to ensure accuracy by 1/16/11 so that interventions may be carried out correctly. Transfer assessments of those residents who are to be transferred with a lift were reviewed and revised by the Unit Manager as of 1/16/11.	



Ann M... Exec. Director
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE 1-25-11 (X6) DATE

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/12/2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 194	Continued From page 1 associate, unless the care plan and/or care guide revealed a need for a two staff member assistance. A record review revealed Resident #65 was admitted to the facility with diagnoses to include Cerebrovascular Accident (CVA), History of Falls, and Bone Fracture. A review of the Minimum Data Set (MDS), dated 12/16/10, revealed the facility assessed the resident as cognitively intact and required extensive assistance of two persons for transfers. The MDS revealed the facility addressed the resident's limitations on one side for upper and lower range of motion. A review of the "Daily Care Guide", dated 01/11/11, revealed the resident used the sit-to-stand lift and required a two staff member assistance with transfers, indicated by a code "3". An observation, on 01/12/11 at 7:45 AM, revealed Certified Nurse Aide (CNA) #1 transferred Resident #65 from the bed to wheelchair with the sit-to-stand lift, without assistance. An interview with CNA #1, on 01/12/11 at 11:35 AM, revealed he referred to and followed the care guide to determine the number of staff needed for transfers. Upon review of Resident #65's care guide, CNA #1 revealed the resident was to have "two assist" with transfers. CNA #1 revealed the care guide for Resident #65 specified "two assist" with transfers, however, he usually transferred the resident by himself. An interview with the Unit Manager, on 01/12/11 at 12:25 PM, revealed if the care guide specified two assist, it should be followed.	N 194	3. Clinical Staff (therapy and nursing) were inserviced by the DON and/or SDC on assessing, initiating a careplan and implementing and following interventions for the careplans/careguides on 1/14/11. DON/SDC also discussed bringing any discrepancies to the attention of a Unit Manager. These areas are also included in our general orientation with the nursing staff. 4. The Unit Managers will complete weekly audits for 4 weeks to ensure proper careplanning is initiated and implemented on mechanical lifts then monthly times two months. Findings of these audits will be presented to the QA committee to determine the need for further monitoring. 5. Completion date:	1/16/11

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/12/2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 220	Continued From page 2	N 220	N 220	
N 220	<p>902 KAR 20:300-8(7)(b) Section 8. Quality of Care</p> <p>(7) Accidents. The facility shall ensure that: (b) Each resident receives adequate supervision and assistive devices to prevent accidents.</p> <p>This requirement is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure the resident's environment remained as free of accident hazards as possible and failed to ensure adequate supervision was provided to prevent accidents for one resident (#65), not in the selected sample. The facility failed to ensure staff was following the mechanical lift manufacturer's guidelines, the facility's, "Mechanical Lift policy" and Resident #65's daily care guide. On 01/12/11, CNA #1 failed to secure Resident #65 in the mechanical lift prior to transferring the resident from the bed to the wheelchair. Findings include:</p> <p>A review of the facility's "Mechanical Lift Policy", undated, revealed lifts may be operated by one trained associate, unless that associate felt more comfortable using a "two assist" or it was indicated on the care plan and/or care guide the resident needed a "two assist" transfer.</p> <p>A review of the facility's policy "Incident Management", dated 11/2008, revealed each resident received adequate assistance and oversight as defined in an individualized plan of care that reduced the risks for incidents.</p>	N 220	<p>N 220</p> <ol style="list-style-type: none"> 1. This C.N.A. was inserviced instructing him to buckle the belt clip and competency checked on 12/10/10. He was suspended on 1/12/11 and terminated on 1/17/11. The resident will be transferred using manufacturer guidelines as of 1/16/11 to include buckling the belt clip. 2. Residents who require the use of a mechanical lift will be transferred using manufacturer guidelines including buckling the belt clip as of 1/16/11. 3. Therapy and nursing staff were inserviced by the SDC and/or DON on 1/14/11 on the policy and procedure of using sit to stand lifts. Associates also received via mail the staff meeting notes on 1/14/11, which included a step by step procedure of using a sit to stand lift (including the use of a belt clip). Competency checks have been increased to twice a year and during orientation to therapy and nursing staff to be completed by the SDC, RSM or Nursing Admin. 4. Unit Managers will audit 10 nurse aides or therapy personnel lifting techniques to ensure safety 	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/12/2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 220	Continued From page 3 A review of the lift manufacturer's "Training Checklist", dated 2009, revealed the "Support Vest" must be applied with the resident in a seated position and should be connected using the "belt clip". A record review revealed Resident #65 was readmitted to the facility, on 09/06/10, with diagnoses to include Cerebrovascular Accident (CVA), History of Falls, and Bone Fracture. A review of an annual Minimum Data Set (MDS), dated 12/16/10, revealed the facility assessed the resident as cognitively intact and required extensive assistance of two persons for transfers. The MDS revealed the resident had limitations on one side of the body affecting the upper and lower range of motion. A review of the "Daily Care Guide", dated 01/11/11, revealed Resident #65 used the sit-to-stand lift with transfers. The care guide specified transfers as a "3", as referenced by the key at the bottom of the care guide as a "two assist" for transfers. An observation, on 01/12/11 at 7:45 AM, revealed Certified Nurse Aide (CNA) #1 transferred Resident #65 from the bed to the wheelchair utilizing the sit-to-stand lift. The accessory for upper torso support, referred to as a "Support Vest", had a "belt clip" which was not secured around the waist of the resident. An interview with CNA #1, on 01/12/11 at 7:45 AM, revealed he did not secure the "belt clip" because the resident was not in the lift for a long period of time. He revealed the resident could be transferred with "one assist". An interview with CNA #1, on 01/12/11 at 11:35	N 220	per week for four weeks then 10 per month times two months. Findings of these audits will be presented to the QA committee to determine the need for further monitoring. 5. Completion date:	1/16/11

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/12/2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 220	Continued From page 4 AM, revealed he was trained to use the "belt clip" while using the sit-to-stand lift, but was distracted during the observation. He revealed the purpose of the "belt clip" was to help support the resident's upper trunk while in the "Support Vest". CNA #1 revealed he used the care guide to determine how much assistance a resident needed with transfers. The care guide for Resident #65 specified a "two assist" with transfers, however, CNA #1 stated, "I usually transfer the resident by myself." An interview with the Staff Development Coordinator (SDC), on 01/12/11 at 11:30 AM, revealed she was responsible for ensuring staff were trained on the proper use of the sit-to-stand lift. Training and competency checks was completed on 12/28/10. She stated the staff were told, "If there is a strap, buckle it." The purpose of the "belt clip" was to prevent a resident from falling in the event the resident's arms fell inside the "Support Vest".	N 220		

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan or correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws."		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to implement care plan interventions for one resident (#15), in the selected sample of 30. The facility failed to ensure a chair remote to the resident's lift chair was kept out of the resident's reach, in accordance with the care plan. Findings include: A record review revealed Resident #15 was admitted to the facility, on 09/09/10, with diagnoses to include Convulsions, Chronic Renal Failure, Hypertension, Mental Disorder, and Dementia. A review of the admission Minimum Data Set (MDS), dated 09/21/10, revealed the facility identified Resident #15 as modified independent	F 282	F282 1. Resident #15's careplan was revised and updated discontinuing the use of the lift chair and remote on 12/2/10 by the Unit manager. Resident discharged 12/22/10 to home. 2. Unit Managers and the Housekeeping Supervisor made a visual audit of rooms to denote the presence of lift chairs by 12/27/10. Resident's whose careplan included a lift chair were reviewed and revised as necessary to ensure safe use by the unit managers by 12/27/10. Lift chairs were removed and/or made inoperable if resident deemed unsafe for usage.		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Exec. Director (X6) DATE: 1-5-11

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.

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 1</p> <p>cognitively and required extensive assistance with activities of daily living.</p> <p>A review of an "Incident Follow-Up and Recommendation Form", dated 11/22/10, revealed Resident #15 used a remote to a lift chair and subsequently, slid out of the chair and sustained no injuries. An order was received to place the remote control out of the resident's reach.</p> <p>Observations, on 11/30/10 at 4:35 PM and at 5:40 PM, and on 12/01/10 at 8:35 AM, revealed Resident #15 was seated in the chair with the remote within reach.</p> <p>An interview with Certified Nursing Assistant (CNA) #43, on 12/01/10 at 10:40 AM, revealed Resident #15 used the remote to raise the lift chair independently. CNA #43 described the resident's cognitive status as varied throughout the day.</p> <p>An interview with CNA #44, on 12/01/10 at 10:43 AM, revealed Resident #15 used the remote to raise the lift chair independently. CNA #44 stated the resident was found using the remote to raise the chair, at least five times in the last month and the day prior to this interview.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 12/01/10 at 10:52 AM, revealed she was unsure whether it was safe for Resident #15 to use the lift chair independently. Resident #15 was found using the lift chair remote, on 11/30/10, during her shift. She lowered the resident's chair to the upright position and placed the remote control beside the resident in the chair.</p>	F 282	<p>3. The Staff Development Coordinator (SDC) inserviced nursing staff to assess, initiate a careplan and implement interventions for the careplans on 12-17-10. These areas are included during our general orientation with the nursing staff.</p> <p>4. The Unit Managers will complete audits weekly for 4 weeks to ensure proper careplanning is initiated and implemented then monthly times two. Findings of these audits will be presented to the QA committee to determine the need for further monitoring.</p> <p>5. Completion date:</p>	2/29/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 Interviews with Registered Nurse/Unit Manager #1, on 12/01/10 at 10:20 AM and on 12/03/10 at 2:40 PM, revealed Resident #15 had not been assessed for the safe use of the lift chair. She revealed the resident's family brought the lift chair to the room. She felt Resident #15 was not safe to use the lift chair, due to a cognitive impairment. The resident "fiddled" with the lift chair remote, when it was within reach. She stated she never received any reports from staff of observations of the resident using the lift chair remote to raise the lift chair independently, prior to 11/30/10.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS An interview with the Director of Nursing, on 12/02/10 at 5:20 PM, revealed she expected staff to follow and check residents' care plans for changes. A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure appropriate treatment and services to maintain or improve the ability to transfer was provided one resident (#8), in the selected sample of 30. Resident #8 was discharged from physical therapy and the facility failed to ensure the resident was transitioned into the restorative maintenance program, per referral. Findings include: A record review revealed Resident #8 was	F 311	F311 1. Resident #8 was re-screened by physical therapy on 12/20/10 and they recommended an FMP to maintain current status to include therapeutic exercises and sit to stand exercises at the handrail to be implemented by Restorative Nursing. 2. Residents who have been discontinued from therapy over the last 3 months have been reviewed by the Rehab Service Manager by 12/23/10 and those residents who could benefit from services to maintain or improve the ability to transfer has now been referred to therapy by 12/28/10.	

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 311	<p>Continued From page 3</p> <p>re-admitted to the facility, on 12/13/09, with a diagnosis of Cerebrovascular Accident (CVA/Stroke). A review of the annual Minimum Data Set (MDS), dated 11/02/10, revealed the facility assessed the resident as severely cognitively impaired and required extensive assistance with transfers.</p> <p>A review of the physical therapy progress note, dated 08/16/10, revealed discharge plans included the resident was to remain in the skilled nursing facility with a functional maintenance plan to be implemented by the facility's restorative services. A review of the "Physical Therapy Plan of Treatment", dated 08/19/10, revealed the resident had responded positively to physical therapy.</p> <p>An interview with the Rehabilitation Manager, on 12/02/10 at 9:40 AM, revealed the functional maintenance plan should have been developed for Resident #8, two weeks prior to discharge from physical therapy, to ensure a smooth transition from physical therapy to restorative care. All residents discharged from physical therapy should have a maintenance or restorative program. She stated the Physical Therapist, working with the resident, should have completed the plan, but ultimately it was her responsibility.</p> <p>Interviews with the Physical Therapist, on 12/01/10 at 3:00 PM and on 12/02/10 at 10:20 AM, revealed he was in charge of the resident's treatment, from 07/21/10 to 08/16/10. He revealed a functional maintenance plan was not developed for the resident. He stated, "That was my fault." The Physical Therapist revealed prior to the resident's discharge from physical therapy, Resident #8 could perform a sit-to-stand transfer</p>	F 311	<p>3. SDC inserviced licensed nurses and therapy on 12-17-10 to ensure residents are given appropriate treatment and services to maintain or improve his or her abilities. Nursing /Therapy Referral forms and Therapy Communication to Nursing/Restorative Forms will be discussed during general orientation by the SDC. The Nursing/Therapy referral form is used to communicate the need for a referral to therapy and the Nursing/Therapy Communication form is used when therapy communicates instructions to nursing after they have screened or discharged a resident from their services.</p> <p>4. Unit managers will audit residents who have been discontinued from therapy with orders to receive a functional maintenance plan and to ensure they have received that service weekly times 4 weeks then monthly times two. They will also audit to ensure that referrals are being made to therapy for</p>		

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 311	Continued From page 4 from the wheelchair, holding to the side of the parallel bar with his/her right upper extremity, with moderate to minimum assistance. An observation, on 12/02/10 at 10:45 AM, revealed Resident #8 was able to stand from the wheelchair, holding onto the side of the parallel bar, but required maximum to moderate assistance to complete the transfer.	F 311	a resident who could benefit from treatment or services that maintain or improve their ability to transfer. Results of these findings will be presented to the QA committee to determine the need for further monitoring.		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for one resident (#8), in the selected sample of 30. The facility failed to ensure a functional maintenance plan was developed and Resident #8 was transitioned into the facility's restorative program, per referral. Findings include: A record review revealed Resident #8 was re-admitted to the facility, on 12/13/09, with a diagnosis of Cerebrovascular Accident (CVA/Stroke). A review of the annual Minimum Data Set (MDS), dated 11/02/10, revealed the	F 318	5. Completion date: F318 1. Resident #8 has been re-screened and the FMP written by the Physical Therapist and implemented by Restorative Nursing 12/20/10. 2. Residents were assessed to determine if there was decreased range of motion or those who could benefit from treatment or services that maintain or improve their abilities by 12-28-10 by the Unit Managers and a therapy referral was initiated if required. Further ensuring that FMPs were developed and implemented if appropriate. 3. The SDC inserviced staff on 12-17-10 that residents with a decreased range of motion should be referred to therapy for a screen and if appropriate	12/29/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	<p>Continued From page 5</p> <p>facility assessed the resident as severely cognitively impaired with range of motion impairment on one side of the resident's body.</p> <p>A review of the Physical Therapy Progress Note, dated 08/16/10, revealed discharge plans for the resident included transition to the facility's restorative program with a functional maintenance plan. A review of the Physical Therapy Plan of Treatment, dated 08/19/10, revealed the resident responded positively to physical therapy.</p> <p>An interview with the Rehabilitation Manager, on 12/02/10 at 9:40 AM, revealed a functional maintenance plan should have been developed, two weeks prior to the resident's discharge from physical therapy to ensure transition from physical therapy to the facility's restorative program. All residents discharged from physical therapy should have a restorative or functional maintenance plan. She stated the Physical Therapist, working with the resident, should have completed the plan, but ultimately it was her responsibility.</p> <p>Interviews with the Physical Therapist, on 12/01/10 at 3:00 PM and on 12/02/10 at 10:20 AM, revealed he was in charge of Resident #8's treatment, from 07/21/10 to 08/16/10. He revealed a functional maintenance plan was not developed for the resident, and stated, "That was my fault." He stated the plan should have included range of motion exercises to the resident's lower extremities. The Physical Therapist stated the resident was capable of performing bilateral lower extremity strengthening exercises with three pound weights, on discharge. The resident obtained partial range of motion in</p>	F 318	<ol style="list-style-type: none"> 3. receive therapy or a functional maintenance program to be implemented by Restorative Nursing. Identification of these residents may be made through changes noted during quarterly assessments, MDS assessments or changes in condition noted by any staff member brought to the Unit Managers attention. Nursing and/or Therapy may initiate these referrals using the Nursing/Therapy referral form. 4. The Unit Managers will audit 5 residents weekly to determine that therapy referrals are being made when appropriate and that screening or treatment is initiated if determined appropriate for 4 weeks then monthly times two. Findings of these audits will be presented to the QA committee to determine the need for further monitoring. 5. Completion date: 	12/29/10

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 6 the left lower extremity.	F 318		
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure the resident's environment remained as free of accident hazards as possible and failed to ensure adequate supervision was provided to prevent accidents for two residents (#7 and #15) in the selected sample of 30. The facility failed to ensure staff was trained appropriately regarding therapy recommendation and manufacturer's guidelines for the safe use of the sit-to-stand lift (assistive device). The facility failed to provide oversight to ensure that staff was using the assistive device appropriately with residents. This failure resulted in Resident #7 sustaining a</p>	F 323	<p>F323</p> <ol style="list-style-type: none"> 1. Resident # 7 was reassessed on 6/22/10 by the Occupational Therapist to determine the safest way to transfer the resident (which was a total lift) Resident #15 was reassessed by the Occupational therapist on 12/1/10 to determine if he could appropriately operate a lift chair. The lift chair was removed on 12/2/10 since it was determined he was not able to operate safely. Resident has since gone home. 2. Residents were reassessed by 12/27/10 by the Unit Managers to determine the proper method of lifting each resident during transfers. Residents who currently had a lift chair in their room were 	

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 7</p> <p>fractured left Femur (thigh bone), during an assisted transfer using the sit-to-stand lift, on 06/12/10. Additionally, the facility failed to ensure the "Incident Management" policy and procedure was followed as the facility's investigation was ineffective in identifying the causal factor of the incident and ;therefore, failed to implement effective interventions to prevent a recurrence. The facility failed to ensure Resident #15 was assessed for the safe use of a lift chair prior to the resident using the assistive device. On 11/22/10, Resident #15 fell from the lift chair after using the remote controls independently. The facility failed to ensure interventions were implemented to prevent the resident from having access to the remote controls of the lift chair. Findings include:</p> <p>A review of the facility's policy and procedure, " Incident Management", dated 11/2008, revealed "Each resident receives adequate assistance and oversight as defined in an individualized plan of care that reduces the risks for incidents. If a resident has had an accident or fall, the facility investigates and provides focused review to minimize the potential for recurrence." Further review of the policy revealed procedures included timely investigations of incidents and assessment of causal factors and/or trends and implementation of reasonable and appropriate action plans, reducing the risk of recurrence. Falls, reportable incidents, incidents with injury, required additional investigation. Subsequent investigation included assessment of possible contributing clinical and environmental factors. A thorough investigation included determination and documentation of a conclusion, if possible, and development of a plan of action to reduce the risk of recurrence.</p>	F 323	<p>reassessed by the Occupational therapist by 12/20/10 to determine if they could appropriately and safely operate a lift chair. Any resident who was determined unsafe at that time had their chair removed or unplugged to prevent usage.</p> <p>3. The SDC inserviced staff on 12-17-10 regarding the new lift policy including manufacturer guidelines and the policy regarding mechanical lifts and liftchairs. These policies will be added to general orientation with nursing and therapy. A competency check of lift use will be added to the general orientation of therapy and nursing staff as of 12/15/10. Nursing staff were also inserviced by the SDC that during their incident investigation to identify causative factors and implement effective interventions to try and prevent the incident from reoccurring. The incident management team will continue to review incidents after they happen and with</p>	
-------	---	-------	---	--

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 1. Observations, on 12/02/10 at 8:20 AM through 9:45 AM, revealed the facility utilized six (6) sit-to-stand lifts. Each lift was equipped with an accessory for upper torso support, referred to as a "SupportVest". Four of the six sit-to-stand lifts were equipped with an accessory referred to as a "calf strap", which was applied to the lower legs to secure the legs and feet during transfer. Two of the six lifts were not equipped with a "calf strap". A review of the manufacturer's "instruction guide", dated 07/07/09, revealed the need to attach and tighten the (calf) strap around the lower legs, just below the knees. Further review of the guide revealed a "Caution" statement, "Lifting and transferring a patient always involves a degree of risk....A complete understanding of the contents of instructions is essential". An interview with the Director of Education for the lift manufacturer, on 12/02/10 at 3:45 PM, revealed the company encouraged the facility to ensure the calf straps were used with residents who were weak in one leg to prevent the resident's calf from "drifting off the foot plate". Record review revealed the facility admitted Resident #7 on 08/03/07 with diagnoses to include Traumatic Brain Injury with secondary Psychosis, Traumatic Fracture to the right forearm, right Humerus (upper arm bone) and left ankle, History of Hemorrhagic Stroke with residual effect, Hemiparesis (one sided weakness) and Seizure disorder with speech disability. A review of the Comprehensive Care Plan, with an onset date of 06/30/09 and last updated on	F 323	with follow-up thereafter to ensure appropriateness of the interventions. New admissions who want to use lift chairs or lift chairs brought in by family will be assessed by OT to determine if the chair is appropriately and can be safely operated by the resident. Competency checks were performed by nursing administration on therapy and nursing staff to ensure they could safely use the mechanical lifts by 12/28/10. 4. Unit Managers will audit 10 nurse aide or therapy lifting techniques to ensure safety per week for four weeks then 10 per month times two. Unit Managers will audit lift chair usage weekly for 4 weeks, then monthly for 2 months to ensure proper care planning interventions are in place and residents are appropriate and safe to use lift chair. Findings of these audits will be presented to the QA committee to determine the need for further monitoring. 5. Completion date:	12/29/10

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 9</p> <p>03/14/10, revealed the problem, "Potential for falls related to diagnosis of Traumatic Brain Trauma with Psychosis" with interventions that included the use of the sit-to-stand lift with the assistance of two staff members for all transfers.</p> <p>A review of the "Communication to Nursing/Restorative Staff" from Occupational Therapy, dated 04/10/10, revealed recommendations for the assistance of two staff with the use of the sit-to-stand lift for transfers. Detailed instructions referred to the need for one staff member to be positioned in front of the resident and one person to be positioned behind the resident, to assist with sitting balance. The recommendation further stated if the resident was unable to be assisted to a full sitting position, the sit-to-stand lift should not be used. A Precaution statement included the reminder for all straps on the sit-to-stand lift to be fastened for all transfers.</p> <p>Nurses notes, dated 06/12/10 at 4:50 AM, revealed Resident #7 sustained a fall resulting in an injury (fracture to the left Femur), during an assisted transfer to the bed from a shower chair, using the sit-to-stand lift. After the fall, the resident was transported to the hospital at 3:15 PM and returned to the facility, on 06/15/10, with a diagnosis of a "Distal non-displaced Femur fracture". An interview with Resident #7's primary physician, on 12/01/10 at 10:15 AM, revealed "The fracture was caused by twisting of the bone". Additionally, the physician stated the Xray report revealed the resident had Osteopenia and a calcium supplement was ordered the day of the interview.</p> <p>An interview with Resident #7's spouse, on 11/30/10 at 11:15 AM, revealed Resident #7</p>	F 323			

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 10</p> <p>sustained a fracture to the left Femur, during a transfer with the sit-to-stand lift. The spouse stated he/she had difficulty with the explanation presented by the facility as the resident fell after slipping from the lift. The spouse stated that if the sit-to-stand was used properly, the resident would not be able to slip away from the lift. The spouse described Resident #7 as having little to no mobility on the left side of his/her body, due to a brain injury.</p> <p>A review of the facility's investigative report, dated 06/12/10 at 4:50 PM, revealed the resident was transferred using a sit-to-stand lift. The resident's feet slid "forward" and the resident was lowered to the floor and assisted to the bed. The resident was assessed for pain and vital signs with no problems identified. Charge Nurse (CN) #1 documented the names of the staff involved, which included Certified Nurse Aide (CNA) #13 and CNA #36. The report stated the resident was being transferred from the bed. The investigative report included interviews with two staff members, CNA #13 and CNA #36.</p> <p>A review of the investigative statement made by CNA #13, on 06/14/10, revealed she was in the process of transferring Resident #7 from a shower chair to the bed, using the sit-to-stand lift. CNA #13 described Resident #7 as non-weight bearing and it was necessary for the resident to support his/her weight, using the arms. The resident's legs slide out from under him/her and the resident was lowered to the floor and assisted to bed. CNA #36 lowered the lift, while she and CN #1 supported and assisted the resident to the floor. CNA #36 then summoned assistance for the resident's transfer back to bed.</p>	F 323			

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 11</p> <p>A review of the investigative statement made by CNA #36 and documented by Unit Manager #1, on 06/15/10, revealed CNA #36 stated on entrance to the resident's room, she observed Resident #7's left leg "bent at the knee and hanging out". She observed CNA #13 attempt to reposition the resident's leg "back in" and the resident's right leg "came out and the resident's knees started to bend" and "The resident was hanging by the arms". CN #1 and CNA#13 held the resident under the arms and lowered the resident to the floor. The resident was positioned on his/her knees and a blanket was placed on the floor and the resident was placed on the blanket on his/her stomach. Afterwards, the resident was assisted to bed by seven people. Review of the investigative report revealed a statement was documented above the signature of CNA #36, which stated, "This associate states that the 'calf straps' were not in place when she entered the room". An additional statement, which was partially mingled with the signature of CNA #36 revealed, "It had already been removed by staff".</p> <p>A review of the investigative statement made by CN #1, on 06/14/10, revealed during the transfer of the resident, using the sit-to-stand lift, the resident's feet began sliding and the resident was hanging by his/her arms. CNA #36 lowered the resident's bed to the lowest position, while CN #1 and CNA #13 supported the resident and CNA #36 lowered the lift. "The resident did not fall" and he/she was "lowered to the ground to his/her knees on seated position".</p> <p>An interview with CNA #6, on 12/01/10 at 2:55 PM, revealed she was summoned to Resident #7's room by CNA #13, on 06/12/10 at 4:50 AM. On entrance to the room, she observed CNA #13</p>	F 323		
-------	---	-------	--	--

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 12</p> <p>as the only staff member present. Resident #7 was suspended from the lift with the left foot off the foot rest. As she attempted to replace the resident's left foot back on the footrest, the resident's right foot slipped off the footrest. CNA #6 stated she observed the resident's legs were not secured to the shin support by a calf strap. CNA #6 stated the calf strap was not usually removed, until the resident was sitting down securely.</p> <p>While the investigation did not include a conclusion and identification of the potential underlying cause(s) related to the fall and the use of the lift, interview with CNA #6 and review of the investigative statements identified that staff did not follow the recommendations of therapy for the number of staff required to assist with the transfer using the lift nor did they follow the manufacturer's guideline to use the calf strap. Additionally, there was no evidence the facility identified an issue with the capability of the staff in using assistive devices appropriately or that the facility evaluated and/or retrained based on such identification. Furthermore, there was no revision to care directed at prevention of a recurrence, based on the investigative findings.</p> <p>Interviews conducted with five CNAs (CNA #21, CNA #22, CNA #15, CNA #16 and CNA #39), on 12/02/10 at 9:10 AM through 5:00 PM, revealed the staff had not received in-service/training regarding the appropriate and safe use of the lifts, to include the need to ensure the accessories were applied correctly and consistently and in accordance with the manufacturer's guidelines and the individual care plan.</p> <p>An interview with the Staff Development</p>	F 323			

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 13</p> <p>Coordinator (SDC), on 12/01/10 at 3:35 PM, revealed the facility had not provided staff in-service/training regarding the safe and proper use of the sit-to-stand lift. The only instruction provided was on the job per a "preceptor" assigned to new hires. Further interview with the SDC, on 12/02/10 at 10:25 AM, revealed competency of new staff was not verified and documented on hire, although the facility had developed a form to use for the purpose, and no training was provided after the resident sustained an injury during an assisted transfer with the sit-to-stand lift.</p> <p>An interview with the Administrator and the DON, on 12/03/10 at 2:40 PM, revealed the capability of preceptors assigned to train staff regarding the use of mechanical lifts was verified by "spot checks" only. The interview revealed the facility had no established system to ensure staff providing care consistently followed the resident's care plan and manufacturer's guideline, related to the safe use of the sit-to-stand lift.</p> <p>2. A record review revealed the facility admitted Resident #15 on 09/09/10 with diagnoses to include Convulsions, Chronic Renal Failure, Hypertension, Mental Disorder, and Dementia. A review of the admission Minimum Data Set (MDS), dated 09/21/10, revealed the facility assessed Resident #15 as having modified independent with cognition and required extensive assistance with activities of daily living.</p> <p>A review of the "Fall Risk Evaluation", dated 11/22/10, revealed the facility assessed and determined Resident #15 was a high risk for falls.</p> <p>A review of an Incident Follow-Up and</p>	F 323			

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 14</p> <p>Recommendation Form, dated 11/22/10, revealed Resident #15 used the remote to the resident's lift chair and subsequently slid out with no injuries documented. There was no evidence in the record that the facility had assessed Resident #15 and determined the resident was safe in the use of the lift chair, prior to or after the 11/22/10 incident.</p> <p>A review of the Comprehensive Care Plan, dated 11/22/10, for the problem, "At Risk for Falls related to history of falls" revealed interventions included placing the lift chair remote out of reach at all times. A review of the Certified Nursing Care Plan, dated 11/30/10, revealed interventions to include placing the remote control out of the resident's reach.</p> <p>Observations, on 11/30/10 at 4:35 PM and 5:40 PM, and on 12/01/10 at 8:35 AM, revealed the remote control to the resident's lift chair was within Resident #15's reach.</p> <p>An interview with CNA #43, on 12/01/10 at 10:40 AM, revealed while Resident #15 was physically able to use the lift chair remote independently, his/her cognitive status varied throughout the day. An interview with CNA #44, on 12/1/10 at 10:43 AM, revealed Resident #15 was physically able to use lift chair remote independently, his/her cognitive status was fifty/fifty (varied). Furthermore, the CNA had found Resident #15 using the lift chair remote control at least five times in the last month and on the day of this interview.</p> <p>An interview with LPN #1, on 12/01/10 at 10:52 AM, revealed she was unsure whether Resident #15 could safely use the lift chair independently.</p>	F 323		
-------	--	-------	--	--

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 15</p> <p>However, on 11/31/10 she found Resident #15 using the lift chair remote and had to lower the resident's chair to the upright position. She then placed the remote control beside the resident.</p> <p>An interview with Registered Nurse Unit Manager #1, on 12/01/10 at 10:20 AM, and on 12/03/10 at 2:40 PM, revealed she did not assess the resident's safety to use the lift chair when family brought the chair to the resident's room. She felt Resident #15 was not safe to use the lift chair due to cognitive impairment. She stated Resident #15 "fiddled" with the lift chair remote if it was within reach. She never received reports from staff observing the resident using the lift chair remote to lift the chair independently, prior to incident.</p> <p>While the facility developed an intervention to prevent Resident #15 from having access to the remote control of the lift chair, staff did not ensure the remote control was inaccessible to the resident and there was no evidence the facility had assessed Resident #15 for the safe use of such an assistive device. Furthermore, an interview with the Administrator on 12/01/10 at 2:35 PM, revealed the facility did not have written policies and procedures to address assessments of residents for the use of the assistive devices.</p>	F 323		

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

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01- MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2010
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 12/03/2010 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

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

TITLE

(X6) DATE

Lon Monerly

Exec. Director

12-22-10

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.