

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

Amended SOD

PRINTED: 06/28/2013
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 _____	<div style="border: 2px solid black; padding: 5px; text-align: center;"> RECEIVED JUL 10 2013 </div>		(X3) DATE SURVEY COMPLETED C 04/10/2013
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY			
(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	<p>INITIAL COMMENTS</p> <p>*Amended--</p> <p>An abbreviated standard survey (KY19978) was initiated on 04/02/13. Immediate Jeopardy was identified on 04/04/13, and was determined to exist on 03/23/13. The facility was notified of the Immediate Jeopardy on 04/04/13. A partial extended survey was conducted on 04/08-10/13. An additional complaint (KY20011) was also investigated during the abbreviated survey. KY20011 was unsubstantiated with no deficient practice identified.</p> <p>Resident #1 had a diagnosis of End Stage Renal Failure and received Hemodialysis three times per week on Tuesday, Thursday, and Saturday. On Saturday, 03/23/13, Resident #1 missed his/her scheduled dialysis treatment. On Tuesday, 03/26/13, the resident was admitted to the hospital and diagnosed with Hyperkalemia. The resident's Potassium level was 7.9 milliequivalents per liter which was noted as being critical (normal level 3.6-5.2 milliequivalents per liter). An interview conducted with Resident #1's Nephrologist revealed the Hyperkalemia was a direct result of the resident missing his/her scheduled dialysis treatment on 03/23/13, and could have caused the resident to die. Resident #1 returned to the facility on 03/29/13.</p> <p>Deficiencies were cited at 42 CFR 483.20 Resident Assessment (F280), 42 CFR 483.25 Quality of Care (F309), and 42 CFR 483.75 Administration (F490) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F309).</p>	F 000	<p>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.</p>			

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

Leah Dames

TITLE

Administrative

(X6) DATE

07-02-13

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: 06/28/2013
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 04/10/2013
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 000	Continued From page 1 An acceptable Allegation of Compliance was received on 04/09/13, which alleged removal of the Immediate Jeopardy on 04/07/13. The State Survey Agency determined the Immediate Jeopardy was removed on 04/07/13, prior to exit, which lowered the scope/severity to "D" at 42 CFR 483.20 Resident Assessment (F280), 42 CFR 483.25 Quality of Care (F309), and 42 CFR 483.75 Administration (F490) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000		
F 280 SS-J	*As the result of an Independent Informal Dispute Resolution, F490 was deleted. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F 280 1. On 3/26/13, Resident #1 was noted to have a change in condition. The nurse notified the primary physician and Resident #1 was sent to the local emergency room for evaluation. Resident #1 was admitted to the hospital and received dialysis on 3/26/13. Resident #1 returned to Parkview on 3/29/13. On 4/4/13, the Director of Nursing, Assistant Director of Nursing and Nurse Unit Manager reviewed and revised Resident #1's comprehensive plan of care to include the days of the week for scheduled dialysis (Tuesday, Thursday, and Saturday to change to Monday, Wednesday, and Friday beginning on 4/8/13) along with interventions for refusal of dialysis.	05/01/13

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

PRINTED: 06/28/2013
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 04/10/2013
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 280	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to have an effective system to ensure that a comprehensive plan of care, with interventions describing the services to be provided, was developed and revised for one of eight sampled residents (Resident #1). Resident #1 had a diagnosis of End Stage Renal Disease (ESRD) and the resident's physician had ordered hemodialysis treatments three times a week, on Tuesday, Thursday, and Saturday, at a dialysis center. Facility staff failed to ensure the comprehensive plan of care for Resident #1 included the days of the week the resident was scheduled to attend dialysis and failed to include interventions related to the resident's periodic refusal to attend dialysis. Documentation in the medical record revealed Resident #1 had a scheduled dialysis treatment for Saturday, 03/23/13. However, documentation on 03/23/13 revealed the facility failed to ensure Resident #1 received the dialysis treatment scheduled for 03/23/13 and there was no documentation that the resident had refused the treatment. On 03/26/13 (three days after the resident missed the dialysis treatment on 03/23/13 and five days since the resident's last dialysis treatment on 03/21/13) Resident #1 was admitted to the hospital with a diagnosis of Hyperkalemia (elevated Potassium level) and was assessed to have a potassium level of "7.9" milliequivalents per liter (normal range from 3.6-5.2 milliequivalents per liter). An interview with Resident #1's nephrologist on	F 280	2. All residents have the potential to be affected by the facility's failure to revise plans of care. On 4/5/13 and 4/6/13, the Director of Nursing, Assistant Director of Nursing, and Nurse Unit Managers reviewed all dialysis residents' care plans and made revisions to include the days of the week for their scheduled dialysis along with any refusals of dialysis treatment. These interventions include but are not limited to nurse to resident education regarding the risk versus benefit of dialysis upon resident's refusal of dialysis. On 4/5/13 and 4/6/13 the Director of Nursing, Assistant Director of Nursing, and Nurse Unit Managers reviewed all current resident records and care plans and made modifications(revisions) to the care plans to ensure accuracy, as needed.		

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

PRINTED: 06/28/2013
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 04/10/2013
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601	
(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 280	<p>Continued From page 3</p> <p>04/03/13, at 12:45 PM, revealed Resident #1's elevated Potassium level was a direct result of the resident missing his/her scheduled dialysis treatment on 03/23/13. According to the nephrologist, the critical level of Resident #1's Potassium could have caused the resident to die. Resident #1 returned to the facility on 03/23/13. (Refer to F309.)</p> <p>The failure of the facility to ensure a comprehensive plan of care, with interventions describing the services to be provided, was developed and revised placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care were determined to exist on 03/23/13. The facility was notified of the Immediate Jeopardy on 04/04/13.</p> <p>An acceptable Allegation of Compliance was received on 04/09/13, and alleged removal of the Immediate Jeopardy on 04/07/13. The State Survey Agency determined the Immediate Jeopardy was removed on 04/07/13, prior to exit, which lowered the scope/severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of a facility policy titled, "Care Plan", dated March 2012, revealed an interdisciplinary care plan would be established for every resident and updated in accordance with state and federal regulatory requirements and on as needed basis. The policy revealed the facility must develop a comprehensive care plan that included measurable objectives and timetables to meet the</p>	F 280	<p>3. a. On 4/3/13 and 4/4/13, the Director of Nursing, Assistant Director of Nursing, and Nurse Unit Managers educated the Licensed Nurses on the changes to dialysis residents' schedules, the facility policy on Coordination of Hemodialysis Service and completion of the Summary of Resident Condition and ESRD communication form, the new Process for Management of Hemodialysis Communication and Services with Other Life Sustaining Entities, the new Resident Refusal Care Plan, Resident Education Record, revision of care plans with residents' changes, documenting refusals of care on the 24 Hour Report, and providing care and services to meet residents' needs. On 4/6/13, the Director of Nursing, Assistant Director of Nursing and Nurse Unit Managers educated the Licensed Nurses on the new Refusal of Dialysis Approach Guide. This education has been included in the orientation packets for new hire nurses</p>	

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

PRINTED: 06/28/2013
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 04/10/2013
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 280	<p>Continued From page 4</p> <p>resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment.</p> <p>A review of Resident #1's medical record revealed Resident #1 had a diagnosis of End Stage Renal Disease and required renal dialysis treatments three times per week on a scheduled basis (Tuesday, Thursday, and Saturday). Documentation revealed Resident #1 received the scheduled dialysis treatments on Tuesday (03/19/13) and Thursday (03/21/13), and was taken to the dialysis center on Wednesday (03/20/13) for an unscheduled visit for "fluid removal only." However, based on documentation, the facility failed to ensure Resident #1 received the scheduled dialysis treatment on 03/23/13, and failed to provide communication to the dialysis center that the resident was not going to receive dialysis on that day or the reason why. Continued review of the medical record revealed on Tuesday (03/26/13) at 5:45 AM, Resident #1 complained of being "short of air," and was transported from the facility to the hospital by ambulance at 6:10 AM.</p> <p>A review of Resident #1's hospital medical record revealed on 03/26/13, the resident was admitted to the hospital with a diagnosis of Hyperkalemia and a Potassium level of 7.9 milliequivalents per liter which was noted on the hospital medical record as being a critical level (normal range 3.6-5.2 milliequivalents per liter).</p> <p>A review of an Annual Minimum Data Set (MDS) assessment dated 01/01/13 revealed the facility had assessed Resident #1's cognition at a Brief Interview for Mental Status (BIMS) score of 9;</p>	F 280	<p>b. On 4/6/13, the Director of Nursing, the Assistant Director of Nursing, and the Nurse Unit Managers placed a Refusal of Dialysis Approach Guide with each dialysis resident's care plan. On 4/5/13 and 4/6/13, the Director of Nursing, the Assistant Director of Nursing, and the Nurse Unit Managers placed a new Resident Refusal Care Plan in each current residents' care plan.</p> <p>c. On 4/5/13, the Vice President of Clinical Services educated the Director of Nursing, the Assistant Director of Nursing, and the Nurse Unit Managers on reviewing the 24 hour report (including resident refusals), new physician orders, and newly returned Summary of Resident Condition and ESRD Communication forms daily 5 x weekly in the Morning Meeting to ensure accuracy and/or revise the residents' care plans accordingly. There are currently no residents receiving dialysis on Saturdays; in the event a resident was placed on dialysis on Saturdays, the</p>	

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

PRINTED: 06/28/2013
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 04/10/2013
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 280	<p>Continued From page 5</p> <p>which was moderately impaired, and assessed the resident to be interviewable. The assessment also revealed Resident #1 received dialysis treatments.</p> <p>Although a review of the comprehensive plan of care for Resident #1 dated 01/02/13 revealed the resident received dialysis treatment, the plan of care did not specify the days the resident was scheduled to attend dialysis (Tuesday, Thursday, and Saturday) or what actions to take if the resident missed a dialysis treatment. In addition, the plan of care did not contain interventions to take when the resident refused and/or missed dialysis treatments.</p> <p>Interview with Resident #1 on 04/03/13, at 9:20 AM, revealed the resident did not recall that he/she had received an extra dialysis treatment on 03/20/13. The resident stated he/she went to dialysis three times every week. The resident stated, "I can refuse to go if I do not want to go and have refused to go at times."</p> <p>A review of a missed treatment log from Dialysis Center #1 revealed Resident #1 had missed 12 dialysis treatments (05/26/12, 06/21/12, 07/17/12, 07/24/12, 09/29/12, 10/04/12, 10/18/12, 11/08/12, 11/20/12, 12/11/12, 03/12/13, and 03/23/13) during a timeframe of ten months.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 04/03/13, at 1:05 PM, revealed she was responsible for the care of Resident #1 on 03/23/13, at 6:00 AM, and was responsible for ensuring Resident #1 was sent to the dialysis center on that date. However, the LPN stated she was given information by LPN #2 in report on</p>	F 280	<p>Customer Care Liaison, who is the Minimum Data Set Coordinator Nurse, would review the 24 hour report (including resident refusals, new physician orders, and newly returned Summary of Resident Condition and ESRD Communication forms) to ensure accuracy and/or revise resident care plans if needed.</p> <p>d. On 4/4/13, the Administrator met with Resident #1's dialysis provider to ensure coordination of services. It was during that meeting along with phone calls and letters to the facility's other dialysis providers on 4/5/13, that the Administrator discussed the importance of completing the Summary of Resident Condition and ESRD Communication forms and returning the completed form to the facility. The dialysis providers were also informed that if the Summary of Resident Condition and ESRD Communication form is not returned or returned incomplete, the dialysis</p>	

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

PRINTED: 06/28/2013
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 04/10/2013
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 280	<p>Continued From page 6</p> <p>03/21/13, that Resident #1 would not be attending his/her regular dialysis treatment on 03/23/13, because the resident had already been to dialysis three times that week. The LPN stated she had not questioned the information because the resident had missed dialysis treatments in the past and had refused to go at times. The LPN stated she always received information as to which residents were scheduled for dialysis in shift report and was unaware if the information related to Resident #1's dialysis treatments/schedule was on the care plan. The LPN stated all nurses were responsible for adding/changing interventions to the care plan, and stated the resident's refusal to receive dialysis at times should also have been added to the resident's care plan.</p> <p>An interview with LPN #2 on 04/04/13, at 11:35 AM, revealed she had been responsible for the care of Resident #1 on 03/21/13. The LPN stated Resident #1 had reported to her upon the resident's return from the dialysis center on 03/21/13 that he/she would not be going to dialysis on Saturday (03/23/13) because he/she had already been three times that week. LPN #2 stated Resident #1 refused to go to dialysis at times. The LPN stated she was not aware the resident had been scheduled an extra treatment for fluid removal on 03/20/13, had not questioned the information given by the resident to her, and had informed staff on the next shift during shift report that according to Resident #1 the resident did not have to receive dialysis on 03/23/13. The LPN stated she had not worked on 03/23/13 and had informed LPN #1 during the shift report on 03/21/13 that the resident stated he/she did not need to go to dialysis on 03/23/13. The LPN</p>	F 280	<p>provider will receive a phone call from the facility requesting the information that was not provided. The Dialysis providers voiced understanding.</p> <p>4. a. On 4/5/13, the Assistant Director of Nursing began conducting Quality Improvement monitoring daily of the facility's Policy and Procedure for Coordination of Hemodialysis Services along with the process to follow for residents attending Hemodialysis and/or Services with other Life Sustaing Outside Entities (to include the process for refusals and care plan modifications) by utilizing the Hemodialysis Communication Education Validation for Licensed Nurses. The method used for this is to have each assigned nurse complete the Hemodialysis Communication Education Validation every shift until the Immediate Jeopardy was removed and then 5 x weekly for 2 weeks, the weekly for 1 month, and</p>	

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

PRINTED: 06/28/2013
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 04/10/2013
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 280	<p>Continued From page 7</p> <p>stated all nurses were responsible for ensuring the care plan was updated with any changes. According to LPN #2, she was unaware if the dialysis schedule was identified on Resident's #1 care plan and stated she "just recalled" the days the resident was to receive dialysis.</p> <p>An interview with Registered Nurse (RN) #1 on 04/03/13 at 3:30 PM revealed she was the Unit Manager for the 300 Floor where Resident #1 resided. The RN stated she was not aware Resident #1 had an extra dialysis treatment on 03/20/13. The RN stated she had not questioned why the resident did not attend dialysis on 03/23/13 because the resident had refused to go to dialysis in the past and the family did not want the resident forced to go. The RN stated staff had failed to ensure the care plan included the resident's dialysis schedule, that the resident refused dialysis treatments at times, or what interventions to take when the resident refused treatment. The RN stated all nurses were responsible for updating the care plans with any changes or any new physician's orders.</p> <p>An interview conducted with the Assistant Director of Nursing (ADON) on 04/04/13 at 3:50 PM, revealed she had previously been the MDS Coordinator and had developed Resident #1's comprehensive plan of care. The ADON stated if the resident had refused a dialysis treatment a care plan should have been developed to address the refusal, and she was unsure why she had not developed a care plan to address the resident's refusal.</p> <p>An interview with the Director of Nursing (DON) on 04/04/13 at 5:10 PM revealed the MDS</p>	F 280	<p>then monthly for 3 months. The Assistant Director of Nursing will provide reeducation immediately if needed to the Licensed Nurse if he/she is at work. If the Licensed Nurse requiring reeducation is not currently at work then he/she will be reeducated by the Assistant Director of Nursing prior to the next scheduled shift. The Director of Nursing reviewed these Quality Improvement tools daily until the Immediate Jeopardy was removed and then will review 5 x weekly for 2 weeks, then weekly for 1 month, and then monthly for 3 months.</p> <p>b. The Nurse Unit Managers will conduct Quality Improvement monitoring of the care plan modification process utilizing the 24 Hour Report, new physician orders, and the Summary of Resident Condition and ESRD Communication forms 5 x weekly for 3 months to ensure care plans reflect residents' condition accurately. The Nurse Unit Managers will</p>	

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

PRINTED: 06/28/2013
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 04/10/2013
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 280	<p>Continued From page 8</p> <p>Coordinators and the nurses were all responsible for the development of each resident's care plan. The DON stated upon Resident #1's admission to the facility, the resident had refused dialysis treatment at times and staff had encouraged the resident to go; however, according to the DON she was not aware the resident continued to refuse to go to dialysis at times. The DON stated the care plan should have reflected the resident's dialysis schedule and staff should have developed interventions to address the resident's refusal to attend dialysis at times.</p> <p>--A review of the Allegation of Compliance (AOC) revealed the following:</p> <p>On 04/04/13, the DON, ADON, and Unit Manager reviewed and revised Resident #1's comprehensive plan of care to include the days of the week for scheduled dialysis (Tuesday, Thursday, and Saturday and to change to Monday, Wednesday, and Friday beginning on 04/08/13) along with interventions to include the refusal of dialysis.</p> <p>On 04/05/13 and 04/06/13, the DON, ADON, and Unit Managers reviewed all dialysis residents' care plans and made revisions to include the days of the week for their scheduled dialysis along with any refusals of dialysis treatment. These interventions included but were not limited to nurse to resident education regarding the risk versus the benefit of dialysis upon a resident's refusal of dialysis.</p> <p>On 04/05/13 and 04/06/13, the DON, ADON, and Unit Managers reviewed all current resident</p>	F 280	<p>provide reeducation immediately, as needed, to the Licensed Nurse if he/she is at work. If the Licensed Nurse requiring reeducation is not currently at work, the Licensed Nurse will be reeducated by the Nurse Unit Managers prior to his/her next scheduled shift. The Director of Nursing will review these Quality Improvement monitoring tools 5 x weekly for 3 months. The Director of Nursing will report the results of the Quality Improvement monitoring to the Quality Assurance Committee monthly for 3 months for continued substantial compliance and/or revision. The facility's Regional Director of Clinical Services will conduct Quality Improvement monitoring of the facility's Quality Assurance process monthly for 3 months for continued substantial compliance and/or revision.</p>	

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

PRINTED: 06/28/2013
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 04/10/2013
--	--	--	---

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 280	<p>Continued From page 9</p> <p>medical records and care plans and made modifications to care plans to ensure accuracy as needed.</p> <p>On 04/03/13 and 04/04/13, the DON, ADON, and Unit Managers in-serviced current facility licensed nurses regarding the facility's policy and procedure for dialysis communication for continuity of care, Coordination of Hemodialysis Services policy and procedure, Summary of Resident Condition and ESRD Communication form, and the new process to follow for residents attending hemodialysis and/or other services with other life sustaining outside entities. This included documentation on the 24-hour report. These in-services were also added to the facility's orientation education for all newly hired licensed nurses.</p> <p>On 04/05/13, the Vice President of Clinical Services in-serviced the DON, ADON, and Unit Managers on reviewing the 24-hour report (including resident refusals), new physician's orders, and newly returned Summary of Resident Condition and ESRD Communication forms daily five times a week in the morning meeting to ensure accuracy and/or to revise the residents' care plans accordingly. Currently there are no residents receiving dialysis on Saturdays; in the event a resident was placed on dialysis on Saturdays, the Customer Care Liaison, who is the MDS Nurse, would review the 24-hour report (including resident refusals, new physician's orders, and newly returned Summary of Resident Condition and ESRD Communication forms, and to ensure accuracy and/or revise the resident's care plan if needed on Saturday.</p>	F 280		

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

PRINTED: 06/28/2013
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 04/10/2013	
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 280	<p>Continued From page 10</p> <p>On 04/06/13, the ADON in-serviced all facility licensed nurses on the Refusal of Dialysis Approach Guide, which was placed with the resident's care plan of the dialysis residents by the DON, ADON, and Unit Manager.</p> <p>On 04/05/13, the ADON began conducting a Quality Improvement monitoring test daily of all scheduled licensed nurses who were working on the facility's policy and procedure for Coordination of Hemodialysis Services along with the process to follow for residents attending hemodialysis and/or any other life sustaining services from outside entities. The test included the process for refusals and care plan modifications. The tool being utilized was the "Hemodialysis Communication Education Validation for Licensed Nurses." Each assigned nurse was required to complete the test every shift they worked until the Immediate Jeopardy was removed and then five times per week for two weeks, weekly for one month, and then monthly for three months. The ADON would provide re-education immediately as needed, and if the nurse was not currently at work then the nurse would be re-educated by the ADON prior to the next scheduled shift.</p> <p>The Unit Managers will conduct Quality monitoring of the care plan modification process utilizing the 24-hour report, new physician's orders, and the Summary of Resident Condition and ESRD Communication forms five times a week for three months to ensure care plans reflect the residents' conditions accurately. The Unit Manager will provide re-education immediately as needed to the licensed nurse if he/she is at work. If the nurse is not at work, he/she will be re-educated by the Unit Manager</p>	F 280		

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

PRINTED: 06/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165256	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2013
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 280	<p>Continued From page 11</p> <p>prior to the next scheduled shift. The DON will review Quality Improvement monitoring tools five times a week for three months.</p> <p>The DON will report the results of the Quality Improvement monitoring to the Quality Assurance/Performance Improvement Committee monthly for three months for continued compliance and/or revision.</p> <p>The Regional Director of Clinical Services will conduct Quality Improvement monitoring of the facility's Quality Assurance/Performance Improvement process monthly for three months for continued substantial compliance and/or revision.</p> <p>-The State Survey Agency validated the corrective actions taken by the facility as follows:</p> <p>A review of the comprehensive care plan for Resident #1 revealed on 04/04/13, it had been updated by the ADON to reflect the days of the week the resident was to attend dialysis (Tuesday, Thursday, and Saturday). Resident #1's care plan had further been updated on 04/06/13, by the ADON to reflect the resident's dialysis days would be changing beginning on 04/08/13, to reflect the resident would be going to dialysis on Monday, Wednesday, and Friday. The care plan had been updated on 04/05/13, to reflect interventions related to refusal of dialysis treatments. The care plan also contained a "Refusal of Dialysis Approach Guide" dated 04/05/13, by the ADON.</p> <p>A review of the comprehensive care plans for Resident #2, Resident #3, and Resident #4 had</p>	F 280	

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

PRINTED: 08/28/2013
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 04/10/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601
--	---

(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 280	<p>Continued From page 12</p> <p>been reviewed on 04/04/13, 04/05/13, and 04/08/13 by the ADON. All four residents' comprehensive plans of care have been revised and contain the date the residents are scheduled for dialysis. The care plans also all contained a "Refusal of Dialysis Approach Guide."</p> <p>A review of a list dated 04/05/13 and 04/06/13, and signed by the DON, ADON, Unit Manager #2, and Unit Manager #3 revealed the comprehensive plans of care for all residents in the facility had been reviewed and/or revised on either 04/05/13 or 04/06/13.</p> <p>A review of in-service rosters dated 04/03/13 and 04/04/13 revealed all licensed facility nurses had attended an in-service regarding the facility's policy and procedure for "Dialysis Communication for Continuity of Care," the facility's policy and procedure for the "Coordination of Hemodialysis Services," "Summary of Resident Condition and ESRD Communication Form," and the process to follow for residents attending hemodialysis and/or services with other life sustaining outside entities. The in-services also educated the staff regarding the documentation of refusals on the 24-hour report.</p> <p>A review of a new employee orientation packet revealed all new licensed nurses would receive in-services in orientation regarding the facility's policy and procedure for "Dialysis Communication for Continuity of Care," the facility's policy and procedure for the "Coordination of Hemodialysis Services," "Summary of Resident Condition and ESRD Communication Form," and the process to follow for residents attending hemodialysis and/or services with other life sustaining outside entities.</p>	F 280		

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

PRINTED: 06/28/2013
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 04/10/2013
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 280	<p>Continued From page 13</p> <p>The in-services would also educate the nurses regarding the documentation of refusals on the 24-hour report.</p> <p>A review of an in-service roster dated 04/05/13, revealed the Vice President of Clinical Services had provided an in-service to the DON, ADON, Unit Manager #2, and Unit Manager #3 regarding reviewing the 24-hour report, physician's orders, resident refusals, and newly returned Summary of Resident Condition and ESRD Communication forms. They were instructed that these were to be reviewed daily five times per week in the morning meeting to ensure accuracy and/or revise the residents' care plans accordingly. They were in-serviced to reflect that the facility currently had no residents who were going to dialysis on Saturdays, but in the event they did the Customer Care Liaison, who was currently the MDS Nurse, would be responsible for reviewing the 24-hour report, new physician's orders, and newly returned Summary of Resident Condition and ESRD Communication forms. They were instructed that these were to be reviewed daily five times per week in the morning meeting to ensure accuracy and/or revise the residents' care plans accordingly.</p> <p>A review of in-service rosters dated 04/06/13, revealed all licensed facility nurses had been in-serviced on "The Refusal of Dialysis Approach Guide," by the DON, ADON, Unit Manager #2, and Unit Manager #3.</p> <p>A review of an in-service roster dated 04/06/13, revealed the Regional Vice President of Operations in-serviced the Administrator on Substandard Quality of Care along with the</p>	F 280			

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

PRINTED: 06/28/2013
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 04/10/2013
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 280	Continued From page 14 administrative process. The Administrator was instructed that the Regional Vice President of Operations and/or the Regional Director of Clinical Services would be providing oversight to ensure facility staff was providing quality care and services to the facility residents. A review of a test being utilized by the facility beginning on 04/05/13, revealed the test covered what the staff was expected to do with resident refusals to attend dialysis, communication with the dialysis centers, where and how to document information, and updating the resident's plan of care. Documentation revealed the test had been completed with licensed nurses every shift and education was given to the nurse regarding every missed question. Documentation revealed the tests had been reviewed by the Regional Director of Clinical Services and the DON. A review of the Quality Assurance/Performance Improvement tool which had been completed by the Unit Managers beginning on 04/07/13 revealed the tool reviewed the 24-hour report, new physician's orders, Summary of Resident Condition, and ESRD Communication forms five times a week to ensure care plans reflected residents' conditions accurately. The Unit Managers had completed the tool, and the tool had been reviewed by the Regional Director of Clinical Services and the DON. A review of a Quality Assurance/Performance Improvement tool which had been completed by the Unit Managers beginning on 04/07/13 revealed the Unit Managers had been reviewing the 24-hour report for resident refusals of hemodialysis services or services with other life	F 280			

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

PRINTED: 06/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2013
--	--	--	---

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 280	<p>Continued From page 15</p> <p>sustaining entities. There was documentation on the tools where they had been reviewed by the Regional Director of Clinical Services and the DON.</p> <p>Interviews conducted with LPN #1 on 04/09/13 at 5:15 PM, LPN #2 on 04/09/13 at 5:40 PM, LPN #13 on 04/09/13 at 6:10 PM, LPN #10 on 04/09/13 at 6:25 PM, LPN #5 on 04/10/13 at 9:50 AM, LPN #9 on 04/10/13 at 10:00 AM, LPN #11 on 04/10/13 at 10:20 AM, LPN #12 on 04/10/13 at 10:30 AM, RN #2 on 04/10/13 at 9:35 AM, and RN #3 on 04/10/13 at 10:05 AM all revealed they had been provided in-services by the facility related to communication forms with the facility and outside entities providing services to the residents, and on the dialysis policy and procedures. The nurses also stated they had been required to take a test every shift related to dialysis and communication. The nurses stated they are required to update all resident care plans with any new orders and changes. The nurses also stated all dialysis resident care plans included a list of interventions to use if a resident refused to go to dialysis.</p> <p>Interviews conducted with Unit Manager #2 on 04/09/13 at 6:00 PM, and Unit Manager #3 on 04/10/13 at 10:30 AM, revealed they completed Quality Assurance/Performance Improvement tools which included reviewing the 24-hour report, all new physician's orders, daily communication sheets, and care plans daily five times a week. They stated these were reviewed in the morning meeting. The Unit Managers revealed if any issues were identified staff would be in-serviced immediately or prior to their next scheduled shift if they were not on duty.</p>	F:280		
-------	--	-------	--	--

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

PRINTED: 06/28/2013
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 04/10/2013
--	--	--	---

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 280	<p>Continued From page 16</p> <p>Interview conducted with the ADON on 04/09/13 at 2:20 PM, revealed she reviewed/updated the comprehensive plans of care for Resident #1, Resident #2, Resident #3, and Resident #4 on 04/04/13, and again on 04/05/13 and 04/06/13. The ADON stated she tested every licensed nurse, on every shift, regarding managing dialysis, outside entity communication, care planning, and resident refusals. The ADON stated she provided education for any missed question. The ADON stated these were reviewed in the morning meeting as well as by the DON. The ADON stated if the nurse was not currently at work, the in-service would be provided prior to the next scheduled shift. The ADON stated Unit Manager #1 was no longer employed by the facility.</p> <p>Interview conducted with the weekend MDS Nurse on 04/10/13, at 2:26 PM revealed she was the Customer Service Liaison on Saturdays and, in the event a resident was scheduled for dialysis on Saturday, she would be responsible for reviewing the 24-hour report, communication forms, any new physician's orders, and the care plans for any updates. The MDS Nurse stated currently no residents were scheduled to go to dialysis on Saturday.</p> <p>Interview conducted with the DON on 04/10/13, at 2:45 PM, revealed she had assisted in reviewing and revising all residents' current care plans and helped to review and revise Resident #1's comprehensive care plan. The DON stated she also assisted with the nursing in-services regarding the facility's policy and procedure for "Dialysis Communication for Continuity of Care,"</p>	F 280		
-------	---	-------	--	--

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

PRINTED: 06/28/2013
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 04/10/2013
--	--	--	---

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 280	Continued From page 17 the facility's policy and procedure for the "Coordination of Hemodialysis Services", "Summary of Resident Condition and ESRD Communication Form," and the process to follow for residents attending hemodialysis and/or services with other life sustaining outside entities. The in-services also included documentation of refusals on the 24-hour report. The DON stated she reviewed all the Quality Assurance/Performance Improvement tools that were put in place, along with the tests that were being taken by the nurses. The DON stated she attended an in-service given by the Vice President of Clinical Services regarding reviewing the 24-hour report, all new physician's orders, daily communication sheets, and care plans daily five times a week to ensure residents were being provided with quality care and services. The DON stated if an issue was identified, related to a care plan not being updated or a communication sheet or Physician's order not being followed through, an in-service would be provided to the nurse.	F 280		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F 309 1. On 3/26/13, Resident #1 was noted to have a change in condition. The nurse notified the primary physician and Resident#1 was sent to the local emergency room for evaluation. Resident #1 was admitted to the hospital and received dialysis on 3/26/13. Resident #1 returned to Parkview on 3/29/13. On 4/4/13, the Director of Nursing,	05/01/13

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

PRINTED: 06/28/2013
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 04/10/2013
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 309	<p>Continued From page 18</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 have an effective system to ensure necessary services were provided to attain or maintain the highest practicable well-being for one of eight sampled residents (Resident #1). The facility failed to ensure Resident #1 received dialysis treatments as ordered by the physician. Record review revealed Resident #1 had a diagnosis of End Stage Renal Disease (ESRD) and received hemodialysis three times per week, on Tuesday, Thursday, and Saturday. Documentation on Saturday, 03/23/13, revealed Resident #1 missed his/her scheduled dialysis treatment on that date; however, the facility failed to ensure communication was provided to and/or received from the dialysis center regarding the missed visit. On Tuesday, 03/26/13 (three days after the resident missed the dialysis treatment and five days since the resident's last dialysis treatment) Resident #1 was admitted to the hospital with a diagnosis of Hyperkalemia (elevated Potassium level) and was assessed to have a Potassium level of "7.9" milliequivalents per liter (normal range from 3.6-5.2 milliequivalents per liter). An interview conducted with Resident #1's nephrologist revealed the Hyperkalemia was a direct result of the resident missing his/her scheduled dialysis treatment on 03/23/13, and could have caused the resident to die. Resident #1 returned to the facility on 03/29/13.</p> <p>The failure of the facility to ensure residents received and facility staff provided the necessary care and services to attain or maintain the highest</p>	F 309	<p>Assistant Director of Nursing, and Nurse Unit Manager reviewed and revised Resident #1's comprehensive plan of care to include the days of the week for scheduled dialysis (Tuesday, Thursday, and Saturday to change to Monday, Wednesday, and Friday beginning on 4/8/13) along with interventions for refusal of dialysis.</p> <p>2. All residents have the potential to be affected by the facility's failure to ensure care and services necessary to attain or maintain the highest practicable physical, mental, and psychosocial well being of the residents in accordance with the comprehensive assessment and plan of care were provided. On 4/4/13, the Director of Nursing and the Nurse Unit Managers reviewed all current facility dialysis residents to ensure the residents were stable by obtaining the residents' vital signs (blood pressure, temperature, pulse, and respirations). Any current facility residents identified as</p>

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

PRINTED: 06/28/2013
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 04/10/2013
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 309	<p>Continued From page 19</p> <p>practicable physical well-being, placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care were determined to exist on 03/23/13. The facility was notified of the Immediate Jeopardy on 04/04/13.</p> <p>An acceptable Allegation of Compliance was received on 04/09/13 and alleged removal of the Immediate Jeopardy on 04/07/13. The State Survey Agency determined the Immediate Jeopardy was removed on 04/07/13, prior to exit, which lowered the scope/severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Coordination of Hemodialysis Services," with a revision date of May 2012, revealed a communication form would be initiated by the facility for any resident going to the dialysis center. The policy stated the dialysis center would review the communication form sent by the facility, and either complete the form sent by the facility to the dialysis center, or send a communication form developed by the dialysis center, back to the facility at each visit. The policy revealed upon the resident's return to the facility, Nursing would review the hemodialysis communication form and communicate with the resident's physician and other ancillary departments as needed.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 01/26/12 with a diagnosis of End Stage Renal Disease and the resident was to receive</p>	F 309	<p>having a change in their condition as related to their vital signs were referred to the primary physician for further orders. On 4/5/13 and 4/6/13, the Director of Nursing, Assistant Director of Nursing, and the Nurse Unit Managers reviewed all current resident medical records and care plans and made modifications to care plans to ensure each accurately reflects the resident and to ensure the necessary care and services are provided to each resident in accordance with the comprehensive assessment.</p> <p>3. a. On 4/3/13 and 4/4/13, the Director of Nursing, Assistant Director of Nursing, and Nurse Unit Managers educated the Licensed Nurses on the changes to dialysis residents' schedules, the facility policy on Coordination of Hemodialysis Service and completion of the Summary of Resident condition and ESRD communication form, the new Process for Management of Hemodialysis Communication and Services with Other Life Sustaining</p>	

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

PRINTED: 06/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18526E	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2013
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 309	<p>Continued From page 20</p> <p>hemodialysis treatments three times per week (Tuesday, Thursday, and Saturday). A review of the communication forms from the dialysis center revealed Resident #1 routinely received dialysis treatments lasting 210 minutes. However, a review of the communication form dated 03/20/13, revealed the dialysis treatment lasted 81 minutes and was for "fluid removal only." Continued review of Resident #1's medical record revealed there was no communication form dated for Saturday 03/23/13, the day Resident #1 had been scheduled to receive dialysis, from the dialysis center. A review of nurse's notes dated 03/26/13, at 6:45 AM (three days after the resident had not received the scheduled dialysis treatment and five days after the last treatment at the facility) revealed Resident #1 was complaining of being "short of air," and on 03/26/13, at 6:10 AM the facility transferred the resident by ambulance to the hospital.</p> <p>A review of Resident #1's hospital medical record revealed the hospital admitted Resident #1 on 03/26/13 with a diagnosis of Hyperkalemia. Based on documentation in the resident's hospital record, upon admission to the hospital the resident's potassium level was noted to be 7.9 milliequivalents per liter and was noted to be at a critical level on the hospital medical record (normal range 3.6-5.2 milliequivalents per liter).</p> <p>An interview conducted on 04/03/13, at 12:45 PM, with the nephrologist that provided treatment to Resident #1 revealed the resident had been scheduled an extra dialysis treatment on 03/20/13 to remove extra fluid from the resident. The physician stated the Hyperkalemia was a direct result of the resident missing his/her scheduled</p>	F 309	<p>Entities, the new Resident Refusal Care Plan, Resident Education Record, revision of care plans with residents' changes, documenting refusals of care on the 24 Hour Report, and providing care and services to meet residents' needs. On 4/6/13, the Director of Nursing, the Assistant Director of Nursing, and the Nurse Unit Managers educated the Licensed Nurses on the new Refusal of Dialysis Approach Guide. This education has been included in the orientation packets for new hire nurses.</p> <p>b. On 4/6/13, the Regional Vice President of Operations educated the Administrator on Substandard Quality of Care along with the administrative process required to ensure quality of care and services to the residents. The Administrator understands that the Regional Vice President of Operations/Regional Director of Clinical Services will provide oversight to ensure facility staff provides quality of care and services to the facility's residents. This oversight includes the daily presence in the facility by the Regional Director of</p>	

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

PRINTED: 06/28/2013
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 04/10/2013
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 309	<p>Continued From page 21</p> <p>dialysis treatment on 03/23/13, and could have caused the resident to die.</p> <p>A review of an Annual Minimum Data Set (MDS) assessment dated 01/01/13 revealed the facility had assessed Resident #1's cognition at a Brief Interview for Mental Status (BIMS) score of 9 which was moderately impaired and assessed the resident to be interviewable.</p> <p>An interview conducted with Resident #1 on 04/03/13, at 9:20 AM, revealed the resident received dialysis treatments three times a week. However, the resident was not aware that he/she had received an extra dialysis treatment on 03/20/13, or that he/she had missed a dialysis treatment on 03/23/13.</p> <p>An interview conducted with Licensed Practical nurse (LPN) #1 on 04/03/13 at 1:05 PM, revealed she had provided care to Resident #1 on 03/23/13 at 6:00 AM, and was responsible to ensure Resident #1 received care in accordance with the resident's assessment and physician's orders, including ensuring the resident was transported to the dialysis center on that date. The LPN stated she was given information by LPN #2 at the change of shift on 03/21/13 that Resident #1 would not be attending his/her regular dialysis treatment on 03/23/13, because the resident had already been to dialysis three times that week. Per interview, she did not instruct the staff to assist the resident in getting prepared to go to the dialysis center and did not call the resident's dialysis center to confirm the resident was not scheduled to have dialysis that morning. The LPN stated she had not questioned the information because the resident had missed</p>	F 309	<p>Clinical Services and/or Regional Vice President of Operations and/or Vice President of Clinical Services along with review of the Quality Assurance Process to include but not be limited to validation of the Quality Improvement tools. This will continue daily until the Immediate Jeopardy is removed.</p> <p>c. On 4/6/13, the Director of Nursing, Assistant Director of Nursing and the Nurse Unit Managers placed a Refusal of Dialysis Approach Guide with each dialysis resident's care plan. On 4/5/13 and 4/6/13, the Director of Nursing, the Assistant Director of Nursing, and the Nurse Unit Managers placed a new Resident Refusal Care Plan in each residents' care plan.</p> <p>d. On 4/4/13, the Assistant Director of Nursing placed a schedule listing dialysis residents' scheduled days for dialysis, their dialysis companies, their nephrologists' names and phone numbers, and their transportation companies at each nursing station. In addition, the Assistant Director of Nursing reviewed dialysis residents' care plans, physician orders, and consultation notes to ensure that interventions and orders had been implemented.</p>	

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

PRINTED: 06/28/2013
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 04/10/2013
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 309	<p>Continued From page 22</p> <p>dialysis treatments in the past because of his/her refusal to go. The LPN stated she should have called the dialysis center to confirm the resident was not scheduled to attend on 03/23/13.</p> <p>An interview conducted with LPN #2 on 04/04/13 at 11:35 AM, revealed she had been responsible to provide care to Resident #1 on 03/21/13. The LPN stated Resident #1 had reported to her upon the resident's return from the dialysis center on 03/21/13 that he/she would not be going to dialysis on Saturday (03/23/13) because he/she had already been three times that week. The LPN stated she did not question the information nor was she aware the resident had received an extra dialysis treatment on 03/20/13 for fluid removal. The LPN stated the paramedic who had transported the resident to and from the dialysis center on 03/21/13 confirmed the resident had been to dialysis three times that week. The LPN stated she did not call the dialysis center to confirm the information and did not review the communication sheet sent from the dialysis center on 03/21/13. LPN #2 acknowledged she should have confirmed the resident's information with the dialysis center. The LPN stated she had not worked on 03/23/13 and had given the report on 03/21/13 to LPN #1 that Resident #1 would not be going to dialysis on 03/23/13.</p> <p>An interview conducted with Registered nurse (RN) #1 on 04/03/13, at 3:30 PM, revealed she was the Unit Manager of the 300 Unit of the facility and was responsible for reviewing the communication forms sent to the facility by the dialysis center. The RN stated she had been unaware Resident #1 had received an extra dialysis treatment on 03/20/13, or that the</p>	F 309	<p>e. On 4/5/13, an ad hoc Quality Assurance meeting was held and the committee reviewed the new process to follow for residents attending Hemodialysis and/or other services with other life sustaining entities and approved the use of this process.</p> <p>f. On 4/4/13, the Administrator met with Resident #1's dialysis provider to ensure coordination of services. It was during that meeting along with phone calls and letters to the facility's other dialysis providers on 4/5/13, that the Administrator discussed the importance of completing the Summary of Resident Condition and ESRD communication forms and returning the completed form to the facility. The dialysis providers were also informed that if the Summary of Resident Condition and ESRD Communication form is not returned or returned incomplete, the dialysis provider will receive a phone call from the facility requesting the information that was not provided. The Dialysis providers voiced understanding.</p>	

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

PRINTED: 06/28/2013
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 04/10/2013
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 309	<p>Continued From page 23</p> <p>communication form provided to the facility on 03/20/13 indicated the resident's treatment on that day was for "fluid removal only." The RN stated she had not questioned the information because the resident had refused to go to dialysis in the past and the family did not want the resident forced to go. Per interview, she should have called the dialysis center to confirm the information and had failed to do so.</p> <p>An interview conducted with the Director of Nursing (DON) on 04/03/13, at 3:50 PM, revealed the facility staff was required to call the dialysis center if a visit was canceled. The DON stated staff had not called the dialysis center because staff was aware Resident #1 had already been to dialysis three times that week and had not been aware that Resident #1's treatment at the dialysis center on 03/20/13 had been for fluid removal only and not a complete dialysis treatment. The DON stated the Unit Manager was responsible for monitoring the communication forms to ensure residents who required dialysis attended as they were ordered by the physicians.</p> <p>An interview conducted with the Administrator on 04/04/13, at 11:10 AM, revealed staff was required to communicate with other facilities by use of the communication forms to ensure residents were provided with dialysis treatments as ordered by the physician. The Administrator stated facility staff had not known Resident #1 had received an extra dialysis treatment on 03/20/13, and had not questioned when the resident told staff he/she had already been to dialysis three times that week. However, the Administrator stated staff should have called the dialysis center to confirm the information.</p>	F 309	<p>g. On 4/5/13, the Vice President of Clinical Services educated the Director of Nursing, the Assistant Director of Nursing, and the Nurse Unit Managers on reviewing the 24 Hour Report (including resident refusals), new physician orders, and newly returned Summary of Resident Condition and ESRD Communication forms daily 5 x weekly in the Morning Meeting to ensure accuracy and/or revise the residents' care plans accordingly. There are currently no residents receiving dialysis on Saturdays; in the event a resident was placed on dialysis on Saturdays, the Customer Care Liaison, who is the Minimum Data Set Coordinator Nurse, would review the 24 Hour Report (including resident refusals, new physician orders, and newly returned Summary of Resident Condition and ESRD Communication forms) to ensure accuracy and/or revise resident care plans if needed.</p> <p>h. On 4/6/13, the Administrator informed the facility's Medical Director of the Immediate Jeopardy.</p>	

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

PRINTED: 06/28/2013
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 04/10/2013
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 309	<p>Continued From page 24</p> <p>--A review of the Allegation of Compliance (AOC) revealed the following:</p> <p>On 03/26/13, after Resident #1 was assessed to have a change in condition, the nurse notified the resident's physician, and the resident was sent to the hospital for further evaluation and treatment. The resident was admitted to the hospital, received dialysis at the hospital, and returned to the facility on 03/29/13.</p> <p>On 04/04/13, the DON, ADON, and Unit Manager reviewed and revised Resident #1's comprehensive plan of care to include the days of the week for scheduled dialysis (Tuesday, Thursday, and Saturday and to change to Monday, Wednesday, and Friday beginning on 04/08/13) along with interventions to include the refusal of dialysis.</p> <p>On 04/04/13, the DON and Unit Managers reviewed all current facility dialysis residents to ensure the residents were stable by obtaining the residents' vital signs (blood pressure, temperature, pulse, and respirations). Any current facility residents identified as having a change in their condition as related to their vital signs were referred to the physician for further orders.</p> <p>On 04/04/13, the ADON reviewed the medical records of residents receiving dialysis to verify their dialysis schedule and transportation schedule per physician's orders.</p> <p>On 04/04/13, the ADON placed a schedule listing dialysis residents' scheduled days for dialysis,</p>	F 309	<p>4. a. On 4/5/13, the Assistant Director of Nursing began conducting Quality Improvement monitoring daily for the facility's Policy and Procedure for Coordination of Hemodialysis Services along with the process to follow for residents attending Hemodialysis and/or Services with Other Life Sustaining Outside Entities (to include the process for refusals and care plan modification) by utilizing the Hemodialysis Communication Education Validation for Licensed Nurses. The method used for this is to have each assigned nurse complete the Hemodialysis Communication Education Validation every shift until the Immediate Jeopardy was removed and then 5 x weekly for 2 weeks, then weekly for 1 month, and then monthly for 3 months. The Assistant Director of Nursing will provide reeducation immediately if needed to the Licensed Nurse if he/she is at</p>	

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

PRINTED: 06/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195256	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2013
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 309	<p>Continued From page 25</p> <p>their dialysis companies, their nephrologists' names and phone numbers, and their transportation companies at each nursing station. In addition, on 04/04/13, the ADON reviewed all dialysis care plans, physician's orders, and consultation notes to ensure that interventions and orders had been implemented.</p> <p>On 04/05/13 and 04/06/13, the DON, ADON, and Unit Managers reviewed all dialysis residents' care plans and made revisions to include the days of the week for their scheduled dialysis, along with any refusals of dialysis treatment. These interventions included but were not limited to nurse to resident education regarding the risk versus the benefit of dialysis upon a resident's refusal of dialysis.</p> <p>On 04/04/13, all licensed facility nurses were in-serviced by the ADON on the changes to the dialysis schedules.</p> <p>On 04/05/13 and 04/06/13, the DON, ADON, and Unit Managers reviewed all current resident medical records and care plans and made modifications to care plans to ensure accuracy as needed.</p> <p>On 04/03/13 and 04/04/13, the DON, ADON, and Unit Managers in-serviced current facility licensed nurses regarding the facility's policy and procedure for dialysis communication for continuity of care, Coordination of Hemodialysis Services policy and procedure, Summary of Resident Condition and ESRD Communication form, and the new process to follow for residents attending hemodialysis and/or other services with other life sustaining outside entities. This</p>	F 309	<p>work. If the Licensed Nurse requiring reeducation is not at work, then he/she will be reeducated by the Assistant Director of Nursing prior to the next scheduled shift. The Director of Nursing reviewed these Quality Improvement tools daily until the Immediate Jeopardy was removed and then will review 5 x weekly for 2 weeks, then weekly for 1 month, and then monthly for 3 months.</p> <p>b. The Nurse Unit Managers will conduct Quality Improvement monitoring of the care plan modification process utilizing the 24 Hour Report, new physician orders, and the Summary of Resident Condition and ESRD Communication forms 5 x weekly for 3 months to ensure care plans reflect residents' condition accurately and to ensure care and services are provided according to the care plan. The Nurse Unit Managers will provide reeducation immediately, as needed, to the Licensed Nurse if he/she is at work. If the Licensed Nurse requiring reeducation is not currently at work, the Licensed Nurse will be reeducated</p>		

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

PRINTED: 06/28/2013
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 04/10/2013
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601		
(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 309	Continued From page 26 included documentation on the 24-hour report. These in-services were also added to the facility's orientation education for all newly hired licensed nurses. On 04/05/13, an ad hoc Quality Assurance/Performance Improvement meeting was held and the committee reviewed the new process to follow for residents attending Hemodialysis and/or other services with other life sustaining outside entities and approved it. On 04/04/13, the Administrator met with Resident #1's dialysis provider to ensure coordination of services. The Administrator also contacted (by phone or letter) all other dialysis providers who had provided dialysis services to residents, and discussed the importance of completing the Summary of Resident Condition and ESRD Communication forms and returning the completed forms to the facility. The dialysis providers were informed that if the Summary of Resident Condition and ESRD Communication form was not returned to the facility or was returned incomplete, the dialysis provider would receive a phone call from the facility requesting the information that was not provided. On 04/05/13, the Vice President of Clinical Services in-serviced the DON, ADON, and Unit Managers on reviewing the 24-hour report (including resident refusals), new physician's orders, and newly returned Summary of Resident Condition and ESRD Communication forms daily, five times a week in the morning meeting to ensure accuracy and/or to revise the residents' care plans accordingly. Currently there are no residents receiving dialysis on Saturdays; in the	F 309	by the Nurse Unit Managers prior to his/her next scheduled shift. The Director of Nursing will review these Quality Improvement monitoring tools 5 x weekly for 3 months. The Director of Nursing will report the results of the Quality Improvement monitoring to the Quality Assurance Committee monthly for 3 months for continued substantial compliance and/or revision. The facility's Regional Director of Clinical Services will conduct Quality Improvement monitoring of the facility's Quality Assurance process monthly for 3 months for continued substantial compliance and/or revision.		

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

PRINTED: 06/28/2013
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 04/10/2013
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 309	<p>Continued From page 27</p> <p>event a resident was placed on dialysis on Saturdays, the Customer Care Liaison, who is the MDS Nurse, would review the 24-hour report (including resident refusals), new physician's orders, and newly returned Summary of Resident Condition and ESRD Communication forms, and to ensure accuracy and/or revise the resident's care plan if needed on Saturday.</p> <p>On 04/06/13, the ADON in-serviced all facility licensed nurses on the Refusal of Dialysis Approach Guide, which was placed with the resident's care plans of the dialysis residents by the DON, ADON, and Unit Manager.</p> <p>On 04/06/13, the Regional Vice President of Operations educated the Administrator on Substandard Quality of Care and services to the residents. The Administrator was informed the Regional Vice President of Operations or the Vice President of Clinical Services would be providing oversight to ensure facility staff was providing quality of care services to the residents. The oversight would include a daily presence in the facility by the Regional Vice President of Operations and/or the Vice President of Clinical Services along with a review of the Quality Assurance/Performance improvement Process to include but not be limited to validation of the Quality Improvement tools; this would continue daily until the Immediate Jeopardy was removed.</p> <p>On 04/06/13, the Medical Director was informed of the Immediate Jeopardy by the Administrator.</p> <p>On 04/05/13, the ADON began conducting a Quality Improvement monitoring test daily of all scheduled licensed nurses who were working on</p>	F 309	

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

PRINTED: 06/28/2013
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 04/10/2013
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. 309	Continued From page 28 the facility's policy and procedure for Coordination of Hemodialysis Services along with the process to follow for residents attending hemodialysis and/or any other life sustaining services from outside entities. The test included the process for refusals and care plan modifications. The tool being utilized was the "Hemodialysis Communication Education Validation for Licensed Nurses." Each assigned nurse was required to complete the test every shift they worked until the Immediate Jeopardy was removed and then five times per week for two weeks, weekly for one month, and then monthly for three months. The ADON would provide re-education immediately as needed, and if the nurse was not currently at work, then the nurse would be re-educated by the ADON prior to the next scheduled shift. The Unit Managers will conduct Quality monitoring of the care plan modification process utilizing the 24-hour report, new physician's orders, and the Summary of Resident Condition and ESRD Communication forms five times a week for three months to ensure care plans reflect residents' conditions accurately. The Unit Manager will provide re-education immediately as needed to the licensed nurse if he/she is at work. If the nurse is not at work, he/she would be re-educated by the Unit Manager prior to the next scheduled shift. The DON will review Quality Improvement monitoring tools five times a week for three months. The DON will report the results of the Quality Improvement monitoring to the Quality Assurance/Performance Improvement Committee monthly for three months for continued compliance and/or revision.	F 309			

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

PRINTED: 06/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2013
--	--	--	---

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 309

Continued From page 29

The Regional Director of Clinical Services will conduct Quality Improvement monitoring of the facility's Quality Assurance/Performance Improvement process monthly for three months for continued substantial compliance and/or revision.

-The State Survey Agency validated the corrective actions taken by the facility as follows:

A review of the progress notes for Resident #1 dated 03/28/13, at 5:45 AM revealed the resident was complaining of "shortness of air," the physician was notified, and on 03/26/13, at 6:10 AM, the resident was transported to the hospital by ambulance.

A review of the hospital record for Resident #1 revealed the resident was admitted to the hospital on 03/26/13, received dialysis services at the hospital, and was readmitted back to the facility on 03/29/13.

An interview conducted with LPN #8 on 04/09/13, at 4:35 PM, revealed she was responsible for assessing Resident #1 on 03/26/13, at 5:45 AM. The LPN stated the resident complained of "shortness of air" when the resident had been awakened to get him/her ready for dialysis. The LPN stated she then called the physician and received a physician's order to send the resident to the hospital for further evaluation. The LPN stated she then notified the resident's guardian and the ambulance service and the resident left the facility by ambulance at 6:10 AM.

A review of the comprehensive care plan for

F 309

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

PRINTED: 06/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2013
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 309	Continued From page 30 Resident #1 revealed on 04/04/13, it had been updated by the ADON to reflect the days of the week the resident was to attend dialysis (Tuesday, Thursday, and Saturday). Resident #1's care plan had further been updated on 04/06/13, by the ADON to reflect the resident's dialysis days would be changing beginning on 04/08/13, to reflect the resident would be going to dialysis on Monday, Wednesday, and Friday. The care plan had been updated on 04/05/13, to reflect interventions related to refusal of dialysis treatments. The care plan also contained a "Refusal of Dialysis Approach Guide" dated 04/05/13, by the ADON. A review of a nurse's note revealed vital signs were taken on 04/04/13, for Resident #1, Resident #2, Resident #3, and Resident #4 who were all the residents in the facility who required dialysis services. All had been assessed by the ADON to be stable. A review of a facility census list revealed all dialysis residents were reviewed for their scheduled days of dialysis, their dialysis companies, and transportation schedules per their physician's orders. This was signed and dated by the ADON on 04/04/13. A review of a dialysis schedule revealed the schedule contained Resident #1, Resident #2, Resident #3, and Resident #4's name, scheduled dialysis days, dialysis companies and phone numbers, nephrologist names and phone numbers, and the resident's transportation company and phone numbers. A review of the comprehensive care plans for	F 309			

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

PRINTED: 06/28/2013
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 04/10/2013
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 309	<p>Continued From page 31</p> <p>Resident #2, Resident #3, and Resident #4 revealed the care plans were reviewed on 04/04/13, 04/05/13, and 04/06/13 by the ADON. All four residents' comprehensive plans of care have been revised and contained the date the residents were scheduled for dialysis. The care plans also contained a "Refusal of Dialysis Approach Guide."</p> <p>A review of in-service rosters for the facility's licensed nurses on 04/04/13 revealed all nurses were in-serviced on the changes to the dialysis residents' schedules.</p> <p>A review of a list dated 04/05/13, and 04/06/13, and signed by the DON, ADON, Unit Manager #2, and Unit Manager #3 revealed the comprehensive plan of care for all residents in the facility had been reviewed and/or revised either on 04/05/13 or on 04/06/13.</p> <p>A review of in-service rosters dated 04/03/13 and 04/04/13, revealed all licensed facility nurses had attended an in-service regarding the facility's policy and procedure for "Dialysis Communication for Continuity of Care," the facility's policy and procedure for the "Coordination of Hemodialysis Services," "Summary of Resident Condition and ESRD Communication Form," and the process to follow for residents attending hemodialysis and/or services with other life sustaining outside entities. The in-services also educated the staff regarding the documentation of refusals on the 24-hour report.</p> <p>A review of the minutes of an ad hoc Quality Assurance/Performance Improvement meeting dated 04/05/13 revealed the new process for</p>	F 309		

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

PRINTED: 06/28/2013
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 04/10/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601
--	---

(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 309	<p>Continued From page 32</p> <p>dialysis communication was discussed by the committee and approved.</p> <p>A review of a new employee orientation packet revealed all new licensed nurses would receive in-services in orientation regarding the facility's policy and procedure for "Dialysis Communication for Continuity of Care," the facility's policy and procedure for the "Coordination of Hemodialysis Services," "Summary of Resident Condition and ESRD Communication Form," and the process to follow for residents attending hemodialysis and/or services with other life sustaining outside entities. The in-services would also educate the nurses regarding the documentation of refusals on the 24-hour report.</p> <p>A review of a letter dated 04/04/13, and signed by the facility Administrator and the Clinic Manager of Dialysis Center #1 which was used by Resident #1, revealed the Administrator had met with the Clinic Manager and discussed a plan and process regarding documentation for communication that would be sent from the facility to the dialysis center and the dialysis center would then complete documentation to accompany the resident back to the facility.</p> <p>A review of a letter dated 04/04/13, and evidence mailed to Dialysis Center #1, Dialysis Center #2, and Dialysis Center #3 on 04/05/13, revealed the Administrator requested that all dialysis centers provide timely written communication for each resident's visit. The letter requested that all pertinent information be placed on the communication form and returned with the resident as well as any deviations from the resident's established dialysis schedule.</p>	F 309		

Received Time Jul. 10. 2013 1:38PM No. 8441

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2013
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 309	<p>Continued From page 33</p> <p>On 04/10/13 at 12:20 PM on the Third Floor, 04/10/13 at 3:55 PM on the Fourth Floor, and 04/10/13 at 3:55 PM on the Fifth Floor, dialysis schedules were observed in the nurses' stations which contained the names of all dialysis residents, scheduled dialysis days, dialysis companies and phone numbers, nephrologist names and phone numbers, and the residents' transportation companies and phone numbers.</p> <p>Interviews conducted with Dialysis Center Manager #1 on 04/10/13 at 8:25 AM, Dialysis Center Manager #2 on 04/10/13 at 8:13 AM, and Dialysis Center Manager #3 on 04/10/13 at 9:30 AM, revealed they had all spoken with the Administrator and she had informed them if the centers did not return a communication form with the resident the facility would be immediately notifying them to fax it to the facility.</p> <p>A review of an in-service roster dated 04/05/13, revealed the Vice President of Clinical Services had provided an in-service to the DON, ADON, Unit Manager #2, and Unit Manager #3 regarding reviewing the 24-hour report, physician's orders, resident refusals, and newly returned Summary of Resident Condition and ESRD Communication forms. They were instructed that these were to be reviewed daily five times per week in the morning meeting to ensure accuracy and/or revise the resident's care plans accordingly. They were in-serviced to reflect that the facility currently had no residents who were going to dialysis on Saturdays, but in the event they did, the Customer Care Liaison, who was currently the MDS Nurse, would be responsible for reviewing the 24-hour report, new physician's</p>	F 309		

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

PRINTED: 05/28/2013
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 04/10/2013
--	--	--	---

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 309	<p>Continued From page 34</p> <p>orders, and newly returned Summary of Resident Condition and ESRD Communication forms. They were instructed that these were to be reviewed daily five times per week in the morning meeting to ensure accuracy and/or revise the residents' care plans accordingly.</p> <p>A review of an in-service roster dated 04/06/13, revealed the Regional Vice President of Operations in-serviced the Administrator on Substandard Quality of Care along with the administrative process. The Administrator was instructed the Regional Vice President of Operations and or the Regional Director of Clinical Services would be providing oversight to ensure facility staff was providing quality of care and services to the facility residents.</p> <p>A review of the Quality Assurance/Performance Improvement tool which had been completed by the Unit Managers beginning on 04/07/13 revealed the tool reviewed the 24-hour report, new physician's orders, Summary of Resident Condition, and ESRD Communication forms five times a week to ensure care plans reflected residents' conditions accurately. The Unit Managers had completed the tool, and the tool had been reviewed by the Regional Director of Clinical Services and the DON.</p> <p>A review of a test being utilized by the facility beginning on 04/05/13, revealed the test covered what the staff was expected to do with resident refusals to attend dialysis, communication with the dialysis centers, where and how to document information, and updating the resident's plan of care. Documentation revealed the test had been completed with licensed nurses every shift and</p>	F 309		

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

PRINTED: 06/28/2013
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 04/10/2013
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 309	<p>Continued From page 35</p> <p>education was given to the nurse regarding every missed question. Documentation revealed the tests had been reviewed by the Regional Director of Clinical Services and the DON.</p> <p>A review of a Quality Assurance/Performance Improvement tool which had been completed by the Unit Managers beginning on 04/07/13 revealed the Unit Managers had been reviewing the 24-hour report for resident refusals of hemodialysis services or services with other life sustaining entities. There was documentation on the tools where they had been reviewed by the Regional Director of Clinical Services and the DON.</p> <p>An interview on 04/08/13 at 11:10 AM with the Medical Director revealed she was notified on 04/06/13, of the Immediate Jeopardy by the Administrator. The Medical Director stated she attended the monthly Quality Assurance/Performance Improvement meetings, and also reviewed all policies and procedures. The Medical Director stated she was available 24-hours a day and did not have a call schedule.</p> <p>Interviews conducted with LPN #1 on 04/09/13 at 5:15 PM, LPN #2 on 04/09/13 at 5:40 PM, LPN #13 on 04/09/13 at 6:10 PM, LPN #10 on 04/09/13 at 6:25 PM, LPN #5 on 04/10/13 at 9:50 AM, LPN #9 on 04/10/13 at 10:00 AM, LPN #11 on 04/10/13 at 10:20 AM, LPN #12 on 04/10/13 at 10:30 AM, RN #2 on 04/10/13 at 9:35 AM, and RN #3 on 04/10/13 at 10:05 AM all revealed they had been provided in-services by the facility related to communication forms with the facility and outside entities providing services to the residents, and on the dialysis policy and</p>	F 309			

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

PRINTED: 06/28/2013
FORM APPROVED
OMS 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 04/10/2013
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 309	<p>Continued From page 36</p> <p>procedures. The nurses also stated they had been required to take a test every shift related to dialysis and communication. The nurses stated they are required to update all resident care plans with any new orders and changes. The nurses stated they are required to complete a communication form to send with a resident to the dialysis center and if a communication form did not accompany the resident back to the facility, they were required to notify the facility to send the form by fax. The nurses stated there was a list located at every nursing station that contained the schedule of all dialysis residents along with the name of the dialysis center, nephrologists' names, mode of transportation required by the resident, and all the phone numbers. The nurses also stated all dialysis resident care plans included a list of interventions to use if a resident refuses to go to dialysis.</p> <p>Interviews conducted with Unit Manager #2 on 04/09/13 at 6:00 PM, and Unit Manager #3 on 04/10/13 at 10:30 AM, revealed they were required to complete Quality Assurance/Performance improvement tools regarding reviewing the 24-hour report, all new physician's orders, daily communication sheets, and care plans daily five times a week. They stated these were reviewed in the morning meeting. The Unit Managers stated if any issues were identified staff would be in-serviced immediately or prior to their next scheduled shift if they were not on duty.</p> <p>An interview conducted with the ADON on 04/09/13 at 2:20 PM, revealed she had assessed Resident #1, Resident #2, Resident #3, and Resident #4 on 04/04/13, and had assessed all</p>	F 309			

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

PRINTED: 06/26/2013
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 04/10/2013
--	--	--	---

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 309 | Continued From page 37

four residents to be stable. The ADON also stated she had reviewed/updated the care plans for Resident #1, Resident #2, Resident #3, and Resident #4 on 04/04/13, and again on 04/05/13 and 04/06/13. The ADON stated she had provided a test to every licensed nurse every shift they worked regarding managing dialysis, outside entity communication, care planning, and resident refusals. The ADON stated she provided education for any missed question. The ADON stated these were reviewed in the morning meeting as well as by the DON. The ADON stated if the nurse was not currently at work, the education would be provided prior to the next scheduled shift. The ADON stated Unit Manager #1 was no longer employed by the facility.

An interview conducted with the weekend MDS Nurse on 04/10/13, at 2:26 PM, revealed she was the Customer Service Liaison on Saturdays, and in the event a resident would be scheduled for dialysis on Saturday she was responsible for reviewing the 24-hour report, communication forms, any new physician's orders, and the care plans for any updates. The nurse stated that currently no residents were scheduled to go to dialysis on Saturday.

An interview conducted with the DON on 04/10/13 at 2:45 PM, revealed she was assisted in reviewing and revising all resident current care plans and helped to review and revise Resident #1's care plan. The DON stated she assisted with the nursing in-services regarding the facility's policy and procedure for "Dialysis Communication for Continuity of Care," the facility's policy and procedure for the "Coordination of Hemodialysis Services," "Summary of Resident Condition and

F 309

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

PRINTED: 06/28/2013
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 04/10/2013
--	--	--	---

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 309	<p>Continued From page 38</p> <p>ESRD Communication Form," and the process to follow for residents attending hemodialysis and/or services with other life sustaining outside entities. The in-services also educated the staff regarding the documentation of refusals on the 24-hour report. The DON stated she also reviewed all the Quality Assurance/Performance Improvement tools that had been put in place, along with the tests that were being taken by the nurses. The DON stated she had attended an in-service given by the Vice President of Clinical Services regarding reviewing the 24-hour report, all new physician's orders, daily communication sheets, and care plans daily five times a week to ensure residents were being provided with quality care and services. The DON stated if it had been identified that a care plan had not been updated or a communication sheet or physician's order had not been followed through, education would be provided to the nurse.</p> <p>An interview conducted with the Administrator on 04/10/13 at 3:35 PM, revealed she had been in-serviced by the Regional Vice President of Operations on Substandard Quality of Care. Per interview, the Regional Vice President of Operations and the Regional Director of Clinical Services would be reviewing all Quality Assurance/Performance Improvement data and attending all Quality Assurance/Performance Improvement meetings for at least three months. The Administrator stated she had met with Dialysis Clinic Manager #1, and had talked by phone with Dialysis Clinic Manager #2 and Dialysis Clinic Manager #3 and had sent a letter to all three clinics. The Administrator stated the clinics were informed they required the dialysis center to notify the facility for any change in the</p>	F 309		
-------	---	-------	--	--

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

PRINTED: 06/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/10/2013
--	--	--	---

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 309	<p>Continued From page 39</p> <p>resident's dialysis schedule and to include the information on the communication form. The Administrator stated she had informed the dialysis centers the facility would send a communication form with the resident to the dialysis center and a communication form would need to be sent back to the facility with the resident. Per interview, if a communication form did not return with the resident to the facility, the facility would be calling the dialysis center to fax a communication form to the facility.</p> <p>An interview conducted with the Regional Director of Clinical Services on 04/10/13 at 3:00 PM, revealed she had been at the facility daily since the Immediate Jeopardy had been identified and would be in the facility daily until the Immediate Jeopardy was removed. The Regional Director of Clinical Services stated she toured the facility daily to ensure staff was providing quality care and services as it had been stated in the AOC. The Regional Director of Clinical Services stated she toured with the AOC in hand, reviewed all Quality Assurance/Performance Improvement tools that had been put in place and if any negative outcomes were identified, provided education to staff. The Regional Director of Clinical Services stated she also would be attending the monthly Quality Assurance/Performance Improvement meetings to provide oversight.</p> <p>An interview conducted with the Vice President of Clinical Services on 04/10/13 at 3:10 PM, revealed on 04/05/13 she had provided an in-service to the DON, ADON, and the Unit Managers regarding reviewing the 24-hour report, all new physician's orders, daily communication</p>	F 309		
-------	---	-------	--	--

Received Time Jul. 10, 2013 1:38PM No. 8441

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

PRINTED: 06/28/2013
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 04/10/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601
--	---

(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 309	<p>Continued From page 40</p> <p>sheets, and care plans daily five times a week to ensure residents were being provided with quality care and services. The Vice President of Clinical Services stated if it was identified that a care plan had not been updated or a communication sheet or physician's order had not been followed through, education would be provided to the nurse. The Vice President of Clinical Services stated she, the Regional Director of Clinical Services, or the Regional Vice President of Operations would be providing a daily presence in the facility until the Immediate Jeopardy was removed.</p> <p>An interview conducted with the Regional Vice President of Operations on 04/10/13 at 3:20 PM, revealed he had provided an in-service to the Administrator on 04/06/13, regarding Substandard Quality of Care. The Regional Vice President of Operations stated he, the Vice President of Clinical Services and/or the Regional Director of Clinical Services had maintained a presence in the facility daily and would continue to do so until the Immediate Jeopardy was removed. The Regional Vice President of Operations stated he would also be reviewing all Quality Assurance/Performance Improvement data, and would be attending all Quality Assurance/Performance Improvement meetings for at least three months with the first meeting scheduled for 04/16/13.</p>	F 309		