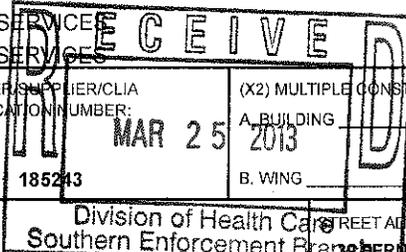


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 308 HERRIDALE APARTMENTS ROAD PINEVILLE, KY 40977
---	---

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

F 000	INITIAL COMMENTS	F 000	Mountain View Nursing & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and purposes 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 provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Mountain View Nursing & Rehabilitation Center's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor is that any deficiency accurate. Further, Mountain View Nursing & Rehabilitation Center reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.	
F 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>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 provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observation during the environmental tour on 02/27/13, beginning at 10:10 AM, revealed one tube feeding pump with a tan-colored dried substance on it, two resident room doors with the plastic guard on the bottom of the door pulled away from the wood leaving sharp edges, one resident room wall with chipped plaster leaving sharp edges, two geri-chairs that were torn and ragged and in need of repair, and one bathroom with a broken toilet paper holder.</p> <p>The findings include: A review of the facility's maintenance policy dated December 1998 revealed every effort would be made to prevent equipment breakdown and repairs would be made on a timely basis.</p> <p>Observation during the environmental tour</p>	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ DATE 3/22/13

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: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	<p>Continued From page 1 beginning on 02/27/13, at 10:10 AM, revealed:</p> <ul style="list-style-type: none"> -Resident rooms 109 and 143 were observed to have entrance doors with the plastic guard pulled apart from the wood and leaving exposed sharp edges. -Resident room 119 was observed to have chipped plaster leaving sharp edges on the left side wall by the sink. -Resident rooms 119 and 145 were observed to have geri-chairs with torn and ragged areas in need of repair. -Resident room 137 was observed to have a broken toilet paper holder in the bathroom. <p>An interview conducted with the Maintenance Supervisor on 02/28/13, at 4:00 PM, revealed all administrative staff was required to monitor a section of the building every day to identify environmental concerns. The Maintenance Supervisor stated this was part of the facility's Quality Assurance process and all the findings were then forwarded to the Administrator. The Maintenance Supervisor stated that any area which was identified by the administrative staff was then to be placed on a work order sheet and given to maintenance staff to make the needed repairs. The Maintenance Supervisor revealed there were no work orders for the areas identified by the surveyor.</p> <p>An interview conducted with the Administrator on 02/28/13, at 5:25 PM, revealed administrative staff was responsible for conducting rounds daily to monitor for maintenance issues. The Administrator stated if administrative staff observed a maintenance issue they were required to complete a work order request,</p>	F 253	<p><u>F253</u></p> <ol style="list-style-type: none"> <u>1.</u> The tube feeding pump was cleaned. Plastic guard on resident doors 109&143 were fixed. One resident room 119 wall chipped plaster was repaired Two Geri chairs that had torn places on cushions were repaired. Toilet paper holder room 137 that was broken was replaced. <u>2.</u> An audit of all feeding pumps was completed on 02/27/13 any found soiled were addressed at that time. Environmental Plant QI made rounds on 03-01-2013 to observe for any environmental issues, any identified were forwarded to maintenance supervisor. 	

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 2 submit it to the maintenance staff, and forward the findings to the Administrator. The Administrator revealed she had not been made aware of the concerns.	F 253	<p><u>3.</u> Administrative Department Heads were re in serviced on daily department head rounds and using the QI rounds tool to monitor the facility environment, and completing work orders for identified issues. Any issues identified will be corrected at the time of the audit, with further retraining to staff as needed.</p> <p><u>4.</u> The results of the QI rounds tool will be reviewed with the DON & Administrator in the weekly QI committee. Any further actions will be taken as necessary. Trends and the accompanying action will be reviewed monthly by the Executive QI committee, consisting of Medical Director, Administrator, DON, ADON, QI Nurse, SDC, MDS Nurses.</p> <p><u>5.</u> April 14, 2013.</p>	4/14/13
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, the facility failed to ensure services provided met professional standards of quality for two of eighteen sampled residents (Residents #4 and #9). Resident #4 had physician's orders for normal saline to be used as a cleaning agent for the resident's wound care. Staff failed to clean the resident's wounds as directed by the physician. In addition, Resident #4 had physician's orders for Pro-Stat 64 (protein supplement), 30 cc to be administered daily; however, facility staff failed to administer the correct dose of the supplement to the resident. Resident #9 had physician's orders for oxygen to be administered at 4 liters per minute; however, observations conducted on 02/26/13 and on 02/27/13, revealed facility staff failed to ensure the oxygen was administered as ordered by the physician. The findings include: Review of the facility's policy regarding	F 281		

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 3</p> <p>physician's orders (no date) revealed guidance for obtaining/processing written, verbal, telephone, and non-drug orders. However, the facility failed to reveal how facility staff would ensure the care needs were provided according to the physician's orders for the residents.</p> <p>1. Review of the medical record revealed the facility admitted Resident #4 on 06/17/91 with diagnoses including Persistent Vegetative State, Chronic Kidney Disease, Late Effects of Cerebrovascular Accident, and Failure to Thrive.</p> <p>Review of the February 2013 physician's orders revealed Resident #4 had a physician's order for normal saline to be used to clean wounds on the resident's sacrum and the gastrostomy tube (G-tube) site daily; and the left outer ankle every three days and as needed. In addition, the physician prescribed Pro-Stat 64, 30 cc to be administered once a day to Resident #4 to promote wound healing.</p> <p>Observations of wound care conducted on 02/26/13, at 1:50 PM, revealed Licensed Practical Nurse (LPN) #4 cleaned Resident 4's G-tube site with Shur-Clens (a non-saline cleaning solution) prior to applying a clean dressing. The LPN was observed to also clean the resident's sacral wound and the left outer ankle wound with Shur-Clens prior to completion of the wound care.</p> <p>Interview with LPN #4 on 02/28/13, at 4:15 PM, revealed the nurse was aware the physician had directed normal saline be used as the cleaning agent for Resident #4's wounds. LPN #4 stated she had been trained to provide wound care per the physician's orders. LPN #4 further stated she</p>	F 281	<p><u>F281</u></p> <p>1. Resident # 4 was given protein supplement as ordered Resident #4's wound was cleaned with normal saline as ordered by physician Resident#9's oxygen was put on correct amount ordered. Respiratory assessment completed.</p> <p>2. Resident #4 and #9 physicians were notified.</p> <p>3. An audit of the physician's orders for oxygen for all current residents was completed by the facility Administrative Nursing Staff, consisting of QI Nurse, Staff Facilitator, & MDS Nurses to ensure that all oxygen was administered as ordered by the physician any issues identified as a result of the audit have been reported to the MD & addressed as appropriate</p> <p>Staff Facilitator in serviced licensed nursing staff and KMA on 2/28/13 on follow through of physician orders and proper medicine/liquid administration.</p>		

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 4</p> <p>had been trained by the facility corporate nurse that Shur-Glens could be used to clean the resident's wounds.</p> <p>2. Observations conducted during a medication administration pass on 02/27/13, at 9:30 AM, revealed LPN #2 administered Resident #4's 9:00 AM medications through the G-tube. The nurse was observed to pour Pro-Stat 64, 30 cc, into a plastic medicine cup and proceed to administer the supplement through the resident's G-tube. However, after the nurse reconnected the G-tube, approximately 2.5 cc of Pro-Stat was left in the plastic medicine cup. The nurse was observed to dispose of the plastic cup in the trashcan in the resident's room.</p> <p>Interview conducted with LPN #2 on 02/27/13, at 9:45 AM, revealed the LPN knew the physician had prescribed 30 cc of Pro-Stat 64 to be administered to Resident #4. The LPN stated she had been trained to administer the correct amount of supplement to residents. However, LPN #2 stated the Pro-Stat was thick and did not pour easily and, as a result, was difficult to administer through the resident's G-tube.</p> <p>Interview with the Director of Nurses (DON) on 02/28/13, 5:00 PM, revealed nurses were responsible to provide wound care and medications, including supplements, as ordered by the physician. The DON stated routine medication audits were conducted at least every three months to monitor for any administration errors. In addition, the DON stated routine wound care observations were conducted by the corporate wound care nurse and the consultant nurse randomly. The DON stated that based on</p>	F 281	<p>4. A weekly QI audit will be conducted by the QI Nurse or designee to ensure that orders have been followed. Any issues identified will be corrected at the time of review with appropriate MD notification completed as necessary.</p> <p>The results of these audits will be reviewed with the DON & Administrator in the weekly QI meeting, consisting of the ADON, QI nurse, Staff Facilitator, & MDS nurse, where the results of these audits will be compiled and assessed for trends by the Committee & actions taken based on these assessments. Trends & the accompanying action will be reviewed monthly by the Executive QI Committee, consisting of the DON, Administrator, Medical Director, QI Nurse and any other person assigned by the Administrator, with further retraining or other such interventions implemented as necessary.</p> <p>5. Completion Date: April 14, 2013</p>	4/14/13

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 5</p> <p>observations no problems with wound care or medication administration had been identified.</p> <p>3. A review of the facility policy related to oxygen administration (dated 02/2012) revealed staff was to administer oxygen at the prescribed rate.</p> <p>A review of the medical record revealed the facility admitted Resident #9 on 05/30/12 with diagnoses that included Congestive Heart Failure, Chronic Kidney Disease, Dyspnea, Anxiety, Depression, and Chronic Back Pain. A review of a physician's telephone order dated 11/13/12 revealed the physician ordered oxygen to be administered at 4 liters per nasal cannula for Resident #9.</p> <p>Observations conducted on 02/26/13 at 9:15 AM (during the initial tour), 11:45 AM, 1:20 PM, 2:40 PM, 3:10 PM, 4:50 PM, and 5:30 PM revealed Resident #9 was lying in bed with oxygen being administered at 2 liters per nasal cannula; on 02/27/13 at 8:35 AM and 9:40 AM, observation revealed Resident #9's oxygen was being delivered at 3 liters per nasal cannula.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #2 at 9:50 AM on 02/27/13 revealed nurses were responsible to check each resident's oxygen setting every two hours. LPN #2 acknowledged she had not checked Resident #9's oxygen since reporting to work at 7:00 AM on 02/27/13 (a timeframe of two and one-half hours). LPN #2 confirmed that based on documentation in the medical record on 11/13/12 Resident #9's physician had ordered Resident #9's oxygen rate to be administered at 4 liters.</p>	F 281		

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 6 Interview with the Director of Nurses (DON) at 5:00 PM on 02/28/13 revealed nurses were supposed to check oxygen settings every two hours. The DON stated administrative staff made daily rounds to identify problems and had not identified problems related to oxygen administration.	F 281	<p><u>F 371</u></p> <p>1. Food is being distributed under sanitary conditions.</p> <p>2. The Director of Dietary Services and the Director of Nursing reviewed the Inspector's observation and determined potential for a similar situation to occur.</p> <p>3. Dietary staff was in serviced 02/29/13 on covering all items that are not covered under the tray dome. Nursing Staff will be re-in serviced by 03/28/13 on tray delivery and moving the food cart from door to door for tray delivery. All new employees will be trained in orientation about delivery process.</p>	
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure food was distributed under sanitary conditions to residents on the East Wing during the lunch meal on 02/26/13 and on the East and West Wings during the dinner meal on 02/26/13. Uncovered food items were observed to be obtained from the meal cart and transported several feet to the resident rooms and, as a result, the food items were potentially exposed to any airborne bacteria and contaminants. The findings include: A review of the facility's Resident Meal Service	F 371		

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 371	<p>Continued From page 7</p> <p>policy (dated September 2006) revealed the tray distribution was the responsibility of the Nursing Service under the supervision of Nursing and monitored by Dietary staff.</p> <p>1. Observations conducted on 02/26/13 at 11:30 AM during the noon meal on the East Wing revealed Certified Nurse Aide (CNA) #1 carried a tray, with dishes of uncovered peaches, down the hallway to resident room 134-B (approximately 20 feet from the food cart) and to room 148-B (approximately 24 feet from the food cart).</p> <p>2. Observations conducted on 02/26/13 at 5:25 PM, of the dinner meal on the East Wing revealed CNA #1 also carried trays, with the dessert dish uncovered, down the hallway to room 138-B (approximately 16 feet from the food cart) and to room 148-B (approximately 24 feet from the food cart).</p> <p>Certified Nurse Aide (CNA) #1 acknowledged in an interview conducted on 02/26/13, at 6:00 PM, that she had delivered the lunch and dinner trays with the food items uncovered. CNA #1 stated she was aware the food items were uncovered, but did not realize she had carried the trays that far away from the food cart. The CNA stated the food items should have been covered.</p> <p>Interview conducted with the Dietary Manager (DM) on 02/28/13, at 4:00 PM, revealed the food items were considered to be covered since the trays were transported to the hallways in a covered food cart. However, the DM stated the nurse aides were responsible to move the food cart from door to door for tray delivery. The DM stated random observations were made of tray</p>	F 371	<p>4. An audit will be completed weekly by the dietary manager, checking the trays for any uncovered items, and to monitor for the tray delivery process. The results of the audit will be reviewed with the Administrator and DON in the weekly QI Committee meeting. Any further actions needed will be taken as necessary.</p> <p>5. April 14, 2013</p>	4/14/13

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 371	<p>Continued From page 8</p> <p>delivery to ensure sanitation was maintained and no problems had been identified.</p> <p>3. Observation of the supper meal service on the West Wing on 02/26/13, at 5:30 PM, revealed Licensed Practical Nurse (LPN) #7 delivered a meal tray from the meal tray cart approximately 15 feet from the cart to the resident in room 103-A. The meal tray was observed to have cake which was uncovered.</p> <p>4. Observation at 5:30 PM, revealed LPN #7 delivered a meal tray from the meal tray cart and carried the tray approximately 18 feet from the cart to the resident in room 117-A. The meal tray was observed to contain a plate of uncovered cake.</p> <p>LPN #7 acknowledged in interview on 02/26/13, at 5:58 PM, that she should not have walked down the hall with the uncovered cake on the tray. The LPN stated she was supposed to place the cart outside the resident's room. The LPN stated she was responsible to monitor the SRNAs to ensure they weren't taking food for residents down the hall uncovered. The LPN stated she was just trying to get the trays out timely and just was not thinking.</p> <p>5. Observation of the supper meal service on the West Wing on 02/26/13, at 5:35 PM, revealed LPN #8 obtained a meal tray from the meal tray cart and delivered the tray to a resident in room 111-A; the meal cart was approximately 10 feet from resident room 111-A. The meal tray was observed to have cake which was uncovered.</p> <p>An interview conducted with LPN #8 on 02/26/13,</p>	F 371		

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(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 371	Continued From page 9 at 5:55 PM, revealed she had helped to deliver supper food trays on the West Wing on 02/27/13, and stated she had never been told by the facility where to place the meal tray cart when delivering food trays to the residents. The LPN stated she should not have carried food down the hall uncovered. The LPN stated she was responsible for monitoring SRNAs to ensure trays were delivered to residents. 6. Observation of the supper meal service on the West Wing on 02/26/13, at 5:53 PM, revealed SRNA #2 obtained a meal tray from the meal tray cart and delivered the tray to room 133-A which was approximately 18 feet from the cart. The meal tray was observed to have cake which was uncovered. An interview conducted with SRNA #2 on 02/26/13, at 6:05 PM, revealed she was aware she was supposed to take the meal tray cart to the resident's room prior to delivering the food tray. The SRNA stated she had attempted to ensure the food trays were passed quickly. An interview conducted with the Director of Nursing (DON) on 02/28/13, at 5:00 PM, revealed staff had been trained to deliver residents' food trays beginning at the top of the cart in room order and all food items were to be covered. The DON further revealed Administrative staff monitored meal pass daily and had not identified any concerns regarding food tray pass.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	<u>F431</u> 1. Identified Tuberculin Purified Protein Derivative vials were immediately discarded and new vials were obtained from the pharmacy. Resident #4 tube feeding was labeled. Dextrose, sodium chloride IV solution, 2 urinary leg bags,	

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 10</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional</p>	F 431	<p>liquid stomach relief medication were all discarded.</p> <ol style="list-style-type: none"> Medication rooms and refrigerators were audited on 2/28/13 by the QI nurse & ADON to ensure no other expired or undated medications were available for use. Licensed nursing staff and KMA's were re-educated 2/28/13 by staff facilitator on to ensure drugs and biologicals are labeled and dated, and ones that have exceeded the manufacturers expiration date were not available for resident use. A QI audit will be completed weekly by the QI nurse to ensure drugs and biologicals are labeled, and there are none that have expired. The results of these audits will be reviewed in the weekly QI committee meeting with the Administrator & DON. Any further actions will be taken as necessary. Trends and the accompanying actions will be reviewed by the Executive Committee. April 14, 2013. 	

A11413

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 11</p> <p>principles. Observation of the West Wing medication room revealed a multi-dose vial of Tuberculin Purified Protein Derivative which was opened, available for use, and contained no date as to when the vial had been opened. Facility staff also failed to label a container of liquid that was administered through Resident #4's gastrostomy tube (G-tube). In addition, the facility failed to ensure drugs and biologicals that had exceeded the manufacturer's expiration dates were not available for resident use.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of the facility's policy titled, "Medication Expiration Dates," which contained no date, revealed all multi-dose vials of injectable medications and vaccines should be dated by the designated staff person at the time the seal was broken and the first dose drawn. <p>Observation of the West Wing medication room on 02/27/13, at 1:45 PM, revealed a multi-dose vial of Tuberculin Purified Protein Derivative in the medication refrigerator that had been opened, was available for use, and contained no date as to when the vial had been opened.</p> <p>An interview conducted with Registered Nurse (RN) #2 on 02/27/13, at 1:50 PM, revealed staff was required to date all multi-dose vials of medication when the vials were opened. The RN stated two nurses were required to check the medications every shift to ensure all multi-use medication vials had been labeled and dated. The RN stated both she and Licensed Practical Nurse (LPN) #5 were responsible on 02/27/13 to check the medications to ensure medications</p>	F 431		

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 12</p> <p>were labeled and dated when opened. The RN stated she was not aware when the vial of Tuberculin Purified Protein Derivative had been opened.</p> <p>An interview conducted with LPN #5 on 02/27/13, at 1:55 PM, revealed staff was required to date all multi-dose vials of medication when the vials were opened. The LPN stated two nurses were required to check the medications every shift to ensure all multi-dose medication vials had been labeled and dated. The LPN stated both he and RN #2 had been responsible on 02/27/13 to check the medications to ensure they were labeled and dated when opened. The LPN also stated he was not aware when the vial of Tuberculin Purified Protein Derivative had been opened.</p> <p>An interview conducted with the Director of Nursing (DON) on 02/28/13, at 5:00 PM, revealed two nurses, one from the shift that was leaving and one from the shift that was beginning, were required to check the medication refrigerator daily to ensure all multi-dose vials of medications had been dated when they were opened.</p> <p>2. Review of facility policy regarding gastrostomy tube (G-tube) feedings (dated February 2007) revealed any unused formula would be discarded within 48 hours. However, the policy did not include how the tube feeding formula would be labeled or that it would include the resident's name, type of formula, date, time, and the person responsible for administering the formula to the resident.</p> <p>Interview conducted with the Director of Nursing</p>	F 431			

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 13</p> <p>(DON) on 2/28/13, at 10:00 AM revealed the facility did not have a policy related to labeling a tube feeding formula.</p> <p>During a tour of the facility conducted on 02/26/13, at 9:10 AM, Resident #4 was observed lying in bed and a container of approximately 900 cc of tube feeding was observed to be connected to a tube feeding pump. The tube feeding was noted to be administered at a rate of 80 milliliters per minute. However, the bag was not labeled to identify the resident's name, type of tube feeding, the date or time, and the person who had initiated the tube feeding. Further observations conducted on 02/26/13, at 11:00 AM, 11:45 AM, 1:30 PM, 3:05 PM, 4:00 PM, and 5:40 PM revealed the tube feeding bag was still not labeled.</p> <p>Interview with Registered Nurse (RN) #1 on 02/26/13, at 5:45 PM, revealed the 6:00 PM to 6:00 AM nurse was responsible to hang the tube feeding formulas for the residents. RN #1 stated she did not hang the tube feeding bag, but should have checked the bag during her shift to ensure the bag was labeled. The RN acknowledged the bag should be labeled with the resident's name, the type of formula, the date, time, rate, and the initials of the nurse who hung the bag and initiated the feeding.</p> <p>Interview with LPN #2 on 02/26/13, at 6:05 PM, revealed she had hung the tube feeding bag for Resident #4 during the 6:00 PM to 6:00 AM shift on 02/26/13. The LPN stated she should have labeled and initialed the bag when the tube feeding formula was placed in the bag. LPN #2 stated the resident's name, type of formula, date, rate, time and the nurse's initials should be noted</p>	F 431			

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 14 on the tube feeding bag when hung.</p> <p>The DON stated in interview on 02/28/13, at 5:00 PM, the nurses had been trained to label the tube feeding bags and should include the resident's name, type of formula, the date, time, and rate for administration. The DON further stated administrative staff conducted daily rounds to monitor for any resident care issues and problems with labeling of the tube feeding bags had not been identified.</p> <p>3. A review of the facility policy, Medication Expiration Dates, not dated, revealed the facility should not administer medications to residents that are past the manufacturer's expiration date.</p> <p>Observation of the East Wing medication room on 02/28/13 at 2:30 PM revealed the following drugs and/or biologicals on a shelf in the medication room, available for resident use, and had exceeded the manufacturer's recommended expiration date:</p> <ul style="list-style-type: none"> -5% Dextrose intravenous (IV) solution with an expiration date of September 2012 (available for resident use four months past the expiration date); -0.2% Sodium Chloride IV solution and Lactated Ringers with 5% Dextrose IV solution with an expiration date of October 2010 (available for resident use two years and three months past the expiration date); and -two urinary leg bags with expiration dates of August 2012 and February 2008 (available for resident use five months and five years past the expiration date). 	F 431		

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 Observation of the medication room further revealed a bottle of liquid stomach relief medication, with the seal broken, that had not been labeled or dated. Interview on 02/28/13 at 2:45 PM with LPN #6 revealed the staff was trained to check any item used for a resident for an expiration date and to date and label any medication that had been opened. The interview further revealed the LPN was not aware the drugs and biologicals identified had exceeded the manufacturer's expiration dates. Interview on 02/28/13 at 5:05 PM with the Director of Nurses (DON) revealed staff was required to check all items for expiration dates before use each time and to label and date a medication when it was opened. The interview further revealed the facility had a new supply clerk that was responsible for stocking the supply rooms and checking for expiration dates, however, the supply clerk may not be aware of the different items having expiration dates.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	F441 1. LPN #3 was provided re-education on 02/28/2013 related to hand washing between tasks and procedures to prevent cross contamination of different body sites according to the facility policy. This re-education was conducted by the Staff Facilitator.	

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERDALE APARTMENTS ROAD PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 16</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to ensure an effective infection control program to prevent the development and transmission of disease and infection was maintained for one of eighteen sampled residents (Resident #4). Facility staff failed to perform appropriate handwashing techniques during wound care for Resident #4.</p> <p>The findings include:</p>	F 441	<p>2. The Director of Nursing reviewed the Inspector's observation and determined that other residents who receive wound care had the potential for a similar situation to occur.</p> <p>3. Staff re-education was initiated for all licensed nurses on 02/28/2013 related to hand washing should be performed between tasks and procedures according to the facility policy. This re-education will be reviewed during orientation for newly hired licensed nurses.</p> <p>4. The staff facilitator or QI Nurse will conduct random audits weekly any identified issues will be corrected with immediate one to one re-education. These audits will be conducted weekly during April 2013 and May 2013 and then per the schedule established by the QI Committee. Results of the weekly audits will be reported to the QI committee on a monthly basis.</p> <p>5. April 14, 2013</p>	4/14/13	

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 17 Review of the facility's Handwashing Policy (dated August 2005) revealed handwashing would be performed between tasks and procedures to prevent cross-contamination of different body sites. Review of the medical record revealed the facility admitted Resident #4 on 06/17/09 with diagnoses including Persistent Vegetative State, Chronic Kidney Disease, Late Effect Cerebrovascular Disease, Convulsions, Failure to Thrive, and Dementia. During a wound care observation conducted on 02/26/13, at 1:50 PM, Licensed Practical Nurse (LPN) #3 was observed to wash her hands and put on gloves prior to beginning the wound care for Resident #4. The nurse was observed to remove the soiled dressing from the resident's gastrostomy tube (G-tube) site, clean the site, and apply a clean dry dressing to the site. LPN #3 then changed her gloves without performing handwashing. The nurse proceeded to reposition Resident #4 and clean a reddened abraded area to the resident's coccyx area and patted the area dry with non-sterile 2x2 gauze. The LPN was observed to change her gloves and again did not perform handwashing procedures. LPN #3 then removed heel booties from the resident's left foot, removed a dressing, patted the area dry with non-sterile 2x2 gauze, and applied a Tegaderm dressing over the site. The LPN then removed the soiled gloves and washed her hands at the sink. Interview conducted with LPN #3 on 02/28/13 at 4:15 PM revealed she had been the facility's	F 441		

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 18 designated treatment nurse since January 2013. LPN #3 stated she had been trained by the facility's corporate wound nurse to wash her hands prior to beginning wound care and to change gloves between each area to be treated. Interview with the Director of Nursing (DON) on 02/28/13, at 5:00 PM, revealed nurses were responsible to change gloves and perform handwashing when going from a dirty area to a clean area. She stated the treatment nurse should have washed her hands between each site during the wound care provided for Resident #4. The DON stated the wound care nurse consultant and the corporate nurse consultant had observed LPN #3 perform wound care and had not identified any concerns related the LPN's wound care technique.	F 441		
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.	F 500	F500 1. Documentation was obtained from dialysis center for November 2012, 12 days; December 2012, 11 days; January 2013, 5 days; and February 2013, 12 days. 2. The Director of Nursing reviewed the Inspector's observation and determined that other residents who receive dialysis had the potential for a similar situation to occur.	

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(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 500	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and record review, of the facility's census of ninety residents, two residents received dialysis services. A sample of two, of the two residents that received dialysis, was selected for review and revealed the facility failed to ensure there was written communication between the nursing facility and the dialysis center for one of the two residents (Resident #13). The findings include: A review of contracted services revealed the facility had a contract with a dialysis center, not dated, to provide services to residents of the facility at an outside dialysis facility. According to the agreement, the outside provider agreed to supply the facility with information both verbally and in writing including the care provided to the resident. A review of the medical record for Resident #13 revealed the facility admitted the resident on 02/01/07 with diagnoses including End-Stage Renal Disease and Chronic Kidney Disease. A review of the physician's orders for Resident #13 revealed the resident was to receive dialysis services three times per week. During the following months/number of days, the facility failed to ensure documentation was provided by or obtained from the dialysis center following the resident's treatment: November 2012, 12 days; December 2012, 11 days; January 2013, 5 days; and February 2013, 12 days.	F 500	3. All Licensed nursing staff was in serviced on completing dialysis communication forms by the ADON. 4. The facility ADON or designee will conduct random audits to ensure communication forms are in place. Any identified issues will be corrected with immediate one to one re-education. These audits will be conducted weekly during the month of April, 2013 and May 2013 with a summary report to the QI Committee. Further audits, if necessary, will be conducted on a schedule established by the QI Committee. 5. April 14, 2013	4/14/13

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977		
(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 500	Continued From page 20 Interview on 02/28/13 at 1:55 PM with Licensed Practical Nurse (LPN) #5 revealed Resident #13 had been receiving dialysis services since September 2012 and had recently switched to a local dialysis clinic. The interview further revealed the nursing facility would send a communication form with the resident to the dialysis center and the dialysis center would fax the communication form back to the nursing facility each evening the resident returned to the facility, or the next day. The LPN stated the communication form was placed in the resident's medical record when the facility received the report; however, according to the LPN, the facility did not have a system in place to ensure the facility received the communication form from the dialysis center. According to the LPN, if the resident experienced problems while he/she received dialysis treatment at the dialysis center, staff at the dialysis center would call the facility to inform them of the problem. However, according to the LPN, the facility did not always receive a written report from the dialysis center related to the problems experienced by the resident. Interview on 02/28/13 at 5:05 PM with the Director of Nursing (DON) revealed there should be written communication between the nursing facility and the dialysis center each time the resident received services from the dialysis center. The DON stated the facility did not have a system in place to ensure the facility received written communication from the dialysis center.	F 500			

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
MAR 25 2013
85243

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 85243	(X2) MULTIPLE CONSTRUCTION A. BUILDING OR MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/26/2013
--	---	--	--

NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE Division of Health Care Enforcement Branch 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977
---	---

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

K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1976</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111(000)</p> <p>SMOKE COMPARTMENTS: Five</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel generator</p> <p>A life safety code survey was initiated and concluded on 02/26/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000	<p>Mountain View 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 of the residents. The plan of correction is submitted as a written allegation of compliance.</p> <p>Mountain View's response to the Statement of Deficiencies and Plan Of Correction does not denote Agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Mountain View reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p>	
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or</p>	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Nelley M. Gaudin TITLE Administrator (X6) DATE 03-22-13

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: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	<p>Continued From page 1</p> <p>hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were maintained according to NFPA standards. This deficient practice affected one of five smoke compartments, staff, and approximately eighteen residents. The facility has the capacity for 100 beds with a census of 90 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 02/26/13 at 10:15 AM with the Director of Maintenance (DOM), a corridor door to the therapy gym was observed not to readily latch when closed.</p>	K 018	<p>K018</p> <p>1. The door to the Therapy Room was replaced with one that readily latched when closed; this was completed on 03-01-2013.</p> <p>2. An audit of the facility was conducted by the facility Administrator on March 1, 2013 and there were no other areas identified to need door latches installed.</p> <p>3. The facility Administrator reviewed the requirements of NFPA 101 (2000 Edition) 19.3.2.1 with the facility Maintenance Director on March 1, 2013.</p> <p>4. The facility Director of Maintenance or designee will oversee any additional renovations and ensure corridor doors are in compliance with the Life Safety Code Standards. Any additional issues will be reported to the QI Nurse for QI Committee review.</p> <p>5. Date of Completion April 14, 2013</p>	4/14/13

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 2 Corridor doors must close and latch to help resist the passage of smoke in a fire situation. An interview on 02/26/13 at 10:15 AM with the DOM revealed he was not aware the coded latching mechanism that had been added to the door did not meet life safety requirements. The findings were revealed to the Administrator upon exit. Reference: NFPA 101 (2000 Edition). 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.	K 018		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain emergency lighting at exits according to NFPA standards. This deficient practice affected two of five smoke compartments, staff, and approximately thirty-six	K 046		

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 046	<p>Continued From page 3</p> <p>residents. The facility has the capacity for 100 beds with a census of 90 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 02/26/13, at 10:40 AM, with the Director of Maintenance (DOM), an exterior exit light located on the West Wing was observed to be full of bird nest material and was not situated to be able to illuminate the path of egress to the public way as required.</p> <p>An interview with the DOM on 02/26/13, at 10:40 AM, revealed he was not aware that exterior lighting should illuminate the path of egress to the public way. During the survey, another exterior exit located on the West Wing was observed not to be able to provide lighting to a public way.</p> <p>The findings were made aware to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.9.1.1*</p> <p>Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following:</p> <p>(1) Buildings or structures where required in Chapters 11 through 42</p> <p>For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.</p>	K 046	<p><u>K046</u></p> <ol style="list-style-type: none"> 1. Bird Nest Material was removed from exterior exit light on west wing. Both exterior exit lights located on west are now providing lighting to a public way. Additional lights were added to outdoor walkway. 2. Administrator completed an audit of all paths of egress to the public way to ensure they were all able to provide lighting to a public way. 3. The facility Administrator reviewed the requirements of NFPA 101 (2000 Edition) 19.3.2.1 with the facility Maintenance Director on March 1, 2013 4. The facility Director of Maintenance or designee will audit the paths of egress to identify any issues with life safety code above. Identified issues will be immediately corrected. Results of these audits will be reported to the QI Committee for one year and will continue per the established schedule thereafter. 5. Date of Completion April 14, 2013. 	4/14/13

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 046	Continued From page 4 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. A.7.8.1.4 An example of the failure of any single lighting unit is the burning out of an electric bulb.	K 046	<p><u>K062</u></p> <ol style="list-style-type: none"> 2 sprinkler heads will be added, on March 29, 2013. One to the West and one to the East Corridor shower rooms. Extra sprinkler heads will be kept as required. An audit of the facility was conducted and no other areas needing sprinkler heads installed were found. The facility Administrator advised the Director of Maintenance of NFPA 13 (1999 Edition) The facility Director of Maintenance will oversee any additional renovations and ensure facility is in compliance with the Life Safety Code Standards April 14, 2013 	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler requirements were maintained. This deficient practice affected two of five smoke compartments, staff, and approximately thirty-six residents. The facility has the capacity for 100 beds with a census of 90 on the day of the survey. The findings include: During the Life Safety Code survey on 02/26/13 at 10:30 AM, with the Director of Maintenance (DOM), inadequate sprinkler coverage was observed in the East Corridor shower room. A wall in the shower room was preventing the sprinkler from reaching all areas in this room. An interview with the DOM on 02/26/13 at 10:30 AM revealed he was not aware of the improper	K 062		

4/14/13

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 5 sprinkler coverage. During the survey, the West Corridor shower room was also observed not to have the proper coverage. On 02/26/13 at 11:30 AM, it was observed that the sprinkler riser room did not contain extra sprinkler heads as required. An interview with the DOM on 02/26/13 at 11:30 AM revealed he was not aware he needed spare sprinkler heads. The findings were revealed to the Administrator upon exit. Reference: NFPA 13 (1999 Edition). 5-5.5.1* Performance Objective. Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. 3-2.9 Stock of Spare Sprinklers. 3-2.9.1 A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced. These sprinklers shall correspond to the types and temperature ratings of the sprinklers in the property. The sprinklers shall be kept in a cabinet located where the temperature to which they are subjected will at no time exceed 100°F (38°C).	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0936-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013	
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected five of five smoke compartments, staff, and all the residents. The facility has the capacity for 100 beds with a census of 90 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 02/26/13, at 10:50 AM with the Director of Maintenance (DOM), wiring was observed to be connected to the battery at the outside generator set. An interview with the DOM on 02/26/13, at 10:50 AM revealed the wiring was connected to a battery charger. Battery chargers are not to be wired directly to the battery for safety and operational reasons. The DOM stated he was not aware the battery charger wiring should not be connected directly to the battery.</p> <p>At 1:45 PM, an interview and record review with the (DOM) revealed he was not aware of the load capacity of the generator when tested. Diesel-powered generators are required to run at least 30 percent capacity or the generator must</p>	K 144	<p><u>K144</u></p> <ol style="list-style-type: none"> The Director of Maintenance has contracted an electrician to do load check and add additional areas of facility and equipment to the backup generator in order to bring the monthly load test above 30 percent of the EPS nameplate rating if needed. Battery charger has been disconnected from the battery and connected to the to the starter. The facility does not have any additional generator equipment. The facility administrator reviewed NFPA 110 (1999) 6-1.1 with the director of maintenance regarding the 30 percent of EPS nameplate requirement. The facility electrical needs and backup power needs were reviewed. It was determined there was 	

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013	
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	<p>Continued From page 7</p> <p>be properly loaded on an annual basis. This type of testing helps ensure the generator operates as intended in an emergency situation. The DOM stated the generator had not been load tested nor was he aware if the generator required load testing. Additionally the DOM was not aware if the generator was carrying a load when tested automatically from a timer or when he manually tested the generator from the transfer switch.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>a. Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.</p> <p>b. Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b).</p> <p>b. Inspection and Testing.</p> <p>1.* Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete</p>	K 144	<p>sufficient generator power available to add additional areas and equipment and maintain sufficient power supply in the event of an actual lengthy power outage. An electrician was contacted to connect additional equipment and areas of the facility to the generator.</p> <p>4. The electrician will document the estimated percentage rating upon</p> <p>completion of the added load. This will be reported to the QI Committee. The Director of Maintenance will record the monthly load tests and will report any issues to the facility Administrator</p> <p>5. April 14, 2013</p>	4/14/13

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	<p>Continued From page 8</p> <p>simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturer's recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating</p>	K 144		

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

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 9 b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144		