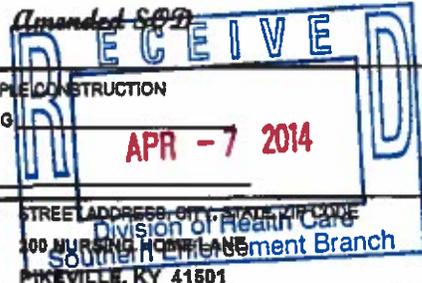


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/01/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186256	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 03/12/2014
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 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 F 151 SS=D	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY21395) was conducted on 03/12/14. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure one of three sampled residents (Resident #1) and one of three unsampled residents (Resident A) exercised his/her rights. A review of facility documentation revealed since 09/16/13, Resident #1 had requested food items that were not included in his/her current diet orders. Interviews with the facility's Dietary Manager (DM) on 03/12/14, revealed Resident #1 had consistently requested "pinto beans, cornbread and potatoes," to eat; however, the resident's physician had prescribed a "low potassium" diet for the resident and Dietary was unable to provide foods to the resident as requested. Continued review of documentation and interviews revealed the facility's "Nursing Management" had been made aware of the resident's requests but no actions were taken to honor the resident's rights related to his/her diet choices. In addition, interview with</p>	F 000 F 151	<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: [Signature] TITLE: Administrator (X5) DATE: 4/7/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 151	<p>Continued From page 1</p> <p>Resident A on 03/12/14 at 3:40 PM revealed he/she had spoken to several staff members at the facility about a diet change/waiver of his/her "renal" diet (a diet prescribed in chronic renal failure and designed to control intake of protein, potassium, sodium, phosphorus, and fluids); however, Resident A stated he/she had not received a waiver and continued to receive a renal diet.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Resident Rights," last revised 09/01/12, revealed the facility would ensure that resident rights were enforced.</p> <p>1. A review of the medical record for Resident #1 revealed the facility admitted the resident on 07/18/13 with diagnoses that included End Stage Renal Disease and Diabetes. A review of physician's orders dated March 2014 revealed the physician had prescribed a "NAS" (no added salt) diet and foods low in potassium for Resident #1. A review of a quarterly Minimum Data Set (MDS) assessment dated 01/29/13, revealed facility staff assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident's cognition was intact.</p> <p>Resident #1 stated in an interview conducted on 03/12/14 at 5:45 PM, "I don't get anything I like to eat." The resident further stated, "I have asked for different food and the staff here doesn't listen." Resident #1 continued to state, "I have been trying to get different food the entire time I have been here."</p> <p>A review of documentation in the Dietary Manager's (DM's) progress notes, dated</p>	F 151	F 151	03/19/14	
			<ol style="list-style-type: none"> On 3/12/14, Resident #1 exercised his/her rights by signing a diet waiver, the primary physician was contacted for orders to change the diet per Resident#1's wishes, and the dietary department was notified of the change. On 3/12/14, the Nurse Unit Manager interviewed Resident A. Resident A exercised his/her rights by choosing not change to his/her diet order at this time. Both residents were informed of the possible consequences of not following a physician ordered therapeutic diet prior to their decisions. All residents have the potential to be affected by the facility's failure to ensure residents may exercise their rights. By 3/19/14, the Social Services Director interviewed all the alert residents to ensure they are able to exercise their rights as a resident of the facility and as a citizen or resident of the United States. All reported they 		

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

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F 151	<p>Continued From page 2</p> <p>09/16/13, revealed Resident #1 had "been asking" for pinto beans, potatoes, and other foods "not offered" on the resident's renal diet. Continued review of the documentation revealed, "Nursing Management had been made aware of concern."</p> <p>Further review of the DM's documentation dated 02/04/14 revealed Resident #1 had requested to sign a diet waiver. Documentation further revealed the DM had identified the risks of eating "those foods" ("beans and potatoes") the resident had requested and the resident had stated, "I know, but I want to eat and drink what I want too." Continued review revealed the resident had reported to the DM that "I understand it may make me sick but that's how I've always ate and I guess I'm not gonna be happy til I get it."</p> <p>A review of documentation from the facility's Social Services Director, not dated, revealed Resident #1 had requested to sign a diet waiver. Continued review revealed the resident stated, "I understand it may make me sick but that's how I've always ate and I guess I'm not gonna be happy til I get it."</p> <p>An interview with Unit Manager (UM) #1 on 03/12/14 revealed she was aware of Resident #1's multiple requests for a diet change and for "soup beans and cornbread." According to UM #1, she had not contacted the resident's physician for a diet change because she had explained the risks of the diet change to the resident and he/she stated he/she was "OK" with not receiving the foods he/she had requested.</p> <p>An interview with the Interim Director of Nursing (DON) on 03/12/14 at 6:45 PM revealed she was</p>	F 151	<p>are able to exercise these rights. By 3/19/14, residents who were unable to answer the questions posed by the Social Services Director concerning exercising their rights were observed by the Social Services Director exercising at least some of the rights that they were physically and/or mentally able to exercise.</p> <p>3. a. By 3/18/14, all staff were reeducated by the Interim Director of Nursing on the residents' right to exercise his/her rights as a resident of the facility and as a citizen or resident of the United States to include the right to refuse/waive an order for a therapeutic diet.</p> <p>b. By 3/17/14, a notice was given and/or read to all residents informing them of the resident's right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. This notice was also posted at all nurses stations as a reminder for staff.</p>	

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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F 151	<p>Continued From page 3</p> <p>not aware Resident #1 "didn't want a renal diet." The DON stated if the resident had requested "any foods to eat and the risks of noncompliance had been explained, then staff should have honored the resident's rights."</p> <p>An interview with the Administrator on 03/12/14 at 7:00 PM revealed facility staff was required to honor the resident's rights. The Administrator further stated staff should have contacted the resident's physician and changed the resident's diet order, as the resident requested.</p> <p>2. Review of the medical record revealed the facility admitted Resident A on 02/14/14 with diagnoses of Multiple Pulmonary Nodules, Chronic Kidney Disease, and Ileostomy. A review of an admission Minimum Data Set (MDS) assessment dated 02/21/14, revealed facility staff assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact. Review of physician orders dated 02/14/14 revealed Resident A was to receive a regular "renal" diet (a diet prescribed in chronic renal failure and designed to control intake of protein, potassium, sodium, phosphorus, and fluids).</p> <p>Review of a care plan dated 02/14/14 revealed Resident A had the right to refuse care, treatment, medication, appointments, diet and any other care and services.</p> <p>Review of a Diet History and Food Preference evaluation dated 02/17/14 revealed Resident A and his/her family wished to sign a dietary waiver.</p> <p>Review of a Nutrition Evaluation dated 02/23/14 revealed Resident A and his/her family member</p>	F 151	<p>4. The Social Services Director will QA/query 25% of the alert residents monthly for three months to ensure they are exercising their rights as they wish. The Social Services Director will QA/observe 25% of the other residents exercising at least one of the rights they are physically/mentally able to exercise monthly for three months. Any concerns will be reported to the Administrator for correction. The results of this QA will be reported to the Quality Assurance Committee monthly for three months for development of an action plan as needed.</p>		

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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F 151	Continued From page 4 had expressed a desire to "waive" the resident's prescribed diet, and wished to allow the resident to have whatever the resident desired. Resident A stated in interview conducted on 03/12/14 at 3:40 PM he/she had spoken to "several" people at the facility regarding a diet change. According to the resident, the facility failed to provide the resident with a dietary change after he/she had requested a dietary waiver and the resident continued to receive a renal diet. Resident A stated he/she had not been provided a dietary waiver to sign to acknowledge his/her request. Interview with the Dietary Manager (DM) on 03/12/14 at 3:00 PM revealed Resident A had expressed a desire for a dietary waiver and she had informed the Unit Manager. However, according to the DM, Resident A had not signed a dietary waiver. Interview with Unit Manager #3 on 03/12/14 at 8:15 PM revealed Resident A had spoken to her about making changes to his/her diet. However, according to the Unit Manager, the resident had not been given or signed a dietary waiver. According to Unit Manager #3, the dietary waiver had not been obtained because Resident A would go "back and forth" about his/her decision of a change in diet.	F 151			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601		
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F 281	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of facility policy, it was determined the facility failed to provide services that met professional standards of practice for one of three sampled residents (Resident #2) and two of three unsampled residents (Residents B and C). Interviews and a review of documentation revealed facility staff failed to accurately document the administration of medications and the results of resident blood glucose levels when they were obtained.</p> <p>The findings include:</p> <p>A review of the facility policy titled "General Dose Preparation and Medication Administration," last revised on 01/01/13, revealed staff was to document on the resident's Medication Administration Record (MAR) when medications were given.</p> <p>1. A review of the medical record for Resident #2 on 03/12/14 at 2:30 PM revealed physician's orders for 1 milligram (mg) of Clonazepam (anticonvulsant), one tablet by mouth three times a day at 6:00 AM, 2:00 PM, and 10:00 PM. However, review of the resident's MAR revealed staff failed to document that the medication was administered at 6:00 AM on 03/02/14.</p> <p>2. A review of the medical record for Resident B on 03/12/14 at 3:36 PM revealed physician's orders for 25 mg of Meclizine HCL Tablet (antiemetic) by mouth every six hours at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Review of the resident's MAR revealed staff failed to document the medication was administered at</p>	F 281	<p>F 281 1. On 3/13/14, Licensed Nurses performed a head to toe assessment of Resident #2, Resident B, and Resident C. The assessments were within normal parameters and there was no evidence of a negative outcome related to lack of documentation of medication administration or blood glucose level (glucometer results). On 3/13/14, the primary physician was notified of the missing documentation and the results of the nursing assessments. No new orders were received.</p> <p>2. All residents have the potential to be affected by the facility's failure to provide services that meet professional standards of quality. On 3/13/14 and 3/14/14, Administrative Nurses</p>	03/19/14

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F 281	<p>Continued From page 6 8:00 AM on 03/08/14.</p> <p>3. A review of Resident C's medical record on 03/12/14 at 4:13 PM revealed physician's orders for Ciprofloxacin HCL 0.3% drops (antibiotic) as directed on the MAR. Review of the MAR revealed staff was to administer the eye drops at 6:00 AM and 9:00PM. However, facility staff failed to document the Ciprofloxacin was administered at 10:00 PM on 03/01/14. Further review of the resident's physician's orders revealed the resident was to receive 1,000 mg of Fish Oil (dietary supplement) by mouth, twice a day, at 1:00 PM and 5:00 PM. Review of the resident's MAR revealed staff failed to document the Fish Oil was administered at 5:00 PM on 03/07/14. Review of the physician's order further revealed the resident was to receive Ketorolac Tromethamine (nonsteroidal anti-inflammatory drug for eye use) as directed by the MAR. Review of the MAR indicated that staff was to administer the Ketorolac at 6:00 AM and 9:00 PM. However, staff failed to document the administration of Ketorolac to the resident at 9:00 PM on 03/01/14. Further review of the physician's orders revealed staff was to obtain the resident's blood glucose level every night at bedtime. However, review of the MAR revealed staff failed to document the resident's blood glucose level at bedtime (9:00 PM) on 03/05/14. The review also revealed staff failed to record the resident's glucose level on the MAR on 03/03/14 and 03/04/14.</p> <p>An interview with Registered Nurse (RN) #1 on 03/12/14 at 6:15 PM revealed she had checked Resident C's blood glucose level on 03/05/14 at 9:00 PM but "forgot" to document the results on the MAR. RN #1 stated that she had been</p>	F 281	<p>audited the March, 2014 Medication Administration Records (MAR's) and Treatment Administration Records (TAR's) for current residents to determine that medications, glucometer readings, and treatments had been documented they were administered per physician orders to ensure services provided met professional standards of quality. Medications, glucometer readings and treatments were documented as administered per physician orders to ensure services provided met professional standards of quality for the current residents.</p>	

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 208 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 7</p> <p>trained on how to properly document on the MAR when medication was administered.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 03/12/14 at 6:23 PM revealed she had given the Fish Oil to Resident C at 6:00 PM on 03/07/14 and "forgot" to document the medication administration on the MAR. The LPN stated she had been trained to document on the resident MAR when she administered medications.</p> <p>An interview with LPN #2, Unit Manager for the 5th floor, on 03/12/14 at 5:45PM revealed on 02/05/14, staff began to conduct medication administration audits on a weekly and ongoing basis. LPN #2 stated that he had not reviewed the MARs for Residents #2, B, or C and, as a result, had not identified the lack of documentation on the resident's MARs.</p> <p>An interview with the Interim Director of Nursing (DON) on 03/12/14 at 6:45 PM revealed she had reviewed the medication administration audits five times a week and was not aware of any errors on any of the MARs. The DON stated the facility had provided in-service education to nursing staff on 03/12/14 on the need to document medications as they administered them. The DON stated that she had not checked all of the resident MARs to date.</p> <p>An interview with Administrator on 03/12/14 at 07:00PM revealed that Unit Managers had conducted audits of the medication administration records. According to the Administrator, the facility had not held a monthly QA meeting for March and she had not been made aware of any concerns related to documentation of medications.</p>	F 281	<p>3. a. By 3/14/14, the Interim Director of Nursing reeducated licensed nurses that the services provided by the facility must meet professional standards of quality including but not limited to administering medications per physician orders and documentation of medication administration and glucometer readings for all residents. At this time, the Licensed Nurses were also educated to the new procedure described below in 3b.</p> <p>b. Daily, at each shift change of nurses, the oncoming and off-going nurses will QA each residents' MAR and TAR for documentation of medication and treatment administration and documentation of glucometer readings. Any discrepancy will be corrected immediately.</p>		

4. The Nurse Unit Managers will QA monitor the MAR's and TAR's of current residents daily 5x weekly for three months. Once a week for three months the Nurse Unit Managers will QA the MAR's and TAR's of residents on a floor other than the one they are assigned to manage. Any discrepancy noted will be reported to the Director of Nursing for disciplinary follow up as needed. The results of the QA will be reported to the Quality Assurance Committee monthly for three months for development of an action plan as needed.

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F 520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and a review of the facility's policies, it was determined the facility failed to maintain a Quality Assessment and Assurance Committee that developed and implemented appropriate plans of action to correct identified quality deficiencies related to accurate documentation of medication administration for one of three sampled residents (Resident #2) and</p>	F 520	<p>F520</p> <ol style="list-style-type: none"> On 3/13/14, Licensed Nurses performed a head to toe assessment of Resident #2, Resident B, and Resident C. The assessments were within normal parameters and there was no evidence of a negative outcome related to lack of documentation of medication administration and glucometer reading. On 3/13/14, the primary physician was notified of the missing documentation and the results of the nursing assessments. No new orders were received. All residents have the potential to be affected by the facility's failure to ensure the facility's quality assessment and 	03/19/14	

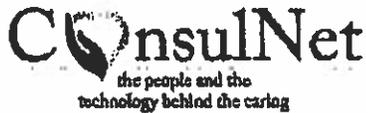
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601		
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F 520	<p>Continued From page 9</p> <p>two of three unsampled residents (Residents B and C). An abbreviated standard survey was previously conducted at the facility on 01/27/14 and concluded on 01/28/14. During that survey, deficient practice was identified related to facility documentation of medication administration. Interviews conducted with facility staff on 03/12/14 revealed Quality Assurance (QA) Audits to ensure medication administration was documented accurately were conducted weekly in March 2014; however, review of the audits revealed the facility failed to identify which resident MARs had been audited and failed to identify concerns related to facility documentation of medication administration. (Refer to F281.)</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Performance Improvement (Quality Assurance)," dated 09/01/12, revealed the Performance Improvement Committee had the responsibility of implementing corrective action plans as needed to resolve identified resident care/service problems.</p> <p>An interview conducted with Unit Manager (UM) #1 on 03/12/14 at 5:00 PM revealed she was required to audit "at least ten" resident MARs weekly, to ensure medication administration was documented accurately. Continued interview with the UM and a review of the audits revealed she had conducted QA audits on 03/04/14 and 03/11/14. However, the UM failed to identify which facility resident MARs had been audited and was unable to recall, during interview, which twenty resident MARs had been audited within the past two weeks. However, the UM stated she had not identified any concerns related to</p>	F 520	<p>assurance committee developed and implemented appropriate plans of action to correct identified deficiencies. On 3/18/14, the QA committee met, reviewed, and revised as needed current action plans to ensure they are appropriate to correct identified deficiencies.</p> <p>3. a. On 3/14/14, the Administrator reeducated the Nurse Unit Managers on the appropriate completion of Quality Assurance Tools that included naming the data source, date reviewed, whether goal was met or unmet, and any actions taken if not met. They were instructed that anyone reading their QA tool must be able to determine what, when, and how reviewed and the results of the review.</p>		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/12/2014
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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F 520	<p>Continued From page 10 medication administration documentation.</p> <p>Interview with the interim Director of Nursing (DON), on 03/12/14 at 6:45 PM, revealed an audit of 25 percent of facility resident Medication Administration Records (MARs) were being conducted weekly. Continued interview revealed the DON had identified concerns related to the QA audits that were being conducted by the facility's Unit Managers "last week" (unable to recall exact date), referring to the dates of 03/03/14 through 03/07/14. The DON acknowledged staff was not conducting "quality monitoring" of identified deficient practice related to the audits of the resident MARs, because the UMs had failed to identify which residents MARs had been audited on a weekly basis. The DON stated she had directed facility UMs to identify which resident MARs had been audited to ensure QA monitoring was conducted for all residents monthly as required. However, the DON stated she had not reevaluated facility audits, and had not notified the facility QA Committee of the concerns identified related to audits being conducted to ensure compliance was maintained related to documenting of medication administration.</p> <p>An interview with the Administrator on 03/12/14 at 7:00 PM, revealed she was not aware of the concerns identified related to facility audits conducted to ensure regularity compliance with documentation of medication administration. The Administrator acknowledged that she had not reviewed "all" the audits to ensure accuracy, and continued to state the UMs are "supposed to be looking at them."</p>	F 520	<p>b. On 3/18/14, the Administrator reeducated the Department Managers on the requirement to develop and implement appropriate plans of action to correct identified deficiencies.</p> <p>c. On 3/18/14, the Administrator educated the Quality Assurance Committee members on the new policy and procedure for Quality Assurance (see attached). The Committee reviewed and accepted this policy.</p> <p>4. The Administrator will serve as the chairperson for the QA Committee, review and accept each months' minutes, and will ensure that the committee develops and implements appropriate plans of action to correct identified quality deficiencies.</p>		



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<p>Policies and Procedures</p>	<p>CLINICAL Performance Improvement</p>	<p>PI-215</p>
<p>Performance Improvement (Quality Assurance) Revision Date: 03-07-2014</p>		
<h3>Policy</h3> <p>The facility and organization will have an ongoing Performance Improvement Program with a design and scope that is ongoing and comprehensive dealing with a full range of services offered by the facility including the full range of departments that addresses all aspects of care. The Design and Scope of the program will systematically monitor and evaluate the quality and appropriateness of Resident care, pursue opportunities to improve resident care, resolve identified problems and identify opportunities for improvement. Performance Improvement Program supports the over all goals of the facility and the organization and examines both outcomes and processes relevant to these outcomes with the objective of improving the organization's performance.</p>		
<h3>Procedure</h3> <ol style="list-style-type: none"> 1. The facility Executive Director is accountable for the overall implementation and functioning of the Performance Improvement Program(s). This may include training on Quality Assurance and Performance Improvement, ensuring resources are provided as needed. The Executive Director is responsible for 2. The program will be a coordinated effort among all departments and services within the organization that involves leadership working with input from facility staff, as well as residents and families as appropriate. 3. Key aspects of care, facility practice and quality of life may include but are not limited to: <ul style="list-style-type: none"> a. Medical care b. Clinical care c. Rehabilitation d. Pharmacy e. Dining Services f. Social Service g. Recreational Services h. Hospitality Services i. Environmental Services j. Admissions k. Business office l. Medical records 4. Important functional areas may include but are not limited to: <ul style="list-style-type: none"> a. Residents rights and responsibilities 		

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Topic: Performance Improvement
Policy Status: Active
Creation Date: 01-07-2012
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Next Review Date: 03-07-2015
Expiration Date: None

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- b. Admission process
- c. Resident assessment
- d. Quality of care
- e. Quality of Life
- f. Potential Adverse Events
- g. Continuity of care
- h. Infection control
- i. Plant technology and safety management
- j. Information management
- k. Human resources
- l. Leadership and credentialing
- m. Resident education

5. Review of activities may include but not be limited to:

- a. Infection control
- b. Incident/accident reports
- c. Resident/family complaints/satisfaction
- d. Interdisciplinary care planning
- e. Medication use
- f. Environment of care/safety
- g. Restraint reduction
- h. Wound care/prevention
- i. Staff orientation, in-service and competence
- j. Weight Program
- k. Psychotropic Drug Reduction
- l. Fall prevention
- m. Med. Error
- n. Physician services

6. The facility will identify areas for continuous quality monitoring and the monitoring tools to be used. These monitoring activities should focus on those processes that affect resident outcomes most significantly. This ongoing monitoring is used to establish the facility's baseline and the predictability of various outcomes.

7. The following sources of data may be used, but not limited to:

- a. Resident medical records
- b. Direct observation
- c. Departmental logs
- d. 24 hours reports
- e. Mock surveys
- f. Accident trending
- g. Resident/family complaints
- h. Committee minutes
- i. Survey process
- j. 24 hour report
- k. Resident council
- l. Med. error reports
- m. Medical record audits
- n. Compliance surveys
- o. Performance Indicators

8. The Performance Improvement Committee will review and coordinate all the proposed activities and identify the priorities for the coming year and as events are identified. The Performance Improvement Committee will create a master Performance Improvement calendar. This calendar may change during the year as priorities change. Criteria for selecting aspects of care for improvement are based but not limited to:

- a. Facility's goals/objectives, mission
- b. High volume ~ the aspect of care occurs frequently or affects large numbers of residents.

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- c. Identification of potential or actual "Adverse Events"
- d. High risk – residents are at risk of serious consequences or are deprived of substantial benefits if the care is not provided correctly, and in a timely fashion or on proper indication.
- e. Problematic – the aspect of care has tended in the past to produce problems for staff or residents.
- f. High cost – the aspect of care involved a high cost either of financial or personnel utilization.
- g. Regulatory – previous or current regulatory items or identified concerns.
9. Once an aspect of care or indicator has been identified or selected, the Performance Improvement Committee will:
- a. Assign a performance Action Team to address the identified area, examine, and improve the identified need.
- b. Identify the goal(s) of the Performance Improvement Project. These goals must be objective, measurable and based on current knowledge and/or clinical experience. These indicators should measure those appropriate dimensions of performance that address:
- i. Appropriateness
 - ii. Effectiveness
 - iii. Timeliness
 - iv. Safety
 - v. Respect and caring for residents
 - vi. Efficiency
 - vii. Consistency with other programs/treatments/staff
- c. Determine how/where to obtain necessary information, the appropriate sample size to be used, time frames and acceptable thresholds.
- d. Determine roles and responsibilities of the Performance Improvement Action Team.
9. The Performance Improvement Action Team will document findings, initiate corrective action as directed and present results to the Performance Improvement Committee. Documentation will include but not be limited to:
- a. What is significance of study
 - b. Decision making process
 - c. Methodology
 - d. Findings: trends, percentages, etc.
 - e. Recommended improvement activities including follow-up
10. The Performance Improvement (QA/PI) Committee will advise individual services and Performance Action Teams on methodology, data collection and data analysis and will review all final reports and recommendations.
11. The goals, plans and results of the facility's Performance Improvement activities will be communicated to all staff by means of staff meetings, changes in policy and procedures or inservice training.
12. The Performance Improvement Program will be evaluated annually by the Performance Improvement Committee to assess that the Program's activities have achieved substantial performance improvement.
14. The Performance Improvement (QA/PI) Committee has the responsibility for designing and implementing corrective action plans as needed to resolve identified resident care/service problems. This is accomplished within local, state, federal and corporate guidelines as well as fiscal restraints. All improvement plans will contain:
- what is to be changed
 - when and how corrective action will be implemented
 - who is responsible for the implementation of the corrective action
 - what time interval is set for reassessment (in order to evaluate the impact of action taken)
- Improvement plans and effectiveness of actions will be documented in the committee minutes.