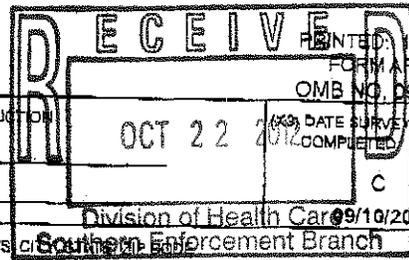


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 10/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS 200 NURSING HOME LANE PIKEVILLE, KY 41601
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	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.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	Parkview Nursing and Rehabilitation Center'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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anaeta Owens TITLE: ADMINISTRATOR (X6) DATE: 10/19/2012

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

Received Time Oct. 22, 2012 8:18AM No. 1957

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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F 225	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy it was determined the facility failed to ensure an incident of suspected neglect was immediately reported to the state survey and certification agency and failed to have evidence that the incident had been thoroughly investigated for one of three sampled residents (Resident #2). On 09/01/12, the facility's Administrator was made aware that staff provided wound care to Resident #2's stasis ulcer and had observed "several" maggots (the larvae of a fly) under the resident's dressing when it was removed. Interview revealed the facility did not consider the report an allegation of neglect and did not conduct an investigation or notify the state agencies of the report.</p> <p>The findings include: A review of the facility's Resident Abuse policy, dated March 2012, revealed the policy defined neglect as a failure to take precautionary measures to protect the health and safety of the resident. The policy further stated all incidents and reports of resident abuse/neglect would be referred to the appropriate officials in accordance with Federal and State Regulations.</p>	F 225	<p>F225</p> <p>1. RN#1 reported she removed the maggot from resident #2 on 9/1/12. Resident #2 was discharged from the facility on 9/24/12. A review by the Health Information Manager on 10/8/12 for Resident #2's treatment record revealed that a Licensed nurse had visualized the wound daily for 8/1-9/8/12 with the exception of 9/6/12(resident refused) and every 3 days from 9/9-9/24/12 during dressing changes. On 10/8/12, the Health Information Manager compared Resident #2's physician orders to the treatment records for August and September, 2012 and they document that the treatment administered to the wound was the treatment and frequency ordered by the physician. On 10/8/12, the Health Information Manager reviewed nursing documentation in the nurses notes for August and September, 2012 and they do not note any foreign objects or signs of infection in or to the wound.</p>	10/10/12

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F 225	<p>Continued From page 2</p> <p>A review of the medical record for Resident #2 revealed the resident was admitted to the facility on 05/09/12, with diagnoses of Peripheral Vascular Disease, Poor Renal Function, and Hypertension. A review of Resident #2's Quarterly Minimum Data Set (MDS) Assessment dated 08/10/12 revealed facility staff assessed the resident to be alert and oriented, with a Brief Interview for Mental Status (BIMS) score of 15. Further review revealed Resident #2 was assessed to have a stasis ulcer present to the resident's right foot. A review of Resident #2's physician's orders revealed staff was to provide wound care every three days and as needed to the resident's stasis ulcer. A review of Resident #2's treatment record revealed staff had provided wound care as ordered by the physician.</p> <p>Interview with Resident #2 on 09/10/12 at 5:20 PM, revealed staff performed wound care daily and sometimes more often.</p> <p>Interview with Registered Nurse (RN) #1 on 09/10/12 at 3:30 PM, revealed she and Licensed Practical Nurse (LPN) #1 provided wound care to Resident #2's stasis ulcer on the morning of 09/01/12 (unsure of exact time). The RN stated "several" maggots were observed under the resident's dressing when it was removed. Further interview revealed RN #1 reported the incident immediately to the Unit Manager. RN #1 stated the Unit Manager instructed her "not to tell anybody or talk about the incident."</p> <p>Interview with the Unit Manager on 09/10/12 at 3:50 PM, confirmed RN #1 reported to her on 09/01/12 (unsure of exact time) that maggots had been observed when wound care was provided to</p>	F 225	<p>2. All residents have the potential to be affected by the facility staff's failure to report and investigate a neglect allegation. Interviews were conducted on 9/26/12, 9/27/12, 10/5/12, and 10/8/12 by the Social Services Director with the alert and oriented residents about staff treatment. No allegations of abuse or neglect were voiced by the residents. Skin assessments of disoriented and nonverbal residents were performed by a licensed nurse on 9/11/12, 9/12/12, 9/13/12, 9/14/12, 9/15/12, 9/16/12, and 9/17/12 and no areas that could be considered abuse or neglect were identified. On 9/4/12, residents' wounds on all three floors were visualized by a Nurse Unit Manager and no maggots or other foreign bodies were noted.</p> <p>3. a. The Administrator and Director of Nursing were educated on 9/27/12 by the Regional Nurse Consultant that sightings of a maggot on a wound could be considered</p>	

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F 225	<p>Continued From page 3</p> <p>Resident #2. The Unit Manager (UM) stated she contacted the Director of Nursing (DON) by phone on 09/01/12 and reported the incident.</p> <p>Interview with the DON on 09/10/12 at 5:15 PM, confirmed she had been notified that maggots had been observed to Resident #2's wound on 09/01/12. The DON stated she did not feel the incident was an allegation of abuse or neglect, and acknowledged the incident had not been thoroughly investigated or reported to state agencies.</p> <p>Interview with the Administrator on 09/10/12 at 5:25 PM, revealed the DON had also been notified that maggots had been observed to Resident #2's wound on 09/01/12. The Administrator stated she had not considered the report to be an allegation of abuse or neglect, and therefore had not thoroughly investigated the incident or reported the allegation to state agencies.</p>	F 225	<p>suspected neglect, the alleged incident must be reported immediately to the agency and there must be evidence of a thorough investigation of the alleged sighting(see attachment).</p> <p>b. On 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, and 10/9/12 the Director of Nursing, the Assistant Director of Nursing and the C.N.A. Preceptor reeducated the facility staff that included managers (inc. Administrator and Director of Nursing), licensed nurses, nursing assistants, housekeepers, laundry workers, dietary workers, activity staff, therapy staff, and maintenance staff on the abuse/neglect policy which includes a definition for and examples of neglect and instructions for identifying, reporting, and thoroughly investigating an allegation of neglect or abuse (see attachment). In addition,</p>		

Licensed Nurses were reeducated on 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, or 10/9/12 by the Director of Nursing or the Assistant Director of Nursing that anything out of the ordinary noted during a dressing change, failure to follow a physician order or facility policy in regard to wound dressings, and/or notification of change in condition related to wounds could be considered neglect(see attachment).

- c. The Nurse Unit Managers for each floor will visualize resident wounds weekly to ensure care is being provided as ordered and there are no foreign bodies present (see attachment).
 - d. The Social Services Director or designee will interview five(5) staff members from Administration, Nursing(inc. Nurses and nursing assistants), Housekeeping, Laundry, Dietary, Maintenance, Therapy, or Activity Departments per week for three months about abuse/neglect identification, reporting, and investigation(see attachment).
4. a. The Social Services Director will report findings of her interviews monthly for three months to the Quality Assurance Committee who will develop an action plan if needed.
 - b. The Administrator will provide oversight by reviewing every allegation to ensure all allegations are reported

P.4A

immediately and thoroughly investigated.

- c. The Director of Nursing or the Assistant Director of Nursing will review the Nurse Unit Managers' weekly wound data collection tools for compliance or needed follow up each week.

p4B