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

RECEIVED FEB 2015 OFFICE OF INSPECTOR GENERAL

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185171		C 02/05/2015

NAME OF PROVIDER OR SUPPLIER: PARKVIEW NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 644 LONE OAK RD. PADUCAH, KY 42003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey Investigating Complaints KY#22736 and KY#22759 was conducted on 01/27/15 through 02/05/15. Complaints KY#22736 and KY#22759 were substantiated with deficiencies cited at the highest scope and severity of a "D".	F 000	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan or correction is prepared and /or executed solely because it is required by law the provision of Federal and State laws."	
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	F 225	1. Resident #1 had a skin assessment completed by the nurse on 1/21/15 with no skin abnormalities noted. Resident #2 had a skin assessment completed on 1/23/15 by the physician and determined that no rape had occurred. Resident #2 went home on 1/24/15 as previously planned. 2. Residents with a BIMs score of less than 8 had skin assessments completed on them by 2/24/15 by nurses to determine no abuse had occurred. Interviews were conducted by the social workers with residents who had a BIMs score of 8-15 to ensure no abuse had taken place by 2/25/15. 3. Staff were inserviced by the SDC on 2/27/15 to ensure a thorough investigation is completed with any allegation of abuse to include indepth interviews and skin	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [illegible] | TITLE: Exec. Director | (X6) DATE: 2-27-15

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	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK RD. PADUCAH, KY 42003

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F 225	Continued From page 1 to the administrator or his designated representative and to other officials in accordance 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation and "Abuse, Neglect, or Misappropriation of Resident Property" policy, it was determined the facility failed to conduct a thorough abuse investigation to include skin assessments of non-interviewable residents and interviews with interviewable residents located in the vicinity of the resident's rooms for two (2) of nine (9) sampled residents (Resident #1 and Resident #2). On 01/21/15, Resident #1 alleged after staff have gone home and the staff puts them to bed at night an older man with a beard comes in the room at night and fondles them." On 01/23/15, Resident #2 made a allegation that he/she had been raped. The facility was made aware of the allegations of rape; however, the facility failed to assess residents who were unable to speak for themselves and interview interviewable residents whose rooms were located on wings that were in the vicinity of the resident's rooms. The findings include: Review of the facility's policy and procedure titled, "Abuse and/or Neglect Investigation", not dated, revealed residents had the right to live at ease in	F 225	assessments in the vicinity of where any allegation is made. The facility has also added this information to their orientation with new hires. Any associate who does not attend the inservice will have a copy of the inservice mailed to them and a signed acknowledgement sent back to the facility for verification of understanding. 4. 5 Skin assessments will be completed on each wing weekly times 4 weeks then monthly times 2 months with residents of BIMS scores of less than 8 to ensure any allegations of abuse have been reported. 2 interviews on each wing will be conducted weekly times4 weeks then monthly times 2 with residents of a BIMS of 8-15 to ensure any allegations of abuse have been reported. Results of the audits will be reviewed at the QA committee meeting to determine the need for further monitoring. 5. Date completed: 3/2/15	3/2/15

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F 225	Continued From page 2 a safe environment without the fear of retaliation when suspected abuse and or/neglect was reported. All reports of abuse will be promptly and thoroughly investigated and shall remain confidential. 1. Record review revealed the facility admitted Resident #1 on 01/09/15 with diagnoses which included Encephalopathy, Esophageal Reflux, Psychosis, Hypertension, and Chronic Ischemic Heart Disease, Review of Admission Data Set (MDS) assessment, dated 01/16/15, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of thirteen (13), which indicated the resident was interviewable. Review of the facility's investigation, conducted on 01/21/15, revealed Resident #1 voiced a complaint that "after staff ave gone home and the staff puts them to bed at night an older man with a beard comes in the room at night and fondles them." Social Services conducted interviews with eight (8) interviewable residents related to whether they were aware of anyone being abused or if they were abused and skin audits were conducted on fourteen (14) non-interviewable residents for signs and symptoms of abuse. All the residents resided on wing 100 where Resident #1's room was located. The total census for wing 100 was 22. There was no evidence interviews and skin audits were conducted on residents on the adjacent wings. 2. Record review revealed the facility admitted Resident #2 on 12/20/14 with diagnoses which included Diverticulitis, Hypertensión, Dementia without Behaviors, Dehydration, Headache and Adult Failure to Thrive. Review of the Admission	F 225		

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F 225	Continued From page 3 MDS assessment, dated 01/04/15, revealed the facility assessed Resident #2's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of 2, which indicated the resident was not interviewable. Review of the facility's investigation, conducted on 01/23/15 revealed an allegation of rape. Social Services conducted interviews with (9) interviewable residents related to whether they were aware of any residents being abused or if they had been abused and skin audits were completed on fourteen (14) non-interviewable residents for signs and symptoms of abuse. All the residents resided on Wing 100 where Resident #2's room was located. The total census for wing 100 was 23. There was no evidence interviews and skin audits were conducted on residents on the adjacent wings. Interview with Certified Nurse Aide #11 (CNA), on 01/28/15 at 8:56 AM, revealed he/she was the only caregiver on Wing 100 throughout the 11 PM-7 AM shift, but at times throughout the night shift he/she would have to go over to Wing 300 to relieve CNA #4 for his/her lunch break and also to ask the CNA for assistance with a resident who was care planned for no male providers. Interview with CNA #4, on 01/28/15 at 9:24 AM, revealed CNA #11 comes over to Wing 300 several times throughout the night to ask for assistance with a female resident that was care planned to have no male providers. CNA #4 stated CNA #11 also comes over to Wing 300 to relieve her for her thirty (30) minute lunch break each night. She stated we work together to cover for each other on both wings.	F 225		

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F 225	Continued From page 4 Interview with Licensed Practical Nurse #1 (LPN), on 01/27/15 at 2:09 PM, revealed skin audits were only completed on the non-interviewable residents on Wing 100, where the allegations were made and no skin audits were completed any where else in the building. She further revealed there was no set number of skin audits to be completed during a investigation. Interview with Licensed Social Worker (LSW), on 01/27/15 at 2:31 PM, revealed she interviewed the residents in the allegation and all interviewable residents on Wing 100. She stated she was not aware she needed to interview any other residents in the facility. Interview with the Director of Nursing (DON), on 01/29/15 at 1:34 PM, revealed she felt like the facility had conducted a thorough investigation and protected the residents. The DON stated there was no set number of how many skin audits or interviews were to be completed during an investigation. The DON revealed skin audits were conducted weekly on all residents and if there had been something it would have been brought to out attention at the morning meeting. The DON stated there were skin audits completed that very day on residents throughout the facility with no concerns identified, although they were not a part of our official investigation. Interview with the Administrator, on 01/29/15 at 11:20 AM, revealed there were no skin assessments or interviews regarding abuse and neglect conducted on any other residents except for where the allegation was alleged to have occurred.	F 225		
F 226	483.13(c) DEVELOP/IMPLMENT	F 226		

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F 226 SS=D	Continued From page 5 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation and "Abuse, Neglect, or Misappropriation of Resident Property" policy, it was determined the facility failed to follow their facility policy to conduct a thorough abuse investigation to include skin assessments of non-interviewable residents and interviews with interviewable residents located on the wings adjacent to where the residents rooms were located for two (2) of nine (9) sampled residents (Resident #1 and Resident #2). On 01/21/15, Resident #1 reported to a therapist "After staff put them to bed and the staff had gone home, an older man with a beard comes in the room at night and fondles them". In addition, on 01/23/15, Resident #2 made a allegation that he/she had been raped. The Administrator was made aware of the allegations on the same days the allegations were made, however, the facility failed to conduct a thorough investigation of each allegation per the facility's policy. The facility failed to assess residents who were unable to speak for themselves and interview interviewable residents on the wings located adjacent to the residents rooms. The findings include:	F 226	1. Resident #1 had a skin assessment completed by the nurse on 1/21/15 with no skin abnormalites. Resident #2 had a skin assessment completed on 1/23/15 by the physician and determined no rape had occurred. Resident #2 went home on 1/24/15 as previously planned. 2. Residents with a BIMS score of less than 8 had skin assessments completed on them by 2/24/15 to determine no abuse had occurred. Interviews were conducted by the social workers with residents who had a BIMS score of 8-15 to ensure no abuse had occurred by 2/25/15. 3. Staff were inserviced by the SDC on 2/27/15 to ensure a thorough investigation is completed with any allegation of abuse to include indepth interviews and skin assessments in the vicinity of where any allegation is	

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F 226	Continued From page 6 Review of the facility's policy and procedure titled, "Abuse and/or Neglect Investigation", not dated, revealed residents had the right to live at ease in a safe environment without the fear of retaliation when suspected abuse and or/neglect was reported. All reports of abuse will be promptly and thoroughly investigated and shall remain confidential. 1. Record review revealed the facility admitted Resident #1 on 01/09/15 with diagnoses which included Encephalopathy, Esophageal Reflux, Psychosis, Hypertension, and Chronic Ischemic Heart Disease, Review of Admission Data Set (MDS) assessment, dated 01/16/15, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of thirteen (13), which indicated the resident was interviewable. Review of the facility's investigation, conducted on 01/21/15, revealed Resident #1 voiced a complaint that "after we are gone home and the staff puts them to bed at night an older man with a beard comes in the room at night and fondles them." Social Services conducted interviews with eight (8) interviewable residents related to whether they were aware of anyone being abused or if they were abused and skin audits were conducted on fourteen (14) non-interviewable residents for signs and symptoms of abuse. All the residents resided on wing 100. The total census for wing 100 was 22. .There was no evidence the facility interviewed interviewable residents and conducted skin assessments on non-interviewable residents on adjacent wings as part of their investigation.	F 226	made. The facility has also added this information to their orientation with new hires. Any associate who does not attend with inservice will have a copy of the inservice mailed to them and a signed acknowledgement sent back to the facility for verification of understanding. 4. 5 skin assessments will be completed on each wing weekly times 4 weeks then monthly times 2 with residents of a BIMS score of 8-15 to ensure there are no signs of abuse. 2 interviews on each wing will be conducted weekly times 4 weeks then monthly times 2 with residents of BIMS score of less than 8 to ensure any allegation of abuse have been reported. Results of the audits will be reviewed at the QA committee to determine the need for further monitoring. 5. Completed by: 3/2/15	3/2/15 LH

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F 226	Continued From page 7 2. Record review revealed the facility admitted Resident #2 on 12/20/14 with diagnoses which included Diverticulitis, Hypertension, Dementia without Behaviors, Dehydration, Headache and Adult Failure to Thrive. Review of the Admission MDS assessment, dated 01/04/15, revealed the facility assessed Resident #2's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of 2, which indicated the resident was not interviewable. Review of the facility's investigation, conducted on 01/23/15 revealed an allegation of rape. Social Services conducted interviews with (9) interviewable residents related to if they were aware of any residents abused or if they had been abused and skin audits were completed on fourteen (14) non-interviewable residents for signs and symptoms of abuse. All the residents resided on Wing 100. The total census for wing 100 was 23. There was no evidence the facility interviewed interviewable residents and conducted skin assessments on non-interviewable residents on adjacent wings as part of their investigation Interview with Certified Nurse Aide #11 (CNA), on 01/28/15 at 8:56 AM, revealed he/she was the only care giver on Wing 100 throughout the 11 PM-7 AM shift, but at times throughout the night shift he/she would have to go over to Wing 300 to relieve CNA #4 for his/her lunch break and also to ask the CNA for her help to assist one female resident with care. Interview with CNA #4, on 01/28/15 at 9:24 AM, revealed CNA #11 comes over to Wing 300 several times throughout the night to ask for assistance with a female resident that is care	F 226		

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F 226	Continued From page 8 planned to have no male providers. CNA #4 stated CNA #11 also comes over to Wing 300 to relieve her for her thirty (30) minute lunch break each night. CNA #4 stated "we work together to cover for each other on both wings". Interview with Licensed Practical Nurse #1 (LPN), on 01/27/15 at 2:09 PM, revealed skin audits were only completed on the non-interviewable residents on wing (1) one, where the allegation was made and no skin audits were completed any where else in the building. She further revealed there was no set number of skin audits to be completed during a investigation. Interview with Licensed Social Worker (LSW), on 01/27/15 at 2:31 PM, revealed she interviewed the residents in the allegation and all interviewable residents on wing (1) one. She stated she was not aware she needed to interview any other residents in the facility. Interview with the Director of Nursing (DON), on 01/29/15 at 1:34 PM, revealed she felt like the facility had followed the facility's policy and conducted a thorough investigation and protected the residents. The DON stated there was no set number of how many skin audits or interviews were to be completed during an investigation. The DON revealed skin audits were conducted weekly on all residents and if there had been something it would have been brought to out attention at the morning meeting. The DON stated there were skin audits completed that very day on residents throughout the facility with no concerns identified, although they were not a part of our official investigation.	F 226		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=D	Continued From page 9 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 interview, record review, and review of the Kentucky Advisory Opinion Statement #14, it was determined the facility failed to ensure the services provided or arranged by the facility must meet professional standards of quality related to the facility's failure to clarify whether a resident needed to be nothing by mouth (NPO) prior to surgery, for one (1) of 9 (nine) sampled residents (Resident #4). The findings include: Review of the Kentucky Advisory Opinion Statement (AOS) #14, revised 10/2010, revealed KRS 314.011(6) defines "registered nursing practice" as the performance of acts requiring substantial specialized knowledge, judgement, and nursing skill based upon the principles of psychological, biological, physical, and social sciences in the application of the nursing process in the care of the resident. Review of KRS 314.011 (10) defines "licensed practical nurse" as the performance of acts requiring knowledge and skill such as are taught or acquired in approved schools for practical nursing in the observing and caring for the resident. Record review revealed the facility admitted Resident #4 on 11/01/14 with diagnoses which included Chronic Kidney Disease, Gout, Dementia, Hypertension, Dementia, Diabetes	F 281	1. Resident #4 was held NPO after midnight of 1/2/15 and sent for surgery that day per physician's orders. 2. A 30 day look back audit was completed by Licensed nurses for all residents who were scheduled for surgery from 1/24/15 to 2/24/15 to ensure the resident was held NPO if required for surgery per physician's orders. 3. Education was provided to licensed nurses by the SDC to ensure services provided to residents meet professional standards including identifying residents scheduled for surgery following physician's orders if NPO is required and clarifying any orders if needed on 2/27/15. This information was also added to our general orientation	

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F 281	Continued From page 10 Mellitus, Lipoprotein deficiencies, Vitamin D deficiency, and Anemia. Review of a facsimile, dated 12/16/14, revealed the resident was scheduled for surgery on 12/22/14 and the surgeon was requesting a surgical clearance by the resident's attending physician. Review of a physician's order, dated 12/18/14 and written by the resident's attending physician, revealed the resident was cleared for surgery and it was okay to give medications prior to going to the hospital the morning of the surgery. Interview with Licensed Practical Nurse (LPN) #4, on 02/03/15 at 6:25 PM, revealed she worked the evening of 12/21/14 and did not recall a physician's order for the resident to be NPO. She stated Resident #4's daughter had brought paperwork to the facility (unsure of date) showing where he/she was evaluated for surgery, and the paperwork was placed in the resident's chart. LPN #4 revealed the paperwork included a list, which included a check-off for pre-surgery prep; however, further record review revealed there was no pre-surgery prep check off list in the record. Review of Physician's Orders, dated 12/16/14-12/22/14, revealed there was no evidence of a physician's order written for NPO status for the day of surgery and no evidence licensed staff clarified with the physician whether the resident needed to be NPO for the surgery. Interview with LPN #5, on 02/03/15 at 4:15 PM, revealed the resident's breakfast tray was sent out the morning of the scheduled surgery. LPN	F 281	for nurses. Any licensed nurse not in attendance will have a copy of the inservice mailed to them with a signed acknowledgement to be returned to the facility for verification of understanding. 4. Weekly audits will be completed by the Unit Managers for 4 weeks to ensure anyone identified for surgery is kept NPO the night before per physician's orders or is clarified if no order is written and then monthly times 2 months. Results of the audits will be presented to the QA committee to determine the need for further monitoring. 5. Completed by : 3/2/15	3/2/15 LM

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F 281	Continued From page 11 #5 stated the Certified Nurse Aide (CNA) passed the tray and the resident was supposed to be NPO for a shunt revision. She revealed if a resident was to be NPO for any procedure, it was the final responsibility of the Charge Nurse on the floor, not the CNA, to ensure the resident did not receive a tray. Interview with CNA #12, on 02/04/15 at 3:05 PM, revealed the facility's procedure when a resident was NPO at that time was for the nurse to put a sign on the resident's bedside table showing the staff that the resident was to receive "no fluids after midnight", as well as communicate this information through shift report. She stated she did not recall any procedure being discussed for 12/22/14 and there was no sign posted so the resident's breakfast tray was served. Further interview with LPN #4, on 02/03/15 at 6:25 PM, revealed when she came in to work at 2:30 PM on 12/22/14 for the 3:00 PM - 11:00 PM shift, she was told the CNA from day shift was not aware the resident was supposed to be NPO and had given the resident a meal tray at 8:00 AM that morning, so the procedure had to be rescheduled. Review of the Physician's Order, dated 12/22/14, revealed an order for surgery on 01/02/15 at 8:30 AM at the local hospital: Shunt revision. NPO on 01/01/15 at midnight. No water, mints or gum. May have Atenolol the morning of 01/02/15 with small sips of water. No make-up, perfumes, or body lotion. Bring list of routine meds and a copy of Advanced Directive, Living Will, or Power of Attorney. Interview with the Director of Nursing (DON), on	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	186171		C 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 281	Continued From page 12 02/04/15 at 4:30 PM, revealed there should have been a phone order for the resident to be NPO, and the information communicated with dietary, family, staff, and supervisor, so the resident would have been NPO the day of the surgery. The DON stated the physician did not write the order for the resident to be NPO and the licensed staff were not aware of what kind of procedure the resident was having to alert them to call the physician to clarify if the resident needed to be NPO or not.	F 281		