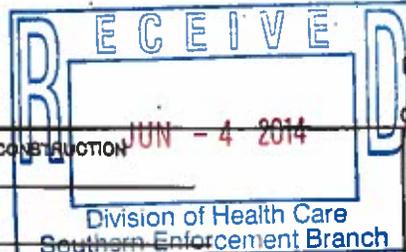


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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2014
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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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(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
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F 000	INITIAL COMMENTS An abbreviated standard survey (KY21635, KY21638) was initiated on 04/30/14 and concluded on 05/12/14. Both complaints were substantiated with deficient practice identified at "D" level.	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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, the facility failed to ensure a comprehensive plan of care was developed and/or revised that included measurable objectives and timetables to meet the	F 279	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: *[Signature]* TITLE: _____ (X6) DATE: 06-03-14

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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F 279 Continued From page 1

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06/11/14

medical and nursing needs for one (1) of four (4) sampled residents (Resident #2). A review of Resident #2's medical record revealed the facility admitted the resident on 04/21/14. A review of Resident #2's Admission Care Plan, dated 04/21/14, revealed staff had circled the pressure sore area of the care plan; however, staff failed to individualize the care plan to include a specific plan and interventions for staff to follow in an attempt to prevent the development and/or worsening of pressure sores.

The findings include:

A review of the facility policy titled "Care Plan," revision date 02/27/14, revealed an interim care plan must be developed within 24 hours of admission to insure that the resident's needs were met appropriately.

A review of Resident #2's medical record revealed the facility admitted the resident on 04/21/14 with diagnoses including Dementia, Cerebrovascular Accident, Diabetes Mellitus, Congestive Heart Failure, and Hypertension. A review of Resident #1's Admission Data Collection (admission assessment), dated 04/21/14, revealed the resident was assessed to require the assistance of one staff member for bed mobility, transfers, and ambulation. Continued review of the admission assessment revealed the resident did not have any signs of skin breakdown. Review of the Braden Scale (tool for predicting the pressure sore risk) revealed staff had assessed the resident to be at moderate risk for the development of pressure sores.

A review of Resident #2's Admission Care Plan,

1. Resident #2 was discharged from the facility prior to identification of the deficient practice.
2. All residents have the potential to be affected by the facility's failure to ensure a comprehensive plan of care was developed based on the medical and/or nursing needs with associated risk factors identified in the facility's assessment. On 5/26/14, the Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinators(MDSC) and the Nurse Unit Managers completed a review of the active diagnosis lists and plans of care for each current resident to ensure any medical and/or nursing need with associated risk factors was identified and had a care plan with individualized interventions, measurable objectives and timetables developed to ensure the residents' medical and nursing needs were met. Any discrepancy was corrected during the review.

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Continued From page 2
dated 04/21/14, revealed staff had circled the pressure sore area of the care plan; however, staff failed to document if the resident had a pressure sore or if the resident was only at risk for developing a pressure sore. Further review of the care plan revealed the facility staff failed to identify and document evidence of pressure sore prevention interventions or interventions to monitor and/or treat pressure sores.

A review of the physician's History of Present Illness, dated 04/22/14, revealed no evidence Resident #2 had pressure sores or skin issues.

Continued review of the medical record revealed documentation in the nurse's notes dated 04/25/14 at 10:30 AM that Resident #2 was transferred to an acute care facility for an evaluation of a fever and congestion. There was no documentation of a skin assessment performed prior to the resident's transfer to the hospital.

A copy of Resident #2's medical record from the acute care facility that the resident was transferred to on 04/25/14 was obtained for review and revealed the resident arrived at the Emergency Department (ED) of the acute care facility on 04/25/14 at 11:14 AM. A review of photographs provided by the acute care facility revealed on 04/25/14, the resident had an area with a scab-like appearance to the left heel area; a purple area to the left bottom heel area; an area with a blister-like appearance to the left inner foot; and an area with a blister-like appearance to the lateral side of the right foot. Continued review of the acute care facility's record revealed "Wound Management Charting," dated 04/25/14 at 8:15 PM, which revealed the resident had multiple

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3. a. On 5/22/14, the Assistant Director of Nursing reeducated licensed nurses to develop a comprehensive care plan for active diagnoses taking into consideration medical and/or nursing needs and development of a care plan with individualized interventions, measurable objectives and timetables based on the results of facility assessments.
- b. The MDSC will now review the records of new admissions the next business day after admission to ensure an interim care plan with individualized interventions, measurable objectives, and time tables has been developed for active diagnoses taking into consideration medical and/or nursing needs and based on the results of facility assessments. Discrepancies will be addressed immediately and reported to the Director of Nursing for reeducation as needed.
4. The results of the reviews by the MDSC will be reported monthly for 3 months to the Quality Assurance Committee for development of an action plan as needed.

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Continued From page 3

deep tissue injuries (DTI) to the bilateral feet, to the medial side of the left foot, and the lateral side of the right foot. Continued review of the Wound Management Charting revealed Resident #1 was assessed to have a large intact deep tissue injury (DTI)/blister to the left heel.

At the time the investigation was conducted on 04/30/14, Resident #2 remained in the acute care facility and a skin assessment or interview was not conducted.

Interview on 05/12/14 at 12:55 PM with Registered Nurse (RN) #2 revealed the RN conducted the admission assessment of Resident #2 when he/she was admitted to the facility on 04/21/14. RN #2 did not have access to Resident #2's medical record at the time of the interview and the RN stated she could not recall if Resident #2 had any skin issues at the time of his/her admission. According to RN #2, if the resident did have skin issues, the RN would have documented them on the admission assessment. Continued interview with RN #2 revealed anytime a resident was assessed to be at moderate risk for the development of pressure sores, staff should identify the risk on the resident's plan of care and should document interventions on the care plan for the prevention of pressure sores. According to RN #2, all residents were turned and repositioned every two hours based on facility policy. RN #2 could not recall the specific interventions required by Resident #2.

Interview on 05/12/14 at 2:22 PM with the Director of Nursing (DON) revealed the facility held "stand up" staff meetings on a daily basis and reviewed the care needs of all new admissions the day after the facility admitted the

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F 279	Continued From page 4 resident. The DON stated there had not been any concerns identified for Resident #2 at the time of his/her admission and stated staff had not assessed Resident #2 to have a pressure sore at the time they developed his/her care plan. The DON acknowledged, based on Resident #2's Braden assessment, the resident was at moderate risk for the development of a pressure sore. Continued interview revealed if staff had determined, based on the Braden assessment, that Resident #2 had a moderate risk for the development of pressure sores, staff should have developed a care plan with interventions and should have implemented the assessed interventions in an effort to prevent the development of pressure sores.	F 279			
F 312 SSFD	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy it was determined the facility failed to ensure necessary services to maintain good nutrition, grooming, and personal and oral hygiene were provided for one (1) of four (4) sampled residents (Resident #1). A review of the medical record for Resident #1 revealed the facility transferred the resident to the Emergency Department (ED) of an acute care facility on 04/24/14 at 11:45 AM. A review of the	F 312	F 312 1. Resident #1 was admitted to the local hospital prior to identification of the deficient practice. 2. All residents who are unable to carry out activities of daily living have the potential to be affected by the facility's failure to ensure residents receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. On 5/1/14, the Director of Nursing viewed the oral cavity of all residents who are dependent upon or require assistance of	06/11/14	

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F 312	<p>Continued From page 5</p> <p>Emergency Department (ED) record revealed on 04/24/14 at 12:45 PM (one hour after the resident was transferred from the facility), ED staff documented Resident #1's "mouth appeared very dry and the residents tongue was coated and furrowed," and took photographs of the resident's mouth. A review of the photographs obtained from the acute care facility revealed a dark yellow, dried, thick substance on Resident #1's tongue.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Oral Hygiene," dated 04/2/14, revealed facility staff would provide oral hygiene in order to cleanse the resident's mouth. The policy further revealed staff would repeat oral hygiene as frequently as necessary to keep the resident's mouth clean and moist.</p> <p>Review of the medical record for Resident #1 revealed facility staff admitted the resident on 03/31/11, with diagnoses which included Alzheimer's, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease. A review of the quarterly Minimum Data Set Assessment (MDS) dated 03/28/14 revealed Resident #1 required extensive assistance with dressing, bathing, and hygiene. Continued review of the MDS revealed Resident #1 was not interviewable and had a Brief Interview for Mental Status (BIMS) score of 4. Documentation in the medical record revealed facility staff transferred Resident #1 to the ED of an acute care facility on 04/23/14, at 11:45 AM, due to increased confusion and decreased responsiveness.</p> <p>A copy of the resident's medical record from the</p>	F 312	<p>staff for oral hygiene. All were receiving or had received good oral hygiene. On 5/1/14, 5/2/14, 5/5/14-5/9/14, and 5/12/14-5/16/14, the Director of Nursing made two rounds daily throughout the facility to visualize the staff assisting the residents who were unable to carry out their activities of daily living independently. No problems were noted.</p> <p>3. On 5/22/14, the Assistant Director of Nursing reeducated the certified nursing assistants and the licensed nurses on their responsibility to assist any resident who is unable to carry out activities of daily living and to ensure each resident receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>4. The Nurse Unit Managers will round on their respective floors twice daily, five times weekly for two weeks, then weekly thereafter to visualize 10 residents/unit receiving</p>		

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F 312	<p>Continued From page 6</p> <p>acute care facility was obtained for review. Documentation in the record revealed at 12:45 PM (one hour after the resident was transferred to the ED of the acute care facility) ED staff documented Resident #1's "mouth appeared very dry and the residents tongue was coated and furrowed." Continued review of the ED record revealed staff at the acute care facility had obtained photographs of Resident #1's tongue on the day he/she arrived at the ED. A review of the photographs revealed a dark yellow, dried, thick substance visible on Resident #1's tongue. The time the photographs were obtained could not be determined.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 04/30/14 at 2:57 PM revealed she had provided direct care to Resident #1 prior to the resident's transfer to the ED of the acute care facility on 04/24/14. LPN #1 stated she had provided mouth care to the resident "right before" he/she was transferred to the acute care facility on 04/24/14. The LPN stated she had not observed any concerns related to Resident #1's oral care at the time the resident was transferred to the acute care facility on 04/24/14.</p> <p>An interview with State Registered Nurse Aide (SRNA) #2 on 04/30/14 at 3:37 PM revealed staff had been "attempting" to provide mouth care to Resident #1 while the ambulance service was waiting to transfer the resident to the ED of the acute care facility. The SRNA stated the resident's mouth was "not as clean as it should be" when the resident was transferred to the hospital on 04/24/14.</p> <p>An interview conducted with Resident #1's Responsible Party (RP) on 05/01/14 at 9:00 AM</p>	F 312	<p>assistance with activities of daily living. Any problems will be corrected immediately. The results of these rounds will be reported monthly for three months to the Quality Assurance Committee for development of an action plan as needed.</p>		

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F 312	Continued From page 7 revealed he/she arrived at the ED of the acute care facility approximately 15 minutes after the resident arrived at the ED from the facility on 04/24/14. The RP stated when he/she arrived, he/she observed Resident #1's tongue and the "roof" of the resident's mouth to have a "dry, patchy substance" present. The RP continued to state he/she assisted hospital staff in photographing and "cleaning" the resident's mouth. The RP stated the photographs were taken "not long after I arrived" and stated "we worked approximately 40 minutes, to clean all of that out of" his/her mouth. An interview with the Director of Nursing (DON) on 05/12/14 at 2:20 PM revealed staff was to provide oral care to facility residents as required and the residents' oral cavities should be kept clean and moist. Continued interview revealed she made "rounds" and looked at the oral cavities of residents randomly every other day. The DON stated she had not identified any concerns related to oral care of residents at the facility.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314	F 314 1. Resident #2 was discharged prior to the identification of the deficient practice. 2. All residents have the potential to be affected by the facility's failure to ensure a new pressure sore does not develop. Between 5/1/14 and 5/8/14, licensed nurses performed skin sweeps on current residents. No newly developed or worsening pressure sores were noted.	06/11/14

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Continued From page 8
by:
Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure care and services were provided based on the comprehensive assessment for one (1) of four (4) residents (Resident #2). Review of the comprehensive assessment and a Braden Scale (tool for predicting the pressure sore risk) assessment revealed staff had identified Resident #2 to be at moderate risk for the development of pressure sores. However, the facility failed to develop a plan of care to address the resident's risk for the development of pressure sores and failed to provide the necessary treatment and services to ensure the resident did not develop pressure sores. The facility transferred Resident #2 to the Emergency Department (ED) of an acute care facility on 04/25/14. A review of the medical record from the acute care facility revealed staff noted Resident #2 had multiple pressure areas upon admission to the facility.

The findings include:

A review of the facility policy titled "Wound Care Prevention and Treatment Objectives," revision date of 09/01/11, revealed the facility would identify residents at risk for pressure sores accurately, identify existing pressure ulcers, and provide proactive intervention and education to optimize healing.

A review of Resident #2's medical record revealed the facility admitted the resident on 04/21/14 with diagnoses including Dementia, Cerebrovascular Accident, Diabetes Mellitus, Congestive Heart Failure, and Hypertension. A review of Resident #1's Admission Data

F 314

3. a. On 5/22/14, the Assistant Director of Nursing reeducated the certified nursing assistants on the importance of examining residents skin at least daily and reporting any changes to the charge nurse immediately.

b. On 5/22/14 the Assistant Director of Nursing reeducated the licensed nurse on their responsibility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable and that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. At this time, the licensed nurses were also reeducated on their responsibility to complete resident assessments and use the results to develop a plan of care with appropriate interventions for that resident.

c. A Braden Scale assessment will now be completed by a licensed nurse on each new admission weekly x 4 weeks. The results of these assessments will be discussed in a weekly skin condition meeting whose members

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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 314	<p>Continued From page 9</p> <p>Collection (admission assessment), dated 04/21/14, revealed the resident was assessed to require the assistance of one staff member for bed mobility, transfers, and ambulation. Continued review of the admission assessment revealed no documentation that facility staff had assessed the resident to have pressure sores. Review of the Braden Scale (tool for predicting the pressure sore risk) assessment revealed staff had assessed the resident to be at moderate risk for the development of pressure sores.</p> <p>A review of Resident #2's Admission Care Plan, dated 04/21/14, revealed staff had circled the pressure sore area of the standardized care plan; however, staff failed to document if the resident had a pressure sore or if the resident was at risk for the development of a pressure sore. Further review of the care plan revealed the facility staff failed to individualize the resident's care plan to address his/her risk for the development of pressure sores, and failed to identify and document interventions to prevent, monitor, and/or treat pressure sores.</p> <p>A review of the documentation on the physician's History of Present Illness, dated 04/22/14, revealed no evidence Resident #2 had skin issues.</p> <p>Continued review of the medical record revealed documentation in the nurse's notes dated 04/25/14 at 10:30 AM that Resident #2 was transferred to an acute care facility for an evaluation of a fever and congestion. There was no documentation of a skin assessment performed prior to the resident's transfer to the acute care facility.</p>	F 314	<p>will include the Director of Nursing, the Assistant Director of Nursing, the Nurse Unit Manager for each resident's unit, and the Dietary Manager. The care plan will be reviewed and revised using the results of these assessments.</p> <p>d. A "skin alert" sheet will now be available for the certified nursing assistants to document any skin issue. These will be forwarded to the charge nurse and Nurse Unit Manager for review.</p> <p>e. The Nurse Unit Manager will perform a skin sweep daily 5 x weekly (Monday through Friday) for the first week on newly admitted or readmitted residents then a licensed nurse will do a skin sweep weekly thereafter.</p> <p>f. The MDSC will review the care plan of newly admitted residents the next business day after admission to ensure a care plan is developed that addresses risk factors and individualized interventions that will provide the necessary treatment and services required.</p>	

JUN/04/2014/WED 11:19 AM

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166256	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED G 05/12/2014
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 314	<p>Continued From page 10</p> <p>A copy of Resident #2's medical record from the acute care facility that the resident was transferred to on 04/25/14 was obtained for review and revealed the resident arrived at the Emergency Department (ED) of the acute care facility on 04/25/14 at 11:14 AM. A review of photographs provided by the acute care facility revealed on 04/25/14, the resident had an area with a scab-like appearance to the left heel area; a purple area to the left bottom heel area; an area with a blister-like appearance to the left inner foot; and an area with a blister-like appearance to the lateral side of the right foot. Continued review of the acute care facility's record revealed "Wound Management Charting" dated 04/25/14 at 8:15 PM, which revealed the resident had multiple deep tissue injuries (DTI) to the bilateral feet, to the medial side of the left foot, and the lateral side of the right foot. Continued review of the "Wound Management Charting" revealed Resident #1 was assessed to have a large intact deep tissue injury (DTI)/blister to the left heel.</p> <p>At the time the investigation was conducted on 04/30/14, Resident #2 remained in the acute care facility and a skin assessment or interview was not conducted.</p> <p>Interview on 04/30/14 with State Registered Nurse Aide (SRNA) #3 at 3:42 PM, SRNA #4 at 6:13 PM, and SRNA #5 at 6:35 PM revealed the SRNAs had provided care to the resident including turning and repositioning the resident and bathing the resident while the resident was at the facility. The interviews further revealed the SRNAs had not observed Resident #2 to have any pressure areas or skin issues while at the facility.</p>	F 314	4. The Nurse Unit Managers will audit 10/unit weekly skin sweeps weekly for 4 weeks, then 5/unit weekly for 2 months to ensure accuracy of the licensed nurse skin sweeps. Results of these audits will be reported monthly for 3 months to the Quality Assurance Committee for development of an action plan as needed.		

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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 05/12/2014
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 314	Continued From page 11 Interview on 04/30/14 at 3:11 PM with SRNA #1 revealed the SRNA had provided care to Resident #2 the day the resident was transferred out to the hospital. The interview further revealed the SRNA had given the resident a bed bath before the resident was transferred to the hospital which included washing the resident's feet. The SRNA denied Resident #2 had any pressure areas or skin issues on the resident's feet. Continued interview revealed the SRNA did not remember the resident having pressure prevention interventions in place except for turn and repositioning. Interview on 04/30/14 at 7:07 PM with Licensed Practical Nurse (LPN) #4 revealed the LPN provided care to Resident #2 the day the resident was transferred out to the acute care facility. The interview further revealed the LPN did not assess the resident's feet because the resident did not have any treatments ordered for the feet. LPN #4 stated she was not aware of any pressure sores Resident #2 had prior to his/her transfer to the acute care facility. Interview on 05/12/14 at 12:55 PM with Registered Nurse (RN) #2 revealed she had completed a skin assessment of Resident #2 the day the resident was admitted to the facility. The interview further revealed the RN did not recall the resident having any skin issues at the time of admission and stated if the resident did have skin issues, it would have been documented. Continued interview revealed interventions should have been put in place for Resident #2 if the resident was assessed to be at risk for the development of pressure areas or if staff had identified any skin impairment.	F 314			

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F 314	Continued From page 12 Interview on 05/12/14 at 2:22 PM with the Director of Nursing revealed staff had discussed Resident #2 at the standup meeting (meeting of staff each weekday to discuss residents) the day after the resident's admission. The interview revealed all new admissions, and any concerns that staff had identified, were discussed at each meeting. Further interview revealed staff had not assessed Resident #2 to have any pressure areas or skin issues upon admission so the resident's skin was not discussed. The DON further revealed residents assessed to be at risk for pressure sore development should have interventions put into place to prevent pressure.	F 314			