

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

Second SOD

PRINTED: 01/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:  185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2011
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 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>A standard health survey was conducted on 12/05-08/11. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, care plan review, and a review of facility policies, it was determined the facility failed to ensure services were provided to one of eighteen sampled residents in accordance with the resident's plan of care (Resident #13). The facility failed to ensure that a care plan intervention for the resident to have fluids restricted to 1500 milliliters per day had been implemented in accordance with the resident's plan of care. A physician's order dated 09/06/11 revealed nursing staff should have provided 900 milliliters of fluid to the resident, per day, and the Dietary Department should have provided 600 milliliters of fluid, for a total of 1500 milliliters of fluid a day. On 12/01/11, 12/02/11, 12/03/11, 12/04/11, 12/05/11, 12/06/11, and 12/07/11, the resident received greater than 1500 milliliters of fluid per day from the nursing staff. The dietary staff was responsible to monitor for the 600 milliliters which had been provided by the Dietary Department. The fluids provided by the Dietary Department were not included with the totals</p>	F 282	<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 the Statement of Deficiencies and Plan of Correction does not denote agreement with the statement of deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Parkview Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated 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

TITLE

(X6) DATE

*Angele Hall Owens*

*ADMINISTRATOR*

*2-2-2012*

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.

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F 282	<p>Continued From page 1 documented by the nurses on the Medication Administration Record (MAR).</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Care Plan" (dated August 2010) revealed the licensed nurse was responsible for initiating the resident care plan. The policy also revealed the care plan would be initiated upon admission to the facility and would be reviewed and revised on an ongoing basis.</p> <p>A review of the medical record for Resident #13 revealed the facility admitted the resident on 11/25/09, with diagnoses which included Chronic Kidney Disease requiring Dialysis and Diabetes Mellitus.</p> <p>A review of an Annual-Minimum Data Set (MDS) assessment dated 09/12/11 revealed the resident had been assessed to have moderately impaired cognition. The MDS also revealed the resident required the limited assistance of one person for eating.</p> <p>A review of the comprehensive care plan for Resident #13 revealed an entry dated 09/06/11 that indicated the resident was to have fluids restricted to no more than 1500 milliliters in 24 hours.</p> <p>A review of the Certified Nursing Assistant (CNA) Assignment Sheet dated 12/07/11 revealed Resident #13 was on fluid restriction, however, the assignment sheet failed to specify how much fluid the resident was allowed to consume.</p>	F 282	<p>F 282</p> <p>1. Resident #13 did not have any adverse outcome as evidenced by 12/14/2011 pertinent labs which noted improvements in levels. Resident and family were educated regarding fluid restrictions to include no pitcher of water at bedside. They acknowledge and understand need for fluid restrictions as well as possible adverse outcomes with noncompliance. The resident's physician was made aware of resident noncompliance. Amount of fluid restriction was added to C.N.A. assignment sheet.</p> <p>2. All residents have the potential to be affected by the deficient practice. The C.N.A. Preceptor compared a list of care plan interventions to actual care provided and the C.N.A. assignment sheets on 1/2/12. Discrepancies were corrected immediately by Unit Manager/ Licensed Nurses and the Director of Nursing was notified.</p>	1/22/12
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F 282	<p>Continued From page 2.</p> <p>A review of the Medication Administration Record (MAR) for Resident #13 dated December 2011 revealed nurses documented fluids the resident received from nursing staff only. The fluids received from the resident's meal trays were monitored by the dietary staff and were not documented on the MAR. Documentation on the MAR revealed on 12/01/11, the resident consumed 1165 milliliters of fluid; on 12/02/11, the resident consumed 1440; on 12/03/11, the resident consumed 1780 milliliters; on 12/04/11, the resident consumed 1550 milliliters; on 12/05/11, the resident consumed 1560 milliliters; on 12/06/11, the resident consumed 1180 milliliters; and on 12/07/11, the resident consumed 2355 milliliters from the nursing staff which were in addition to the 600 milliliters received from the Dietary Department.</p> <p>Observation of Resident #13 on 12/07/11, at 1:10 PM, revealed the resident was sitting on the side of the bed. The observation also revealed a cup filled with ice water sitting on the overbed table and within reach of the resident.</p> <p>An interview conducted on 12/07/11, at 1:45 PM, with CNA #1 revealed Resident #13 was on a fluid restriction and should not have had a cup with ice water on the overbed table. The CNA was unsure who provided the resident with the ice water. The CNA also revealed she was unaware of how much fluid staff could provide the resident. The CNA stated she received information on the resident's care needs from the CNA Assignment Sheet. The CNA further stated she would have to ask the nurse for the fluid limits for the resident as she was unsure of the amount the resident could receive. The CNA stated she did not report</p>	F 282	<p>3. A.)Nursing staff have been reeducated 12/9, 12/12, and 12/13/2011 regarding fluid restriction protocol by the Assistant Director of Nursing and C.N.A. Preceptor. All staff will be reeducated January 5, 2012 regarding: a) The NURSES responsibility to maintain I&amp;Os for any resident who is on fluid restrictions and the total daily intake must include the fluids consumed on the meal tray. b) Nurses only are responsible for the distribution of any fluids to these residents other than what is provided on the meal trays c.)all staff must report to the nurse when a resident requests any additional fluids other than what is available on their meal tray d) CNAs can only provide fluids that are on the resident's meal trays and report the amount of those fluids consumed to the nurse. C.N.A.s must report any resident noncompliance with fluid restrictions to the nurse, who will inform the primary physician.</p>		

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F 282	<p>Continued From page 3</p> <p>the amount of fluids taken in by the resident per shift to the nurse. The CNA stated she did not monitor the resident's intake from meals to calculate the resident's intake for a 24-hour period. The CNA also stated she was assigned to care for Resident #13 on 12/07/11.</p> <p>An interview conducted on 12/07/11, at 2:00 PM, with CNA #2 revealed she was aware Resident #13 was on a fluid restriction but was unaware of the amount of fluid the resident was allowed to have. The CNA also stated she was able to document outputs in the computer but had no way of documenting fluid intakes and did not have an intake sheet or anywhere to document the resident's intake. The CNA stated she did not report fluid intakes for Resident #13 every shift. The CNA stated she was unaware of how the resident got the cup of ice water.</p> <p>An interview conducted on 12/07/11, at 2:15 PM, with CNA #3 revealed there was no place for the CNAs to document the fluid intake for Resident #13. The CNA also stated she had not been told Resident #13 was on fluid restriction and had not been keeping up with the resident's fluid intake. The CNA stated she did not report fluid intakes to the nurse every shift as required. The CNA revealed she was unaware of how the resident got the cup of ice water.</p> <p>An interview conducted on 12/07/11, at 2:10 PM, with Licensed Practical Nurse (LPN) #1 revealed the resident should not have a cup of ice water within his/her reach due to the resident's fluid restriction. The LPN stated she did not know who had provided the ice water to the resident. According to the LPN, she had talked to the</p>	F 282	<p>B.)The Director of Nursing or designee will review daily intake totals to ensure intake totals do not exceed fluid restriction as ordered by physician for seven days, then weekly for 3 months. Reeducation will be provided as needed during the observations.</p> <p>C.)The Director of Nursing and / or designee will conduct random observations and staff interviews weekly for three months to ensure staff compliance with fluid restriction protocol. Reeducation will be provided as needed during the observations.</p> <p>D.)The C.N.A. Preceptor and the Unit Managers will compare a list of care plan interventions to the C.N.A. assignment sheets and actual care provided monthly for 3 months. Any discrepancies will be corrected and a report given to the Director of Nursing.</p> <p>E.) During the January and February change over, Administrative nurses will compare physician orders, care plans, and C.N.A. assignment sheets to ensure care plan interventions are current. Corrections will be made as needed.</p>		

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F 282	<p>Continued From page 4</p> <p>CNAs on 12/07/11, at 2:00 PM, and the resident had already taken in greater than 1500 milliliters and would receive additional fluids with the supper meal. The reported intake did not include the amount of fluids the resident had received from meals. The interview with the LPN revealed CNAs had not routinely reported the resident's fluid intake to her and she had not asked the CNAs to report the fluid intakes to her. The LPN also stated the fluid intakes documented on the MAR were only what the resident received from nursing staff and was in addition to what the resident received from the Dietary Department. The LPN stated Dietary monitored the amount of fluids provided on the resident's meal tray.</p> <p>An interview conducted on 12/08/11, at 9:50 AM, with the Unit Manager (UM) for the fourth floor of the facility revealed the UM had been unaware the CNAs had not reported resident fluid intake to nursing staff for Resident #13. The UM revealed the Dietary Department monitored the fluids delivered to the residents and these amounts were not documented on the MARs. The UM stated the fluid intake documented on the MARS was the amount of fluids given to the resident by the nursing staff.</p> <p>An interview conducted on 12/08/11, at 10:10 PM, with the Director of Nursing (DON) revealed it was the responsibility of the nurse to ensure the CNAs were aware of the fluid restrictions for Resident #13. The DON stated the nurse was responsible for documenting the fluids administered to the resident on the MAR in addition to the fluids given to the resident by the Dietary Department by monitoring intakes for the resident. The DON stated CNAs were expected</p>	F 282	<p>F.) The Director of Nursing/Assistant Director of Nursing/designee will observe 10 residents weekly for 4 weeks, then 10 residents monthly for 2 months to determine if specific care plan intervention are being followed. Discrepancies will be corrected immediately and re-education provided as indicated.</p> <p>4. Results of the Director of Nursing observations, Preceptor and Unit Manager reports, and change over results will be reported monthly for 3 months to the Risk Management/Quality Improvement Committee by the Director of Nursing for review and development of an action plan as needed.</p>		

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F 282	Continued From page 5 to report to the nurses regarding the amount of fluid consumed by Resident #13 every shift and prior to administering any additional fluid to the resident. The DON further stated the facility did not currently have any monitors in place to ensure staff was monitoring residents with fluid restrictions.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of eighteen sampled residents (Resident #13). Resident #13 had a physician's order dated 09/06/11 for fluids to be restricted to no more than 1500 milliliters in a 24-hour period. The physician's order also revealed dietary staff was to give the resident 600 milliliters of fluid with meals and nursing staff was to give the resident no more than 900 milliliters with medications and snacks in a 24-hour period. A review of the fluid intake record for Resident #13 revealed from 12/01/11 through 12/07/11, the resident had consumed greater than the prescribed 900	F 309	F 309  1. Resident #13 did not have any adverse outcome as evidenced by 12/14/2011 pertinent labs which noted improvements in levels. Resident and family were educated regarding fluid restrictions to include no pitcher of water at bedside. They acknowledge and understand need for fluid restrictions as well as possible adverse outcomes with noncompliance. The resident's physician was made aware of resident noncompliance.  2. No other residents have fluid restrictions ordered therefore no other residents were identified to have the potential to be affected with regard to fluid restrictions.	01/22/12

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F 309	<p>Continued From page 6</p> <p>milliliters of fluid provided by nursing staff and the 600 milliliters provided to the resident by the Dietary Department.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Fluid Maintenance" (dated June 2009) revealed it was the responsibility of the nurse to communicate to the nursing staff that the resident was on a fluid restriction. The policy also stated it was the nurse's responsibility to monitor the resident's hydration status and to monitor for compliance. In addition, the policy revealed a resident that required fluid maintenance should not have a water pitcher at the bedside.</p> <p>Documentation in Resident # 3's medical record revealed the facility admitted the resident on 11/25/09. The resident's diagnoses included Diabetes Mellitus and Chronic Kidney Disease.</p> <p>A review of the Annual Minimum Data Set (MDS) assessment for Resident #13 dated 09/12/11 revealed the resident was assessed to require the assistance of one person to eat. The assessment further revealed the facility assessed Resident #13 to have moderately impaired cognition.</p> <p>A review of the physician's orders for Resident #13 revealed an order dated 09/06/11 for fluids to be restricted to 1500 milliliters every day. Based on the order, the Dietary Department was to provide 600 milliliters of fluids and nursing staff was to provide 900 milliliters in a 24-hour period.</p> <p>A review of the comprehensive plan of care for</p>	F 309	<p>3. A.) Nursing staff have been reeducated 12/9, 12/12, and 12/13/2011 regarding fluid restriction protocol by the Assistant Director of Nursing and C.N.A. Preceptor. All staff will be reeducated January 5, 2012 regarding: a) The NURSES responsibility to maintain I&amp;Os for any resident who is on fluid restrictions and the total daily intake must include the fluids consumed on the meal tray. b) Nurses only are responsible for the distribution of any fluids to these residents other than what is provided on the meal trays c) all staff must report to the nurse when a resident requests any additional fluids other than what is available on their meal tray d) CNAs can only provide fluids that are on the resident's meal trays and report the amount of those fluids consumed to the nurse. C.N.A.s must report any resident noncompliance with fluid restrictions to the nurse, who will inform the primary physician</p>		

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F 309	<p>Continued From page 7</p> <p>Resident #13 revealed an intervention had been added to the plan of care on 09/06/11, in which the resident had been placed on fluid restrictions of no more than 1500 milliliters in a 24-hour timeframe.</p> <p>A review of the assignment sheet for the Certified Nursing Assistant (CNA) assigned to provide care for Resident #13 on 12/07/11, revealed Resident #13 was to have been on a fluid restriction; however, the assignment sheet did not specify how many milliliters of fluid the resident was allowed to have. The assignment sheet had been developed and provided to the CNA by a nurse.</p> <p>A review of the Medication Administration Record (MAR) for Resident #13 revealed staff had documented the resident's fluid intake provided by nursing staff on the MAR. The review further revealed on 12/01/11, the resident consumed 1165 milliliters of fluid; on 12/02/11, the resident consumed 1440 milliliters of fluid; on 12/03/11, the resident consumed 1760 milliliters of fluids; on 12/04/11, the resident consumed 1550 milliliters of fluids; on 12/05/11, the resident consumed 1560 milliliters of fluids; on 12/06/11, the resident consumed 1180 milliliters of fluids; and on 12/07/11, the resident consumed 2355 milliliters of fluid.</p> <p>Observation of Resident #13 on 12/07/11, at 1:10 PM, revealed a large drinking cup of ice and water on the resident's overbed table.</p> <p>An interview conducted on 12/07/11, at 1:45 PM, with CNA #1 revealed the facility utilized the large drinking cups as water pitchers and further stated Resident #13 should not have had a water pitcher</p>	F 309	<p>B.) The Director of Nursing or designee will review daily intake totals to ensure intake totals do not exceed fluid restriction as ordered by physician for seven days, then weekly for 3 months. Reeducation will be provided as needed during the observations.</p> <p>C.) The Director of Nursing and / or designee will conduct random observations and staff interviews weekly for three months to ensure staff compliance with fluid restriction protocol. Reeducation will be provided as needed during the observations.</p> <p>4. Results of the Director of Nursing observations will be reported monthly for 3 months to the Risk Management/Quality Improvement Committee by the Director of Nursing for review and development of an action plan as needed.</p>		

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F 309	<p>Continued From page 8</p> <p>because the resident was on fluid restrictions. The CNA stated she was assigned to provide care for the resident on 12/07/11, but did not know who had provided the resident with the water. In addition, the CNA stated she was aware the resident was on fluid restrictions but was not aware of how much fluid the resident was allowed to have. The CNA further stated she would need to ask the nurse for the fluid limits for the resident but had failed to ask the nurse. The CNA stated she had not been told to report to the nurse the amount of fluids consumed by the resident every shift.</p> <p>An interview conducted on 12/07/11, at 2:00 PM, with CNA #2 revealed she had been aware Resident #13 was on fluid restrictions, was not aware of the amount of fluid the resident was allowed to have, and had not asked the nurse. The CNA also stated she had never been told to report fluid intakes for Resident #13 every shift to the nurse and had not documented the resident's fluid intake. The CNA also stated she referred to the CNA assignment sheet for direction related to the resident's care.</p> <p>An interview conducted on 12/07/11, at 2:15 PM, with CNA #3 revealed she was not aware Resident #3 was on fluid restrictions, had not documented Resident #3's fluid intake and had not been told to report the resident's fluid intake to the nurse. The CNA also stated she referred to the CNA assignment sheet for direction related to each resident's care needs.</p> <p>An interview conducted on 12/07/11, at 2:10 PM, with Licensed Practical Nurse (LPN) #1 revealed Resident #13 was on fluid restrictions, should not</p>	F 309		

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F 309	<p>Continued From page 9</p> <p>been given a cup of ice/water, and LPN #1 was not aware the resident had received the cup of water. The LPN stated CNAs had not reported Resident 13's fluid intake to her and she had not asked the CNAs for the information. The LPN also stated the resident's fluid intake documented on the MAR was the amount of fluid that nursing staff had provided and was in addition to what the resident had received from the Dietary Department.</p> <p>An interview conducted on 12/08/11, at 9:50 AM, with the Unit Manager (UM) of the fourth floor revealed the UM had not been aware CNAs had not reported the resident's fluid intake to the nurses. The UM revealed the Dietary Department monitored the fluids provided by the Dietary Department to residents, and these amounts were in addition to what had been documented on the MAR by the nurses. The UM stated the fluid intake documented on the MAR was the amount of fluids provided by nursing staff.</p> <p>An interview conducted on 12/08/11, at 10:10 PM, with the Director of Nursing (DON) revealed it was the responsibility of the nurse to ensure CNAs were made aware of the fluid restrictions for Resident #13 and also to monitor the resident's intake to ensure compliance with the fluid restrictions. The DON stated the nurse should document the fluid consumed by the resident on the MAR and, according to the DON, this amount was in addition to the fluids provided by the Dietary Department. The DON stated CNAs were expected to report the amount of fluid consumed by Resident #13 to the nurses every shift and prior to the administration of any</p>	F 309			

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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  12/08/2011
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 309	Continued From page 10 additional fluid to the resident. The DON further stated the administrative staff did not currently have any monitors in place to ensure staff monitored residents with fluid restrictions.	F 309			
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM  The facility must maintain an effective pest control program so that the facility is free of pests and rodents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, a review of the facility's policy and pest control contract, it was determined the facility failed to maintain an effective pest control program to ensure the facility was free of pests. Gnats were observed on 12/05/11, at 7:00 PM, and on 12/06/11, at 9:10 AM and 5:23 PM in resident room 520-A. Gnats were also observed in resident room 515-A on 12/07/11, at 3:17 PM. A group interview conducted on 12/06/11, with nine residents assessed by the facility to be interviewable, revealed the residents had complained about gnats being a problem in the facility.  The findings include:  A review of the facility's pest control contract dated 11/22/11 revealed the pest control company would treat the facility for small and large flies, rodents, ants, and termites. However, there was no evidence the facility would be	F 469	F 469 1. Resident rooms 520 and 515 were treated with Finito 12/8/2011 by pest control service. A follow-up visit by pest control company was conducted 12/14/2011 on the 5 <sup>th</sup> floor. The 5 <sup>th</sup> floor nurses station and hallways were treated 12/14/2011 by pest control company.  2. A walk through of the entire facility was conducted 12/19/2011 by facility maintenance staff and pest control service representative and any issues were addressed at that time. According to the contracted pest control service gnats are covered in the existing contract as small flies.	01/22/12	

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F 469	<p>Continued From page 11 treated for gnats.</p> <p>Gnats were observed in resident room 520-A on 12/05/11, at 7:00 PM, and on 12/06/11, at 9:10 AM and 5:23 PM.</p> <p>Gnats were also observed in resident room 515-A on 12/07/11, at 3:17 PM.</p> <p>In addition, a group interview conducted on 12/06/11, at 3:00 PM, with nine residents assessed by the facility to be interviewable, revealed gnats had been an ongoing problem in the facility, especially in resident rooms.</p> <p>An interview conducted with the Housekeeping Supervisor (HS) on 12/08/11, at 1:00 PM, revealed staff reports when they observe pests and housekeeping staff thoroughly cleans the room. However, the HS stated he had not been aware of any problem with gnats.</p> <p>An interview conducted with the Maintenance Supervisor (MS) for the facility on 12/08/11, at 1:15 PM, revealed the MS had not been made aware of any problem with gnats and that a pest control company had treated the facility on 12/05/11. The MS stated he monitored the building once a week to check for pests.</p> <p>An interview with the Administrator on 12/08/11, at 1:30 PM, revealed Department Managers were expected to monitor five rooms each week to monitor for pests. If pests were identified, staff was to report the findings to the HS or MS. The Administrator stated any room identified to have gnats was to be cleaned.</p>	F 469	<p>3. Housekeeping Supervisor will view Rooms 520 and 515 for gnats daily for five days, then weekly for three months. Resident rooms will be checked by Department Managers for gnats weekly for three months. The Unit Managers will observe common areas on their respective units daily for five days then weekly for three months. All staff education provided 12/9, 12/12, 12/13/11, and 1/5/2012 regarding procedure that maintenance is to be notified immediately when pests are sighted within the facility, and the completion, content, and placement of a maintenance repair request form. Pest control company will treat facility for gnats as needed.</p> <p>4. Results of the Housekeeping Supervisor, Department Manager and Unit Manager monitoring will be reported monthly for three months to the Risk Management / Quality Improvement Committee for review and 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 41601	
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K 000	INITIAL COMMENTS  CFR: 42 CFR §483.70 (a)  BUILDING: 01  PLAN APPROVAL: 1989  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: Five story, Type II (222)  SMOKE COMPARTMENTS: Thirteen  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLED, SUPERVISED (WET SYSTEM)  EMERGENCY POWER: Type II diesel generator  A life safety code survey was initiated and concluded on 12/06/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.  Deficiencies were cited with the highest deficiency identified at "F" level.	K 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. Parkview Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the statement of deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Parkview Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies through informal dispute resolution, formal appeal, and/or any other administrative or legal proceedings.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  All required smoke detectors, including those activating door hold-open devices, are approved,	K 054		

RECEIVED  
FEB 10 2012  
Agency Health Care  
Southern Enforcement Branch

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Angela Owens TITLE ADMINISTRATOR (X6) DATE 2-2-2012

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 Feb. 10. 2012 3:03PM No. 5404

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K 054	<p>Continued From page 1</p> <p>maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain the fire alarm system by NFPA standards. This deficient practice affected thirteen of thirteen smoke compartments, staff, and all the residents. The facility has the capacity for 120 beds with a census of 83 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 12/06/11 at 2:00 PM, with the Director of Maintenance (DOM), a record review revealed there were no reports made available regarding the sensitivity testing of the smoke/heat detectors. A sensitivity report entails the testing of components associated with the fire alarm system; i.e., smoke detectors and heat detectors.</p> <p>An interview on 12/06/11 at 2:10 PM, with the DOM revealed he depended on the facility's fire alarm contractor to maintain these items.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light</p>	K 054	<p>K054</p> <ol style="list-style-type: none"> <li>A.)Addressable fire system installed by 1/22/12. B.)Contract signed on 12/15/11 with an alternate fire system service provider knowledgeable of NFPA requirements.</li> <li>All areas of facility had potential to be affected.</li> <li>A.) Installation of addressable fire system. B.)Contract with an alternate fire system service. C.) Administrator reeducated Maintenance Director and Assistant on 12/8/11 and 1/3/12 regarding required sensitivity testing methods and respective record keeping.</li> <li>Service contractor documentation will be reviewed by the Director of Maintenance or assistant upon completion.</li> </ol>	1/22/12	

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K 054	<p>Continued From page 2</p> <p>gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer's calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</li> <li>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</li> </ol> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.</p> <p>Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.</p>	K 054		

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K 054	Continued From page 3  7-3.2.2 Test frequency of interfaced equipment shall be the same as specified by the applicable NFPA standards for the equipment being supervised.  7-3.2.3 For restorable fixed-temperature, spot-type heat detectors, two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year, with records kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested.	K 054			