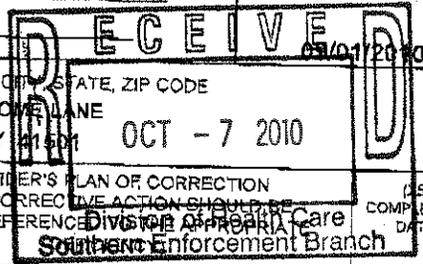


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Second Sub

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
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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	F 000		
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>Criteria 1</p> <p>A. Resident #1's primary physician was notified on 8/31/10 of resident's continued refusal of Prilosec 20mg and Ditropan XL 10mg.</p> <p>B. Resident #14's primary physician was notified on 9/3/10 of residents continued refusal of Ferrous Sulfate 325mg.</p> <p>C. A hemocrit and hemoglobin level was obtained and addressed by the primary physician.</p> <p>Criteria 2</p> <p>100% audit of residents Medication Administration Record (MAR) for the past 30 days was completed to identify resident refusal of medications. Primary physician was notified as indicated to discuss refusals and possible interventions.</p>	10/8/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE NHA	(X6) DATE 10/7/10
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time Oct. 7. 2010 2:25PM No. 3371

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the attending physician for two (2) of twenty-six (26) sampled residents when residents #1 and #14 continuously refused medications prescribed by the resident's physician.</p> <p>The findings include:</p> <p>1. A review of the medical record revealed resident #1 was admitted to the facility on July 1, 2009, with diagnoses of Delusional Disorder, Neurogenic Bladder, Esophageal Reflux, Paranoid Schizophrenia, Paraplegia secondary to a gunshot, and Seizures. A review of the current physician's orders revealed resident #1 had orders for Prilosec 20 mg and Ditropan XL 10 mg to be administered once a day.</p> <p>A review of the August 2010 Medication Administration Record (MAR) revealed Prilosec and Ditropan were circled 13 days during the month of August 2010. Further notation dated August 8, 28, 30, and 31, 2010, on the MAR revealed the staff nurse noted resident #1 refused medications after three attempts. However, there was no documentation the resident's physician had been informed of the resident's continuous medication refusal until August 31, 2010.</p> <p>An interview conducted with LPN #2 on August 31, 2010, at 9:50 a.m., revealed if a resident refused their medications, the nurse was required to circle the medication on the MAR and document the reason on the back of the MAR after three attempts were made to administer the</p>	F 157	<p>Criteria 3</p> <p>A. Licensed staff, including Nurse #1, #2, and #3 was re-educated by the ADON on the policies concerning medication refusal and physician notification on 9/24/10, 9/25/10, 9/26/10, 9/27/10, 9/28/10, 9/29/10 and 9/30/10.</p> <p>B. The Unit Manager on each floor will QA monitor resident MAR's 5x week for one month, then weekly for 3 months to determine medication refusal and physician notification.</p> <p>Criteria 4</p> <p>Findings of the Unit Managers will be brought to the Monthly QA meeting by the DON/ADON for 3 months for review and development of an action plan as needed.</p>	
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F 157	<p>Continued From page 2</p> <p>prescribed medications to the resident. LPN #2 further stated the physician was required to be notified if the resident refused medications. However, the LPN stated he/she could not recall reporting the medication refusals to resident #1's physician.</p> <p>An interview conducted with the DON on August 31, 2010, at 11:20 a.m., revealed the nurse was required to circle the initials on the MAR, note an entry in the nurse's notes, and notify the resident's physician when a resident refused a medication.</p> <p>An interview conducted with LPN #3 on August 31, 2010, at 12:20 a.m., revealed the MAR was to be initiated by the nurse and circled when a resident refused a physician-ordered medication. LPN #3 stated the reason for the refusal should be documented on the back of the MAR and the resident's physician should be notified.</p> <p>A review of the facility's policy/procedure related to refusal of medications/treatments (dated 2005) revealed the facility staff was required to circle the caregiver's initials on the MAR when a resident refused medications and to try to determine the reason for the refusal. The policy/procedure directed that staff was required to notify the resident's physician of the refusal of medication/treatments to determine if a change in medication/treatment was appropriate. The policy/procedure further noted the timeliness of the notification was to be determined by the potential effect of the refusal and the physician was required to be notified if a resident's refusal of medication/treatment was consistent.</p> <p>2. Review of the medical record revealed</p>	F 157		

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F 157	<p>Continued From page 3</p> <p>resident #14 was admitted to the facility on August 1, 2007, with diagnoses of Dementia with mental changes, Diabetes Mellitus, and Degenerative Arthritis. Review of the Significant Change in Status Assessment dated July 20, 2010, revealed the facility assessed resident #14 as being moderately impaired in daily decision-making. Review of the Resident Assessment Protocol (RAP) dated July 20, 2010, revealed resident #14 had mild memory impairment and had poor decision-making.</p> <p>Observation during medication pass on August 30, 2010, at 6:00 p.m., revealed LPN #1 prepared three medications for resident #14. Prior to entering resident #14's room, LPN #1 informed the surveyor that resident #14 had been refusing to take the iron pill (Ferrous Sulfate). Resident #14 refused to take the Ferrous Sulfate tablet during the medication pass on August 16, 2010, at 6:00 p.m., and reported to LPN #1 that the medication "hurts my bottom." LPN #1 disposed of the Ferrous Sulfate tablet.</p> <p>Review of the physician's orders dated March 27, 2010, revealed the physician had ordered for resident #14 to receive Ferrous Sulfate 325 mg two times a day.</p> <p>Review of the July 2010 Nurse's Medication Notes/Medication Administration Record revealed the nurses recorded resident #14 had refused the iron preparation (Ferrous Sulfate) 27 times. Further review revealed on July 2, 2010, the physician and responsible party were notified that resident #14 refused to take the Ferrous Sulfate at 9:00 a.m.</p> <p>Review of the August 2010 Nurse's Medication</p>	F 157			

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F 157	Continued From page 4 Notes/Medication Administration Record revealed resident #14 had refused to take the Ferrous Sulfate 27 of the 62 times the medication was ordered and scheduled to be administered. Further review of the medical record revealed no documentation that staff had notified resident #14's physician of the resident's refusal to take the Ferrous Sulfate since July 2, 2010.  Review of a Complete Blood Count (CBC) dated April 6, 2010, revealed resident #14's hemoglobin was 11.5 (reference range 12.2-16.2) and the hematocrit was 32.9 (reference range 37.7-47.9).  Interview on September 1, 2010, at 2:40 p.m., with LPN #1 revealed if a resident refused a medication the nurse should circle the initials on the MAR and make an entry on the back of the MAR to explain why the medication was missed. LPN #1 stated resident #14 had refused the Ferrous Sulfate most of the time and the physician should be notified. LPN #1 stated the LPN had not called the physician due to not having the time to make the call.  Interview on September 1, 2010, at 3:00 p.m., with the Unit Manager revealed the physician should be notified each time a resident refused a medication.	F 157			
F 164 SS=F	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and	F 164	Criteria I A. Curtains and blinds were placed at the windows of showers rooms on 3 <sup>rd</sup> , 4 <sup>th</sup> , and 5 <sup>th</sup> floors. B. A bariatric shower chair was purchased.	10/8/2010	

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F 164	<p>Continued From page 5</p> <p>meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract, or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to provide personal privacy for all residents who showered on the third, fourth, and fifth floors. Observations of the third, fourth, and fifth floor shower rooms on September 1, 2010, revealed no curtains on windows to the outside in shower rooms, allowing full visibility from the outside into the shower rooms.</p> <p>The findings include:</p> <p>Observations during the environmental tour on September 1, 2010, revealed no curtains over the windows to the outside on the third, fourth, and</p>	F 164	<p>Criteria 2 Any resident showered without a window curtain or blinds has the potential to be affected.</p> <p>Criteria 3</p> <p>A. Nursing staff was re-educated on a resident's right to dignity and privacy by the ADON on 9/24/10, 9/25/10, 9/26/10, 9/27/10, 9/28/10, 9/29/10 and 9/30/10. B. Staff to be re-educated on completion of maintenance requests and reporting. C. Maintenance Department to monitor window curtain/blind placement on 3<sup>rd</sup>, 4<sup>th</sup>, and 5<sup>th</sup> floor weekly for 1 month then monthly for 3 months.</p> <p>Criteria 4 Findings of the monitoring will be brought to the Monthly QA meeting by the Maintenance Director for 3 months for review and development of an action plan as needed.</p>	

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F 164	Continued From page 6 fifth floor shower rooms.  Interview with resident #20 on September 1, 2010, revealed the resident did not like to take showers as there were no shower chairs large enough for the resident, no curtain over the window to the outside in the shower room, and the resident was uncomfortable with the idea of being in front of an uncovered window during a shower.  An interview with the Maintenance worker on September 1, 2010, at 1:00 p.m., revealed that curtains should be over all the windows in the shower rooms.  An interview with the Administrator on September 1, 2010, at 2:00 p.m., revealed coverings for all windows in the shower rooms should be in place. The Administrator did not know why there were no curtains over the windows.	F 164			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide one (1) of twenty-six (26) residents (resident #20) who utilize bariatric wheelchairs with reasonable	F 246	Criteria 1 The doorway between the activity room and dining room has been widened.  Criteria 2 Any resident requiring the use of a bariatric wheelchair for mobility has the potential to be affected.  Criteria 3 The doorway was widened on 9/25/2010 to accommodate all wheelchairs.	10/8/2010	

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F 246	<p>Continued From page 7</p> <p>accommodations within the physical environment of the facility.</p> <p>The findings include:</p> <p>During the Quality of Life Assessment group interview conducted on August 30, 2010, at 10:00 a.m., resident #20 expressed a concern that residents who utilized bariatric wheelchairs for mobility were unable to access the dining room area.</p> <p>An interview with resident #20 on September 1, 2010, at 9:45 a.m., revealed resident #20 desired to eat in the dining room with friends. Resident #20 stated that the facility could/would walk the resident into the dining room; however, the resident was not always able to walk related to edema in resident #20's feet and legs.</p> <p>Observations on September 1, 2010, during the environmental tour revealed the bariatric chairs would not fit through the dining room doorway while the chair was in an open position.</p> <p>An interview with the Administrator on September 1, 2010, at 2:00 p.m., revealed the Administrator was concerned with the fact that the bariatric wheelchairs would not fit into the dining room area, and stated a plan would be put into place to correct the matter.</p> <p>An interview with the Assistant Administrator on September 1, 2010, at 3:00 p.m., revealed resident #20 was able to walk into the dining room with the assistance of staff. The Assistant Administrator further stated that resident #20 did have times when the resident was physically unable to walk and would need to utilize the</p>	F 246	<p>Criteria 4</p> <p>The Activity Director will attend monthly Resident Council meeting for three months to determine that accommodation of needs related to access to the dining room is being met. The Activity Director will report any negative findings in the monthly QA meeting for three months. The Administrator will review the Residents Council meeting minutes for three months for compliance.</p>		

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F 246	Continued From page 8	F 246		
F 281 SS=D	<p>bariatric wheelchair for mobilization.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide services to meet professional standards of quality for two (2) of twenty-six (26) residents (residents #6 and #12). Resident #6 had a physician's order for an intravenous antibiotic to be administered every twelve (12) hours; however, the medication was not administered to the resident on August 30, 2010, at 9:00 a.m. Resident #12 had a physician's order for a personal alarm to be utilized at all times; however, no personal alarm was observed to be in place for the resident.</p> <p>The findings include:</p> <p>1. Resident #6 was observed during the initial facility tour conducted on August 30, 2010, at 1:20 p.m. A medication container was noted to be connected to an intravenous (IV) administration pump and was sitting beside the resident's bed. The medication container was labeled Cefepine HCL 2 grams (gm)/100 milliliters (ml) Normal Saline and was dated August 30, 2010, at 9:00 a.m. Further observations revealed approximately 100 ml remained in the medication container.</p> <p>A review of the physician's orders dated August 26, 2010, revealed a physician's order was</p>	F 281	<p>Criteria 1 A. Resident #6's primary physician was notified of refusal of intravenous (IV) medication on 8/31/10. B. A personal alarm was placed on the resident #12, and use of personal alarm was placed on the resident's nursing assistant assignment sheet.</p> <p>Criteria 2 A. 100% audit was conducted by Unit Managers on each floor on 9/27/10, 9/28/10, 9/29/10 and 9/30/10 to determine if physician orders were being followed. Any negative findings were addressed immediately. B. Resident nursing assistant assignment sheets were reviewed and revised as needed to include placement of personal safety devices.</p> <p>Criteria 3 A. Certified Nursing Assistants, including C.N.A. #1 was re-educated to follow interventions on their assignment sheets on 9/24/10, 9/25/10, 9/26/10, 9/27/10, 9/28/10, 9/29/10 and 9/30/10 by the ADON. B. Licensed staff, including nurse #1, was re-educated on the policy of following physician's orders by the ADON on 9/24/10, 9/25/10, 9/26/10, 9/27/10, 9/28/10, 9/29/10 and 9/30/10.</p>	10/8/2010

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F 281	<p>Continued From page 9</p> <p>obtained for Cefepine HCL 2 gm to be administered IV to resident #6 in a normal saline solution every twelve hours for ten days.</p> <p>A review of the Medication Administration Record (MAR) for August 2010 revealed the medication was to be administered at 9:00 a.m. and 9:00 p.m. to resident #6. Further review of the MAR revealed the medication was initialed as being administered to resident #6 on August 30, 2010, at 9:00 a.m.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on August 31, 2010, at 8:50 a.m., revealed the LPN had connected the IV medication to the IV pump at 8:30 a.m. on August 30, 2010. The LPN stated resident #6 requested the medication be stopped so the resident could have a scheduled smoke break. LPN #1 stated the medication was stopped after three to five minutes of infusion. LPN #1 further stated the LPN asked resident #6 at 9:05 a.m., and again at 10:00 a.m., if the medication administration could be completed. The resident continued to refuse to have the medication administered. LPN #1 stated he/she got busy and forgot to discard the refused medication. LPN #1 also stated if IV medication had not been administered within one to two hours the medication should be discarded, and the initials on the MAR should be circled and the refusal should be documented on the back of the MAR. In addition, LPN #1 stated the resident's physician should have been informed that the medication had not been administered to resident #6 as prescribed. LPN #1 stated the IV medication had not been discarded until a walking end-of-shift report had been conducted with the oncoming nurse and the medication was noted to still be in resident #6's room. LPN #1 stated the</p>	F 281	<p>.C. The Certified Nursing Assistant Preceptor will monitor the C.N.A. assignment sheets for daily 5 times a week for 4 weeks, and then weekly for 3 months to ensure the need for a safety device is communicated.</p> <p>D. The Unit Managers will monitor the IV administration records and nurse's notes for residents receiving IV therapy daily 5 times a week for 4 weeks then weekly for 3 months to determine any refusals, actions taken if refused, and physician notification.</p> <p>Criteria 4 Findings of the monitoring will be brought to the Monthly QA meeting by the DON/ADON for 3 months for review and development of an action plan as needed.</p>		

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F 281	<p>Continued From page 10</p> <p>medication was discarded on August 30, 2010, at 2:20 p.m.</p> <p>A review of the facility's policy/procedure related to medication administration (dated June 2008) revealed facility staff was required to follow the principles of medication administration, including administering medications to residents at the right time.</p> <p>An interview conducted with the Director of Nurses (DON) on August 31, 2010, at 11:20 a.m., revealed the facility did not have a specific policy/procedure to address failure to administer IV medications within the appropriate timeframe. The DON stated the LPN should have provided the resident with education regarding the importance of timeliness of medications and documented the length and time of the IV infusion. The DON further stated the LPN should have notified the resident's physician when the medication was not administered as ordered to the resident.</p> <p>2. A review of the medical record revealed resident #12 was admitted to the facility on August 17, 2010, with diagnoses of Multiple Rib Fractures, Fracture of the T11 and T12, and Osteoporosis. A review of the physician's orders dated August 17, 2010, revealed resident #12 had a physician's order for a personal alarm to be utilized at all times and a bed alarm to be used when the resident was in bed. According to the nurse aide care plan, resident #12 was to have personal and bed alarms in use.</p> <p>Resident #12 was observed on September 1, 2010, at 11:15 a.m., to be sitting in a wheelchair</p>	F 281			

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F 281	Continued From page 11 in the hallway of the facility with a brace in place on the resident's upper trunk. At 1:00 p.m., resident #12 was observed to be sitting up in a wheelchair in the resident's room. However, there was no evidence that a personal alarm was in place on the resident's wheelchair. In addition, there was no bed alarm observed to be in place on the resident's bed.  An interview conducted with resident #12 on September 1, 2010, at 2:00 p.m., revealed resident #12 had experienced a fall at home prior to admission to the facility and sustained multiple rib fractures and fractures of the T11 and T12 of the spine. Resident #12 stated the resident did not use an alarm in the wheelchair or the bed. The resident further stated he/she had not experienced any falls since being at the facility.  An interview conducted with Certified Nurse Aide (CNA) #1 on September 1, 2010, at 1:15 p.m., revealed no alarms (personal/bed) had been used for resident #12. CNA #1 stated the CNA assignment/care plan was used to identify individual resident care needs for the residents. CNA #1 stated he/she was not aware the alarms were to be used for resident #12.	F 281			
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334	Criteria 1 Resident #1 will be administered the Influenza Vaccine during the 2010 flu vaccination period if he still desires it.	10/8/2010	

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F 334	<p>Continued From page 12</p> <p>annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that –</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p>	F 334	<p>Criteria 2</p> <p>100% chart audit by the Unit Managers was completed on 9/29/10 to determine that consents for vaccinations were signed. If signed, the vaccine will be administered during the 2010 flu vaccination period</p> <p>Criteria 3</p> <p>A. Licensed staff, including Nurse #3, will be re-educated on the policy regarding influenza vaccination by the ADON on 9/24/10, 9/25/10, 9/26/10, 9/27/10, 9/28/10, and 9/30/10.</p> <p>B. Clinical records of new admissions will be reviewed by DON/ADON/Unit Managers within 24 hours after admission in the daily operations meeting or the next business day after admission to ensure consent for vaccination has been administered if in season.</p> <p>Criteria 4</p> <p>DON/ADON will monitor findings of the post admission chart review weekly for one month, then monthly for 2 months. Findings will be presented to the QA committee monthly for review and development of an action plan as indicated.</p>	

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F 334	<p>Continued From page 13</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the influenza vaccine was provided for one (1) of twenty-six (26) sampled residents (resident #1).</p> <p>The findings include:</p> <p>A review of the medical record for resident #1 revealed the resident was admitted to the facility on July 1, 2009. A review of the pneumococcal and annual influenza vaccine information/request form revealed the risks/benefits of the influenza vaccine were reviewed by resident #1's responsible party (R/P) when the resident was admitted to the facility. A review of the consent to administer the influenza vaccine form revealed resident #1's R/P had signed the consent form to allow the influenza vaccine to be administered to resident #1. However, a review of the immunization administration record revealed no evidence the influenza vaccine had been</p>	F 334			

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F 334	Continued From page 14 administered to resident #1 after the resident was admitted to the facility.  A review of the facility's policy/procedure related to pneumococcal/influenza immunizations (dated February 2009) revealed counseling would be provided to each resident regarding the benefits and adverse effects regarding the influenza vaccine prior to administration. The policy/procedure noted a request or decline would be obtained from the resident or R/P and documented on the applicable form. The policy/procedure further noted the vaccine would be administered per manufacturing guidelines and documented on the Medication Administration Record (MAR).  An interview conducted with LPN #3 on September 1, 2010, at 11:35 a.m., revealed there was no documentation to indicate resident #1 had received the influenza vaccine after being admitted to the facility.	F 334		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the foods served during the evening meal for the fifth floor residents on the long hall on August 30, 2010, were palatable and served at	F 364	Criteria 1 5 <sup>th</sup> floor residents were offered a replacement tray.  Criteria 2 Any resident that received a tray on 3 <sup>rd</sup> , 4 <sup>th</sup> , or 5 <sup>th</sup> floors from the dietary department food carts had the potential to receive a tray	10/8/2010

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F 364	Continued From page 15 the proper temperatures to prevent foodborne illness.  The findings include:  Observation of the evening meal service revealed the second closed unheated meal cart was transferred from the kitchen to the long hall on the fifth floor on August 30, 2010, at 5:45 p.m. The last tray was served from the food cart at 6:20 p.m., and food temperatures were obtained. The food temperatures obtained from the pureed dinner tray were as follows: Italian Vegetable Blend was 110 degrees Fahrenheit and tasted tepid and bland with no seasoning; the Cheese Ravioli was 114 degrees Fahrenheit and tepid when tasted. No fluids had been added to the tray at the time temperatures were obtained.  A review of the Food Temperature Record recorded by the Dietary Cook on August 30, 2010, prior to tray assembly, revealed the Italian Vegetables were 165.1 degrees Fahrenheit and the Cheese Ravioli was 168.2 degrees Fahrenheit.  An interview conducted with the Dietary Manager (DM) on September 1, 2010, revealed the Registered Dietitian (RD) had conducted an audit of meal service on August 28, 2010. The DM stated the audit revealed the food cart sat for an extended period of time on the fourth floor, but no food temperatures had been obtained. The DM stated no corrective action had been implemented to address this concern.	F 364	that was not palatable or at the proper temperature.  Criteria 3 A. Nursing staff was re-educated on tray pass and importance of timeliness of tray pass to ensure proper food temperatures by the ADON on 9/24/10, 9/25/10, 9/26/10, 9/27/10, 9/28/10, 9/29/10 and 9/30/10. B. Dietary staff was re-educated on importance of following menu seasonings by the Dietary Manager on 9/27/2010. C. The Dietary Manager of the cook will be assigned to monitor tray delivery at each meal for one week, then 5 meals per week randomly for 3 months to ensure timeliness of tray pass to ensure food remains the correct temperature and is palatable. Findings will be logged at each meal monitored and trays will be replaced if indicated.  Criteria 4 Findings of the monitoring will be brought to the Monthly QA meeting by the DON/ADON for 3 months for review and development of an action plan as needed.		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must -	F 371	Criteria 1 Substitute trays were offered to affected residents.	10/8/2010	

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F 371	<p>Continued From page 16</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure foods were distributed to residents on the fifth floor under sanitary conditions.</p> <p>The findings include:</p> <p>During the evening meal observation conducted on August 30, 2010, at 5:45 p.m., facility staff was observed to remove the resident food trays from a covered cart on the long hall of the fifth floor. The food items were covered except for a salad and a dessert. The Certified Nurse Aides (CNAs) responsible for distributing the trays to residents were observed to remove the trays from the covered cart and transport the trays containing the uncovered food items up to 42 feet from the covered food cart.</p> <p>The lunch meal was observed on August 31, 2010, at 11:33 a.m., for both the short and long halls of the fifth floor. Food items were covered on the lunch meal trays except for the cooked apples. The CNAs were observed to remove the trays from the covered cart and transport the trays containing the uncovered food item on the short hall up to 20 feet and up to 60 feet on the</p>	F 371	<p>Criteria 2 Any resident that received a tray on 3<sup>rd</sup>, 4<sup>th</sup>, or 5<sup>th</sup> floors from the dietary department food carts had the potential to receive a tray that was not palatable or at the proper temperature.</p> <p>Criteria 3 A. Nursing staff, including the 5<sup>th</sup> floor nursing assistants, were re-educated by the ADON on 9/24/10, 9/25/10, 9/26/10, 9/27/10, 9/28/10, 9/29/10 and 9/30/10 On tray transport, including not transporting uncovered food down the hall, and delivery of trays timely to residents. B. Licensed nursing staff were re-educated by the ADON on 9/24/10, 9/25/10, 9/26/10, 9/27/10, 9/28/10, 9/29/10 and 9/30/10, On observation of tray pass to ensure food items are covered if they will not be transporting by a closed food cart.</p>	

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F 371	Continued From page 17 long hall.  In addition, a CNA was observed on August 30, 2010, at 6:16 p.m., to remove a meal tray from a resident's room and place the "dirty" tray on the food cart containing three resident trays that had not been served.  An interview conducted with CNA #3 on August 30, 2010, at 6:30 p.m., revealed the foods were to be covered in the Dietary Department. CNA #3 stated the food cart was to be moved from room to room when the trays were distributed. The CNA stated he/she did not recognize that all food items were not covered during the evening meal on August 30, 2010. CNA #3 also stated the CNA was aware that "dirty" trays were not to be placed on a cart with "clean" trays.  An interview conducted with CNA #2 on August 31, 2010, at 12:40 p.m., revealed the trays were to be covered by the dietary staff. CNA #2 stated the cart was to be moved from room to room during tray pass and the CNA did not realize that the cooked apples were not covered.  An interview conducted with the Dietary Manager (DM) on September 1, 2010, at 4:05 p.m., revealed food trays were transported from the kitchen area to the resident floors in a covered cart. The DM stated the CNAs had been trained to move the cart from room to room when distributing the meal trays to the residents.	F 371	C. Nursing staff, including the 5 <sup>th</sup> floor nursing assistants, were re-educated on infection control regarding not placing dirty trays on the cart with clean trays by the ADON on 9/24/10, 9/25/10, 9/26/10, 9/27/10, 9/28/10, 9/29/10 and 9/30/10. D. Licensed staff on the 5 <sup>th</sup> floor will monitor tray delivery for each meal for one week, then 5 meals per week for 3 months to ensure timely delivery, covered food if transporting, and no dirty trays are placed on a cart with clean trays.  Criteria 4 Findings of the monitoring will be brought to the Monthly QA meeting by the DON/ADON for 3 months for review and development of an action plan as needed.	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425	Criteria 1 Identified opened, undated medications were discarded.	10/8/2010

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F 425	<p>Continued From page 18</p> <p>§483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to provide pharmaceutical services to assure the accurate administering of all drugs and biologicals. The facility failed to assure that out-of-date medications were not available for resident use on the third and fifth floors of the facility. Two (2) oral medications, one (1) nebulizer treatment medication, and one (1) intravenous solution were out-of-date and remained available for resident use.</p> <p>The findings include:</p> <p>Observation of the third floor medication room/carts on September 1, 2010, at 3:15 p.m., revealed sublingual Nitroglycerin was dispensed for resident #21 on February 8, 2009. The vial of</p>	F 425	<p>Criteria 2 Medication carts and refrigerators will be audited by Unit Managers on each floor to identify and discard any opened, undated medications. The results of these audits were presented to the DON/ADON on 9/29/10.</p> <p>Criteria 3 A. Licensed staff will be re-educated by the ADON to date any medication containers when they are opened, to discard any found undated, and report this to the DON on 9/24/10, 9/25/10, 9/26/10, 9/27/10, 9/28/10, 9/29/10 and 9/30/10. B. Unit Managers on each floor will audit medication carts and refrigerators weekly for three months, then monthly thereafter for opened, undated medication containers. The results of these audits were presented to the DON on 9/29/10.</p> <p>Criteria 4 Findings of the monitoring will be brought to the Monthly QA meeting by the DON/ADON for 3 months for review and development of an action plan as needed.</p>		

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F 425	<p>Continued From page 19</p> <p>sublingual Nitroglycerin had an expiration date of June 2010, and remained available for resident use.</p> <p>Further observation revealed a 12-ounce bottle of Aluminum Hydroxide (Alternagel, a liquid antacid) was dispensed for resident #23; however, the antacid had an expiration date of August 2010, and remained available for resident use.</p> <p>Resident #22 was dispensed a box of single-dose Ipratropium Bromide (a solution for a nebulizer treatment) on October 3, 2009; however, the Ipratropium Bromide had expired February 2010, and remained available for resident use.</p> <p>Interview on September 1, 2010, at 3:30 p.m., with the third floor Unit Manager (UM) revealed the UM was responsible for checking the medication cabinets and refrigerators for outdated medications one time a week. The UM stated the medication nurses were responsible for checking the medication carts for expired medications. The UM stated he/she performed spot checks of the medication carts one time a month; however, the expired items apparently had been missed.</p> <p>Observation on September 1, 2010, at 3:50 p.m., of the fifth floor medication room/carts revealed a stock intravenous solution of D5NS available for resident use; however, the intravenous solution had an expiration date of August 2010.</p> <p>An interview conducted with LPN #1 on September 1, 2010, at 4:10 p.m., revealed all nurses were required to monitor the IV stock medications for expiration dates.</p> <p>Review of the facility's policy related to Storage</p>	F 425		

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F 425	Continued From page 20 and Expiration Dating of Medications, Biologicals, Syringes, and Needles, revised May 10, 2010, revealed medications that have an expired date on the label should be stored separate from other medications until destroyed or returned to the supplier.	F 425			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS; LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	Criteria 1 The identified expired medications were discarded.  Criteria 2 Medication carts, medication refrigerators, and IV stock was audited by Unit Managers on each floor to identify and remove any expired medications on 9/29/10.  Criteria 3 A. Unit Managers on each floor will audit medication carts, medication refrigerators, and IV stock weekly for three months, then monthly thereafter for expired medications. The results of these audits were presented to the DON on 9/29/10... B. Licensed staff will be re-educated on reviewing the expiration date prior to administration of any medication by the ADON on 9/24/10, 9/25/10, 9/26/10, 9/27/10, 9/28/10, 9/29/10 and 9/30/10.  Criteria 4 Findings of the monitoring will be brought to the Monthly QA meeting by the DON/ADON for 3 months for review and development of an action plan as needed.	10/8/2010	

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F 431	Continued From page 21 be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles. Observation on September 1, 2010, revealed liquid medications dispensed for residents #24, #25, and #26 were not dated when opened. Additionally, one (1) vial of insulin dispensed for resident #3 was not dated when opened, and remained available for resident use.  The findings include:  Observation of the third floor medication room/carts on September 1, 2010, at 3:15 p.m., revealed a bottle of Milk of Magnesia (a laxative) had been dispensed for resident #24 on February 23, 2010. Additionally, a bottle of Milk of Magnesia had been dispensed for resident #26 on August 2, 2010. Further observation revealed staff had failed to date the bottles of Milk of Magnesia to indicate when the bottles had initially been opened.  Further observation revealed resident #25 had been dispensed Colace liquid (a stool softener) on June 18, 2010, and Potassium Chloride liquid on May 28, 2010. The two liquid medications for resident #25 were not dated when initially opened.  Interview on September 1, 2010, at 3:30 p.m., with the third floor Unit Manager (UM) revealed all	F 431		

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F 431	Continued From page 22 liquid medications were to be dated by the medication staff when initially opened.  Observation of the fifth floor medication storage room on September 1, 2010, at 3:50 p.m., revealed a multi-dose vial of Novolin R U-100 Insulin for resident #3 was opened. However, the vial was not dated to indicate when the vial was initially opened.  Interview conducted with LPN #1 on September 1, 2010, at 4:10 p.m., revealed Insulin vials were required to be dated when opened and discarded after 30 days.  Review of the facility's policy regarding Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles, revised May 10, 2010, revealed staff was required to record the date opened on the medication container.	F 431		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined the facility failed to provide the effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment. There were numerous areas throughout the building on all five (5) floors of the facility in need of repairs and cleaning, including chipped doors, walls,	F 465	Criteria 1 A. The damaged ceiling tiles on 1 <sup>st</sup> floor, in the 4 <sup>th</sup> floor men's shower room, and in room 320 were replaced. B. The non-functioning water fountain in the dining room has been removed. C. The unsteady dining room table was removed from use immediately upon notification. D. The dining room door and the handrail in the dining room were repaired. E. The floor tiles have been replaced in room 303 bathrooms, room 313 and the entrance to long hall of 5 <sup>th</sup> floor.	10/8/2010

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F 465	<p>Continued From page 23</p> <p>baseboards, stained ceiling tiles, cracked floor tiles, rolling bedside tables and dressers, ripped/torn/worn chairs, loose grab bars in bathrooms, and a black mold-like substance on shower room tiles.</p> <p>The findings include:</p> <p>Observations of the facility during the environmental tour on August 30, 2010 and September 1, 2010, revealed the following items were in need of repair/cleaning:</p> <p>First floor--</p> <ul style="list-style-type: none"> <li>-The ceiling tiles in the clean laundry room were observed to be discolored with a brown substance and were noted to be sagging over the clean laundry. In addition, a brown substance was noted to be in a drip pattern on the wall behind the clean laundry.</li> <li>-The Physical Therapy Department office (which was in sight of a patient care area) had chipped, bubbled paint with a brown substance noted under the painted area.</li> </ul> <p>Second floor--</p> <ul style="list-style-type: none"> <li>- The dining room contained a water fountain that was not functioning and was rusted and corroded. A dining room table was noted to be wobbly/unsteady. The dining room door was chipped and rough, and a handrail in the dining room did not have an end cap, leaving a sharp metal edge exposed.</li> </ul> <p>Third floor--</p> <ul style="list-style-type: none"> <li>-Resident room 303 was observed to have cracked floor tile in the bathroom, and a stain around the base of the commode.</li> </ul>	F 465	<p>F. The mesh coverings on the shower chair and the bath lounge chair in the 4<sup>th</sup> floor shower room have been replaced.</p> <p>G. The chair and the chipped bedside table in room 509 were removed from use.</p> <p>H. The water pressure in room 517 was adjusted.</p> <p>I. The long hall 5<sup>th</sup> floor water fountain has been transformed into an eye wash station.</p> <p>J. The bedside table and dresser in room 312, the bedside table in room 314, and the bedside table in room 316, the bedside table in room 319 were removed from use.</p> <p>K. The wall in the laundry room, the Therapy Dept. office, the men's 3<sup>rd</sup> floor shower room, the area behind the 4<sup>th</sup> floor eye wash station, the air conditioning units in the 3<sup>rd</sup> floor men's shower and the 5<sup>th</sup> floor men's shower rooms have been painted.</p> <p>L. The grab bars around the toilet in the 3<sup>rd</sup> floor men's shower room have been tightened.</p> <p>M. The chipped drywall in the bathroom of room 306, the hole in the drywall under the sink in room 306, the splintered door to room 306, the loose baseboard under the sink in room 309, the splintered door to room 315, the loose baseboard under the sink in room 320, the chipped wallboards at the end of 4<sup>th</sup> floor short hall, the holes in the wall of room 410, and the baseboard in room 509 will be repaired by 10/12/2010.</p> <p>N. Additional grab bars will be installed in the 3<sup>rd</sup> floor shower room by 10/12/2010.</p> <p>O. The light fixture in the 4<sup>th</sup> floor men's shower room will be replaced by 10/12/2010.</p>	
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F 465	<p>Continued From page 24</p> <ul style="list-style-type: none"> <li>-Resident room 306 contained chipped drywall along the baseboard in the bathroom, a hole in the drywall under the sink, and the entrance door was noted to be splintered with rough edges.</li> <li>-Resident room 309 contained a loose baseboard under the sink.</li> <li>-A rolling bedside table with splintered and chipped/rough edges was observed in resident room 312, and a dresser with a surface that was chipped and splintered.</li> <li>-Resident room 313 contained chipped floor tiles under the bed frame at the head of the bed.</li> <li>-A rolling bedside table with a loose edge was observed in resident room 314 and the drywall was flaking under the sink.</li> <li>-The entrance door to resident room 315 was splintered and rough.</li> <li>-Resident room 316 contained a rolling bedside table with chipped/splintered edges, and a hole was observed in the drywall.</li> <li>-Resident room 319 contained a rolling bedside table with chipped splintered edges.</li> <li>-Resident room 320 had a loose baseboard under the sink, and a stained ceiling tile in the bathroom.</li> <li>-The women's shower room on the third floor was utilized for storage, with lifts, medication carts, and treatment carts being stored in this shower room.</li> <li>-The men's shower room on the third floor was observed to contain paint peeling from the wall below the window and a rust buildup on the heat/air-conditioning unit. The grab bars around the toilet were loose and easily swayed back and forth when touched. There were no grab bars or benches in the area where showers were given.</li> </ul> <p>Fourth floor--</p> <ul style="list-style-type: none"> <li>-The end of the short hall on the fourth floor had</li> </ul>	F 465	<p>P. The tile grout in the men's 5<sup>th</sup> floor shower room will be replaced by 10/12/2010.</p> <p>Q. The women's shower rooms on the 4<sup>th</sup> and 5<sup>th</sup> floors have been converted to storage rooms and the men's shower rooms on all floors have been converted to Central Baths with appropriate signage on all doors.</p> <p>Criteria 2 The maintenance Director and Administrator will make rounds of the facility to list all needed repairs by 10/8/2010. They will develop a quarterly plan to address any repairs noted that do not require immediate action by 10/8/2010.</p> <p>Criteria 3 A. Maintenance staff was in serviced on completion of maintenance repair requests on 10/1/2010 by the Administrator. B. The Maintenance Director and the Administrator will tour facility weekly for one month then monthly thereafter to note any repairs needed.</p> <p>Criteria 4 Findings of the monitoring will be brought to the Monthly QA meeting by the Maintenance Director for 3 months for review and development of an action plan as needed.</p>	

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F 465	<p>Continued From page 25</p> <p>chipped wallboards below a window and a bent window screen with sharp edges.</p> <ul style="list-style-type: none"> <li>-The women's shower room on the fourth floor was utilized for storage with treatment carts, housekeeping carts, and lifts observed to be stored in the shower room.</li> <li>-The men's shower room on the fourth floor contained a bath lounge chair with a mesh covering. There were brown stains observed on the covering of the lounge chair, a ceiling tile in the shower stall with brown stains, and a light fixture that wasn't working with a brown stained cover. The mesh back of a shower chair in the shower room had a worn/rough edge in need of replacing.</li> <li>-The area behind the eye wash station on the long hall of the fourth floor was in need of painting.</li> <li>-Holes were observed in the wall near the floor boards by the sink area in resident room 410.</li> </ul> <p>Fifth floor--</p> <ul style="list-style-type: none"> <li>-Resident room 509 contained a chair with a torn arm that was in need of repair, a bedside table with chipped splintered edges, and baseboard was observed to be loose from the wall beside the bed.</li> <li>-Resident room 517 had low hot water pressure at the sink.</li> <li>-Floor tiles were cracked and uneven at the entrance to the long hall on the fifth floor.</li> <li>-The alcove in front of the long hall on the fifth floor was missing a water fountain, leaving exposed metal pipes with sharp metal clamps.</li> <li>-The women's shower room on the fifth floor was utilized as storage for treatment carts, housekeeping carts, and lift chairs.</li> <li>-The men's shower room on the fifth floor contained a black mold-like substance on the tile</li> </ul>	F 465		
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F 465	<p>Continued From page 26</p> <p>grout in the shower stall, and below the air-conditioning/heater unit. The air-conditioning/heater unit was rusted and in need of paint.</p> <p>An interview with the maintenance worker on September 1, 2010, at 1:00 p.m., revealed it was difficult to get all the needed repairs completed, as there was only one maintenance worker at the facility. However, according to the maintenance worker, the facility was allowing a kitchen worker and the Activity Director to assist with the needed repairs at the present time. The maintenance worker further stated that staff had maintenance repair forms that were to be completed and turned in at the nursing stations for needed repairs on each floor. The maintenance worker stated the forms were reviewed and the needed repairs were then completed.</p> <p>An interview with the Administrator on September 1, 2010, at 2:00 p.m., revealed many of the needed repairs had been identified upon the Administrator's arrival at the facility in the middle of August 2010. The third floor hallway had already been completed with the carpeting removed from the walls, the hallway walls painted, and new floor boards being installed. The Administrator further stated the floor in the smoke room had been worked on, and the fifth floor carpeting had been removed from the hallways, but the painting had not been completed. The Administrator stated the kitchen worker had been assigned to assist the maintenance worker when not scheduled to work in the kitchen. The Administrator reported that more maintenance workers were being hired and the facility was in the process of interviewing for those positions. The Administrator had initiated</p>	F 465			

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F 465	Continued From page 27 morning rounds to be completed by House Supervisors and documentation related to needed repairs was to be turned in at the morning meetings. The morning rounds form included environmental concerns. The Administrator stated the needed repairs would be taken care of.	F 465			



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K 018	<p>Continued From page 1</p> <p>maintained according to NFPA standards. Wedges were observed to be used holding open two (2) doors, impeding the closure of the doors.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on September 1, 2010, from 11:30 a.m. to 2:00 p.m., with the Director of Maintenance, a wedge was observed holding open the Therapy and Activity room corridor doors. According to regulations, wedges are not an approved device to hold corridor doors open.</p> <p>An interview on September 1, 2010, at 11:30 a.m., with the Director of Maintenance revealed he/she was not aware that wedges should not be used to hold corridor doors open.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted</p> <p>A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches</p> <p>19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous</p>	K 018	<p>Criteria 4</p> <p>The department head rounds will be reviewed each morning, and findings will be submitted to the Maintenance Director for correction daily 5x week.</p>	

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NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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K 018  K 025 SS=F	Continued From page 2 areas. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire/smoke dampers that penetrated the fire/smoke barrier walls in the attic area. This deficient practice affected eleven (11) of eleven (11) smoke compartments, staff, and all the residents. The facility has the capacity for 120 beds with a census of 94 on the day of the survey.  The findings include:  During the Life Safety Code survey on September 1, 2010, at 10:45 a.m., with the Director of Maintenance, a fire/smoke barrier wall above the fire doors on the fifth and fourth floor was observed to have ductwork that contained a fire/smoke damper. A fire/smoke damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four years.	K 018  K 025	<u>K025</u>  Criteria 1 The fire dampers were inspected by Hazard Fire and Safety on September 27, 2010.  Criteria 2 An audit was conducted on all fire dampers to ensure they were working properly.  Criteria 3 Maintenance will conduct an audit of fire dampers weekly to ensure that preventative maintenance is being done. The Maintenance staff will be in serviced by Hazard Fire and safety on maintaining fire dampers, and having record of inspection every 4 years.  Criteria 4 The Maintenance Director will report on progress in the monthly QA meeting for review and development of an action plan if needed.	10/13/2010	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/01/2010
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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K 025	Continued From page 3  An interview with the Director of Maintenance on September 1, 2010, at 10:45 a.m., revealed the Director of Maintenance was unaware of the requirements pertaining to fire/smoke dampers or if there was a record the dampers had been maintained. The Director of Maintenance stated these fire/smoke dampers were on all the floors.  Reference: NFPA 90a (1999 Edition).  3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 025		
K 062 SS-F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on an interview, the facility failed to ensure the sprinkler system was maintained by NFPA standards. This deficient practice affected eleven (11) of eleven (11) smoke compartments, staff, and all the residents. The facility has the capacity for 120 beds with a census of 94 on the day of the survey.  The findings include:	K 062	K062  Criteria 1 The fire pump was tested for proper functioning by Hazard fire and safety on 9/27/2010.  Criteria 2 The fire pump was run for 12 minutes while being tested by Hazard Fire and Safety on 9/27/2010.  Criteria 3 Maintenance staff was in serviced by Hazard fire and safety on properly testing the fire pump, and allowing it to run a minimum of 10 minutes weekly, and logging the activity.	10/13/2010

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K 062	Continued From page 4 During the Life Safety Code survey on September 1, 2010, at 12:00 p.m., an interview with the Director of Maintenance revealed there was not a written preventive maintenance schedule for the facility's sprinkler fire pump assembly and no one had been properly trained on the operation of the fire pump assembly. According to regulations, the fire pump is required to be tested weekly by a properly trained individual.  Reference: NFPA 25 (1998 Edition).  5-3.2 Weekly Tests. Qualified operating personnel shall be in attendance during the weekly pump operation. 5-3.2.1 A weekly test of electric motor-driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes. Exception: A valve installed to open as a safety feature shall be permitted to discharge water.  5-5.1* A preventive maintenance program shall be established on all components of the pump assembly in accordance with the manufacturer's recommendations. Records shall be maintained on all work performed on the pump, driver, controller, and auxiliary equipment. In the absence of manufacturer's recommendations for preventive maintenance, Table 5-5.1 provides alternative requirements.	K 062	Criteria 4 The fire pump will be tested weekly on going, and the Maintenance Director will report on progress in the monthly QA meeting for review and development of an action plan if needed.	10/13/2010
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K147  Criteria 1 The medical equipment was removed from the multi- outlet adapters in rooms 519, 303, 308, 317, and 318.	

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K 147	<p>Continued From page 5-</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure multiple-outlet adapters were being used in an approved manner. This deficient practice affected seven (7) residents. The facility has the capacity for 120 beds with a census of 94 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on September 1, 2010, at 11:05 a.m., with the Director of Maintenance, an electric bed, suction machine, nebulizer, and IV pump were observed to be plugged into a multi-outlet adapter in resident room 519. In addition, multi-outlet adapters were observed to be in use with medical equipment in resident rooms 303, 308, 317, and 318. Generally, multiple-outlet adapters with surge protection may be used for resident TVs, computers, radios, etc., on an as-needed basis but not to be used with medical equipment to help prevent against electrical shock.</p> <p>An interview with the Director of Maintenance on September 1, 2010, at 11:05 a.m., revealed the Director of Maintenance was not aware of the proper use of multiple-outlet adapters. The Director of Maintenance stated that sometimes there were not enough receptacles in resident rooms.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D 2. Minimum Number of Receptacles. The number</p>	K 147	<p>Criteria 2 The Maintenance Director toured the facility to determine if any other resident's rooms had multi-outlet adapters in use for medical equipment and removed them if indicated.</p> <p>Criteria 3 A. Four plug outlets were replaced in resident rooms. B. The Maintenance Director will tour the facility weekly for one month, then monthly thereafter to ensure multi-outlet adapters are not in use with medical equipment. C. Staff will be in serviced on appropriate use of electrical outlets and multi-outlet adapters by 10/1/2010.</p> <p>Criteria 4 The Maintenance Director will report on his findings in the monthly Quality Assurance meeting for review and development of action plans as needed.</p>	10/13/2010

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K 147	Continued From page 6 of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			