

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

PRINTED: 05/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	RECEIVED JUN - 1 2012 05/20/2012	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME PLANE PIKEVILLE, KS 67001	Division of Health Care Enforcement Branch
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F 000	INITIAL COMMENTS	F 000	Parkview Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction, to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care and safety of the residents. The plan of correction is submitted as a written allegation of compliance. Parkview Nursing and Rehabilitation Center's response to this State of Deficiencies and Plan of Correction does not denote agreement with the statement of deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Parkview Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the state deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal, and/or any other administrative or legal proceedings.	
F 279 SS=D	<p>A standard health survey was conducted on 05/08-10/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a care plan was developed for one of seventeen sampled residents (Resident #10) that included measurable objectives and timetables to meet the resident's needs. Resident #10 was</p>	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angele Owens TITLE: ADMINISTRATOR (X6) DATE: 5-31-2012

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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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 279	<p>Continued From page 1</p> <p>admitted to the facility with a diagnosis of Diverticulosis. In addition, a review of the bowel elimination record revealed Resident #1 also experienced episodes of constipation. However, the facility failed to develop a plan of care for Resident #1 that addressed the resident's problems related to diverticulosis and constipation. (Refer to F309.)</p> <p>The findings include:</p> <p>A review of the facility's Care Plan Policy (dated March 2012) revealed the facility was required to develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment.</p> <p>Review of the medical record revealed the facility admitted Resident #10 on 04/28/11, with diagnoses that included Coronary Artery Disease, Dementia, and Diverticulosis. Review of the annual assessment for Resident #10 with a reference date of 04/05/12, revealed the resident required extensive assistance of two staff members for toileting, was continent of bowel, and was assessed to have constipation.</p> <p>Review of the comprehensive care plan reviewed and updated on 04/05/12, for Resident #10 revealed no evidence the facility had identified a problem related to the resident's problem with constipation and/or the diagnosis of Diverticulosis.</p> <p>Observation of Resident #10 on 05/09/12, at 10:10 AM, revealed staff responded to the</p>	F 279	<p>F279</p> <ol style="list-style-type: none"> <li>1. A care plan was developed for resident #10 addressing constipation and Diverticulosis with measurable objectives and a time table to meet this resident's needs on 5/10/12 by the Minimum Data Set Coordinator.</li> <li>2. The Minimum Data Set Coordinator and the Unit Managers reviewed diagnoses lists and physician orders of current residents for active diagnoses and medications to ensure each was addressed in a care plan that included measurable objectives and a time table to meet the residents' needs by 6/1/12. Administrative Nurses reviewed the last comprehensive assessment care area trigger worksheets for each current resident to ensure any need identified had a care plan that included measurable objectives and a time table to meet the need by 6/8/12.</li> </ol>	06/12/12

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F 279	Continued From page 2 resident's request for assistance to the bathroom. Two staff members were observed to transfer Resident #10 to the bedside commode with a gait belt.  Interview conducted on 05/10/12, at 12:53 PM, with Registered Nurse (RN) #1 revealed she had completed the annual assessment and care plan dated 04/05/12, for Resident #10. RN #1 stated she had reviewed the bowel records during the assessment reference period and determined Resident #10 had experienced a problem with constipation. The RN stated she had failed to identify and develop a care plan related to Resident #1's diagnosis of Diverticulosis and problems with constipation.	F 279	3. a. The Regional Nurse provided reeducation to the Minimum Data Set Coordinator on 5/30/12 that included development of a care plan for active diagnoses, medications, and needs identified in the comprehensive assessment(s) with measurable objectives and a time table to meet each residents' needs. b. Licensed nurses were reeducated by the Assistant Director of Nursing by 5/23/12 to develop a care plan for any new diagnoses and/or medications.		
F 309 SS=E	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 a review of facility policies, it was determined the facility failed to ensure care and services were provided in accordance with the comprehensive assessment, plan of care, and/or established protocols to attain or maintain the physical, mental, and psychosocial wellbeing for five of seventeen sampled residents (Residents	F 309	4. The Regional Nurse will review 25% of new comprehensive assessment care area trigger worksheets and care plans monthly for three months to ensure a care plan with measurable objectives and a time table has been developed for each need identified. Reeducation will be provided to the Minimum Data Set Coordinator immediately by the Regional Nurse as needed and reported to the Administrator for disciplinary follow up.		

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F 309	<p>Continued From page 3</p> <p>#1, #10, #11, #12, and #14). Residents #1, #11, #12, and #14 received dialysis services; however, a review of documentation revealed the facility failed to have effective communication with the dialysis center related to the residents' treatment/condition. In addition, the facility failed to follow established protocols to promote regular bowel elimination for Resident #10.</p> <p>The findings include:</p> <p>Review of the facility's Dialysis Communication policy (dated August 2010) revealed a "facility form" was required to be sent to the dialysis center with the resident at each dialysis visit. The policy noted the facility was responsible to complete the following information on the form prior to the dialysis visit: vital signs, last blood sugar, dietary concerns, medications given pre-dialysis and medications to be administered during dialysis, and any changes or special instructions. The form required the dialysis center to complete the following information: pre- and post-dialysis weight, vital signs, access/shunt information, labs/results, any non-routine medications administered, complications during treatment, dietary instructions, condition of resident upon discharge, and signature of the dialysis nurse. The completed form was to be returned to the facility and was to be maintained in the resident's clinical record.</p> <p>Review of the facility's Bowel Movement Assessment policy (dated March 2012) revealed if a resident did not have a bowel movement by the third day from the most recent bowel movement, the resident would be given a laxative/suppository, depending upon the</p>	F 309	<p>F309</p> <ol style="list-style-type: none"> <li>1. a. Current communications from the dialysis centers were obtained for residents # 1, #11, #12, and #14 by 5/14/12.</li> <li>b. A review on 5/15/12 of resident #10's bowel elimination record indicated no current need for medical intervention as bowel movements were recorded at 3 days or less intervals.</li> <li>2. a. Two other residents were receiving dialysis at this time and had the potential to be affected however only one did not have communication from the dialysis center in the medical record for every visit.</li> <li>b. The elimination reports for current residents were reviewed on 5/15/12 by Administrative Nursing. Only one other resident did not receive bowel care medicine after the third day with no bowel movement documented (received bowel care medicine after fourth day with no bowel movement documented).</li> </ol>	06/12/12	

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F 309	<p>Continued From page 4 physician's orders.</p> <p>1. Review of the medical record revealed the facility admitted Resident #1 on 04/19/12, with diagnoses to include Diabetes Mellitus Type II, Hyperthyroidism, and End Stage Renal Disease.</p> <p>Review of physician's orders dated 04/19/12, revealed the resident had a physician's order for hemodialysis three times a week on Monday, Wednesday, and Friday.</p> <p>Further record review revealed Resident #1 had received dialysis services on nine different days after admission to the facility, however, continued review of documentation revealed the dialysis center had returned only one hemodialysis form to the facility following the resident's hemodialysis treatment. The form that was returned to the facility was dated 04/27/12, and included only information regarding the resident's pre-weight and medications administered during the dialysis procedure. There was no additional communication/information from the dialysis center to the facility.</p> <p>Interview conducted with Unit Manager (UM) #1 on 05/10/12, at 10:50 AM, revealed a dialysis form was sent with the resident at each visit to the dialysis center. However, the UM stated the form was not always sent back with the resident. The UM stated that although it was not after each of the resident's dialysis treatments, she had talked to the dialysis staff by telephone on occasion regarding issues/concerns for Resident #1. UM #1 confirmed there had been no additional forms received from the dialysis center for Resident #1.</p>	F 309	<p>3. a. Nursing staff reeducated on dialysis communication procedure by Assistant Director of Nursing by 5/23/12. Unit Managers will audit records of residents who receive dialysis twice weekly for one month then weekly for two months to ensure communication to and from dialysis occurs for each resident visit. Any discrepancies will be reported to the Director of Nursing and/or Administrator for follow up with the nursing staff and/or dialysis center as needed.</p> <p>b. Nursing staff reeducated on bowel protocol by the Assistant Director of Nursing by 5/23/12. Unit Managers will review bowel elimination report and bowel care medication administration records five times weekly for one month then weekly for two months to ensure nurses are following bowel protocol. Any discrepancies will be addressed immediately and reported to the Director of Nursing for disciplinary follow up as needed.</p>	

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F 309	<p>Continued From page 5</p> <p>Interview conducted with the Director of Nurses (DON) on 05/10/12, at 2:35 PM, revealed nurses were responsible to send the required form to the dialysis center with the resident. However, the DON stated she was not aware the form was not being returned from the dialysis center.</p> <p>2. Review of the medical record revealed the facility admitted Resident #14 on 05/03/12, with diagnoses to include Diabetes Mellitus Type II, Hypertension, and Chronic Renal Failure. A review of the admission physician's orders revealed the resident was to receive dialysis services three times a week.</p> <p>Continued record review conducted on 05/10/12, revealed the resident had been transported to the dialysis center three days since the resident's admission on 05/03/12. However, there was no evidence the facility had sent/received the dialysis form for communication between the facility and dialysis center since the resident was admitted to the facility on 05/03/12, a timeframe of seven days.</p> <p>Interview with the Unit Manager (UM) #1 on 05/10/12, at 10:50 AM, revealed a dialysis form was to be sent with the resident at each visit to the dialysis center. However, the UM stated no forms had been returned from the dialysis center for Resident #14.</p> <p>3. A review of the medical record for Resident #11 revealed the facility admitted the resident on 01/26/12, with diagnoses to include End Stage Renal Disease (ESRD) with Hemodialysis, Diabetes Mellitus, Pancreatitis, Cerebrovascular</p>	F 309	4. Results of Unit Managers' audits will be reported monthly for three months by the Director of Nursing/designee to the Quality Assurance Committee for revision of the action plan if needed.	

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F 309	<p>Continued From page 6</p> <p>Accident, Hypertension, and history of Coronary Artery Bypass Graft.</p> <p>A review of the current physician's orders dated 04/26/12, and the resident's plan of care dated 02/02/12, revealed Resident #11 had a physician's order to receive hemodialysis three times a week. According to the plan of care, the facility would communicate with the dialysis center and keep them informed of any new orders that may impact the dialysis process.</p> <p>A review of the medical record for Resident #11 revealed a Hemodialysis Communication Form. However, the communication form in the record for Resident #11 did not contain any communication/information from the dialysis center to the facility.</p> <p>An interview conducted at 2:05 PM on 05/10/12, with LPN #1 revealed the facility sends the communication form to the dialysis center each time Resident #11 goes to dialysis. However, LPN #1 stated the dialysis center never sends the communication form back to the facility with any information regarding Resident #11's condition while at the dialysis center.</p> <p>4. Review of the medical record revealed the facility admitted Resident #12 on 02/19/11, with diagnoses to include Diabetes Mellitus, Acute Renal Failure, and Chronic Kidney Disease. A review of the current physician's orders revealed the resident was to receive dialysis services three times a week.</p> <p>Continued record review conducted on 05/10/12, revealed Resident #12 had been transported to</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>the dialysis center three days a week for approximately one year and two months since the resident's admission on 02/19/11. However, there was no evidence the facility had consistently sent/received the dialysis form for communication between the facility and dialysis center during the past year and two months.</p> <p>Interview with Unit Manager (UM) #2 on 05/10/12, at 1:02 PM, revealed a dialysis treatment sheet should be sent back by the dialysis center with the resident after each treatment and placed on the resident's chart. The interview also revealed nurses were to check the resident back into the facility after the dialysis treatments and it was the nurses' responsibility to ensure the treatment sheets were returned to the facility from the dialysis center; and if the treatment sheet was not available, the nurse was to call the dialysis center to request the treatment sheet.</p> <p>5. Review of the medical record revealed the facility admitted Resident #10 on 04/28/11, with diagnoses to include Coronary Artery Disease, Hypothyroidism, Diverticulosis, Gastroesophageal Reflux Disease, and Diabetes Mellitus.</p> <p>Review of the annual comprehensive assessment with a reference date of 04/05/12, revealed Resident #10 was assessed to require extensive assistance of two staff persons for toileting, was continent of bowel, and was assessed to have episodes of constipation. A review of the facility's assessment of the resident's cognitive ability revealed the resident had a Brief Interview Mental Status (BIMS) score of 6, which indicated the resident was severely impaired.</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>A review of the May 2012 physician's orders revealed Resident #10 had orders to receive 10 mg of Dulcolax (laxative) once a day, 30 ml of Milk of Magnesia (laxative) once a day, and a Fleet Enema as needed for constipation.</p> <p>A review of the Bowel Detail Report dated 03/11/12 through 05/05/12, revealed, based on documentation, the resident failed to have a bowel movement in excess of three days for the following timeframes: from 03/17/12 through 03/21/12; from 03/27/12 through 04/01/12; from 04/03/12 through 04/07/12; from 04/16/12 through 04/18/12; and from 04/29/12 through 05/01/12. However, a review of documentation revealed staff failed to administer the prescribed laxative to Resident #10 on the third day as directed by the Bowel Movement policy/protocol.</p> <p>Observation of Resident #10 on 05/09/12, at 10:10 AM, revealed staff responded to the resident's request for assistance to use the bathroom. Two staff members were observed to transfer Resident #10 to the bedside commode with a gait belt. The facility had assessed Resident #10 to be cognitively impaired; therefore, an Interview was not attempted with the resident.</p> <p>Interview with the Power of Attorney (POA) for Resident #10 on 05/08/12, at 4:30 PM, revealed Resident #10 had recent problems with constipation. The POA reportedly provided Incontinence care for the resident at times and found hardened stool at the resident's rectum.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #1 on 05/10/12, at 10:15 AM,</p>	F 309		
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F 309	<p>Continued From page 9</p> <p>revealed the day shift nurse was responsible to print out the resident's bowel record daily and to administer the prescribed laxative on the third day if no bowel movement had been documented. LPN #1 stated the bowel movement reports were not maintained, but she did not know why Resident #10 had not received a laxative on the third day when no bowel movement was recorded.</p> <p>Interview conducted with LPN #2 on 05/10/12, at 10:50 AM, also revealed the nurse was responsible to administer prescribed laxatives to a resident when no bowel movement was recorded on the third day. LPN #2 stated she did not know why the laxative had not been administered to Resident #10 when indicated.</p> <p>An interview conducted with Unit Manager (UM) #1 on 05/10/12, at 10:50 AM, revealed she obtained the bowel movement list daily and passed it on to the staff nurses to administer the prescribed laxatives to the residents. UM #1 stated she was not aware Resident #10 had not received the prescribed laxatives when the resident did not have a regular bowel movement. The UM stated she should have checked the Medication Administration Records (MARs) to confirm medications had been administered as ordered to promote a regular bowel movement for Resident #10.</p> <p>Interview conducted with the Director of Nursing (DON) on 05/10/12, at 2:35 PM, revealed the UM was responsible to check the bowel records daily and to give a list of resident names to the staff nurse when a laxative was indicated to be given. The DON stated the prescribed medications</p>	F 309		

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F 309	Continued From page 10 should be administered to the resident on the third day. The DON further stated the UM was also responsible to bring the bowel list to the administrative meetings conducted each morning for review to ensure residents were having regular bowel movements. The DON stated no problems had been identified.	F 309		
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	F 431	F431 1. The bag of IV fluid was immediately removed from the emergency cart upon notification. 2. Unit Managers on all floors looked at all IV fluids for expiration and did not find any expired fluids on 5/10/12. The pharmacy tech checked all biologicals for outdates on 5/15/12 and did not find any expired. 3. a. Licensed nurses were reeducated by the Assistant Director of Nursing to check expiration dates prior to administration of all medications by 5/23/12. b. The pharmacy tech is to audit biologicals for expiration and, if expired, remove from stock monthly for three months. Results of these audits will be reported to the Director of Nursing for follow up.	06/12/12

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NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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F 431	<p>Continued From page 11</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, the facility failed to ensure drugs and biological were stored in accordance with accepted professional principles. Observation of the facility's Fourth Floor emergency cart on 05/10/12, revealed intravenous (IV) fluid that exceeded the recommended expiration date and were available for resident use.</p> <p>The findings include:</p> <p>Review of the facility's Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy (dated May 2010) revealed the facility should ensure all expired medications, and biologicals are destroyed or returned to the pharmacy.</p> <p>During the environmental tour on 05/10/12, the emergency cart was observed to have a bag of IV fluids containing 1,000 cubic centimeters (cc) of 9% normal saline with an expiration date of November 2011 available for resident use.</p> <p>Interview with Unit Manager (UM) #2 on 05/10/12, at 2:00 PM, revealed the emergency carts were to be evaluated nightly by the third shift nurses, and the nurses were to sign a document on the emergency cart indicating the cart had been evaluated and that all equipment and medications</p>	F 431	<p>4. The Director of Nursing will report the results of the pharmacy tech audits to the Quality Assurance Committee monthly for three months for development of an action plan if 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 41501
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F 431	Continued From page 12 were available and ready for use. The UM stated the third shift nurses should have notified the pharmacy of the expired IV fluids. The UM stated the pharmacist comes to the facility on a monthly basis and checks the medication carts, the emergency drug boxes, and the controlled drugs but was unsure if the pharmacist checked the emergency medication carts.  Interview with the Director of Nursing (DON) on 05/10/12, at 2:30 PM, revealed the third shift nurses were to check the emergency carts for equipment availability and medications for expiration dates. In addition, according to the DON, the nurses were to sign a document on the cart indicating all equipment was available and in working condition and that medications were available and not expired. The DON stated the documents on the emergency carts were reviewed and kept monthly; however, the emergency cart was not monitored except by third shift nursing. The DON did not know why there were expired IV fluids available for resident use on the Fourth Floor emergency cart.	F 431		
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT  If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section.  Arrangements as described in section 1861(w) of the Act or agreements pertaining to services	F 500	F500  1. Facility Administrator met with the Director of Dialysis Center #1 to initiate an update of the contract to include the change in management and name on 5/11/12.	06/12/12

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F 500	<p>Continued From page 13</p> <p>furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and a review of the facility dialysis contracts, the facility failed to ensure the written agreement for an outside dialysis center was current and up to date for two of seventeen sampled residents (Residents #1 and #11).</p> <p>The findings include:</p> <p>A review of the facility contracts revealed the facility held contracts with two dialysis centers (Dialysis Centers #1 and #2) to provide hemodialysis services for residents at the facility.</p> <p>Based on a review of documentation, Residents #1 and #11 received dialysis services from Dialysis Center #1.</p> <p>The Administrator acknowledged in interview on 05/10/12, at 2:50 PM, the facility had contracts with Dialysis Centers #1 and #2 to provide dialysis services to residents of the facility. The Administrator stated Dialysis Center #1 had a change in ownership and management but she was not sure when the change occurred. A review of the dialysis contract from Dialysis Center #1 revealed the contract failed to reflect the correct name of the agency and the change in management. The Administrator stated she had</p>	F 500	<ol style="list-style-type: none"> <li>2. Only three other residents received services from dialysis center #1 as of 5/11/12.</li> <li>3. Facility Administrator signed an updated contract with Dialysis Center #1 with an effective date of 5/24/12.</li> <li>4. Contracts between the facility and entities providing services to residents will be reviewed annually by the Facility Administrator to determine any need to update said contracts.</li> </ol>	

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F 500	Continued From page 14 not considered the need to update the agreement/contract with the new management.	F 500			

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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 Division of Health Care Southern Enforcement Branch
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  Building: 01  Survey under: NFPA 101 (2000 Edition)  Plan approval: 1989  Facility type: SNF/NF  Type of structure: Five story, Type II (222)  Smoke Compartments: 13  Fire Alarm: Complete fire alarm with smoke detectors installed in corridors. Installed 01/21/12.  Sprinkler System: Complete sprinkler system (wet)  Generator: Type 2 generator powered by diesel  A standard Life Safety Code survey was conducted on 05/09/12. Parkview Nursing and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 83. The facility is licensed for 120 beds.  The highest scope and severity was at "D" level.  NFPA 101 LIFE SAFETY CODE STANDARD	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 this State of Deficiencies and Plan of Correction does not denote agreement with the statement of deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Parkview Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the state deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal, and/or any other administrative or legal proceedings.	
K 018 SS=D	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Owens TITLE: ADMINISTRATOR (X6) DATE: 5-31-12

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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K 018	<p>Continued From page 1</p> <p>those constructed of 1 1/2 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in corridors were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three smoke compartments, ten residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 05/09/12, at 10:43 AM, revealed doors to resident rooms 508 and 509 would not latch when closed. Further observation revealed the same for resident rooms 306, 307, and 311. Doors located in the corridor must latch to prevent the spread of smoke. The observations</p>	K 018	<p>K 018</p> <ol style="list-style-type: none"> <li>1. Doors to rooms 306, 307, 311, 508, and 509 were adjusted to ensure proper latch and closure by maintenance staff on 5/9/12.</li> <li>2. All facility doors were checked to ensure proper latch and closure by maintenance staff on 5/9/12.</li> <li>3. A memo was posted on all resident floors 5/30/12 reminding staff of the work order (repair requisition) procedures.</li> <li>4. Maintenance staff will check all facility doors for proper latch and closure monthly for three months then quarterly thereafter and will repair as needed.</li> </ol>	06/12/12	

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K 018	Continued From page 2 were confirmed with the Director of Maintenance.  Interview on 05/09/12, at 10:43 AM, with the Maintenance Director, revealed he was not aware of the doors not latching and was also unaware of any work orders being submitted for the doors not latching.  Reference: NFPA 101 (2000 Edition).  19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018			
K 062 SS=D	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	K 062			

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K 062	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one smoke compartment.</p> <p>The findings include:</p> <p>Observation on 05/09/12, at 11:34 AM, revealed four of four sprinkler heads located in the laundry room were corroded. The observation was confirmed with the Director of Maintenance. Corroded sprinkler heads must be replaced to ensure their reliability.</p> <p>Interview on 05/09/12, at 11:34 AM, with the Director of Maintenance, revealed the sprinkler system was completely checked in January 2012 with the installation of the new fire alarm system and he was not aware the sprinkler heads were corroded.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.</p> <p>Exception No. 2: Sprinklers installed in areas that</p>	K 062	<p>K 062</p> <ol style="list-style-type: none"> <li>Four new sprinkler heads were installed in the laundry room on 5/11/12.</li> <li>All facility sprinkler heads were checked 5/9/12 and all others were free of any corrosion.</li> <li>Maintenance staff will visualize all facility sprinkler heads quarterly to ensure they are free of corrosion. Any identified issues will be corrected.</li> <li>All sprinklers will be inspected annually by an outside contractor to ensure they are properly maintained.</li> </ol>	06/12/12

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K 062	Continued From page 4 are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062			
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain two of thirty-five fire extinguishers in the facility. The deficiency had the potential to affect two smoke compartments, one resident, staff, and visitors.  The findings include:  Observation on 05/09/12, at 1:31 PM, revealed a fire extinguisher located at the Third Floor nursing station had a service collar that indicated a service date of 2003. Fire extinguishers must have a service collar indicating that the extinguishers had been emptied, internally examined, and recharged every six years. Further observation revealed the fire extinguisher located at the Fourth Floor nursing station had been manufactured in 2005 with no service collar. The observation was confirmed with the Director of Maintenance.  Interview on 05/09/12, at 1:31 PM, with the Director of Maintenance, revealed the facility depends on a contractor to maintain these items.	K 064	K 064  1. The two outdated fire extinguishers were removed and replaced by an outside contractor on 5/9/12.  2. All other facility fire extinguishers were checked on 5/9/12 and no others were found to be deficient.  3. Maintenance staff will maintain a log of fire extinguisher expiration dates for replacement as needed.  4. Fire extinguishers will be inspected by an outside contractor annually to ensure they are properly maintained and replaced as needed.	06/12/12	

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K 064	Continued From page 5  Reference: NFPA 10 (1998 Edition).  4-4.3* Six-Year Maintenance. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date. Exception: Nonrechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture. Nonrechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3. 4-4.4* Maintenance Recordkeeping. Each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed and that identifies the person performing the service. 4-4.4.1* Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. x 1 1/2 in. (5.1 cm x 3.8 cm). The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information: (a) Month and year the maintenance was performed, indicated by a perforation such as is	K 064		

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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	
(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
K 064	Continued From page 6 done by a hand punch (b) Name or initials of person performing the maintenance and name of agency performing the maintenance. 4-4.4.2* Verification of Service (Maintenance or Recharging). Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999. Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.	K 064		