

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

PRINTED: 03/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2012
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey and an abbreviated survey (KY #17917) was conducted on 02/27/12 through 03/02/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E." KY #17917 was substantiated with deficiencies cited.	F 000	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan or correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws."	
F 164 SS=D	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 meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. 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. 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. 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.	F 164	F 164 1. The window blind was closed during bathing after the surveyor informed the C.N.A. on 2/29/12 about the occurrence for Resident #5. Social services interviewed resident on 3/19/12 to determine there were no ill effects from the blind not closed. No ill effects were found. 2. All residents benefit from receiving privacy during care. 3. Staff were inserviced by the Assistant DON on 3/23/12 and via mail for any associate who did not attend on providing privacy during care to include pulling privacy curtains and closing blinds. Direct caregivers will be in-serviced	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Roi M. M... Exec. Director TITLE: _____ (X6) DATE: 3-23-12

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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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident had the right to personal privacy while bathing for one resident (#5), in the selected sample of thirty residents. Findings include: A review of the facility's policy/procedure, "Dignity/Resident Rights," undated, revealed staff provided privacy by pulling curtains and closing blinds during in room care. A record review revealed the facility re-admitted Resident #5 on 11/03/10 with diagnoses to include Left Below the knee Amputee, Arthropathy, Anemia, Esophageal Reflux, Convulsions, Osteoporosis, Cerebrovascular Accident, Diabetes Mellitus Type II and Congestive Heart Failure. A review of the quarterly Minimum Data Set (MDS), dated 01/18/12, revealed the facility identified the resident as cognitively intact and required extensive assistance with bathing. An observation of a bed bath for Resident #5, on 02/28/12 at 10:30 AM, revealed the resident's bed was located beside the window. Further observation revealed Certified Nurse Aide (CNA) #3 did not close the window blind during provision of the resident's bath. The facility's parking lot could be visualized from the window.	F 164	upon hire during general orientation, annually, and PRN relating to providing privacy during care. 4. Five observation audits per wing per week will be conducted by the Unit Managers times 4 weeks then 5 observations per month times 2 months to ensure privacy is provided during care. Results will be reviewed by the QA committee who will then determine the need for further monitoring. 5. Completed by	3/28/12

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F 164	Continued From page 2 An interview with CNA #3, on 02/29/12 at 1:05 PM, revealed she was not aware the resident's window blind was open during the resident's bath. She revealed the window blind was "usually" closed.	F 164		
F 226 SS=D	An interview with the Director of Nursing (DON), on 03/01/12 at 5:10 PM, revealed she expected the staff to close the window blind before providing care to the resident. 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation and review of the facility's policy/procedure, it was determined the facility failed to ensure polices were implemented to prevent the mistreatment and abuse for one resident (#24), in the selected sample of thirty residents. During the early morning hours of the midnight shift of 09/10/11, Certified Nurse Aide (CNA) #9 made an allegation of verbal abuse against CNA #8 while he was providing care for Resident #24. CNA #9 reported the allegation to Licensed Practical Nurse (LPN) #2 (the charge nurse). LPN #2 reported the incident to her unit manager. After being made aware of the allegation on 09/10/11, Unit Manager (UM) #2 completed a skin assessment. She noted redness to Resident #24's chest, bruising to	F 226	F 226 1. The unexplained bruise of Resident #24 was investigated on 9/8/11 by the interdisciplinary team and was determined to have potentially been the result of a blood draw in the Left antecubital area on 9/7/11 but was not mentioned in the facilities final investigative notes of the incident investigation. 2. All residents received weekly skin assessment between 3/19/12 to 3/26/12 and any bruised areas found were investigated by Nurse Management to ensure origin of bruise was documented. 3. All Staff were inserviced by the ADON on 3/23/12 and via mail for any associate who did not attend on reporting and investigating any bruises.	

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F 226	<p>Continued From page 3</p> <p>his/her left forearm, bruising to his/her right inner upper arm and a new bruise to his/her right forearm. Further review of the record revealed the facility failed to investigate the newly identified bruising the resident incurred to determine how he/she received them.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Reporting Alleged Abuse," dated 02/09, revealed the facility does not condone resident abuse and/or neglect by anyone. This includes but is not limited to staff members, other residents, consultants, volunteers, staff from other agencies serving our residents, family members, the responsible party, sponsors, friends or other individuals. All personnel will promptly report any incident or suspected incident of resident abuse and/or neglect including injuries of unknown origin. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g., bruising and skin tears) will be promptly reported to the administrator and/or director of nursing.</p> <p>A record review revealed the facility admitted Resident #24 on 09/14/09 with diagnoses to include Alzheimer's Disease, Chronic Ischemic Heart Disease, Hypertension and Venous Thrombosis. A review of the annual Minimum Data Set (MDS), dated 08/09/11, revealed the resident was severely cognitively impaired. Further review revealed the resident required extensive assistance to total dependence of staff for activities of daily living.</p> <p>A review of the weekly skin integrity data</p>	F 226	<p>Staff are in-serviced upon hire during general orientation, quarterly, and PRN on the abuse and neglect policy, and reporting/investigating of bruising.</p> <p>4. Unit Managers will audit 5 resident skin assessments audits per week for 4 weeks for any bruises to ensure an investigation is completed if required. Then Unit Managers will audit 10 skin assessments per month for 2 months. Results of the audits will be reviewed by the QA committee to determine the need for further monitoring.</p> <p>5. Completed by</p>	3/28/12

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F 226	<p>Continued From page 4</p> <p>collection completed by the UM, dated 09/10/11, revealed redness to Resident #24's chest. Redness and a new bruise was identified on his/her right forearm. A bruise was noted to the left forearm.</p> <p>An interview with UM #2, on 02/29/12 at 3:54 PM, revealed CNA #9 came to her and reported an allegation of verbal abuse that she witnessed involving CNA #8, and shortly after that, LPN #2 reported the allegation. After notifying the Director of Nursing (DON), and making the weekend supervisor aware of the allegation, UM #2 went to Resident #24's room to assess him/her. She observed redness to his/her chest and there were some old bruises present. She stated the bruise to his/her inner upper arm "looked fresh" and she documented the information on the skin assessment grid.</p> <p>A review of the facility's investigation, dated 09/10/11 at 09:15 AM, revealed the Executive Director arrived to the facility and she assessed the resident. No redness or bruising was noted on the resident's chest. A small curved bruise was noted on his/her left upper interior inner arm. There were several bruises on his/her forearm, and she was unable to determine the cause of bruise on the upper arm, or when it occurred.</p> <p>A review of a fax sent to the resident's primary care physician by LPN #3, dated 09/10/11 at 11:10 AM, revealed the nurse stated Resident #24 was combative with the nurse aides. Bruising was noted to his/her left arm, and it was unknown if it was caused by they resident's combativeness with staff.</p>	F 226			

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F 226 Continued From page 5
An interview with the Executive Director, on 03/01/12 at 1:45 PM, revealed investigations were a group effort and she took the lead role in them. She received a call on the morning of 09/10/11 from the staff and entered the facility later that morning (between 7:00 AM and 10:30 AM). She revealed there was documentation about the bruises on the resident's arm on previous skin assessments. She revealed she did not personally investigate the bruise on Resident #24's inner arm. She stated, "If we do not know how a resident sustained a bruise, then we would investigate. We did not know if the bruise was from [him/her] or from staff based on [his/her] behavior, but we should have investigated the new bruise on the resident."

F 226

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.

F 246

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to provide services in the facility with reasonable accommodations of individual needs and preferences for one resident (#14), in the selected sample of thirty residents, related to the failure to provide desired dental care.

F 246

1. The Social Services Director spoke with Resident #14 on 3/2/12 and 3/5/12 the resident stated the resident doesn't want to pursue getting new dentures made. Resident #14's son is also in agreement.
2. Residents benefit from receiving accommodations of individual needs and preferences. Social services

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F 246	<p>Continued From page 6</p> <p>Findings include:</p> <p>There was no evidence of a facility policy provided specific to accomodation of individual needs and preferences.</p> <p>A record review revealed the facility admitted Resident #14 on 12/02/09 with diagnoses to include Congestive Heart Failure, Depressive Disorder, Hypertension, Osteoporosis and Anxiety.</p> <p>A review of the initial data collection tool/nursing service, dated 12/02/09, revealed Resident #14's dentures, "Do not fit good, move around because [he/she] lost weight, needs soft food." There was no evidence that Social Services was consulted to accommodate the resident's ill-fitting dentures.</p> <p>A review of a Speech Therapy progress note, dated 04/01/10, revealed the resident was tried on a regular diet and tolerated the regular diet with no signs and symptoms of aspiration.</p> <p>A review of a nursing-therapy referral tool, dated 05/17/11, revealed Resident #14 wanted to be evaluated for hopes of an increased diet texture from mechanical soft to regular. A review of a rehabilitation services multidisciplinary screening tool, dated 08/09/11, revealed, "Resident requesting to be re-evaluated in hopes of a diet texture upgrade from a mechanical soft to regular diet. Resident is edentulous with no dentures. Resident expressed concerns about adequately chewing regular meat texture, stated [he/she] should remain on ground meat. Resident was not eligible for a diet upgrade to regular at this time." A review of the nurses' notes, Social Services</p>	F 246	<p>has interviewed residents with a BIMs score of 13-15 to ensure their needs and preferences have been met and addressed any issues which came up during those interviews between 3/19/12 and 3/23/12. Resident's whose BIMs score was less than 13 have been assessed by Nurse Management for dental needs. Any needs identified were addressed with residents, physician and family.</p> <p>3. Staff were inserviced on 3/23/12 by the ADON regarding residents having the right to reside and receive services in the facility specific to accommodations, needs and preferences. The ED in-serviced the Social Service Director and the Social Service Assistants on 3/23/12 regarding residents having the right to reside and receive services in facility specific to accommodations, needs, and preferences.</p> <p>4. Each Social Worker will interview 5 residents per week to ensure their needs and accommodations have been</p>	
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F 246	<p>Continued From page 7</p> <p>notes, and Speech Therapy notes, revealed no referral was made to address the resident's ill-fitting dentures.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 01/08/12, revealed the facility assessed Resident #14 as cognitively independent and required extensive assistance with dressing and personal hygiene. There was no evidence on the dental section of the MDS related to the resident having broken or loose-fitting full or partial dentures.</p> <p>An interview with Resident #14, on 02/28/12 at 10:50 AM, and on 02/29/12 at 3:20 PM, revealed he/she had to eat a mechanical soft diet due to ill-fitting dentures. Resident #14 stated he/she desired a regular diet if his/her dentures could be fixed, but no efforts had been made to replace/realign his/her dentures. Resident #14 stated, due to past weight loss, he/she was unable to wear the dentures, because they "fopped" around in his/her mouth. The resident stated this problem was present upon admission to the facility in 2009, but to this day, no one approached him/her about replacing/realigning the dentures. He/she voiced a concern to the cost of fixing the dentures when he/she consulted a dentist prior to admission to the facility. An interview with Resident #14's son, on 03/01/12 at 11:37 AM, revealed he was responsible for the resident's financial decisions and he participated in the care meetings. He stated when he discussed the resident's dental status in meetings with the facility, nothing was mentioned about the need to fix the resident's dentures in order to be able to consume regular consistency food.</p>	F 246	<p>met for 4 weeks, then 10 per month for an additional 2 months. Results of these audits will be reviewed by the QA committee to determine the need for further monitoring.</p> <p>5. Completed by</p>	3/28/12

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F 246	<p>Continued From page 8</p> <p>Interviews with Certified Nurse Aides (CNAs) #5 and #6, on 03/02/12 at 8:58 AM and at 9:04 AM, respectively, revealed Resident #14 did not wear dentures due to them being ill-fitted. They stated the staff were aware of this issue.</p> <p>An interview with the Social Services Director, on 03/01/12 at 10:53 AM, revealed if a resident required dental services, she mad a referral to the dentist, and handled the financial costs. She stated she was unaware of any issues about Resident #14's dental status.</p> <p>An interview with the Director of Nursing (DON), on 03/02/12 at 10:58 AM, revealed Resident #14 did not wear dentures, and she was not aware of any issues about ill-fitting dentures. She stated the resident's son informed her that the resident was not wearing dentures prior to the resident's admission to the facility, and did not provide a reason why. She stated if nursing identified the dentures to be ill-fitting, then she expected the staff to contact the resident's family dentist. She stated it was the resident's right to get his/her dentures fixed, but was not aware that Resident #14 voiced any concerns about any dentures.</p>	F 246		
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 250	<p>F 250</p> <p>1. The Social Services Director spoke with Resident #14 on 3/2/12 and 3/5/12 the resident stated the resident doesn't want to pursue getting new dentures made. Resident #14's son is also in agreement.</p>	

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F 260	<p>Continued From page 9</p> <p>Based on record review and interview, it was determined the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one resident (#14), in the selected sample of thirty residents, related to the failure to provide a referral to fix ill-fitting dentures.</p> <p>Findings include:</p> <p>A review of the Social Services Assistant job description, revised 10/05/10, revealed it was the responsibility of social services to assist with social service programs to meet the medically-related social and emotional needs of residents as well as State, Federal, Corporate, and Division guidelines.</p> <p>A record review revealed the facility admitted Resident #14 on 12/02/09 with diagnoses to include Congestive Heart Failure, Depressive Disorder, Hypertension, Osteoporosis and Anxiety.</p> <p>A review of the initial data collection tool/nursing service, dated 12/02/09, revealed Resident #14's dentures, "Do not fit good, move around because [he/she] lost weight, needs soft food." There was no evidence that Social Services was consulted to accommodate the resident's ill-fitting dentures.</p> <p>A review of a Speech Therapy progress note, dated 04/01/10, revealed the resident was tried on a regular diet and tolerated the regular diet with no signs and symptoms of aspiration.</p> <p>A review of a nursing-therapy referral tool, dated</p>	F 250	<p>2. Residents benefit from receiving accommodations of individual needs and preferences. Social services has interviewed residents with a BIMs score of 13-15 to ensure their needs and preferences have been met and addressed any issues which came up during those interviews between 3/19/12 and 3/23/12. Resident's whose BIMS score was less than 13 have been assessed by Nurse Management for dental needs. Any needs identified were addressed with residents, physician and family.</p> <p>3. Staff were inserviced on 3/23/12 by the ADON regarding residents having the right to reside and receive services in the facility specific to accommodations, needs and preferences. The ED in-serviced the Social Service Director and the Social Service Assistants on 3/23/12 regarding residents having the right to reside and receive services in facility specific to accommodations, needs, and preferences.</p>	

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F 250	<p>Continued From page 10</p> <p>05/17/11, revealed Resident #14 wanted to be evaluated for hopes of an increased diet texture from mechanical soft to regular. A review of a rehabilitation services multidisciplinary screening tool, dated 08/09/11, revealed, "Resident requesting to be re-evaluated in hopes of a diet texture upgrade from a mechanical soft to regular diet. Resident is edentulous with no dentures. Resident expressed concerns about adequately chewing regular meat texture, stated [he/she] should remain on ground meat. Resident was not eligible for a diet upgrade to regular at this time." A review of the nurses' notes, Social Services notes, and Speech Therapy notes, revealed no referral was made to address the resident's ill-fitting dentures.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 01/06/12, revealed the facility assessed Resident #14 as cognitively independent and required extensive assistance with dressing and personal hygiene. There was no evidence on the dental section of the MDS related to the resident having broken or loose-fitting full or partial dentures.</p> <p>An interview with Resident #14, on 02/28/12 at 10:50 AM, and on 02/29/12 at 3:20 PM, revealed he/she had to eat a mechanical soft diet due to ill-fitting dentures. Resident #14 stated he/she desired a regular diet if his/her dentures could be fixed, but no efforts had been made to replace/realign his/her dentures. Resident #14 stated, due to past weight loss, he/she was unable to wear the dentures, because they "fopped" around in his/her mouth. The resident stated this problem was present upon admission to the facility in 2009, but to this day, no one</p>	F 250	<p>4. Each Social Worker will interview 5 residents per week to ensure their needs and accommodations have been met for 4 weeks, then 10 per month for an additional 2 months. Results of these audits will be reviewed by the QA committee to determine the need for further monitoring.</p> <p>5. Completed by</p>	3/28/12

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F 250	<p>Continued From page 11</p> <p>approached him/her about replacing/realigning the dentures. He/she voiced a concern to the cost of fixing the dentures when he/she consulted a dentist prior to admission to the facility. An interview with Resident #14's son, on 03/01/12 at 11:37 AM, revealed he was responsible for the resident's financial decisions and he participated in the care meetings. He stated when he discussed the resident's dental status in meetings with the facility, nothing was mentioned about the need to fix the resident's dentures in order to be able to consume regular consistency food.</p> <p>Interviews with Certified Nurse Aides (CNAs) #5 and #6, on 03/02/12 at 8:58 AM and at 9:04 AM, respectively, revealed Resident #14 did not wear dentures due to them being ill-fitted. They stated the staff were aware of this issue.</p> <p>An interview with the Social Services Director, on 03/01/12 at 10:53 AM, revealed if a resident required dental services, she made a referral to the dentist, and handled the financial costs. She stated, if a resident was on Medicaid, a voucher was submitted to pay for the resident's denture costs. She stated she was unaware of any issues with Resident #14's dental status, and was unsure as to whether nursing was knowledgeable on how to notify her if outside dental services were needed. She stated she made the referrals if nursing notified her.</p> <p>An interview with the Director of Nursing (DON), on 03/02/12 at 10:58 AM, revealed Resident #14 did not wear dentures, and she was not aware of any issues about ill-fitting dentures. She stated the resident's son informed her that the resident was not wearing dentures prior to the resident's</p>	F 250			

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F 250	Continued From page 12 admission to the facility, and did not provide a reason why. She stated if nursing identified the dentures to be ill-fitting, then she expected the staff to contact the resident's family dentist. She stated it was the resident's right to get his/her dentures fixed, but was not aware that Resident #14 voiced any concerns about any dentures.	F 250			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to provide appropriate catheter care for one resident (#5), in the selected sample of thirty residents. Findings include: A review of the facility's policy/procedure, "Daily Catheter Care," undated, revealed a policy/procedure was in place for daily catheter care, but was not specific to cleaning the catheter tubing nor disposal of soiled washcloths.	F 315	F 315 1. Resident #5 has been provided proper catheter care since 2/29/12 by the C.N.As. Please note no adverse effect occurred. 2. All residents requiring Foley Catheters benefit from receiving proper catheter care. 3. Staff were inserviced on 3/23/12 by the ADON on how to provide appropriate catheter care for the residents specific to how to clean the tube and use of individual washcloths and their disposal. Direct caregivers will be in-serviced upon hire during general orientation, annually, and PRN on proper Foley Catheter care. 4. Unit Managers will audit all residents with catheters to ensure that appropriate catheter care was delivered for 4 weeks. Then monthly for 2		

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F 315	<p>Continued From page 13</p> <p>A record review revealed the facility re-admitted Resident #5 on 11/03/10 with diagnoses to include Left Below the knee Amputee, Arthropathy, Anemia, Esophageal Reflux, Convulsions, Osteoporosis, Cerebrovascular Accident, Diabetes Mellitus Type II and Congestive Heart Failure. A review of the quarterly Minimum Data Set (MDS), dated 01/18/12, revealed the facility identified the resident as cognitively intact and required extensive assistance with bathing.</p> <p>An observation of catheter care for Resident #5, on 02/28/12 at 10:30 AM, revealed Certified Nurse Aide (CNA) #3 washed and rinsed the resident's legs, using two different washcloths. She placed one of the washcloths in the water basin and the other washcloth on the bedside table. A third washcloth was used to cleanse the resident's face. She then used the three soiled washcloths to provide catheter care to the resident. During catheter care, she used a soiled washcloth to cleanse the catheter tubing, using a back and forth motion on the tubing. Further observation revealed she used the same back and forth motion while rinsing and drying the resident's catheter tubing.</p> <p>An interview with CNA #3, on 02/29/12 at 8:00 AM, revealed she used the soiled washcloths to provide catheter care; however, she "thought" four washcloths were used. She further admitted that she cleansed the resident's catheter tubing in an upward motion, because she was "nervous."</p> <p>An interview with the Director of Nursing (DON), on 03/01/12 at 5:10 PM, revealed she expected the staff to use clean washcloths when providing</p>	F 315	<p>additional months. The results of the audits will be reviewed by the QA committee to determine the need for further monitoring.</p> <p>5. Completed by</p>	3/28/12	

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F 315	Continued From page 14	F 315			
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure the resident's environment remained as free from accident hazards as is possible related to observation of a knife being stored on an over bed table for one resident (#34), not in the selected sample. Observations on four consecutive days of the survey revealed a large knife with a serrated edge remained in plain view on a resident's over bed table.</p> <p>Findings include: A review of the facility's policy/procedure, "Risk Management," (undated), included the definition of risk management as "safety of residents and associates." Additionally, the policy/procedure included "to remove all objects that could cause an injury."</p>	F 323	<p>F 323</p> <ol style="list-style-type: none"> 1. The knife had a protective sleeve on it. The knife was removed from Resident #34's room on 3/2/12 by the Unit Manager upon notification by the surveyor. 2. All resident's rooms were examined to ensure they were free from accident hazards by 3/23/12 by Nursing Administration. 3. Staff were inserviced on 3/23/12 by the ADON to observe resident's environments for hazards to include sharp items which could cause injury. Staff will be in-serviced upon hire during general orientation, annually, and PRN regarding observing residents rooms when in resident rooms to ensure they are free from accident hazards. 4. Administrative Staff will audit 7 resident rooms on each unit to ensure the rooms are free from hazards for 4 weeks. Then 20 random room audits 		

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F 323	<p>Continued From page 15</p> <p>A review of the facility's elopement risk book revealed twenty-six (26) residents were identified by the facility to have wandering behaviors.</p> <p>A record review revealed the facility admitted Resident #34 on 06/19/09 with diagnoses to include Osteoarthritis, Depression and Anxiety Disorder. A review of the quarterly Minimum Data Set (MDS), dated 12/12/11, revealed the facility assessed the resident with no cognitive impairment and required assistance with all activities of daily living, to include limited assistance with eating.</p> <p>Observations, on 02/27/12 at 2:35 PM and at 5:45 PM, revealed a large knife with a serrated edge was on the resident's over bed table and in plain view. Observations, on 02/28/12 at 10:30 AM, on 03/01/12 at 2:00 PM, and on 03/02/12 at 9:45 AM, revealed the knife remained in plain view on the resident's over bed table.</p> <p>An interview with Resident #34, on 03/02/12 at 9:45 AM, revealed [his/her] family brought the knife to the facility about a year ago, and [he/she] used it frequently when meals from outside the facility were brought in by family or friends.</p> <p>Interview with Certified Nurse Aides (CNAs) #1 and #2, on 03/02/12 at 10:00 AM and at 10:05 AM, respectively, revealed they frequently redirected wandering residents from Resident #34's room. They stated that other residents from other units were found wandering and required assistance back to their units located in another area of the facility. CNA #1 and CNA #2 both stated they did not recall being aware that Resident #34 kept a knife on his/her over bed</p>	F 323	<p>will be completed by Administrative Staff monthly for an additional 2 months. Results of the audits will be reviewed by the QA committee to determine the need for further monitoring.</p> <p>5. Completed by</p>	3/28/12	

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F 323	Continued From page 16 table. An interview with Registered Nurse (RN) #2, on 03/02/12 at 10:10 AM, revealed she was unaware of a knife kept on the resident's over bed table, and stated it was a safety issue for wandering residents as well as Resident #34. An interview with the Director of Nursing (DON), on 03/02/12 at 10:30 PM, revealed she was unaware the resident kept a knife in plain view on his/her over bed table and it was a safety concern. Additionally, the DON stated the residents' room were not routinely searched for contraband items, and a large knife was considered an item that was not acceptable to be in plain view on a resident's over bed table. The DON acknowledged there were several residents with wandering behaviors in the facility.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure that it was free of a medication error rate of five percent (5%) or greater. Observation of the medication pass, on 02/28/12, revealed the staff failed to administer medications in accordance with the physician's orders for two residents (#31 and #32), not in the selected sample. There was a	F 332	F 332 1. Res #31's Physician, and family were notified on 2/29/12 related to LPN #1 instilling eye drops in both of resident's eyes. No new orders were obtained. Please note resident had no adverse effect related to the eye drops. Res #32's Physician and family were notified on 2/29/12 related to RN #1 crushing an enteric coated	

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F 332	Continued From page 17 total of 48 opportunities with eight errors resulting in a medication error rate of 16%. Findings include: A review of the facility's policy/procedure, "Medication Administration," undated, revealed the procedural steps included washing your hands before beginning the procedure. Verify the identity of the resident by checking the photo or wristband. Gently pull the lower eyelid down and instruct the resident to look up. Drop the medication into the mid lower eyelid. Do not touch the eye or eye lid with the dropper. Instruct the resident to close his/her eyelid. Gently dry eyelid with cotton if dripping occurs. If both eyes are treated, change gloves before treating the second eye. Discard any disposable items into the trash receptacle. Wash your hands thoroughly after the procedure has been completed. Additionally, the "Medication Pass Inservice" revealed do not give any medications without a physician's order. Before you crush a medication, make sure the drug is allowed to be crushed. Any medication to be crushed must have a "may crush" order. The six rights for passing medications include right drug, right resident, right time, right dose, right form, and right route. 1. A record review revealed the facility admitted Resident #31 on 06/28/08 with diagnoses to include Mental Disorder, Chronic Ischemic Heart Disease, Diabetes Mellitus and Hypertension. A review of the Medication Administration Record (MAR), dated 02/12, revealed an order for "Pataday 0.2% eye drops, instill one (1) drop into	F 332	aspirin given per the G-tube. An order was obtained to discontinue the enteric coated aspirin. Please note resident had no adverse effect related to the enteric coated aspirin being crushed and given per G-tube. Res #32's Physician and family were notified on 2/29/12 related to RN #1 administering Acetaminophen 650mg per G-tube without a PO order. New order was obtained to administer Acetaminophen 650mg PO, crushed per G-Tube or rectal suppository every 4 hours PRN for pain or temp >than 101. Please note resident had no adverse effect related to receiving acetaminophen 650mg. 2. Residents with eye drops and G tubes were reviewed by the Unit Managers between 3/19/12 and 3/23/12 to ensure resident's were free of a medication error rate of 5% or greater. 3. Licensed Nurses were inserviced on 3/23/12 by the ADON that the facility must maintain a less than 5%		

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F 332	<p>Continued From page 18</p> <p>the right eye once a day for redness/allergy." Observation of a medication pass on Hall 3, on 02/28/12 at 7:56 AM, revealed Licensed Practical Nurse (LPN) #1 administered one eye drop in Resident #31's left eye and three drops in his/her right eye.</p> <p>An interview with LPN #1, on 02/29/12 at 10:50 AM, revealed she was suppose to review the MARs before administration of the resident's medication and usually did so. She stated she not realize the resident was to receive only one eye drop in his/her right eye. She stated she had been administering the resident's eyedrops in both eyes. She revealed she became distracted, and did not review the order prior to the administration of the eyedrops; therefore, she did not follow the physician's order.</p> <p>An interview with the Director of Nursing (DON), on 03/01/12 at 5:08 PM, revealed the staff were suppose to observe the five rights related to medication administration. The nurses were expected to follow the physician's orders and administer the medication accordingly.</p> <p>2. A review of the facility's "Do Not Crush Guide," revealed Aspirin Enteric-Coated (EC) 81 milligrams (mg) was listed on the do not crush list. The EC key indicated, "Enteric coated; special coating will be destroyed if crushed, tablet/cap may not dissolve where intended."</p> <p>A record review revealed the facility admitted Resident #32 on 02/27/12 with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Cerebral Vascular Accident with Left Sided Weakness and</p>	F 332	<p>medication error rate, to administer medications per physician's orders, and eye drop administration and following resident rights as it relates to delivery of medication. Medication administration will be inserviced during general orientation and quarterly thereafter.</p> <p>4. Unit Managers will audit 10 medication passes per week for 4 weeks to ensure a less than 5% medication error rate occurs and that physician's orders and resident rights were followed. Then Unit Managers will audit 10 medication passes per month for an additional 2 months. Results of the audits will be reviewed by the QA committee to determine the need for further monitoring.</p> <p>5. Completed by</p>	3/28/12	

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F 332	<p>Continued From page 19</p> <p>Dysphagia.</p> <p>A review of the physician's order and the MAR, dated 02/27/12, revealed "Aspirin Enteric Coated 162 milligrams (mg) by mouth (po) once daily at 9:00 AM, Sotalol 60 mg po once daily at 9:00 AM, Citalopram 10 mg po once daily at 9:00 AM, Acetaminophen 650 mg suppository rectally every eight hours as needed, and Macrobid 100 mg po twice daily at 9:00 AM and 9:00 PM."</p> <p>An observation of a medication pass, on 02/28/12 at 8:01 AM, revealed Registered Nurse (RN) #1 administered Macrobid 100 mg, Aspirin Enteric Coated 81 mg (two) tablets, Acetaminophen 650 mg, and Citalopram 10 mg, through the resident's gastrostomy tube (g-tube).</p> <p>An interview with RN #1, on 02/29/12 at 3:02 PM, revealed the medications should have been clarified with the physician to reflect the correct route (g-tube). She stated that Tylenol should have been administered rectally and she should have clarified the order with the physician. Additionally, she stated the Aspirin EC should have not been crushed, in accordance with the Do Not Crush Guide.</p> <p>An interview with Unit Manager #1, on 03/02/12 at 9:18 AM, revealed she expected the staff to clarify Resident #32's physician's order prior to medication administration.</p> <p>An interview with the DON, on 03/02/12 at 10:58 AM, revealed it was unacceptable practice to administer Enteric Coated Aspirin via g-tube. She stated she expected the staff to clarify Resident #32's orders to determine the correct route of</p>	F 332			

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F 332 F 411 SS=D	<p>Continued From page 20 administration.</p> <p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's dental services agreement, it was determined the facility failed to provide or obtain routine and emergency dental services to meet the needs for one resident (#14), in the selected sample of thirty residents, related to the failure to provide outside dental services when the facility identified the resident's dentures were ill-fitted.</p> <p>Findings include: A review of the facility's agreement with dental services revealed the facility had the ability to obtain outside services to maintain a resident's dentures.</p>	F 332 F 411	<p>F 411</p> <ol style="list-style-type: none"> 1. Resident #14 was spoken to twice by the social worker on 3/2/12 and 3/5/12 and both times the resident has stated the resident doesn't want to pursue getting new dentures made. Her son is also in agreement 2. Resident's were assessed to determine the need for any other dental care issues by the nurses between 3/19/12 to 3/23/12. Referrals were made where appropriate to Social Services to contact our outside dental service. 3. Staff were inserviced by the ADON on 3/23/12 that it is the facility's responsibility to provide or obtain routine and emergency dental services to meet the need of the residents. Dental referrals were also 	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2012
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003
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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 411	<p>Continued From page 21</p> <p>A record review revealed the facility admitted Resident #14 on 12/02/09 with diagnoses to include Congestive Heart Failure, Depressive Disorder, Hypertension, Osteoporosis and Anxiety.</p> <p>A review of the initial data collection tool/nursing service, dated 12/02/09, revealed Resident #14's dentures, "Do not fit good, move around because [he/she] lost weight, needs soft food." There was no evidence that Social Services was consulted to accommodate the resident's ill-fitting dentures.</p> <p>A review of a Speech Therapy progress note, dated 04/01/10, revealed the resident was tried on a regular diet and tolerated the regular diet with no signs and symptoms of aspiration.</p> <p>A review of a nursing-therapy referral tool, dated 05/17/11, revealed Resident #14 wanted to be evaluated for hopes of an increased diet texture from mechanical soft to regular. A review of a rehabilitation services multidisciplinary screening tool, dated 08/09/11, revealed, "Resident requesting to be re-evaluated in hopes of a diet texture upgrade from a mechanical soft to regular diet. Resident is edentulous with no dentures. Resident expressed concerns about adequately chewing regular meat texture, stated [he/she] should remain on ground meat. Resident was not eligible for a diet upgrade to regular at this time." A review of the nurses' notes, Social Services notes, and Speech Therapy notes, revealed no referral was made to address the resident's ill-fitting dentures.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 01/08/12, revealed the facility</p>	F 411	<p>discussed and will be added to our general orientation presentation by the Social Workers.</p> <p>4. Social workers will audit weekly and on-going to ensure that any referrals for dental services have been provided or arranged. Results of the audits will be reviewed by the QA committee to determine the need for further monitoring.</p> <p>5. Completed by</p>	3/28/12
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F 411	<p>Continued From page 22</p> <p>assessed Resident #14 as cognitively independent and required extensive assistance with dressing and personal hygiene. There was no evidence on the dental section of the MDS related to the resident having broken or loose-fitting full or partial dentures.</p> <p>An interview with Resident #14, on 02/28/12 at 10:50 AM, and on 02/29/12 at 3:20 PM, revealed he/she had to eat a mechanical soft diet due to ill-fitting dentures. Resident #14 stated he/she desired a regular diet if his/her dentures could be fixed, but no efforts had been made to replace/realign his/her dentures. Resident #14 stated, due to past weight loss, he/she was unable to wear the dentures, because they "flopped" around in his/her mouth. The resident stated this problem was present upon admission to the facility in 2009, but to this day, no one approached him/her about replacing/realigning the dentures. He/she voiced a concern to the cost of fixing the dentures when he/she consulted a dentist prior to admission to the facility. An interview with Resident #14's son, on 03/01/12 at 11:37 AM, revealed he was responsible for the resident's financial decisions and he participated in the care meetings. He stated when he discussed the resident's dental status in meetings with the facility, nothing was mentioned about the need to fix the resident's dentures in order to be able to consume regular consistency food.</p> <p>Interviews with Certified Nurse Aides (CNAs) #5 and #6, on 03/02/12 at 8:58 AM and at 9:04 AM, respectively, revealed Resident #14 did not wear dentures due to them being ill-fitted. They stated the staff were aware of this issue.</p>	F 411			

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F 411	<p>Continued From page 23</p> <p>An interview with the Social Services Director, on 03/01/12 at 10:53 AM, revealed if a resident required dental services, she made a referral to the dentist, and handled the financial costs. She stated, if a resident was on Medicaid, a voucher was submitted to pay for the resident's denture costs. She stated she was unaware of any issues with Resident #14's dental status, and was unsure as to whether nursing was knowledgeable on how to notify her if outside dental services were needed. She stated she made the referrals if nursing notified her.</p> <p>An interview with the Director of Nursing (DON), on 03/02/12 at 10:58 AM, revealed Resident #14 did not wear dentures, and she was not aware of any issues about ill-fitting dentures. She stated the resident's son informed her that the resident was not wearing dentures prior to the resident's admission to the facility, and did not provide a reason why. She stated if nursing identified the dentures to be ill-fitting, then she expected the staff to contact the resident's family dentist. She stated it was the resident's right to get his/her dentures fixed, but was not aware that Resident #14 voiced any concerns about any dentures.</p>	F 411			

17. Indicate below the number of minority group patients or beneficiaries in today's census by type of room assignment according to the following breakdown:

Type of Room Assignment	African American	American Indian	Asian	Spanish Surmamed American
Number of minority patients or beneficiaries in single rooms or in room alone	0	0	0	0
Number of minority patients or beneficiaries in semi-private or ward rooms having only minority persons.	6	0	0	0
Number of minority patients or beneficiaries in semi-private or ward rooms with one or more non-minority persons.	11	0	0	2
Total	17	0	0	2

Indicate the number of patients or beneficiaries in today's census whose charges made by your facility are paid in part or full by Medicare or Public Welfare.

Type of Aid	Total	African American	American Indian	Asian	Spanish Surmamed American
Medicare	43	2	0	0	0
Medicaid	134	15	0	0	2

18. Estimate the number of patients or beneficiaries of the minority groups admitted during the past year:

0 1-10 11-20 21-50 Over 50

19. Does this facility have more than one dining room used by patients? yes no

20. If you have one patient dining room, is it used by persons of different races simultaneously? yes no

21. If you have more than one patient dining room (give number) is one used predominantly by one race? yes no

22. Are all services and facilities used routinely by all persons without regard to race, color, or national origin (i.e., nursing care, beauty salons, etc.)? yes no

23. If "No" specify which are not.

24. Are services rendered in this facility without regard to the race of either the patient or the person rendering the service? yes no

25. If "No" specify which services are not.
 26. Is the use of courtesy title (Mr., Mrs., etc.) uniform throughout this facility on records, news releases, public address systems, name tags, etc., and in addressing patients? yes no

27. Estimate below the number of physicians and other licensed paramedical personnel not on your payroll that gave patient service in this facility during the last month by race of the physician or person rendering the service.

Physicians and Other Non-salaried Paramedical Personnel	Total	African American	American Indian	Asian	Spanish Surmamed American
	0	0	0	0	0

28. Has the staff been notified, in writing, of the facility's policies as they apply to the Civil Rights Act of 1964? yes no

29. Are referrals to other facilities and services (e.g., skilled, intermediate, or residential care facilities) made routinely without consideration of the race of the patient? yes no

30. Are referrals made to other facilities or services which consider race in the acceptance of patients? yes no

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF:

[Signature] E.D. 2-27-12 Title Date

Signature of Authorized Official

[Signature] MCH/NR Title of Reviewer

Signature of Reviewer

CHECKLIST FOR COMPLIANCE WITH KRS 214.620 (4) HIV/AIDS PATIENT INFORMATION

DISTRIBUTION METHOD

YES NO Agency uses patient information form developed by the Department for Health Services.

YES NO Agency uses their own patient information form. *both*

YES NO Agency distributes patient information in admissions package.

AGENCY FORM INCLUDES THE FOLLOWING INFORMATION

METHODS OF TRANSMISSION:

YES NO sexual contact (anal, oral, or vaginal intercourse) with an infected person when blood, semen or cervical/vaginal secretions are exchanged;

YES NO sharing a syringe/needle with someone who is infected;

YES NO infected mother may pass HIV to unborn child; and

YES NO receiving contaminated blood or blood products, organ/tissue transplants, and artificial insemination (rare now since testing for HIV antibodies began).

METHODS OF PREVENTION:

YES NO no sexual intercourse except with a monogamous partner who is not infected;

YES NO sexual relations with anyone else requires use of latex condom, female condom, or dental dam;

YES NO do not share syringes or needles with anyone;

YES NO should be tested for HIV if pregnant or plan to be pregnant; and

YES NO education of self & others about HIV infection & AIDS.

APPROPRIATE ATTITUDES & BEHAVIORS

YES NO assurances that the agency provides quality services to all patients, regardless of HIV status.

WHAT YOU SHOULD KNOW ABOUT HIV/AIDS

WHAT IS AIDS?

AIDS is the Acquired Immune Deficiency Syndrome—a serious illness which makes the body unable to fight infection. A person with AIDS is susceptible to certain infections and cancers. When a person with AIDS cannot fight off infection, this person becomes ill. Some people with AIDS may die.

WHAT CAUSES AIDS?

AIDS is caused by a virus called Human Immunodeficiency Virus or HIV.

HIV CAN BE SPREAD BY:

- sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, semen or cervical/vaginal secretion are exchanged.
- sharing a syringe/needle with someone who is infected
- receiving contaminated blood or blood products (very unlikely now because blood used for transfusions has been tested for HIV antibodies since March, 1985)
- an infected mother may pass HIV to her unborn child before or during childbirth

YOU CANNOT GET HIV THROUGH CASUAL CONTACT SUCH AS:

- sharing food, utensils, or plates
- touching someone who is infected with HIV
- touching or shaking hands
- donating blood—(this has NEVER been a risk for contracting HIV)
- using public rest rooms
- being bitten by mosquitoes or any other insect

PREVENTION

- do not share needles or syringes with anyone
- do not have sexual intercourse except with a permanent partner whom you know is not infected. If you choose to have sex with anyone else, use latex condoms along with a spermicide containing Nonoxynol-9 every time you have sex
- educate yourself and others about HIV infection and AIDS
- should be tested for HIV if pregnant or plan to be pregnant

TREATMENT

Early diagnosis of HIV infection is important! If you have been told you have HIV you should get prompt medical treatment. Your doctor will help you determine the best treatment for you.

YOU DO NOT HAVE TO BE AFRAID OF A PERSON LIVING WITH HIV OR AIDS!

WHO SHOULD BE TESTED BY HIV ANTIBODIES?

Free testing and counseling is available at every health department in Kentucky. After being infected with HIV, it takes between two weeks and three months before the test can detect the virus.

You should be tested if you:

- have had sex with someone who has HIV
- have shared needles or syringes with someone who has HIV
- have had multiple sex partners
- have had sex through prostitution (male or female)
- have had sex with injecting drug users
- had a blood transfusion between 1978 and 1985

Remember: you can't tell whether or not someone has HIV just by looking at them.

It is this facilities policy to admit patients/residents regardless of diagnoses as long as we can meet their physical, emotional, and spiritual needs.

NOTE: Anyone with active TB may not be admitted related to the TB isolation criteria.

Does Not Participate

DEPARTMENT FOR MEDICAID SERVICES
PROGRAM VISIT REPORT
NURSING FACILITY

SURVEY DATE:

02/27/12

Facility Name: Parkeview Nursing & Rehab

Facility Address: 544 Lone Oak Rd, Paducah Ky 42003

Nurse Aide Training Provider Number: _____

Program Coordinator: _____
(Can be Director of Nurses)

Program Instructor: _____
(Cannot be Director of Nurses)

MOI: Yes () No () 2 years as R.N.: Yes () No () 1 year long term experience: Yes () No ()

Yes No

- _____ _____ Course Curriculum - Adapted Mosby's Textbook for LTC Assistants as of July 1, 1997.
- _____ _____ Observed Classroom (i.e. necessary equipment and supplies available): ***6th Edition Book**
- _____ _____ Observed class in session. **Mandatory 3/1/11.**
- _____ _____ Observed clinicals performed.

1. Is the learning environment conducive for adult students: (i.e. well-lighted, well-ventilated, quiet)?

2. What evidence exists that the class is being conducted within submitted plan?

3. Is there sufficient number of faculty to meet ratios for classroom and clinical (maximum is 1:15)?

4. Is there documentation of staff development offered to nurse aides (12 hours/year): Yes () No ()

Yes No

- _____ _____ 5. Are performance records available to nurse aide and employer?
- _____ _____ 6. Are performance records maintained for a minimum of five (5) years?
- _____ _____ 7. Pass/Fail for last two (2) classes: Date: _____ # Pass: _____ # Fail: _____
Date: _____ # Pass: _____ # Fail: _____
- _____ _____ 8. Does facility notify Medicaid of **all** program changes within thirty (30) days?
(i.e. new administrator, classroom, coordinator, instructor)

Signature of Reviewer: B. Williams Ambrose

Date: 02/27/12

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1968</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (222)</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 02/28/12. Parkview Nursing & Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for two-hundred twenty-eight (228) beds and the census was two-hundred three (203) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan or correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws."</p> 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jm Mundy Sacc Director</i>	TITLE	(X6) DATE 3-23-12
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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.

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K 000	Continued From page 1 Fire)	K 000			
K 027 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA Standards. The deficiency had the potential to affect the eight (8) of twelve (12) smoke compartments, residents, staff, and visitors. The facility is licensed for two-hundred twenty-eight (228) beds with a census of two-hundred three (203) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/28/12 between 8:00 AM and 3:30 PM, with the Director of Maintenance revealed the cross-corridor doors located on 100, 300, and 500 halls would not close completely</p>	K 027	<p>K 027</p> <ol style="list-style-type: none"> 1. The cross-corridor doors will be repaired by a contracted company to ensure they close properly by 6/1/12. Maintenance inspected all other cross corridor doors for proper functioning by 3/23/12. 2. The Maintenance Dept. and Administration was in serviced to monitor doors for proper closure by the Administrator on 3/23/12. 3. The Maintenance Dept will audit doors to ensure that the smoke doors close properly and appropriate smoke barrier maintained weekly for 4 weeks then monthly times 2 months. The results of the audits will be reviewed by the QA committee to determine the need for further monitoring. 4. Date completed: 	6/1/12	

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K 027	Continued From page 2 due to the t-astragal being installed on the door. Further observation showed the cross-corridor doors on the 200, 800, and 900 halls would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Interview, on 02/28/12 between 8:00 AM and 3:30 PM, with the Director of Maintenance revealed they were unaware the doors would not close all the way leaving a gap between the doors in the closed position and acknowledged the doors would not resist the passage of smoke in the event of an emergency. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 101 LIFE SAFETY CODE STANDARD	K 027		
K 029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	K 029 1. The self closing devices will be installed for the door to the kitchen, the purchasing manager's door, the janitor room, the dry storage room, the marketing material room, and the storage room at the end of wing 3 by 4/1/12. The	

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K 029	<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 meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect six (6) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for two-hundred twenty-eight (228) beds with a census of two-hundred three (203) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/28/12 between 8:00 AM and 3:30 PM, with the Director of Maintenance revealed the door to the Kitchen from the Vending Hall did not have a self closing device. The purchasing manager/ central supply also had no self-closing device. The door for the janitor room/ electrical room was another hazardous area with no self-closing device. Further observation showed the dry storage at the end of the vending hall needs to have a door closer. The marketing material room had hazardous storage without a closer. The last hazardous area without a proper closer was the storage room at the end of 300 hall, also known as the yellow room, also the door and frame were not rated for hazardous storage.</p> <p>Interview, on 02/28/12 between 8:00 AM and 3:30 PM, with the Director of Maintenance revealed they were not aware the self closing devices were required for hazardous areas.</p>	K 029	<p>Door and frame for the "yellow room" will be installed by 4/1/12. (work completed by contract company)</p> <ol style="list-style-type: none"> Maintenance inspected all other doors to ensure they function and close properly by 3/23/12. The Maintenance Dept. was inserviced on the requirements of Protection of Hazards in accordance with NFPA standards by the Administrator on 3/23/12. The Maintenance Dept will audit doors to ensure that the self closing devices installed are in working order weekly for 4 weeks then monthly times 2. The results of the audits will be reviewed by the QA committee to determine the need for further monitoring. Date completed: 	4/1/12	

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

PRINTED: 03/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2012
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 029	Continued From page 4 Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft 2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft 2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than	K 029			

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K 029 K 032 SS=D	Continued From page 5 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the exit access from the laundry dryer area in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff, and visitors. The facility is licensed for two-hundred twenty-eight (228) beds with a census of two-hundred three (203) on the day of the survey. The findings include: Observation, on 02/28/12 at 9:10 AM, with the Director of Maintenance revealed there was no second exit to the laundry area. Further observation showed that the outline of a wall that had been removed to make the area open storage. Interview, on 02/28/12 at 9:10 AM, with the Director of Maintenance revealed he was not aware the laundry area needed a second exit. Further interview determined the area had a second exit that was converted into a storage area.	K 029 K 032	K 032 1. The second exit will be installed in the laundry room as of 5/11/12. The wall will be replaced and the door and frame and self closure will be installed per code as of 5/11/12. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The Maintenance Dept was inserviced to maintain the exit access from the laundry dryer area in accordance with NFPA standards by the Administrator on 3/23/12. 4. The Maintenance Dept will monitor the dryer area to ensure the exit access is maintained weekly times 4 then monthly times 2. The results of the audits will be reviewed by the QA committee to determine the need for further monitoring. 5. Date completed:	5/11/12	

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K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect two (2) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for two-hundred twenty-eight (228) beds with a census of two-hundred three (203) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/28/12 between 9:30 AM and 10:30 AM, with the Director of Maintenance revealed the Wing 3 exit does not have a durable surface to a public way and the exit is blocked by a gate. Further observation showed the exit for the 200 hall did not have a durable surface that was 4 feet across.</p> <p>Interview, on 02/28/12 between 9:30 AM and 10:30 AM, with the Director of Maintenance revealed he was unaware the exit needed a durable surface to the public way and that 4 feet is required.</p>	K 038	<p>K 038</p> <ol style="list-style-type: none"> Concrete will be installed to the Wing 4 (this was named wrong in the SOD) exit to ensure a durable surface to the public way and 200 hallway exit will be increased to 4 feet across with concrete by 5/10/12. All exits were assessed to ensure exits have been maintained by the Maintenance Dept by 3/23/12. The Maintenance Dept was inserviced on the importance of maintaining the facility exits by the Administrator on 3/23/12. The Assistant Administrator will monitor exit areas to ensure they are maintained weekly times 4 then monthly times 2. The results of the audits will be reviewed by the QA committee to determine the need for further monitoring. Date completed: 	5/10/12

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K 038	<p>Continued From page 7</p> <p>Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. 7.7.1</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p>	K 038		

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K 038	<p>Continued From page 8</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a</p>	K 038		

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K 038	Continued From page 9 sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit	K 045	K 045 1. The lights to both the exterior exit for the basement and the	

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K 045	<p>Continued From page 10</p> <p>discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for two-hundred twenty-eight (228) beds with a census of two-hundred (203) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/28/12 between 8:00 AM and 12:30 PM, with the Director of Maintenance revealed the exterior exit for the basement was equipped with a single bulb for illuminating egress path to the public way from the exit. Further observation showed the exit off the vending hall next to the new locker area also revealed no exterior lighting to the public way</p> <p>Interview, on 02/28/12 between 8:00 AM and 12:30 PM, revealed the Director of Maintenance was unaware the lighting did not meet NFPA standards for exits.</p> <p>Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness.</p>	K 045	<p>exit off the vending hall will be replaced with double bulb lighting fixtures by a contracted company by 5/01/12.</p> <ol style="list-style-type: none"> 2. All other exit areas were assessed to ensure they were equipped with proper lighting per code by the Maintenance Dept by 3/23/12. 3. The Maintenance Dept was inserviced that all exits must be equipped with proper lighting so not to leave the exit in complete darkness with any single bulb failure on 3/23/12 by the Administrator. 4. The Maintenance Dept will audit exit areas to ensure proper lighting is maintained weekly times 4 weeks then monthly times 2. The results of the audits will be reviewed by the QA committee to determine the need for further monitoring. 5. Date Completed: 	5/1/12