

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

PRINTED: 06/03/2013
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 05/17/2013
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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 000	INITIAL COMMENTS A recertification survey was conducted 05/14/13 through 05/17/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "F".	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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	F 157 1. The physician was notified by the licensed nurse on 5/17/13 and new orders received for Resident #21. The resident was her own responsible party and is aware of the issue. 2. The DON, ADON, and Unit Managers completed an audit of residents by 6/7/13 to ensure no other change in condition had occurred without notification and with any issues identified the physician and responsible party was notified. 3. Licensed Nurses were in-serviced by the Administrator on 5/31/13 to ensure physicians and responsible parties were notified of any changes in condition, injury, room changes, etc. Education will be provided upon hire and as needed. The DON, ADON, Unit Managers will review physician orders daily (M-F) to ensure Physician and responsible party notification has occurred with changes in condition. 4. Unit Managers will audit for 10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Ron Nunnally* TITLE: Exec. Director (X6) DATE: 6-17-13

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 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</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 physician was made aware of an open, draining wound for one resident (#21), in the selected sample of thirty (30) residents. An observation, on 05/16/13, and review of the weekly skin assessments revealed the resident had an open area to the right calf since 05/10/13; however, the physician was not contacted until 05/17/13.</p> <p>Findings include:</p> <p>A review of the facility's undated policy/procedure for Post-admission Weekly Skin Assessments, revealed the physician must be made aware of all pressure sores in order for a resident-specific protocol to be initiated.</p> <p>An observation of Resident #21, on 05/16/13 at 3:30 PM, revealed the resident to have an uncovered, open area to the back of the right calf. He/ she stated no one had offered to place a dressing over the wound, in order to prevent the visible brown-colored wound drainage to the back of the resident's heel boot.</p> <p>A record review revealed the facility admitted Resident #21, on 01/24/12, with diagnoses to include Type II Diabetes, Open Wound to the Right Foot and Acute Kidney Failure.</p>	F 157	<p>(per units they manage) changes in condition, decline, injuries to ensure the physician and responsible parties have been notified weekly times 4 weeks then for 10 changes per month times 2 months. Results of the audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by:</p>	6/12/13	

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F 157	<p>Continued From page 2</p> <p>A review of the annual MDS, dated 05/03/13, revealed the resident was cognitively intact, required the extensive assist of one staff for transfer and bed mobility, was non-ambulatory and had acquired an unstagable pressure sore to the right lateral foot. A review of the care plan for skin integrity, dated 05/03/13, revealed the resident had a deep tissue injury to the right foot which required heel lift boots and heels off the bed.</p> <p>A review of the skin assessments, dated 05/10/13, revealed an open area to the right calf.</p> <p>A review of the Medication Administration Records (MARs), Treatment Administration Records (TARs) and physician's orders, dated May 2013, revealed no order or treatment for the right calf area.</p> <p>An interview with Licensed Practical Nurse (LPN) #4, on 05/16/13 at 3:23 PM, revealed she was unaware of the area to Resident #21's right calf. After review of the physician's orders, MARs, and TARs, LPN #4 stated she was unsure if this was reported to the physician for an order for treatment to be administered, as there were no orders for treatment. She stated she would "make a note of this."</p> <p>An interview with LPN #5 and LPN #6, on 05/17/13 at 1:05 PM, revealed the physician was not notified and an order was not obtained for treatment of the area to the right calf.</p> <p>An interview with the Director of Nursing (DON), on 05/17/13 at 2:25 PM, revealed the LPN should</p>	F 157			

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F 157	Continued From page 3 have addressed the new area, noted it on the skin assessment on 05/10/13, notified the unit manager, and received a physician's order for treatment and dressing to the site to prevent drainage, and to heal the wound.	F 157		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure a care plan was developed for one (1) resident (#7), in the selected sample of thirty (30) residents. Review of Resident #7's Minimum Data Set (MDS)	F 279	F 279 1. A careplan was developed for Resident#7 to include nutrition and pain by the MDS Coordinator on 5/21/13. 2. Residents were assessed to determine if nutrition and pain should be added to their careplan and implemented by the MDS Coordinators, Registered Dietitians and Unit Managers by 6/7/13. 3. Licensed Nurses were in-serviced on 5/31/13 by the Administrator to ensure after any assessment that the resident's current problems, goals, care, treatment and services were addressed on the careplan to include nutrition and pain. Education will be provided upon hire, quarterly and as needed related to careplanning to include nutrition and pain. 4. Unit Managers will audit 15 resident careplans weekly (M-F) to ensure resident's current needs, current problems, goals, care, treatment and services were addressed on the care plan to include nutrition and pain are care planned appropriately; then will audit 15 per month for 2 additional months. Results of the audits will be brought to the QA committee to	

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F 279	<p>Continued From page 4</p> <p>assessment, dated 02/11/13, revealed he/she was assessed to be at risk for nutritional deficits and pain; however, there was no evidence of development of a care plan.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure, "Resident Care Plan" dated 12/08, revealed " The individualized, interdisciplinary care plan is to be completed by participation of all disciplines and printed within 7 days of the Resident Assessment Instrument (RAI) completion according to the RAI guidelines." Additionally, "a review of the care plan is done at least quarterly and as needed to reflect the resident's current needs, problems, goals, care, treatment, and services."</p> <p>A record review revealed the facility admitted Resident #7 on 02/04/13 with diagnoses to include Unspecified Pleural Effusion, Chronic Obstructive Pulmonary Disease, Depression, Dementia, and History of Pneumonia.</p> <p>A review of the Care Area Assessment (CAA), dated 02/11/13, revealed the resident was assessed for potential for nutrition and pain, and a care plan was to be implemented; however, there was no evidence of a care plan in the record.</p> <p>An interview with the Registered Dietician (RD), on 05/16/13 at 10:20 AM, revealed she was responsible for completing care plans in certain areas of the facility and was responsible to complete Resident #7's care plans. She stated she kept up with his/her progress on a weekly basis through the Nutrition at Risk (NAR)</p>	F 279	<p>determine the need for further monitoring.</p> <p>5. Completed by:</p>	6/12/13

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F 279	Continued From page 5 program. Additionally, she revealed she had all of the NAR notes and was aware a care plan must be implemented within 21 days of a resident's admission to the facility; however, she stated she did not complete a care plan for Resident #7. An interview with the MDS Coordinator, on 05/16/13 at 10:10 AM, revealed she should have implemented Resident #7's care plan for pain related to his/her pressure ulcers and diagnoses of Chronic Obstructive Pulmonary Disease. No further explanation was provided.	F 279			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 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 services provided by the facility were in accordance with the written plan of care for one resident (#1), in the selected sample of thirty (30) residents. Observations, on 05/14/13 at 11:50 AM, and on 05/15/13 at 9:30 AM, revealed Resident #1 was seated in a wheelchair with an underseat alarm which was not in the functioning mode. Interviews revealed the Certified Nursing Assistants (CNA) and a Licensed Practical Nurse	F 282	F 282 1. The Unit Manager replaced Resident#1 alarm with a new alarm and assessed functioning and placement 5/21/13. Resident #1's careplan was revised to include check function and placement every shift and as needed on 5/21/13. Resident #1's careguide was updated on 5/21/13 to reflect the need to check placement and functioning of alarms and to report to a supervisor if not functioning. 2. Resident Care plans were audited by Unit Managers and MDS coordinators by 6/7/13 to ensure check function and placement of alarms every shift and as needed were included on the care plans. 3. The Administrator educated staff on 5/31/13 to ensure safety devices were properly placed and that they were functioning each shift by staff. Education will be provided to licensed nurses and certified nursing assistants upon hire, quarterly and as needed		

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F 282	<p>Continued From page 6</p> <p>(LPN) did not check or ensure the resident's alarm was in place and in the functioning mode.</p> <p>Findings include:</p> <p>Review of the facility's undated "Fall Management" policy/procedure, revealed "Understanding the significance of mobility, movement, and the ingrained nature of walking, it is our intention to promote programs geared to improving mobility, stamina and reduce the risk of falls through a comprehensive, interdisciplinary process of assessment, care plan development and implementation with ongoing monitoring and review". Additionally, the policy included "An interdisciplinary plan of care will be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions".</p> <p>A record review revealed the facility admitted Resident #1 on 11/13/12 with diagnoses to include Dementia, Anemia, Adult Failure to Thrive and Insomnia. Review of the quarterly Minimum Data Set (MDS), dated 02/14/13, revealed the facility assessed the resident with to be severely cognitively impaired and required total assistance for transfers/ambulation, and was at risk for falls.</p> <p>Further record review revealed the resident sustained a fall from the wheel chair without injury, on 12/08/12, and a psychiatric assessment was obtained. On 01/28/13, Resident #1 sustained a fall from the wheelchair and was assessed and treated for a urinary tract infection.</p> <p>Review of Resident #1's care plan, "At risk for physical injury from falls related to unsteady gait,</p>	F 282	<p>checking the function and placement of alarms every shift and as needed. Facility will add to TAR to check alarms function and placement every shift and change batteries monthly.</p> <p>4. Administrative staff and Unit Managers will audit 10 safety devices per wing weekly (M-F) to ensure they are properly placed and are functioning for 4 weeks, then audit 20 per month for an additional 2 months. Results of the audits will be presented to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by:</p>	6/12/13	

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F 282	<p>Continued From page 7</p> <p>history of falls and non compliance with safety issues", dated 02/14/13, revealed interventions to include a bed sensor alarm and an alarm to the wheel chair.</p> <p>An observation, on 05/14/13 at 11:50 AM, revealed Resident #1 was in his/her room seated in a wheel chair with an alarm attached to the back of his/her wheel chair. The alarm's indicator light was not turned on to indicate the alarm was in the functioning mode.</p> <p>An interview with CNA #3, on 05/14/13 at 11:50 AM, revealed she had not looked at Resident #1's alarm; however, she should have checked it. She stated the midnight shift assisted the resident to the wheel chair and should have turned the alarm to the function mode.</p> <p>An observation, on 05/15/13 at 9:30 AM, revealed Resident #1 was seated in his/her room in a wheel chair with the alarm in place. LPN #1 was administering medications to the resident. Further observation revealed the indicator light on the alarm was not flashing to indicate it was in the function mode. LPN #1 verified the alarm was not on, and stated she had checked the resident's bed alarm; however, she did not check the resident's wheel chair alarm.</p> <p>An interview with CNA #2, on 05/15/13 at 11:05 AM, who was providing care for Resident #1, revealed she did not assist the resident up to the wheelchair and did not check the resident's alarm.</p> <p>An interview with CNA #3, on 05/15/13 at 11:10 AM, revealed she had not verified Resident #1's</p>	F 282		

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F 282	Continued From page 8 alarm functioned; however, she normally checked the alarms when transferring a resident. An interview with the Director of Nursing (OON), on 05/17/13 at 2:50 PM, revealed the staff nurse was to sign off on the Treatment Administration Record (TAR) when alarms were checked for placement and functioning. The DON stated she expected the nurse to ensure Resident #1's care plan for the safety alarm was implemented.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure a resident received the necessary care and services related to a newly developed pressure ulcer for one resident (#7), in the selected sample of thirty (30) residents. Observation of a skin assessment, on 05/15/13 at 9:40 AM, revealed Resident #7 had an unidentified pressure ulcer to his/her right outer (pinkie) toe. Findings include:	F 314	F 314 1. The physician and Resident #7's responsible party, which was venous in nature per the nurse practitioner on 5/15/13. A treatment order was also obtained on this day although the physician was aware of this area earlier and had chosen not to treat it. 2. Resident's skin was assessed on each wing by Licensed nurses by 6-6-13. The physician was notified of any issues identified and treatment orders were obtained on that day. 3. Licensed Nurses were in-serviced by the Administrator on 5/31/13 that residents who enter the facility should not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new pressure sores. Education will be provided upon hire, quarterly and as needed to Licensed Nurses and certified Nursing Assistants related to residents	

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F 314	<p>Continued From page 9</p> <p>A review of the facility's policy/procedure, "Pressure Ulcer Prevention" revealed "On a weekly basis, a licensed professional searches for areas of skin that differ from surrounding tissue. These areas may be painful, firm, boggy, soft, warmer, or cooler in temperature compared to adjacent tissue, looking also for edema and induration (hardness). Particular attention is given to bony prominences."</p> <p>A record review revealed the facility admitted Resident #7 on 02/04/13 with diagnoses to include Unspecified Pleural Effusion, Chronic Obstructive Pulmonary Disease, Depression, Dementia, and History of Pneumonia.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 05/01/13, revealed Resident #7 had a Stage II pressure ulcer with an onset date of 02/28/13. The interventions coded on the MDS included a pressure reducing device for the bed and pressure ulcer care.</p> <p>A review of the Initial Data Collection Tool/Nursing Service, dated 02/04/13, revealed the resident had a pink, blanchable dark area on his/her coccyx upon admission as well as bruises, scar, and a scab.</p> <p>A review of the Pressure Ulcer Risk Assessment Tool, dated 02/04/13, revealed a Stage I pressure ulcer to the sacral area.</p> <p>A review of the comprehensive care plan, dated 02/08/13, revealed, on 02/28/13, an unstageable wound (Stage IV) developed on the resident's left heel. Further review revealed the resident was at</p>	F 314	<p>who enter the facility should not develop pressure sores unless the resident's condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new pressure sores.</p> <p>4. Unit Managers will audit weekly skin assessments (10 per wing) to determine if any new areas were identified and avoidable or unavoidable. Then Unit Managers will audit 10 per month for an additional 2 months. The results of the audits will be presented to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by:</p>	6/12/13

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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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 10 risk for breakdown related to weakness, incontinence, and decreased mobility. Care plan goals revealed the skin will remain intact with skin breaks through the next 90 days. Observation of a skin assessment, on 05/15/13 at 9:40 AM, revealed Resident #7 had an unidentified pressure ulcer to his/her right outer (pinkie) toe. Interview with Certified Nursing Assistants (CNAs) #5, #6, and #9, on 05/15/13 at 2:30 PM, at 2:40 PM, and at 3:10 PM, respectively, revealed they had not observed any new areas on Resident #7's foot during bathing or dressing. An interview with Licensed Practical (LPN) #3, on 05/16/13 at 2:40 PM, revealed he/she had not worn shoes for a month or longer. She was unaware of how the area to his/her right pinkie toe developed. She stated it was possible that he/she hit his/her toe on something causing a deep tissue injury. She further revealed the resident had a daughter who was a nurse, who came in often and checked the resident from head to toe, due to the resident's diagnosis of Peripheral Vascular Disease; however, she had not mentioned a new area to the nursing staff. An interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), on 05/16/13 at 11:00 AM, revealed the process of identifying new areas on a resident by the CNAs was completed during bathing/showering. Any new areas would be documented on the shower/bath sheets and turned in to the charge nurse and unit manager on duty.	F 314			
F 323	483.25(h) FREE OF ACCIDENT	F 323	F323		

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F 323 SS=D	<p>Continued From page 11 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, the facility failed to ensure the resident environment remained as free of accident hazards as is possible and assistance devices to prevent accidents for one resident (#1) in the selected sample of thirty (30) residents. Observations, on 05/14/13 at 11:50 AM, and on 05/15/13 at 9:30 AM, revealed Resident #1 was seated in a wheelchair with an underseat alarm which was not in the functioning mode. Interviews revealed the Certified Nursing Assistants (CNA) and a Licensed Practical Nurse (LPN) did not check or ensure the resident's alarm was in place and in the functioning mode.</p> <p>Findings include: Review of an undated policy, "Management of Resident Safety Equipment," revealed "Each resident will be assessed on admission and quarterly thereafter for the use of a safety device based on the resident's safety awareness,</p>	F 323	<p>F 323</p> <ol style="list-style-type: none"> The Unit Manager replaced Resident #1 alarm with a new alarm and assessed functioning and placement 5/21/13. Resident #1's careplan was revised to include check function and placement every shift and as needed on 5/21/13. Resident #1's careguide was updated on 5/21/13 to reflect the need to check placement and functioning of alarms and to report to a supervisor if not functioning. Resident Care plans were audited by Unit Managers and MDS coordinators by 6/7/13 to ensure check function and placement of alarms every shift and as needed were included on the care plans. The Administrator educated staff on 5/31/13 to ensure safety devices were properly placed and that they were functioning each shift by staff. Education will be provided to licensed nurses and certified nursing assistants upon hire, quarterly and as needed checking the function and placement of alarms every shift and as needed. Facility will add to TAR to check alarms function and placement every shift and change batteries monthly. Administrative staff and Unit Managers will audit 10 safety devices per wing weekly (M-F) to ensure they are properly placed and are functioning for 4 weeks, then audit 20 per month for an additional 2 months. Results of the 		

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F 323	<p>Continued From page 12</p> <p>cognition fall history, mobility, sensory status, medications or predisposing health condition. An interdisciplinary plan of care will be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions". The procedure section of the policy included "The interdisciplinary team will decide on the least restrictive safety device and apply appropriately to the resident, bed, wheelchair, etc" and "Safety devices will be monitored and will be responded to promptly".</p> <p>A record review revealed the facility admitted Resident #1 on 11/13/12 with diagnoses to include Dementia, Anemia, Adult Failure to Thrive and Insomnia. Review of the quarterly Minimum Data Set (MDS), dated 02/14/13, revealed the facility assessed the resident to be severely cognitively impaired and required total assistance for transfers/ambulation, and was at risk for falls.</p> <p>Further record review revealed the resident sustained a fall from the wheel chair without injury, on 12/08/12, and a psychiatric assessment was obtained. On 01/28/13, Resident #1 sustained a fall from the wheelchair and was assessed and treated for a urinary tract infection.</p> <p>Review of Resident #1's care plan, "At risk for physical injury from falls related to unsteady gait, history of falls and non compliance with safety issues", dated 02/14/13, revealed interventions to include a bed sensor alarm and an alarm to the wheel chair.</p> <p>An observation, on 05/14/13 at 11:50 AM, revealed Resident #1 was in his/her room seated</p>	F 323	<p>audits will be presented to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by:</p>	6/12/13	

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F 323	<p>Continued From page 13</p> <p>in a wheel chair with an alarm attached to the back of his/her wheel chair. The alarm's indicator light was not turned on to indicate the alarm was in the functioning mode. An observation, on 05/15/13 at 9:30 AM, revealed Resident #1 was seated in his/her room in a wheel chair with the alarm in place. LPN #1 was administering medications to the resident. Further observation revealed the indicator light on the alarm was not flashing to indicate it was in the function mode. LPN #1 verified the alarm was not on, and stated she had checked the resident's bed alarm; however, she did not check the resident's wheel chair alarm.</p> <p>An interview with CNA #3, on 05/14/13 at 11:50 AM, revealed she had not looked at Resident #1's alarm; however, she should have checked it. She stated the midnight shift assisted the resident to the wheel chair and should have turned the alarm to the function mode. Further interview with CNA #3, on 05/15/13 at 11:10 AM, revealed she had not verified functioning of Resident #1's alarm; however, she normally checked the alarms when transferring a resident.</p> <p>An interview with CNA #2, on 05/15/13 at 11:05 AM, who was providing care for Resident #1, revealed she did not assist the resident up to the wheelchair and did not check the resident's alarm.</p> <p>An interview with the Director of Nursing (DON), on 05/17/13 at 2:50 PM, revealed she expected the nurse to ensure Resident #1's care plan intervention for the safety alarm was implemented and to sign off on the Treatment Administration Record (TAR).</p>	F 323			

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F 441 SS-D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441</p> <p>1. The soiled boot of Resident#21 was replaced with a new one on 5/17/13 by the Licensed Nurse. Resident#21's physician was notified on 5/17/13. A new order was obtained regarding a treatment to the resident's calf. Please note the resident did not have any adverse effect from the boot being soiled.</p> <p>2. Protective Devices of other residents were assessed by Unit Managers and Licensed Nurses to ensure they were sanitary, safe and in good repair by 6/6/13. Any item deemed unsanitary, unsafe or not in good repair was replaced at that time.</p> <p>3. The administrator in-serviced staff on the Infection Control Program to include: providing a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection on 5/31/13 ensuring protective devices were clean and sanitary, safe and in good repair was also discussed. Education will be provided to staff upon hire, annually and as needed. In addition, Administrative staff and licensed staff will monitor this through their rounds and report any issues to Maintenance.</p> <p>4. The Unit Managers will audit 5 protective devices per wing for 4 weeks and general infection control procedures to ensure environments remain safe, sanitary and comfortable to help prevent</p>		

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F 441	Continued From page 15 This REQUIREMENT Is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure an infection control program was maintained to prevent the development and transmission of disease and infection. The facility failed to ensure a soiled boot was cleaned or replaced for one resident (#21), in the selected sample of thirty (30) residents. Findings include: A record review revealed the facility admitted Resident #21, on 01/24/12, with diagnoses to include Type II Diabetes, Open Wound to the Right Foot, and Acute Kidney Failure. A review of the annual Minimum Data Set (MDS), dated 05/03/13, revealed the resident was cognitively intact, needed the extensive assist of one staff for transfer and bed mobility, was non-ambulatory and had acquired an unstagable pressure sore to the right foot. A review of the care plan for skin integrity, dated 05/03/13, revealed the resident had a deep tissue injury to the right foot and required heel lift boots and heels off the bed. A review of the skin assessments, dated 05/10/13, revealed an open area to the right calf. A review of the Medication Administration Records (MARs), Treatment Administration Records (TARs) and physician's orders, dated May 2013, revealed no evidence of an order or treatment for the right calf area. An observation of Resident #21, on 05/16/13 at 3:30 PM, revealed the resident to have an uncovered, open area to the back of the right calf	F 441	the development and transmission of disease and infection. Audits will include the observation of devices to ensure sanitary, safe and good repair. Then Unit Managers will audit 10 of the same per month for an additional 2 months. Results of the audits will be presented to the QA committee to determine the need for further monitoring. 5. Completed by:	6/12/13	

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F 441	<p>Continued From page 16</p> <p>and brown-colored drainage noted to the back of the frayed and worn, foam heel boot, lying in the chair next to the resident. He/she stated the boot had been worn for some time and no one had offered to replace the boot or place a dressing over the wound, to prevent the drainage.</p> <p>An interview with Licensed Practical Nurse (LPN) #4, on 05/16/13 at 3:23 PM, revealed she was unaware of the area to Resident #21's right calf. After reviewing the physician orders, MARs and TARs, the LPN stated sha was not sure this had been reported to the physician so that treatment would have been administered and stated the boot should have been replaced, after it was noted to have drainage from the wound and a Physical Therapy Consult should have been obtained to evaluate for another boot, that would not rub up against the open area.</p> <p>An interview with LPN #5 and LPN #6, on 05/17/13 at 1:05 PM, revealed the physician had not been called and nor an order obtained for treatment of the area. In addition, the resident was still wearing the same soiled heel boot to the right fool.</p> <p>An interview with the Director of Nursing (DON), on 05/17/13 at 2:25 PM, revealed the LPN should have addressed the new area, noted on the skin assessment 05/10/13, notified the unit manager and received an order from the physician for treatment and dressing to the site to prevent drainage, and therapy should have been contacted to replace the heel boot. Further interview with the DON revealed there was no specfic policy for the replacement of soiled assistive devices.</p>	F 441			

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F 490 SS=F	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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: Based on observation and interview, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. During a Life Safety Code (LSC) survey, conducted 05/15/13, there was a deficiency cited on the previous annual survey (02/28/12) which had not been corrected. (Refer to K 0027)</p> <p>Findings include: Observation, on 05/14/13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed the cross-corridor doors located at rooms # 402, 602, 201, 101, 112, and next to the main dining room 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. Further observation revealed the doors at room #502 had a coordinating device that was not functioning properly.</p>	F 490	<p>F 490</p> <ol style="list-style-type: none"> 1. Cross-corridor doors (402, 602, 201, 101, 112 and the ones next to the dining room) were adjusted to close completely on 5/20/13 by the Maintenance dept. The coordinating device was repaired by a contractor at room 502 to ensure it was functioning properly by 6/28/13. 2. Doors were inspected by the Maintenance dept to ensure proper closure and that gaps would prevent the passage of smoke by 5/30/13. 3. The Maintenance Dept and staff were in-serviced on the proper amount of gaps between doors and to ensure coordinating devices function properly by the Administrator on 5/31/13. This will also be added to our general orientation. The Administrator was in-serviced by the Divisional Vice President to ensure resources are administered in a manner that enables the facility to use them effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident on 5/28/13. The Administrator will perform random audits of the doors listed below to maintain compliance. 4. The Maintenance Dept will audit doors to ensure that the smoke doors close properly and maintain an appropriate smoke barrier for 4 weeks then monthly times 2 months. The Administrator or Asst. Administrator 		

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F 490	Continued From page 18 Interview, on 05/14/13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed he was unaware the doors would not close all the way leaving a gap between the doors in the closed position. Further interview revealed the doors were a large focus at the facility since they were cited last survey. He stated they have a computer program TELS that triggers them to audit the doors monthly. Interview, on 05/15/13 at 10:41 AM with the Administrator, revealed she was unaware of how the maintenance personnel conduct the monthly audits of the cross-corridor doors at the facility. The Administrator revealed that she conducted training on 03/23/12 that followed the plan of correction but she was unaware of the allowable gap in the cross-corridor doors. Further interview revealed that reporting gaps in the corridor doors was discussed in the training that was conducted on 03/23/12 but she could not recall if the maximum allowable gap was discussed in the training. This is a repeat deficiency.	F 490	will audit doors times 5 weekly times 2 months, 5 doors monthly times 2 then 5 doors randomly month. The results of the audits will be presented to the QA committee to determine the need for further monitoring. 5. Date completed:	6/12/13	

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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 installed in 1968 and upgraded March 2012, with 102 smoke detectors and 09 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1968.</p> <p>GENERATOR: Type II generator installed in 1996. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 05-14-13 to 05-15-13. Parkview Nursing and Rehab Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Two-Hundred Twenty-Eight (228) beds with a census of Two-Hundred Nine (209) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</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>Ann M... Eric Director</i>	TITLE	(X6) DATE 7-22-13
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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	K 000			
K 018 SS=E	<p>Regulations, 483.70(a) et seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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 corridor doors of resident rooms were in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of twelve (12) smoke compartments, twenty (20) residents, staff and</p>	K 018	<p>1. The trashcan was removed from in front of resident room #405 on 5-16-13 by the Maintenance staff. The corridor doors to rooms # 601,310,312,208,209, and 107 have been adjusted by the Maintenance staff to ensure they latch properly by 5-20-13. The gap above the door of room 909 was adjusted to ensure proper closing and that it met the standard concerning the passage of smoke by the Maintenance staff on 6/5/13.</p> <p>2. The Maintenance dept checked all other doors for proper closing and to ensure they met the standard of passage of smoke by 5/30/13.</p> <p>3. The Maintenance dept and staff were educated by the ED to ensure nothing blocks resident's doors from closing and to monitor for gaps in the doors above 1/8" and report any issues to the Maintenance dept promptly on 5/31/13.</p> <p>4. Maintenance dept will audit 50 doors per week to ensure proper closure and monitor for proper gap width in doors. Then 50 doors per month for an additional 2 months. Results of the audits will be presented to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by:</p>	6/12/2013	

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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	
(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 018	<p>Continued From page 2</p> <p>visitors. The facility is certified for Two-Hundred Twenty-Eight (228) beds with a census of Two-Hundred Nine (209) on the day of the survey. The facility failed to ensure resident doors could be closed with a single motion, and doors would properly latch.</p> <p>The findings include:</p> <p>Observations, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed the corridor doors to the resident rooms were blocked from closing. The rooms affected by this were room 's# 405 bed blocking door and 808 had trash can blocking door.</p> <p>Interviews, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed he was unaware the items were blocking the doors from closing.</p> <p>Observations, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed the corridor doors to rooms# 601, 310, 312, 311, 208, 209, 107 would not latch properly. Further observation revealed the door to room# 909 had a gap at the top of the door.</p> <p>Interview, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed he was unaware of doors not latching and revealed he was unaware these doors were not latching properly. The Director of Maintenance was aware that all resident room doors must latch in the event of an emergency.</p> <p>Reference: NFPA 101 (2000 edition)</p>	K 018		

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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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K 018	Continued From page 3 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. 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: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 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 19.3.6.3.3* Hold-open devices that release when the door is	K 018			

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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		
(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 018	Continued From page 4 pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018			
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect twelve (12) of twelve (12) smoke compartments, all residents, staff and visitors. The facility is certified for Two-Hundred Twenty-Eight (228) beds with a census of Two-Hundred Nine (209) on the day of the	K 025	K025 1. The smoke partitions, extending above the ceiling located at rooms # 601, 501, 101, 201, 301, 401, and 902 have been repaired by our maintenance dept and contractors by 6/28/13. The Maintenance director has obtained the fire rating of the insulation material used at the top of the barriers. 2. The Maintenance dept has inspected smoke partitions to ensure they maintain a smoke barrier that is acceptable as of 6/21/13. 3. The Maintenance dept was in-serviced on 5/31/13 by the Administrator on maintaining proper smoke barriers between compartments and to keep spec sheets on any types of insulation materials used. They also were in-serviced on 5/31/13 to monitor the		

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 644 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 025	<p>Continued From page 5</p> <p>survey. The facility failed to ensure nine (9) smoke barriers were sealed around pipes and wires to resist the passage of smoke.</p> <p>The findings include:</p> <p>Observations, on 05-14-13 between 10:40 AM and 12:00 PM with the Director of Maintenance, revealed the smoke partitions, extending above the ceiling located at room# 601, 501, 101, 201, 301, 401, 112, and at 902 were penetrated by pipes and wires. Further observation revealed the walls at the dining area, room# 411, the kitchen and at 511 had insulation stuffed in the top of the barrier and no paperwork on the fire rated time of that material.</p> <p>Interview, on 05-14-13 between 10:40 AM and 12:00 PM with the Director of Maintenance, revealed he was unaware of the penetrations in the smoke barriers as the facility only monitored the corridor areas. Further interview revealed he was unaware of the rating of the insulation material used at the top of the barriers.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed 	K 025	<p>corridors and all parts of the smoke compartments by the Administrator.</p> <ol style="list-style-type: none"> 4. The Maintenance dept will audit 10 smoke compartments per week to ensure the proper smoke barrier has been maintained and will check to ensure any contractors/ our staff in the building leave us proper paperwork on insulation used. Then the Maintenance dept will monitor 10 compartments per month for an additional 2 months. The results of the audits will be presented to the QA committee to determine the need for further auditing. 5. Completed by: 	6/28/13

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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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K 025	Continued From page 6 for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025			
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 027	K 027 1. The Maintenance dept. adjusted the cross-corridor doors at rooms 602, 210, 101 and 112 and next to the main dining room to ensure they close completely to prevent the passage of smoke by 5/20/13. The contractors repaired the door located near 402 by 6/28/13. The door at 502 was		

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K 027	<p>Continued From page 7</p> <p>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 nine (9) of twelve (12) smoke compartments, two-hundred four (204) residents, staff and visitors. The facility is certified for Two-Hundred Twenty-Eight (228) beds with a census of Two-Hundred Nine (209) on the day of the survey. The facility failed to ensure seven (7) doors in the smoke barriers had a gap less than 1/8 inch where the doors meet. Furthermore the facility was cited this deficiency previously on 02-28-12 regarding the cross-corridor doors, the facility conducts monthly audits which failed to identify these issues.</p> <p>The findings include:</p> <p>Observation, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed the cross-corridor doors located at room # 402, 602, 201, 101, 112, and next to the main dining room 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. Further observation revealed the doors at room# 502 had a coordinating device that was</p>	K 027	<p>adjusted by the Maintenance dept on 5/21/13. Maintenance dept also added additional door stripping to ensure the safety of our residents and reduce the gap on 7/19/13.</p> <ol style="list-style-type: none"> The Maintenance dept checked all other doors for proper closing and to ensure they met the standard of the passage of smoke by 5/30/13. The Maintenance dept and staff were educated by the ED to ensure nothing blocks resident's doors from closing and to monitor for gaps in the doors above 1/8" and report any issues to the Maintenance dept promptly on 5/31/13. The Maintenance dept will audit 50 doors per week to ensure proper closure and monitor for proper gap width in doors. Then 50 doors per month for an additional 2 months. Results of the audits will be presented to the QA committee to determine the need for further monitoring. Completed by: _____ 	7/19/13

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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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K 027	<p>Continued From page 8 not functioning properly.</p> <p>Interview, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed he was unaware the doors would not close all the way leaving a gap between the doors in the closed position. Further interview revealed the doors were a large focus at the facility since they were cited last survey. He stated they have a computer program TELS that triggers them to audit the doors monthly.</p> <p>Interview, on 05-15-13 at 10:41 AM with the Administrator, revealed she was unaware of how the maintenance personnel conduct the monthly audits of the cross-corridor doors at the facility. The Administrator revealed that she conducted training on 03-23-12 that followed the plan of correction but she was unaware of the allowable gap in the cross-corridor doors. Further interview revealed that reporting gaps in the corridor doors was discussed in the training that was conducted on 03-23-12 but she could not recall if the maximum allowable gap was discussed in the training.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7</p>	K 027		

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K 027	Continued From page 9 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of twelve (12) smoke compartments, fifty-seven (57) residents, staff and visitors. The facility is certified for Two-Hundred Twenty-Eight (228) beds with a census of Two-Hundred Nine (209) on the day of the survey. The facility failed to ensure all egress doors had the proper signage for delayed egress doors. The findings include: Observation, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed three doors in the facility were equipped with signage for the delayed egress doors with no contrasting background on the signs.	K 038	K038 1. New signs were made for each of the delayed egress doors to include a contrasting background for each sign. They were replaced by the maintenance dept on 5/27/13. 2. Delayed egress doors had new stickers applied with a contrasting background by the maintenance dept on 5/27/13. 3. The Maintenance dept and staff were in-serviced by the Administrator of the need for contrasting backgrounds on our signs of delayed egress doors on 5/31/13. 4. The Asst. Administrator will audit the delayed egress doors to ensure the stickers remain intact with the contrasting backgrounds weekly for 4 weeks then monthly for 2 additional months. The results of the audits will be presented to the QA committee to determine the need for further monitoring. 5. Completed by:	6/12/2013

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K 038	Continued From page 10 Interview, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed he was unaware the signs must have a contrasting background. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 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,	K 038			

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K 038	<p>Continued From page 11</p> <p>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> <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</p>	K 038		

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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	
K 038	Continued From page 12 not exceeding 30 seconds shall be permitted. (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	K 038			
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	K 051 1. The pull stations at the laundry exit, wing 3 exit, wing 2 exit and outpatient and front entrances were moved within 5 feet of the exit door by a contractor by 6/28/13. 2. All other pull stations were located within 5 feet of an exit door or met the standard of the fire alarm system with approved components and/or equipment by observation from our maintenance dept on 6/6/13. 3. The Maintenance dept and staff were serviced by the Administrator of the requirement to have pull stations within 5 feet of an exit door on 5/31/13. 4. The Asst. Administrator will audit 5 exits per week to ensure we have pull stations within 5 feet of an exit then will audit 5 exits per month for an additional 2 months. The results of the audits will be presented to the QA committee to determine the need for further monitoring. 5. Completed by:	6/28/13	

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K 051	<p>Continued From page 13</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficiency had the potential to affect five (5) of twelve (12) smoke compartments, all residents, staff and visitors. The facility is certified for Two-Hundred Twenty-Eight (228) beds with a census of Two-Hundred Nine (209) on the day of the survey. The facility failed to ensure five (5) exits had a manual fire alarm pull station located within 5 feet of the door.</p> <p>The findings include:</p> <p>Observation, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed the laundry exit, wing 3 exit, wing 2 exit, the front entrance, and the outpatient therapy exit did not have a manual pull station located within 5 feet of the exit door.</p> <p>Interview, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed some of the exits had been moved and new exits were added. He was unaware of the requirement to have a fire pull located at each exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.4.2* Initiation. Initiation of the required fire alarm systems shall</p>	K 051		

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K 051	Continued From page 14 be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems. Exception No. 1: Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses' control stations or other continuously attended staff location, provided that such manual fire alarm boxes are visible and continuously accessible and that travel distances required by 9.6.2.4 are not exceeded.	K 051		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, in accordance with NFPA standards. The deficiency had the potential to affect twelve (12) of twelve (12) smoke compartments, all residents, staff and visitors. The facility is certified for Two-Hundred Twenty-Eight (228) beds with a census of Two-Hundred Twenty-Eight (209) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated. The findings include: Observation, on 05-14-13 between 10:40 AM and 4:30 PM with the Director of Maintenance, revealed several stuffed animals, wreaths, and	K 073	K 073 1. Social Services removed stuffed animals for decoration and had maintenance spray flame retardant on any residents combustible items by 7/31/13. 2. All residents benefit when from having combustible items sprayed with flame retardant and logged. 3. Staff were in-serviced on 7/26/13 by SDC to ensure any combustible item brought into the facility will be fire treated by maintenance and logged appropriately. 4. Social Services will audit 5 rooms per week for 4 weeks then 5 monthly x 2 months on each hallway to ensure combustible decorations/stuffed animals have been properly treated with fire retardant. Results of the audits will be presented to the QA Committee to determine the need for further monitoring. 5. Completed by	7/31/13

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K 073	Continued From page 15 artificial floral arrangements throughout the facility had no documentation of flame retardant being applied. Interview, on 05-14-13 between 10:40 AM and 4:30 PM with the Director of Maintenance, revealed he was unaware combustible decorations brought into the facility were required to be treated with a fire retardant spray. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 076		

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K 076	<p>Continued From page 16</p> <p>determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect three (3) of twelve (12) smoke compartments, one-hundred forty (140) residents, staff and visitors. The facility is certified for Two-Hundred Twenty-Eight (228) beds with a census of Two-Hundred Twenty-Eight (209) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored 5 feet away from any combustibles and ignition sources were located five (5) feet from the floor.</p> <p>The findings include:</p> <p>Observation, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed twenty-five (25) oxygen tanks in the Fall Prevention/O2 room on 6, 7, 8; fifteen (15) tanks stored in the 200 hall; and sixty-five (65) tanks stored in the O2 room on wing 10. The oxygen tanks were being stored within five (5) feet of combustible items and ignition sources were not located over five (5) feet from the floor.</p> <p>Interview, on 05-14-13 between 2:33 PM and 4:30 PM with the Director of Maintenance, revealed he was unaware oxygen tanks could not be stored within five (5) feet of combustible materials and all electrical ignition sources must be located five (5) feet from the floor once the storage equals over 300 cubic feet in a smoke compartment.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than</p>	K 076		

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K 076	Continued From page 17 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside	K 076			

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K 076	Continued From page 18 storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076		
K 103 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to construct a wall using noncombustible or limited combustble materials in a noncombustible structure 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 certified for Two-Hundred Twenty-Eight (228) beds with a census of Two-Hundred Twenty-Eight (209) on the day of the survey. The facility failed to ensure two (2) walls were properly completed in the facility. Findings include: Observation, on 05-15-13 at 8:54 AM with the Director of Maintenance, revealed that the wall that separated back of the dryers from the laundry was constructed of non-listed, ordinary, two by four wood framing materials covered with sheet rock. The wood framing was visible on the inside, unfinished wall of the room that was not covered with sheet rock. Further observation revealed the wall that separated the dirty linen sorting area from the laundry was not complete to	K 103		

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K 103	<p>Continued From page 19 the ceiling.</p> <p>Interview, on 05-15-13 at 8:54 AM with the Director of Maintenance, revealed the facility was not aware of the requirement to prohibit the use of combustible materials for interior walls and partitions in Type II buildings.</p> <p>Reference: (NFPA 101 2000 ed.) 19.1.6.3 All interior walls and partitions in buildings of Type I or Type II construction shall be of noncombustible or limited-combustible materials. Exception:* Listed, fire-retardant-treated wood studs shall be permitted within non-load bearing 1-hour fire-rated partitions.</p>	K 103	