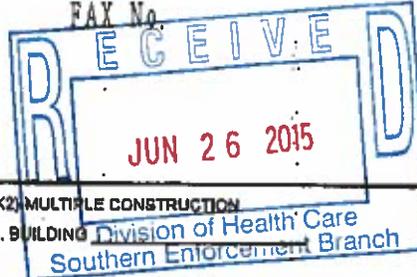


JUN/26/2015/FRI 12:54 PM

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P. 005

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

PRINTED: 06/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186266	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>Division of Health Care Southern Enforcement Branch</u> B. WING _____	(X3) DATE SURVEY COMPLETED C 06/04/2015
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 F 246 SS=E	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY23313) was initiated on 06/03/15 and concluded on 06/04/15. The complaint was substantiated with deficient practice identified at "E" level.</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility policy it was determined the facility failed to ensure residents' needs were accommodated by ensuring the residents' call lights were within reach for six (6) of thirty-six (36) residents who resided on the facility's third floor. Observations conducted during the initial tour of the facility revealed Resident #3, Resident #4, Resident A, Resident B, Resident C, and Resident D's call lights were not within reach for resident use. Interviews revealed staff was required to ensure call lights were within reach of the residents at all times.</p> <p>The findings include: Review of the facility policy titled "Call Light," dated 11/30/14 revealed call lights would be</p>	F 000 F 246	<p>F-246</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.</p> <ol style="list-style-type: none"> On June 3, 2015 Residents #3, #4, A, B, and C had their call lights placed within reach immediately after being brought to the attention of the Assistant Director of Clinical Services (ADCS) by the State Survey Agency (SSA). All residents have the potential to be affected by the failure to ensure call lights are within reach. On June 3, 2015 the Director of Clinical Services (DCS), ADCS and the Certified Nursing Assistant (CNA) Preceptor made rounds to ensure the call lights were in reach for current in-house residents; any other issues identified were corrected immediately. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE 06-26-15
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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.

JUN/26/2015/FRI 12:54 PM

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P. 006

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2015
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601		
(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 246	<p>Continued From page 1</p> <p>answered promptly by all staff. The policy did not address or instruct staff to ensure call lights were within reach of facility residents.</p> <p>1. Review of the medical record for Resident #3 revealed the facility admitted the resident on 05/28/15 with diagnoses that included Difficulty Walking, Muscle Weakness, and Lack of Coordination. A Minimum Data Set (MDS) Assessment had not been completed related to the resident's recent admission. However, an interview with the facility Social Worker (SW) on 06/03/15 at 4:15 PM revealed the resident was interviewable with a Brief Interview for Mental Status (BIMS) score of 15. The Social Worker also stated the resident required extensive assistance of two staff members for ambulation and toileting.</p> <p>Observations and interview of Resident #3 on 06/03/15 at 1:35 PM revealed the resident was lying in bed and upon the surveyor entering the room the resident stated, "Sugar, where is my call light?" Observations revealed the resident's call light was at the top of the resident's headboard, out of reach of the resident. The resident stated staff was "always putting my call light where I can't find it."</p> <p>2. Review of the medical record for Resident #4 revealed the facility admitted the resident on 05/15/15 with diagnoses that included Venous Stasis Ulcers to right lower extremity and Dementia. The resident was not interviewable per the Admission MDS and required extensive assistance of two staff members for transferring and bathing. The record review revealed the resident had experienced a fall on 05/21/15 with no serious injury.</p>	F 246	<p>3. On 06/04/2015 and 06/05/2015 the ADCS and the CNA Preceptor in-serviced the nursing staff that call lights are to be within resident's reach at all times.</p> <p>4. The DCS/Nurse Manager will conduct Quality Improvement (QI) monitoring of the regulation F246 to ensure the accommodation of resident needs by ensuring call lights are within reach. QI monitoring will be conducted via observations across all three shifts five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months and/or until substantial compliance is obtained alternating shifts using a sample size of five random residents. The DCS/Nurse Manager will report findings to two quarterly Quality Assurance Performance Improvement (QAPI) committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to</p>		

JUN/26/2015/FRI 12:54 PM

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P. 007

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2016
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 246	Continued From page 2 Observations of Resident #4 on 06/03/15 at 1:45 PM revealed the resident's bed was in a low position, a fall alarm was present, and fall mats had been placed on the floor on both sides of the resident's bed. Resident #4's call light was observed on the floor to the right side of the resident's bed and was not within reach of the resident. 3. Review of the Certified Nurse Aide (CNA) Kardex and information face sheet for Resident A revealed the facility admitted the resident on 08/19/14 with diagnoses that included Difficulty Walking, Muscle Weakness, and Lack of Coordination. Resident A required extensive assistance of two staff members for transfers and ambulation. Facility staff had assessed the resident to have a BIMS score of 4 and the resident was not interviewable. Observations conducted on 06/03/15 at 1:48 PM revealed the resident's call light was under the resident's mattress, not within reach of the resident. 4. Review of the CNA Kardex and Information face sheet for Resident B revealed the facility admitted the resident on 02/21/14 with diagnoses that included Debility and Anxiety. Continued review revealed Resident B required assistance of two staff members for bed mobility and transfers. Facility staff assessed the resident to not be interviewable. Observations on 06/03/15 at 1:50 PM revealed Resident B was lying on his/her right side in bed and the resident's call light was attached to the left side of the resident's bed, out of reach of the	F 246	be taken and determine the continued time schedule for further monitoring. 5. Date of Compliance: July 10, 2015		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 246	<p>Continued From page 3 resident.</p> <p>5. Review of the CNA Kardex and information face sheet for Resident C revealed the facility admitted the resident on 10/23/14 with diagnoses that included Muscle Weakness and Difficulty in Walking. Resident C required assistance of two staff members for bed mobility and transfers. Facility staff assessed the resident to not be interviewable.</p> <p>Observations of Resident C on 06/03/15 at 1:52 PM revealed the resident's call light was attached to the top of the resident's pillow, out of reach of the resident.</p> <p>6. Review of the CNA Kardex and information face sheet for Resident D revealed the facility admitted the resident on 09/23/14 with diagnoses that included Depression and Osteoarthritis. Resident D required assistance of two staff members for bed mobility and ambulation. Facility staff assessed the resident to not be interviewable.</p> <p>Observations on 06/03/15 at 1:58 PM revealed the resident's bed was in a low position and a bed alarm was in use to the resident's bed. The resident's call light was on the floor on the right side of the resident's bed, out of reach of the resident.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 06/03/15 at 4:44 PM revealed she had been trained to ensure call lights were within reach of the residents at all times. The SRNA stated she was assigned to provide care to facility residents whose call lights were observed to not be within reach. SRNA #1 stated she was unsure</p>	F 246			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 156268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2015
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601		
(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 246	Continued From page 4 why call lights were not within reach as required. Interview with the Assistant Director of Nursing (ADON) on 06/03/15 at 2:45 PM revealed staff had been trained to ensure call lights were within reach of the residents at all times. He stated he ensured call lights were within reach by making walking rounds. The ADON stated he had made walking rounds prior to the surveyor's arrival on 06/03/15, but had not identified that the resident's call lights were not within reach. Interview with the Director of Nursing (DON) on 06/04/15 at 2:00 PM revealed staff had been trained to ensure call lights were within reach of facility residents. The DON stated rounds were conducted daily, and no concerns had been identified related to call lights being within reach of facility residents.	F 246			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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.	F 441	F-441 1. Residents #3, B, and C showed no apparent harm. 2. Residents who reside in the center have the potential to be affected by failing to maintain infection control practices including changing gloves when they become contaminated while providing incontinent care.		

JUN/26/2015/FRI 12:55 PM

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601		
(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 441	<p>Continued From page 6</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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility policy it was determined the facility failed to establish and maintain an effective Infection control program related to incontinence care provided to facility residents for one (1) of four (4) sampled residents (Resident #3) and two (2) of four (4) unsampled residents (Residents B and C). Observations conducted of Incontinence care revealed staff failed to change their gloves when they became contaminated when incontinence care was provided to facility residents.</p> <p>The findings include:</p>	F 441	<p>3. The Regional Director of Clinical Services (RDCS) re-educated the Director of Clinical Services (DCS) on June 04, 2015 on maintaining infection control practices including changing gloves when they become contaminated while providing incontinent care.</p> <p>The (DCS) re-educated the ADCS and the CNA preceptor on maintaining infection control practices while providing incontinence care. The DCS/ADCS/CNA Preceptor will have the nursing staff re-educated on maintaining infection control practices including changing gloves when they become contaminated while providing incontinent care by June 30, 2015.</p> <p>4. The DCS/Nurse Manager will conduct Quality Improvement (QI) monitoring of the regulation F441 to ensure infection control practices are</p>		

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41601		
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F 441	<p>Continued From page 6</p> <p>Review of the facility policy titled "Incontinent Resident Care," dated 11/30/14 revealed incontinence care would be provided to residents to ensure adequate skin care, control odor, and provide personal hygiene. The policy instructed staff to wear disposable gloves, but did not address the need for staff to change gloves when contamination occurred.</p> <p>1. Review of the Certified Nursing Assistant (CNA) Kardex and information face sheet for Resident B revealed the facility admitted the resident on 02/21/14 with diagnoses that included Debility and Anxiety. Continued review revealed Resident B required assistance of two staff members for toileting and was incontinent of bowel and bladder. Facility staff assessed the resident to be non-interviewable.</p> <p>Observations conducted of incontinence care for Resident B on 06/03/15 at 3:00 PM revealed staff provided perineal care, cleaned urine from the resident, and discarded a urine-soiled brief. Staff was observed to apply a clean brief, touch the resident's clothing, linen, and bed railing without discarding the urine-contaminated gloves.</p> <p>2. Review of the CNA Kardex and information face sheet for Resident C revealed the facility admitted the resident on 10/23/14 with diagnoses that included Muscle Weakness and Difficulty In Walking. Resident C required assistance of two staff members for bed mobility and transfers. Facility staff assessed the resident to be non-interviewable.</p> <p>Observations conducted of incontinence care for Resident C on 06/03/15 at 3:15 PM revealed staff</p>	F 441	<p>maintained while providing Incontinent care. QI monitoring will be conducted via observations across all three shifts five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months and/or until substantial compliance is obtained alternating shifts using a sample size of five random employees while providing incontinent care. The DCS/Nurse Manager will report findings to two quarterly Quality Assurance Performance Improvement (QAPI) committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> <p>5. Date of compliance: July 10, 2015</p>		

JUN/26/2015/FRI 12:56 PM

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 7</p> <p>provided perineal care and cleaned urine and stool from the resident. After cleaning urine and stool from the resident, staff was observed to apply a clean brief and touch the resident's clothing with soiled gloves. Staff was observed to also change the resident's gown, and touch the resident's bed linen and bed railing without removing the contaminated gloves.</p> <p>3. Review of Resident #3's medical record revealed the facility admitted the resident on 05/28/15 with diagnoses that included Difficulty Walking, Muscle Weakness, and Lack of Coordination. A Minimum Data Set (MDS) Assessment had not been completed related to the resident's recent admission. However, an interview with the facility Social Worker (SW) on 06/03/15 at 4:15 PM revealed Resident #3 was interviewable with a Brief Interview for Mental Status (BIMS) score of 15. The Social Worker also stated the resident required extensive assistance of two staff members for ambulation and toileting.</p> <p>Observations conducted of incontinence care for Resident #3 on 06/03/15 at 3:35 PM revealed staff provided perineal care, cleaned urine from the resident, and discarded a urine-soiled brief. Staff was observed to apply a clean brief and touch the resident's clothing, linen, and bed railing without changing the gloves, which had been contaminated from urine.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 06/03/15 at 4:44 PM revealed she had provided incontinence care that was observed to Resident #3 and Resident B. The SRNA acknowledged she failed to change her gloves after they became contaminated when</p>	F 441			

JUN/26/2015/FRI 12:57 PM

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P. 013

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 290 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 8</p> <p>Incontinence care was provided. SRNA #1 stated she had not been trained to change gloves after they became contaminated when providing incontinence care to facility residents.</p> <p>Interview with SRNA #2 on 06/03/15 at 5:05 PM revealed she had provided incontinence care to Resident C. The SRNA acknowledged she failed to change her gloves after she cleaned urine and stool from the resident. SRNA #2 stated she should have changed her gloves after she cleaned urine and stool from the resident and further stated she had never been trained to do so.</p> <p>Interview with the facility's Education Coordinator (EC) on 06/04/15 at 2:20 PM revealed she was responsible for training and ensuring SRNAs were providing incontinence care appropriately to facility residents. The EC stated she had not trained staff and was not aware staff was required to change their gloves after they became contaminated with urine or stool. The EC stated "that does make sense though" and it could be "an infection control issue."</p> <p>Interview with the Director of Nursing (DON) on 06/04/15 at 1:45 PM revealed she was not aware how SRNAs had been trained to provide incontinence care. The DON stated the EC was responsible to ensure infection control measures were appropriate when incontinence care was provided to facility residents. The DON stated the failure to change gloves after they became contaminated with urine or stool was an infection control concern for facility residents.</p>	F 441			