

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



PRINTED: 02/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED  C 02/14/2014
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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 000	INITIAL COMMENTS	F 000		
F 425 SS=E	<p>An abbreviated standard survey (KY21271) was initiated on 02/12/14 and concluded on 02/14/14. The complaint was substantiated with deficient practice identified at "E" level.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's investigation and policies, it was determined the facility failed to ensure a system was in place for the receipt and disposition of controlled/narcotic medications for one of three sampled residents (Resident #1).</p>	F 425	<p>Parkview Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction, to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care and safety of the residents. The plan of correction is submitted as a written allegation of compliance. Parkview Nursing and Rehabilitation Center's response to this State of Deficiencies and Plan of Correction does not denote agreement with the statement of deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Parkview Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the state deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal, and/or any other administrative or legal proceedings.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X5) DATE <i>03/07/14</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time Mar. 7. 2014 1:16PM No. 4130

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NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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F 425	<p>Continued From page 1</p> <p>The facility attempted to re-order a medication for Resident #1 on 01/25/14 and was informed by the pharmacy the resident should have an individual controlled/narcotic medication card with thirty (30) pills still available. The facility failed to identify discrepancies in the counts of the medications that were secured to the individual controlled/narcotic medication cards (cards that contained controlled/narcotic medications) and the individual declining inventory sheet (used by staff to document when a medication was removed from the controlled/narcotic medication card to show the number of medications that remained) prior to the pharmacy notification. Interview with the Director of Nursing revealed the system staff utilized to monitor receipt and disposition of narcotic medications was used on all three floors of the facility's resident care areas.</p> <p>The findings include:</p> <p>A review of the facility policy, Acceptance of Controlled Drugs, revision date of 01/04/13, revealed controlled drugs, including narcotics, would be delivered to the facility by the pharmacy. According to the policy, two nurses would sign receipt of the medications on the pharmacy delivery slip. Continued review of the policy revealed the medications would be placed into the medication cart by the nurses that received the medication from the pharmacy and the individual declining inventory sheet from the pharmacy would be placed in the Narcotic Book.</p> <p>A review of the facility's policy, Controlled Drug Count, revision date of 01/04/13, revealed the "on coming" and the "off going" nurses assigned to a medication cart were responsible to ensure the accuracy of the controlled drug count. Continued</p>	F 425	<p>F 425</p> <ol style="list-style-type: none"> <li>1. Resident #1 experienced no negative outcome and was never without his/her prescribed medication as the facility purchased emergency replacement medication from the pharmacy at no cost to the resident. On 1/25/14, upon notification by a nurse, the Director of Nursing initiated an investigation into the allegedly missing medication. At this time, the Director of Nursing made the necessary notifications to all federal and state agencies on behalf of Resident #1. The Director of Nursing completed her investigation on 1/29/14 and the results were faxed to the appropriate federal agency on behalf of Resident #1. By 1/31/14, the Assistant Director of Nursing had reeducated the Licensed Nurses on receiving medications into the facility.</li> <li>2. All residents who receive controlled/narcotic medications have the potential to be affected by the facility's failure to ensure a system was in place for the receipt and disposition of controlled/narcotic medications. By 3/7/14, the Nurse Unit Managers for each unit, the Director of Nursing, and the Assistant Director of Nursing had audited each residents' narcotic order,</li> </ol>	03/19/2014	

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F 425	<p>Continued From page 2</p> <p>review of the policy revealed the two nurses were to count the number of individual controlled drugs by observing each medication and verifying that the number of individual controlled drugs matched the number on the individual declining inventory sheet. Further review of the policy revealed the two nurses would count the number of the individual declining inventory sheets and the individual narcotic medication cards to verify that the number of the individual declining inventory sheets matched the number of individual narcotic medication cards. According to the policy, staff was to record the number of both the individual controlled/narcotic medication cards and the individual declining inventory sheets on the Controlled Drug Count Sheet.</p> <p>A review of the facility's investigation revealed on 01/25/14, a nurse attempted to order a controlled medication from the pharmacy for Resident #1 and was informed by the pharmacy the resident should have a controlled/narcotic card that contained 30 pills still available at the facility. Continued review of the investigation revealed the facility had verified the pharmacy had delivered two controlled/narcotic medication cards to the facility for Resident #1 on 01/09/14. Further review of the investigation revealed the facility had not identified any discrepancies in the controlled/narcotic counts.</p> <p>Observations on 02/12/14 at approximately 11:20 AM of the individual controlled/narcotic medication cards and individual declining inventory sheets on the medication carts, located on the fourth floor, with Registered Nurse (RN) #2 and Licensed Practical Nurse (LPN) #2 revealed the controlled/narcotic count was accurate; however, observation of the Controlled Drug</p>	F 425	<p>their controlled/narcotic medication cards, and their declining inventory sheets to ensure all residents have their prescribed narcotics available. No discrepancies were noted.</p> <p>3. a. On 3/6/14, the Director of Nursing consulted with the facility's licensed pharmacist concerning the facility's identified deficient practice. From now on, the pharmacy will initiate a declining inventory sheet that will be capable of documenting up to 120 tablets and, regardless of the number of tablets sent, there will only be one sheet for each. The label on the medication packet will now reflect the number of tablets sent and will indicate the number of packets to correspond with the label on the declining inventory sheet.</p> <p>b. Beginning 3/7/14, the delivery sheet from the pharmacy that accompanies the delivery of controlled/narcotic medications will be signed by two nurses and placed in the controlled/narcotic book for each medication cart. In addition to the traditional reconciliation of the medications with the declining inventory sheets, each shift, nurses will reconcile the medications and the</p>		

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F 425	<p>Continued From page 3</p> <p>Count Sheet revealed staff had made numerous changes to the number of controlled/narcotic medication cards and the number of individual declining inventory sheets that remained, but failed to document an explanation of why the changes were made. Based on the review, staff had not always ensured the accuracy of the controlled/narcotic count and had failed to verify the previous controlled/narcotic counts to determine if the medications that remained were accurate. Interviews on 02/12/14 with RN #2 at 11:20 AM and with LPN #2 at 12:02 PM also revealed the nursing staff had only counted the inventory sheets and medication cards and if that came out correctly then they documented the count was accurate.</p> <p>Interview on 02/12/14 at 11:20 AM with RN #2 revealed the controlled/narcotic medications were counted at the beginning and end of each shift or when another nurse was "taking over" the medication cart. The interview further revealed the controlled/narcotic medication cards were compared to the individual declining inventory sheet to ensure the correct number of medications remained in each card. The RN further revealed the number of controlled/narcotic medication cards and individual declining inventory sheets were each counted and if the number matched she "thought" the count was correct. The RN acknowledged she did not always look at the previous count to confirm her count was correct.</p> <p>Interview on 02/12/14 at 12:02 PM with LPN #2 revealed at the beginning and end of each shift the controlled/narcotic medications were counted by the "on coming" and "off going" nurses. Continued interview revealed the</p>	F 425	<p>declining inventory sheets delivered the night before with the medications and the declining inventory sheets present. The nurses will contact the Director of Nursing if any discrepancy in any part of the process is noted and the Director of Nursing will initiate an investigation.</p> <p>c. By 3/7/14, the Assistant Director of Nursing had reeducated the Licensed Nurses on the facility policy for "Acceptance of Controlled Drugs (revision 01/04/13)", the facility policy for "Controlled Drug Count", the new procedure for reconciliation (see step 3b), and the facility's requirement to provide routine and emergency drugs and biologicals to its residents, provide pharmaceutical services to meet the needs of each resident, and to employ the services of a licensed pharmacist for consultation. This education included that if a change was made to the number of controlled/narcotic medication cards and/or the number of individual declining inventory sheets an explanation for the change must be documented.</p> <p>4a. The Nurse Unit Managers will QA</p>	

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F 425	<p>Continued From page 4</p> <p>controlled/narcotic medication cards were compared to the individual declining inventory sheet to ensure the correct number of medications remained in each card. The LPN further revealed the number of controlled/narcotic medication cards and the number of individual declining inventory sheets were counted and if the number matched the count was considered correct. The LPN acknowledged she did not always look at the previous count to ensure the count was accurate.</p> <p>Interview on 02/13/14 at 1:15 PM with RN #1 revealed the facility received medications on the night shift. According to RN #1, the nurse assigned to the third floor would go to the fourth and fifth floors in order to sign the pharmacy delivery sheet with the nurses assigned to the fourth and fifth floors. The interview further revealed the nurse assigned to each floor would place the individual controlled/narcotic medication cards in the medication cart and place the individual declining inventory sheets in the controlled/narcotic book. Continued interview revealed the nurses on the night shift did not add the medications to the Controlled Drug Count Sheets at the time the medications were received. RN #1 stated the medications were added during the next narcotic count at the end of the night shift. Further interview with the RN revealed she did not always review the previous narcotic counts if the numbers between the controlled/narcotic medication cards and individual declining inventory sheets matched.</p> <p>Interview on 02/14/14 at 4:35 AM with LPN #1 revealed the pharmacy had delivered two controlled/narcotic medication cards and one declining inventory sheet for Resident #1 on</p>	F 425	<p>monitor 25% of residents' controlled/narcotic medication cards, declining inventory sheets and delivery sheets for accuracy 5 x weekly for 4 weeks, the weekly for 2 months. Any discrepancy will be reported to the Director of Nursing for reeducation and disciplinary follow up as needed.</p> <p>b. The results of the Nurse Unit Managers' QA will be reported to the Quality Assurance Committee monthly for 3 months for development of an action plan as needed.</p> <p>c. The Director of Nursing will meet monthly for 3 months with the licensed pharmacist to ensure consultation on all aspects of the provision of pharmacy services in the facility.</p>		

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F 425	Continued From page 5 01/09/14. The interview further revealed the third floor nurse has to come to each floor with the person from Pharmacy and both nurses sign the delivery sheet and the floor nurse placed the controlled/narcotic medications in the medication cart. Continued interview revealed the facility did not require the nurse to add the medication to the Controlled Drug Count Sheet at the time the medication was received; however the controlled/narcotic medication cards and individual declining inventory sheets would be added during the next controlled/narcotic count with the "on coming" shift nurse. The LPN also revealed she did not always verify that the number of the current medication/narcotic count matched the previous count and added she "thought" the count was correct if the number of individual controlled/narcotic medication cards and individual declining inventory sheets matched.  Interview on 02/12/14 at 1:15 PM with the Director of Nursing (DON) revealed administrative staff counted the controlled/narcotic medication cards and individual declining inventory sheets on the medication carts each week, and if the number of individual controlled/narcotic medication cards matched the individual declining inventory sheets number the count would be considered accurate. The DON acknowledged she was aware of the facility's policy that indicated two nurses (the "on coming" and the "off going" nurses) were to count the number of individual controlled drugs by observing each medication and verifying that the number of individual controlled drugs matched the number on the "declining inventory" sheet. However, the DON stated she did not look to see if the count was correct in relation to the previous	F 425			

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F 425	Continued From page 6 shift's count on the controlled drug count and assumed the count was accurate if the counts matched up between the inventory sheet and the medication cards. The DON stated she had counted the medication cards and inventory sheets but she had not looked back to verify the counts were consistent with the previous shift counts. The DON also stated the system staff utilized to monitor receipt and disposition of narcotic medications was used on all three floors of the facility's resident care areas.	F 425			