

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

PRINTED: 04/16/2014
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 C 04/03/2014
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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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F 000	INITIAL COMMENTS An Abbreviated Survey Investigating #KY21519 and #KY21501 was conducted on 04/01/14 through 04/03/14. #KY21519 was unsubstantiated with no deficiencies cited. #KY#21501 was substantiated with deficiencies cited.	F 000	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan or correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws."	
F 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	1. Resident #1 was discharged home on 3-24-14 but the physician was notified during the survey on 4-24-14. 2. The DON, ADONS, SDC and Unit Managers completed an audit from 4/4/14 to 4/20/14 for any medication discrepancies and appropriate notification to the physicians and responsible parties. 3. Licensed nurses were in-serviced by the DON on 4-17-14 to ensure physicians are notified if medications are not available. Any nurse unable to attend was hand delivered an education packet or mailed a packet by 4/23/14. Education will be provided upon hire and as needed. The DON, ADONS, and Unit Managers will review new admission physician orders daily (M-F) to ensure physician and responsible party notifications have occurred and any new orders implemented. 4. Unit Managers will audit new admission physician orders weekly for four weeks and then 10 monthly for an additional 2 months. Results of the audits will be brought to the QA committee to determine the need for further auditing. 5. Completed by:	5/10/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 6-9-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003		
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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 interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to consult with the resident's physician the need to alter treatment significantly for one (1) resident of three (3) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>Review of the facility's Changes in Resident's Condition or Status policy/procedure, (not dated), revealed nursing services would be responsible for notifying the resident's attending physician when there was a need to alter the resident's treatment or medications significantly.</p> <p>Record review revealed the facility admitted Resident #1 on 02/20/14 with diagnoses which included Atrial Fibrillation, Congestive Heart Failure, Chronic Ischemic Heart Disease, and Hypertension.</p> <p>Review of the Physician's Orders, dated 02/20-28/14, revealed an order for Betapace-Sotalol 160 milligrams (mg) every twelve hours for a diagnosis of Atrial Fibrillation. Review of the Medication Administration Record (MAR), dated February 2014, revealed the Betapace-Sotalol should be administered at 9:00 AM and 9:00 PM. Review of the Nurse's Medication Notes, dated 02/24/14 at 7:15 AM, revealed the resident's medications were not available. The notes revealed medications arrived</p>	F 157			

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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		
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F 157	Continued From page 2 from the pharmacy, on 02/24/14 at 2:40 PM. Interview with Registered Nurse (RN) #1, on 04/02/14 at 1:45 PM, revealed the resident's Betapace was not available the morning of 02/24/14. She revealed the medication was given to the resident as soon as it was received from the pharmacy; however, she did not notify the physician. Interview with the Unit Manager, on 04/02/14 1:50 PM, revealed RN #1 reported to her on 02/24/14 when it was discovered Resident #1's medications were not available. She revealed the resident's medication was received from the pharmacy and given at 2:40 PM, instead of 9:00 AM. She stated the physician would not be notified unless a complete dose was missed. Interview with the Primary Physician, on 04/02/14 2:05 PM, revealed Betapace should be given as close as possible to the timeframe ordered. He revealed there was a risk of cardiac ectopy if not given every 12 hours. He would expect staff to notify him if they were unable to give the medication, per the order. Interview with the Director of Nursing (DON), on 04/03/14 10:00 AM, revealed she would not necessarily expect staff to notify the physician if a resident's Betapace was not given per order; however, she would expect the nurse to call the pharmacy or reference a drug book for recommendations.	F 157			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333			

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F 333	<p>Continued From page 3 any significant medication errors.</p> <p>This REQUIREMENT Is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure that residents were free from any significant medication errors for one (1) of three (3) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>Review of the Policies for Medication Administration, last revised 04/02/13, revealed all medications would be administered safely and appropriately to help residents overcome illness, relieve/prevent symptoms, and help in diagnosis.</p> <p>Record review revealed the facility admitted Resident #1 on 02/20/14 with diagnoses to include Atrial Fibrillation, Congestive Heart Failure, Chronic Ischemic Heart Disease, and Hypertension.</p> <p>Review of the Physician's Orders, dated 02/20-28/14, revealed an order for Betapace-Sotalol 160 milligrams (mg) every twelve hours for a diagnosis of Atrial Fibrillation. Review of the Medication Administration Record (MAR), dated February 2014, revealed the Betapace-Sotalol should be administered at 9:00 AM and 9:00 PM. Review of the Nurse's Medication Notes, dated 02/24/14 at 7:15 AM, revealed the resident's medications were not available. The notes revealed medications arrived from the pharmacy, on 02/24/14 at 2:40 PM.</p>	F 333	<ol style="list-style-type: none"> Resident #1 was discharged on 3-24-14. The DON, ADONS, SDC and Unit Managers completed an audit from 4/4/14 to 4/20/14 for any medication discrepancies and appropriate notification to the physicians and responsible parties. Licensed nurses were in-serviced on 4-17-14 by the DON on: medication administration, medication errors, physician notification, and medication availability. Any nurse who was unable to attend was hand delivered an education packet or mailed a packet by 4/23/14. Education will be provided upon hire and as needed. A med pass audit will be completed by the pharmacy monthly. A competency test will be completed by each nurse between 4/25/14 and 5/9/14 on medication administration. Unit Managers, ADONS, SDC and /or the DON will audit 12 medication passes per week for 4 weeks then 12 per month for 2 months to ensure medications were administered safely and appropriately to residents. The pharmacist will complete a med pass audit monthly. Results of the audits will be brought to the QA committee to determine the need for further monitoring. Completed by : 	5/10/14	

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F 333	<p>Continued From page 4</p> <p>Interview with Registered Nurse (RN) #1, on 04/02/14 1:45 PM, revealed the resident's Betapace was not available the morning of 02/24/14. She revealed the medication was given to the resident as soon as it was received from pharmacy.</p> <p>Interview with the Unit Manager, on 04/02/14 1:50 PM, revealed RN #1 reported to her on 02/24/14 when it was discovered Resident #1's medications were not available. She revealed the resident's medication was received from pharmacy and given at 2:40 PM.</p> <p>Interview with the Primary Physician, on 04/02/14 2:05 PM, revealed Betapace should be given as close as possible to the timeframe ordered. He revealed there was a risk of cardiac ectopy if not given every 12 hours.</p> <p>Interview with the Director of Nursing (DON), on 04/03/14 10:00 AM, revealed she would expect the nurse to call the pharmacy or reference a drug book for recommendations when the medication was not available.</p>	F 333			