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

PRINTED: 11/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	C 11/10/2011

RECEIVED DEC 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	544 LONE OAK RD. PADUCAH, KY 42003

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F 000	INITIAL COMMENTS Abbreviated surveys (KY #16359, KY #16405, KY #16054, and KY #16468) were conducted on 11/07/11 through 11/10/11 to determine the facility's compliance with Federal requirements. The facility is not in compliance with Federal requirements with deficiencies cited at the highest S/S of an "E." KY #16359 was unsubstantiated with unrelated deficiencies cited. KY #16405, KY #16054, and KY #16468 were unsubstantiated with no 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 333	
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy/procedure review, it was determined the facility failed to ensure one resident (#8), in the selected sample of nine, was free of significant medication errors. Eight opportunities for a significant medication error occurred from 11/01/11 through 11/08/11, as a result of a medication transcription and administration error. Neurontin (for Peripheral Neuropathy) 1600 milligrams (mg) orally (po) was administered to Resident #8 at bedtime or hour of sleep (hs) from 11/01/11 through 11/08/11; however, the physician's order revealed to administer Neurontin 400 mg po at hs. Findings include: A review of the policy/procedure "Administration	F 333	1. The order was re-written to clarify the correct dosage for Resident #8 and number of tabs to be given on 11/9/11 by the RN Unit Manager. Resident #8 was assessed with no adverse effects noted. 2. Between 11/28/11 and 11/30/11 a 100% audit of resident's Physician's order sheets were reviewed comparing physician's orders to medication administration records by our group of Change over Nurses. Any discrepancies were corrected at that time. 3. Nurses handling the change over of our orders from month to month were inserviced by the DON on 12/5/11 not to change pre-printed POS (physician's order sheet) unless it has been validated through reviewing the resident's chart, reviewing the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lori Moneley TITLE: Exec. Director (X6) DATE: 12-21-11

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 333	Continued From page 1 of Medication," revised 10/04, revealed "responsibility of the nursing professional: be aware of the classification, action, correct dosage, and side effects of a medication before administration." A record review revealed Resident #8 was admitted to the facility on 10/20/11 with diagnoses to include Peripheral Neuropathy, Peripheral Vascular Disease and Chronic Back Pain. A review of the physician's order, dated 10/20/11, revealed to administer Neurontin 100 mg po, four (4) capsules at hs. A review of the current Medication Administration Record (MAR), dated 11/01/11 through 11/30/11, revealed to administer Neurontin 400 mg po at hs; however, below the physician's order on the MAR, it was handwritten to "give 4 capsules." An interview with a Registered Nurse (RN), Unit Manager #1, on 11/09/11 at 1:30 PM, revealed she made the changes to the MAR by hand and made the transcription error on the MAR. She further stated the Neurontin dose on the November MAR was incorrect and did not match the physician's order for Neurontin 100 mg po, four (4) capsules at hs. An observation of the medication cart with Unit Manager #1, on 11/09/11 at 4:30 PM, revealed there were Neurontin 400 mg capsules and 100 mg capsules available for use. Both boxes of Neurontin capsules (100 mg and 400 mg), dated 10/20/11, revealed discrepancies related to the count of the medication. On 10/20/11, there were thirty (30) of the 400 mg capsules sent to the	F 333	medication in the cart, validation/notification through pharmacy before making changes. Inservice was made to 11-7 Nurses by the ADON on 11/30/11to make another MAR to MAR /TAR to TAR check before placing the new month's MAR and TAR in the Medication/Treatment Books. The SDC inserviced licensed personnel by 12/16/11 regarding the above procedures and noting the strength and dosage of the medication before administering to the resident. 4. Each Unit Managers and/or ADONs will audit 10 charts with new orders a week matching POS to telephone orders to MAR to medication in the medication cart and noting any discrepancies for 4 weeks then monthly times 2 months. Results of the audits will be presented to the D.O.N. and the Quality Assurance committee monthly indicating the need for further monitoring monthly. 5. Completed by:	12/17/11

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F 333	Continued From page 2 facility, and sixty (60) of the 100 mg capsules sent to the facility. On 11/09/11 (20 days later), the count of the Neurontin 400 mg capsules revealed there were fifteen (15) capsules in the box; however, there should have been ten (10) capsules. The count of the Neurontin 100 mg capsules revealed there were ten (10) capsules in the box; however, there should have been twenty (20) capsules. An interview with an RN, Unit Manager #2, on 11/09/11 at 2:45 PM, revealed by looking at the MAR, she thought the resident was to receive Neurontin 1600 mg po at hs. She stated the facility policy/procedure was "to yellow out all order changes and rewrite the correct physician's order on another page. Never write the dose or change the number because the change could result in an overdose." A review of the "Saunders Drug Handbook," dated 2008, revealed potential adverse reactions related to Neurontin included slurred speech, lethargy, diarrhea, impaired renal function and seizures. An observation and interview with Resident #8, on 11/09/11 at 4:30 PM, revealed he/she was alert and talkative with the staff. Further interview with Unit Manager #1, on 11/09/11 at 4:35 PM, revealed "we have notified Resident #8's physician and informed him of the medication errors."	F 333		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428	F 428 1. The pharmacist reviewed Resident #8's drug regimen on	

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F 428	Continued From page 3 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy/procedure review, it was determined the Pharmacy Consultant failed to identify or report a medication irregularity related to the medication Neurontin for one resident (#8), in the selected sample of nine. Findings include: A review of the facility's policy/procedure "Medication Regimen Review," dated May 2010, revealed "the pharmacy consultant will conduct medication regimen reviews if required under a pharmacy consultant agreement." A record review revealed Resident #8 was admitted to the facility on 10/20/11 with diagnoses to include Peripheral Neuropathy, Peripheral Vascular Disease and Chronic Back Pain. A review of the physician's order, dated 10/20/11, revealed to administer Neurontin 100 milligrams (mg), two (2) capsules (200 mg) orally (po) once a day at 9:00 AM, and administer Neurontin 100 mg, four (4) capsules (400 mg) po at bedtime or	F 428	11/10/11and the order was clarified by nursing on 11/9//11. The family and physician were notified on 11/9/11 of the transcription error. Another medication regimen review of the chart was completed by the pharmacist on 11/30/11on Resident #8. 2. Other residents were reviewed on 12/5/11and 12/6/11 by the pharmacist comparing pharmacy orders from November to December to ensure correct transcription was completed. Any unused drugs were discontinued and new drugs were obtained. New admissions medication orders will be reviewed by the pharmacy upon entering the facility and a copy sent to the DON. 3. The Executive Director inserviced the pharmacist on 12/5/11 regarding the requirement to review each resident's drug regimen at least monthly and report any irregularities to the physician and DON ensuring that reports are acted upon. 4. The pharmacist will perform a drug regimen review monthly to include an in depth audit of 10 records comparing orders from the chart to MAR to Med. Cart. Reporting any issues to the DON.	

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F 428	Continued From page 4 hour of sleep (hs) (9:00 PM), for Peripheral Neuropathy. A review of the medication administration record (MAR), dated November 2011, revealed Neurontin 100 mg capsule, give two (2) capsules (200 mg) po once a day at 9:00 AM. Further review of the November 2011 MAR revealed Neurontin 400 mg capsule, give "four (4)" capsules po at bedtime or hs (9:00 PM), for Peripheral Neuropathy. The number "4" was handwritten in at the 9:00 PM administration time on the MAR. An interview with a Pharmacy Consultant, on 11/09/11 at 7:50 AM, revealed she was at the facility on 11/08/11 and reviewed Resident #8's record and found no irregularities or concerns at that time. An interview with the Director of Nursing (DON), on 11/09/11 at 8:00 AM, revealed "the pharmacy consultant should have caught the error because it was on the chart for her to see." The DON further stated the purpose of the facility's agreement with the pharmacy consultant was to review medications for irregularities.	F 428	These additional checks will be done for 6 months. Then randomly from that point. Additionally, the Certified Pharmacy tech will complete an audit of 10% of the residents comparing the physician's orders, to the MAR to the medication in the cart on 12/16/11. The audit from the tech will be ongoing each month , thereafter. A written report of these audits will be given to the DON and any issues will be brought before the QA committee to determine the need for additional audits. 5. Completed by:	12/17/11