

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

PRINTED: 06/22/2011
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	<div style="border: 2px solid black; padding: 5px; text-align: center;"> RECEIVED JUL - 1 2011 06/08/2011 </div>
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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 Division of Health Care Southern Enforcement Branch
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F 000	INITIAL COMMENTS An abbreviated standard survey (KY16500) was conducted on June 6-8, 2011. The allegation was substantiated. Deficient practice was identified with the highest scope and severity at 'F' level.	F 000	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.	
F 425 SS=F	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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. 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. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a procedure was in place for the accountability of controlled medication (medication with a high risk of abuse or diversion). Two of four sampled	F 425		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Orfan Cho</i>	TITLE <i>Administrator</i>	(X8) DATE 7/1/11
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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 Jul. 1. 2011 12:52PM No. 0050

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F 425	<p>Continued From page 1</p> <p>residents (residents #1 and #3) were scheduled to receive controlled medications as needed per physician's order. The facility failed to ensure a procedure was in place to monitor medication logs to ensure the accountability of all controlled substances.</p> <p>The findings include:</p> <p>Review of the facility policy "Inventory Control of Controlled Substances" (revision date May 1, 2010) revealed staff was to ensure that all Schedule II controlled substances (category of drugs considered to have a strong potential for abuse or addiction) and other medications with a risk of abuse or diversion were counted at the change of each shift, or at least once daily, and the results documented on the "Controlled Substance Count Verification/Shift Count sheet." The policy further stated facility staff was to regularly check medication inventory records to reconcile the current and discontinued inventory of controlled substances.</p> <p>1. A review of Resident #1's physician's orders for May 2011 and June 2011 revealed an order for Hydrocodone with Acetaminophen (narcotic analgesic) 7.5/500 milligrams (mg) to be administered to the resident every six hours as needed for pain. A review of resident #1's Medication Administration Record (MAR) for May 18, 2011 through June 6, 2011, revealed Hydrocodone with Acetaminophen was administered to the resident 28 times. However, a review of the Controlled Drug Record for the same timeframe, May 18, 2011 through June 6, 2011, revealed staff had administered Hydrocodone with Acetaminophen to the resident</p>	F 425	<p>F 425</p> <p>Criteria #1 No corrective action can be taken for Resident #1 and #3.</p> <p>Criteria #2 Any resident receiving narcotics has the potential to be affected.</p> <p>Criteria #3 A. Nurses were reeducated on 6/10/11, 6/11/11, and 6/12/11 to document administration of narcotics on the Medication Administration Record (MAR) and/or in the nurses notes. B. Pharmacy will email the Director of Nursing (DON) daily a listing of all narcotics delivered to the facility the previous night. The Unit Managers will compare the delivery sheets to the narcotic sign out sheets weekly for 3 months. Any discrepancies will be reported to the DON for investigation. C. The DON/designee will audit 15 resident records (MARs, Nurses Notes, and narcotic sign out sheets) weekly for 3 months. Any discrepancies will be investigated and addressed immediately.</p>	07/23/11
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F 425	<p>Continued From page 2</p> <p>54 times, leaving a discrepancy of 26 tablets of Hydrocodone with Acetaminophen which the facility could not account for. Facility staff could not provide the Controlled Drug Record prior to May 18, 2011.</p> <p>2. A review of resident #3's physician's orders for May 2011 revealed an order for Lortab 7.5 mg, one tablet to be given every three hours as needed for pain. Further review revealed on May 16, 2011, an order was received to give Percocet (narcotic analgesic) 10/650 mg every four to six hours as needed for pain. Review further revealed an order received on June 2, 2011, to discontinue the Lortab and only give the Percocet per order. A review of resident #3's MAR for May 20, 2011 through June 6, 2011, revealed Lortab 7.5 mg had been administered to the resident six times. However, the facility could not provide the Controlled Medication Record for the administration of Lortab 7.5 mg. Resident #3's MAR revealed facility staff had administered Percocet 10/650 mg to the resident 48 times from May 14, 2011 through June 6, 2011. However, a review of the Controlled Drug Record for May 20, 2011 through June 6, 2011, revealed facility staff had administered Percocet to the resident 69 times, a discrepancy of 21 tablets. Facility staff could not provide the Controlled Drug Record for the Percocet prior to May 20, 2011.</p> <p>Interview with the Assistant Director of Nursing (ADON) on June 6, 2011, at 4:45 p.m., revealed controlled drugs were counted daily by nursing staff at shift change and the two nurses were required to sign the Controlled Drugs Count Record to indicate the count was accurate. However, facility staff could not provide the</p>	F 425	<p>F 425</p> <p>Criteria #4 The DON will report the results of the Unit Manager audits and her audits monthly for 3 months to the Quality Assurance Committee for development of an action plan as needed.</p>	
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F 425	<p>Continued From page 3</p> <p>Controlled Drugs Count Record prior to June 2011. Further interview revealed the ADON was not aware of any facility staff member who was assigned to monitor the Controlled Drug Record or the MAR as required by facility policy to ensure the medication counts were accurate.</p> <p>Interview with the Unit Manager (UM) of the third floor on June 6, 2011, at 5:00 p.m., revealed the UM does "occasional" audits of the narcotics, however, the UM did not document the results of these "occasional" audits.</p> <p>Interview with the Health Information Manager (HIM) on June 6, 2011, at 5:45 p.m., revealed facility staff shredded each resident's Controlled Drug Record after completion and stated facility staff did not perform audits or reconciliation of controlled drugs. Interview with the HIM on June 6, 2011, at 8:35 p.m., revealed the facility did not require staff to sign out narcotics in one designated place. The HIM stated staff could sign them out anywhere as long as the narcotic was signed out somewhere showing it had been administered.</p> <p>Interview with the Administrator on June 6, 2011, at 7:15 p.m., revealed the Administrator was not aware if facility staff performed audits on controlled substances and was not able to locate any of the Controlled Drug Count Records prior to June 1, 2011.</p> <p>Interview with the former Director of Nursing (DON) on June 6, 2011, at 8:10 p.m., revealed she resigned on June 1, 2011, and is no longer employed at the facility. The former DON stated the facility staff did not perform routine audits or</p>	F 425		
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F 425	Continued From page 4	F 425		
	reconciliation of controlled narcotics. The former DON did receive the Controlled Drug Records after the resident medications had been used. The former DON gave the completed Controlled Drug Records to the HIM who would then shred the documents.			
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	Criteria #1 No corrective action can be taken for residents #1 and #3.	07/23/11
	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1978 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the</p>		<p>Criteria #2 Any resident receiving narcotics has the potential to be affected.</p> <p>Criteria#3 A. Nurses were reeducated on 6/10/11, 6/11/11, and 6/12/11 to document administration of narcotics on the Medication Administration Record (MAR) and/or the nurses notes. B. Nurses were educated on 6/24/11, 6/25/11, and 6/26/11 to place completed or discontinued narcotic count sheets in the residents' charts as they will no longer be shredded. C. The Registered Pharmacist will meet with the DON monthly for 3 months to review Quality Assurance documentation on reconciliation of narcotics. D. Pharmacy technician will continue Quality Assurance monitoring of controlled substances and report discrepancies to DON monthly.</p>	

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F 431	<p>Continued From page 5</p> <p>quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the services of a licensed pharmacist had been obtained to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, to determine that drug records were in order, and ensure an account of all controlled drugs were maintained and periodically reconciled. The facility could not provide documentation that controlled drugs had been accurately reconciled by facility staff. A review of documentation revealed the Medication Administration Record (MAR) and Controlled Drug Records for two of four sampled residents (residents #1 and #3) contained discrepancies.</p> <p>The findings include:</p> <p>A review of the facility policy "Inventory Control of Controlled Substances" (revision date of May 1, 2010) revealed facility staff was required to ensure that all Schedule II controlled substances (a category of drugs considered to have a strong potential for abuse or addiction) and other medications with a risk for diversion were counted/reconciled at the change of shift or at least one time during the shift. Facility staff was required to regularly check the inventory records to reconcile medication inventory. A review of the policy "General Dose Preparation and Medication Administration" (revision date of May 1, 2010)</p>	F 431	<p>F 431</p> <p>Criteria #4 DON will report the results of the Quality Assurance monitoring monthly for three months to the Quality Assurance Committee for development of an action plan if needed.</p>		

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F 431	<p>Continued From page 6</p> <p>revealed after administration of a medication facility staff was required to document the medication administration in accordance with facility policy and applicable laws.</p> <p>A review of KRS 218A.200 effective June 20, 2005, revealed a record of substances received, and a record of all substances administered, dispensed, or professionally used was required to be retained by the facility for a period of five years.</p> <p>A review of resident #1's MAR for May 18, 2011 through June 6, 2011, revealed the resident received physician-ordered Lortab 7.5 milligrams (mg) 28 times during this period; however, the Controlled Drug Record revealed resident #1 received Lortab 7.5 mg 54 times during the same timeframe, leaving a discrepancy of 26 Lortab tablets. Facility staff could not provide the Controlled Drug Record prior to May 18, 2011.</p> <p>A review of resident #3's MAR for May 18, 2011, through June 6, 2011, revealed the resident received physician-ordered Lortab 7.5 mg six times. However, the facility could not provide the Controlled Drug Record to verify the administration of Lortab 7.5 mg for this resident. A review of resident #3's MAR for May 14, 2011 through June 6, 2011, revealed resident #3 received Percocet 10/650 mg 48 times. However, a review of the Controlled Drug Record from May 20, 2011 through June 6, 2011, revealed resident #3 received Percocet 69 times, a discrepancy of 21 Percocet tablets.</p> <p>Interview with the third floor Unit Manager (UM) on June 6, 2011, at 5:00 p.m., revealed the facility</p>	F 431		

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F 431	<p>Continued From page 7</p> <p>did not have a system to perform audits and reconciliation of controlled medications and as a result audits were not performed by facility staff.</p> <p>Interview with the Health Information Manager (HIM) on June 6, 2011, at 5:45 p.m., revealed no facility staff performed audits or reconciliation for controlled narcotics. Interview further revealed facility staff was unable to provide documentation of a Controlled Drugs Count Record prior to June 1, 2011, to ensure the controlled medications had been counted and accurately verified for the day.</p> <p>Interview with the Administrator on June 7, 2011, at 7:15 p.m., revealed the Administrator was not aware of any system utilized by facility staff or the pharmacist to perform audits or reconciliation of controlled drugs. The Administrator further stated for the last several months the pharmacy technician had been performing monthly audits at the facility which included comparing the resident's MARs to the Controlled Drug Record, performing actual counts of the controlled drugs, and visualizing a medication pass with no problems identified regarding the accountability of the controlled medications.</p> <p>However, interview with the pharmacy technician on June 7, 2011, revealed the pharmacy technician had started performing audits, per the facility request, approximately six months ago. She stated the monthly audit included comparing the resident's MARs to the Controlled Drug Record for the current month, visualizing a medication pass, and counting all controlled medications for five residents on each floor. The pharmacy technician stated she had identified discrepancies between the amount of</p>	F 431		
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F 431	<p>Continued From page 8</p> <p>medications available on the Controlled Drug Record and the MAR. The pharmacy technician stated she had discussed her findings with facility staff upon leaving the facility. The pharmacy technician was not aware if the facility had a system for the reconciliation of controlled drugs, nor was she aware the facility had destroyed the Controlled Drug Records for each resident. A review of the pharmacy technician's May 2011 visit revealed the technician performed an as-needed audit of controlled substances and gave the facility a score of 82 percent. However, on June 8, 2011, the Administrator stated that the pharmacy technician did not exit with the facility; therefore, the facility was not aware of the discrepancies in the medications.</p> <p>Interview on June 6, 2011, at 8:10 p.m., with the former Director of Nursing (DON), who resigned on June 1, 2011, revealed the facility did not have a system to account for the usage, disposition, and reconciliation of controlled drugs. The former DON stated the facility did not keep a record of receipt of all controlled medications with detail to allow for reconciliation. The DON further stated the facility did not perform periodic reconciliation of records of receipt, disposition, and inventory for all controlled medications. Further interview revealed the facility destroyed all Controlled Drug Records after they were completed and the former DON was not aware of where the Controlled Drugs Count Record prior to June 1, 2011, was located.</p> <p>Interview with the Pharmacy General Manager (GM) and the Consultant Pharmacist on June 7, 2011, at 2:20 p.m. and 3:20 p.m., revealed neither pharmacist had a system to perform</p>	F 431		
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F 431	Continued From page 9 reconciliation of records of controlled substances, nor did they ensure that an account of all controlled drugs was maintained by the facility. The Pharmacy General Manager and the Consultant Pharmacist further stated they were not aware facility staff did not perform periodic reconciliation on controlled drugs. The Consultant Pharmacist stated the drug regimen reviews performed on each resident monthly did not entail specifically controlled drugs. Both pharmacists stated they were not aware the facility destroyed the Controlled Drug Records and were also not aware the facility did not perform reconciliation of controlled drugs. The Pharmacy GM stated that he kept a record of when controlled drugs were delivered to the facility, however, after the controlled drugs were delivered to the facility it was then the facility's responsibility to perform reconciliation.	F 431		
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