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Division of Health Care
Southern Enforcement Branch

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185258		C 01/28/2014

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 000	INITIAL COMMENTS An abbreviated standard survey (KY21234) was initiated on 01/27/14 and concluded on 01/28/14. The complaint was substantiated with deficient practice identified at "D" 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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policy, it was determined the facility failed to ensure services provided met professional standards of quality for one of three sampled residents (Resident #1). Interview conducted with Resident #1 on 01/27/14 revealed the resident had not received "a few" physician ordered medications on the evening of 01/26/14. A review of the resident's Medication Administration Record (MAR) confirmed some medications ordered to be administered at 9:00 PM had not been documented as being administered as ordered by the physician. Continued record review and interview with staff revealed the resident had a physician's order to receive Digoxin (used to treat heart failure and atrial fibrillation) 0.125 milligrams (mg) by mouth, every day. Interviews revealed staff was required to obtain a heart rate prior to administering Digoxin; however, continued interviews with staff revealed the resident's heart rate had not been obtained prior to administering Digoxin as required.	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 02/13/14

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/28/2014
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 281	Continued From page 1 The findings include: A review of the facility policy titled General Dose Preparation and Medication Administration, last revised on 01/01/13, revealed staff was to document on the resident's MAR when medications were given. A review of the facility policy titled Medication Administration Times, with a revision date of 05/01/10, revealed the facility should administer medications within 60 minutes before or after the designated times of administration as determined by the physician. An interview conducted with the Director of Nursing (DON) on 01/27/14 at 4:45 PM revealed the facility had no policy related to the administration of Digoxin. However, the DON stated it was a standard of practice for staff to obtain a heart rate prior to the administration of Digoxin. The DON further stated Digoxin should not be administered to residents with a heart rate less than 60 beats per minute (bpm). Review of the Nursing Drug Handbook, 31st Edition, revealed nurses were directed to check the patient's apical-radial pulse for one minute before giving Digoxin, record, and notify prescriber of significant changes (sudden increase or decrease in pulse rate, pulse deficit, irregular beats, and particularly regularization of previously irregular rhythm). 1. A review of the medical record for Resident #1 revealed the facility admitted the resident on 09/15/13 with diagnoses that included Diabetes, Depression, and Atrial Fibrillation. A review of the quarterly Minimum Data Set (MDS) assessment	F 281	F 281 1. On 1/27/14, the Director of Nursing reviewed Resident #1's weekly vital sign record-all vital signs for the month of January, 2014 were within normal parameters for Resident #1. On 1/28/14, a registered nurse assessed Resident #1 for any indication of adverse effects from not having the pulse taken when the digoxin was administered and not documenting the administration of 9pm medications on 1/26/14. This assessment included a set of vital signs. Resident #1's assessment was within normal parameters and there was no evidence of a negative outcome. The registered nurse then notified the primary physician of the missing documentation and the results of the assessment of Resident#1. The primary physician ordered a digoxin level for the next morning which was also within normal parameters.	02/05/14

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F 281	Continued From page 2 dated 10/31/13, revealed the facility assessed Resident #1 to be interviewable with a Brief Interview for Mental Status (BIMS) score of 15. An interview with Resident #1 on 01/26/14 at 11:25 AM revealed the resident stated, "I didn't get my meds last night." The resident continued to state, "I've been getting my meds here; last night was just a problem for me." The resident continued to state, "I do refuse medicine sometimes." Resident #1 stated, "The melatonin I do refuse sometimes, it makes me sleepy, but I want the order though; I have the right to have it ordered." A review of Resident #1's physician's orders for January 2014 revealed the resident had orders to receive the following medications at 9:00 PM on 01/26/14: Metformin (medication to manage blood glucose levels) 500 mg, Catapres (a medication to treat high blood pressure) 0.2 mg, Doxepin (medication to treat depression) 25 mg, Melatonin (a medication for sleep apnea) 3 mg, and Ambien (medication for sleeplessness) 5 mg. Further review of the resident's MAR revealed staff failed to document the medications had been administered as ordered by the physician at 9:00 PM on 01/26/14. An interview with Licensed Practical Nurse (LPN) #3 on 01/28/14 at 9:45 AM confirmed she had been assigned to administer medications to Resident #1 on 01/26/14 at 9:00 PM. The LPN stated she had administered all the medications that were ordered for 9:00 PM on 01/26/14 to Resident #1, excluding the Ambien. However, the LPN stated she had "forgot to sign the medications off" as required. LPN #3 stated Resident #1 had refused to take the Ambien	F 281	2. All residents have the potential to be affected by the facility's failure to provide services that meet professional standards of quality. On 1/27/14, the Director of Nursing audited the Medication Administration Records (MAR's) for January, 2014 of all residents receiving Digoxin. All had a pulse recorded for administration of Digoxin. By 2/4/14, Administrative Nurses audited the January, 2014 MAR's and Treatment Administration records(TAR's) for current residents to determine that medications had been documented they were administered per physician orders to ensure services provided met professional standards of quality. Medications and treatments were documented as administered per physician orders to ensure services provided met professional standards of quality for the current residents.	

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F 281	Continued From page 3 when she attempted to administer the resident's 9:00 PM medications on 01/26/14. An interview with the Director of Nursing (DON) on 01/27/14 at 4:45 PM confirmed staff was required to document medication administration when medications were administered to facility residents. The DON further stated LPN #3 should have documented Resident #1's medications as administered when the resident received the medications. 2. A review of Resident #1's physician's orders for January 2014 revealed the resident had physician's orders to receive Digoxin 0.125 mg daily. Continued review of the resident's MAR, dated January 2014, revealed no evidence the resident's pulse had been obtained before the medication had been administered to Resident #1. An interview with LPN #2 on 01/27/14 at 3:35 PM revealed he had administered Resident #1's Digoxin at 9:00 AM on 01/27/14. The LPN stated he had been trained to obtain a heart rate prior to administering Digoxin, and not to administer Digoxin to a resident if the resident's heart rate was less than 60 beats per minute (bpm). However, the LPN stated he had failed to obtain Resident #1's heart rate prior to administering Digoxin at 9:00 AM on 01/27/14. The LPN acknowledged that ensuring a resident's heart rate was at least 60 bpm was standard of practice with the administration of Digoxin, but had failed to obtain the resident's heart rate because "there wasn't a physician's order on the resident's MAR to get one." An interview with LPN #1 on 01/27/14 at 3:10 PM	F 281	3. By 1/31/14, the Assistant Director of Nursing reeducated the licensed nurses, including LPN #1, #2, and #3 that the services provided by the facility must meet professional standards of quality including but not limited to documentation of a pulse with administration of Digoxin , administering medications per physician orders, and documentation of all medication administration for all residents. 4. a. The Nurse Unit Managers will QA monitor the MAR's and for residents receiving Digoxin daily 5x weekly for one month, then weekly for two months to ensure a pulse is documented with administration of the digoxin. Any discrepancy will be addressed and the Director of Nursing will be notified for disciplinary follow up as needed.	

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F 281	Continued From page 4 revealed she had been trained, that it was a standard of practice, to ensure a resident's heart rate was at least 60 bpm before Digoxin was administered to a resident. Even though the LPN had been trained, she stated she had administered Digoxin a "few times" to Resident #1, and had failed to ensure the resident's heart rate was at least 60 bpm as required. LPN #1 stated she had not obtained a heart rate for Resident #1 because there was not a physician's order to do so. An interview conducted with the Director of Nursing (DON) on 01/27/14 at 4:45 PM revealed the DON stated it was a standard of practice for staff to obtain a heart rate prior to the administration of Digoxin. The DON further stated Digoxin should not be administered to residents with a heart rate less than 60 bpm, and staff should have obtained Resident #1's heart rate prior to administering Digoxin to the resident.	F 281	b. The Nurse Unit Managers will QA monitor 25% of resident MARs and TAR's daily 5x weekly for one month then weekly for two months to ensure documentation of medication and treatment administration is present. Any discrepancy will be addressed and the Director of Nursing will be notified for disciplinary follow up as needed. c. The results of the QA audits will be reported by the Unit Managers to the Quality Assurance Committee monthly for three months for development of an action plan as needed.	

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