

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER Parkview Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 128 North Hardesty Kansas City, MO 64123	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transcribe physician orders correctly for an opioid pain medication (controlled pain medication for moderate to severe pain) and failed to clarify the physician orders when the medication was not received by the pharmacy for one sampled resident (Resident #500) of out of 12 sampled residents. The facility census of 107 Residents.</p> <p>1. Review of Resident #500's Face Sheet showed he/she admitted to the facility on [DATE] with a diagnosis of frost bite with necrosis (death of body tissue) to his/her left foot and non-pressure chronic wound (caused by prolonged pressure, arise from other factors like poor circulation, trauma, or infection) to his/her left foot.</p> <p>Review of the resident's hospital discharge instruction and summary dated 3/1/25 at 1:50 P.M. showed:</p> <p>-Had diagnosis to include frost bite to his/her left foot.</p> <p>-Oxycodone (opioid-control substance pain reliever) 5 milligram (mg), give one tab by mouth every six hours as needed for severe pain (for 7-10 days) dated 3/2/25.</p> <p>Review of the resident's physician's History and Physical Assessment Note dated 3/3/25 showed:</p> <p>-He/she had reviewed the resident medication list from the hospital and listed on the physician order sheet.</p> <p>-The resident was to receive Oxycodone-Acetaminophen 2.5 mg-325 mg, to give 2.5 mg tab by mouth every six hours as needed for severe pain dated 3/2/25.</p> <p>Review of the resident's Physician Order Sheet (POS) dated March 2025 showed:</p> <p>-Oxycodone-Acetaminophen 2.5 mg-325 mg, to give one-tab by mouth every six hours as needed for severe pain was ordered 3/2/25.</p> <p>-Note: This was ordered from the pharmacy but not received. The order from the hospital was 5 mg and the facility POS order was for 2.5 mg.</p> <p>Review of the resident's Medication Administration Record (MAR) dated 3/3/25 to 3/10/25 showed:</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Oxycodone-acetaminophen 2.5 mg-325 mg gives one-tab by mouth every six hours as needed for severe pain.</p> <p>--This was not received by the pharmacy and not administered to the resident.</p> <p>--Note: The resident had been treated by other non-opioid pain medications and his/her pain was documented as controlled.</p> <p>During an interview on 3/17/25 at 4:20 P.M., the resident said:</p> <p>-During the daytime his/her pain was under-controlled.</p> <p>-He/she had more pain in his/her ankles and feet during nighttime when his/her feet were cold. The coldness in the air would cause his/her feet to hurt.</p> <p>-He/she did not notify the nursing staff or asked for pain medication the during the night shift.</p> <p>-He/she had been receiving other pain medication.</p> <p>During an interview on 3/17/25 at 1:30 P.M. Registered Nurse (RN) A said:</p> <p>-On 3/2/25 he/she contacted the hospital to have them send a written prescription for the resident's prescribed Oxycodone 5 mg, give one tab by mouth every six hours as needed for severe pain.</p> <p>-The resident was getting alternative pain control medication.</p> <p>-The resident pain medication order was as needed medication and the resident had to ask for those medication.</p> <p>-The resident was to be seen by the physician on Monday and Friday.</p> <p>-When a resident was admitted on Saturday, then he/she would be seen on Monday by the resident physician.</p> <p>-Physician A would not write prescription for controlled pain medication until seen by him/her first.</p> <p>-The resident had no complaints pain that was not controlled with alternative medication that was given.</p> <p>During an interview on 3/17/25 at 3:30 P.M., Licensed Practical Nurse (LPN) A said:</p> <p>-The facility cannot access the Pyxis (electronic pharmacy medication dispensing machine help ensure medications and supplies are available when and where they're needed) without pharmacy approval for each residents medication.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The facility no longer has a tool box Emergency medication kit (E-Kit, that store extra common medication to include possible control substance medication) for those residents who were new admissions or a resident with new medication changes.</p> <p>-The hospital did not send a written prescription for the oxycodone and the facility had reached out to the hospital with no response. The facility sent the medication list to pharmacy upon admission. The pharmacy required the physician to contact them to get the oxycodone filled.</p> <p>-The resident had other non-opioid pain medications that were administered.</p> <p>During an interview on 3/17/25 at 3:40 P.M., Registered Nurse (RN) A said:</p> <p>-He/she would expect admitting nurse to follow-up with physician orders and pharmacy related to any medication not received as ordered including as needed opioid pain medication.</p> <p>-He/she should have written a progress note that he/she had attempted to get the resident medication refilled on 3/3/25 and required a written script from the physician to be sent to pharmacy. The pharmacy was needing the physician medication number to be able fill the oxycodone medication.</p> <p>-The resident did not voice concern with pain during the day shift.</p> <p>-The resident's pain had been monitored and managed by other pain medications.</p> <p>During an interview on 3/17/25 at 3:55 P.M., Director of Nursing (DON) said:</p> <p>-He/she was not aware the resident was without as needed prescribed substance-controlled pain medication, which was not delivered to the facility.</p> <p>-When a resident discharge from the hospital, would normally send a prescription or supply of medication with the resident, until the facility was able to obtain and send physician ordered for medication needed from pharmacy.</p> <p>-He/she would expect nursing staff to document in progress notes the attempts to obtain medication and who had contacted to be able to get the medication was ordered upon admission.</p> <p>-He/she had talked with the resident several times that week and never mention not having medication needed until 3/10/25.</p> <p>-A new order was obtained for opioid pain medication on 3/10/25 when this was brought to his/her attention.</p> <p>During an interview on 3/17/25 at 4:39 P.M. with Physician A said:</p> <p>-He/she had approved the oxycodone, but the pharmacy needed an electronic script from him/her before could send the medication. Normally the facility sends the medication prescribed ordered to pharmacy and the pharmacy would have to notify the physician of any additional physician orders needed to include for opioid medication.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she not made aware the resident did not receive the prescribed Oxycodone pain medication use as needed until 3/10/25 when he/she saw the resident.</p> <p>-The resident had not voiced any complaints of uncontrolled pain while on site.</p> <p>-He/she had observed the resident up walking with therapy staff that day.</p> <p>-He/she would expect the facility nursing staff to contact him/her if not able to get pain medication.</p> <p>-When reviewing the resident script submitted was noted as the wrong dosage to receive, the pharmacy does not have 2.5 mg tab for that pain medication.</p> <p>-After review he/she noted the actual order was for 5 mg and to give $\frac{1}{2}$ tab, which would be 2.5 mg to be given as needed for pain.</p> <p>-That could have been the possible reason why the prescription did not go through.</p> <p>Complaint # MO 00250736</p>