

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

PRINTED: 01/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045375	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/09/2008
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NAME OF PROVIDER OR SUPPLIER PARKVIEW REHABILITATION & HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 BARROW ROAD LITTLE ROCK, AR 72204
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(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
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F 000	INITIAL COMMENTS	F 000		
F 333 SS=E	<p>Complaint #13188 was substantiated (all or in part) with a deficiency cited at F333.</p> <p>483.25(m)(2) MEDICATION ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13188 was substantiated (all or in part) in these findings.</p> <p>Based on record review and interview, the facility failed to ensure insulin was administered as ordered by the Physician for 2 (Residents #5 and #6) of 3 (Residents #2, #5 and #6) case mix residents who had Physician orders for sliding scale insulin. This failed practice had the potential to affect 19 residents in the facility who received sliding scale insulin, according to the Administrator on 1/9/08 at 10:34 a.m. The findings are:</p> <p>1. Resident #6 had diagnoses of Diabetes Mellitus and Hypertension. The Medicare 30-Day Minimum Data Set (MDS) dated 10/29/07 documented the resident was moderately impaired in cognitive skills for daily decision-making and required extensive assistance with most activities of daily living.</p> <p>a. The Physician Order dated 11/20/07 documented, "Accu-checks AC (before meals), every HS (hour of sleep)."</p> <p>b. The Physician Order dated 11/20/07 documented, "Novolog sub-Q (subcutaneous) per</p>	F 333		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

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F 333	<p>Continued From page 1 sliding scale as follows:</p> <p>> (greater than) 200 = 5 Units</p> <p>>250 = 7 Units</p> <p>>300 = 10 Units."</p> <p>c. The resident's January 2008 Medication Administration Record (MAR) documented the resident's blood sugar reading on 1/3/08 at 7:30 a.m. as 260. The MAR documented that Licensed Practical Nurse (LPN) #1 administered 5 Units of Novolog Insulin, instead of the 7 Units, ordered by the Physician.</p> <p>d. On 1/8/07 at 9:36 a.m., LPN #1 was asked why she administered 5 Units of Insulin instead of the ordered 7 Units. She stated, "Oh, I made a mistake. I should've given 7 [units of insulin]. That's my med (medication) error."</p> <p>e. This was a significant medication error due to the classification of the medication (antidiabetic).</p> <p>2. Resident #5 had a diagnosis of Insulin Dependent Diabetes Mellitus (IDDM). The MDS dated 1/4/08 documented the resident had modified independence in cognitive skills for daily decision making and required limited to extensive assistance with activities of daily living.</p> <p>a. The Physician order dated 11/1/07 documented, "Novolin R (Regular) Insulin per sliding scale as follows:</p> <p>200 - 270 = 4 Units,</p> <p>271 - 370 = 6 Units,</p>	F 333			

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F 333	<p>Continued From page 2</p> <p>371 - 400 = 8 Units, >400 call M.D. (Medical Doctor)".</p> <p>The resident's January 2008 MAR documented, "9/28/07 Check Accu-checks QD (everyday) AC (before each meal) QHS (every bedtime) 0730 (7:30 a.m.) rslt (result), 1130 (11:30 a.m.) rslt , 1630 rslt (4:30 p.m.), 2100 (9:00 p.m.) rslt..."</p> <p>b. The resident's December 2007 MAR documented the following:</p> <p>1) On 12/2/07 at 4:30 p.m., the resident's accu check result was 319 and 8 units of insulin was given, instead of 6 units as per the sliding scale ordered by the physician.</p> <p>2) On 12/4/07 at 9:00 p.m., the resident's accu check result was 386 and 4 units of insulin was given, instead of 6 units as per the sliding scale ordered by the physician.</p> <p>3) On 12/19/07 at 11:30 a.m., the resident's accu check result was 188 and 4 units of insulin was administered. According to the sliding scale, no insulin was to be given.</p> <p>4) On 12/19/07 at 4:30 p.m., the resident's accu check result was 197 and 4 units of insulin was administered. According to the sliding scale, no insulin was to be given.</p> <p>c. The resident's January 2008 MAR documented the following:</p> <p>1) On 1/1/08 at 9:00 p.m., the resident's accu check result was 346 and 8 units of insulin was</p>	F 333			

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F 333	Continued From page 3 administered, instead of 6 units according to the sliding scale. 2) On 1/7/08 at 4:30 p.m., the resident's accu check result was 195 and 4 units of insulin was administered. According to the sliding scale, no insulin was to be given. d. On 1/8/08 at 11:50 a.m., LPN #1 was asked about the resident's sliding scale and accu check results for 1/7/08 at 4:30 p.m. The 2008 MAR for January documented 4 units was administered. The LPN was asked why and she stated, "I must've looked at the MAR wrong." e. On 1/9/08 at 10:35 a.m., the Administrator was asked to provide a policy for insulin administration; she stated the facility did not have a policy for insulin administration. f. This was a significant medication error due to the classification of the medication (antidiabetic) and frequency of the error.	F 333			