### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:

445387

#### (X2) MULTIPLE CONSTRUCTION

A. BUILDING
B. WING

#### (X3) DATE SURVEY COMPLETED

08/10/2011

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### NAME OF PROVIDER OR SUPPLIER

PARKWAY HEALTH & REHAB

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<table>
<thead>
<tr>
<th>ID TAG</th>
<th>PREIX</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>F 278</td>
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#### (X4) ID PREIX TAG

<table>
<thead>
<tr>
<th>F 278 SS=D</th>
<th>(g) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</th>
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<td></td>
<td>The assessment must accurately reflect the resident's status.</td>
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A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

### Requirement

This REQUIREMENT is not met as evidenced by:

- Based on medical record review and interview, it was determined the facility failed to complete the Minimum Data Set (MDS) to accurately assess each resident for wound size and urinary incontinence for 2 of 23 (Residents #8 and 14).

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### LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Natalie Beasley, Administrator

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### TITLE

8-24-11

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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 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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FORM CMS-2567(02-99) Previous Version's Obsolete

Event ID: SKVL11 Facility ID: TN7918 If continuation sheet Page 1 of 15
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bladder] INCONTINENCE...Check for incontinence...Q [every] 2 [symbol for hour]...”
Review of the care plan dated 6/21/11 documented, "...has bowel and bladder incontinence...Interventions...disposable briefs.
Change Q2hrs [hours] and prn [as needed]...INCONTINENT: Check the resident Q2hrs and as required...Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes...” Review of the "ADL [Activity of Daily Living] FLOW SHEET" for 6/2- through 30/11, 7/1-31/11, and 8/1-9/11 documented, "...BLADDER FUNCTION...I [incontinent]...” Review of the 5-day and 30-day MDS assessments dated 6/9/11 and 6/22/11 documented, "...Section H...Urinary Continence...0. Always continent...”

During an interview on the West hall on 8/9/11 at 4:47 PM when asked if Resident #14 is continent of urine, Nurse #9 stated, "...No...she's totally incontinent...” When asked if Resident #14 was continent of urine on admission Nurse #14 stated, "...incontinent...total care...”

During an interview at the West hall nurses station on 8/10/11 at 11:10 AM when asked who entered the urinary continence status on Resident #14’s MDS, Nurse #11 confirmed that she had entered the information. When asked how she obtains the information to enter on the MDS, Nurse #11 stated, "...interview the resident, review the chart and ADL’s [activities of daily living]...” When asked if Resident #14 is continent of urine, Nurse #11 stated, "...no...that’s inaccurate...it’ll be corrected on the next assessment...”

F 309 PROVIDE CARE/SERVICES FOR...
**F 309 Continued From page 3**

**HIGHEST WELL BEING**

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This **REQUIREMENT** is not met as evidenced by:

Based on review of the facility's "**DIABETIC PROTOCOL**," medical record review, and interview, it was determined the facility failed to ensure sliding scale insulin (SSI) was administered as ordered, that blood sugars (BSs) were rechecked as ordered and that the protocol was followed for treatment of residents with low BSs for 3 of 10 (Residents #13, 17 and 22) sampled residents receiving insulin.

The findings included:

1. Review of the facility's "**DIABETIC PROTOCOL**" documented, "...SLIDING SCALE INSULIN NOVOLOG 200-300 MG/DL [milligrams/deciliter] = 4 UNITS 300-400 MG = 6 UNITS RECHECK BLOOD SUGAR IN TWO HOURS IF GREATER THAN 300 - CALL MD [medical doctor] IF BLOOD SUGAR DOES NOT DECREASE OVER 400 = 12 UNITS AND CALL MD HYPOGLYCEMIC PROTOCOL (BLOOD GLUCOSE LEVELS OF LESS THAN 60 MG/DL)
   A. CALL MD B. IF CONSCIOUS, GIVE 4 PACKS OF GRANULATED SUGAR IN JUICE OR H2O [water] PC [by mouth] OR PEG"
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X(1) PROVIDER/SUPPLIER CLIA IDENTIFICATION NUMBER.**

445387

**X(2) MULTIPLE CONSTRUCTION**

A. BUILDING ____________________

B. WING ____________________

**X(3) DATE SURVEY COMPLETED**

08/10/2011

**NAME OF PROVIDER OR SUPPLIER**

PARKWAY HEALTH & REHAB

**STREET ADDRESS, CITY, STATE, ZIP CODE**

200 SOUTH PARKWAY WEST

MEMPHIS, TN 38109

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2. Medical record review for Resident #13 documented an admission date of 4/12/11 with diagnoses of Atrial Fibrillation, Hypertension, End Stage Renal Disease and Diabetes Mellitus. Review of the "DIABETIC MONITORING FLOW SHEET" for April 2011 documented the following:

a. 4/15/11 - 4:30 PM, BS = 385, there was no documentation of a recheck of the BS.

b. 4/16/11 - 11:30 AM, BS = 337, there was no documentation of a recheck of the BS.

c. 4/18/11 - 4:30 PM, BS = 45, 5:00 PM, BS = 49, there was no documentation of physician's notification of the low BSs or the resident was treated per protocol for the low BSs.

d. 4/30/11 - 11:30 AM, BS = 200, there was no documentation of insulin given, amount to be given = 4 units.

Review of the "DIABETIC MONITORING FLOW SHEET" for May 2011 documented the following:

a. 5/3/11 - 6:30 AM, BS = 236, there was no documentation of insulin given, amount to be given = 4 units.

b. 5/6/11 - 6:30 AM, BS = 247, there was no documentation of insulin given, amount to be given = 4 units.

c. 5/8/11 - 4:30 PM, BS = 224, there was no documentation of insulin given, amount to be given = 4 units.

d. 5/14/11 - 4:30 PM, BS = 363, there was no documentation of a recheck of the BS.

e. 5/14/11 - 9:00 PM, BS = 366, there was no documentation of a recheck of the BS.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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08/10/2011

**NAME OF PROVIDER OR SUPPLIER:**

PARKWAY HEALTH & REHAB

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

200 SOUTH PARKWAY WEST
MEMPHIS, TN 38109

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**F 309**

Continued From page 5

f. 5/15/11 - 6:00 AM, BS = 262, there was no documentation of insulin given, amount to be given = 4 units.

g. 5/21/11 - 11:30 AM, BS = 308, there was no documentation of a recheck of the BS.

Review of the "DIABETIC MONITORING SHEET" for June 2011 documented the following:

a. 6/1/11 - 4:30 PM, BS = 59, there was no documentation of physician notification of the low BS or that the resident was treated per protocol for the low BS.

b. 6/8/11 - 8:30 AM, BS = 322, there was no documentation of a recheck of the BS.

c. 6/11/11 - 9:00 PM, BS = 362, there was no documentation of a recheck of the BS.

d. 6/21/11 - 11:30 AM, BS = 47, there was no documentation the resident was treated per protocol for the low BS.

3. Medical record review for Resident #17 documented an admission date of 2/3/10 with diagnoses of Hypertension, Dementia, Diabetes, and Muscle Weakness. Review of the "DIABETIC MONITORING FLOW SHEET" for May 2011 documented the following:

a. 5/2/11 - 6:30 PM, BS = 303, there was no documentation of physician notification of the rechecked blood sugar result over 300.

b. 5/3/11 - 8:30 PM, BS = 311, there was no documentation of physician notification of the rechecked blood sugar result over 300.

c. 5/5/11 - 6:30 PM, BS = 409, there was no documentation of physician notification of the rechecked BS result over 400.

d. 5/5/11 - 8:30 PM, BS = 311, there was no documenting of physician notification of the rechecked BS result over 300.

e. 5/17/11 - 11:30 AM, BS = 372, there was no...
Continued From page 6

documentation of a recheck BS performed.
f. 5/17/11 - 4:30 PM, BS = 367, there was no
documentation of a recheck BS performed or
notification of the physician.
g. 5/18/11 - 8:30 PM, BS = 373, there was no
documentation of physician notification of the
rechecked BS result over 300.
h. 5/26/11 - 4:30 PM, BS = 328, there was no
documentation of a recheck BS performed or
notification of the physician.
i. 5/29/11 4:30 PM, BS = 322, there was no
documentation of a recheck BS performed or
notification of the physician.
Review of the "DIABETIC MONITORING FLOW
SHEET" for June 2011 documented the following:
a. 6/11/11 6:30 AM, BS = 58, there was no
documentation of physician notification of the low
BS or that the resident was treated per protocol
for the low BS.
Review of the "DIABETIC MONITORING FLOW
SHEET" for July 2011 documented the following:
a. 7/7/11 4:30 PM, BS = 312, there was no
documentation of a recheck BS performed or
notification of the physician.
b. 7/24/11 4:30 PM, BS = 358, there was no
documentation of a recheck BS performed or
notification of the physician.

4. Medical record review for Resident #22
documented an admission date of 5/10/10 with
diagnoses of Hypertension, Dysphagia, Acute
Kidney Failure and Diabetes Mellitus. Review of
the "DIABETIC MONITORING FLOW SHEET"
for June 2011 documented the following:
6/25/11 - 4:30 PM, BS = 51, there was no
documentation of physician notification or that the
resident was treated per protocol for the low BS.
Review of the "DIABETIC MONITORING FLOW
**F 309** Continued From page 7

SHEET for July 2011 documented the following:

a. 7/3/11 - 4:30 PM, BS = 200, there was no documentation of insulin given, amount to be given = 4 units.

b. 7/6/11 - 4:30 PM, BS = 317, there was no documentation of a recheck of the BS.

c. 7/10/11 - 4:30 PM, BS = 392, there was no documentation of a recheck of the BS.

During an interview in the conference room on 8/10/11 at 9:45 AM, the Director of Nursing (DON) stated, "...if you don't receive any further directives from the physician, you would follow the diabetic protocol..."

**F 332**

483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:

Based on "MED-PASS COMMON INSULINS" provided by the American Society of Consultant Pharmacist, policy review, medical record review, observation and interview, it was determined the facility failed to ensure 3 of 8 (Nurses #2, 4 and 7) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 5 errors were observed out of 41 opportunities for error, resulting in a medication error rate of 12.19%.

The findings included:

1. Review of "MED-PASS COMMON INSULINS:"
### Pharmacokinetics, Compatibility, and Properties

*Continued From page 8*

Pharmacokinetics, Compatibility, and Properties provided by the American Society of Consultant Pharmacists for typical dosing administration of insulin related to meals documented, "Humulin 70/30 ONSET [in hours, unless noted]...30 min...TYPICAL DOSING/COMMENTS...Give approximately 30 minutes before meals...Novolin 70/30 ONSET [in hours, unless noted]...15 min...TYPICAL DOSING/COMMENTS...Give close to meals, e.g. [example], within 15 minutes before a meal..."

2. **The Staff Development Coordinator** will conduct a Medication Pass Competency with each licensed nurse now and quarterly with a focus on A) Insulin within proper time frame of meal B) Providing food as ordered with medication C) Metered Dose Inhaler. The Medication Pass Competency will be maintained in the licensed nurse file.

3. **The Pharmacy consultant will monitor Medication Pass Competency monthly and report findings to monthly CQI.**

4. **Nursing Management** will monitor daily medication administration with a focus on A, B & C and report findings to monthly CQI.

### Medical record review

2. The medical record review for Resident #7 documented an admission date of 1/21/09 with diagnoses of Dementia, Dysphagia, Pressure Ulcers, Chronic Kidney Disease, and Hypertension. Review of a physician's order dated 8/11/11 documented, "CALCULUS WITH VITAMIN D 600 MG [milligrams]-400 TABLET FOR CALTRATE D 1 TAB EVERY DAY WITH FOOD...JEVITY 1.5 AT 70 CC[CUBIC CENTIMETERS]/PER HOUR X [FOR] 20[HRS] [HOURS] PER PEG [percutaneous endoscopy gastrostomy] /PUMP (10A-6A)"

Observations in Resident #7's room on 8/8/11 beginning at 9:05 AM, revealed Nurse #7 administered Calcium 600 mg with 400 IU (international units) Vitamin D mixed with 5 cc of...
### F 332

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Water into the percutaneous endoscopy gastrostomy (PEG) tube. The PEG tube formula was not infusing and the resident did not receive any food with the medication. The administration of the medication without food resulted in medication error #1.

During an interview in Resident #7's room on 8/8/11 at 9:05 AM, Nurse #7 confirmed, "...the formula is not infusing..."

4. Medical record review for Resident #13 documented an admission date of 4/12/11 with diagnoses of Atrial Fibrillation, Hypertension, End Stage Renal Disease and Diabetes Mellitus. Review of a physician's order dated 8/1/11 documented, "...NOVOLOG MIX 70/30 100U/1ML (units/milliliter) INJECT 40 UNITS SUB-Q [subcutaneous] EVERY MORNING..."

Observations in Resident #13's room on 8/9/11 at 7:40 AM, revealed Nurse #4 administered 40 units of Novolog Mix 70/30 to Resident #13. Resident #13 did not receive a meal tray until 8:27 AM. The administration of the insulin more than 47 minutes before breakfast was served resulted in medication error #2.

5. Medical record review for Resident #18 documented an admission date of 9/9/10 with diagnoses of Hypertension, Acute Kidney Failure and Diabetes Mellitus. Review of a physician's order dated 8/1/11 documented, "...NOVOLIN 70/30 100u/ML UNIT 35 UNITS SUB-Q EVERY MORNING..."

Observations in Resident #18's room on 8/9/11 at 7:30 AM, revealed Nurse #4 administered 35
| F 332 | Continued From page 10
|-------|------------------------------------------
|       | units of Novolin 70/30 to Resident #18. Resident #18 did not receive a meal tray until 8:17 AM. The administration of the insulin more than 47 minutes before breakfast was served resulted in medication error #3.
|       | During an interview on the West hall on 8/9/11 at 11:40 AM, Nurse #4 confirmed that the insulin was given too soon in relation to meals.
|       | 6. Medical record review for Resident #17 documented an admission date of 2/3/10 with diagnoses of Hypertension, Dementia, Paralytic Ileus and Diabetes Mellitus. Review of a physician's order dated 8/1/11 documented, "...NOVOLOG 100 U/1ML UNIT INJECT 6 UNITS SUB-Q THREE TIMES DAILY BEFORE BREAKFAST BEFORE LUNCH AND BEFORE SUPPER..."
|       | Observations in Resident #17's room on 8/9/11 at 7:54 AM, revealed Nurse #4 administered 6 units of Novolog insulin to Resident #17. The administration of the insulin after breakfast resulted in medication error #4.
|       | During an interview on the West hall on 8/9/11 at 11:45 AM, Nurse #4 stated, "If I had known his was before breakfast I would have given it before he went to breakfast."
|       | 7. Review of the facility's "Administering Medications through a Metered Dose Inhaler" policy documented, "...15. Repeat inhalation, if ordered. Allow at least one (1) minutes between inhalations of the same medication..."
|       | Medical record review for Random Resident (RR)
### F 332
Continued From page 11

Observations in RR #1's room on 8/8/11 at 9:43 AM, revealed Nurse #2 administered two puffs of an [Pr]opertium inhaler to RR #1. Nurse #2 paused 10 seconds between the puffs. Failure to pause at least one minute between puffs resulted in medication error #5.

During an interview at the West hall nurses’ station on 8/9/11 at 11:30 AM, Nurse #2 stated, "I thought about that last night. I should have waited at least two to three minutes between the puffs."

### F 333
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 "MED-PASS COMMON INSULINS" provided by the American Society of Consultant Pharmacists, policy review, medical record review, observation and interview, it was determined the facility failed to ensure residents were free of significant medication errors. The nursing staff failed to administer insulin within the proper time frame related to meals for 3 of 10 (Residents #13, 17 and 18) sampled residents.

### F Tag 333 (D)
Residents Free of Significant Med Errors

1. Residents #13, 17 and 18 are monitored daily to ensure that insulin is administered within the proper time frame related to meals.

2. All residents receiving insulin are being monitored to ensure that insulin is administered within the proper time frame related to meals.
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The findings included:

1. Review of "MED-PASS COMMON INSULINS: Pharmacokinetics, Compability, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, "Humulin 70/30...ONSET [In hours, unless noted]...30 min [minutes]...TYPICAL DOSING/COMMENTS...Give approximately 30 minutes before meals...Novolog 70/30...ONSET [In hours, unless noted]...15 min...TYPICAL DOSING/COMMENTS...Give close to meals, e.g. [example], within 15 minutes before a meal."

2. Review of the facility's "Administering Medications" policy documented, "...Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meals orders)..."

3. Medical record review for Resident #13 documented an admission date of 4/12/11 with diagnoses of Atrial Fibrillation, Hypertension, End Stage Renal Disease and Diabetes Mellitus. Review of a physician's order dated 8/1/11 documented, "...NOVOLOG MIX 70/30 100U/1ML [units/milliliter] INJECT 40 UNITS SUB-Q [subcutaneous] EVERY MORNING..."

Observations in Resident #13's room on 8/9/11 at 7:40 AM, revealed Nurse #4 administered 40 units of Novolog Mix 70/30 to Resident #13. Resident #13 did not receive a meal tray until 8:27 AM. The administration of the insulin more than 47 minutes before breakfast was served resulted in a significant medication error.

3. An in-service was conducted by the DON with the licensed nurses in regards to medication administration with a focus on administering insulin within proper time frame of a meal.

4. Nursing Management will monitor daily to ensure that insulin is administered within the proper time frame related to meals and report findings to monthly CQI.

5. The Pharmacy consultant will monitor for compliance administering insulin within proper time frame of a meal monthly and report findings to monthly CQI.
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4. Medical record review for Resident #18 documented an admission date of 9/9/10 with diagnoses of Hypertension, Acute Kidney Failure and Diabetes Mellitus. Review of a physician's order dated 8/1/11 documented, "...NOVOLIN 70/30 100u/ML UNIT 35 UNITS SUB-Q EVERY MORNING...".

Observations in Resident #18's room on 8/9/11 at 7:30 AM, revealed Nurse #4 administered 35 units of Novolin 70/30 to Resident #18. Resident #18 did not receive a meal tray until 8:17 AM. The administration of the insulin more than 47 minutes before breakfast was served resulted in a significant medication error.

During an interview on the West hall on 8/9/11 at 11:40 AM, Nurse #4 confirmed that the insulin was given too soon in relation to meals.

5. Medical record review for Resident #17 documented an admission date of 2/3/10 with diagnoses of Hypertension, Dementia, Paralytic Illus and Diabetes Mellitus. Review of a physician's order dated 8/1/11 documented, "...NOVOLOG 100 U/1ML UNIT INJECT 6 UNITS SUB-Q THREE TIMES DAILY BEFORE BREAKFAST BEFORE LUNCH AND BEFORE SUPPER...".

Observations in Resident #17's room on 8/9/11 at 7:54 AM, revealed Nurse #4 administered 6 units of Novolog insulin to Resident #17. The administration of the insulin after breakfast resulted in a significant medication error.

During an interview on the West hall on 8/9/11 at...
Continued From page 14
11:45 AM, Nurse #4 stated, "If I had known his was before breakfast I would have given it before he went to breakfast."

**F 333**

**RECEIVED**

Air Date