

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225497	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Parkway Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1190 Vfw Parkway Boston, MA 02132	

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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40702</b></p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose physician's orders included the administration of oral hypoglycemic agents for treatment and management of his/her diabetes, the Facility failed to ensure he/she was free from a significant medication error, when on 02/09/25 nursing did not properly identify Resident #1 prior to administering him/her Levemir insulin (a long-acting insulin) via subcutaneous injection. Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation and was admitted to the Intensive Care Unit (ICU) for close monitoring of his/her blood sugars and treatment, as needed.</p> <p>Findings Include:</p> <p>Review of the Facility's Policy titled Medication Administration-General Guidelines, undated, indicated the following:</p> <ul style="list-style-type: none"> <li>-medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so</li> <li>-medications are administered in accordance with written orders of the prescriber,</li> <li>-five rights: right resident, right drug, right dose, right route, and right time,</li> <li>-residents are identified before medication is administered using two methods of identification: checking photograph attached to medical record, calling resident by name (except in residents with cognitive impairments), having the resident verify his/her last name, and if necessary, verifying resident identification with other facility personnel.</li> </ul> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 02/14/25, indicated that on 02/09/25 the Director of Nursing (DON) administered 40 units of Levemir insulin (via subcutaneous injection) to Resident #1 in error. The Report indicated that when the DON identified she made the medication error, the on-call provider was alerted, and orders were given to transfer Resident #1 to the Hospital for observation as a precaution. The Report indicated that Resident #1 returned to the Facility the following day, and new orders were given to assess his/her blood glucose levels before meals and at bedtime for three days.</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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an article in Drugs.com the Official Website, dated 03/01/2024, indicated Levemir (detemir) is a man-made form of insulin (a hormone that is produced in the body), that insulin works by lowering levels of glucose (sugar) in the blood, and is used to improve blood sugar control in adults and children with Diabetes Mellitus. The Website indicated Levemir is a long-acting insulin that starts to work several hours after injection and keeps working evenly for up to 24 hours. The Website further indicated an insulin overdose can cause life-threatening hypoglycemia (low blood sugar); symptoms include drowsiness, confusion, blurred vision, numbness or tingling in your mouth, trouble speaking, muscle weakness, clumsy or jerky movements, seizure (convulsions), or loss of consciousness.</p> <p>Resident #1 was admitted to the Facility in June 2024, diagnoses included type 2 diabetes mellitus (non-insulin dependent, the body does not produce enough insulin, or the cells cannot effectively use the insulin that is available), Alzheimer's, hypertension, hyperlipidemia (high cholesterol), and bilateral hearing loss.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], indicated that he/she had severe cognitive impairment.</p> <p>Review of Resident #1's Medication Error Report, dated 02/09/25, indicated that Resident #1 received 40 units of Levemir insulin in error. The Report indicated Resident #1 was immediately assessed, the on-call Provider was notified, and orders were given to transfer him/her to the Hospital ED for evaluation.</p> <p>Review of Resident #1's Medication Administration Record (MAR), dated February 2025, indicated that he/she did not have a physician's order for Levemir insulin, that he/she received Metformin (oral hypoglycemic, lowers blood sugar) to manage his/her diabetes, and that he/she did not have any orders for administration of insulin.</p> <p>Review of Resident #2's Medication Administration Record (MAR), dated February 2025, indicated that he/she had a physician's order for the following:</p> <p>-Insulin Detemir (brand name Levemir) Solution 100 unit/milliliters (ml), inject 40 unit subcutaneously (under the skin) two times a day at 09:00 (9:00 A.M.) and 21:00 (9:00 P.M.).</p> <p>Review of Resident #1's On-Call Provider Note, dated 02/09/25, indicated that medication was given to Resident #1 in error, he/she was not on insulin, his/her blood sugar was 128 and to transfer him/her to the ED for monitoring and treatment.</p> <p>Review of Resident #1's Progress Note, dated 02/09/25, indicated that Resident #1's blood sugar was 154 at 1:10 P.M., (prior to him/her being sent to the Hospital ED).</p> <p>Review of Resident #1's Hospital Discharge Summary (DC), dated 02/10/25, indicated that Resident #1 presented to the ED for an accidental overdose of insulin. The Summary indicated his/her Diabetes had been managed with diet modification and Metformin, was administered 40 units of Levemir accidentally and brought to the ED for further evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The DC Summary indicated that Resident #1's glucose level was 160 milligrams per deciliter (mg/dl) upon arrival to the ED. The Summary indicated that Resident #1 was initially started on D 10 W (dextrose 10% in water intravenous solution), with Intravenous (IV) fluids, which were stopped and they continued to monitor him/her off the IV fluids.</p> <p>The DC Summary indicated Resident #1 was under observation for insulin overdose, and was admitted to the Intensive Care Unit (ICU). The DC Summary indicated his/her blood glucose checks were to be done every one to two hours, and to hold off on Dextrose (sugar, also known as glucose to treat low blood sugar) administration until his/her blood glucose dips below 100 mg/dl.</p> <p>The DC Summary indicated that Resident #1's blood glucose levels (normal range 74-106 mg/dl) were monitored on 02/09/25 and 02/10/25, with levels dropping (low level) and increasing (high level) and documented as follows:</p> <p>-02/09/25 14:09 (2:09 P.M.) 160 mg/dl</p> <p>-02/09/25 14:15 (2 :15 P.M.) 160 mg/dl</p> <p>-02/09/25 14:17 (2:17 P.M.) 146 mg/dl</p> <p>-02/09/25 15:11 (3:11 P.M.) 135 mg/dl</p> <p>-02/09/25 16:09 (4:09 P.M.) 150 mg/dl</p> <p>-02/09/25 18:03 (6:03 P.M.) 132 mg/dl</p> <p>-02/09/25 20:02 (8:02 P.M.) 169 mg/dl</p> <p>-02/09/25 22:10 (10:10 P.M.) 94 mg/dl</p> <p>-02/10/25 00:19 (12:19 A.M.) 108 mg/dl</p> <p>-02/10/25 02:11 (2:11 A.M.) 84 mg/dl</p> <p>-02/10/25 04:24 (4:24 A.M.) 124 mg/dl</p> <p>-02/10/25 05:50 (5:50 A.M.) 78 mg/dl</p> <p>-02/10/25 06:52 (6:52 A.M.) 91 mg/dl</p> <p>-02/10/25 09:32 (9:32 A.M.) 145 mg/dl</p> <p>-02/10/25 11:39 (11:39 A.M.) 103 mg/dl</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/19/25 at 12:31 P.M., Nurse #1 said on 02/09/25, she worked the 7:00 A.M. to 3:00 P.M. shift. Nurse #1 said the Director of Nurses (DON), who was working on another unit, asked her (Nurse #1) for help using the tablet (computer device) so she could contact the on-call provider. Nurse #1 said that the DON told her she (DON) had made a medication error and had administered insulin to the wrong resident (Resident #1).</p> <p>During an interview on 03/20/25 at 2:20 P.M., (which included review of her written statement) the Director of Nursing (DON, now the Former DON) said she worked on one of the nursing units on 02/09/25 because they had no nursing coverage for the 7:00 A.M. to 3:00 P.M. shift. The DON said she was not familiar with the residents on the unit and needed help from the CNA's to identify some of the residents.</p> <p>The DON said Resident #2 was in his/her room that morning, she checked his/her blood sugar and administered his/her insulin coverage, as ordered. The DON said later that morning she asked CNA #1 who Resident #2 was, that CNA #1 pointed to a resident (later identified as Resident #1) who was sitting in the dining room and said she (DON) administered 40 units of Levemir insulin to him/her.</p> <p>The DON said she went to Resident #2's room later to check his/her afternoon blood sugar, and when she went to document the results on his/her MAR, that after looking at his/her photo on the MAR, she realized that she had given the 40 units of Levemir insulin to the wrong resident, and had administered Resident #2's insulin to Resident #1. The DON said Resident #1 was the resident that had been in the dining room earlier that morning, when she had asked a CNA who Resident #2 was. The DON said she notified the on-call provider and obtained an order to send Resident #1 to the Hospital ED for monitoring.</p> <p>The DON said all facility residents have photos on their MARs in Point Click Care (PCC, electronic medical record system) and photos at their bedside. The DON said she had Resident #2's MAR in front of her but could not recall if she looked at the photo on the MAR before she administered the 40 units of Levemir insulin to Resident #1. The DON said she should not have depended on a CNA to identify who the resident was.</p> <p>During an interview on 03/19/25 at 1:00 P.M., (which included review of her interview done by Facility Administration) Certified Nurse Aide (CNA) #1 said she worked the 7:00 A.M. to 3:00 P.M. shift on 02/09/25 and the DON was the Nurse on the unit that day. CNA #1 said that the names of the residents on the unit were similar, and that they all had pictures in their rooms so staff could identify them.</p> <p>CNA #1 said the DON asked her a couple times that day to point out and show her who a certain resident was that she was looking for, but said the DON did not ask her (CNA #1) to point out who Resident #1 or Resident #2 was. CNA #1 said Resident #1 always ate his/her breakfast and lunch in the unit dining room and Resident #2 was not in the dining room that day (02/09/25) because he/she liked to stay in his/her room to eat.</p> <p>During an interview on 03/20/25 at 1:51 P.M., (which included review of her interview done by Facility Administration) CNA #2 said she worked the 7:00 A.M. to 3:00 P.M. shift on 02/09/25 and the nurse on the unit that day was the DON. CNA #2 said she knew the residents on the unit by their room numbers, pictures in their room and on their meal trays.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #2 said the DON had asked her (CNA #2) to point out who some of the residents were that day because she (DON) said she did not know them. CNA #2 said the DON did not ask her (CNA #2) who Resident #1 or Resident #2 were.</p> <p>During an interview on 03/19/25 at 1:17 P.M., the Director of Infection Control said on 02/09/25 the DON notified her that she (DON) had made a medication error, that she (DON) had administered insulin to the wrong resident (administered Resident #2's insulin to Resident #1) and that Resident #1 was being sent to the Hospital ED for evaluation.</p> <p>During an interview on 03/19/25 at 2:45 P.M., the Director of Operations said she was made aware of the medication error on 02/10/25, that the DON told her (Director) that she had administered insulin to Resident #1 in error. The Director said Resident #1 was a Diabetic, but he/she was not insulin dependent and was only taking an oral medication (Metformin) for diabetes.</p> <p>The Director said her expectation is that nurses follow the rights of medication administration, that nurses properly identifying residents prior to them receiving administration of any medications, and that medication administration is conducted in accordance with facility policy.</p> <p>On 03/19/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addressed the area(s) of concern as evidenced by:</p> <p>A. On 02/10/25, Resident #1 returned to the Facility and his/her blood sugars were monitored before meals and at bedtime for three days.</p> <p>B. On 02/14/25 through 02/18/25, the Corporate Clinical Team completed a house audit on all residents who were receiving insulin to ensure their insulin orders were carried out per Physician orders.</p> <p>C. On 02/14/25, 02/15/25, and 02/17/25, The Assistant Director of Nursing provided education to all Licensed Nursing Staff on the Rights of Medication Administration, the Facility's Policy and Procedure on Medication Administration, and Nursing Care of the Resident with Diabetes Mellitus.</p> <p>D. On 02/18/25, an Ad-Hoc QAPI Committee meeting was held to review Facility Policy, the medication error, corrective actions and plans to be implemented.</p> <p>E. The Corporate Nurse and/or designee will conduct daily audits on medication administration of insulin to ensure there are no medication errors identified for two months, then weekly for four weeks, the audits will continue until overall compliance is achieved.</p> <p>F. The results of the audits will be presented and reviewed at the monthly QAPI Committee meeting for three months or until compliance is achieved.</p> <p>G. The Assistant Director of Nursing and/or designee are responsible for overall compliance.</p>