



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF THE INSPECTOR GENERAL**

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Governor**

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Secretary**

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TYPE "A" CITATION

January 12, 2009

**Winchester Center for Health & Rehab
200 Glenway Road
Winchester, Kentucky 40391**

ADMINISTRATOR: Mr. Dennis McNatt

This citation is issued pursuant to KRS 216.555 and KRS 216.557 and 900 KAR 2:040, Section 2 for violations of 902 KAR 20:300, Section 8 (12) (c) 2, and Section 14. This citation may be appealed according to the provisions of 900 KAR 2:020, which state that a written request for a hearing must be made to the Secretary of the Cabinet for Health and Family Services within twenty (20) days of the receipt of the written notice of the action. Any penalty assessed for this citation may be appealed under the same provisions.

Based on the findings of an abbreviated and extended survey, concluded on 01/09/09, it was determined the facility failed to ensure residents were free from significant medication errors for one resident (#20). The facility failed to ensure the proper dosage of Dilantin was dispensed from the pharmacy for resident #20. The facility failed to ensure the licensed staff administered the proper dosage of Dilantin and the proper route of administration for the medication from 11/17/08 through 12/27/08. On 11/16/08, a physicians order was received increasing Resident #20's routine Dilantin to 450 milligrams (extended release capsule), to be administered by mouth, at hour of sleep. The facility's pharmacy dispensed two 100 milligram extended release capsules twice a day (for a total of 400 milligrams). The facility staff administered the improper dosage. Additionally, the facility administered the Dilantin per the resident's Gastrostomy tube which removed the extended release properties of the medication. Resident #20 experienced a grand mal seizure on 12/27/08. A Dilantin level, obtained at that time, was critically low, at 2.6. Resident #20's therapeutic range for the Dilantin Level was 25.9 – 37.3, (normal range is 10.0-20.0). The facility failed to have an effective system in place to ensure medications were properly administered. In addition, the facility failed to have an effective system in place to ensure medications received from the pharmacy were labeled and dispensed per the physician's order. These facility failures placed residents in imminent danger and at substantial risk of death or serious harm. The facility was notified of the imminent danger on 01/09/09.

ISSUED BY: Allen Burnett RECEIVED BY: Jonathan

TITLE: Asst. TITLE: Director of Operations

DATE: 1/12/09 DATE: 1-12-09

WITNESS: Jessie Mobby

DATE TO BE CORRECTED: IMMEDIATELY

CORRECTED DATE: _____

VERIFIED CORRECTED DATE: _____
