

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

PRINTED: 04/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/19/2016
NAME OF PROVIDER OR SUPPLIER ALDERSGATE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 SW ALBRIGHT DRIVE TOPEKA, KS 66614		
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F 000	INITIAL COMMENTS	F 000			
F 333 SS=G	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED 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: The facility identified a census of 179 residents. The sample included 4 residents. Based on observation, interview, and record review the facility failed to provide adequate supervision and orientation to new licensed staff to prevent the (significant medication error) wrong administration of another resident's medications, without physician orders, to a cognitively impaired resident (#2). This resulted in the transfer of the resident by emergency services to an acute care hospital and admission to an intensive care unit for treatment with intravenous medications to counter the effect of those medications.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The clinical face sheet documented the facility admitted resident #2 with diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), unilateral primary osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of right knee, insomnia (inability to sleep), hyperlipidemia [condition of elevated blood lipid (fat) levels], anxiety disorder (mental or emotional reaction 	F 333			

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

TITLE

(X6) DATE

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</p> <p>characterized by apprehension, uncertainty and irrational fear), seasonal allergic rhinitis (runny nose), and arteriosclerotic heart disease [thickening and hardening of the walls of the coronary (heart) arteries].</p> <p>The quarterly Minimum Data Set Assessment dated 1/12/16 recorded the resident's Brief Interview for Mental Status (BIMS) score of (6), which indicated severe cognitive impairment. The resident required extensive to total assist for activities of daily living, except supervision with eating.</p> <p>The residents care plan dated 2/22/16 documented the resident required assistance with activities of daily living and staff administered analgesic (pain relief) medications as ordered by the physician for right knee osteoarthritis.</p> <p>Nursing notes (NN) dated 3/21/16 at 10:46 A.M., recorded at approximately 9:15 A.M. nursing staff observed the resident moaning and leaning over in his/her chair in the dining room. Licensed nursing staff K assessed the resident and asked license nursing staff I what medications he/she administered to the resident before breakfast. Licensed nursing staff K observed the medication administrator record, which included heart medications, were for resident #1, with the same first name. Licensed nursing staff I reported, he/she had given these medications to resident #2. Licensed nursing staff K called emergency medical services to transfer the resident to an emergency room for treatment, and notified the resident's primary care physician.</p> <p>The facility investigation documented staff administered the following medications, recorded</p>	F 333			

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F 333	Continued From page 2 on resident #1's medication administration record to resident #2 (in error): Diltiazem HCL (hydrochloride) ER (extended release) 24 hours tablet, 240 milligrams (mg), an antiarrhythmic calcium channel blocker (a prescription medication that relaxes blood vessels and increased the supply of blood and oxygen to the heart while also reducing the heart's workload, used to treat high blood pressure, and congestive heart failure (a condition with low heart output and the body becomes congested with fluid), and coronary artery disease (abnormal condition that may affect the flow of oxygen to the heart); Carvedilol (COREG) 25 mg, a beta-blocker, a prescription medication that reduces the workload of the heart, and affects the blood flow through arteries and veins), used to treat hypertension (high blood pressure); Carbidopa-levodopa 25/100 mg, a prescription medication used to relieve the symptoms of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike face, shuffling gait, muscle rigidity and weakness); Requip (ropinirole) 4 mg, a prescription medication used to relieve the symptoms of Parkinson's disease; Isosorbide mononitrate ER 90 mg, a prescription medication, vasodilator/nitrate (directly opens the blood vessels), used to treat hypertension; Aspirin-dipyridamole ER 12-hour, 25-200 mg, a prescription medication, antiplatelet (prevent the formation of blood clots) -vasodilator to prevent strokes and heart attacks; Venlafaxine HCL 75 mg, a prescription medication used to treat depression; Lasix 40 mg, a prescription diuretic medication to promote the formation and excretion of urine.	F 333			

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F 333	Continued From page 3 An acute care hospital history and physical dated 3/21/16 timed 2:16 P.M., documented the resident was admitted with low blood pressures in the 50's and 70's (normal systolic blood pressure 90 to 120), and had nausea and vomiting. An acute care hospital discharge summary dated 3/24/16 timed 1:33 P.M., documented the resident with the admission diagnosis of hypotension due to accidental drug ingestion (beta blocker and nitrates), Alzheimer's disease and possible aspiration pneumonitis. The resident accidentally ingested a different resident's medications, developed hypotension (low blood pressure), and bradycardia (slow heart rate). The resident was admitted through the emergency room and monitored in the intensive care unit (ICU). The medications, which were all new to the resident, could affect his/her blood pressure adversely and his/her regular medications were held. The resident continued on a dopamine infusion (chemical neurotransmitter used to treat shock and low blood pressure caused by heart attack and trauma) and levophed (a vasoconstrictor medication which makes blood vessels narrower and increases blood pressure) and gentle intravenous fluid hydration, with gradual improvement in his/her heart rate and blood pressure and was transferred to medical floor. The resident received an antibiotic empirically because of the hypotension, and placed on a pureed diet after speech valuation for a risk of aspiration. The resident received an IJ (internal jugular intravenous line, a catheter placed in the veins of the neck) because of the emergent low blood pressure and poor intravenous access.	F 333			

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F 333	<p>Continued From page 4</p> <p>NN dated 3/24/16 at 2:02 P.M., recorded the resident returned from the hospital.</p> <p>A physician exam note dated 3/25/16 documented the resident returned to the facility after hospitalization from an overdose of cardiac medications that resulted in hypotension, nausea, and vomiting.</p> <p>Observation on 4/14/16 at 9:15 A.M. revealed resident #1 and #2 rooms were located next to each other on the same unit at the facility. Observation of the resident's #1 and #2 paper chart record in the nursing station revealed an orange sticker, that documented "name alert" on the outside of the binder.</p> <p>Observation on 4/14/16 at 11:10 A.M. revealed the resident sat in a Broda chair (specialized wheelchair with the ability to tilt and recline) of the unit living room and watched the group activity.</p> <p>During an interview on 4/14/16 at 9:43 A.M., direct care staff N, reported staff used the resident's picture on the electronic medication administration record (EMAR) to identify the residents when passing medications. Direct care staff N revealed the door name plaque also posted each resident's photo. There are two sets of residents with the same names on his/her unit.</p> <p>Interview on 4/14/16 at 9:55 A.M., licensed nursing staff J revealed he/she was hired the second week of March. Staff rechecked the medication administration record three times with the orders, medication card, and asked the resident his/her name if the resident could tell him/her. Staff verified the resident room number and the EMAR posted a photo of the resident.</p>	F 333			

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F 333	Continued From page 5 Interview on 4/14/16 at 10:05 A.M., licensed nursing staff G revealed he/she received supervision and training for medication administration, when hired by the facility. Licensed nursing staff G reported, when two residents had the same first name, he/she asked their nickname. The resident's MAR and chart recorded both the name and the nickname for the resident. Interview on 4/14/16 at 10:15 A.M., direct care staff O, reported he/she received orientation and training for medication administration during orientation. Direct care staff O always looked at the resident's photo on the EMAR prior to administering medications and the doors have photos and names of the residents. Direct care staff O revealed three residents on this unit had the same first name. Interview on 4/14/16 at 2:30 P.M., administrative nursing staff E revealed during the orientation process, new licensed staff trained with their preceptor/mentor and worked one on one during the orientation. Administrative nursing staff E reported, staff attempted to keep residents with the same name separated from hall to hall or moved one resident to another hall. Staff revealed the unit secretary kept photos up to date for the resident's clinical record. Interview on 4/14/16 at 2:55 P.M., licensed nursing staff H reported the resident sat in a wheelchair in the hallway the morning of 3/21/16 when licensed nursing staff I was in orientation. Licensed nursing staff H revealed the facility placed name alert stickers on resident's physical charts for residents with similar names. However,	F 333			

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F 333	<p>Continued From page 6</p> <p>the EMAR did not distinguish between residents with similar names. Licensed nursing staff H revealed during breakfast the morning of 3/21/16, he/she heard the resident moaning, and observed the resident exhibit uncontrollable tremors of the left arm and hand for a few seconds before he/she went limp. The resident moaned in response to his/her name, was pale with a droopy face and his/her eyes barely open.</p> <p>Interview on 4/14/16 at 2:51 P.M., licensed nursing staff I revealed on 3/21/16, he/she was on day 3 of orientation for medication administration. Licensed nursing staff I asked the resident his/her name and the resident answered with the correct first name. Licensed nursing staff I administered what staff I believed was the resident's medications on 3/21/16 at 8:43 A.M. The electronic record did not identify an alert for residents with the same name and he/she was unaware there were two residents with the same first name. Licensed nursing staff I reported the system he/she was familiar with included the scanning of the medications and resident identification into the system to prevent errors. Licensed nursing staff reported the EMAR posted a photo of the resident.</p> <p>Interview on 4/14/16 at 3:05 P.M., licensed nursing staff K reported he/she was providing orientation with licensed nursing staff I on 3/21/16. Licensed nursing staff K revealed, he/she went into a residents room to help assist with a transfer while licensed nursing staff I passed medications. Licensed nursing staff K reported resident #1 and #2 rooms are right next to each other. The binding of the resident's hard chart contained the similar name alert tag. The EMAR displayed a photo the resident, however</p>	F 333			

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F 333	<p>Continued From page 7</p> <p>did not identify residents with similar names.</p> <p>Interview on 4/14/16 at 3:45 P.M., administrative nursing staff D reported during the orientation process, the preceptor/mentor was expected to stay with the new staff during medication administration.</p> <p>Interview on 4/15/16 at 1:50 P.M., physician consultant FF revealed the resident would not have been able to stay at the facility for treatment. Basically, the resident's blood pressure bottomed out, and he/she was admitted to the ICU for treatment, fluids, and after about 24 hours the situation reversed.</p> <p>The facility lacked a policy to ensure mentors/preceptors supervised the orientation of new licensed nursing staff with medication administrator.</p> <p>The facility provided undated policy Medication administration, general guidelines, documented medications were administered as prescribed in accordance with good nursing principles and practices and only by a person legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Staff checked residents' identification before medication was administered. Methods of identification included: 1) checking identification band [none in this facility]; 2) checking photograph attached to the medical record; 3) calling resident by name; 4) if necessary, verifying resident identification with other facility personnel.</p> <p>The facility failed to ensure staff correctly identified the resident prior to administration of</p>	F 333			

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F 333	Continued From page 8 medications. The deficient practice of medication administration for this cognitively impaired resident resulted in an avoidable significant medication error that required the resident transfer to an acute care hospital, admission to the intensive care unit, and treatment with intravenous medications to counteract the effects of the cardiovascular medications which were administered in error to this resident.	F 333		