

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

PRINTED: 01/18/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/12/2022
NAME OF PROVIDER OR SUPPLIER MERRIAM GARDENS HEALTHCARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 9700 W 62ND STREET MERRIAM, KS 66203		
(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
{F 000}	INITIAL COMMENTS The following citations represent the findings of a Non-compliance Revisit and Complaint investigation KS00168553, KS00168538 and KS00168541.	{F 000}			
{F 760} SS=D	The 2567 was sent electronically on 01/18/22. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility identified a census of 76 residents. The sample included three residents with three reviewed for medication errors. Based on observation, record review and interviews, the facility failed to prevent a significant medication error when Certified Medication Assistant (CMA) R carried two residents' medications to the room simultaneously for administration and administered the wrong medications to Resident(R)1. On 01/10/22 at approximately 11:00 A.M. R1 received his roommate's medications after which R1 experienced malaise, discomfort and vomiting which placed the resident at risk. Findings included: - R1's electronic medical record (EMR) documented he admitted to the facility on 04/06/21 for treatment of multiple medical diagnoses including: diabetes mellitus (a group of diseases that affect how your body uses blood sugar), chronic obstructive pulmonary disease (a	{F 760}			

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

TITLE

(X6) DATE

01/18/2022

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 760}	Continued From page 1 group of lung diseases that block airflow and make it difficult to breathe), hypertension (abnormally high blood pressure) and 40 other medical problems. The "Quarterly Minimum Data Set" (MDS) dated 10/02/21 documented R1 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The assessment recorded R1 was independent with most activities of daily living (ADL's) such as transfers, dressing, and toileting. The MDS documented the resident received insulin (medication used to control blood glucose) for diabetes, an anticoagulant (blood thinning) medication and a diuretic (medication to remove excess body fluid). R1's "Care Plan" revised 01/04/22 documented the resident's cognitive and functional abilities and directed staff to administer medications as ordered. Review of the "Nurses Progress Notes" in R1's EMR documented on 01/10/22 at 11:15 AM R1 received the following medications without a physician order: vitamin B12,(given to treat low levels of the vitamin), Aricept (a medication used to treat dementia (progressive mental disorder characterized by failing memory, confusion), Carafate (a medication used to treat ulcers), and losartan (an antihypertensive drug used to treat high blood pressure). A "Nurses Progress Notes" for 01/10/22 recorded R1 experienced vomiting after receipt of the wrong medications. Review of the "Facility Investigation" documented on 01/10/21 at approximately 11:00 AM CMA R	{F 760}			

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{F 760}	Continued From page 2 inadvertently gave R1 his roommate's medication. The report documented Licensed Nurse (LN) G assessed R1 for any adverse drug reaction; notified R1's physician who would follow-up with the resident and R1's emergency contact was notified. The charge nurse provided reeducation to CMA R. On 01/12/2022 at 12:00 PM R1 was observed in the facility dining room eating lunch and talking with tablemates. Interviewed on 01/12/22 at 12:09 PM, CMA R stated she was not immediately aware of the of medication error. CMA R said she entered R1's room and measured his blood pressure and the blood pressure of his roommate as well. CMR R reported she then recorded both blood pressures and went back to R1's room with medications for R1 and his roommate. CMA R stated R1's roommate was no longer in the room, so she administered the medications to R1 and left to return the unused medications to the cart. CMA R then realized she had given R1 his roommates medications in error. CMA R acknowledged she received reeducation as LN G assessed R1 and notified his physician. Interviewed on 01/12/2022 at 01:16 PM R1 stated he remembered receiving the incorrect medications and stated as a result he was "sicker than a mule" and acknowledge he had vomited. R1 added that he "felt puny for about a day" but was feeling good at the time of the interview. The facility's "Preventing Medication Errors" policy revised 11/23/21 documented medication error means the observed or identified preparation or administration of medication or	{F 760}			

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{F 760}	Continued From page 3 biologicals which is not in accordance with the prescriber's order, manufactures specifications or accepted professional standards and principals. The policy documented a tutorial for administration of medications as well as calculation of medications error rates. The facility failed to prevent a significant medication error for R1, when CMA R administered R1 his roommate's medications in error. The failure caused R1 to experience malaise, stomach upset and vomiting.	{F 760}			