

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

PRINTED: 12/10/2021
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 C 12/08/2021
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	F 000			
F 760 SS=D	The following citations represent the findings of complaint investigation #KS00167417, KS00167459 and KS00167381. The 2567 was sent electronically on 12/10/21. 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 75 residents. The sample included five residents for medication review. Based on observation, record review and interviews, the facility failed to prevent a significant medication error when the licensed nurse failed to verify medication dosage to be given to Resident (R) 1 prior to administering the medication. On 11/22/21 at 10:47 PM Licensed Nurse G administered R1 more than the prescribed amount of oxycodone (an opioid narcotic pain relief medication). After nursing realized R1 received the incorrect medication dosage, R1 received a 4 milligrams (mg) dose of Narcan (a prescription medicine used for the treatment of a known or suspected narcotic overdose). R1 was sent emergently to an acute care facility, and was admitted to the hospital for observation. Findings included: - R1's electronic medical record (EMR) recorded she admitted to the facility on 05/11/21 for treatment of multiple medical diagnoses	F 760			

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

TITLE

(X6) DATE

12/10/2021

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 including: diabetes mellitus (a group of diseases that affect how your body uses blood sugar), a stage 4 pressure ulcer (a full thickness skin loss with extensive destruction; such as dead tissue), quadriplegia (paralysis from the neck down, including the trunk, legs and arms), and anemia (a deficiency of red blood cells or of hemoglobin in the blood, resulting in pallor and weariness). The "Quarterly Minimum Data Set" (MDS) dated 08/06/21 documented R1 had short- and long-term memory problems and severely impaired cognition. R1 required total assistance of one to two staff members with activities of daily living (ADL's) such as: transfers, repositioning, incontinence care, personal hygiene. R1 receive food fluids and medication by a gastrostomy tube (G-tube: a tube inserted through the abdomen directly into the stomach for the administration of food, fluids and/or medications to residents with swallowing problems) and R1 was on a pain management program. She received opioid (narcotic pain medication) seven of the seven look back days. The resident's "Care Plan" last revised on 9/30/2021 documented R1 was at risk for pain due to sepsis related to a sacral pressure ulcer infection. The "Care Plan" directed staff to administer analgesia (pain killer) Tylenol (acetaminophen), hydrocodone/acetaminophen (opioid narcotic with acetaminophen) per orders and to give analgesics one half hour before treatments such as therapy or wound dressing changes. The "Physician's Orders" documented an order dated 09/23/21 for oxycodone solution 5 milligrams (mg) per 5 milliliters (ml) and directed	F 760			

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F 760	Continued From page 2 staff to give 5 ml (5 mg) by G-Tube every 3 hours as needed for mild to moderate pain for a 0-5 rating on the pain scale (method of rating pain on a scale from zero to 10 where zero is no pain and 10 is the worst pain you can imagine). It further directed to give 10 ml (10 mg) by G-Tube every 3 hours as needed for moderate to severe pain 6-10 rating on pain scale. An "Incident Note" dated 11/22/2021 at 11:32 PM documented Licensed Nurse (LN) G and another unidentified nurse from West hall went to do R1's dressing change. R1 appeared very uncomfortable and moaned loudly. She had facial grimacing and tensed body language. R1's as needed oxycodone was administered. While signing out the as needed medication administered, LN G realized the dosing on the bottle read oxycodone 100mg/5ml and not Oxycodone 5mg/5ml. LN G realized R1 received 10ml of the medication. LN g contacted the unidentified on call provider and confirmed order for Narcan and received order to administer Narcan and send R1 to the hospital for evaluation. LN G initiated emergency medical services and also contacted R1's family/responsible party. LN G alerted Administrative Nurses D and E. R1's vital signs at the time of transfer were documented as blood pressure 120/56, pulse rate 65, respirations 16, and temperature 97.9 degrees Fahrenheit. The "Facility Investigation" documented on 11/22/21 at 10:47 PM recorded LN G administered oxycodone prior to R1's wound dressing change. LN G located R1's oxycodone bottle that had just been delivered, verified the resident's name and that is was the correct medication and administered 10ml via R1's	F 760			

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F 760	Continued From page 3 G-Tube. While counting medications at shift (less than 30 minutes later), LN G noticed the dosage on R1's oxycodone bottle was different from that in the EMR. The bottle directions indicated there was 100 milligrams in five milliliters of solution, concentrated, with instructions to give 0.25ml-0.5ml (5-10 mg) by mouth every three hours as needed. The "General Progress Note" from the acute care hospital recorded R1 admitted to the hospital on 11/23/21 and discharged on 11/24/21. Her principal diagnosis was recorded as sepsis (whole-body immune response to infection). The note recorded R1 also had a "possible accidental medication overdose." The note documented it was reported R1 received 200 mg of oxycodone at approximately 11:00 PM on 11/22/21. R1 received two doses of Narcan totaling 6 mg. R1's Glasgow Coma Scale (GCS- most common scoring system used to describe the level of consciousness in a person) remained near her baseline and she remained awake and alert, with reactive pupils. R1's respirations remained 12-16 in the emergency room and she remained stable since the dosing. On 12/08/21 at 11:37 AM R1 laid in bed, on her right side, with pillows for support and comfort. Her breathing was unlabored. No acute distress observed. On 12/08/21 at 11:50 PM LN G was unavailable for interview. Interviewed on 12/08/21 at 11:51 AM LN H stated she provided care to R1 today. She stated she was aware of the medication error and confirmed the new bottle sent from the pharmacy contained	F 760			

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F 760	Continued From page 4 a more concentrated amount of medication. LN H stated when she left the facility on 11/23/21 the bottle had just a little bit of medication left and was 5mg/5ml so the five milligrams would have been correct using that medication. She further said that bottle must have been used up and the pharmacy sent out a bottle that had a more concentrated solution. LN H stated she thought LN G assumed it was the same and, without double checking administered the wrong dose. Interviewed on 12/08/21 at 01:24 PM Administrative Nurse D stated Consultant Physician GG had recorded the medication prescription through "Express Scripts." Consultant GG increased the concentration due to the fact R1 used so much of the medication. Administrative Nurse D stated typically these changes are made from within the facility so nursing staff was aware and the orders were updated in the electronic medical record. She said since this order from outside the facility, it did not automatically update in the electronic medical record so when the new bottle arrived (in a different concentration) the nurse did not pay attention to the dosage on the bottle and administered based on the old order. Interviewed on 12/08/21 at 01:30 PM Administrative Staff A stated the facility had identified the error and situation and had immediately began an audit of all resident records and medications to ensure accuracy. The facility interdisciplinary team, including the facility's Medical Director met to discuss and implement an immediate plan to ensure no further occurrences. The facility's "Administration of Medications"	F 760			

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F 760	Continued From page 5 policy documented all medications were administered in a safe and timely manner as prescribed. The facility failed to prevent a significant medication error for R1, a cognitively impaired resident, when LN G failed to verify R1's medication dose/concentration prior to administration. This placed R1 at risk for adverse side effects related to possible accidental opioid overdose.	F 760			