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	175551	A. BUILDING _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF OLATHE	21250 WEST 151ST STREET OLATHE, KS 66061

(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		

The following citations represent the findings of complaint investigations #KS00180982 and KS00180932.

On 06/26/23 at 01:40 PM, Administrative Staff A received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for Resident (R) 1.

On 06/18/23 at approximately 09:00 AM, Licensed Nurse (LN) G administered R2's medications to R1, which included three antihypertensive (medication used to treat hypertension [high blood pressure]) medications, one antianxiety (medication used to treat anxiety [mental or emotional reaction characterized by apprehension, uncertainty and irrational fear]) medication, one antidepressant (medication used to treat depression [major mood disorder]) medication, one narcotic (medication used to treat pain) medication, and eight other medications. LN G did not verify R1's name before she gave R1 the medications. When LN G identified the error, she called Consultant GG who gave orders to monitor R1 and ordered a medication to help increase R1's blood pressures. At 09:30 to 09:50 PM, R1's blood pressure was 90/64 millimeters per mercury (mmHg) with a pulse of 49 beats per minute (bpm). About two hours later, R1's oxygen saturation began declining. LN H notified the on-call provider on 06/19/23 at 12:35 AM and received an order to send R1 to the hospital. When Emergency Medical Services (EMS) arrived, R1 was unresponsive, and EMS began cardiopulmonary resuscitation (CPR- emergency medical procedure for restoring normal heartbeat

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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and breathing to victims of heart failure, drowning, et cetera) until confirmation of her do not resuscitate (DNR) status. R1 passed away in the facility on 06/19/23 at 01:26 AM. The facility failure to ensure R1 remained free from significant mediation errors placed R1 in immediate jeopardy.

The facility implemented the following corrective action, which were completed by 06/19/23:

LN G was suspended pending investigation, was counseled, and received education 06/19/23. She was assigned computer training and observation and performance of skills training before she worked by herself again in the facility.
Inservice with all Certified Medication Aides (CMAs) and nurses on the "Six Rights of Medication Administration" on 06/19/23.
An emergency "Quality Assurance Performance Improvement (QAPI)" meeting was held on 06/19/23 with a "Root Cause Analysis (RCA)" and "Performance Improvement Plan (PIP)" identified and put into place.
Name alerts for residents with similar names were placed in the EMR on 06/19/23.
Name plates outside of residents' rooms were updated with first and last names on 06/19/23.
Medication administration observations were initiated on 06/19/23 with a plan to be completed for five residents daily for five days then five residents weekly for five weeks.

Completion of the corrective actions were verified onsite and therefore the deficient practice was deemed past noncompliance and remained at the scope and severity of "J."

The 2567 was sent electronically on 07/11/23.

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F 760 SS=J	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 53 residents. The sample included three residents. Based on record review and interviews, the facility failed to ensure Resident (R) 1 remained free of significant medication errors. On 06/18/23 at approximately 09:00 AM, Licensed Nurse (LN) G administered R2's medications to R1, which included three antihypertensive (medication used to treat hypertension [high blood pressure]) medications, one antianxiety (medication used to treat anxiety [mental or emotional reaction characterized by apprehension, uncertainty and irrational fear]) medication, one antidepressant (medication used to treat depression [major mood disorder]) medication, one narcotic (medication used to treat pain) medication, and eight other medications. LN G did not verify R1's name before she gave R1 the medications. When LN G identified the error, she called Consultant GG who gave orders to monitor R1 and ordered a medication to help increase R1's blood pressures. At 09:30 to 09:50 PM, R1's blood pressure was 90/64 millimeters per mercury (mmHg) with a pulse of 49 beats per minute (bpm). About two hours later, R1's oxygen saturation began declining. LN H notified the on-call provider on 06/19/23 at 12:35 AM and received an order to send R1 to the hospital. When Emergency Medical Services (EMS) arrived, R1 was unresponsive, and EMS began cardiopulmonary resuscitation (CPR- emergency medical procedure for restoring normal heartbeat	F 760	Past noncompliance: no plan of correction required.	

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F 760	Continued From page 3	F 760		

and breathing to victims of heart failure, drowning, et cetera) until confirmation of her do not resuscitate (DNR) status. R1 passed away in the facility on 06/19/23 at 01:26 AM. The facility failure to ensure R1 remained free from significant mediation errors placed R1 in immediate jeopardy.

Findings included:

- The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of cognitive communication deficit, need for assistance with personal care, and generalized muscle weakness.

The "Significant Change Minimum Data Set (MDS)" dated 06/05/23, documented R1 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. R1 required extensive assistance with one staff for bed mobility; extensive assistance with two staff for transfers and toileting; supervision with one staff for locomotion, eating, and personal hygiene; and limited assistance with one staff for dressing.

The "Cognitive Loss/Dementia (progressive mental disorder characterized by failing memory, confusion) Care Area Assessment (CAA)" dated 06/14/23, documented R1 had a BIMS score of 11.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated 06/14/23, documented R1 needed help with ADLs and mobility.

The "Care Plan" dated 10/05/22 and last revised

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on 01/16/23, documented R1 had an ADL self-care performance deficit and directed staff to explain all procedures/tasks before starting.

The facility's "Investigation" dated 06/22/23, documented on 06/18/23 at approximately 09:00 AM, LN G administered R2's medications to R1. The medications given to R1 were carvedilol (antihypertensive medication) 25 milligrams (mg), losartan potassium (antihypertensive medication) 50 mg, metoprolol tartrate (antihypertensive medication) 50 mg, gabapentin (medication used to treat seizures and neuropathy [nerve pain]) 100 mg, guaifenesin (expectorant- medication used to thin mucus in the air passages to make it easier to cough and clear the airways) 400 mg, Tylenol (pain medication) 650 mg, buspirone (antianxiety medication) hydrochloride (HCl) 5 mg, cholecalciferol (vitamin) 1000 Units, Claritin (allergy medication) 10 mg, duloxetine HCl (antidepressant medication), levothyroxine (medication used to treat hypothyroidism [condition characterized by decreased activity of the thyroid gland]) 25 micrograms (mcg), multivitamin, omeprazole (medication used to treat acid reflux [backflow of stomach contents to the esophagus]), and oxycodone (narcotic pain medication) 5 mg. LN G discovered her error within 10 minutes and immediately called Consultant GG. She received orders to monitor R1's condition and blood pressure and to administer midodrine (medication used to increase blood pressure) five mg with meals for one day. Consultant GG assessed R1 within a couple of hours and R1 was stable at that time. There were orders to continue to monitor R1's condition and to take her blood pressure every four hours. Throughout the afternoon and evening, R1 was stable without any changes in

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her blood pressure. At 09:30 PM, LN H noted R1's blood pressure dropped to 90/60 mmHg. LN H administered extra oral fluids and oxygen as her oxygen saturations were dropping, as well. She called the provider since R1 was not responding to the interventions and was told to send her to the hospital. When EMS arrived, they found R1 unresponsive and R1 was a DNR. R1 passed away shortly after EMS arrival.

In a "Witness Statement" on 06/19/23, LN G stated on 06/18/23, she passed morning medications. She asked LN H if it was R1 or R2 sitting at the table. She stated she heard LN H say it was R2 sitting at the table, so she got R2's medications ready. LN G stated she checked the resident's blood pressure and then gave her the medications. She continued to pass medications down the hallway and when she got to R1's room, she saw she had already labeled a cup to put her medications in. She then realized R1 received the wrong medications, and she went in to check on her and got a full set of vitals with assessment. LN G stated she called the on-call number and was advised to call the on-call nurse practitioner. She stated she called Consultant GG and did what she told her to do. LN G stated Consultant GG came by later to check on R1. She stated Consultant GG put orders in to check R1's blood pressure at designated intervals which she stated she did. LN G stated at the end of her shift, R1 was stable, and she reported to the oncoming shift about the new orders and the medication error.

In a "Witness Statement" on 06/19/23, LN H stated she was asked by LN G which resident was in the dining room. She explained the resident in the dining room was R1 and that R2

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usually stayed in her room for meals. About an hour and a half later, LN G stated she thought she had given the wrong medications to the wrong resident. LN H stated she advised LN G to call the staffing number to get instructions on what to do next. She stated she was instructed to help LN G fill out the risk assessment form. LN H stated that was all the involvement she had in the situation, and she never saw or evaluated R1.

In a "Witness Statement" on 06/19/23, LN I stated she reported for her scheduled night shift on 06/18/23. She received report from LN G and was told that a medication error was made involving R1, who was given the wrong medications. LN I stated she was told that an order for midodrine two doses had been administered before 05:00 PM and that R1's blood pressures did come up. She stated frequent blood pressures were to be done. LN I stated when she saw R1 at approximately 06:30 PM, R1 was lethargic and almost asleep. She asked R1 if she was going to eat her dinner and R1 stated, no she did not want it. LN I stated she gave R1 her bedtime medications and left the room. At approximately 09:30 PM, she took R1's blood pressure and pulse which were 90/54 mmHg and 49 bpm. R1 was still lethargic but continued to converse and answer questions. Two Certified Nurse Aides (CNAs) assisted with making R1 comfortable and blood pressures were taken many times with systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) ranging from 85 to 78 mmHg and pulses in the 50's, 40's, and 30's bpm. LN I stated at that time, her blood oxygen level was noted to be in the high 70's to middle 80's, she then placed R1 on oxygen. She stated R1 remained conversant and answered questions

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until approximately 12:00 AM. She called the on-call provider and received an order to send R1 to the hospital then called 911. LN I stated R1 had coded in her room and paramedics were working on her. EMS did chest compressions until they were told to stop by EMS direction, as R1 had a DNR order. R1's time of death was 01:26 AM.

On 06/26/23 at 11:03 AM, Administrative Nurse D stated on 06/18/23, LN G was passing morning medications and asked LN H if a resident was R1 or R2. LN G thought she heard LN H say it was R2. He stated when LN G got to R2's room, she saw R2 was in her room and realized she made a medication error. Administrative Nurse D stated LN G notified Consultant GG, who saw R1. He stated R1's blood pressure and heart rate dropped, and staff administered two doses of midodrine and R1 stabilized until later that night. Around 10:00 PM to 12:00 AM, LN I noted R1 was more lethargic, and LN I encouraged fluids, as her blood pressure and pulse were low, and R1's blood oxygen level was dropping, so LN I placed R1 on oxygen. LN I notified the provider and received an order to send R1 to the hospital. Administrative Nurse D stated when EMS arrived, they found R1 unresponsive and started compressions but stopped when they confirmed R1's DNR status.

On 06/26/23 at 12:26 PM, LN I stated she was told in report on 06/18/23 that R1 received R2's medications. She stated when she saw R1, R1 was more tired but carried on a conversation. She went to give R1 her medications around 06:30 PM because R1 liked to go to bed early and noticed something was not quite right with R1. LN I stated she took R1's blood pressure around 09:00 PM, not knowing she had scheduled hourly

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blood pressures, and R1's blood pressure kept dropping along with her blood oxygen level. She stated R1 was drinking fluids and carried on a conversation. LN I stated she notified the provider around 11:30 PM to 12:00 AM.

On 06/28/23 at 04:11 PM, Consultant GG stated on 06/18/23 around 09:00 to 09:30 AM, she received a call about R1's medication error. She stated she gave a stat (immediate) order to administer midodrine and to call her back in 15 minutes with a full set of vitals. Consultant GG stated she was on her way to the facility and saw R1, who was alert and oriented. She stated she put an order in for scheduled midodrine because she was given antihypertensive medications and an order to check BP and pulse with a directive to call the provider if R1's SBP was less than 90 mmHg, or her pulse was less than 50 bpm.

On 06/28/23 at 07:03 PM, LN G stated on 06/18/23 she started labeling medication cups and reviewed the "Medication Administration Record (MAR)" and "Treatment Administration Record (TAR)" for what she had to do. She stated around breakfast, she was passing medications to residents in the dining room first and saw a resident in the dining room. She asked a coworker if the resident was R1 or R2 and the coworker said the wrong name. LN G stated she gave the resident medications and continued down the hallway. When she got to R1's room some time after breakfast, saw her in her room, saw she still had a medication cup labeled with R1's room number, and realized she had given R1 the wrong medications earlier in the dining room. LN G stated she notified Consultant GG who gave an order for midodrine and blood pressure monitoring every 15 minutes then every

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four hours. She stated R1 was stable the rest of her shift. She stated R1 had an order to monitor blood pressure and pulse with parameters to call the provider if they were below a certain number. LN G stated she passed the order on in report.

The facility's "Six Rights of Medication Administration" dated March 2023 directed the facility administered medications in accordance with care and practice and while typically five rights of medication were commonly acknowledged, the policy included an additional protocol for consideration of administration of medications. The "policy" directed the six rights of medication administration as right medication, right dose, right route, right time, right resident, and right documentation. The "policy" directed staff checked resident photo and addressed resident by their name.

The facility failed to ensure R1 remained free of significant medication errors on 06/18/23 at approximately 09:00 AM, when LN G administered R1's morning medications to R2. This deficient practice resulted in R1 becoming hypotensive and placed R1 in immediate jeopardy.

The facility implemented the following corrective action, which were completed by 06/19/23:

LN G was suspended pending investigation, was counseled, and received education 06/19/23. She was assigned computer training and observation and performance of skills training before she worked by herself again in the facility.
Inservice with all Certified Medication Aides (CMAs) and nurses on the "Six Rights of Medication Administration" on 06/19/23.

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F 760	Continued From page 10 An emergency "Quality Assurance Performance Improvement (QAPI)" meeting was held on 06/19/23 with a "Root Cause Analysis (RCA)" and "Performance Improvement Plan (PIP)" identified and put into place. Name alerts for residents with similar names were placed in the EMR on 06/19/23. Name plates outside of residents' rooms were updated with first and last names on 06/19/23. Medication administration observations were initiated on 06/19/23 with a plan to be completed for five residents daily for five days then five residents weekly for five weeks. Completion of the corrective actions were verified onsite and therefore the deficient practice was deemed past noncompliance and remained at the scope and severity of "J."	F 760		