

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/27/2023
NAME OF PROVIDER OR SUPPLIER MORNINGSIDE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 6921 W 81ST STREET OVERLAND PARK, KS 66204		
(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citation represent the findings of an abbreviated survey for complaint #184060 of the above named facility conducted on 11/27/23.	S 000		
S3026 SS=G	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (1) (B) The facility reported a census of 63 residents. The sample included one "Resident" (R)1. Based on record review and interview the administrator failed to ensure the facility's "Licensed Nurse's" ((LN)'s A, B and C), provided physician follow up services for R1's medications. This failure prevented R1 from receiving her prescribed medications for 25 days, which included Eliquis (a blood thinner). During this time R1 developed a "Deep Vein Thrombosis" (DVT) in her lower left extremity. Findings included:	S3026		

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

TITLE

(X6) DATE

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S3026	Continued From page 1 - Record review for R1 revealed an admission date of 10/19/23, with diagnoses of Tinea unguium, unspecified atherosclerosis of native arteries of extremities of bilateral legs, unspecified dementia, difficulty in walking, anxiety disorder due to known physiological condition, hypokalemia, encephalopathy, hypertensive heart disease without heart failure, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, general muscle weakness, and altered mental status. R1's "Functional Capacity Screening" (FCS) dated 10/20/23 revealed R1 required physical assistance with bathing, dressing, toileting, transferring, mobility, eating and she lacked the ability to manage her own medications. She was marked with impaired; short-term memory, long-term memory, memory recall and decision making. She used a wheelchair mobility device. R1's combined "Negotiated Service Agreement / Health Service Plan" (NSA/HSP) dated 10/20/23, identified the facility would provide physical assistance with bathing, eating, dressing, toileting, and the LN or "Certified Medication Aide" (CMA) would administer medications and perform all task related to ordered treatments. Review of R1's "Progress Notes" dated 10/19/23 to 11/26/23 revealed the following entries: On 10/19/23 at 09:32 PM R1 arrived at the community with her daughter and required extensive assistance from one person. R1 did not arrive with any medications. R1 would use the facility's preferred pharmacy and the medication list was faxed to the pharmacy. The	S3026		

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S3026	Continued From page 2 "Nurse Practitioner" (NP) was notified of R1 arrival and was "ok" to admit with current medication list. On 11/13/23 at 08:36 PM the order to R1's for venous doppler to the left lower extremity ordered. On 11/15/23 at 10:53 AM Family was notified results of the doppler was positive for a deep vein thrombosis in the left leg. The "Power of Attorney" (POA) wanted R1 left in the community to be treated. A late entry in the progress notes entered on 11/16/23 at 09:49 AM revealed "On 11/13/23 "Advanced Practice Registered Nurse" (APRN) was here and was informed R1's medication was not available from pharmacy since admission. Order received for Venous Doppler lower let extremity related to deep vein thrombosis". Signs/symptoms were swelling and pain of the left lower extremity. R1's "Electronic Medication Administration Record" (e-MAR) dated 10/19/23 to 11/18/23 revealed the following; Eliquis (medication used to prevent blood clots) Tablet 5 milligram take one tablet by mouth twice daily. The e-MAR revealed R1 did not receive the morning dose of this medication until 11/14/23 (missed 25 days), and she did not receive the evening dose until 11/17/23 (missed 27) days. Metoprolol Tartrate (medication for high blood pressure) tablet 25 milligram. Take one half	S3026		

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S3026	Continued From page 3 tablet (12.5 milligram) by mouth every morning. The E-mar revealed R1 did not receive this medication from 10/22/23 to 11/18/23 (missed 28 days). Review of the E-mar "Medication Notes" dated 10/21/23 to 11/15/23 revealed the facility CMAs documented "Medication not found nursing contacted" and "Pending pharmacy delivery" for the missed medication doses. In an interview on 11/27/23 with LN D at 01:28 PM, he stated that on 10/21/23 the CMA on duty did not call him to report that R1's medications were not in the medication cart. In an interview on 11/27/23 with CMA E at 02:48 PM, she stated on 10/21/23 she "may have hit the wrong button" when charting, she continued to state she thought that the nurse was automatically notified if she charted the medications were not available, and she concluded she could not remember if she "actually told" the charge nurse that R1's medications were not available. Review of the facility provided document titled "Physician Telephone Order" dated 10/20/23 and signed by an unreadable signature on the physician line and dated 10/20/23 as signed by the physician revealed Provider DD was listed at the top of the page and had the following statement "medications as previously given from previous facility". In an interview on 10/27/23 at 03:13 PM with Director of Operations of the Pharmacy F, he revealed the pharmacy did an internal	S3026		

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S3026	Continued From page 4 investigation on the reason R1 did not receive her medications, and found the following: On 10/20/23 the pharmacy received a telephone order, "Electronic Prescription" (E-script), and a copy of the prior facility's medication list. The documents sent to the pharmacy lacked the Resident Service Agreement, face sheet/move in record, and the pharmacy staff did not interpret the medication list from the prior facility as meeting the prescription requirements for the pharmacy. On 10/21/23 the pharmacy faxed a document to the community requesting allergies and a physician signature on the medication list. The pharmacy received a face sheet with R1's prior facility heading and prior health care provider CC. R1's current health care provider was no on the document. On 10/22/23 the pharmacy faxed provider CC the medication list for prescription approval. On 10/23/23 the pharmacy received the resident service agreement from the facility. On 10/24/23 a fax was sent from the pharmacy to the facility, which stated the pharmacy continued to await a valid prescription for dispensing R1 medications and placed the document into the medication delivery tote that went to the facility. On 10/26/23 the pharmacy again faxed provider CC the medication list for prescription approval. On 11/06/23 the pharmacy again faxed provider	S3026		

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S3026	Continued From page 5 CC the medication list for prescription approval. On 11/07/23 the pharmacy received a call from LN B, to go over a report and an inquiry was made about R1's medications. The pharmacy staff explained to LN B that they were still awaiting a response from provider CC. On LN B failed to verify the provider of the prescriptions during the phone call with the pharmacy. On 11/08/23 the pharmacy sent a fax to the facility that indicated the prescriptions for R1 continued to await authorization and the document was placed into the medication delivery tote that went to the facility. On 11/09/23 the pharmacy sent an E-script to Provider CC for R1. On 11/13/23 the pharmacy received a call from LN B inquiring about medications for several residents. The pharmacy staff again stated R1's prescriptions were pending authorization from Provider CC. The pharmacy was informed at this time that APRN G was currently in the facility and would authorize the orders. Review of the fax/ "Electronic Mail" (E-mail) correspondence from LN A revealed the following: On 10/21/23 at 10:23 AM a fax/E-mail was sent to the facility from the pharmacy, and on 10/23/23 at 10:02 AM this fax/E-mail was forwarded to LN A and LN C. The content of the transmission was R1's the medication pages	S3026		

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S3026	Continued From page 6 from the prior facility requesting the provider's signature. On 10/24/23 at 08:12 AM a fax/E-mail was sent to the facility from the pharmacy, and on 10/24/23 at 09:54 AM it was forwarded to LN A and LN C. The content of the fax/E-Mail was the request for completion of the "Resident Service Agreement Form". On 11/08/23 at 02:48 PM a fax/E-mail was sent to the facility from the pharmacy, and on 11/08/23 at 02:57 PM was forwarded to LN A and LN C. The content of the fax/E-Mail was a document titled "Cycle Notification Report" that listed several residents. R1 was listed with the following comment typed into the form; "Pending Valid Prescriptions for dispensing", and the prescriber line lacked the name of the provider. In an interview on 11/27/23 at 12:30PM with LN A revealed he was out of the facility from 10/22/23 through 10/30/23, and in his absence LN C was "in charge". He stated that the fax/E-mails came to the facility and were forwarded to himself, and LN C. LN A stated the pharmacy built the "Medication Administration Records" (MARS) for the residents for the electronic medical records system the facility used. In an interview on 11/27/23 at 12:38 PM with LN B, she stated that on 11/08/23 LN C performed the admission for R1. She stated on 11/08/23 she was asked by LN C to call APRN G about R1's medication orders. LN B continued to state APRN G asked that LN C re-write the medication orders and that APRN G would sign them. LN B stated that at no time did the CMAs inform her	S3026		

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S3026	Continued From page 7 that R1 had no medications on the medication cart. LN B stated she did not work from 11/09/23, to 11/12/23. She stated on 11/13/23 when she came back, R1's medications were still not in the building. She continued to state on 11/13/23 R1 was seen by APRN G and a doppler was ordered at this time. LN B stated she called the pharmacy, obtained the orders, had them signed by APRN G and returned the signed orders the pharmacy. (This was confirmed by the timeline provided by Director of Operations of the Pharmacy F from their internal investigation). In an interview on 11/27/23 with LN C at 01:45 PM, she confirmed she did the admission for R1 and that she did fax the medication list for R2 to the pharmacy. She stated that when the faxes came in, they went directly to Administrator H, and they were then forwarded to her and LN A. She stated that on 11/04/23 CMA I reported R1, and one other resident were out of medications on the medication cart. She stated she did not call the pharmacy and she wrote it in the 24-hour book for the next nurse to take care of. She stated LN B would have worked the next shift. She continued to state that on her next shift there was no follow up for her to go over upon her return to the facility. In an interview on 11/27/23 at 05:18 PM with LN B, she stated on 11/05/23 she noticed a note for missing medications and further stated she "May have called the pharmacy". She stated she thought the call was only for the creams missing from the nurse treatment cart. LN B confirmed on 11/08/23 that LN C called her and asked her to	S3026		

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S3026	Continued From page 8 call APRN G for R1's medication orders, and re confirmed she told LN C that APRN G asked for the orders to be re-written. She further stated on 11/07/23 when speaking to the pharmacy, she did not know if they stated provider CC by name. She stated she was "still pretty new" at that time. The administrator failed to ensure LN A, LN B, and LN C, provided health care services for R1's medications when they failed to follow up on medication orders for R1. This failure prevented R1 from receiving her ordered medications that included Eliquis, from 10/20/23 to 11/13/23 which resulted in R1 developing a deep vein thrombosis in her lower left extremity.	S3026		