STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175465	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE PITTSBURG INC	1502 E CENTENNIAL PITTSBURG, KS 66762

(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 citation represent the findings of complaint investigation #KS00186159 and KS00186315. This 2567 was electronically sent to the facility on 03/14/24.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/14/2024

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 755	Continued From page 1	F 755		

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 83 residents. The sample included three residents reviewed for pain-controlled substance medication. Based on observation, interview, and record review, the facility failed to prevent a medication error when Licensed Nurse (LN) I failed to document in Resident (R)1's Electronic Health Records (EHR). On 02/28/24 at 06:00 AM, LN I administered oxycodone (opioids [narcotic analgesics]), five milligram (MG) tablet, as an as needed (PRN) pain medication. On 02/28/24 at 08:00 AM, two hours later, LN H administered R1's scheduled oxycodone, which was to be administered one hour prior to leaving for dialysis (a blood purifying treatment given when kidney function in not optimum), for pain. The facility failed to ensure no use of as needed (PRN) administered within a six-hour time frame of the scheduled doses, as ordered by the physician. This failure caused R1 to receive two doses of oxycodone, five mg, two hours apart.

Findings Included:

- The signed "Physician Order Sheet" (POS) for R1, dated 02/28/24, documented R1 admitted to the facility on 02/22/24, with the following diagnoses that included pneumonia (inflammation of the lungs) and pain.

The "Admission Minimum Data Set", dated 02/22/24, documented the resident had a "Brief Interview of Mental Status" of eight, that indicated moderately impaired cognition.

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F 755	Continued From page 2	F 755		

The residents "Pain Care Plan" dated 02/22/24, guided staff that resident rated his pain on a scale of four out of 10.

The "Physician's Orders" included Oxycodone, five milligrams (mg), one tablet, by mouth, every Monday, Wednesday, and Friday, one hour prior to leaving for dialysis and as needed (PRN) every six hours as needed for pain. Ensure no use of as needed script within six-hour time frame of the scheduled doses, dated 02/23/24.

Review of the "Controlled Drug Receipt/Record/ Disposition Form", revealed on 02/28/24 at 06:00 AM, Licensed Nurse (LN) I signed out for R1's Oxycodone, five milligrams. At 08:00 AM, LN H signed out for R1's Oxycodone.

Review of the "Medication Administration Record" (MAR) on 02/28/24, revealed the MAR lacked documentation of the Oxycodone at 06:00 AM medication.

On 02/28/24, at 05:56 AM, the progress notes revealed R1 refused cares but allowed the nurse to administer his medications.

On 3/07/24 at 11:41 AM, Licensed Nurse (LN) I reported R1 requested to take his pain medication early. LN I reported that she administered his as needed oxycodone and verified she did not document the administration in the MAR. She reported that she did log it on the controlled substance control log.

On 03/07/24 at 03:13 PM, Administrative Nurse D reported staff should document the date, time, and staff initials on the bubble pack of

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medication, check the control substance log and EHR. Administrative Nurse D stated staff should not have a medication error if nursing staff were following the correct way to administer medications.

The facility's "Medication Administration Policy", revised 12/2021, documented that the individual administering must verify three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. The individual administering the medication is to document on the Medication Administration Record after giving each medication and before administering the next one.

The facility failed to prevent a medication error when Licensed Nurse (LN) I failed to document in Resident (R)1's Electronic Health Records (EHR). On 02/28/24 at 06:00 AM, LN I administered oxycodone (opioids [narcotic analgesics]), five milligram (MG) tablet, as an as needed (PRN) pain medication. On 02/28/24 at 08:00 AM, two hours later, LN H administered R1's scheduled oxycodone, which was to be administered one hour prior to leaving for dialysis (a blood purifying treatment given when kidney function in not optimum), for pain. The facility failed to ensure no use of as needed (PRN) administered within a six-hour time frame of the scheduled doses, as ordered by the physician. This failure caused R1 to receive two doses of oxycodone, five mg, two hours apart.