STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175298	A. BUILDING _____ B. WING _____	C 03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND POST ACUTE REHABILITATION	**7850 FREEMAN AVENUE KANSAS CITY, KS 66112**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00186391, KS00185658, and KS00184708. The 2567 was sent electronically on 03/25/24.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 110 residents. The sample included three residents. Based on record review, interview, and observation, the facility failed to ensure staff implemented nursing services consistent with standards of care when staff failed to follow a physician's order to notify emergency medical services (EMS) when Resident (R) 1 had chest pain and required a second dose of nitroglycerine (NTG-medication used to relieve an angina attack that is already occurring) and failed to assess vital signs to monitor resident status. This deficient practice placed R1 at risk for delayed emergency care and complications related to the use of NTG. Findings included: - R1's Electronic Medical Record (EMR) under	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/25/2024

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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the "Diagnosis" tab listed diagnoses of atrial fibrillation (rapid, irregular heartbeat), atherosclerotic heart disease (a condition where the arteries become narrowed and hardened due to buildup of plaque (fats) in the artery wall), cerebral infarction (stroke), and hypertension (elevated blood pressure).

The "Annual Minimum Data Set" (MDS) dated 06/16/23 documented R1 scored a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 required partial to moderate assistance with toileting and showering.

R1's "Activity of Daily Living (ADL) Care Area Assistance" (CAA) dated 06/16/23 directed R1 was at risk for alteration in self-care related to bowel and bladder incontinence and required assistance with ADLs.

R1's Physicians Orders under the "Orders" tab listed:
Nitroglycerin tablet sublingual (under the tongue) 0.4 milligrams (mg) give one tablet sublingually every five minutes as needed for chest pain ordered 02/28/24. Dissolve the one tablet under the tongue, may repeat up to two times at five-minute intervals. The order directed nursing to call 911 if the pain persisted longer than five minutes after the first dose and the resident continued to take the second and third dose if pain persisted.

Review R1's March "Medication Administration Record" (MAR) documented R1 received three doses of NTG on 03/04/24 at 11:40 PM, then at 11:46 PM, and lastly at 11:52 PM.

A review of R1's "Vitals" tab documented the

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F 684	Continued From page 2	F 684		

following blood pressures after the administration of NTG doses at 62/38 millimeters of mercury (mmHg) at 12:19 AM on 03/05/24 and 75/50 mmHg at 12:21 AM on 03/05/24.

R1's "Vitals" tab lacked evidence staff assessed blood pressure directly before the first dose of NTG and before the second dose of NTG.

The "Medication Administration Note" dated 03/04/24 at 11:40 PM documented R1 complained of sharp chest pain and was administered a first dose of NTG.

The "Medication Administration Note" dated 03/04/24 at 11:45 PM documented the first dose of NTG that was administered was ineffective.

R1's clinical record lacked evidence the physician was notified after the first dose was ineffective.

The "Medication Administration Note" dated 03/04/24 at 11:46 PM documented a second dose of NTG was administered.

The "Medication Administration Note" dated 03/04/24 at 11:51 documented the second dose of NTG was ineffective.

R1's clinical record lacked evidence the physician was notified after the second dose was ineffective.

The "Medication Administration Note" dated 03/04/24 at 11:52 documented that a third dose of NTG was administered.

The "Medication Administration Note" dated 03/04/24 at 11:57 PM documented the third dose

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of NTG was ineffective.

The "Medication Administration Note" dated 03/05/24 at 12:24 AM documented R1 had a change of condition of left eye pain, redness, and drainage with the provider notified, as well as family and R1.

The "Nursing Note" dated 03/05/24 at 12:37 AM documented R1 reported sharp chest pain and her vitals were assessed. R1 received NTG as ordered by the physician and R1 stated she wanted to go to the hospital and complained of feeling dizzy with chest pain. 911 was called for R1 and she was sent to the Emergency Room (ER).

Review of R1's Emergency Room "After Visit Summary" dated 03/05/24 documented R1 had a blood pressure of 161/63 mmHg and a Troponin I (the Troponin test measures the levels of Troponin I proteins in the blood-these proteins are released when the heart muscle has been damaged, such as occurs with a heart attack) blood level of 10 nanograms per Liter (ng/L) which indicated a normal level.

On 03/11/24 at 01:35 PM, R1 lay in bed with her eyes closed and no signs or symptoms of distress.

On 03/11/24 at 01:58 PM Administrative Nurse F stated that the nurses should have followed the physician's orders. Administrative Nurse F stated the nurse was expected to follow the physician's orders and Licensed Nurse (LN) G should have called the doctor after R1 received the first dose and then LN G should have called EMS when R1 continued to have pain.

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F 684	Continued From page 4 On 03/11/24 at 02:25 PM LN G stated that she remembered checking R1's initial vitals but must not have recorded her vitals in R1's chart. LN G stated that the physician was called when R1 received the third dose of NTG. LN G looked at the physician orders in R1's EMR and revealed she failed to see R1's order and directed staff to call 911 after the first dose if the resident continued to have chest pain. The facility's policy "Pharmacy Services: Physician Orders" revised 09/2018 documented it was the policy of the facility that drugs would be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs. The facility's policy lacked directions to follow the written order of the drugs. The facility failed to ensure staff implemented nursing services consistent with standards of care when staff failed to follow a physician's order to notify emergency medical services (EMS) when R1 received three consecutive doses of NTG. The facility further failed to ensure that R1's blood pressure was checked in between doses and that the physician was contacted after the first dose was administered.	F 684		