| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175180 | A. Building<br>B. Wing | 01/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Overland Park Center for Rehabilitation and Health | 5211 W 103rd Street<br>Overland Park, KS 66207 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39752<br><br>The facility identified a census of 112 residents. The sample included three residents with three reviewed for diabetic services. Based on interview, record review, and observation the facility failed to ensure licensed nursing staff possessed the skills and knowledge necessary to follow physician orders, and failed to ensure the licensed nurses possessed knowledge regarding insulin (hormone which regulates blood sugar)administration and monitoring of residents who received fast acting insulin. On 01/17/22 Resident (R)1 admitted to the facility with orders for sliding scale insulin 0-5 units four times daily dependent upon R1's blood glucose levels. The facility staff inaccurately entered an order to administer insulin lispro (fast acting insulin) 10 milliliters four times daily with no reference to the blood glucose level. Licensed nursing (LN) staff failed to identify the dose ordered, 10 ml equal to 1000 units, as a potentially lethal dose of insulin and failed to call the physician and clarify the order. LN staff administered an altered dose of 10 units, but failed to call the physician for clarification and failed to correct the order dosing. LN staff further failed to document the actual amount of insulin administered. LN staff failed to apply the standards of nursing practice when they administered the excessive dose of fast acting insulin on three occasions when R1's blood glucose was less than 100 milligrams per deciliter (mg/dl) (normal blood glucose levels range between 90 and 130 mg/dl). LN staff failed to assess R1's blood glucose level when he was identified as unconscious in the facility on 01/21/22 at 11:26 PM. Emergency responders assessed R1 and found his blood glucose level at 21 mg/dl. He required emergent transfer to the acute care hospital where he was admitted with profound hypoglycemia (low blood glucose). These failures placed R1 in Immediate Jeopardy.<br><br>Findings included:<br><br>- R1's Electronic Medical Record (EMR), under the Diagnosis tab listed diagnoses of muscle weakness and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) type two.<br><br>The Five Day Minimum Data Set (MDS) dated [DATE] recorded R1's Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 required extensive assistance of one staff member for activities of daily living (ADL) including bed mobility, transfers, locomotion on the unit, dressing, toilet use, and personal hygiene. R1 required supervision with set up help only for eating. The MDS documented R1 received injections of insulin three days during the look back period.<br><br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Care Plan initiated 01/20/22 directed staff to administer medications as ordered and monitor/document side effects and effectiveness.<br><br>The Care Plan lacked interventions for diabetic management.<br><br>The Hospital Discharge Orders dated 01/17/22 documented insulin lispro 100 units/milliliter (mL) injection one to five units subcutaneously (beneath the skin) four times daily before meals and nightly for diabetes mellitus type two.<br><br>The hospital Medication Administration Record (MAR), scanned into R1's EMR recorded the following sliding scale used for R1:<br><br>Blood glucose (BG) 0-120 mg/dl: Give 0 units.<br><br>BG 121-150 mg/dl: Give 0 units.<br><br>BG 151-200 mg/dl: Give 0 units.<br><br>BG 201-250 mg/dl: Give 1 unit.<br><br>BG 251-300 mg/dl: Give 2 units.<br><br>BG 301-350 mg/dl: Give 3 units.<br><br>BG 351-400 mg/dl: Give 4 units.<br><br>BG greater than (>) 400 mg/dl: Give 5 units.<br><br>R1's EMR lacked evidence facility nursing staff clarified the insulin orders with the discharging hospital or R1's physician upon admission.<br><br>The Orders tab in R1's EMR documented the following orders:<br><br>Accu-check (blood sugar-testing devices) four times daily before meals and nightly ordered 01/17/22. The order directed staff to call the physician if BG measured below 60 or above 400.<br><br>Insulin lispro 100 units/mL ordered 01/17/22, inject 10 mL subcutaneously (SQ) before meals and at bedtime for diabetes mellitus, type two.<br><br>R1's January 2022 MAR documented the following BG and insulin lispro administration:<br><br>01/17/22 09:00 PM 10 ml insulin administered by LN K no BG recorded.<br><br>01/18/22 07:30 AM BG 130 mg/dl,10 ml insulin administered by LN L.<br><br>01/18/22 11:30 AM BG 271 mg/dl, 10 ml insulin administered by LN L.<br><br>01/18/22 04:30 PM BG 120 mg/dl, 10 ml insulin administered by LN P.<br><br>(continued on next page) |

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|---|---|
| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 01/18/21 09:00 PM BG 133 mg/dl, 10 ml insulin administered by LN P.<br><br>01/19/22 07:30 AM BG 112 mg/dl, 10 ml insulin administered by LN Q.<br><br>01/19/22 11:30 AM BG 92 mg/dl, 10 ml insulin administered by LN Q.<br><br>01/19/22 04:30 PM BG 210 mg/dl, 10 ml insulin administered by LN P.<br><br>01/19/22 09:00 PM BG 210 mg/dl, 10 ml insulin administered by LN K.<br><br>01/20/22 07:30 AM BG 162 mg/dl, 10 ml insulin administered by LN R.<br><br>01/20/22 11:30 AM BG 112 mg/dl, insulin held by LN R for documented reason Not required.<br><br>01/20/22 04:30 PM BG 113 mg/dl, 10 ml insulin administered by LN K.<br><br>01/20/22 09:00 PM BG 200 mg/dl,10 ml insulin administered by LN K.<br><br>01/21/22 07:30 AM BG 97 mg/dl, 10 ml insulin administered by LN H.<br><br>01/21/22 11:30 AM BG 98 mg/dl, 10 ml insulin administered by LN H.<br><br>01/21/22 04:30 PM BG 117 mg/dl,10 ml insulin administered by LN G.<br><br>01/21/22 09:00 PM BG 107 mg/dl,10 ml insulin administered by LN G.<br><br>The Progress Note dated 01/21/22 at 11:26 PM documented R1 found on his bed and unresponsive. Licensed Nurse (LN) I assessed R1's oxygen saturation levels as 99 percent and contacted emergency medical services (EMS). EMS arrived at the facility and measured R1's BG as 21 mg/dl. The note documented R1 did not respond to any commands. R1's responsible party requested R1 go to the hospital for treatment and evaluation.<br><br>The Progress Notes lacked evidence facility staff assessed R1's blood glucose levels prior to arrival of EMS and lacked evidence staff took actions to identify and/or reverse R1's acute hypoglycemic condition other than EMS notification.<br><br>The hospital History and Physical (HPI) from R1's admission on 01/22/22 at 12:32 AM recorded R1 presented to the emergency department from his nursing home with altered mental status. EMS measures a BG of 20. The HPI documented review of the facility MAR reveled the order for insulin lispro 100 units/ml, inject 10 ml SQ before meals and bedtime. The HPI recorded it was unclear how much insulin R1 received. The HP further documented there were significant discrepancies in R1's most recent discharge medication list and the medication list sent by the facility. The HPI listed a diagnosis of profound hypoglycemia.<br><br>(continued on next page) |

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|---|---|
| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 01/27/22 at 11:35 AM Administrative Nurse D stated when a resident admitted to the facility, the admitting nurse put in the physician orders that came with the resident from the hospital. Administrative Nurse D further stated that either herself or another administrative nurse would review the orders the following day. Administrative Nurse D then revealed there was no system in place to verify which newly admitted residents' orders were checked and verified by an administrative nurse. Administrative Nurse D stated if a resident admitted with unclear orders, the nurse was expected to call the physician to clarify the orders.<br><br>On 01/27/22 at 01:48 PM LN G reviewed R1's insulin lispro order sand stated that although the insulin order read 10 mL, she only administered 10 units of insulin. LN G further revealed she had not held any insulin when she cared for R1. LN G reported she received training on insulin administration and care of diabetic patients in nursing school. LN G stated she did not assess R1's BG level when identifying he was unresponsive, because she had notified emergency services.<br><br>On 01/27/22 at 12:39 PM Consultant Provider GG reviewed the insulin lispro order under the Orders tab and stated the nurses should have called to clarify that order. Consultant GG further stated that even 10 units seemed a bit excessive for a resident that had not previously been insulin dependent.<br><br>On 01/27/22 at 01:53 PM LN H stated she would not have administered 10 mL of insulin to R1, and stated she was unsure what the order should have been. LN H reported she administered 10 units instead of 10 ml because ml and units were the same. LN H reported it never occurred to her to hold the fast-acting insulin and contact the physician based on a lower BG level.<br><br>On 01/27/22 at 02:05 PM Consultant Nurse HH stated the nurse did the right thing by calling EMS, waiting for them to arrive, and not doing anything else to assess R1. Consultant HH stated when a resident was unconscious, it was appropriate to call emergency responders and then wait for them to arrive.<br><br>On 01/27/22 at 2:20 PM Administrative Staff A stated that he expected Administrative Nurse D to be auditing the orders for admitting residents and following up on any discrepancies or administration concerns.<br><br>The facility's Insulin Administration policy revised on 05/2021 recorded the type of insulin, dosage requirements, strength and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. The nurse shall notify the director of nursing services and the attending physician of any discrepancies before giving the insulin. The nurse should notify the physician if the resident has signs and symptoms of hypoglycemia that are not resolved by following the facility protocol for hypoglycemia management.<br><br>The facility's Change in a Resident's Condition or Status policy revised 11/2017 directed staff to notify the resident's attending physician or on-call physician when there has been a significant change in the resident's physical, mental, or psychosocial status either in life-threatening conditions or clinical complications.<br><br>The facility failed to ensure licensed nursing staff possessed the skills and knowledge necessary to follow physician orders, to administer insulin and monitor diabetic residents who receive fast acting insulin according to the standards of practice. This failure placed R1 in immediate jeopardy.<br><br>(continued on next page) |

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|---|---|
| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The immediacy was removed when the facility implemented the following:<br><br>An investigation started on 1/31/22.<br><br>Staff identified as allegedly providing wrong dose of insulin has been suspended pending investigation.<br><br>The Assistant Director of Nursing began education on 01/31/22 related to physician order transcription, facility insulin administration policy an identifying and managing medication errors and adverse consequences as well as notifying the physician of any potential error in medication orders. Any licensed nurses not working were reeducated prior to their next shift.<br><br>A Root Cause Analysis was performed in order to help identify and prevent further incidents of this nature.<br><br>Any nurse transcribing any new insulin orders will have orders reviewed by a second licensed nurse prior to administering any insulin.<br><br>The Director of Nursing or Designee will review all new medication orders during morning clinical meeting for accuracy.<br><br>A skills competency check will take place for all licensed nurses prior to the administration of any insulin.<br><br>The scope and severity of the deficient practice remained at a G. |

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|---|---|
| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39752<br><br>The facility identified a census of 112 residents. The sample included three residents with three reviewed for diabetic services. Based on interview, record review, and observation the facility failed to prevent a significant medication error when the facility failed to ensure Resident (R) 1 received the correct physician ordered sliding scale insulin (hormone which regulates blood sugar). On 01/17/22 R1 admitted to the facility with orders for sliding scale insulin 0-5 units four times daily dependent upon R1's blood glucose levels. The facility inaccurately entered an order to administer 10 milliliters four times daily with no reference to the blood glucose level. Staff then administered 10 units of insulin on eleven occasions when no insulin was required per the correct order. Staff also administered 10 units of insulin on three occasions when only 1 unit was required, and one occasion when only 2 units were required. Subsequently, on 01/21/22 after staff administered the incorrect dose of 10 units of insulin, R1 was found unconscious with a blood glucose level of 21 milligrams per deciliter (mg/dl) (normal blood glucose levels range between 90 and 130 mg/dl). He required emergent transfer to the acute care hospital where he was admitted with profound hypoglycemia (low blood glucose). This placed R1 in Immediate Jeopardy.<br><br>The facilty further failed to prevent a medication error for R2, who received a double dose of the antipsychotic medication risperadone and received a dose of a medication used to lower blood pressure (atenolol) that was not ordered by the physician.<br><br>Findings included:<br><br>- R1's Electronic Medical Record (EMR), under the Diagnosis tab listed diagnoses of muscle weakness and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) type two.<br><br>The Five Day Minimum Data Set (MDS) dated [DATE] recorded R1's Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1's required extensive assistance of one staff member for activities of daily living (ADL) including bed mobility, transfers, locomotion on the unit, dressing, toilet use, and personal hygiene. R1 required supervision with set up help only for eating. The MDS documented R1 received injections of insulin three days during the look back period.<br><br>The Care Plan initiated 01/20/22 directed staff to administer medications as ordered and monitor/document side effects and effectiveness.<br><br>The Care Plan lacked interventions for diabetic management.<br><br>The Hospital Discharge Orders dated 01/17/22 documented insulin lispro 100 units/milliliter (mL) injection one to five units subcutaneously (beneath the skin) four times daily before meals and nightly for diabetes mellitus type two.<br><br>The hospital Medication Administration Record (MAR), scanned into R1's EMR recorded the following sliding scale used for R1:<br><br>Blood glucose (BG) 0-120 mg/dl: Give 0 units<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | BG 121-150 mg/dl: Give 0 units.<br><br>BG 151-200 mg/dl: Give 0 units.<br><br>BG 201-250 mg/dl: Give 1 unit.<br><br>BG 251-300 mg/dl: Give 2 units.<br><br>BG 301-350 mg/dl: Give 3 units.<br><br>BG 351-400 mg/dl: Give 4 units.<br><br>BG greater than (>) 400 mg/dl: Give 5 units.<br><br>R1's EMR lacked evidence facility nursing staff clarified the insulin orders with the discharging hospital or R1's physician upon admission.<br><br>The Orders tab in R1's EMR documented the following orders:<br><br>Accu check (blood sugar-testing devices) four times daily before meals and nightly ordered 01/17/22. The order directed staff to call the physician if BG measured below 60 or above 400.<br><br>Insulin lispro 100 units/mL ordered 01/17/22, inject 10 mL subcutaneously (SQ) before meals and at bedtime for diabetes mellitus type two.<br><br>R1's January 2022 MAR documented the following BG and insulin lispro administration:<br><br>01/17/22 09:00 PM 10 ml insulin administered by LN K no BG recorded.<br><br>01/18/22 07:30 AM BG 130 mg/dl,10 ml insulin administered by LN L<br><br>01/18/22 11:30 AM BG 271 mg/dl, 10 ml insulin administered by LN L<br><br>01/18/22 04:30 PM BG 120 mg/dl, 10 ml insulin administered by LN P<br><br>01/18/21 09:00 PM BG 133 mg/dl, 10 ml insulin administered by LN P<br><br>01/19/22 07:30 AM BG 112 mg/dl, 10 ml insulin administered by LN Q<br><br>01/19/22 11:30 AM BG 92 mg/dl, 10 ml insulin administered by LN Q<br><br>01/19/22 04:30 PM BG 210 mg/dl, 10 ml insulin administered by LN P<br><br>01/19/22 09:00 PM BG 210 mg/dl, 10 ml insulin administered by LN K<br><br>01/20/22 07:30 AM BG 162 mg/dl, 10 ml insulin administered by LN R<br><br>01/20/22 11:30 AM BG 112 mg/dl, insulin held by LN R for documented reason Not required'<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 01/20/22 04:30 PM BG 113 mg/dl, 10 ml insulin administered by LN K<br><br>01/20/22 09:00 PM BG 200 mg/dl,10 ml insulin administered by LN K<br><br>01/21/22 07:30 AM BG 97 mg/dl, 10 ml insulin administered by LN H<br><br>01/21/22 11:30 AM BG 98 mg/dl, 10 ml insulin administered by LN H<br><br>01/21/22 04:30 PM BG 117 mg/dl,10 ml insulin administered by LN G<br><br>01/21/22 09:00 PM BG 107 mg/dl,10 ml insulin administered by LN G<br><br>The Progress Note dated 01/21/22 at 11:26 PM documented R1 was found on his bed and unresponsive. Licensed Nurse (LN) I assessed R1's oxygen saturation levels as 99 percent and contacted emergency medical services (EMS). EMS arrived at the facility and measured R1's BG as 21 mg/dl. The note documented R1 did not respond to any commands. R1's responsible party requested R1 go to the hospital for treatment and evaluation.<br><br>The hospital History and Physical (HPI) from R1's admission on 01/22/22 at 12:32 AM recorded R1 presented to the emergency department from his nursing home with altered mental status. EMS measures a BG of 20. The HPI documented review of the facility MAR reveled the order for insulin lispro 100 units/ml, inject 10 ml SQ before meals and bedtime. The HPI recorded it was unclear how much insulin R1 received. The HP further documented there were significant discrepancies in R1's most recent discharge medication list and the medication list sent by the facility. The HPI listed a diagnosis of profound hypoglycemia.<br><br>On 01/27/22 at 11:35 AM Administrative Nurse D stated when a resident admitted to the facility, the admitting nurse put in the physician's orders that came with the resident from the hospital. Administrative Nurse D further stated that either herself or another administrative nurse would review the orders the following day. Administrative Nurse D then revealed there was no system in place to verify which newly admitted residents' orders were checked and verified by an administrative nurse. Administrative Nurse D stated if a resident admitted with unclear orders, the nurse was expected to call the physician to clarify the orders.<br><br>On 01/27/22 at 01:48 PM LN G reviewed R1's insulin lispro order sand stated that although the insulin order read 10 mL, she only administered 10 units of insulin. LN G further revealed she had not held any insulin when she cared for R1. LN G reported she received training on insulin administration and care of diabetic patients in nursing school. LN G stated she did not assess R1's BG level when identifying he was unresponsive because she had notified emergency services.<br><br>On 01/27/22 at 12:39 PM Consultant Provider GG reviewed the insulin lispro order under the Orders tab and stated the nurses should have called to clarify that order. Consultant GG further stated that even 10 units seemed a bit excessive for a resident that had not previously been insulin dependent.<br><br>On 01/27/22 at 01:53 PM LN H stated she would not have administered 10 mL of insulin to R1, and stated she was unsure what the order should have been. LN H reported she administered 10 units instead of 10 ml because ml and units were the same. LN H reported it never occurred to her to hold the fast-acting insulin and contact the physician based on a lower BG level.<br><br>(continued on next page) |

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|---|---|
| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 01/27/22 at 2:20 PM Administrative Staff A stated that he expected Administrative Nurse D to be auditing the orders for admitting residents and following up on any discrepancies or administration concerns.<br><br>The facility's Identifying and Managing Medication Errors and Adverse Consequences revised 04/2007 documented staff and practitioner shall try to prevent medication errors and adverse medication consequences and shall strive to identify and manage them appropriately when they occur.<br><br>The facility's Reconciliation of Medications of Admission revised 10/2010 documented this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility.<br><br>The facility's Insulin Administration policy revised on 05/2021 recorded the type of insulin, dosage requirements, strength and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. The nurse shall notify the director of nursing services and the attending physician of any discrepancies before giving the insulin. The nurse should notify the physician if the resident has signs and symptoms of hypoglycemia that are not resolved by following the facility protocol for hypoglycemia management.<br><br>The facility failed to prevent a significant medication error when the facility failed to ensure R1 received the correct physician ordered sliding scale insulin. R1 admitted to the facility with orders for sliding scale insulin 0-5 units four times daily dependent upon R1's blood glucose levels. The facility inaccurately entered an order to administer 10 milliliters four times daily with no reference to the blood glucose level. Staff then administered 10 units of insulin on eleven occasions when no insulin was required per the correct order. Subsequently, on 01/21/22 after staff administered the incorrect dose of 10 units of insulin, R1 was found unconscious with a blood glucose level of 21 milligrams per deciliter (mg/dl). He required emergent transfer to the acute care hospital where he was admitted with profound hypoglycemia (low blood glucose). This placed R1 in Immediate Jeopardy.<br><br>The immediacy was removed when the facility implemented the following:<br><br>An investigation started on 1/31/22.<br><br>Staff identified as allegedly providing wrong dose of insulin has been suspended pending investigation.<br><br>The Assistant Director of Nursing began education on 01/31/22 related to physician order transcription, facility insulin administration policy an identifying and managing medication errors and adverse consequences as well as notifying the physician of any potential error in medication orders. Any licensed nurses not working were reeducated prior to their next shift.<br><br>An audit of all residents who require insulin was initiated on 1/31/2022 to ensure that orders are transcribed as written in a clear way.<br><br>A Root Cause Analysis was performed in order to help identify and prevent further incidents of this nature.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Any nurse transcribing any new insulin orders will have orders reviewed by a second licensed nurse prior to administering any insulin.<br><br>Director of Nursing or Designee will review all new medication orders during morning clinical meeting for accuracy.<br><br>The scope and severity of the deficient practice remained at a G.<br><br>- R2's Electronic Medical Record (EMR), under the Diagnosis tab listed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), atrial fibrillation (rapid, irregular heart beat),and muscle weakness.<br><br>The Entry Minimum Data Set (MDS) dated [DATE] documented R2 admitted to the facility.<br><br>The Hospital Discharge Orders, dated 01/12/22, documented the following orders:<br><br>Acetaminophen (used to treat mild to moderate pain) 650 milligrams (mg) take two tablets by mouth every eight hours.<br><br>Diclofenac (used to relieve pain and swelling) topical apply two grams topical to right knee four times daily.<br><br>Diltiazem (used to prevent chest pain) 240mg/24 hours capsule extended release take one by mouth daily<br><br>Ferrous sulfate (used to treat or prevent low blood levels of iron) 325 mg tablet by mouth daily<br><br>Losartan (used to treat high blood pressure) 50 mg by mouth daily<br><br>Potassium chloride (medication used to prevent low amounts of potassium in the blood) 10 milliequivalent (mEq) by mouth daily<br><br>Pravastatin (used to help lower bad cholesterol and fats and raise good cholesterol in the blood) 40 mg by mouth daily<br><br>Risperidone (used to treat a certain mental/mood disorder called schizophrenia) one mg by mouth at bedtime<br><br>Tamsulosin (medication used by men to treat the symptoms of an enlarged prostate) 0.4 mg by mouth daily<br><br>Warfarin (medication use for blood thinner) three mg by mouth daily, adjust to INR goal two to three.<br><br>The Order tab documented the following orders:<br><br>Atenolol (blood pressure medication) give 25 mg by mouth in the evening for hypertension ordered 01/12/22<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175180 | A. Building<br>B. Wing | 01/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Overland Park Center for Rehabilitation and Health | 5211 W 103rd Street<br>Overland Park, KS 66207 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Risperdal give one mg by mouth at bed time for depression ordered 01/12/22<br><br>Risperidone give one mg by mouth at bed time for depression ordered 01/13/22<br><br>Review of the January 2022 Medication Administration Record (MAR) revealed R2 received atenolol 25 mg on 01/13/22. R2's clinical record lacked evidence a physician ordered the atenolol. The MAR further documented R2 received a duplicate dose of risperidone 1 mg twice at bed time on 01/13/22 for a total of 2 mg<br><br>The progress notes lacked documentation of medication orders to reflect a change from discharge orders R2 admitted with from the hospital.<br><br>On 01/27/22 at 11:10 AM Licensed Nurse (LN) J stated that the orders were put in by the nurse that admits the resident to the facility. He further revealed that it was an administrative nurse that reviewed the orders for a second set of eyes.<br><br>On 01/27/22 at 11:35 AM Administrative Nurse D stated when a resident admitted to the facility, the admitting nurse put in the orders that came with the resident. Administrative Nurse D further stated that either herself or another administrative nurse would review the orders the following day. Administrative Nurse D then revealed that there was no system in place to verify which resident had admitting orders double checked and which one hadn't received that oversight. Administrative Nurse D stated if a resident admitted with unclear orders, the nurse was expected to call the physician to clarify the orders.<br><br>The facility's Reconciliation of Medications of Admission revised 10/2010 documented this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility.<br><br>The facility failed to prevent a medication error when morders were transcribed inaccurately for R2 when the admitting nurse entered the risperidone order twice and the atenolol that was not ordered for R2 when he admitted to the facility. |