STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175180	A. Building B. Wing	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overland Park Center for Rehabilitation and Health	5211 W 103rd Street 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 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22686 The facility identified a census of 102 residents. The sample included six residents reviewed for medication. Based on record review and interviews, the facility failed to prevent a significant medication error when Resident (R)1 received eight times the prescribed amount of morphine sulfate, (a narcotic pain reliever). On 12/06/22 at 02:53 AM, Licensed Nurse (LN) L administered forty milligrams (mg) of morphine sulfate (narcotic medication used to treat moderate to severe pain) instead of the physician ordered five mg. An assessment on 12/06/22 at 05:30 AM revealed a change in R1's breathing and level of consciousness. On 12/06/22 at 08:00 AM, R1 transferred to the hospital for emergent care related to the medication error . Findings included: - The electronic medical record (EMR) documented R1 admitted to the facility on [DATE], discharged to the hospital on 11/21/22, and readmitted to the facility on [DATE]. R1's EMR listed diagnoses under the Diagnosis tab of alcoholic cirrhosis of the liver with ascites (a destruction of normal liver tissue with a buildup of fluid in the abdomen); acute kidney failure (when the kidneys suddenly become unable to filter waste products from the blood) and encephalopathy (a problem in the brain, caused by a chemical imbalance in the blood, due to disease.). The Admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The assessment recorded R1 needed supervision with most activities of daily living (ADL) such as transfers, dressing, and toilet use. The assessment documented R1 received an antidepressant (medication to relieve feelings of sadness), antibiotic (medication used to treat infections), and diuretic (medication used to remove excess fluid from the body) medication during the seven-day look back period. R1's Care Plan dated 10/26/22 directed staff to administer medications as ordered and monitor for side effects. A Progress Note, dated 12/05/2022 at 01:32 PM, documented R1's return to the facility after hospital treatment for an exacerbation of existing medical conditions. The progress note recorded R1 was approved for treatment by hospice services and receive comfort medications. (continued on next page)

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.

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	An Admission Evaluation dated 12/05/22 documented R1 was alert and oriented to person, place, and time. R1 could feed himself but required limited assistance of one to two persons with most ADL and used a wheelchair for ambulation. The Physicians Orders tab documented an order dated 12/06/22 which directed to administer morphine sulfate concentrate solution 20 mg per milliliter (ml); give five mg by mouth every six hours as needed for pain. The Medication Administration Record (MAR) documented R1 received the morphine sulfate once on 12/06/22 at 02:53 AM. A Progress Note dated 12/06/22 at 05:30 AM documented LN J was summoned by LN L to assess R1, due to LN L reported R1 was not at his baseline (a condition that is taken at an early time point and used for comparison over time to look for changes). LN J recorded R1 was responsive and communicated with the nurse; R1's skin was warm and dry; R1 had equal strength in both hands, denied having pain or headache, and maintained eye contact. LN J instructed LN L to monitor R1 and notify LN J and the hospice nurse if R1 had any change. A Progress Note, dated 12/06/2022 08:00 AM by LN L, documented at approximately 02:34 AM, LN L administered R1 too much morphine. The note recorded LN L was unaware of the error until the hospice nurse arrived. LN L documented she had LN J assess R1 because R1 had a problem breathing, and when the hospice nurse arrived, the medication error was discovered. On 12/06/22, facility review of R1's narcotic record (count sheet) revealed LN L recorded five ml (100 mg) was removed from R1's morphine sulfate bottle. (This notation was later determined inaccurate as only two ml (40 mg) was absent from the bottle.) The Facility Investigation of the medication error documented the following timeline on 12/06/22: 02:53 AM LN L administered morphine 40 mg to R1. 05:18 AM R1 was assessed for pain. 05:30 AM LN J assessed R1, who was reportedly not at his baseline. 05:35 AM staff notified hospice. 06:15 AM Consultant Nurse (CN) K arrived from hospice. Police arrived. 06:17 AM staff reassessed R1. 06:20 AM the medication error was identified; the physician was notified as well as 911. 06:30 AM emergency medical services (EMS) arrived. 07:17 AM facility staff notified R1's responsible party. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The hospital emergency room Report dated 12/06/22 at 07:51 AM recorded R1 presented with altered mental status. The report recorded R1 was a limited historian at that moment; the nursing home stated to EMS that R1 was possibly overdosed on morphine at 02:30 AM that morning. In a Witness Statement dated 12/06/22 CN K performed an assessment for respiratory changes due to LN L gave R1 two ml of morphine at 02:34 AM, but documented that five ml were given. R1's vitals were as follows: breathing was shallow and oxygen saturation (level of oxygen in the blood, should be 90 % or greater) was at 86%. R1's blood pressure was decreased with a reading of 84/59 millimeters of mercury (mmHg-normal blood pressure 120/60 mmHg). R1's pulse/heart rate was elevated at 109 beats per minute (bpm). The statement noted CN K consulted with LN J, called 911, and R1 transferred to the hospital for evaluation. An undated Witness Statement by LN J recorded LN L administered two ml of morphine sulfate. After assessment, staff decided to send R1 to the hospital because R1 was a full code (desired full resuscitative measures) and R1 was not oriented enough to refuse transport. The statement further noted CN K decided against administering Narcan (medication used to immediately reverse the effects of opioids). Staff notified emergency services and R1 transferred to the hospital. LN J and CN K reviewed the morphine order and the remaining amount in the morphine bottle. The order was for 0.25 ml, but LN L documented five ml were given. LN J recorded that LN L stated repeatedly that she only administered two ml. LN L could not give a reason for documenting a different amount than what was given. During a telephone interview on 12/08/22 at 02:02 PM Consultant Pharmacist (CP) GG stated he confirmed (as best as could be without using a graduate) using the scale on the side of the bottle, the amount of morphine sulfate remaining was in fact 28 ml, with only two ml missing. CP GG stated this was consistent with the nurse having given two ml and not five ml as was recorded. CP GG had been evaluating the facility medications for several months and had not identified this type of situation at the facility before. During a telephone interview on 12/08/22 at 02:11 PM Consulting Practitioner HH stated the facility acted appropriately in that they immediately sought help for the resident and then notified Consultant Practitioner HH. Consultant Practitioner HH stated, in the future, he may consult with the pharmacy and write orders to reflect the number of milliliters to be given, as he felt LN L looked at the amount of liquid to be given instead of the milligrams. Interviewed on 12/08/22 at 01:27 PM, Administrative Nurse E stated the expectation of the nurse was to follow the physician's orders correctly, using the five rights of medication administration. Administrative Nurse E said LN L reported checking the order with the bottle, Administrative Nurse E felt LN L could not have checked because the bottle clearly stated give 0.25 ml. Administrative Nurse E stated LN L believed the policy was followed. Administrative Nurse E stated, after R1 was sent out to hospital, LN L was terminated and a notice of do not return provided to the nurse's staffing agency. Interviewed on 12/08/22 at 02:30 PM, Administrative Staff A acknowledged the errors in the nurse actions and noted the issue was being reviewed in Quality Assurance (QA), a performance improvement plan was implemented, and audits were conducted. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The facility's Administrating Medications Oral policy revised 05/2022 directed staff to check the label on the medication and confirm the medication name and dose with the MAR; and check the medication dose; recheck to confirm the proper dose. The facility failed to prevent a significant medication error for R1, when LN L administered R1's pain relieving medication in an amount which exceeded the physician's order. R1's developed breathing difficulty and a decreased level of consciousness and required emergent hospitalization and monitoring. The facility completed the following corrective actions prior to the survey event: Immediate education was provided to all nurses, including administrative nurses as well as Administrative Staff A, regarding the right of medication administration, and correct dosing. All narcotic medications were reviewed and verified. All residents under LN L's care were immediately assessed. The incident was reported to the state agency and a QA meeting and plan was initiated. The deficient practice was cited as past non-compliance.