STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175158	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN TERRACE AT OVERLAND PARK	7541 SWITZER ROAD OVERLAND PARK, KS 66214

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 -** Immediate jeopardy **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 131 residents. Based on record review and interviews, the facility failed to prevent a significant medication error when staff failed to have available and administer Resident (R) 1's physician ordered anti-[MEDICAL CONDITION] medication. The facility further failed to notify the residents physician immediately when the medication error was discovered. R1 did not receive her anti-[MEDICAL CONDITION] medication the evening of 05/26/20, and the morning and evening doses on 05/27/20. On 05/28/20, R1 was documented with [MEDICAL CONDITION] activity and on 05/30/20, R1 was found unresponsive (not reacting) with [MEDICAL CONDITION] signs and symptoms (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness). R1 was transferred to the emergency room and admitted to the hospital's intensive care unit (ICU). The deficient practice placed R1 in immediate jeopardy. Findings included: - R1's electronic medical record (EMR) recorded she admitted to the facility on [DATE] for treatment of [REDACTED]. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) Score of nine which indicated her cognition was severely impaired. She required extensive assistance of one to two staff with most of her activities of daily living (ADL's). R1's Care Plan, revised 05/20/20, directed staff to administer her anti-[MEDICAL CONDITION] medication as ordered by the physician. the Care Plan further directed after a [MEDICAL CONDITION] staff were to turn R1 on her side with her head back, hyper-extended to prevent aspiration, keep her airway open, take vital signs, and perform neurological checks. It also instructed staff to document: duration, level of consciousness, any incontinence, [MEDICAL CONDITION] activity, type of [MEDICAL CONDITION] activity (jerks, convulsive movements, trembling), sleeping or dazed and postictal stated (period of time following a [MEDICAL CONDITION]). R1's EMR, under the Orders' tab, documented a physician order [REDACTED]. According to the Food and Drug Administration (FDA.gov) lacosamide (also known as [MEDICATION NAME]) is a medication used to prevent and control [MEDICAL CONDITION]. FDA.gov also informs: lacosamide tablets should be withdrawn gradually (over a minimum of 1 week) to minimize the potential of increased [MEDICAL CONDITION] frequency in patients with [MEDICAL CONDITION] disorders. Review of the electronic Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. A nurse's Progress Note, located in the EMR under Progress Notes, dated 05/28/2020 at 06:10 AM documented R1 was non-responsive to stimuli. Her body shook, and eyes darted back and forth. The bed was lowered and R1 was placed on her side, in a laying position. R1's blood pressure was recorded as 225/73, her pulse was recorded as 61 beats per minute, her respirations were recorded at 20 breaths a minute and her oxygen saturation (measure of how much oxygen the blood carried as a percentage of the maximum it could carry) was recorded as 98 percent (%). Physician X was notified and at 06:17 AM R1 resumed responsiveness. A nurse's Progress Note, located in the EMR under Progress Notes, dated 05/28/2020 at 04:37 PM documented R1's responsible party was contacted about R1. R1's responsible party was unhappy to hear that R1 was having [MEDICAL CONDITION] and medication had not been administered due to unavailability. R1's responsible party reported to facility staff that past [MEDICAL CONDITION] contributed to the R1's decline. A nurse's Progress Note, located in the EMR under Progress Notes, dated 05/30/2020 at 01:15 PM documented the nurse assessed R1 related to reports of her being non-responsive. The nurse arrived in R1's room,and observed R1 lying in bed, supine (lying on the back) with her head on the pillow facing the wall (turned toward the left). R1's arms were across her chest/stomach. The nurse attempted to speak with R1, asked her questions, but R1 did not attempt to respond. The nurse performed sternal rubs and loudly called R1's name with no response. The note recorded R1 did not open her eyes or turn her head toward the nurse. R1 did not moan or cry in pain or annoyance. The nurse turned R1's head to the right, but R1 did not open her eyes or respond to stimuli. When R1's head was released, R1 moved it towards the left once again. The note further documented the Certified Nurse Aide (CNA) reported she attempted to have R1 drink and eat some mashed potatoes earlier, but R1 was unable to swallow food for a long time and coughed a bit when she did. The CNA stopped feeding the resident due to safety reasons. The nurse called Physician X and updated him on R1's status, and received orders to send R1 to the emergency room . Review of the hospital emergency room report, dated 05/31//20, documented R1 admitted from her skilled nursing facility where she had been having up to eight [MEDICAL CONDITION] daily since 05/27/20. This same report recorded the hospitalist impression/[DIAGNOSES REDACTED]. The hospitalist plan of care included an intravenous (IV) loading dose of lacosamide and restarted the twice daily dose of lacosamide. The facility did not provide an investigation of the medication error and/or a reporting of the error to the state agency. On 06/17/20 at 01:15 PM Administrative Nurse E stated R1 missed a total of three doses of the lacosamide. Administrative Nurse E called the pharmacy and the pharmacy stated they needed a new prescription. Administrative Nurse E called the physician to obtain a new prescription. The pharmacy delivered five pills of lacosamide on 05/28/20. Administrative Nurse E stated R1's physician was not notified of the missed medication doses and stated it was just an oversight that the physician was not made aware of the missed doses at that time. On 06/17/20 at 02:08 PM Administrative Nurse D stated if the medication was not available in the facility, she expected staff to call the pharmacy and find out where the medication was. Administrative Nurse D stated staff did not follow the facility policy for securing medications or reporting a medication error. Administrative Nurse D stated Physician X was notified, at some point, of the medication error. During a telephone interview, on 06/17/20 at 03:22 PM, Physician X stated sudden disruption in anti-[MEDICAL CONDITION] medication did contribute to increased [MEDICAL CONDITION] activity and expressed the medication had a warning which included serious reactions, including [MEDICAL CONDITION], could occur if the medication was withdrawn or abruptly discontinued. The facility's Administration of Medications policy revised 04/24/19 documented all medications were administered safely and appropriately per physician order [REDACTED]. The policy lacked documentation to include any information and/or direction for the unavailability of medications. The facility did not provide a policy related to significant medication errors. The facility failed to prevent a significant medication error for R1, a cognitively impaired and dependent resident, when the facility failed to ensure her [MEDICAL CONDITION] medication was available for administration and failed to administer the medication resulting in R1 being admitted to the ICU for treatment. This failure placed R1 in immediate jeopardy beginning on 05/27/20 when the medication error first occurred. The immediate jeopardy was removed when the facility implemented the following interventions: The Regional Director of Clinical Services reviewed active physician orders, against their [MEDICAL CONDITION] medications, for resident's diagnosed with [REDACTED]. The Assistant Director of Nursing and Staff Development Coordinator educated all facility licensed nursing and certified medication staff including agency staff on the procedure for reordering of [MEDICAL CONDITION] medications to ensure physician orders [REDACTED]. A Quality Assurance and Performance Improvement (QAPI) meeting was held with the QAPI Committee and Medical Director via telephone. The deficient practice remained at a scope and severity of a G.

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

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.