STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175243	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDICALODGES GARDNER	223 BEDFORD STREET GARDNER, KS 66030

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** The facility identified a census of 39 residents. The sample included four residents. Based on observation, 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 resident's physician immediately when the facility discovered the medication error. R1 did not receive his anti-[MEDICAL CONDITION] medication the evening of 07/05/20 and the morning dose of 7/06/20. 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 required emergency room treatment and admission to the hospital. Findings included: - The electronic medical record (EMR) recorded R1 admitted to the facility on [DATE] for treatment of [REDACTED]. The Admission Minimum Data assessment dated [DATE] documented staff assessed the resident with a Brief interview for Mental Status (BIMS) Score of 12 which indicated moderately impaired cognition. He required extensive assistance of one to two staff with most of his activities of daily living (ADLs) such as dressing, transfers, and ambulation. The resident's Care Plan revised 06/19/20 documented R1 received lacosamide (an [MEDICAL CONDITION] medication) and required monitoring for side effects because lacosamide had a Black Box Warning (medication determined by the Food and drug administration to have severe, potentially life-threatening side effects). The Care Plan lacked documentation of any interventions and/or measures to address if the resident experienced [MEDICAL CONDITION]. A physician's orders [REDACTED]. Review of the electronic Medication Administration Record [REDACTED]. The clinical record lacked documentation the physician was notified of the missed doses of medication until after the missed dose on 07/06/20. A Progress Notes documented on 07/06/20 at 06:22 PM recorded staff notified the physician of the resident's [MEDICAL CONDITION] activity [MEDICATION NAME] greater than seven minutes. The note documented the physician ordered [MEDICATION NAME] (an antianxiety medication) and continue to monitor the resident. The note documented the resident started another [MEDICAL CONDITION] shortly thereafter that continued greater than seven minutes. Staff notified the physician and ordered to transfer the resident to the local hospital. The note documented the resident did not receive his lacosamide on 7/5/20 at HS (bedtime) or this AM as ordered. The note recorded staff notified the pharmacy last night for medication that was received this day around 5pm. The medication had not been given. Review of the hospital's emergency room Report dated 07/08/20 documented R1 admitted from his skilled nursing facility where he was not given his [MEDICATION NAME] (lacosamide). This same report recorded the hospitalist's impression/[DIAGNOSES REDACTED]. The hospitalist's plan of care included to resume [MEDICATION NAME] (by mouth) when R1 was alert and able to swallow safely, consult with neurology, resume [MEDICATION NAME] as needed, and consult the social worker for discharge when stable. Observation on 07/09/20 at 11:12 PM revealed R1 sat in a padded wheelchair in his own room. R1 was aware he was in the hospital for [MEDICAL CONDITION] activity, but was not aware he did not receive his anti-[MEDICAL CONDITION] medication. R1 exhibited facial features which indicated surprise and/or irritation. On 07/9/20 at 12:15 PM Administrative Staff A stated a nurse on the evening shift on Sunday 07/05/20 discovered the medication was not available when she went to give the dose. She ordered it from pharmacy. The pharmacy indicated the medication would arrive the next day. When the medication did not arrive, the pharmacy called the director of nursing and stated said it was a mix up with the insurance company, as they had the wrong payer source entered into the computer. Administrative Staff A reported staff notified the resident's physician of the error on 07/06/20 when he ordered the resident transferred to the hospital. Administrative Staff A stated to prevent recurrence, the pharmacy had agreed to notify the facility immediately if a resident's prescription could not be filled for whatever reason. Physician X recommended every Thursday, before the weekend, the administrative nursing staff should check with nursing to ensure availability of medications. On 06/17/20 at 02:08 PM Administrative Nurse D stated if a medication was not available, she expected staff to call the pharmacy and find out the location of the medication. Administrative Nurse D stated staff did not follow the facility policy for securing medications and reporting a medication error. Administrative Nurse D stated Physician X was notified, at some point, of the medication error. During a telephone interviewon 07/15/20 at 11:11 AM with Consultant Pharmacist (CP) W stated missing a scheduled dose of the medication would not be good. She stated that while there would still be some medication remaining in the resident's system it is possible and probable the missed doses caused R1's increased [MEDICAL CONDITION] activity. During a telephone interview, on 07/15/20 at 11:09 AM Physician X stated he was aware of R1's missed [MEDICAL CONDITION] medication. Physician X stated he was working with the facility to ensure inclusion of this occurrence into their Quality Assurance Program. According to the Food and Drug Administration (FDA.gov) lacosamide was a medication used to prevent and control [MEDICAL CONDITION]. FDA.gov also indicated lacosamide tablets should be withdrawn gradually, over a minimum of one week, to minimize the potential of increased [MEDICAL CONDITION] frequency in patients with [MEDICAL CONDITION] disorders. The facility's Administration of Medications policy revised 12/2012 documented all medications should be administered safely and appropriately per physician order [REDACTED]. The policy lacked documentation to include information and/or direction for the unavailability of medications. The facility's Medication Monitoring policy revised 9/2010 and Medication Error Reporting and Adverse Drug Reaction Prevention and Detection policy revised 9/2010 policy lacked documentation to include information and/or direction for the unavailability of medications. The facility failed to prevent a significant medication error for R1, a cognitively impaired and dependent resident, when the facility failed to ensure his anti- [MEDICAL CONDITION] medication was available for administration and failed to notify the physician when the doses were missed. This deficient practice resulted in R1 developing increased [MEDICAL CONDITION] activity which required treatment in an acute care hospital. The deficient practice was identified as past-non-compliance on 7/8/2019.

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.