STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175409	A. BUILDING _____ B. WING _____	**06/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKVIEW CARE CENTER	**811 N 1ST STREET OSBORNE, KS 67473**

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 0554 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 44 residents. The sample included four residents. Based on observation, record review, and interview, the facility failed to complete a medication self-administration assessment for Resident (R) 3. Findings included: - R3's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented the resident required set up assistance with personal hygiene and independent with all other Activities of Daily Living (ADLs). The Black Box Warning Care Plan (medication warning use to draw attention to serious or life-threatening risks), dated 04/02/2020 instructed staff to administer medications as ordered by the physician and to monitor for abnormal results. The care plan lacked documentation for the resident to self-administer medications. R3's Medical Record lacked documentation of a physician's orders [REDACTED]. The Nurse's Note, dated 05/27/2020 at 10:20 PM, documented the resident ingested his spouse's scheduled bedtime medication instead of his own. The note documented the resident grabbed his spouse's medication cup that sat to the left of him on their bedside table instead of his medication cup that was in front of him. The resident ingested the medications before the nurse could intervene and correct the error. The facility's Event Report, dated 05/27/2020 at 10:03 PM, documented the resident ingested the following medications: [REDACTED]. R3's Physician Orders, dated 05/27/2020, directed staff to hold his scheduled bedtime medications for the night, monitor his vital signs every hour for 12 hours, and notify the physician if the resident's blood pressure was less than 90/50. R3's Medical Record documented the following out of parameter blood pressures: 05/27/2020 at 11:31 PM - 78/52 05/28/2020 at 01:03 AM - 60/58 05/28/2020 at 02:30 AM - 60/46 05/28/2020 at 02:52 AM - 50/40 05/28/2020 at 03:25 AM - 80/68 R3's physician's orders [REDACTED]. On 06/08/2020 at 12:10 PM, observation revealed Licensed Nurse (LN) H administered [MEDICATION NAME] (an antidepressant) 5 mg, one tablet by mouth, three times daily, Iron (a supplement) 325 mg, one tablet by mouth, daily, and [MEDICATION NAME] (pain medication) 500 mg, one tablet by mouth, daily to the resident. On 06/08/2020 at 09:11 AM, LN G stated the resident and his spouse usually set across the room from each other but that evening they were both seated by the bedside table. The resident's spouse told LN G to set the medication down in front of them and they would take the medications. LN G stated she sat the medication down in front of them and instead of reaching in front of him to take his medications, he reached to his right and took his spouse's medications. LN G stated before she could intervene, he had taken the wrong medications. LN G stated she contacted the physician and was given specific orders. On 06/08/2020 at 12:23 PM, Administrative Nurse D verified the resident did not have an assessment completed to self-administer medication. The facility's Self-Administration of Medications policy, dated [DATE], documented if a resident requests to have medications in their room for self-administration or for the nurse to leave medications at the bedside or on the dining room table, a medication self-administration assessment must be completed to show that the resident is safe to do so. The policy further documented a physician order [REDACTED]. A medication self-administration assessment would be reevaluated annually and with a significant change MDS as deemed necessary by nursing staff. The facility failed to complete a medication self-administration assessment for R3, who ingested his spouse's medications, placing the resident at risk for further medication errors and adverse reactions.

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