STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175182	A. BUILDING _____ B. WING _____	C 08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF OVERLAND PARK	12100 W 109TH STREET OVERLAND PARK, KS 66210

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation # 102499.	F 000		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility identified a census of 92 residents. The sample included 3 residents. Based on observation, record review and interview, the facility failed to monitor the placement and side effects of pain medication (Duragesic patch) (a skin patch containing fentanyl, narcotic pain medication) for 1 (#1) of 3 residents sampled for use of a Duragesic patch which resulted in the resident ' s hospitalization for narcotic overdose. Findings included: - Resident #1 May 2016 physician's order sheet included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that interfere with one's daily activities),neuralgia (intense, typically intermittent pain along the course of a nerve), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), major depressive disorder (abnormal emotional state characterized by exaggerated feelings of	F 333		

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

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sadness, worthlessness, emptiness and hopelessness) and constipation.

Review of the annual minimum data set (MDS) dated 8/14/16 documented a brief interview for mental status (BIMS) score of 3, which indicated severely impaired cognition. The resident received scheduled pain medication and staff observed facial expressions as an indicator of pain 1-2 days of the assessment.

Review of the quarterly MDS dated 5/10/16 documented a BIMS of 4, which indicated severely impaired cognition. The resident received scheduled pain medication during the assessment.

The Care Area Assessment (CAA) for pain dated 8/14/15 documented the resident was not able to rate his/her pain and had a Duragesic patch ordered by the physician.

The care plan dated 8/20/15 indicated the resident had chronic pain related to osteoporosis and neuropathy and directed staff to administer the Duragesic patch as ordered by the physician and to evaluate, record and report the effectiveness and any adverse side effects.

A physician order dated 10/9/2014 documented Duragesic (fentanyl) patch 12 microgram (mcg) per hour and instructed staff to apply 1 patch topically (to the skin) every 72 hours for pain and rotate sites of application between the back and shoulders only.

A physician order dated 8/22/12 documented to record the removal of the Duragesic patch every three days, chart site and required the signature

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of two nurses.

The Black Box Warning (a black box warning issued by the FDA (US Food and Drug Administration) is a warning of serious or life-threatening risks located on the label of a prescription drug) Care Plan initiated 8/20/15 lacked documentation of a black box warning for Duragesic.

According to www.fda.gov <http://www.fda.gov>, Duragesic had a black box warning of fatal overdose due to respiratory depression. Due to the mean elimination half-life of 17 hours of Duragesic, patients who have had a serious adverse event, including overdose, would require monitoring and treatment for at least 24 hours.

The May 2016 Aux-narc Flowsheet documented the administration of Duragesic 12-mcg per hour transdermal on 5/1/16 on the right shoulder, 5/4/16, 5/7/16, 5/10/16, and 5/13/16 on the left chest.

The flowsheet lacked documentation of the site of the patch on 5/4/16, 5/7/16, and 5/10/16.

The flowsheet lacked documentation of monitoring placement of the Duragesic patch for 21 shifts from 5/1/16 through 5/15/16.

The flowsheet lacked documentation of a second nurse witness for the removal and destruction of the Duragesic patch on 5/7/16 and 5/10/16.

A progress note dated 5/15/16 at 8:45 A.M. documented the resident was in the dining room for breakfast and staff noted he/she did not look well. The resident was removed from the dining

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room for an assessment and was found to be non-responsive and diaphoretic (sweating heavily). Recorded vital signs at this time were a blood pressure of 93/57, a heart rate of 157, respirations of 28 and an oxygen saturation of 84% while receiving two liters of oxygen per minute. Nursing staff obtained a physician order and transferred the resident to the emergency room for evaluation and treatment.

A progress note dated 5/15/16 at 3:15 P.M. documented staff had called the hospital for report at 10:30 A.M. for a report on the resident ' s condition and was told the hospital physician had removed two fentanyl patches from the resident and had administered Narcan (a medication used to treat narcotic overdose in an emergency situation).

Review of the hospital history and physical dated 5/15/16 documented the resident was admitted to the intensive care unit for altered mental status and a narcotic overdose from Duragesic patch. In the emergency room, the resident was found to have two fentanyl patches on which were removed and he/she was given Narcan in the emergency room.

Review of the hospital progress note dated 5/16/16 documented constipation with fecal impaction and anemia with acute blood loss. The resident was unresponsive, had several bloody stools throughout the night.

The facility ' s Medication Error Report dated 5/15/16 documented on 5/13/16 the Duragesic patch 12-mcg transdermal was changed as prescribed but the Duragesic patch that was currently on the resident was not removed as

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ordered.

The resident returned to the facility on 5/19/16 and was admitted to hospice services for end stage dementia.

A progress note dated 6/9/16 at 9:00 P.M. documented the resident was found to have no vital signs at 4:35 P.M. and his/her body was released to the funeral home at 6:18 P.M.

Observations were unavailable as the resident no longer resided at the facility.

During an interview on 6/28/16 at 10:33 A.M., the resident ' s family member stated hospital staff found two patches on the resident ' s body, one dated 5/10/16 and one dated 5/13/16. The resident was unresponsive, required Narcan for the narcotic overdose, and was sent to the intensive care unit to be monitored.

During an interview on 7/13/16 at 4:17 P.M., direct care staff O stated he/she was unsure what to observe for with a resident who received too much pain medication. He/she said drowsiness might be a symptom of many different conditions and not just pain medication overdose.
During an interview on 7/13/16 at 5:00 P.M., licensed nursing staff I stated all Duragesic patches were to be placed at 8:00 in the morning and the removal and destruction of the patch should be witnesses by two licensed nursing staff. Licensed nursing staff I stated a licensed nurse must verify and document the location of the patch every shift. If the patch was missing, he/she would verify the placement with what had been charted and report the missing patch to the physician and the director of nursing.

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During an interview on 7/13/16 at 5:11 P.M., direct care staff P stated he/she would look for signs of sleeping through meals and anything out of the resident ' s normal routine as a possible concern with pain medication overdose.

During an interview on 7/14/16 at 11:25 A.M., licensed nursing staff J stated the process for placing and removing a Duragesic patch was to verify the physician order, remove the old Duragesic patch, place the new patch, and have a second licensed nurse document on the flowsheet that they had witnessed the destruction of the old patch. Licensed nursing staff J stated if a patch could not be found, staff should have another nurse help look for it on the resident and then notify the physician. He/she would monitor the resident for signs and symptoms of a narcotic patch overdose such as unusual behavior or lethargy.

During an interview on 7/14/16 at 11:30 A.M., consultant staff JJ stated having multiple Duragesic patches left on the resident ' s body would have contributed to a decrease in level of consciousness and a rapid decline in vital signs. Consultant staff JJ stated he/she was not aware the resident had received Narcan while in the hospital.

During an interview on 7/14/16 at 12:04 P.M., administrative nursing staff D stated two licensed nurses should be present to remove and replace a resident ' s Duragesic patch.

During an interview on 7/14/16 at 12:56 P.M., licensed nursing staff K stated two nurses should document the removal of a Duragesic patch and should monitor the resident for signs and

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F 333	Continued From page 6 symptoms of a narcotic overdose such as lethargy, dizziness, and low blood pressure. The undated " Fentanyl Patches " policy documented the nurse that administered the Fentanyl patch needed to document where the new patch was placed and every shift thereafter would check for placement of the patch and document it in the treatment administration record. The facility failed to ensure this resident was free from a significant medication error when they failed to remove the Duragesic patch from the resident and placed a new patch on as ordered which caused the resident to become over sedated with a diagnosis of narcotic overdose, and required the resident to be sent to the hospital.	F 333		