STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175185	A. BUILDING _____ B. WING _____	C 02/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY HILL REHABILITATION CENTER	1007 JOHNSTOWN AVENUE SALINA, KS 67401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by the Kansas Department for Aging and Disability Services (KDADS), on behalf of the Centers for Medicare and Medicaid Services (CMS) on 01/30/2020. The facility was found not to be in substantial compliance with 483.45. On 02/03/2020 at 05:10 PM, Administrative Staff A and Administrative Nurse D were provided a copy of the IJ Template and notified the facility failed to administer Resident (R) 1's physician ordered medication from 11/15/19 through 01/19/2020, which caused R1 altered mental status, a critical low thyroid level and hospitalization. The immediate jeopardy was determined to begin on 11/15/19 when the facility admitted the resident and failed to properly document his admission medication orders. The deficient practice was identified as Past Non-Compliance and corrected on 01/21/2020 when the facility suspended Licensed Nurse (LN) G, a licensed nurse monitored LN G's first new admission to the facility after she returned from suspension and all licensed nurses were educated on the new procedure for new admission medication verification.	F 000		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility had a census of 72 residents. The sample included three residents. Based on	F 760		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/04/2020

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interview and record review, the facility failed to administer Resident (R) 1's physician ordered medication from 11/15/19 through 01/19/2020, which caused R1 altered mental status, a critical low thyroid level and hospitalization. This deficient practice placed R1 in immediate jeopardy. The deficient practice had the potential to affect other new admissions to the facility.

Findings included:

- R1's "Physician Order Sheet," dated 11/15/2019, documented diagnoses of hypothyroidism (condition characterized by decreased activity of the thyroid gland), hypertension (elevated blood pressure), and hyperlipidemia (condition of elevated blood lipid levels).

R1's "Admission Minimum Data Set" (MDS), dated 11/19/19, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition, and received anticoagulant (medication used to prevent formation of blood clots), diuretic (medication to promote the formation and excretion of urine), and pain medications.

The "Medication Care Plan," dated 12/02/2019, directed staff to administer the resident's medications as ordered.

The "Hospital Patient Transfer Form," dated 11/15/19, directed staff to administer Amlodipine (medication for high blood pressure) 2.5 milligrams (mg) by mouth daily, Aspirin 81 mg by mouth daily, atorvastatin (medication for high cholesterol) 80 mg by mouth at bedtime, levothyroxine (medication for thyroid) 150

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micrograms (mcg) by mouth 60 minutes prior to breakfast, and Omega 3 fish oil 1000 mg by mouth daily.

The "November 2019, December 2019, and January 1-20, 2020 Medication Administration Records (MAR)" did not list Amlodipine, Aspirin, Atorvastatin, Levothyroxine, and Omega 3 fish oil.

The "Nurse's Note," dated 01/19/2020 at 08:30 AM, documented the resident stated the Certified Nurse Aides (CNAs) took his cell phone, staff informed the resident the cellphone was on his bed and the CNAs placed it in his pocket. The resident removed the phone and started talking on it while closed and upside down. The resident then stated someone was on top of his legs, was being tied down and he could not breathe. When staff attempted to talk to the resident, he continued yelling and screaming. Staff notified the on-call physician and received an order to send the resident to the emergency room (ER) for altered mental status.

The "Emergency Department Report," dated 01/19/2020, documented the resident presented with altered mental status, upon investigation the patient's thyroid medication had been stopped at some point within last year, and unsure as to why it was not given. Laboratory test results revealed the resident's TSH (Thyroid Stimulating Hormone - blood test to determine thyroid functioning) was high 41.263 (normal range 0.5 - 3.0), Free T4 (thyroid blood test) was undetectable, and potassium level was low 2.7 (normal range 3.5 - 5.0). The report documented hospital staff administered intravenous (administered into a vein) levothyroxine and oral potassium while the resident was in the ER.

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The "Nurse's Note," dated 01/19/2020 at 03:40 PM, documented the resident returned from the ER and indicated the resident had abnormal lab values and needed to be rechecked in two weeks. The resident's potassium levels needed to be rechecked in two to three days.

The "Nurse's Note," dated 01/20/2020 at 08:01 AM, documented therapy came to Licensed Nurse (LN) G and stated the resident would not wake up and when he was in his chair, his oxygen saturation would drop to the 80's (normal range 95 to 100). LN G went to the resident's room and checked his blood pressure (B/P) 86/40 millimeters of Mercury (mmHg) (normal range 90/60 - 120/80). Staff notified Consultant (C) GG and obtained an order to send the resident to the ER.

The "Nurse's Note," dated 01/20/2020 at 12:52 PM, documented ER staff called the facility and stated the resident admitted to the hospital Intensive Care Unit (ICU) for myxedema coma (severe hypothyroidism leading to decreased mental status, and hypothermia, a condition of having abnormally low body temperature) and other symptoms related to slowing of function in multiple organs.

The facility's "Corrective Action Paperwork," dated 01/21/2020 documented the facility suspended LN G while investigating the medication error, educated all licensed nurses on the new procedure for new admission medication verification and a licensed nurse monitored LN G's first new admission upon return to the facility.

On 02/03/2020 at 10:33 AM, LN G stated on

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11/15/19 R1 was her second new admission after working at the facility for approximately one month. LN G stated R1's admission packet sent with the resident from the hospital was given to Administrative Nurse D to input the resident's medication orders into the computer. On 01/19/2020 the resident had hallucinations, was sent to the ER, and upon return to the facility, hospital staff notified facility staff the resident's potassium and Thyroid levels were very low. LN G stated on 01/19/2020, she discovered the resident had a diagnosis of hypothyroidism but had not received any medication for that diagnosis. LN G stated she discovered a medication card for Levothyroxine in the overflow medication area in the bottom draw of the medication cart and no order in the computer for this medication.

On 02/03/2020 at 12:52 PM, Consulting Pharmacist HH stated the facility faxed the pharmacy a medication sheet with the resident's medications for them to fill that included Amlodipine, Atorvastatin and Levothyroxine. Consulting Pharmacist HH stated the pharmacy delivered the following medications to the facility on 11/16/19 at 12:32 PM and signed for by LN H : Amlodipine 2.5 mg, Atorvastatin 80 mg and Levothyroxine 150 mcg.

On 02/03/2020 at 01:08 PM, Administrative Nurse D verified she entered R1's admission medication orders into the computer on 11/15/19 and the admission orders she used to input the medication orders did not include five of the resident's physician ordered medications. Administrative Nurse D stated the next day, Administrative Nurse E, Assistant Director of Nursing (ADON) did not compare the admission

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orders to the admission packet to verify the admission medications. Administrative Nurse H verified the medication card for Levothyroxine should not have been placed into the overflow medication area in the medication cart.

On 02/03/2020 at 01:15 PM, LN H stated when the pharmacy delivered medications to the facility, the nurses checked the computer to see which time slot the medication cards should be placed. LN H stated if she checked the computer and there was not an order for the medication, she would check the admission packet for the medication order. LN H stated if the medication was on the admission papers and not in the computer, she would input the medication order into the computer. LN H stated if she received a medication card and did not have an order in the computer or on admission papers, she would call the pharmacy and ask how they filled the order and have the day shift nurse call to clarify the medication order. LN H verified the only medication cards placed in the overflow area of the medication cart were extra cards of same medications.

On 02/03/20 at 01:36 PM, C GG stated if a resident was not given their prescribed Levothyroxine they could hallucinate and go into a myxedema coma. C GG stated usually one of the first signs was decreased mental status. C GG stated she expected two nurses to double check all of the resident's admission medications.

The facility's "Reconciliation of Medication on Admission" policy, dated July 2017 documented using an approved medication reconciliation form or other record, list all medications from the medication history, the discharge summary, the

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previous MAR, and the admitting orders. List the dose, route, and frequency for all medications. Review the list carefully to determine if there are discrepancies or conflicts. If there was a discrepancy or conflict in medications, dose, route or frequency, determine the most appropriate action to resolve the discrepancy. For example: contact nurse from referring facility, contact the physician from referring facility, contact resident's primary physician, or contact community pharmacy used by resident. Document findings and actions.

The facility's "Medication Orders and Receipt Record" policy, dated April 2007, documented the receiving nurse shall record medication orders received on the receipt record. The receiving nurse shall verify each delivered med and check off the order form. Noted discrepancies shall be reported to the dispensing pharmacy.

The facility failed to administer R1 physician ordered Levothyroxine from 11/15/19 through 01/19/2020 which caused altered mental status, a critical low thyroid level, and hospitalization, placing R1 in immediate jeopardy.

The facility removed the immediate jeopardy on 01/21/2020 when the facility suspended LN G, educated all licensed nurses on the new procedure for new admission medication verification and a licensed nurse monitored LN G's first new admission upon return to the facility.

The deficient practice remained at a scope and severity of a J.