STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two sampled residents (Resident #2 and #3) were free from medication errors, out of 10 sampled residents. On 3/25/24 Resident #2 was given the wrong medication when the Certified Medication Technician (CMT) handed the medication to Licensed Practical Nurse (LPN) A, who then administered the medication to the wrong resident, and on 4/4/24 Resident #3 was given his/her medication twice. A family member had given the medication to the resident and it was not signed out on the Medication Administration Record (MAR). When the resident returned to the facility the medication was given to the resident for the second time. The facility census was 48 residents. Review of the facility's Medication Administration policy, dated 6/29/2023, showed: -Purpose was to administer medications at approximate times as an individual would in their home environment while continuing to comply with physician orders. -The policy was to assure that prescribed medications are administered safely, accurately and in accordance with good nursing practice while accommodating the resident's routines and requests in medication administration. -Procedure: --Physician orders for specific medication administration times shall be followed. --The individual administering the medication must enter their initials into the resident's electronic MAR after giving each medication and before administering the next ones. -All reasonable accommodation for resident requests regarding medication administration will be followed by nursing staff. Review of the facility's Safe Medication Administration Practices, Long-term Care policy, dated 5/20/24, showed: -To promote a culture of safety and prevent medication errors, nurse must adhere to the five rights of medication administration. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-These rights are to identify the right resident by using at least two resident-specific identifiers, select the right medication, administer the right dose, administer the medication at the right time, and administer the medication by the right route. -Recent literature identifies nine rights of medication administration - which, in addition to the five right, include the right documentation, the right action (or reason for prescribing the medication), the right form, and the right response. -The term medication error refers to a mistake that occurs during the medication administration process. -When a mistake occurs, it's considered an error regardless of whether it harmed a resident. -Federal regulations require that long-term care residents remain free from any significant medication errors. -A medication error that doesn't cause resident harm is referred to as a potential adverse drug event (ADE) because the actions of the resident or clinician averted the error before it affected the resident. -A potential ADE is also referred to as a near miss or close call. -Implementation: --Avoid distractions and interruptions when preparing and administering medication to prevent medication errors. --Check the resident's medical record to make sure that all required documents, medication information, sensitivities, history and physical examination findings, diagnoses, and laboratory results are present and current. --Confirm the resident's identity using at least two resident identifiers. -Administering high-alert medications: --Identify high-alert medications based on your facility's approved list. --High-alert medications include opioids. --Carefully monitor medication dosing, especially if dosing adjustments are necessary based on narrow therapeutic windows. -Familiarize yourself with all medications that you administer and be aware of potential ADEs that might occur. -Know where to obtain resources to confirm potential ADEs if you aren't familiar with the medications in use. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #2's Face Sheet showed the resident was admitted on [DATE] with diagnoses including cystitis (infection of the urinary bladder) and neuromuscular dysfunction of the bladder. Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 4/30/24, showed the resident was cognitively intact. Review of the facility Medication Error Report, dated 4/4/24, showed: -The resident was given the medication Rifaximin (an antibiotic used to treat irritable bowel syndrome) that he/she did not have an order for. -LPN A assisted with medication pass. -As the CMT was pulling the medication, he/she said the name of a different resident. -LPN A took the medication to the resident named. -Once administered, it was realized the resident was not ordered the medication. -LPN A assessed the resident and monitored the resident. -No adverse reaction was noted. Review of the resident's Physician Orders for April 2024 showed: -No orders for Rifaximin. Review of the resident's MAR for April 2024 showed no orders or administration of Rifaximin. During interview on 7/31/24 at 1:53 P.M. LPN A said: -He/she was helping CMT B on another hall pass medications. -While CMT B was preparing the medication to be administered, he/she said another resident's name. -CMT B handed the medication to LPN A to administer. -He/she administered the medication to the resident. -CMT B asked if the medication had been given, LPN A confirmed the medication was given. -CMT B realized the medication was administered to the wrong resident. -The resident was assessed and monitored and had no negative effects. -The resident was made aware of the error and the physician had been notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN A discussed ways to prevent further errors like this from happening with CMT B. -LPN A confirmed the medication, Rifaximin, was given to the resident and the resident did not have an order for the medication. During an interview on 7/31/24 at 2:15 P.M., CMT B said: -LPN A was helping him/her with passing medications. -He/she felt LPN A misheard the resident's name. -The resident received medication ordered for another resident. -The resident did not have any adverse effects as a result of the error. -He/She and LPN A discussed ways to prevent errors like that happening again. During an interview on 7/23/24 at 4:28 P.M., the resident said: -He/she did not recall the medication error in which he/she received the wrong medication on 4/4/24. -He/She felt he/she didn't recall the incident because nothing happened as a result. During an interview on 7/24/24 at 8:02 A.M., the Physician said: -He/she was aware of the error in which the resident received medication he/she was not ordered. -He/she confirmed there were no negative effects as a result of the medication error. During an interview on 7/24/24 at 2:09 P.M. the Administrator said: -He/she knew about the resident receiving the wrong medication on 4/4/24. -The resident did not have any negative effects as a result. 2. Review of Resident #3's Face Sheet showed the resident was admitted on [DATE] with diagnoses including paralysis of the left side of the body after a stroke. Review of the resident's Quarterly MDS, dated [DATE] showed the resident was mildly cognitively impaired. Review of the resident's Physician Orders for March 2024 showed: -Baclofen (a drug used to treat muscle spasms) 20 mg, take one tablet oral three times a day (TID) every day for muscle spasms. -Acetaminophen (a drug for pain) 325 mg, take two tablets oral TID every day for pain management. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Tizanidine (a drug for hypertension) 2 mg by mouth TID every day. -Gabapentin 300 mg by mouth every eight hours every day, take one tablet TID daily. *Note: facility liberilized medication pass times were 7:00 A.M. to 10:00 A.M., 11:00 A.M. to 2:00 P.M., and 4:00 P.M. to 7:00 P.M. Review of the resident's MAR for March 2024 showed all medications documented as given on 3/25/24 at all three medication passes. Review of the resident's Nurse Notes, dated 3/25/24 at 4:03 P.M., showed: -The resident had taken his/her 2:00 P.M. medications twice (medications not signed off when given to the family member to administer). -Resident returned early to his/her room. -When the resident was questioned about his/her 2:00 P.M. scheduled medications, the resident could not recall if he/she received the medications. -The medications administered again were Tizanidine 2 mg tablet, Gabapentin 300 mg, and Acetaminophen 325 mg tablet two tablets. -The resident was evaluated by the physician in house and determined the resident did not have any negative side effects to be alarmed about. Review of the facility Medication Error Report dated 3/25/24 showed: -Resident was given his/her 2:00 P.M. medications twice because the scheduled medications were given to the family member without signing the medications off in the MAR. -The nurse realized the medications had not been signed off and the resident did not recall if the medications were given. -The following medications were given twice Acetaminophen 325 mg two tablets, Gabapentin 300 mg, and Tizanidine 2 mg. -The resident was evaluated by the provider in house who reported the resident was stable and the double dose did not have any negative side effects. During an interview on 7/23/24 at 4:22 P.M. the resident said: -He/she did get his/her medications twice on 3/25/24. -He/she did not have any negative reactions as a result of taking his/her medications twice. -He/she had been with his/her family member. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When he/she left with his/her family member, staff would send his/her medications with his/her family member. -His/her family member had given him/her the medication while he/she was out. -Upon returning the staff administered the medications to him/her again. During an interview on 7/23/24 at 4:25 P.M. the resident's family member said: -When he/she took the resident out of the facility, the staff would give him/her the medications to give to the resident. -On 3/25/24 the staff had given him/her the medication to be given on or about 2:00 P.M. -He/she gave the resident the medications about 2 P.M. -When they returned to the facility the staff administered the scheduled medications for the second time. -They reported to him/her the medications were not signed off as given which prompted them to give the resident the medications again. -The resident did not have any negative effects. During an interview on 7/24/24 at 8:02 A.M. the Physician said: -He/she was aware of the resident receiving a double dose of his/her 2:00 P.M. medications on 3/25/24. -The resident did not have any adverse effects as a result of the medication error.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one sampled resident (Resident #1) was free from a significant medication error. On 7/12/24 Resident #1 was administered 5 milliliters (ml) (100 mg (milligrams)/5 ml) oral solution of morphine concentrate (a opiate medicine used to treat moderate to severe pain) instead of the physician ordered 0.5 ml (10 mg) by mouth PRN (as needed) every 6 hours for pain. Narcan (a medicine that can save someone from a prescription Opioid medicine overdose) was ordered by the physician due to the dosage being 10 times the amount ordered and administered. The facility census was 48 residents. The Administrator was notified on 7/24/24 at 2:12 P.M., of an Immediate Jeopardy (IJ) which began on 7/12/24. The IJ was removed on 7/24/24 as confirmed by surveyor onsite verification. Review of the facility's Medication Administration policy, dated 6/29/2023, showed: -Purpose was to administer medications at approximate times as an individual would in their home environment while continuing to comply with physician orders. -The policy was to assure that prescribed medications are administered safely, accurately and in accordance with good nursing practice while accommodating the resident's routines and requests in medication administration. -Procedure: --Physician orders for specific medication administration times shall be followed. --The individual administering the medication must enter their initials into the resident's electronic MAR (medication administrator record) after giving each medication and before administering the next ones. -All reasonable accommodation for resident requests regarding medication administration will be followed by nursing staff. Review of the facility's Safe Medication Administration Practices, Long-term Care policy, dated 5/20/24, showed: -To promote a culture of safety and prevent medication errors, nurse must adhere to the five rights of medication administration. -These rights are to identify the right resident by using at least two resident-specific identifiers, select the right medication, administer the right dose, administer the medication at the right time, and administer the medication by the right route. -Recent literature identifies nine rights of medication administration - which, in addition to the five right, include the right documentation, the right action (or reason for prescribing the medication), the right form, and the right response. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The term medication error refers to a mistake that occurs during the medication administration process. -When a mistake occurs, it's considered an error regardless of whether it harmed a resident. -Federal regulations require that long-term care residents remain free from any significant medication errors. -Implementation: --Avoid distractions and interruptions when preparing and administering medication to prevent medication errors. --Check the resident's medical record to make sure that all required documents, medication information, sensitivities, history and physical examination findings, diagnoses, and laboratory results are present and current. --Confirm the resident's identity using at least two resident identifiers. -Administering high-alert medications: --Identify high-alert medications based on your facility's approved list. --High-alert medications include opioids. --Carefully monitor medication dosing, especially if dosing adjustments are necessary based on narrow therapeutic windows. -Familiarize yourself with all medications that you administer and be aware of potential (adverse drug event) ADEs that might occur. -Know where to obtain resources to confirm potential ADEs if you aren't familiar with the medications in use. 1. Review of the Morphine Sulfate Oral Solution package insert, dated January 2012, showed -Take care to avoid dosing errors due to confusion between different concentrations and between milligram (mg)/and milliliters (ml), which could result in accident overdose and death. -Respiratory depression: Increased risk in elderly, debilitated patients, those suffering from conditions accompanied by hypoxia, hypercapnia, or upper airway obstruction. (5.2) - Controlled substance: Morphine sulfate is a Schedule II controlled substance with an abuse liability similar to other opioids. (5.3) (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- (Central Nervous System- made up of brain and spinal cord) CNS effects: Additive CNS depressive effects when used in conjunction with alcohol, other opioids, or illicit drugs. (5.4) - Elevation of intracranial pressure: May be markedly exaggerated in the presence of head injury, other intracranial lesions. (5.5) - Hypotensive effect: Increased risk with compromised ability to maintain blood pressure. (5.6) - Special Risk Groups: Use with caution and in reduced dosages in patients with severe renal or hepatic impairment, Addison's disease, hypothyroidism, prostatic hypertrophy, or urethral stricture, elderly, CNS depression, toxic psychosis, acute alcoholism and delirium tremens, may aggravate or induce seizures. (5.9) - Impaired mental/physical abilities: Caution must be used with potentially hazardous activities. (5.10) Review of Resident #1's Face Sheet showed the resident: -Was admitted on [DATE]. -Had diagnoses including dementia and Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). -discharged on 7/13/24. Review of the resident's Discharge Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 7/13/24, showed the resident was severely cognitively impaired. Review of the resident's Medical Status Summary, dated 7/10/24, showed the resident: -Was admitted to hospice services (end of life care) related to dementia. -Was on a pain management program. Review of the Resident's Physician Orders, dated July 2024, showed: -Morphine concentrate 100 mg/5 mL oral solution, give 0.5 mL by mouth (10 mg total dose) as needed (PRN) every (Q) 2 hours PRN for pain, ordered 7/10/24. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Naloxone (Narcan) 4 mg/actuation nasal spray, nasal PRN Q 5 minutes PRN, spray 1 mg each nare for suspected opioid overdose emergency with signs of breathing problems and severe sleepiness or not being able to respond. May repeat in 4 minutes if symptoms recur, ordered 7/10/24. Review of the resident's July 2024 MAR showed: -Morphine concentrate administered on 7/12/24 at 12:16 A.M., 2:12 A.M., 5:12 A.M., 10:09 A.M., 3:43 P.M., no other administration documented for this date. -Naloxone (Narcan) administered on 7/12/24 at 1:10 P.M. Review of the resident's Nurse Notes, dated 7/12/24 at 4:40 P.M., showed: - Assistant Director of Nursing (ADON) administered the resident his/her morphine concentrate for pain. - ADON spoke with Certified Medication Technician (CMT) A related to the dose and amount to pull from the stock. - ADON administered 5 ml of morphine concentrate to the resident. -When the ADON returned to document administration, he/she realized he/she gave the incorrect dose of morphine concentrate. - ADON assessed the resident to have a respiratory rate of 16 with shallow (of little depth) breaths per minute (Normal respirations are 16 to 20 per minute). - ADON notified the Director of Nursing (DON) and the physician. - ADON administered Narcan at 1:10 P.M. nasally into left nare. - ADON assessed the resident's respiratory rate of 18 breaths per minute, regular breathing through mouth at 1:15 PM. - ADON reassessed resident at 1:20 P.M., 1:30 P.M., 1:45 P.M., and 2:00 P.M., showing regular respiratory rate of 18 breaths per minute. -At 4:00 P.M., the resident's spouse requested pain medication and morphine concentrate 0.5 mL was administered without difficulty. Review of the facility Medication Error Report, dated 7/12/24, showed: -Morphine concentrate 100 mg/5 mL oral solution, give 0.5 mL by mouth (10 mg total dose) PRN every 2 hours as needed for pain was ordered for the resident. -ADON administered 5 mL of morphine concentrate. -Medication was double checked with CMT A. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Prior to administration the resident was restless and complained to his/her spouse of pain. -When ADON returned to document the dose given, he/she noticed on the narcotic sheet the dose previously given was 0.5 mL. - ADON spoke with the DON, spouse, and physician. -The physician asked how the resident was doing and requested Narcan be given. -The resident's respiratory rate was 16 breaths per minute and shallow prior to Narcan administration. -Narcan was administered at 1:10 P.M., nasally. -The ADON stayed with the resident for 15 minutes monitoring his/her respiratory status and pain. -The resident had an increase in respiratory rate and depth after the administration of Narcan. During an interview on 7/23/24 at 2:21 P.M., CMT A said: -If a narcotic needs to be given, a nurse will come to the hall and administer the narcotic. -CMTs are not allowed to administer narcotics in long-term/skilled care. -He/she was unaware of how the ADON was notified that the resident needed his/her morphine. -The ADON asked CMT A about the dosage of the morphine concentrate. -CMT A observed the ADON pull up the morphine concentrate in a syringe and was going to put the morphine in a medication cup. -He/She told the ADON the resident would not get the medication correctly if administered from a medication cup. -He/she tried to tell the ADON the amount pulled for administration was the wrong dose by saying, I don't think that is right. -The ADON kept reading the orders on the box for the morphine concentrate. -When the ADON returned to CMT A's cart to sign out the morphine concentrate, the ADON realized he/she had given the wrong amount. -The ADON administered Narcan to the resident as a result of giving too much morphine concentrate. During an interview on 7/23/24 at 2:50 P.M., the ADON said: -Narcotics cannot be given by CMTs. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she recalled the medication error regarding the resident on 7/12/24. -He/she was not sure who asked him/her to give the resident his/her morphine concentrate. -He/She asked CMT A where the morphine concentrate was located. -CMT A showed him/her where the medication was in the locked narcotic drawer. -CMT A was standing with him/her as he/she pulled out the medication to be administered. -He/she misread the administration amount and pulled up more than the ordered dose. -He/she put the morphine concentrate in a medication cup and administered the medication to the resident. -When he/she returned to sign out the medication and he/she noticed he/she was signing out more than everyone else had previously. -He/she informed the DON of the error and together they contacted the physician. -He/she has given narcotics on the floor about three times since he/she started in April 2024. -He/she verified the morphine concentrate 5 mL (100 mg) was given at 12:50 P.M. followed by Narcan administered at 1:10 P.M. -He/she was aware of the appropriate medication practices and he/she needed to follow them. -He/she did not verify the appropriate dose to be administered. -He/she should have looked at the label on the bottle, checked the MAR, and the order if needed. -The administration of 100 mg of morphine concentrate instead of the ordered amount of 10 mg of morphine was a preventable event. -He/she felt if CMT A had not been side by side with him/her at the time he/she was pulling up the medication, he/she would of went to another licensed nurse to verify the dose instead of CMT A. During an interview on 7/23/24 at 3:52 P.M., the DON said: -CMTs are not allowed to administer narcotics of any kind, they are supposed to get a nurse to come to the hall to administer any and all narcotics. -On 7/12/24 there was hospice staff with the resident and requested that he/she be given morphine concentrate for pain. -Hospice nurses do not administer medications in the facility. -The ADON said he/she would give the medication. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The hospice staff were not present at the time the ADON administered the morphine concentrate 100 mg. -The ADON notified him/her immediately upon discovering morphine concentrate was administered at 100 mg instead of 10 mg as ordered. -Together they contacted the physician, who ordered Narcan be given. -There was not a policy in place to have liquid morphine be verified by another licensed nurse. -The medication error was preventable. -He/she expected safe medication administration practices for all nurses. During an interview on 7/24/24 at 8:02 A.M., the Physician said: -He/She was aware of the medication error on 7/12/24 involving the resident. -He/She ordered morphine concentrate 0.5 mg (10 mg) every two hours as needed for pain consistent with hospice/palliative care. -Agreed with the dose of 5 mL (100 mg) was a significant medication error. -Due to the dose being 10 times the amount ordered, he/she felt Narcan was an appropriate pathway. -Although no clinical harm was done, it doesn't negate the fact an error was made. -There are checks and balances in place to minimize the risk of this kind of medication error. During an interview on 7/24/24 at 2:09 PM the Administrator said: -He/she was aware of the medication error on 7/12/24. -He/she expected staff to follow procedure as the procedures are in place to protect the resident. -Although the medication was significant, he/she wants to cultivate a positive culture for reporting to rectify errors if/when they occur and contact the doctor immediately. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265768	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Spencer Place, Inc, The	4301 Madison Avenue Kansas City, MO 64111

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 to resident health or safety Residents Affected - Few	MO00239368