STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175220	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onaga Operator, LLC	500 Western Street Onaga, KS 66521

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	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 31 residents with three residents reviewed for medication errors. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1 remained free of significant medication errors. On 02/12/24 R1 returned to the facility from a cardiology appointment with a new order for metolazone, a diuretic (medication to promote the formation and excretion of urine), 2.5 milligrams (mg) that day, and another dose on 02/14/24. Licensed Nurse (LN) G incorrectly read the order as 25 mg and instructed LN H to administer five of R1's 5 mg metolazone from his PRN (as needed) stock. When the pharmacy delivered the medication to the facility a few hours later, LN G saw the dose was 2.5 mg. LN G called R1's cardiologist and received orders to monitor R1 for depleted fluid volume and to obtain a basic metabolic panel (BMP-laboratory blood test) the next day. On 02/13/24, R1's BMP showed R1's potassium level was critically low at 2.6 millimoles per liter (mmol/L) (normal range is 3.5 to 5.2 mmol/L). R1 admitted to the hospital and received intravenous fluids and potassium. R1's potassium remained critically low through 02/14/24 and low through 02/19/24 when he returned to the facility on oral potassium supplements. The facility's failure to ensure R1 remained free from significant medication errors resulted in R1 receiving ten times the ordered dose of metolazone which placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and chronic kidney disease. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of fourteen which indicated intact cognition. The MDS documented R1 had shortness of breath at rest, with exertion, and while lying flat. The MDS documented R1 was on oxygen. The MDS documented R1 required substantial or maximal assistance with toileting, and partial or moderate assistance with bathing and lower body dressing. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/16/23, documented R1 was at risk for cognitive loss and had disorganized thinking. Staff frequently oriented R1 to the date, time, and events. The CAA documented R1's head of bed was elevated due to difficulty breathing when lying flat. (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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Activities of Daily Living (ADL) Functional Rehabilitation Potential CAA, dated 06/16/23, documented R1 was at risk for decline in his functional ability with ADL. The CAA documented R1 required one staff assistance with most of his ADL, R1 was able to make his needs known, and he used the call light for assistance. R1's Care Plan, dated 06/12/23, directed staff to administer R1's medications as ordered. The plan directed staff to elevate R1's head of the bed to prevent shortness of breath while lying flat. The plan directed staff to administer R1 oxygen as ordered by his physician. Staff were directed to monitor R1 for difficulty breathing, signs and symptoms of respiratory insufficiency, and anxiety. The Progress Note, dated 02/12/24 at 11:25 AM, documented R1 had an appointment with his cardiologist and new orders were received for metolazone 25 mg on Monday 02/12/24 and Wednesday 02/14/24. The facility was ordered to check R1's labs and call the cardiologist with the results on Thursday or Friday. R1's February 2024 Medication Administration Record (MAR) documented R1 received 25 mg of metolazone on 02/12/24. R1's Laboratory Report, dated 02/12/24, documented R1's potassium level was 3.9 mmol/L. The Progress Note, dated 02/12/24 at 12:45 PM, documented the facility received R1's metolazone from the pharmacy. The pharmacy sent metolazone 2.5 mg, but R1 had already received metolazone 25 mg. LN G called R1's cardiologist's nurse and left a message about the 25 mg dose staff administered to R1. The Progress Note, dated 02/12/24 at 12:52 PM, documented R1's cardiologist nurse called the facility with orders from R1's cardiologist to watch R1. R1 should have some urine output getting the fluid off. The office nurse directed if R1 started showing signs of depleted fluid volume the facility staff should contact R1's primary care physician. R1's cardiologist ordered a BMP to be drawn on Tuesday 02/13/24, and Wednesday 02/15/24. The facility was ordered not to give R1 2.5 mg of metolazone on Wednesday. The Progress Note, dated 02/13/24 at 11:08 AM, documented a BMP was obtained from R1 and sent to the lab. The Progress Note, dated 02/13/24 at 12:14 PM, documented the medication error occurred as a result of poor penmanship by the provider and staff not seeing the warning when entering the order into the EMR. The Progress Note, dated 02/13/24 at 02:04 PM, documented R1's primary care physician requested the facility send R1 to the emergency department due to R1's critically low potassium at 2.6 mmol/L. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LN G's 02/14/24 Witness Statement documented on Monday, 02/12/24, R1 had a cardiologist appointment at 09:00 AM. R1 returned from his appointment with an orange piece of paper with handwritten orders. LN G read the order as metolazone 25 mg on Monday and Wednesday and to check labs and call the cardiologist's office with the results on Thursday or Friday morning. LN G called R1's responsible party to notify her of the new order. R1's responsible party stated she talked with R1's cardiologist and knew R1 would be getting extra water pills because R1 had lots of extra fluid he needed to get rid of. LN G then showed LN H the orders and LN H commented on the large dose. LN G told LN H R1's responsible party said R1 had a lot of fluid to get rid of. LN G then put the order into the computer EMR to be administered now and again on Wednesday. LN G asked LN H to pull five pills of R1's PRN 5 mg metolazone to equal 25 mg. R1 received the 25 mg of metolazone before noon. LN G stated at about 12:30 PM, the pharmacy delivered a bubble pack of metolazone 2.5 mg with directions to give 2.5 mg on Monday and Wednesday. LN G showed LN H the directions on the bubble pack and proceeded to call R1's cardiologist. R1's cardiologist's nurse answered, and LN G notified her the wrong dose was administered to R1. The cardiologist's nurse told LN G to monitor R1 and if he started showing signs of low fluid volume then R1 would need to go to the emergency department for fluids and to call R1's primary care physician with any other concerns over the next few days. Within two minutes R1's cardiologist's nurse called LN G with orders to not give R1 the metolazone 2.5 mg on Wednesday, and to draw a BMP on Tuesday and Wednesday. The cardiologist's nurse told LN G to monitor R1 for intolerance as the fluid may come off too quickly and if R1 had problems, he would have to go to the emergency department for fluids to replenish his electrolytes. LN G called R1's responsible party and told her the facility would monitor R1 for low fluid volume or signs he was not handling it well. LN H's Witness Statement, dated 02/14/24, documented on Monday, 02/12/24, R1 went to an appointment and upon return, LN G showed LN H the new orders. Upon reading the orders, LN H told LN G the dose was high, and said the physician must be trying to get that fluid off. LN G told LN H R1 had a lot of fluid. LN H told LN G she would have to wait until the pharmacy delivered the medication. LN G told LN H that R1 had PRN metolazone 5 mg. LN G said she would put in the orders and then LN H could get R1 his medication and not have to wait. LN G put the order in the EMR. LN H pulled up the MAR and it directed to give R1 five tablets of 5 mg metolazone. LN H gave R1 the medication as ordered. Later towards the end of LN H's shift, the pharmacy delivered R1's medication. LN G received the medication and the orders read to give R1 2.5 mg of metolazone. The updated Root Cause Analysis, documented the problem was R1 received the wrong dose of medication. The reason for the wrong dose administration was LN G read the order incorrectly, LN G did not use the template in the EMR to enter the order and did not pay attention to the alert from the EMR. LN H, who gave the medication, did not see the alert indicating a dose warning. LN G and LN H did not realize the dose was greater than what was acceptable, and LN G and LN H pulled the medication from R1's PRN dose instead of waiting for the medication to come from the pharmacy. The Progress Note, dated 02/16/24 at 06:45 PM, documented R1 readmitted to the facility post-hospitalization for low potassium. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Hospital Discharge Summary, dated 02/16/24, documented R1 admitted to the hospital for low potassium on 02/13/24 after nursing staff accidentally gave R1 metolazone 25 mg after his cardiologist ordered metolazone 2.5 mg. R1's BMP on 02/13/24 showed a potassium level of 2.6 mmol/L. R1 admitted to the hospital and received two liters of normal saline with 20 milliequivalents (mEq) of potassium. On 02/14/24 R1's potassium level was 2.4 mmol/L after administration of 40 mEq of potassium intravenously (IV-administered directly into the bloodstream via a vein) and 40 mEq of potassium by mouth. On 02/15/24, R1's potassium level was 3.0 mmol/L despite continued potassium replacement. R1 received an additional 40 mEq of potassium IV in addition to his oral dosing. On 02/16/24, R1's potassium level was 3.1 mmol/L. R1 received a total of 80 mEq of potassium orally and 40 mEq of potassium by IV. A potassium level check in the afternoon showed R1 had a potassium level of 5.0 mmol/L, a normalized potassium level, and discharged back to the nursing home. The Facility Incident Report, dated 02/19/24, documented at approximately 11:42 AM LN H gave R1 25 mg of metolazone instead of 2.5 mg. R1 returned from a cardiology visit and had a new handwritten order for 2.5 mg of metolazone. LN G and LN H interpreted the order as 25 mg. LN G entered the order as 25 mg metolazone and LN H gave the medication dose that was entered into the MAR. LN H gave the medication from R1's PRN card. When the local pharmacy delivered the prescription at approximately 12:40 PM, LN G noticed the pharmacy sent a dose of 2.5 mg of metolazone. LN G immediately called the cardiologist and requested to speak to his nurse. LN G told the nurse what happened. The nurse instructed LN G to monitor R1 for any signs of low fluid volume because R1 would need to go to the emergency department and call R1's primary care physician with any concerns. Approximately two minutes later, R1's cardiologist's nurse called LN G back and ordered LN G to monitor for signs and symptoms of hypovolemic (abnormally low circulating blood volume) shock (an acute medical condition associated with a fall in blood pressure), in which case R1 would need to go to the emergency department, and not to give R1 the 2.5 mg of metolazone on Wednesday, and to draw a BMP on Tuesday, 02/13/24, and Wednesday, 02/14/24. R1 was monitored for low fluid volume. A BMP was drawn as ordered and showed a potassium level of 2.6 mmol/L. The clinic staff notified the facility of the critical lab value and gave the order to transport R1 to the emergency department. On 03/13/24 at 10:30 AM, R1 laid in bed with his oxygen on watching TV. R1 wore pajama pants and slippers. On 03/13/24 at 10:30 AM, R1 stated when he found out he had received the wrong dose of medication, he was scared. R1 stated he was still uneasy about his medication being wrong. On 03/13/24 at 09:45 AM, Administrative Staff A stated the medication error should never have happened because if the nurse putting in the medication had paid attention to the alerts in the EMR, instead of clicking through them, the medication would not have been given. Administrative Staff A stated all the nurses had been trained to pay attention to the alerts and adhere to the alerts. On 03/13/24 at 01:00 PM, LN H stated she thought the dose of metolazone was high and she questioned LN G about it. LN G told her R1 had a lot of fluid that needed to come off and LN G was going to put the order in for now, for 25 mg of metolazone. LN H stated she listened to her charge nurse and administered 25 mg of metolazone. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/13/24 at 01:15 PM, LN G stated when she received the order for metolazone she thought the order read 25 mg. LN G stated she knew R1 had as needed metolazone 5 mg tablets, so she put the order in for five 5 mg tablets (metolazone) to be given now. LN G stated she did not wait for the pharmacy to deliver the medication because metolazone was a diuretic and she did not want R1 to be up all-night urinating. LN G denied that she had clicked through the alerts in the EMR when she input the order. The Physician Medication Orders, and Documentation of Medication Administration Policy, revised September 2023, documented medications shall be administered only upon written order of a person duly licensed and authorized to subscribe medications. The facility shall maintain a medication administration record to document all medications administered. The facility's failure to ensure R1 remained free from significant medication errors resulted in R1 receiving ten times the ordered dose of metolazone which placed R1 in immediate jeopardy. On 02/13/24 the facility completed education which included The Rights of Medication Administration, Face to Face Order Entry (using EMR template - if dose is not available get a double check), Pay Attention to Alerts (medication allergy/maximum dose exceeded), and Transcribing Orders and Order Entry into PCC. All corrective actions were completed prior to the onsite survey therefore the deficient practice was deemed past noncompliance. The scope and severity remained at a J.