STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175303	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parsons Presbyterian Manor	3501 Dirr Avenue Parsons, KS 67357

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** 40689 The facility reported a census of 29 residents. The sample included three residents reviewed for medications. Based on observation, interview, and record review, the facility failed to prevent the significant medication error of cognitively impaired Resident (R) 1. On 09/12/24 Certified Medication Aide (CMA) R incorrectly administered another resident's (R2's) medications to R1, which included Crestor (anti-hyperlipidemic) 20 milligram (mg) and Coreg (anti-hypertensive) 25 mg, as well as R1's scheduled mirtazapine (anti-depressant) 15 mg. The health care provider advised (HCP) to transport the resident to the Emergency Department (ED) via Emergency Medical Services (EMS) due to R1's life-threatening hypotension (low blood pressure) which occurred within an hour and a half hour of the medication error. While waiting for the facility van to arrive at the front of the facility to take R1 to the ED, R1 began to tremor (shaking or trembling movement), and her eyes rolled in different directions. The nursing staff assisted the resident to the floor from the wheelchair and called EMS. The resident had very shallow breathes and did not respond to her name when called for a short period. She eventually began to speak with nursing staff. EMS arrived to transport the resident to the ED at 08:20 PM. Findings included: - R1's Physician Order sheet (POS), dated 10/01/24, revealed R1 admitted on [DATE] with the following diagnoses: hypertension (elevated blood pressure) and edema (swelling resulting from an excessive accumulation of fluid in the body tissues). The 04/12/24 Admission Minimum Data Set (MDS), documented the resident had a severely impaired cognition, with a Brief Interview for Mental Status score of nine. R1 required a manual wheelchair, propelled by staff, for mobility device due to weakness and reduce mobility. The resident required substantial assistance by nursing staff for Activities of Daily Living (ADL). The resident was able to feed herself with supervision. The ADL [Activities of Daily Living] Functional/Rehabilitation Protentional Care Area Assessment (CAA) dated 04/26/24 revealed the resident required substantial to maximum assistance for dressing, bathing, grooming/hygiene, and bed mobility. The resident required total assistance from two staff during transfers, toileting, and shower transfers. Mobility was maintained through use of a wheelchair with total assistance from staff. The resident was non ambulatory, and she was afraid of standing and bearing weight. Resident was able to feed herself with supervision provided. (continued on next page)

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 10/12/24 Quarterly MDS, documented the resident had severely impaired cognition, with a BIMS score of five. The resident was dependent on nursing for ADLs. The resident was able to feed herself with supervision. Mobility was maintained through use of a wheelchair with total assistance from staff. R1's Care Plan, dated 10/22/24, instructed staff that R1 had short-term memory problems, impaired decision making due to natural aging process, consult with primary care provider (PCP) due to cognitive deficits. R1 required total assistance with her wheelchair and touch assistance with ADLs. The resident was able to feed herself with supervision. A Nursing Note dated 09/12/24, revealed nursing staff monitored R1's vital signs and condition due to a staff member passing medications which resulted in a medication error, as a precautionary measure for the resident. R1 received the following medications on 09/12/24: R1's Electronic Medication Administration Records (EMAR) included Mirtazapine (antidepressant), start 6/28/24, Mirtazapine 15 mg tablet administer one tablet by mouth once daily for appetite stimulation. This medication was schedule at 05:01 PM - 09:00 PM. and R2's Electronic Medication Administration Records (EMAR) reflects the following orders: Coreg 25 mg tablet [Carvedilol] (anti-hypertensive) start date 8/30/24, administer by mouth one table twice a day for atherosclerotic heart disease; hold for BP less than 100/60 or Pulse less than 60. This medication was schedule at 05:01 PM - 09:00 PM. Crestor 20 mg tablet [Rosuvastatin], (ant-hyperlipidemic) start date 3/22/23, administer between 05:01 - 09:00 pm, administer one tablet by mouth on time daily for hyperlipidemia. This medication was schedule at 05:01 PM - 09:00 PM. Reviewed R1's systolic average pressure, from 09/01/24 - 09/11/24; documented 109-142 mmHg. Reviewed R1's diastolic average pressure, from 09/01/24 - 09/11/24; documented 55-73 mmHg. Review of License Nurse (LN) H witness statement, dated 09/12/24, documented she obtained R1's vital signs at approximately 09:30 PM. R1's blood pressure was 82/45 mmHg. LN H verified using a different cuff and the resident's blood pressure was 75/37 mmHg. The health care provider was notified and advised to send the resident to the ED. Observed that the resident was limp in the transportation wheelchair and not responding. The resident was transferred to the floor, with shallow breathing. She began to respond by saying her name and rubbing her. Staff called 911 and she was transported to ED by EMS. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Nursing Note dated 09/12/24 at 06:01 PM documented the medication error occurred at the supper meal when CMA R administered R2's medications to R1. The medications were: Crestor 20 mg and Coreg 25 mg. R1's vital signs were stable at time of the medication error. R1's blood pressure was 158/74 mmHg, and her heart rate was 87 (beats per minute). The staff notified R1's HCP and her Durable Power of Attorney (DPOA). The HCP advised staff to monitor R1's vital signs every two hours for 12 hours. Review of Nursing Note dated 09/12/24 at 09:49 PM documented R1's blood pressure had decreased in one and a half hours, dropping from 158/74 mmHg to 82/45 mmHg, to 72/37 mmHg. The staff notified the resident's HCP who advised LN G to send the resident to the ED by EMS due to life threatening hypotension. Nursing staff transferred the resident into her wheelchair to transport her to the ED. While waiting for the facility van to move around to the front of the facility, nursing staff advised LN G that R1 was shaking, and her eyes went in different directions. LN G immediately assisted nursing staff to lower R1 to the floor and called 911. The resident had very shallow breathing and was not responding when staff called her name for a short period of time. The resident began to respond to her name as EMS arrived. EMS transported her to the ED at 08:20 PM. During an interview on 10/29/24 at 11:27 AM, R2 reported she was doing well and had received her medications without concern. During an interview on 10/29/24 at 12:09 PM Certified Medication Aide (CMA) R reported on 09/12/24 she was working the medication cart from 03:00 PM to 07:00 PM on the second floor. CMA R reported she should not have passed medication that shift due to excessive fatigue and needed to splash water in her eyes during the shift due to fatigue. During the 05:00 PM to 07:00 PM medication pass, CMA R reported she reviewed R2's medications and prepared to administer the medications. R1 and R2 sat together at the dining table on the second floor. At approximately 05:45 PM, CMA R reported she administered R2's medications to R1. CMA R reported she realized the medication error and immediately obtained R1's vital signs and immediately advised LN G of the medication error after obtaining R1's vital signs and CMA R continued to pass medications until her shift ended at 07:00 PM. During an interview on 10/29/24 at 03:34 PM Licensed Nurse (LN) G reported that she had not had concerns previously related to CMA R passing mediations. LN G reported she had not noticed on 09/12/24 that CMA R appeared to be very exhausted. She did not report to me after the incident that she was tired, and splashed water in her eyes. LN G said CMA R appeared very upset about the incident. At approximately 05:45 PM, CMA R advised she had administered R2's Crestor 20 mg and Coreg 25 mg medication to R1, along with R1's scheduled mirtazapine 15 mg. LN G reported she immediately notified R1's health care provider of the medication error and R1's vital signs were stable. The HCP wanted R1's vital signs monitored every two hours. R1 had an adverse event at approximately 07:30 PM in which her blood began to decrease to 82/45 mmHg and then to 75/37 mmHg. R1's HCP was advised of the adverse event and gave the order to transport the resident to the ED via EMS due to the substantial decrease in blood pressure within an hour and a half. LN G requested the nursing staff to transfer the resident into the wheelchair to transport to the ED. While waiting for a nursing staff member to drive the facility van to the front of the facility, R1 began to tremor (shaking or trembling movement) and her eyes rolled in different directions. The nursing staff assisted the resident to the floor from the wheelchair and called 911. The resident had very shallow breaths and did not respond to her name when called, for a short period. She eventually began to speak with nursing staff. EMS arrived to transport the resident to the ED at 08:20 PM. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/29/24 at 11:00 AM, CMA S reported a residents' medication must be verified with the residents EMAR and Physician Order Sheet (POS) and following the medications seven rights of administration. CMA S reported that if staff were unable to verify who the resident was, the staff should verify with the resident's picture as well as with another staff member who worked closely with the residents. She reported she did receive education related to Administration of Medication and Competency Skills Checklist prior to the following shift she worked. During an interview on 10/29/24 at 02:12 PM Certified Nurse Aide (CNA) R reported she was advised the residents eyes had rolled to back of her head and nursing staff needed assistance. She reported she then assisted the nursing staff to transfer R1 to the floor and laid R1 on her side. LN G advised CNA R to call 911 and EMS arrived shortly after. During an interview on 10/29/24 at 02:22 PM Certified Nurse Aide (CNA) N reported while she sat with R1, she observed the residents' eyes roll and R1 went limp in the transportation wheelchair. The staff transferred R1 to the floor and called 911. During an interview on 10/29/24 at 04:32 PM CNA M reported she noticed the nursing staff assisted the resident to the floor, and she begun to assist the nursing staff due to the resident was in distress. EMS did show up during that time and transferred the resident to the ED. During an interview on 10/29/24 at 05:10 PM Administrative Staff A reported she arrived at the facility at approximately 07:00 PM to begin the investigation. CMA R had been checked off on passing medications previously. Administrative Staff A had not heard concerns with CMA R that she was fatigued or that she was covering for another staff member. Administrative Staff A reported she was advised by LN G that CMA R had administered R2's medications to R1, and R1 had an adverse effected and was transferred to the ED by EMS per HCP orders. The resident admitted with hypotension. CMA R was immediately removed from the medication cart and suspended at 07:00 PM. During an interview on 10/29/24 at 05:20 PM, Administrative Nurse D confirmed she expected the nursing staff to always advise Administrative Staff if a nursing staff member was covering a shift for another nursing staff member for Administrative Staff approval. Administrative Nurse D also reported if the LN, CMA, or CNA were too tired to work a shift, he/she should always advise the administrative staff prior to working the shift and should not work the shift. Administrative Nurse D stated CMA R had not reported she was very tired and needed to splash water on her face during her shift. Administrative Nurse D said had she or any other staff reported those concerns or witnessed it, the facility expected staff to report the behaviors and CMA R would not have passed medications. The facility failed to prevent the significant medication error of dependent and cognitively impaired R1 on 09/12/24 when Certified Medication Aide (CMA) R incorrectly administered another resident's (R2's) medications which included the following: Crestor 20 mg and Coreg mg 25 MG, as well as R1's scheduled mirtazapine 15 mg. R1 suffered life threatening hypotension and required EMS transfer to the ED. The immediate jeopardy was determined to first exist on 09/12/24 at 05:50 PM, when Certified Medication Aide (CMA) R incorrectly administered another resident's medications to R1. The surveyor verified the facility identified and implemented corrective actions completed on 09/16/24 when the facility completed the following: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. On 09/12/24 at 07:00 PM, the facility suspended CMA R. 2. Licensed Nurses (LN) and Certified Medication Aides (CMA) were provided education on 09/12/24 at 07:00 PM through 09/16/24 at 09:16 AM related to Medication Administration. 3. Licensed Nurse (LN) and Certified Medication Aides (CMA) completed a Medication Administration check-off observed by Administrative Nurse A on 09/12/24 at 07:00 PM through 09/16/24 at 09:16 AM. Due to corrective actions the facility completed prior to the onsite visit, the deficient practice was deemed past non-compliance and exited at a J scope and severity.