STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175387	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Homes	200 Willow Rd Hillsboro, KS 67063

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40801 The facility reported a census of 38 with three residents included in the sample. Based on interviews and record review the facility failed to prevent a medication error when Licensed Nurse C did not follow the physician order and incorrectly administered five times the ordered amount of Ativan to Resident (R)1, who was on hospice. Findings included: - R1's Electronic Medical Record (EMR) dated 10/24/24 indicated the diagnosis of dementia with agitation (progressive mental disorder characterized by failing memory, confusion). R1's Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of three, indicating severely impaired cognition. The MDS noted R1 had behaviors symptoms of physical and verbal towards others. The 01/02/25 Significant Change (MDS) indicated R1's placement on hospice. The Care Area Assessment (CAA) dated 10/24/24 revealed behaviors triggered due to the physical, verbal abuse towards staff. The contributing factors included unspecified dementia with unspecified severe agitation and risk factors included injuring self and others. The Care Plan revised on 01/24/25 revealed R1 could become agitated at times, could be verbally and physically abusive, combative to staff, and resistive to care. The staff were to administer medications as ordered and monitor/document for side effects and effectiveness. The EMR revealed an order dated 01/09/25 for topical Ativan (lorazepam, a medication to treat anxiety) 1 milligram (mg) per 0.1 mg, every four hours as needed for anxiety, and use only 0.1 mg of syringe per dose (the syringe contained 5 doses in one syringe) every four hours, as needed for anxiety, and apply to the inner wrist or back of neck. Review of the Nurses Notes dated 01/14/25 to 01/20/25 lacked documentation regarding R1's response to the amount of Ativan given in error. The 01/16/25 at 04:32 PM note included staff notified the physician regarding the medication error that occurred on 01/14/25 with no new orders received (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/17/25 at 02:30 PM Administrative Nurse B revealed Licensed Nurse (LN) C gave the wrong dose of Ativan. Administrative Nurse B said instead of administering one dose as ordered LN C gave five doses of the resident's topical Ativan all at once. Administrative Nurse B stated this occurred on 01/14/25 and the error was not discovered until 01/16/25 when another nurse discovered the wrong dose had been given. Administrative Nurse B stated they completed a teachable moment of education with LN C on 01/16/25 regarding medication error. During an interview on 03/17/25 at 03:50 PM, Licensed Nurse (LN) C revealed R1 had a lot of anxiety and needed an as needed Ativan. LN C said she was used to the single dose syringes of topical ativan, and she looked at the syringe incorrectly and administered the wrong dose. During an interveiw on 03/17/25 at 04:00 PM, Administrative Nurse B revealed she expected the nurses to check the dose of medication and follow the medication rights when administering medications. The facility's policy Medication Administration dated October 2024 revealed the facility must ensure that its residents are free of any significant medication errors. The individual administering the medication must check the label three times to verify the right medication, right dosage right time and right method (route) of administration before giving the medications, The facility failed to prevent a medication error for R1 when Licensed Nurse C administered five times the physician ordered dose of Ativan to the hospice resident.