STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avita Health and Rehab at Reeds Cove	2114 N 127th Court East Wichita, KS 67228

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 10/11/24, Certified Medication Aide (CMA) R incorrectly administered R2's medications to R1, which included clopidogrel (antiplatelet medication) 75 mg (milligram), morphine (opioid medication used to treat severe pain) extended release (ER) 15 mg, as well as acetaminophen (analgesic) 650 mg. On 10/11/24 at 06:00 AM, during nursing shift report, Licensed Nurse (LN) G ensured that CMA R knew that R1 had a jejunostomy tube (J-Tube, a soft plastic tube surgically inserted into the small intestine to deliver food and medicine) and R1 could not receive any medications by mouth. CMA R drew a line through R1's medications and documented do not give medications. Later, LN G heard R2 coughing, assessed her oral cavity, and found four tablets in R2's mouth. LN G removed the four tablets to further prevent coughing or choking due to residents' history of aspiration pneumonia (a lung infection that occurs when food, liquid, or other substances are inhales into the lungs).

Findings included:

- R1's Physician Order Sheet (POS), dated 11/08/24, revealed R1 admitted on [DATE] with the following diagnoses; hereditary ataxia (a group of neurological disorders that cause a loss of balance and coordination due to faulty genes, multiple system atrophy (a rare, progressive neurodegenerative disease that affects the autonomic nervous system and other parts of the brain and nervous system), quadriplegia, (a condition that causes the complete or severe loss of motor function in all four limbs), basal ganglia dysfunction (a problem with the deep brain structures that help start and control movement), dysphagia (difficulty swallowing), and aphagia (the inability or refusal to swallow food, liquid, or saliva).

The 05/03/24 Annual Minimum Data Set (MDS), documented the resident had short-term and long-term memory problems. R1 was dependent on nursing staff for Activities of Daily Living (ADLs). The resident required a peg-tube for nutrition and fluid intake and medication administration.

The Nutrition Care Area Assessment (CAA), dated, 05/13/24, revealed the resident was dependent on a jejunostomy tube for nutrition and water flushes. The licensed nurse would continue to administer medications via the tube feeding as ordered for nutrition.

(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: 175532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avita Health and Rehab at Reeds Cove	2114 N 127th Court East Wichita, KS 67228

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's 08/02/24 Quarterly MDS documented the resident had short-term and long-term memory problems. R1 was dependent on nursing staff for ADL. The resident required a peg-tube for nutrition and fluid intake and medication administration. R1's Care Plan, revised on 07/10/24, documented R1's medications would be managed by the nursing and physician team during her stay. The care plan noted R1's medications were administered through the J-Tube. A Nursing Note, dated 10/11/24, revealed LN G reported to the Administrative Staff A, Licensed Nurse H, and the health care provider that R1 had been administered R2's medications. The health care provider ordered a chest X-ray, due to the resident's history of aspiration pneumonia (a lung infection that occurs when food, liquid, or other substances are inhaled into the lungs instead of swallowed), vitals signs to be obtained every four hours for 72 hours, and Augmentin (antibiotic) for ten days. A Health Care Provider (HCP) Encounter, dated 10/11/24, revealed the resident was assessed after nursing staff reported a medication error. R1 was administered R2's medications. R1 is NPO (nothing by mouth) and has a J-Tube for administration of medications. The HCP ordered a chest x-ray with no specific findings; however, the HCP did recommend Augmentin (antibiotic) for ten days and to monitor her vital signs every four hours for 72 hours. R1's Mobile Chest x-ray, dated 10/11/24, documented an increased airspace disease (a condition that occurs when the air in the lungs' alveoli is replaced by other substances, such as fluid, pus, blood, cells or fat) in the medial (middle or center) right lung base which may represent atelectasis (a partial or complete collapse of a lung that can cause shortness of breath), infection (occurs when a microorganism, like a virus, bacteria, or fungi, enters the body and causes harm), and/or aspiration (accidentally inhaling food or liquid through your vocal cord into your airway. CMA R's Witness Statement, dated 10/11/24, documented she walked into R1's room and administered R2's medications including clopidogrel 75 mg, morphine extended release (ER) 15 mg, as well as acetaminophen 650 mg to R1. R2's Electronic Medical Administration Records (EMAR) reflects the following orders: Plavix 75 mg tablet (clopidogrel Bisulfate) start date 03/17/22, administered by mouth in the morning for coronary artery disease. Morphine Sulfate ER Tablet Extended Release 15 mg, state date 08/08/24, administered one tablet my mouth every 12 hours for pain do not crush. Acetaminophen tablet 325 mg, start date 11/01/23, administer two tablets by mouth three times a day for pain. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/11/24 at 10:30 AM Licensed Nurse (LN) G reported she was walking past R1's room and heard R1 coughing. She entered R1's room and assessed her oral cavity to find four tablets in her mouth. LN G removed the four tablets from R1's mouth. While LN G was in R1's room, CMA R entered R1's room to advise her that she had walked out of R2's room and realized she administered R2's medications to R1. LN G verified on CMA R's report from earlier that morning and CMA R had appropriately identified R1 as do not give medications. LN G reported she educated CMA R the resident had a J-Tube and only a nurse could administer R1's medications. CMA R verbalized she understood. CMA R administered R2's medications which included clopidogrel 75 mg, Morphine Sulfate ER 15 mg, acetaminophen 650 mg 2 tablets. LN G notified the physician extended, who assessed the resident. The HCP ordered a chest x-ray due to R1's history of aspiration pneumonia, Augmentin (antibiotic) for ten days, and to monitor her vital signs every four hours for 72 hours. On 11/14/24 at 12:33 PM Consultant GG reported she was advised by LN G that CMA R had administered R2's medications to R1, that included clopidogrel 75 mg, Morphine Sulfate ER 15 mg, acetaminophen 650 mg. Consultant GG ordered a chest x-ray that indicated nonspecific findings related to the medications error. Consultant GG ordered R1's vital signs to be monitored four times a day for 72 hours and Augmentin for 10 days, as a precautionary, due to R1's history of aspiration pneumonia. The provider recommended a follow up chest x-ray in one month that indicated no concern. On 11/14/24 at 10:09 AM Administrative Staff A reported that LN G reported CMA R incorrectly administered R2's medications to R1. LN G reported to her that CMA R verbalized understanding and drew a line through R1's name with a note of do not administer medications. CMA R completed a witness statement and was asked to leave the building and put on a do not return (DNR) list for the facility. Administrative Staff A expected the CMAs to follow all medication orders and if the CMAs had questions, she expected them to ask the LN. On 11/14/24 at 2:16 PM the Administrative Nurse A was provided the IJ Template. The facility was notified they failed to prevent the significant medication error of dependent and cognitively impaired R1 on 10/11/24 when CMA R incorrectly administered R2's medications, orally to R1 who had a J-tube, placed R1 in immediate jeopardy. The immediately jeopardy was determined to first exist on 10/11/24 at 09:00 AM, when CMA R incorrectly administered R2's medications orally to NPO resident R1. The surveyor verified the facility identified the implemented corrective actions were completed prior to onsite survey on 11/14/24 when the facility completed the following: 1. On 10/11/24 at 09:00 AM the facility asked the CMA R to complete a witness statement, was escorted out of the facility, and placed the CMA on the Do Not Return (DNR) list. 2. Licensed Nurses (LN) and Certified Medications Aides (CMA) were provided education on 10/11/24 at 09:30 AM through 10/15/24 at 06:00 AM related to medications administration. 3. Licensed Nurses (LN) and Certified Medications Aides (CMA) completed a medication administration checkoff, observed by the Unit Managers on 10/11/24 at 09:30 AM through 10/15/24 at 06:00 AM. Due to corrective actions the facility completed prior to the onsite visit, the deficient practice was deemed past non-compliance and existed at a J scope and severity.