STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265512	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee's Summit Place	1501 SW 3rd Street Lees Summit, MO 64081

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** On 5/26/26, the Administrator was notified of the past noncompliance which took place on 5/11/26. The resident's physician was notified of the error. The Director of Nursing (DON) provided facility staff training on 5/11/26 with return demonstration provided. The deficiency was corrected on 5/11/26. Review of facility policy entitled Medication Administration revised 2/7/24 showed:-Medications were administered by licensed nurses, or other staff who were legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. -Identified resident by photo in the Medication Administration Record (MAR).-Review MAR to have identified medication to be administered. -Compare medication with MAR to have verified resident name, medication name, form, dose, route, and time. -Observed resident consumption of medication. 1.Review of Resident #2 admission Record showed the resident admitted to the facility on [DATE] with the following diagnosis:-Essential Hypertension (High Blood Pressure).-Peripheral Vascular Disease (a slow, progressive circulation disorder characterized by narrowed, blocked, or spasmodic blood vessels outside the heart and brain).-Atrial Fibrillation (a condition where the heart's upper chambers (atria) beat irregularly and out of sync with the lower chambers).-Hyperlipidemia (high levels of lipids (fats), such as cholesterol and triglycerides, in the blood). Review of facility investigation dated 5/11/26 showed:-Resident #2 received the following medications in error:--Allopurinol (a prescription medication primarily used to prevent gout attacks and kidney stones by lowering uric acid levels in the blood) 100 milligram (mg).--Ascorbic Acid (naturally occurring, water-soluble micronutrient better known as Vitamin C) 500 mg.--Cephalexin (antibiotic used to treat a wide variety of bacterial infections, such as those affecting the skin, respiratory tract, bones, and urinary tract) 500 mg.--Cetirizine (antihistamine used to treat allergy symptoms like sneezing, runny nose, itchy or watery eyes, and hives) 10 mg.--Cholecalciferol ((Vitamin D3) is a naturally occurring, fat-soluble vitamin) 5000 units.--Duloxetine (antidepressant and nerve pain medication) 30 mg.--Kerendia (used to slow the progression of chronic kidney disease (CKD)) 20 mg.--Lamotrigine (prescription medication classified as an anticonvulsant) 200 mg.--Senna-Docusate 8.6 mg-50 mg (stool softener).--Slow Iron Extended Release (supplement) 142 mg.--Torsemide (a loop diuretic, or water pill, that helps your body get rid of excess salt and fluid) 10 mg. --Acetaminophen Extra Strength (pain relief medication) 500 mg.-A root cause analysis of the event.-Witness statement from the nurse involved.-A completed Medication Error Incident Report. Review of Incident Note dated 5/11/26 at 11:09 A.M. showed:-The nurse notified the DON that a resident received medication intended for another resident. The Nurse Practitioner was notified immediately. The resident was immediately assessed Vital signs: blood pressure 159/75 millimeters mercury (mmHg) (normal range 90-120/60-80 mmHg), pulse 60 beats per minute (BPM)(normal range 60-100 BPM), reparations 16 even and unlabored (normal range 12-20), Oxygen saturation 93% on room air (normal range 92-100), blood sugar was 237 (normal range 80-130). Resident was alert and able to verbize needs. The resident complained of nausea and anti-nausea medication administered per NP order. No additional reactions noted no respiratory distress, changes in level of consciousness, chest pain, or alteration in mental status. Following further review of medications administered and out of abundance of (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 - Minimal harm or potential for actual harm Residents Affected - Few	precaution NP gave orders to transfer the resident to the hospital for further monitoring. Resident transferred to the hospital in stable condition. Report called to hospital and daughter notified. Review of Witness Statement from Certified Medication Technician (CMT) A dated 5/11/26 showed:-He/She was distracted by another resident when preparing medications for a resident.-As he/she was preparing medications for a resident when another resident interrupted him/her asking for medication.-He/She stopped working on the medications for the current resident and gave the requested medication to the resident who interrupted him/her. -Then went back to doing the medications for the resident he/she had prepared medications for. -He/She then went in and gave the medications to Resident #2.-He/She then came back to the medications cart to sign out the medications and realized he/she gave Resident #2 medications that were meant for another resident. During an interview on 5/26/26 at 10:36 AM, CMT A said:-He/She got distracted during medication pass when another resident interrupted him/her during medication pass. -He/She stopped working on the medication for one resident and gave the resident that had interrupted him/her the mediation the resident was requesting. -He/She finished preparing the medication that was to be given. -He/She went into the wrong room and gave the resident the wrong medications. -He/She thought she knew the resident who he/she was giving medications too. -He/She did not follow the five rights of medication administration (right patient, right medication, right dose, right route, and right time).-He/She came back out to the medication cart to chart medication given and then realized she gave Resident #2 the wrong medication that belonged to another resident. -When he/she realized the error he/she notified the DON and the doctor. -The doctor said to give the resident his/her correct medication, and to monitor the resident, and send the resident to the hospital in case the resident had a serious reaction. -The resident did not have any serious reactions to receiving the wrong medication but was sent to the hospital just in case for more detailed monitoring. -He/She was reeducated on the five rights of medication administration by the DON, as well as all staff, and did a new medication pass competency to show he/she could safely pass medication. During an interview on 5/26/26 at 12:03 PM, Licensed Practical Nurse (LPN) A said:-When you gave medication you verified the resident by the picture of the resident on the Medication Administration Record (MAR) to ensure you had the correct resident. -Once you verified the picture on the MAR matched the resident you were doing medications for you then followed the five rights of medication administration. -When the five rights of medication administration were followed no residents would get the wrong medications. -He/She heard a resident had gotten the wrong meds.-The residents had no sever adverse reactions but was sent to the hospital for precautions. -The medication error was preventable. -After the incident all the staff received education on medication administration, five rights of medication administration, and staff were observed to ensure medication pass done properly and followed the five rights of medication administration.During an interview on 5/26/26 at 12:20 P.M., CMT B said:-He/she followed the five rights of medication administration to ensure that medication errors were prevented. -If a resident was interrupting him/her you finished preparing the medications for the resident you were getting medications for, and resident that interrupted you would have told that you would be with next once these medications for the resident you were working on was done and focus on the meds and tell the resident that was interrupting you to wait nicely. -There was training on medication administration and how to ensure there were no medication errors, and observation on medication administration. During an interview on 5/26/26 at 12:47 P.M., DON said:-It was his/her expectation that nurses and CMT's would follow facility policy.-It was his/her expectation that staff passing medications would have followed the five rights of medication administration. -It was his/her expectation that when staff were preparing medication to be given to a resident, that if another resident interrupted the staff during that process that the staff would have told the resident that the staff were preparing another residents medication, and when the staff were done with that residents medication then the staff could help that resident. -If the staff had followed the five rights of medication administration, then the medication error would not have happened. -When he/she was (continued on next page)

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