STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265579	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Park Rehabilitation & Health Care Center	4600 Little Blue Parkway Independence, MO 64057

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. Based on interview and record review, the facility failed to ensure residents were free from significant medication errors when staff administered the wrong medications to one sampled resident (Resident #1) out of six sampled residents. The facility census was 95 residents. On 2/4/25 the Administrator and acting Director of Nursing (DON) were notified of past non-compliance which occurred on 1/31/25. On 1/31/25 the facility Administrator was notified of the incident and the investigation was started. Certified Medication Technician (CMT) A notified Licensed Practical Nurse (LPN) A of an medication error he/she had made. CMT A and all nursing staff were educated on medication administration on 1/31/25. The deficiency was corrected on 1/31/25. Review of the facility Medication Pass Tips dated 5/2019 showed: -The following is a compilation of points to keep in mind during medication pass. -Prior to preparing medications, verify the resident's identity. -A photo is available on the electronic Medication Administration Record (eMAR). -Another staff member who is familiar with the resident may be consulted to verify identity. -Also, call the resident by name. -Verify each drug against the eMAR. -Ensure the label matches the eMAR exactly. -Verify the dose in each blister against the eMAR. -Verify the route against the eMAR. -Administer each medication as instructed on the eMAR and within the timeframe established by the facility. Review of the facility's Medical Errors & Adverse Events Policy dated 12/2024, showed: -When medical errors or adverse resident events are identified, the facility will: (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 - Minimal harm or potential for actual harm Residents Affected - Few	--Analyze the cause. --Implement corrective actions to prevent future events. --Conduct monitoring to ensure desired outcomes and achieved and sustained. 1. Review of Resident #1's admission Record showed he/she was admitted to the facility with the following diagnoses: -Chronic Systolic (Congestive) Heart Failure (the heart is unable to pump blood effectively, leading to a buildup of fluid in the body). -High Blood Pressure. -Dementia (the loss of cognitive functioning- thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). -Ulcerative Colitis (a type of inflammatory bowel disease that causes inflammation and sores, called ulcers that can bleed). Review of the resident's Quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 1/16/25 showed the resident was severely cognitively impaired. Review of the resident's Physician's Order Sheet (POS) dated 2/1/25, showed the resident did not have orders for the following medications: -Atorvastatin (blocks enzyme that is needed by the body to make cholesterol and reduces the amount of cholesterol in the blood) 80 milligram (mg) tablet. -Baclofen (muscle relaxer) 10 mg tablet. -Apiraban (Eliquis an oral anticoagulant to prevent and treat blood clots) 5 mg tablet. -Mirtazapine (Remeron - antidepressant) 15 mg tablet. Review of the resident's Care Plan dated 3/27/24, showed: -He/She had impaired cognitive function/dementia or impaired thought process. -Administer medications as ordered. -Monitor/document/report to physician any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. Review of the resident's Incident Report dated 1/31/25 at 6:15 P.M., showed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN A was notified by CMT A that Resident #1 receiving the wrong medications. -Upon assessment LPN A noted the resident received Atorvastatin 80 mg, Baclofen 10 mg, Apiraban 5 mg, and Mirtazapine (Remeron) 15 mg. -Vitals signs were taken and the Nurse Practitioner (NP), Assistant Director of Nursing (ADON), family, and Hospice (end of life care) were notified of the medication error. -New order to monitor for any signs or symptoms of bleeding. -Resident was not able to state what happened. During an interview on 2/4/25 at 2:14 P.M., CMT A said: -He/She was passing medications and had just given medications to Resident #1's roommate and left the room. -He/She then started getting the medications ready for Resident #6 in the next room when he/she remembered he/she did not give Resident #1 his/her medications. -He/She set the cup of medications for Resident #6 on the medication cart and got Resident #1's medications ready and set them on the medication cart also. -He/She grabbed a cup of medications and gave them to Resident #1. -When he/she went to give Resident #6 his/her medications that is when he/she noticed that he/she had given Resident #1 Resident #6's medications. -He/She went and notified LPN A about giving Resident #1 the wrong medications. -He/She had been educated on proper medication administration on 1/31/25. During an interview on 2/5/25 at 3:58 P.M., LPN A said: -He/She was notified by CMT A that he/she had given Resident #1 Resident#6's medications. -He/She went over the medications that were given to Resident #1. -He/She assessed Resident #1 and took his/her vitals and notified the NP, ADON, and family of the medication error. -The NP gave an order to monitor the resident for any change in condition or bleeding. -Resident #1 did not have any adverse reactions to the medications he/she was given in error. During an interview on 2/6/25 at 10:55 A.M., the physician said: -Facility staff should notify the physician of the medications given in error. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident would be monitored for any adverse reactions. -If any reactions, he/she should be notified of the reactions and from there see if the resident would need to be sent out to the hospital. -With the resident just receiving one dose of these medications they should not cause any harm to the resident. -Staff should make sure they are giving the right medications to the right residents through the five rights as soon as getting the medications ready. -He/She was notified of the medication error on 1/31/25. MO00248924