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	175508	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS NURSING & REHABILITATIVE CENTER	302 E IOWA STREET HIAWATHA, KS 66434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent to the facility on 11/15/21.	F 000		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/15/2021

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F 756	Continued From page 1 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 44 residents. The sample included 15 residents, with five residents sampled for medication review. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified a blood pressure medication order for Resident (R)35 lacked a pulse parameter ordered by the physician or documentation of the pulse , and blood pressure and pulse reading for R13 was not documented. This deficient practice had the potential risk for unnecessary medication and unwarranted side effects for those two sampled residents. Findings included: - The electronic medical record (EMR) for R35 documented diagnoses of atrial fibrillation (a rapid, irregular heartbeat), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid). The "Admission Minimum Data Set" (MDS) documented R35 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. He required extensive assistance to total dependence of two staff members for his activities of daily living (ADLs), had an impairment on one side of the upper and lower extremity, and required a wheelchair for mobility. He received a	F 756		

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F 756	Continued From page 2	F 756		

diuretic (a medication to promote the formation and excretion of urine) medication six of seven days during the look back period.

The "ADL Care Area Assessment" (CAA) dated 10/06/21 documented R35 was an extensive to total assist of one to two staff. He was left sided paralysis (the loss of muscle function, sensation, or both).

The "Admission Care Plan" dated 10/11/21 did not address cardiac medications.

In the "Orders" tab report documented an order dated 09/29/21 for metoprolol tartrate (a medication used to control heart rhythm, treat chest pain, and reduce blood pressure) 25 milligrams (mg) tablet to administer 50 mg via gastric tube twice daily for CHF. This order was discontinued on 10/14/21.

In the "Orders" tab report documented an order dated 10/14/21 for metoprolol tartrate 25 mg tablet to administer 50mg by mouth twice daily for CHF.

The facility had standing physician orders and parameters for vital signs documented that the physician would be notified if the pulse was below 60 beats per minutes (BPM) or more than 120 BPM. Blood pressure medications would be held if the pulse was less than 60 BPM.

R35's medication order for metoprolol tartrate lacked pulse parameters and an area on the September "Medication Administration Record" (MAR) to record/document a pulse reading. The pulse reading was not documented three out of three opportunities when medication was

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administered on the MAR or anywhere in the clinical record.

The October MAR for metoprolol tartrate for R35 lacked a pulse parameter and documentation of the pulse reading on 62 of 62 opportunities.

The November MAR for metoprolol tartrate for R35 lacked a pulse parameter and documentation of a pulse reading on seven of seven opportunities.

The October "Medication Regimen Review" (MRR) dated 10/12/21 done by the CP documented no noted irregularities for the metoprolol tartrate for R35.

On 110/04/21 at 07:15 AM R35 rested in bed, head of bed elevated, the staff nurse was in the room at this time administering his ordered medications, medications taken and swallowed without difficulty.

In an interview with Licensed Nurse on 110/04/21 at 12:05 PM, she stated that for parameters the facility has standing physician orders that state if the pulse is below 50 BPM or above 120 BPM to call the physician. She further stated that some physicians have their own set of parameters for blood pressure medications and those would be documented under the orders or as a general order under the special instructions. The staff member that is passing/administering medications is responsible for following the parameters and to notify the nurse if it was a medication aide passing medications, the nurse would notify the physician, and the medication would be held if out of parameter and that would be documented on the MAR. The CP remotely

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reviews resident's charts monthly and emails the recommendations to the Director of Nursing (DON), then each halls nurse takes care of entering the recommendations into the computer.

In an interview with Administrative Nurse E on 11/04/21 at 08:10 AM, she stated that they do get blood pressure and pulse reading for certain medications. Each physician has their set parameters and how often they should be taken. She stated that R35 was a new resident and it looked like the pulse reading and parameter was not input at the time the medication was entered into the MAR at admission.

In an interview with Administrative Nurse D on 11/04/21 at 12:39 PM, she stated that parameters are documented on the MAR when they are obtained for a medication. The order should have the parameter for the pulse rate in it, if they physician has a specific parameter that is different from the facility's standing physician orders. If the medication was held that would be documented on the MAR. The nurse should be reporting any out of parameter vitals to the physician and document a progress note in the resident's chart. The CP reviews the charts monthly and will make recommendations then the recommendations are emailed to her and she gives the recommendations to the nurse in each hall.

In an interview with CP GG on 11/08/21 at 0953 AM, she stated that she typically reviewed resident charts monthly and looked at any new and existing orders as well as vital signs, blood sugars, and progress notes for residents. She does not have access to residents MAR, so she was not able to view if a pulse or blood pressure

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was obtained before a medication was administered. She does review all physician orders that would have any parameters for medications on them. Some residents have been there long term and only require a weekly blood pressure and pulse reading.

The facility policy "Medication Regimen Review" dated 10/02/19 documented: The CP will perform a drug regiment review on each resident living in the community monthly in long term care. The drug regimen review will identify: medications prescribed for residents without adequate indication for use documented in the resident's clinical record; indication for an ordered medication identified, but medication was not administered; medication ordered and/or administered was not the proper medication for the condition; medications that were ineffective to treat the identified condition; medications ordered and administered in excessively high dose or duration; residents whose clinical record and/or clinical condition indicates and adverse drug reaction to an ordered medication; and medications used without adequate monitoring.

The facility failed to ensure that the CP identified and reported irregularities in the MAR for R35, when a pulse was not obtained and documented before administration of his metoprolol tartrate, which had the potential for unnecessary medications and unwarranted side effects.
- The electronic medical record (EMR) for R13 documented diagnoses of heart failure and chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

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The "Admission Minimum Data Set" (MDS) dated 8/19/2021 for R13 documented a Brief Interview for Mental Status (BIMS) score of nine which indicated moderate cognitive impairment. R13 required extensive assist with one staff for all activities of daily living (ADL's).

The "ADL's Care Area Assessment" dated 8/19/2021 documented staff assisted R13 with cares and encouraged resident to maintain current level of ADL.

The "Orders" tab in the EMR under the "Order Report" documented an order dated 08/09/2021 for carvedilol (Coreg-a medication used to treat high blood pressure and heart failure) 3.125 milligram (MG) tablet to be given by mouth twice a day for heart failure. The physician-ordered parameters indicated that the medication should be held if the systolic pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) below 110 or a pulse below 60 beats per minute (bpm).

The "Orders" tab in the EMR under "Order Report" documented an order dated 8/10/2021 for vitals signs (blood pressure, temperature, pulse, respiration rate, and oxygen saturation) to be taken every Monday (weekly).

R13's "Medication Administration Record" (MAR) and clinical record for September, October and November 2021 indicated no parameters were documented and lacked evidence blood pressure and pulse were assessed before administering the medication.

The "Progress Notes" under "Resident Reports" indicate no entries from staff or physician

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regarding R13's medications withheld or vital sign documentation for September, October, and November.

The "Medication Administration Review" completed by the consulting pharmacist (CP) for R13 for the month of September and October 2021 showed no noted irregularities for the prescribed carvedilol or the lack of blood pressure and pulse readings for the medication during those months.

On 11/03/21 at 07:37 AM R13 slept in her wheelchair. The resident briefly awoke and called for help.

On 11/04/2021 at 12:05 PM Licensed Nurse (LN) G stated that whoever passed medications was responsible for checking and documenting parameters. She stated that if the certified nurses aid (CNA) checked vitals, they were responsible for notifying the nurse of parameters. The medication would be held, and the physician notified. LN G was unable to locate the documented parameters at the time of interview and acknowledged that they had not been documented for this specific medication. LN G stated that the administrative nurses completed chart audits monthly and the consulting pharmacy was responsible for conducting monthly medication reviews.

On 11/04/2021 at 12:39 PM Administrative Nurse D stated that she audited the charts each month. She stated that the parameters were documented in the MAR. If a medication was held the physician must be notified. The CP was also responsible for reviewing the resident's orders and communicating irregularities.

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F 756	Continued From page 8 The facility policy "Medication Regimen Review" implemented on 10/02/2021. Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication.The "MRR" policy indicates that if the consulting pharmacist identifies immediate action required regarding a finding, he/she will communicate with the physician and note in report, as well as, the licensed nurse caring for the resident. The facility failed to ensure that the CP identified and reported irregularities for R13, when a SBP and/or pulse was not obtained and documented before administration of Coreg, which had the potential for unnecessary medications and unwarranted side effects.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		

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§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 44 residents. The sample included 15 residents, with five residents sampled for medication review. Based on observation, record review, and interview, the facility failed to ensure that a pulse was obtained and documented for Resident (R)35's metoprolol tartrate (a medication used to control heart rhythm, treat chest pain, and reduce blood pressure) prior to administration; and blood pressure and a pulse reading for R13 was not documented prior to administration of carvedilol (a medication used to high blood pressure and heart failure). This deficient practice had the potential risk for unnecessary medications and unwarranted side effects for those two sampled residents.

Findings included:

- The electronic medical record (EMR) for R35 documented diagnoses of atrial fibrillation (a rapid, irregular heartbeat), and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid).

The "Admission Minimum Data Set" (MDS) documented R35 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. He required extensive assistance to total dependence of two staff members for his

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activities of daily living (ADLs), had an impairment on one side of the upper and lower extremity, and required a wheelchair for mobility. He received a diuretic (a medication to promote the formation and excretion of urine) medication six of seven days during the look back period.

The "ADL Care Area Assessment" (CAA) dated 10/06/21 documented R35 was an extensive to total assist of one to two staff. He was left sided paralysis (the loss of muscle function, sensation, or both).

The "Admission Care Plan" dated 10/11/21 did not address cardiac medications.

In the "Orders" tab report documented an order dated 09/29/21 for metoprolol tartrate 25 milligrams (mg) tablet to administer 50 mg via gastric tube twice daily for CHF. This order was discontinued on 10/14/21.

In the "Orders" tab report documented an order dated 10/14/21 for metoprolol tartrate 25 mg tablet to administer 50mg by mouth twice daily for CHF.

The facility had standing physician orders and parameters for vital signs documented that the physician would be notified if the pulse was below 60 beats per minutes (BPM) or more than 120 BPM. Blood pressure medications would be held if the pulse was less than 60 BPM.

R35's medication order for metoprolol tartrate lacked pulse parameters and an area on the September "Medication Administration Record" (MAR) to record/document a pulse reading. The pulse reading was not documented three out of

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three opportunities when medication was administered on the MAR or anywhere in the clinical record.

The October MAR for metoprolol tartrate for R35 lacked a pulse parameter and documentation of the pulse reading on 62 of 62 opportunities.

The November MAR for metoprolol tartrate for R35 lacked a pulse parameter and documentation of a pulse reading on seven of seven opportunities.

On 110/04/21 at 07:15 AM R35 rested in bed, head of bed elevated, the staff nurse was in the room at this time administering his ordered medications, medications taken and swallowed without difficulty.

In an interview with Licensed Nurse on 11/04/21 at 12:05 PM, she stated that for parameters the facility has standing physician orders that state if the pulse is below 50 BPM or above 120 BPM to call the physician. She further stated that some physicians have their own set of parameters for blood pressure medications and those would be documented under the orders or as a general order under the special instructions. The staff member that is passing/administering medications is responsible for following the parameters and to notify the nurse if it was a medication aide passing medications, the nurse would notify the physician, and the medication would be held if out of parameter and that would be documented on the MAR.

In an interview with Administrative Nurse E on 11/04/21 at 08:10 AM, she stated that they do get blood pressure and pulse reading for certain

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medications. Each physician has their set parameters and how often they should be taken. She stated that R35 was a new resident and it looked like the pulse reading and parameter was not input at the time the medication was entered into the MAR at admission.

In an interview with Administrative Nurse D on 11/04/21 at 12:39 PM, she stated that parameters are documented on the MAR when they are obtained for a medication. The order should have the parameter for the pulse rate in it, if they physician has a specific parameter that is different from the facility's standing physician orders. If the medication was held that would be documented on the MAR. The nurse should be reporting any out of parameter vitals to the physician and document a progress note in the resident's chart.

The facility failed lacked a policy for "Medication Administration".

The facility failed to ensure that staff administering medications obtained and documented a pulse for R35 before administration of his metoprolol tartrate, which had the potential for unnecessary medications and unwarranted side effects.
- The electronic medical record (EMR) for R13 documented diagnoses of heart failure and chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Admission Minimum Data Set" (MDS) dated 8/19/2021 for R13 documented a Brief Interview for Mental Status (BIMS) score of nine which

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indicated moderate cognitive impairment. R13 required extensive assist with one staff for all activities of daily living (ADL's).

The "ADL's Care Area Assessment" dated 8/19/2021 documented staff assisted R13 with cares and encouraged resident to maintain current level of ADL.

The "Orders" tab in the EMR under the "Order Report" documented an order dated 08/09/2021 for carvedilol (Coreg-a medication used to treat high blood pressure and heart failure) 3.125 milligram (MG) tablet to be given by mouth twice a day for heart failure. The physician-ordered parameters indicated that the medication should be held if the systolic pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) below 110 or a pulse below 60 beats per minute (bpm).

R13's "Medication Administration Record" (MAR) and clinical record for September, October and November 2021 indicated no parameters were documented and lacked evidence blood pressure and pulse were assessed before administering the medication.
The "Orders" tab in the EMR under "Order Report" documented an order dated 8/10/2021 for vitals signs (blood pressure, temperature, pulse, respiration rate, and oxygen saturation) to be taken every Monday (weekly).

The "Progress Notes" under "Resident Reports" indicate no entries from staff or physician regarding R13's medications withheld or vital sign documentation for September, October, and November.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175508	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS NURSING & REHABILITATIVE CENTER	302 E IOWA STREET HIAWATHA, KS 66434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 14 On 11/03/21 at 07:37 AM R13 slept in her wheelchair. The resident briefly awoke and called for help. On 11/04/2021 at 12:05 PM Licensed Nurse (LN) G stated that whoever passed medications was responsible for checking and documenting parameters. She stated that if the certified nurse's aid (CNA) checked vitals they were responsible for notifying the nurse of parameters. The medication would be held, and the physician notified. LN G was unable to locate the documented parameters at the time of interview and acknowledged that they had not been documented for this specific medication. LN G stated that the administrative nursed completed chart audits monthly. On 11/04/2021 at 12:39 PM Administrative Nurse D stated that she audits the charts each month. She stated that the parameters were documented in the MAR. If a medication was held the physician must be notified. The facility did not provide a policy. The facility failed to ensure staff obtained and documented a blood pressure and pulse as ordered prior to administration of R13's carvedilol. This had the potential of unnecessary medication administration and unwarranted side effects for R13.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		

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F 761	Continued From page 15	F 761		

professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 44 residents. The facility had two medication storage rooms. Based on observation, record review and interview, the facility failed to ensure medications were stored properly in one of the two medication storage rooms. This placed residents at risk for decreased medication effectiveness and unnecessary side effects.

Findings Included:

- On 11/02/2021 at 07:40 AM observation revealed the medication storage refrigerator which contained controlled substances (drugs which have a high abuse risk) was not locked.

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	175508	A. BUILDING _____ B. WING _____	11/04/2021

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F 761	Continued From page 16	F 761		

The following medications were present:
R1's morphine sulfate (controlled narcotic pain medication) 20 milligrams (mg)/milliliter (ml) bottle, lorazepam (medication used to treat agitation, anxiety and air hunger) 2mg/ml bottle
R15's morphine sulfate 20mg/ml bottle, lorazepam 2mg/ml bottle
R9's morphine sulfate 20mg/ml bottle, lorazepam 2mg/ml bottle
R38's morphine sulfate 20mg/ml bottle, lorazepam 2mg/ml bottle

On 11/02/2021 at 07:45 AM, the medication refrigerator temperature log lacked 11 of 30 entries for September 2021 and 12 of 31 entries for October 2021.

On 11/02/2021 at 07:50 AM, three bottles of expired medications were stored with the active medications. The expired medication bottles identified were as follows:
R33's hydroxyzine (treats anxiety, itchiness, and allergies) 25mg -Discard after 06/08/2021
R42's metoprolol (treats high blood pressure, chest pain, and heart failure)) 25mg -Discard after 09/18/2021 Synthroid (treats low thyroid hormone) 50 micrograms (mcg) -Discard after 09/03/2021

The facility's "Storage of Medication" policy dated 09/20/2019 stated that Schedule II controlled medications are maintained within a separately locked permanently affixed compartment. A locked drawer or section of the medication cabinet will be designated for storage of controlled substances. The key to the drawer or section will be different from the key that opens to the locked drawer. The medication cabinet will remain locked except when in use.

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F 761	Continued From page 17	F 761		

No policy was provided by the facility for refrigerator temperature inspection.

The facility's "Destruction of Drugs and Biological" policy dated 10/02/2019 indicated that discontinued, outdated, and deteriorated drugs and biologicals will be destroyed as provided by state and federal law.

On 11/02/2021 at 07:50 AM, Licensed Nurse (LN) G stated that the refrigerator temperatures are taken daily by the on-duty nurse. LN G stated that the medication refrigerator was usually locked when not in use and a nurse may have counted controlled medications and forgot to lock it. LN G stated that the expired medication was brought in by the resident's wife and was not being used by the resident. LN G moved the medication away from the active medication storage area to the return to pharmacy rack.

On 11/04/2021 at 12:40 PM, Administrative Nurse D stated that controlled medications should be locked up under double lock when not in use. She stated that medication room audits occur regularly, and nurse should not be leaving the refrigerator unlocked. She stated that expired medication should be destroyed if the families do not take them home with them.

The facility failed to properly secure schedule II control medications, dispose of expired medications, and track refrigerator temperatures for medications. This could potentially cause adverse consequences or ineffective treatment to the affected residents.