STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	C 10/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	**1501 INVERNESS DRIVE LAWRENCE, KS 66047**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #KS00156889, #KS00156261, and #KS00153075. The 2567 was sent to the facility electronically on 10/28/20.	F 000		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: The facility identified a census of 70 residents with three residents sampled for deaths in the facility. Based on observations, interviews, and record reviews the facility failed to ensure one Resident (R)1 received her rights for self-determination, related to her desire for "Cardiopulmonary Resuscitation" (CPR- emergency medical procedure for restoring normal heartbeat and breathing to victims of heart failure, drowning, etc.) were honored. Findings included: - R1's electronic medical record (EMR) documented diagnoses of heart failure, pulmonary hypertension (elevated blood pressure which affects arteries in the lungs and heart), cor- pulmonale (abnormal enlargement of the right side of the heart), congestive heart failure (CHF- a condition with low heart output and the	F 678		

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

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body becomes congested with fluid) and, cancer of the bronchus (passage of airway that conducts air into the lungs) and lung.

The "Five Day Minimum Data Set" (MDS) dated 05/29/20 documented R1 was able to make consistent and reasonable decisions, independently. She appeared to have adequate short and long- term memories. R1 required staff assistance with her "Activities of Daily Living".

The "Baseline Care Plan" lacked documentation for advanced directives.

The "Preferred Intensity of Medical Care and Treatment" tab, in her EMR. documented R1 wished to be a Full Code (performance of CPR), signed by R1's next of kin, and the physician.

The "Physician Orders for Transfer", from the hospital, documented R1's resuscitation status was a "No Code Blue" (performance of CPR), signed by a physician on 05/28/20.

The EMR documented a physician's order for CPR-full code status dated 05/29/20.

A "Progress Note" dated 05/30/20 at 12:28 AM documented R1 had stable vital signs (pulse, blood pressure, and respiration levels), was able to transfer to the bathroom with minimal assistance. She was provided with supplemental oxygen use.

A "Progress Note" dated 05/30/20 at 12:36 PM documented R1 had a temperature of 97.9 Fahrenheit, a blood pressure of 148/70, a pulse of 68 beats per minute, and respirations of 18 per minute.

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A "Progress Note" dated 05/30/20 at 03:38 PM documented a Certified Medication Aide (CMA) found R1 unresponsive, cool to touch, and was a pale gray color. R1 had no heart rate or respirations.

Review of the facility's incident investigation revealed the Certified Nurse Aide (CNA) informed the charge nurse R1 complained of pain. The CNA then assisted R1 to the bathroom and told her to call when she was done. In about five or ten minutes the CMA found R1 slumped on the toilet. R1 was gray, was not breathing, and a pulse was not detected.

On 10/20/20 at 12:05 PM Licensed Nurse (LN) G stated the residents' EMRs documented their wishes for code status. The residents' rooms name plates are coded by color. A blue name plate indicated the resident wished to have no CPR initiated and a white name plate indicated the resident wished for CPR to be initiated.

On 10/20/20 at 12:20 PM CNA M stated she knew a resident's code status by the color of the name plate on the resident's door. A white name plate indicated the resident wished not to have CPR initiated. And a blue name plate indicated the resident wished for CPR to be initiated.

On 10/20/20 at 12:25 PM Administrative Nurse (AN) D stated he expected staff to initiate CPR if a resident had a full code order. A resident's code status was documented in his/her EMR. The residents' doors name plates also indicated code status. A bold name plate indicated a wish for CPR to be initiated and a wish for no initiation of CPR was not bold.

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On 10/20/20 at 01:02 PM LN H stated she was the charge nurse at the time of the incident. LN H was notified a resident wanted to talk to her about pain. LN H thought the CNA who made the notification referred to the resident next to R1's room. LN H finished with her assistance of a resident across the hall and assessed the resident located next to R1's room. She returned to the room across the hall to assist that resident. In about five or ten minutes the CNA indicated R1 required immediate assistance. LN H found R1 on the toilet. R1 had no pulse or respirations. R1 had a light gray almost light green tint to her body and her body was cool. LN H did not initiate CPR since R1's hospital records had indicated she wished to have no initiation of CPR. LN H stated residents' code status was located on their EMRs.

On 10/20/20 at 01:36 PM LN I stated a resident's code status was documented in his/her EMRs. The name plate on the resident's door also indicated code status. A blue name plate indicated the resident wished to have no CPR initiated and a white name plate indicated the resident wished for CPR initiated.

On 10/20/20 at 02:27 PM AN D stated the facility's Social Worker received the code status from the residents/representatives and relayed the information to the facility staff. AN D was unsure why R1's hospital records indicated a no code status and the documentation in R1's EMR indicated CPR was to be initiated.

On 10/21/20 at 2:03 PM Licensed Social Worker Y stated he reviewed new admission's code status wishes with the residents and/or

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F 678	Continued From page 4 representatives. He talked with R1's child, and it was decided to sign the "Full Code" directive, at the time of R1's admission to the facility. The facility's "Advanced Directives (Patient Self-Determination Act) policy dated 09/01/28 documented the facility honored the residents' preferences for medical care and treatment. The facility facilitated the process for residents to express their preferences for medical care and treatment, including the withholding or withdrawal of life-sustaining treatment. All direct care staff are notified of the existence and location of a resident's Advance Health Care Directive (document in which a person describes the kind of health care that he/she would like to receive or refuse). The policy lacked documentation on the color-coded name plate indicators. The facility failed to perform CPR in accordance with R1's "Preferred Intensity of Medical Care and Treatment" documentation and per physician's order. This failure lead to R1's wish for the initiation of CPR to be carried out. This failure had the potential for staff to initiate or hold CPR which was not in accordance with the residents' wishes.	F 678		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility identified a census of 70. Three residents were sampled for medication errors. Based on observations, record review, and interviews, the facility failed to ensure the	F 760		

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residents were free from significant medication errors when a certified Medication Aid (CMA) administered Resident (R) 2 medications ordered for another resident. This deficient practice resulted in R2 becoming ill, hypotensive (low blood pressure), and vomited. R2 required emergency treatment at an acute care hospital as a result of the medication error.

Findings included:

- The "Diagnoses" tab of R2's electronic medical record (EMR) documented diagnoses of Alzheimer's disease (progressive mental disorder characterized by failing memory, confusion) and impulse disorder (condition in which a person has trouble controlling emotions or behaviors).

The "Admission Minimum Data Set (MDS)" dated 04/21/20 documented a Brief Interview for Mental Status (BIMS) score of four which indicated severe cognitive impairment. R2 received antianxiety (class of medication used to treat anxiety) medication four days, antidepressants (class of medications used to treat mood disorders and relieve symptoms of depression) seven days, and diuretics (medication to promote the formation and excretion of urine) seven days out of seven days during the assessment period.

The "Quarterly MDS" dated 07/16/20 documented a BIMS score of seven which indicated severe cognitive impairment.

The "Cognitive Loss/Dementia Care Area Assessment" dated 04/21/20 documented R2 had diagnoses of Alzheimer's disease and impulse disorder.

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The "Care Plan" dated 04/19/20 documented R2 received medications with black box warnings (warnings to alert medical professionals of potentially severe adverse reactions a drug has demonstrated) and directed staff to be aware of R2's medications that have black box warnings.

The "Facility Investigation," not dated, recorded R2 received R6's morning (AM) medications. R6's medication administration record recorded the following medications for AM: furosemide 40 milligrams (mg) (diuretic), losartan 50 mg (antihypertensive- medication to treat high blood pressure), sertraline 50 mg (antidepressant), thera-M tablet (multivitamin), vitamin D3 2000 Units, Aggrenox 25-200 mg (antiplatelet-medication that stops platelets from sticking together and forming a clot), gabapentin 100 mg (anticonvulsant- used to prevent or reduce the severity of epileptic fits or other convulsions), and quetiapine 50 mg (antipsychotic- class of medications used to treat psychosis and other mental emotional conditions).

The "Decision Matrix Medication Incident" dated 10/12/20 documented overall and severity subtotal of medication error at 23 which is a high severity and a category five with possible termination. Classifications of drugs received were vitamins, anticonvulsants, antidepressants, antipsychotics, diuretics, and antihypertensives. R2 was sent to the emergency room (ER) due to vomiting, low blood pressure, and low heart rate.

A "Health Status Note" in the "Progress Notes" tab of R2's EMR on 10/10/20 at 02:03 PM documented R2 received another resident's AM medications. Staff observed R2 slumped in back of a chair, pale, and vomiting in a trash can, then

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laid back in chair with her eyes closed, with pale ashen color.

A "Health Status Note" in the "Progress Notes" tab of R2's EMR on 10/10/20 at 02:40 PM documented the on call doctor ordered to send R2 to the hospital at once for evaluation and treatment. Staff monitored R2 one-on-one and documented she had poor response and lack of response with stimuli. Staff called an ambulance for transport.

A "Health Status Note" in the "Progress Notes" tab of R2's EMR on 10/10/20 at 03:52 PM documented the ER doctor confirmed that sending R2 to the ER was the only appropriate action to implement and stated next time the facility should try to do it quicker.

On 10/20/20 at 01:06 PM R2 sat on a sofa, eyes closed, and appeared to be resting comfortably.

In an interview on 10/20/20 at 12:07 PM CMA R stated she was supposed to give medications to R6 but gave them to R2 instead. She stated she got confused by their name and that most of the residents were in the dining hall or living area when she passed the medications. She discovered she gave them to the wrong resident when the nurse asked where R6's medications were because R6 stated she hadn't received any yet and she was leaving. She stated she gave R2 the scheduled AM medications for R6.

In an interview on 10/20/20 at 1:08 PM, Licensed Nurse (LN) J stated the medication aide mixed up two people and R2 received R6's morning medications. LN J stated thedirector of nursing instructed staff to monitor the resident. At shift

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F 760	Continued From page 8 change, R2 started vomiting. In an interview on 10/20/20 at 1:40 PM, Administrative Nurse D stated the nurse reported to him that CMA R gave R2 the wrong medications. He stated he instructed the nurse to monitor the resident for adverse reactions and monitor vital signs. He stated there should have been documentation for monitoring. He stated it did not look like staff followed the medication administration policy. The facility's pharmacist was unavailable for interview on 10/21/20. "Medication Management Guidelines" dated 05/28/02 lacked information on medication errors. The policy directed staff to notify physician immediately if an adverse reaction was suspected. The facility failed to ensure R2 was free of significant medications errors. This deficient practice resulted in adverse medication reactions and acute emergency treatment for R2.	F 760		