STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 02/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 complaint investigation #KS00168851. The 2567 was sent electronically on 02/21/22.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/21/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 02/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 755	Continued From page 1	F 755		

is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 51 residents. The sample included three residents reviewed for medications. Based on record review and interviews, the facility failed to ensure mediations were available for administration for Resident (R)1 as ordered. This placed R1 at risk for complications due to ineffective medication regimen.

Findings included:

- R1's electronic medical record (EMR) from the "Diagnoses" tab documented hypothyroidism (condition characterized by hyperactivity of the thyroid gland), elevated white blood cell count, and difficulty in walking.

The "Admission Minimum Data Set" (MDS) dated 10/28/21 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R1 was independent with no physical help from staff from bed mobility; supervision with on staff member assistance for toilet use, dressing, locomotion off the unit; and limited assistance of one staff member for transfers. The MDS documented R1 received opioid (narcotic pain medication) medications three days during the look back period.

R1's "Cognitive Loss Care Area Assessment" (CAA) did not trigger.

R1's "Care Plan" initiated 10/19/21 lacked directions related to medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 02/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 755	Continued From page 2	F 755		

Review of the EMR under the "Orders" tab revealed a physician order:

Timolol maleate solution (used to control ocular pressure) instill one drop in both eyes one time a day for historic medication dated 10/19/21.
K2 plus D3 tablet 100-1000 micrograms per unit (vitamin D-Vitamin K) give one tablet by mouth one time a day for supplement dated 10/19/21.
Magnesium Oxide tablet 250 milligrams (mg) give one tablet by mouth one time a day for supplement dated 10/19/21.

Review of the "Medication Administration Record" (MAR) for October 2021 revealed R1 had not received Timolol nine out of 11 opportunities; magnesium oxide four out of 12 opportunities; and K2 plus D3 seven out of 12 opportunities.
Review of the MAR for November 2021 revealed R1 had not received Timolol nine out of nine opportunities; magnesium oxide one out of nine opportunities; or K2 plus D3 seven out of nine opportunities.

Review of the "Progress Notes" for R1's stay in the facility documented central supply (CS) was notified about needing magnesium oxide and K2 plus D3 on 10/21/21, 10/23/21, 10/24/21, and 11/01/21.

Review of the "Progress Notes" further revealed that the pharmacy had been contacted regarding the timolol on 10/21/21, 10/22/21, 10/24/21, 10/25/21, 10/26/21, 10/29/21, 10/30/21, 11/01/21, and 11/05/21.

On 02/07/22 at 02:00 PM Licensed Nurse (LN) G stated that she would get over the counter medications from the designated storage place

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 02/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 755	Continued From page 3	F 755		

inside the facility. She said if she was not able to locate the medications in the storage area, she would call and request the medication from the pharmacy. LN G further stated that the provider would be notified if medications were not admisnitered per the orders.. LN G stated she would ask the provider what medications the provider wanted the resident to have in as a substitution or clarification.

On 02/07/21 at 2:51 PM Administrative Nurse D stated that staff would notify central supply if medications were needed and then CS was unable to obtain, staff talked to the provider to see if there was any other medications the provider wanted to change it to or just hold the medication until it was available.

The facility's "Pharmacist, services of a Licensed" policy revised 08/2017 documented the pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs, that are consistent with current standards of practice, and that meet state and federal requirements.

The facility failed to ensure medication was available to be administered as ordered by the physician for R1. This deficient practice placed R1 at risk for complications due to ineffective medication regimen.