STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A443	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Care Center	115 East 83rd Street Kansas City, MO 64114

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50579 Based on observation, interview and record review, the facility failed to ensure staff administered medications with a rate less than 5%. Facility staff made eight medication errors out of 29 attempts, resulting in a medication error rate of 27.59%. This affected three of seven sampled residents (Residents #2, #4, and #160) for medication pass. The facility census was 13. A facility policy titled Medication Administration-General Guidelines, dated 9/1/2006, showed: -Medications were to be administered per physician orders. -Medications were to be administered within 60 minutes of the ordered time. -The individual who administered the medication was to document the administration directly after the medication was given. 1. Resident #160's Physician Order Sheet (POS), obtained 6/13/24, showed: -An order for Carbidopa-Levodopa (a medication given for tremors) 25 milligrams (mg) Carbidopa/100 mg Levodopa, four times daily (9:00 A.M., 12:00 P.M., 5:00 P.M., and 9:00 P.M.) -An order for Lorazepam (a controlled medication given for anxiety) 0.5 mg, three times daily (between 7:00 A.M.-10:00 A.M., between 11:00 A.M.-1:00 P.M., and between 7:00 P.M.-9:00 P.M.) During an interview on 6/13/24 at 7:20 A.M., Certified Medication Technician (CMT) A said: -The night nurse would often pass some day shift medications but would not document the medications as given. -He/She would have to look through the medication cart to see who had received medications and who had not. -The only way to tell if the medications had been given was to look at the timed/dated pill packs that some of the medications came from the pharmacy in to see if they were missing. -If the medication pack was missing, he/she would assume all the resident's morning medications had been given, even if they were not documented as given by the night shift nurse. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the medication pass on 6/13/24 at 7:30 A.M.: -CMT A reviewed Resident #160's Medication Administration Record (MAR). -The MAR indicated the only medication due for the resident was Carbidopa-Levodopa. -CMT A said the night nurse gave many of the morning meds, and he/she was unsure which had been given. -After review of the resident MAR, CMT A removed a Lorazepam 0.5 mg tablet from the locked narcotic box and signed the tablet out of the narcotic book. -CMT A administered the 0.5 mg Lorazepam tablet to the resident. -CMT A documented in the MAR that he/she gave Carbidopa-Levodopa, but did not document that he/she gave Lorazepam. Surveyor reconciliation of the medication administration on 6/13/24 at 8:14 A.M., showed Carbidopa-Levodopa had been signed out at 7:00 A.M. by Licensed Practical Nurse (LPN) B and again at 7:30 A.M. by CMT A. Further reconciliation revealed LPN B had documented the Lorazepam being given at 6:14 A.M. During an interview on 6/13/24 at 8:24 A.M., CMT A said he/she had given the resident only Lorazepam at the 7:30 A.M. administration. During review of the MAR and an interview on 6/13/24 at 8:28 A.M., CMT A then said he/she administered both Lorazepam and Carbidopa-Levodopa to the resident and he/she did not know why the MAR documentation did not show he/she gave the Lorazepam. CMT A verified the MAR showed Lorazepam was administered at 6:14 A.M., but that he/she gave the resident a second dose at 7:30 A.M. Review of the resident's medication administration record (MAR) on 6/13/24, showed: -One documented administration of Lorazepam at 6:14 A.M. by LPN B. -A documented administration of Carbidopa-Levodopa at 7:32 A.M. by CMT A. -The CMT documented in error that he/she gave the Carbidopa-Levodopa, when he/she gave the resident a second dose of Lorazepam instead. During an interview on 6/13/24 at 8:30 A.M., the Director of nursing (DON) said: -He/she would not expect the Carbidopa-Levodopa to be documented if not given. -The Lorazepam appeared to be given to the resident twice within a one-hour timeframe. 2. Review of Resident #4's POS on 6/13/24 showed physician orders for: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Metoprolol (a drug given for high blood pressure and an elevated heart rate) 50mg tab to be given at 9:00 A. M. -Gabapentin (a drug given for nerve pain) 100 mg to be given at 9:00 A.M. -Cyclobenzaprine (a drug given for muscle spasms) 10mg to be given at 9:00 A.M. During an interview on 6/13/24 7:34 A.M., CMT A said Resident #4 had already had his/her medications administered because some had been documented on by night shift and the pill pack containing all of the medications was missing, so he/she would not be giving the resident any medications that morning. Review of the resident's MAR on 6/13/24 at 7:35 A.M., at that time, indicated Gabapentin, Metoprolol and Cyclobenzaprine had not been administered and were due at 9:00 A.M. During an interview on 6/13/24 at 7:36 A.M., CMT A stated again he/she would not be administering those medications, as they had already been given by the night shift and were not in the medication cart. Review of the MAR provided by the facility on 6/13/24 at 11:00 A.M., showed the doses of Gabapentin, Metoprolol, and Cyclobenzaprine had not been administered. 3. Review of Resident #2's POS showed physician orders for: -Acetaminophen (an over-the-counter pain medication) 500 mg, two tablets, at 8:00 A.M. -Metoprolol 50mg to be given at 9:00 A.M. -Tramadol (a narcotic pain medication) to be given at 9:00 A.M. -Linzess (a drug for maintaining healthy bowel movements) to be given at 9:00 A.M. During an observation on 6/13/24 at 8:01 A.M.: -CMT A took two Acetaminophen 500 mg tablets from the medication cart and attempted to administer them to the resident. -The resident declined and said he/she had already received all their medications that morning, including the Acetaminophen. -No medications were administered. -CMT A returned to the medication cart and documented Acetaminophen, Metoprolol, Tramadol and Linzess as administered at 8:08 A.M. Review of the resident's MAR provided by the facility on 6/13/24, showed the medications had been documented as administered at 8:08 A.M. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 6/13/24 at 8:30 A.M., the Director of nursing (DON) said: -Night shift may pick and choose some medications to administer for the day shift. -He/She expected medications to be given no earlier than one hour before or no later than one hour after the time on the MAR. -He/She expected any medications given by the night shift to be documented by the staff administering the medication. -He/She would not expect the day shift to have to guess who had received medications. -He/she expected staff to only document administration of medications they had administered themselves. -He/she expected the medications to be documented as they were given, not hours later.