STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 investigations #KS 159332, #KS 163736, #KS 166276, and #KS 166655. This 2567 was electronically sent to the facility on 11/02/21.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 54 residents with three residents reviewed for medication administration. Based on record review and interview, the facility failed to ensure that one of the three sampled residents, Resident (R) 1, received medication as ordered by the physician in accordance with professional standards of practice, when the physician ordered to discontinue a medication and the facility continued to administer the medication, from 08/12/21 through 08/20/21. Findings included: - The signed "Physician Orders" (PO), dated 08/23/21, for R1, documented the resident with diagnoses of congestive heart failure (a serious	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/02/2021

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.

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F 684	Continued From page 1	F 684		

condition in which the heart doesn't pump blood as efficiently as it should), and paroxysmal atrial fibrillation (a rapid, erratic heart rate that begins suddenly and then stops on its own within 7 days).

A physician order, dated 06/26/21, instructed the staff to administer, Aspirin (nonopioid analgesic) low dose tablet chewable 81 milligrams (mg), give 81 mg by mouth, one time a day, related to atherosclerotic heart disease of native coronary artery without angina pectoris (chest pain).

Review of the resident's "hospital discharge summary," dated 08/10/21, documented a PO stating do not resume home ASA (aspirin) and Eliquis (blood thinner) until neurosurgery follow-up in six to eight weeks. The summary also documented notable medication changes of stopping the ASA and Eliquis due to a subdural hematoma (a bleeding area in the brain region).

Review of the resident's August 2021 "Medication Administration Record" (MAR) revealed the facility staff discontinued the medication of Eliquis, but failed to discontinue the Aspirin medication, as ordered by the physician on 08/10/21, and the resident's hospital return, the resident received the medication daily from 08/12/21 through 08/20/21.

Interview, on 10/28/21 at 11:44 AM, with Administrative Nursing Staff D revealed she assisted with entering the resident's hospital return admission orders and the order to discontinue the aspirin "just got missed." It was an oversight by nursing staff that the medication did not get discontinued as the physician ordered and the staff continued to administer the

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F 684	Continued From page 2 medication. The facility policy for "Medical Records Admission Orders Procedure," reviewed 08/12/21, documented ...to provide guidelines to ensure that admission orders include all required information to provide continuity of care ...staff will review the following information for accuracy and completeness ...3. Medication orders ...7. All treatment instructions ... The facility failed to ensure the resident received medication as ordered by the physician in accordance with professional standards of practice, when the physician ordered to discontinue a medication and the facility continued to administer the medication, upon hospital return, from 08/12/21 through 08/20/21.	F 684		