STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175309	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS CITY PRESBYTERIAN MANOR	1711 N 4TH STREET ARKANSAS CITY, KS 67005

(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 partial extended survey for complaint investigations #KS00163362 and #KS 00164177. This 2567 was electronically sent to the facility on 07/28/21.	F 000		
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 reported a census of 38 residents, with three residents sampled for medication administration. Based on observation, interview, and record review the facility failed to ensure the medication regimen was free of significant medication errors for one of the residents sampled. Staff administered anti-hypertensive medications without a physician's order to Resident (R) 4, and the resident required hospitalization and intervention for decreased blood pressure. Findings included: - Review of Resident (R)4 's "Physician Orders" dated 07/15/21, revealed diagnoses that included pleural effusion (abnormal accumulation of fluid in the lungs), hypoxia (deficiency in the amount of oxygen reaching the tissues), and chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in	F 760		

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

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 760	Continued From page 1	F 760		

breathing). The resident did not have a diagnosis of hypertension (high blood pressure) or hypotension (low blood pressure).

The "Entry Minimum Data Set" (MDS) dated 07/15/21 revealed the resident admitted to the facility on 07/15/21.

The "Baseline Care Plan " dated 07/15/21 directed the staff the resident was able to verbalize her needs. The facility reviewed the resident's medication list provided by the resident on admission and she wanted staff to administer her medications.

The resident's "Physician Orders," dated 07/15/21, included the following orders:

1. Tramadol 50 milligrams (mg) tablet by mouth every 6 hours as needed (prn) for arthritis, ordered 07/15/21.

2. Cholecalciferol (vitamin D3) 1,250 micrograms (mcg)/(50,000units) once a week by mouth for osteoporosis, ordered 07/15/21.

3. Calcium 500 mg twice daily by mouth, ordered 07/15/21.

4. Lipitor 40 mg by mouth for hypercholesterolemia (medication used to treat high cholesterol accumulation in the body) at bedtime, ordered 07/15/21.

5. Fosamax 70 mg tablet by mouth weekly for osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), ordered 07/15/21.

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Her physician prescribed medications lacked orders for medications to treat hyper/hypotension.

The "Interdisciplinary Nurses' Notes" (IDTNN) dated 07/20/21 at 07:13 PM included at approximately 05:00 PM, the Certified Medication Aide (CMA) notified the nurse the following meds were administered to this resident in error:

1. Clonidine 0.1 mg (antihypertensive medication used to lower blood pressure).

2. Lisinopril 20 mg (antihypertensive medication used to lower blood pressure).

3. Colace 100 mg (a medication used to soften stool).

Staff called and had the on-call physician paged to notify him staff administered the wrong medication to the resident.

On 7/20/21 at 05:26 PM the physician returned the call and the nurse informed him of the medication error. The physician's order included to monitor the resident's blood pressure (B/P) every 30 minutes for two hours, then every hour for 22 hours, and notify the on-call physician if the resident's B/P was below 110/80 .

Furthermore, the "IDTNN" dated 07/20/21 at 09:19 PM included the following documentation:

1. On 07/20/21 at 05:30 PM, the resident's B/P was 95/42 millimeters of mercury (mmHg) and staff paged for the on-call physician.

2. On 07/20/21 at 06:00 PM the resident's B/P was 65/40 mm/Hg.

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3. On 07/20/21 at 06:30 the resident's B/P was 80/40 mm/Hg.

4. On 07/20/21 at 07:00 PM the resident's B/P was 68/35 mm/Hg. The on-call physician returned the call and gave orders to send the resident to the emergency room (ER) via ambulance.

5. On 07/20/21 at 07:30 PM the resident's B/P was 63/42 mm/Hg.

6. On 07/20/21 at 07:40 PM the resident transported to the hospital via ambulance .

On 07/20/21 at 10:03 PM the "IDTNN" documentation included the Durable Power of Attorney (DPOA) called the facility and stated the resident would be kept overnight for observation and to monitor the resident's B/P.

Review of the "Emergency Department" records from 07/20/21 to 07/21/21 revealed the resident received Levophed (medication used to treat life-threatening conditions such as shock and low blood pressure) and Normal Saline infusions intravenous (IV).

On 07/21/21 at10:39 AM an "IDTNN" documented the resident returned to the facility at 10:13 AM. The resident's vital signs on reentry to the facility included a B/P of 90/50 mm/Hg.

On 07/22/21 at 01:58 PM the resident was in the bed resting. On inquiry, she reported she did not feel dizzy nor experienced any chest pain and she answered questions appropriately .

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On 07/22/21 at 02:05 PM Certified Medication Aide (CMA) T verified on 07/20/21 at approximately 04:15 PM to 04:30 PM, she administered medications to the wrong resident when she administered another resident's medications to R4. She was aware of the medication error after she administered R5's medication to R4, only after R5 inquired about her medication. CMA T verified she administered medications in the dining room, and she failed to correctly identify R5. CMA T reported she should have reviewed the medication administration record (MAR) for the picture identification, because R4 and R5 were both new admissions to the facility and she failed to identify the correct resident with the correct medications.

On 07/22/2021 at 02:46 PM CMA S stated staff should identify residents by looking at their picture in the MAR prior to giving them their medications. Staff should ask the resident their names and/or ask someone else on staff to verify the resident's identity if there are any questions regarding the resident's identity.

On 07/22/21 at 01:25 PM Licensed Nurse (LN) G reported staff should compare the pictures of the resident on the MAR before giving medications to a resident to ensure the medications administered to the right resident. She reported if the resident was a new admission, she was not familiar with the resident she would ask other staff to confirm the resident's identity.

On 07/22/21 at 12:19 PM Administrative Nurse D and Administrative Nurse E confirmed staff administered the incorrect medications to R4 that included two antihypertensive medications ordered for R 5, due to mistaken identity.

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F 760	Continued From page 5 Administrative Nurses D and E agreed the staff should administer medications to residents as ordered by the physician after verifying the resident's identity. The facility's policy for "Medication Administration," dated 04/27/21, documentation included to identify the resident. If necessary, verify the resident with other staff personnel. The facility failed to ensure the medication regimen was free of significant medication errors for this newly admitted resident, when staff administered the wrong medications, that included anti-hypertensive medications, and the resident required hospitalization intervention for decreased blood pressure.	F 760		