STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175301	A. BUILDING _____ B. WING _____	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICHITA PRESBYTERIAN MANOR	**4700 W 13TH STREET NORTH WICHITA, KS 67212**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00154671 and KS00151073.	F 000		
F 760 SS=D	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 census totaled 37 residents (R) with three residents in the complaint sample. Based on observation, interview, and record review, the facility failed to ensure facility staff administered the correct dosage of Xarelto (a blood thinner) to R1 for a total of seven dosages. Findings included: - Review of R1's pertinent diagnoses from the "Physician's Order Discharge Transfer Records" dated 02/11/20 revealed: right sub-capital femoral neck fracture (right hip fracture) status post right hip hemiarthroplasty (after surgical procedure that involved replacing half of the hip joint). A review of the "Admission Minimum Data Set" (MDS), dated 02/17/20, revealed a brief interview for mental status (BIMS) of 15, indicating intact cognition. R1 used an anticoagulant for six days of a seven-day review period. Review of the "Discharge Minimum Data Set" (MDS), dated 02/27/20, revealed a brief interview for mental status (BIMS) of 15, indicating intact cognition. R1 used an anticoagulant for one day	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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of the seven-day review period.

Review of "Care Plan" dated 02/14/20, R1 had multiple medications and was at risk of side effects or complications due to polypharmacy (simultaneous multiple medication usage). R1 received Lovenox Injections (blood thinner) twice a day for Deep Vein Thrombosis (DVT- blood clots) prophylaxis (prevention). Staff needed to monitor R1 skin for excessive bruising and bleeding.

Review of "Physician Orders" dated 02/11/20 revealed Xarelto 10 milligrams (mg) by mouth (PO) daily for 20 days and then discontinue.

Review of 02/11/20 "Acute Care Hospital Discharge" record revealed resident to take Xarelto 10mg by mouth daily for 20 days for DVT prevention and then discontinue the order.

Review of 02/11/20 "New Admit Drug Regimen Review" revealed the pharmacist noted Xarelto order as "Xarelto 20 mg every day for 20 days".

Review of "Medication Administration Record" (MAR) dated February 2020 revealed an order for Xarelto 10 mg daily for 20 days. Staff documented daily administration of Xarelto to R1 from 02/11/20 until 02/18/20, excluding 02/15/20, due to the physician order to not administer the dose for that day. The medication was adminstered by four different staff members and per facility provided documentation, only one staff member was provided reducation regarding medication adminstration.

Review of "IDT (interdisciplinary team) Note" dated 02/15/20 at 11:26 AM revealed R1's family

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had questions about lab results regarding the hemoglobin (protein in the blood responsible for the transporting oxygen) level. The family requested staff not to administer R1's Xarelto on 02/15/20, and the staff obtained an order from the physician to hold the medication that day.

Review of "IDT note" dated 02/18/20 at 07:40 PM revealed Licensed Nurse (LN) D received a call from the pharmacy consultant reporting they sent the wrong dose of Xarelto to the facility as they had sent 20 mg instead of the prescribed 10 mg. LN D checked the medication card and reported that R1 had received seven doses of the 20 mg medication (double the dosage of what the physician ordered).

Interview with LN B on 08/03/20 at 04:56 PM revealed the facility staff had administered the wrong dose of Xarelto to R1. She stated the pharmacy sent the wrong dose, and it was given to the resident when LN B did not compare the physician's order to the medication card. She did not know how many doses the R1 received of the medication but believed it was administered over several weeks at the higher dose. She reported that she should have checked the medication dose on the card to the actual order.

Interview with LN D on 08/04/20 at 02:02 PM revealed the facility was going to re-order the medication, and found that R1's Xarelto card was the wrong dose, 10 mg more than R1 needed per the medication order on the MAR in EMR (electronic medical record).

Interview with Administrative Nurse A on 08/04/20 at 02:52 PM revealed she expected the pharmacist who reviewed the medications on

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02/11/20 to have caught the medication dosage error. The facility sent R1's hospital discharge paperwork over to the pharmacist for a medication review, and that paperwork had the correct dosage of Xarelto 10 mg. The LN and CMA's should always check the medication order against the medication card when they are administering medications to ensure the correct dosage.

Interview with Consultant Pharmacist E on 08/05/20 at 11:33 AM revealed the order came over for R1's Xarelto, and it was not transcribed correctly from the hospital discharge instructions to the new admit paperwork. Instead of Xarelto 10 mg for 20 days, the order was entered as 20 mg for 20 days. When the error was found by the pharmacist, they called the facility, but R1 had received seven doses of the incorrect 20 mg dose. There could have been bleeding issues with R1 due to the increased dose of the Xarelto.

Review of revised 06/10/29 "Drug Regimen Review" policy revealed a Drug Regimen Review (DRR) will be conducted by a clinical staff member within 24 hours of admission, and this review can include the wrong medication dose. The consultation of a pharmacist is documented in the medical record. The pharmacist has access to the resident's medical records.

Review of revised 06/18/19 "Medication Administration" policy revealed it is the responsibility of the nursing professional to be aware of the correct dosage of medication before administration. The procedure includes checking the Electronic Medication Administration Record (EMAR) before administration, the medication and dosage schedule on the EMAR is compared

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F 760	Continued From page 4 with the medication label. Read the label three times. If there is any discrepancy between the EMAR and the label, check Primary Care Provider (PCP) orders before administering the medication. Review of revised 06/10/19 "Medication Errors" policy revealed the community must ensure that residents are free of any "significant medication errors." "Significant medication error" means one that jeopardizes his/her health and safety. A "medication error" is defined by the type of error and categorized as one of the following: the wrong dose. Medication errors result because of the failure to comply with accepted professional standards. The facility failed to ensure the facility staff did not administer R1 double the ordered dose of Xarelto for seven doses.	F 760		