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

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

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 REDACTED]. A review of the Admission Minimum Data Set (MDS), dated [DATE], 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 [DATE], revealed a brief interview for mental status (BIMS) of 15, indicating intact cognition. R1 used an anticoagulant for one day 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 [MEDICATION NAME] Injections (blood thinner) twice a day for [MEDICAL CONDITION] ([MEDICAL CONDITION]- blood clots) [MEDICATION NAME] (prevention). Staff needed to monitor R1 skin for excessive bruising and bleeding. Review of Physician order [REDACTED]. Review of 02/11/20 Acute Care Hospital Discharge record revealed resident to take Xarelto 10mg by mouth daily for 20 days for [MEDICAL CONDITION] 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 [REDACTED]. 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 [REDACTED]. 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 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 orders [REDACTED]. 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 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 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.

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.