STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175504	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRING VIEW MANOR	**412 S 8TH STREET CONWAY SPRINGS, KS 67031**

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 reported a census of 32 residents with four residents selected for medication review. Based on observation, interview and record review, the facility failed to prevent a significant medication error, when the facility failed to administer an injection of Vitamin K (a medication used to prevent abnormal bleeding) in a timely manner, as ordered by the physician, for one resident (R) 3, for a critically elevated INR (international normalized ratio which is a laboratory measurement of how long it takes blood to form a clot to prevent adverse bleeding). Findings included: - Resident (R) 3's Quarterly Minimum Data Set (MDS), dated [DATE], assessed the resident with a BIMS (brief interview for mental status) score of 15, which indicated normal cognitive status. The resident had seven days of anticoagulant therapy in the seven day look-back period. The Care Plan, updated 05/23/20, instructed staff to monitor the resident for bleeding risk as [MEDICATION NAME] (anticoagulant medication) may cause major or fatal bleeding. Review of (R3's Physician order [REDACTED].) The Physician order [REDACTED]. A laboratory report, dated 07/07/20 revealed an INR of 5.6 (per Mayo Clinic Critical Laboratory Results, an INR greater than or equal to 5.0 is considered critical.) A Nursing Progress Note, dated 07/07/20 at 11:45 AM, documented the licensed nurse left a message on the called the physician's office voice mail and faxed the physician the laboratory results. A Physician order [REDACTED]. until a recheck of the INR in two days. A Nursing Progress Note, dated 07/07/20 at 01:37 PM, documented a physician ordered staff to administer Vitamin K one time injection, hold the [MEDICATION NAME] until the INR was 2.0, repeat the INR on 07/10/20 and then to restart the [MEDICATION NAME] 2 mg daily. A Nursing Progress Note, dated 07/08/20 at 03:11 PM, documented the pharmacy did not have the injectable Vitamin K, and the facility E (emergency) kit did not stock injectable Vitamin K, but did contain an oral Vitamin K. Licensed Nurse (LN) G telephoned the provider on 07/08/20 at 11:00 AM and 12:30 PM, and left messages regarding the Vitamin K availability. LN G documented in this note that the pharmacy delivered the medication at approximately 02:30 PM, and she administered it subcutaneously to the resident at that time. Interview, on 07/13/20 at 4:09 PM, with LN G, revealed she worked as charge nurse on 07/08/20. LN G stated she called the provider's office twice regarding the Vitamin K injectable availability and did not receive a return call. LN G stated the pharmacy delivered the medication to the facility at approximately 02:30 PM at which time she administered the medication (approximately 25 hours after the physician gave the order.) Interview, on 07/14/20 at 09:30 AM, with pharmacy consultant GG, confirmed the facility's E kit did not contain injectable Vitamin K, and the pharmacy did not stock injectable Vitamin K and had to order it from a supplier and did not know if other pharmacies carried it as oral administration was the preferred route of administration. Interview on 07/14/20 at 10:39 AM, with Administrative Nurse D confirmed the facility E kit did not stock injectable Vitamin K but did have oral Vitamin K. Nurse D confirmed the INR of 5.6 was a critical value and the facility Nurse D stated staff should have contacted the physician or the on call physician (for the provider and Nurse Practitioner when they are out of the office) to immediately obtain a change from injectable Vitamin K to oral Vitamin K. Nurse D stated the licensed nurse should have contacted administrative staff to assist in locating injectable Vitamin K. The facility policy Anticoagulation Therapy dated 07/10/20, instructs staff appropriate antagonist for anticoagulants will be available in the facility emergency kit, including Vitamin K. The facility policy Medication Errors, undated, instructs staff to report the error in detail on the incident report and significant medication errors are those which require medication intervention and/or result in possible or confirmed morbidity or mortality. The facility failed to prevent a significant medication error when they failed to administer Vitamin K injection in a timely manner, as ordered by the physician to counteract the critically elevated INR to prevent abnormal bleeding in this resident.

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.