STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175407	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF WICHITA	**622 N EDGEMOOR STREET WICHITA, KS 67208**

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 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 89 residents with five selected for review of unnecessary medications. Based on observation, record review, and interview the facility contracted pharmacist failed to identify the lack of physician notifications for blood glucose of less than 60 mg/dL (milligrams per deciliter, a measurement that indicates the amount of a particular substance (such as glucose) in a specific amount of blood) or greater than 350 mg/dL for Resident (R) 40 per physician order. Findings Include: - Review of R40's signed physician orders [REDACTED]. Review of R40's Admission Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating severly impaired cognition. R40 had a [DIAGNOSES REDACTED]. Review of R40's Care Plan dated 02/03/20 revealed the resident had a [DIAGNOSES REDACTED]. Review of the Physicians Order Sheet dated 08/19/20 revealed as of 06/09/20, blood sugar levels were to be obtained before meals and at bedtime. Staff was to call the physician if the results were less than 60 mg/dLor greater than 350 mg/dL for further orders. Review of the July and August 2020 Electronic Medication Administration Record [REDACTED]. Interview on 08/13/20 at 09:47 AM with Licensed Nurse (LN) D revealed that R40 had orders to call the physician if blood sugars are less than 60 mg/dLor greater than 350 mg/dL. LN C stated that if the blood sugars were outside of the parameters, staff should call the residents doctor for further instructions or new orders, and the LN should document in the resident's medical record. Interview on 08/13/20 at 12:29 PM with Administrative Nursing Staff B revealed that if a blood sugar fell outside of parameters, the nurse should notify the physician and documented in the nursing progress notes. Administrative Staff B stated she expected that the consultant pharmacist would inform the facility if the nursing staff were not notifying the physician for blood sugars outside of parameters. Interview on 08/17/20 at 08:50 AM consultant staff E stated that he does review the parameters to ensure that the facility is following up with them and would note discrepancies in his report. He also stated that he has however been unable to enter the facility due to COVID-19 and that the facility is changing some things from paper to computer. Review of the Medication Regimen Review dated 11/28/16 documented that the consultant pharmacist will conduct medication regimen reviews if required under a pharmacist consultant agreement and will make recommendations based on the information available in the residents' health record. The facility failed to ensure the consultant pharmacist identify physicians' notifications for blood sugars out of physician-ordered parameters to ensure this resident stay free from medication side effects.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 89 residents with five reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to adequately monitor the results of blood sugar checks for Resident (R) 40 who received insulin injections. Findings Include: - Review of Resident (R) 40's signed physician orders [REDACTED]. Review of R40's annual Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating they could not determine the resident's cognition. R40 had a [DIAGNOSES REDACTED]. Review of R40's Care Plan dated 02/03/20 revealed the resident had a [DIAGNOSES REDACTED]. Review of the Physicians Order Sheet dated 08/19/20 revealed as of 06/09/20 Accuchecks (blood glucose measuring system used for the monitoring of glucose) were to be obtained before meals and at bedtime for blood sugar levels. Staff were to call the physician if the results were less than 60 mg/dL (milligrams per deciliter), or greater than 350 mg/dL for further orders. Humalog (fast-acting insulin) 100 unit/ml, inject three units subcutaneously three times a day for diabetes. Review of the July and August 2020 Electronic Medication Administration Record [REDACTED]. Observation of R40 on 08/11/20 at 12:16 PM revealed him sitting on the edge of his bed with his bedside table pulled up in front of him with his lunch meal. Interview on 08/13/20 at 01:13 PM with direct staff C revealed that the nurse obtained the Accuchecks. Interview on 08/13/20 at 09:47 AM with Licensed Nurse (LN) D revealed R40 had orders to call the physician if blood sugars are less than 60 mg/dLor greater than 350 mg/dL. LN C stated that if the blood sugars were outside of the parameters staff should call the resident's doctor for further instructions or new orders and this should be documented in the nursing notes. Interview on 08/13/20 at 12:29 PM with Administrative Nurse B revealed that if a blood sugar fell outside of parameters the nurse should notify the physician. This notification should be documented in a nursing progress note. Administrative Nurse B stated it was her expectation that the consultant pharmacist would notify the facility if nursing staff were not notifying the physician for blood sugars outside of parameters. The facility was unable to provide a policy which addressed blood sugar parameters and physician notification specifically. The facility failed to adequately monitor blood sugar results for this resident who received daily insulin injections and had elevated blood sugars outside of physician ordered parameters with failure to notify the physician.

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.