STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165208	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANGER NURSING & REHABILITATION CENTER	**2001 KENNEDY STREET GRANGER, IA 50109**

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** Based on clinical record review, facility record review. staff interview, pharmacy interview, and observation, the facility failed to transcribe all admission orders [REDACTED]. The facility reported a census of 39 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 identified the resident readmitted to the facility on [DATE] after an acute hospital stay. The MDS documented [DIAGNOSES REDACTED]. The MDS coded the use of anticoagulant medication use on 1 out of 7 days of the assessment reference period. An undated care plan revision identified the resident at risk for adverse consequences related to chronic health conditions, which included a history of wedge compression fracture T9 to T10 vertebrae, dementia, chronic pain, dysphagia, or meds taken for conditions. An undated change to the problem area added pelvic fracture to the list of diagnoses. Another undated care plan revision instructed staff to monitor for side effects of [MEDICATION NAME] (anticoagulant medication also known as [MEDICATION NAME]) and documented the resident received [MEDICATION NAME] every day for 45 days. The Patient Discharge & Transfer Form dated 6/4/20 at 2:30 p.m. recorded physician orders [REDACTED]. [MEDICATION NAME] 40 mg per 0.4 ml (milliliters) injectable solution; give 0.4 mls subcutaneously every day for 45 days. The pharmacy shipping manifest dated 6/4/20 at 7:12 p.m. recorded the pharmacy sent the facility a quantity of 2.8 mls of [MEDICATION NAME] 40 mg per 0.4 ml syringes, which equaled a total of 7 doses for Resident #1. The June 2020 Medication Administration Record [REDACTED]. b. The entry documented the facility administered the medication one time on 6/5/20. Review of the electronic order details for [MEDICATION NAME] revealed the [MEDICATION NAME] entered incorrectly on 6/4/20. Staff entered the order entered as 40 mg subcutaneously one time a day every 45 days instead of every day for 45 days. The Medication Error report dated 6/19/20 at 2:49 p.m. recorded an error discovered that the resident did not receive the [MEDICATION NAME] as prescribed by the physician. The report documented education provided to staff. The education dated 6/22/20 provided to Staff A, Licensed Practical Nurse (LPN)/Admissions Director/Clinical Liaison, documented the following: Staff A re-educated by the Director of Clinical services to always review her order transcription for complete accuracy before leaving. Staff A also knew of the double/triple check system put in place to ensure order transcription accuracy. Staff A felt the education received adequate to mitigate any further medication transcription errors. On 7/9/20 at 11:26 a.m., Staff A recalled she completed the transcription of Resident #1's admit orders in the later afternoon or towards end of day on 6/4/20. Staff A stated she felt the [MEDICATION NAME] transcription error occurred because she apparently entered the order in the electronic record wrong. Staff A commented she remembered entering the [MEDICATION NAME] order as once a day for 45 days and remembered looking back over the orders. Staff A stated she must have hit every 45 days instead and she just missed it when she read over the orders and clicked the wrong box. Staff A identified herself as the first person to take the hospital orders and input them into the computer. Staff A said she assumed someone would double check the orders after she put everything on the desk and told the nurse the orders needed double checked. On 7/9/20 at 3:22 p.m., the pharmacy representative confirmed 7 daily doses of [MEDICATION NAME] sent to the facility on [DATE]. The pharmacy representative reported they filled the order correctly, as they used the orders from the hospital to fill the order and not the transcribed orders the facility entered. The pharmacy representative reported only 7 doses out of 45 sent due to frequently those types of medications changed, so they send a little at a time. Observation on 7/10/20 at 1:15 p.m. revealed the MDS Coordinator demonstrated how to enter a medication order into the electronic medical record. The MDS Coordinator showed a drop down box to select the frequency of a medication. The first box listed every day, the second box listed every X days to indicate a medication given on different days, i.e. Monday, Wednesday, Friday, or odd/even days. If staff selected the second drop down box, then another box engaged for entry of how many X days. The MDS Coordinator stated Staff A should have chosen the first line for every day rather than second line and that was how the medication transcribed in error. On 7/10/20 at 2:03 p.m., the Assistant Director of Nursing (ADON) reported the process for entering admission orders [REDACTED].

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