STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F402	A. BUILDING _____ B. WING _____	**06/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WARE MEMORIAL CARE CENTER	**1510 S. VAN BUREN ST. AMARILLO, TX 79101**

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 interview and record review; the facility failed to ensure residents remained free of any significant medication errors for 1 of 8 residents reviewed for medication errors (Resident #2). LVN A administered Resident #2 33 units of [MEDICATION NAME] (a fast acting insulin) instead of the ordered 33 units of [MEDICATION NAME] (a long acting insulin) resulting in Resident #2 being sent to the hospital. The facility's failure to administer medications correctly could affect all residents resulting in exacerbation of their condition resulting in complications from deterioration in health, hospitalization s, and death. Findings include: Record review of Resident #2's clinical record revealed a [AGE] year old female admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Record review of Resident #2's annual MDS dated [DATE] revealed she had short-term and long-term memory problems and was moderately impaired for making daily decisions. Resident #2 required extensive assistance by 2 or more staff members for bed mobility, transfers, dressing, personal hygiene, toilet use and bathing. Record review of Resident #2's physician's orders [REDACTED].= 0 units 141-170 = +1 unit 171-200 = +2 units 201-250 = +3 units 251-300 = +5 units >301 = +7 units Dx DM Order Date: 7/31/18 Start Date: 7/31/18 Record review of nurse's note written by LVN A, on 3/22/20 at 9:33 am documented the following: Late entry 0640 (6:40 am) residents blood sugar 346 administered 33 units [MEDICATION NAME] instead of 33 units [MEDICATION NAME]. Immediately gave oral [MEDICATION NAME] sublingually and [MEDICATION NAME] 1 mil IM injection to right arm. Called EMS to have resident sent to hospital. Resident blood sugar at 0655 (6:55 am) was 402. Ambulance arrived at 0700 (7:00 am) to transport resident to (hospital) gave report resident alert and answering questions appropriately. Called and notified (named removed) on call supervisor. Notified DON (named removed). Notified residents daughter (named removed). Called (named removed) FNP and notified received orders to give [MEDICATION NAME] Ekit and send resident to hospital. (sic) Record review of the facility's Provider Investigation Report signed and dated by DON on 3/24/20 documented the following: Incident Date: 3/22/2020 Time: 6:40 am Investigation Summary: Resident, (Resident #2), has orders for both [MEDICATION NAME] and Novalog. The nurse, (LVN A), was training a new employee and had both vials of insulin out, explaining the orders to him. (LVN A) drew up and administered insulin to (Resident #2), then mentally reviewed her actions and recognized she had drawn insulin out of the wrong vial. (LVN A) immediately self-reported the error and took action to prevent or minimize harm to (Resident #2). Review of the morning revealed the screening process for Covid 19 with multiple phone calls had disrupted her routine and could have contributed to the medication error. (sic) Investigation Findings: Confirmed During an interview with LVN B on 6/24/20 at 11:15 am, when asked what could happen when a resident is given [MEDICATION NAME] instead of [MEDICATION NAME], she said they can go into a diabetic coma. She said Resident #2 was given around 30 units of [MEDICATION NAME] and that was a big amount. LVN said Resident #2 was super fragile and her blood sugar can either be super high or super low. During an interview on 6/24/20 at 3:19 pm ADON said he was proud of the nurse for catching the med error quickly. Resident #2 was sent to the hospital and they just monitored her, nothing extra had to be done. ADON said this med error could have caused [DIAGNOSES REDACTED], drowsiness, she could have gone into diabetic coma. ADON added death could have occurred. Record review of the facility's Drug Administration Policy, dated 1/26/17, documented the following: Except for self-administered, drugs and biologicals are administered in accordance with physician's orders [REDACTED].

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.