STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kansas Veterans Home	1220 World War II Memorial Drive Winfield, KS 67156

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** 32360 The facility had a census of 79 residents. The sample included 19 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported to the facility that staff failed to follow the physician's orders in response to blood glucose monitoring for Resident (R)62, who received insulin (controls the amount of sugar in the blood by moving into the cells). This placed the resident at risk for physical decline and an ineffective medication regimen. Findings included: - The Electronic Medical Record (EMR) for R62 documented diagnoses of diabetes mellitus type two (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (high blood pressure), and posttraumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R62 had moderately impaired cognition, and required substantial/maximum assistance with toileting, bathing, dressing, personal hygiene, and transfers. The assessment revealed R62 received insulin and hypoglycemic (a group of medications used to help reduce the amount of sugar present in the blood) medication. R62's Care Plan, dated 02/07/24, initiated on 05/23/23, directed staff to monitor for signs of high and low blood sugars and administer medications as ordered by the physician. The Physician's Order, dated 05/21/23, directed staff to administer Humulog (fast-acting insulin), five units as needed for blood sugar over 250 milliliters (ml) per deciliter (dl). The Physician's Order, dated 08/11/23, directed staff to obtain R62's blood sugar four times per day for monitoring. (continued on next page)

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R62's Treatment Administration Record, dated February 2024, documented the following days R62's blood sugar was above 250 ml/dl and the as-needed Humalog insulin was not administered as ordered. 02/11/24 at 08:27 AM - 293 mm/dl 02/13/24 at 11:57 AM - 258 mm/dl 02/14/24 at 07:36 PM - 275 mm/dl R62's Treatment Administration Record, dated March 2024, documented the following days R62's blood sugar was above 250 ml/dl and the as-needed Humalog insulin was not administered. 03/03/24 at 03:54 PM - 281 mm/dl 03/06/24 at 11:18 AM - 264 mm/dl 03/11/24 at 03:03 PM - 307 mm/dl 03/13/24 at 10:00 AM - 252 mm/dl 03/28/24 at 02:03 PM - 270 mm/dl 03/31/24 at 11:10 AM - 254 mm/dl R62's Treatment Administration Record, dated April 2024, documented the following days R62's blood sugar was above 250 ml/dl and the as-needed Humalog insulin was not administered. 04/16/24 at 11:07 AM - 265 mm/dl The CP's Medication Regimen Review for the months of February and March 2024 lacked evidence the CP identified and reported R62's Humalog was not administered per orders as related to the blood glucose monitoring. On 04/18/24 at 08:30 AM, observation revealed R62 in the dining room eating breakfast. On 04/22/24 at 11:30 AM, Administrative Nurse D stated the CP had not notified her that the insulin was not administered in response to the resident's blood glucose levels as ordered by the physician. The facility's Consultant Pharmacist policy, dated 04/22/23, documented the Pharmacist shall perform monthly reviews of the methods, procedures, storage, administration, disposal, and record-keeping of drugs and biologicals. The findings of irregularities shall be given to the residents attending provider, nursing department, or other departments as appropriate. The resident-specific recommendations are documented in the resident's active medical record. The facility's CP failed to identify and report to the facility that staff failed to follow the physician's orders in response to blood glucose monitoring for R62. This placed the resident at risk for physical decline and an ineffective medication regimen.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 32360 The facility had a census of 79 residents. The sample included 19 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to administer medication as ordered by the physician in response to blood glucose monitoring for Resident (R) 62, who received insulin (controls the amount of sugar in the blood by moving into the cells). This placed the resident at risk for physical decline and an ineffective medication regimen. Findings included: - The Electronic Medical Record (EMR) for R62 documented diagnoses of diabetes mellitus type two (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (high blood pressure), and posttraumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R62 had moderately impaired cognition, and required substantial/maximum assistance with toileting, bathing, dressing, personal hygiene, and transfers. The assessment revealed R62 received insulin and hypoglycemic (a group of medications used to help reduce the amount of sugar present in the blood) medication. R62's Care Plan, dated 02/07/24, initiated on 05/23/23, directed staff to monitor for signs of high and low blood sugars and administer medications as ordered by the physician. The Physician's Order, dated 05/21/23, directed staff to administer Humulog (fast-acting insulin), five units as needed for blood sugar over 250 milliliters (ml) per deciliter (dl). The Physician's Order, dated 08/11/23, directed staff to obtain R62's blood sugar four times per day for monitoring. R62's Treatment Administration Record, dated February 2024, documented the following days R62's blood sugar was above 250 ml/dl and the as-needed Humalog insulin was not administered as ordered. 02/11/24 at 08:27 AM - 293 mm/dl 02/13/24 at 11:57 AM - 258 mm/dl 02/14/24 at 07:36 PM - 275 mm/dl R62's Treatment Administration Record, dated March 2024, documented the following days R62's blood sugar was above 250 ml/dl and the as-needed Humalog insulin was not administered. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/03/24 at 03:54 PM - 281 mm/dl 03/06/24 at 11:18 AM - 264 mm/dl 03/11/24 at 03:03 PM - 307 mm/dl 03/13/24 at 10:00 AM - 252 mm/dl 03/28/24 at 02:03 PM - 270 mm/dl 03/31/24 at 11:10 AM - 254 mm/dl R62's Treatment Administration Record, dated April 2024, documented the following days R62's blood sugar was above 250 ml/dl and the as-needed Humalog insulin was not administered. 04/16/24 at 11:07 AM - 265 mm/dl On 04/18/24 at 08:30 AM, observation revealed R62 in the dining room eating breakfast. On 04/22/24 at 09:17 AM, Licensed Nurse (LN) H stated R62 received five units of Humalog insulin if the resident's blood sugar was over 250 mm/dl. LN H said the physician was notified if R62's blood sugar got worse. On 04/22/24 at 11:30 AM, Administrative Nurse D verified R62 did not receive the as-needed insulin as ordered for the above dates and stated she would contact the physician to see if the order could be changed to administer if R62's blood sugar was over 300 mm/dl. The facility's Blood Glucose Monitoring Procedure, dated 12/15/22, documented that staff should verify the order for the procedure and document the blood glucose reading. Staff document any unusual findings and administer prescribed medications, including injections for the treatment of high or low blood glucose. The facility failed to administer medication as ordered by the physician in response to blood glucose monitoring for R62 who received insulin. This placed the resident at risk for physical decline and an ineffective medication regimen.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 27168 The facility had a census of 79 residents. The sample included 19 residents. The facility had four medication carts and four treatment carts. Based on observation, interview, and record review, the facility failed to date Resident (R)10, R13, R180, and R62's insulin (a hormone which allows cells throughout the body to uptake glucose) flex pen when opened and outdated and failed to discard expired stock medications. This deficient practice placed the affected residents at risk for ineffective medications. Findings included: - On 04/17/24 at 09:00 AM, observation of the facility's 500 nurse treatment cart revealed the following: R180's Lantus (long-acting insulin) flex pen lacked an open date and discard date. R10's Lantus flex pen lacked an open and discard date. R13'a Fiasp (fast acting) flex pen lacked an open and discard date. On 04/17/24 at 08:20 AM, observation of the facility's 500 nurse medication cart revealed the following: One bottle of acetaminophen (pain medication) 325 milligrams (mg) 100 tablets, expired February 2024. On 04/17/24 at 09:12 AM, observation of the facility's 300 nurse treatment cart revealed the following: R62's Lantus flex pen lacked an open and discard date. On 04/17/24 at 09:14 AM, Licensed Nurse (LN) G verified that Lantus lacked an open date and a discard date. On 04/21/24 at 11:00 AM, Administrative Nurse D verified the nurses were to date the insulin with an opened and discard date. Administrative Nurse D said staff were to discard expired stock medications. Medlineplus.gov directs open, unrefrigerated vials or pens of Lantus and Fiasp can be used within 28 days but after that time they must be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication Administration policy dated 04/22/24, documented that insulin pens would be clearly labeled with the resident's name or other identifying information. The policy documented before administering insulin with an insulin pen, the nurse would verify that the correct pen is used for that resident. The drugs dispensed in the manufacturer's original container would be labeled with the manufacturer's expiration date and the nurse would check the expiration date of each medication before administering it. The policy documented all expired medications would be removed from the active supply, regardless of the amount remaining. The facility failed to date R10, R13, R180, and R62s' flex pen insulin with the date opened and discard date and failed to discard expired stock medications placing the residents at risk for ineffective medication.