Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 8, 2023

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: CCN: 245189
Cycle Start Date: January 3, 2023

Dear Administrator:

On January 20, 2023, we notified you a remedy was imposed. On February 6, 2023 the Minnesota Department of Health ompleted a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 2, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 3, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 9, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 3, 2023, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 2, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 8, 2023

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

Re: Reinspection Results
Event ID: VO4P12

Dear Administrator:

On February 6, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 17, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	C 01/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/17/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirments for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H51897223C (MN00089795), with a deficiency cited at F755 and F760. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		2/2/23

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

Electronically Signed | 01/30/2023

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.

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F 755	Continued From page 1 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure two prescribed antibiotics were available for 1 of 1 resident (R1) who missed multiple doses of both antibiotics prescribed for infection. Findings include: R1's admission Minimum Data Set (MDS) dated 12/26/22, indicated R1 was cognitively intact and required intravenous (IV) antibiotics. R1's diagnosis list printed 1/17/23, indicated R1 had diagnoses of chronic pain syndrome and cellulitis (bacterial skin infection) of the right lower leg.	F 755	R 1 has since discharged from the facility. Current residents who receive IV antibiotic medications were reviewed and there were no discrepancies noted. A risk management incident will be created and thoroughly investigated for identification of root cause. Results from the root cause will be implemented. Future resident who requires IV antibiotic therapy, their IV medications will be transcribed into their medication record upon admission per facility policy. Licensed nursing staff will be in-serviced on the Reconciliation of Medications on admission with emphasis on the general guidelines item #1 that Medication	

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F 755	Continued From page 2 R1's hospital discharge orders dated 12/24/22, indicated R1 had the following orders: -cefepime (antibiotic) 2 gram(g) in normal sodium (NS) 50 milliliters (ml) IV every 8 hours until 1/6/23. -vancomycin 1 g in NS 250 ml IV intermittently to keep trough (vancomycin blood level) between 10-15 until 1/6/23. R1's provider orders printed 1/17/22, indicated R1's orders for cefepime and vancomycin were not transcribed into R1's medical recored until 12/26/22, which was 2 days after R1 admitted to the facility. R1's Medication Administration Record (MAR) dated 12/2022, lacked indication R1 had received cefepime IV or vancomycin IV. When interviewed on 1/17/23, at 12:08 p.m. registered nurse (RN)-A stated R1's hospital discharge orders were sent to the pharmacy. RN-A contacted the pharmacy who stated there was not a correct order for R1's IV antibiotics and would not send them without a correct order. RN-A was not sure what was missing from the orders and attempted to obtain clarification of the orders from R1's hospital provider but was unsuccessful. When interviewed on 1/17/22, at 12: 40 p.m. the regional pharmacy manager (RPM) reviewed R1's hospital discharge orders and verified the orders for cefepime and vancomycin were in place. RPM stated the vancomycin order required clarification as there was no frequency ordered and it was not clear when to start the intermittent dose. RPM further stated the	F 755	reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. In addition, the nursing staff will be in-serviced on the Polaris Pharmacy Medication Ordering and Receiving: Emergency Pharmacy Services and Emergency Kit Policy and Procedures with emphasis on item C that the pharmacy is available 24/7 and should be called for medication emergencies and item F which details emergency medications that are available within the facility. Director of Nursing and/or designee is responsible for compliance. Audits on timely medication reconciliation for IV therapy will begin 2x week for 2 weeks, weekly x2 weeks then monthly to ensure sustained compliance. All audit results will be reviewed by the Executive Administrator and the Executive Administrator will take audit results to QAPI for further review and recommendation. Compliance: February 2, 2023	

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F 755	Continued From page 3 cefepime order was complete and stated there was not any clarification needed. RPM verified there was no pharmacy documentation of why the IV cefepime was not sent. RPM acknowledged pharmacy "dropped the ball" and had expected the cefepime to have been sent to the facility. When interviewed on 1/17/22, ar 2:30 p.m. the Assistant Director of Nursing (ADON) stated R1's cefepime order appeared correct and was not sure why it was not sent. ADON further stated she was the leader on call for the facility on 12/24/22- 12/25/22 and was not sure if she was notified R1 had not received his antibiotics. When interviewed on 1/17/22, at 4:45 p.m. the administrator stated he expected pharmacy to provide medication timely when ordered. A facility policy titled Medication and Treatment Orders reviewed 1/2/22, directed orders for medications to include name and strength, number of doses or duration of therapy, dose and frequency of administration, and route of administration. A facility policy titled Medication ordering and Receiving from Pharmacy revised 1/2018, directed staff to provide physician's orders to the pharmacy when a new resident was admitted and promptly reports omissions to the pharmacy and supervisor.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		2/2/23

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F 760	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow physician orders for the administration of intravenous (IV) antibiotics after admission to the facility for 1 of 1 residents (R1) reviewed for IV antibiotics. Findings include: R1's admission Minimum Data Set (MDS) dated 12/26/22, indicated R1 was cognitively intact and required IV antibiotics. R1's diagnosis list printed 1/17/23, indicated R1 had diagnoses of chronic pain syndrome and cellulitis (bacterial skin infection) of the right lower leg. R1's hospital discharge orders dated 12/24/22, indicated R1 had the following orders: - cefepime (antibiotic) 2 gram(g) in normal sodium (NS) 50 milliliters (ml) IV every 8 hours until 1/6/23. -vancomycin 1 g in NS 250 ml IV intermittently to keep trough (vancomycin blood level) between 10-15 until 1/6/23. R1's provider orders printed 1/17/22, indicated R1's IV cefepime and vancomycin orders were not transcribed until 12/26/22 which was 2 days after R1 admitted to the facility. R1's Medication Administration Record (MAR) dated 12/2022, lacked indication R1 had received cefepime IV or vancomycin IV. When interviewed on 1/17/22, at 10:05 a.m. nurse practitioner (NP)-A stated on 12/26/22, she	F 760	R 1 has since discharged from the facility. Current residents who receive IV antibiotic medications were reviewed and all IV medications were transcribed upon admission and administered per physician order. A risk management incident will be created and thoroughly investigated for identification of root cause. Results from the root cause will be implemented. Future resident who requires IV antibiotic therapy, their IV medications will be transcribed into their medication record and medication that require clarification will be held until confirmed per facility policy. Licensed Nursing staff will be in serviced on the Medication Treatment Order policy with emphasis on item #12 that orders which need clarification will be subject to an automatic stop date. Director of Nursing and/or designee is responsible for compliance. Audits on timely medication reconciliation and resolution for the IV therapy will begin 2x week for 2 weeks, weekly x2 weeks then monthly to ensure sustained compliance. All audit results will be reviewed by the Executive Administrator and the Executive Administrator will take audit results to QAPI for further review and recommendation. Compliance: February 2, 2023	

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F 760	Continued From page 5 was notified R1 had not been getting the IV antibiotics prescribed by the hospital since R1 had admitted to the facility on 12/24/22, as pharmacy was requesting an order. NP-A further stated she reviewed the hospital discharge orders (on 12/26/22) and felt they looked valid but placed orders right away. NP-A stated medical doctor (MD-A) was on call from 12/24/22- 12/25/22, had not passed on any information or documentation the facility had contacted him about antibiotic orders needed clarifying for R1. NP-A expected staff to call providers if there were a problem obtaining medications for residents. Furthermore, NP-A stated R1 had been in the facility earlier in the month with an ongoing and complicated infection in the right leg and was at risk of amputation if the infection worsened. Missed antibiotic doses for R1 was significant and had the potential to impact R1's health status. When interviewed on 1/17/22, at 10:38 a.m. licensed practical nurse (LPN-A) stated at shift start on 12/26/22, she was told in report R1's antibiotics had not been received from pharmacy and had not been given since admission. LPN-A stated she notified the facility provider who clarified R1's IV antibiotic orders. LPN-A stated R1 was very upset about the missed doses of antibiotics and increased pain and demanded to be transferred to the hospital before the facility was able to get the antibiotics from pharmacy. LPN-A stated if clarification was needed for medications, there was always a provider to call, even after hours. LPN-A further stated it was important to get medication orders straightened out right away, so residents don't miss any needed treatment. When interviewed on 1/17/23, at 12:08 p.m.	F 760		

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F 760	Continued From page 6 registered nurse (RN)-A stated R1's hospital discharge orders were sent to the pharmacy upon admission. Pharmacy stated there was not a correct order for R1's IV antibiotics and would not send them without a correct order. Furthermore, RN-A stated several attempts made to R1's hospital provider and the infectious disease clinic to obtain additional orders was unsuccessful. RN-A further stated the on-call facility provider was not notified to help obtain correct orders as there was often push back and some unwillingness to order medications for residents' providers had not previously seen. RN-A had told R1 he would not get any antibiotics until after the weekend as the hospital orders had to be clarified and the infectious disease clinic was open. RN-A acknowledged R1 had missed doses of IV antibiotics and that increased R1's risk of worsening infection. When interviewed on 1/17/22, at 12:23 p.m. RN-B stated he was made aware antibiotics had not been started upon R1's admisssion to the facility after R1 was sent back to the hospital on 12/26/22. RN-B further stated it appeared the pharmacy order was not completed from the hospital discharge orders and staff had reached out to the hospital to clarify. RN-B further stated staff would not necessarily notify the on-call provider for clarification as the providers are not always willing to prescribe for a resident they have not seen or do not know. When interviewed on 1/17/22, at 2:30 p.m. the Assistant Director of Nursing (ADON) stated R1 had been in the facility prior on antibiotic and was going to be admitted again with IV antibiotics. ADON verified R1 had not received antibiotics during the two days here. R1's cefepime order	F 760		

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F 760	Continued From page 7 appeared correct and was not sure why it was not sent from pharmacy. ADON stated she was on call for the facility and did not recall being contacted by staff regarding R1's antibiotics. ADON stated "usually" staff were expected to reach out to providers to clarify but acknowledged sometimes the primary providers are more helpful and clarification may be left for the primary to follow up on during the week. ADON further stated she was unsure if missing these antibiotics would impact R1's health, but acknowledged antibiotics were important to be given to prevent risk of infections getting worse. A facility policy titled Admission Criteria reviewed 1/2/22, directed staff to ensure the residents provider provides the facility with information needed to immediately care for the resident including medication orders. The policy also directed staff to address concerns of residents and families during the admission process.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 01/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/17/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 01/17/2023

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H51897223C (MN00089795), with a licensing order issued at 1545 and 1550. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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SOUTHVIEW ACRES HEALTHCARE CENTER	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the	21545		2/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00102	A. BUILDING: _____ B. WING _____	C 01/17/2023

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21545	Continued From page 3 resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow physician orders for the administration of intravenous (IV) antibiotics after admission to the facility for 1 of 1 residents (R1) reviewed for IV antibiotics. Findings include: R1's admission Minimum Data Set (MDS) dated 12/26/22, indicated R1 was cognitively intact and required IV antibiotics. R1's diagnosis list printed 1/17/23, indicated R1 had diagnoses of chronic pain syndrome and cellulitis (bacterial skin infection) of the right lower leg. R1's hospital discharge orders dated 12/24/22, indicated R1 had the following orders: - cefepime (antibiotic) 2 gram(g) in normal sodium (NS) 50 milliliters (ml) IV every 8 hours until 1/6/23. -vancomycin 1 g in NS 250 ml IV intermittently to	21545	Corrected	

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21545	Continued From page 4 keep trough (vancomycin blood level) between 10-15 until 1/6/23. R1's provider orders printed 1/17/22, indicated R1's IV cefepime and vancomycin orders were not transcribed until 12/26/22 which was 2 days after R1 admitted to the facility. R1's Medication Administration Record (MAR) dated 12/2022, lacked indication R1 had received cefepime IV or vancomycin IV. When interviewed on 1/17/22, at 10:05 a.m. nurse practitioner (NP)-A stated on 12/26/22, she was notified R1 had not been getting the IV antibiotics prescribed by the hospital since R1 had admitted to the facility on 12/24/22, as pharmacy was requesting an order. NP-A further stated she reviewed the hospital discharge orders (on 12/26/22) and felt they looked valid but placed orders right away. NP-A stated medical doctor (MD-A) was on call from 12/24/22- 12/25/22, had not passed on any information or documentation the facility had contacted him about antibiotic orders needed clarifying for R1. NP-A expected staff to call providers if there were a problem obtaining medications for residents. Furthermore, NP-A stated R1 had been in the facility earlier in the month with an ongoing and complicated infection in the right leg and was at risk of amputation if the infection worsened. Missed antibiotic doses for R1 was significant and had the potential to impact R1's health status. When interviewed on 1/17/22, at 10:38 a.m. licensed practical nurse (LPN-A) stated at shift start on 12/26/22, she was told in report R1's antibiotics had not been received from pharmacy and had not been given since admission. LPN-A stated she notified the facility provider who	21545		

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21545	Continued From page 5 clarified R1's IV antibiotic orders. LPN-A stated R1 was very upset about the missed doses of antibiotics and increased pain and demanded to be transferred to the hospital before the facility was able to get the antibiotics from pharmacy. LPN-A stated if clarification was needed for medications, there was always a provider to call, even after hours. LPN-A further stated it was important to get medication orders straightened out right away, so residents don't miss any needed treatment. When interviewed on 1/17/23, at 12:08 p.m. registered nurse (RN)-A stated R1's hospital discharge orders were sent to the pharmacy upon admission. Pharmacy stated there was not a correct order for R1's IV antibiotics and would not send them without a correct order. Furthermore, RN-A stated several attempts made to R1's hospital provider and the infectious disease clinic to obtain additional orders was unsuccessful. RN-A further stated the on-call facility provider was not notified to help obtain correct orders as there was often push back and some unwillingness to order medications for residents' providers had not previously seen. RN-A had told R1 he would not get any antibiotics until after the weekend as the hospital orders had to be clarified and the infectious disease clinic was open. RN-A acknowledged R1 had missed doses of IV antibiotics and that increased R1's risk of worsening infection. When interviewed on 1/17/22, at 12:23 p.m. RN-B stated he was made aware antibiotics had not been started upon R1's admisssion to the facility after R1 was sent back to the hospital on 12/26/22. RN-B further stated it appeared the pharmacy order was not completed from the hospital discharge orders and staff had reached	21545		

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21545	Continued From page 6 out to the hospital to clarify. RN-B further stated staff would not necessarily notify the on-call provider for clarification as the providers are not always willing to prescribe for a resident they have not seen or do not know. When interviewed on 1/17/22, at 2:30 p.m. the Assistant Director of Nursing (ADON) stated R1 had been in the facility prior on antibiotic and was going to be admitted again with IV antibiotics. ADON verified R1 had not received antibiotics during the two days here. R1's cefepime order appeared correct and was not sure why it was not sent from pharmacy. ADON stated she was on call for the facility and did not recall being contacted by staff regarding R1's antibiotics. ADON stated "usually" staff were expected to reach out to providers to clarify but acknowledged sometimes the primary providers are more helpful and clarification may be left for the primary to follow up on during the week. ADON further stated she was unsure if missing these antibiotics would impact R1's health, but acknowledged antibiotics were important to be given to prevent risk of infections getting worse. A facility policy titled Admission Criteria reviewed 1/2/22, directed staff to ensure the residents provider provides the facility with information needed to immediately care for the resident including medication orders. The policy also directed staff to address concerns of residents and families during the admission process SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff	21545		

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21545	Continued From page 7 and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure two prescribed antibiotics were available for 1 of 1 resident (R1) who missed multiple doses of both antibiotics prescribed for infection. Findings include: R1's admission Minimum Data Set (MDS) dated 12/26/22, indicated R1 was cognitively intact and required intravenous (IV) antibiotics. R1's diagnosis list printed 1/17/23, indicated R1 had diagnoses of chronic pain syndrome and cellulitis (bacterial skin infection) of the right lower leg. R1's hospital discharge orders dated 12/24/22, indicated R1 had the following orders: -cefepime (antibiotic) 2 gram(g) in normal sodium	21550	Corrected	2/2/23

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21550	Continued From page 8 (NS) 50 milliliters (ml) IV every 8 hours until 1/6/23. -vancomycin 1 g in NS 250 ml IV intermittently to keep trough (vancomycin blood level) between 10-15 until 1/6/23. R1's provider orders printed 1/17/22, indicated R1's orders for cefepime and vancomycin were not transcribed into R1's medical recored until 12/26/22, which was 2 days after R1 admitted to the facility. R1's Medication Administration Record (MAR) dated 12/2022, lacked indication R1 had received cefepime IV or vancomycin IV. When interviewed on 1/17/23, at 12:08 p.m. registered nurse (RN)-A stated R1's hospital discharge orders were sent to the pharmacy. RN-A contacted the pharmacy who stated there was not a correct order for R1's IV antibiotics and would not send them without a correct order. RN-A was not sure what was missing from the orders and attempted to obtain clarification of the orders from R1's hospital provider but was unsuccessful. When interviewed on 1/17/22, at 12: 40 p.m. the regional pharmacy manager (RPM) reviewed R1's hospital discharge orders and verified the orders for cefepime and vancomycin were in place. RPM stated the vancomycin order required clarification as there was no frequency ordered and it was not clear when to start the intermittent dose. RPM further stated the cefepime order was complete and stated there was not any clarification needed. RPM verified there was no pharmacy documentation of why the IV cefepime was not sent. RPM acknowledged pharmacy "dropped the ball" and had expected	21550		

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21550	Continued From page 9 the cefepime to have been sent to the facility. When interviewed on 1/17/22, ar 2:30 p.m. the Assistant Director of Nursing (ADON) stated R1's cefepime order appeared correct and was not sure why it was not sent. ADON further stated she was the leader on call for the facility on 12/24/22- 12/25/22 and was not sure if she was notified R1 had not received his antibiotics. When interviewed on 1/17/22, at 4:45 p.m. the administrator stated he expected pharmacy to provide medication timely when ordered. A facility policy titled Medication and Treatment Orders reviewed 1/2/22, directed orders for medications to include name and strength, number of doses or duration of therapy, dose and frequency of administration, and route of administration. A facility policy titled Medication ordering and Receiving from Pharmacy revised 1/2018, directed staff to provide physician's orders to the pharmacy when a new resident was admitted and promptly reports omissions to the pharmacy and supervisor. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21550		

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