DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered via Email
January 29, 2021

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: December 29, 2020

Dear Administrator:

On January 29, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
December 18, 2020

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: December 9, 2020

Dear Administrator:

On December 9, 2020, a survey was completed at your facility by the Minnesota Department of Health , to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

## ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 9, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 9, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245258 | A. BUILDING _____ B. WING _____ | C 12/09/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FRANCISCAN HEALTH CENTER** | **3910 MINNESOTA AVENUE DULUTH, MN 55802** |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>On 12/8/20, through 12/9/20, an abbreviated survey was completed at your facility by the Minnesota Department of Health (MDH). The facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be substantiated: H5258038C<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 755 SS=E | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>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.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures | F 755 | | 1/22/21 |

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

Electronically Signed | 12/23/2020

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| F 755 | Continued From page 1<br>that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§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<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders for 4 of 4 resident (R1, R2, R3, and R4) for allegations of medications not being given.<br><br>Findings include:<br><br>R1's Face Sheet printed 11/9/20, indicated R1's diagnoses included CHF.<br><br>R1's signed Physician Orders dated 11/19/20, included orders for potassium chloride-K-Dur (medication to treat or prevent low amounts of potassium in the blood) 20 meq (milliequivalent) by mouth 4 times daily at 5:00 a.m., 10:00 a.m., 2:00 p.m., and 8:00 p.m. | F 755 | The Administrator and Director of Nursing will oversee all sections of this plan of correction, including the education, auditing and review of those materials.<br>• On 12/01/2020 and 12/08/2020 Medication cart audits completed to verify all medication administration was administered accurately. All medication errors have identified and followed up on.<br>• On 12/8/2020 Physician and families of R1, R2, R3 and R4 were notified of medication errors.<br>• After identification of further medication errors found on 12/08/2020 by LPN-A, LPN-A suspended upon completion of investigation.<br>• After completion of investigation | |

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| F 755 | Continued From page 2<br><br>A facility document titled Incident Details dated 12/8/20, indicated R1 had not been given her potassium chloride-K-Dur 20 meq medication scheduled to be administered at 2:00 p.m. on 12/1/20. The incident further indicated the medication error was identified on 12/1/20, at 10:58 p.m., however, R1's provider had not been made aware of the medication error until 12/8/20.<br><br>R2's Face Sheet printed 11/9/20, indicated R2's diagnoses included COPD, major depression and HTN.<br><br>R2's signed Physician Orders dated 11/26/20, included orders for Lexapro (antidepressant) 10 mg (milligram) by mouth 1 time daily at 8:00 a.m., multivitamin 1 tablet by mouth daily at 8:00 a.m., Colace (stool softener) 200 mg dose by mouth 2 times daily at 8:00 a.m. and 5:00 p.m., Lasix (to treat fluid build-up due to heart failure) 20 mg by mouth 1 time daily at 12:00 p.m., Tylenol 650 mg 2 times daily at 12:00 p.m. and 8:00 p.m., potassium 20 meq by mouth 1 time daily at 8:00 a.m., Prednisone (steroid) 2.5 mg by mouth 1 time daily at 8:00 a.m., Prilosec (decreases stomach acid) 10 mg by mouth 1 time daily at 8:00 a.m., vitamin D3 5,000 unit tablet by mouth 1 time daily at 8:00 a.m., and hydrocodone-acetaminophen (narcotic pain medication) 7.5-325 mg by mouth 3 times daily at 8:00 a.m., 2:00 p.m., and 8:00 p.m.<br><br>A facility document titled Incident Details dated 12/8/20, indicated R2 had not been given her Lexapro, multivitamin, colace, Lasix, tylenol, K-Dur, Prednisone, Prilosec, and vitamin D medications scheduled to be administered at 8:00 a.m. on 12/1/20. The report further indicated the | F 755 | LPN-A was placed on a work plan which included further one-on-one medication administration training, review of medication administration policy, review of 8 rights of medication administration, Employee training checklist and Educare modules titled “medication administration overview” and “Medication administration routes” were assigned.<br>• After initial work plan meeting with LPN-A and education reviewed by DON, LPN-A unable to complete work plan due to immediate retirement as of 12/16/2020.<br>• All residents have potential to be impacted by this practice.<br>• All Licensed Nursing staff will be re-educated on the facility Medication Administration Policy, 8 rights of Medication Administration and Medication Error policy.<br>• Medication administration audits, observing for any medication errors, will be completed 1/week x 4 weeks, then 1/two weeks x 1 month and monthly thereafter.<br>• Unit Managers will review all medication errors promptly, to ensure they are completed correctly and verify that providers notify of error according to our policy.<br>• Monitoring will be reported to the next QA&A and as needed. Committee will monitor and make ongoing recommendations as needed. | |

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| F 755 | Continued From page 3 | F 755 | | |

medication error was identified on 12/1/20, at 10:58 p.m. however, R2's provider had not been made aware of the medication error until 12/8/20.

A facility document titled Incident Details dated 12/8/20, indicated R2 had not been given her hydrocodone-acetaminophen pain medications scheduled to be administered at 2:00 pm. on 12/8/20. The incident report further indicated the medication error was identified on 12/8/20, at 6:01 p.m. and R2's provider had been notified of the medication error on 12/9/20.

R3's Face Sheet printed 11/9/20, indicated R3's diagnoses included dementia, restless leg syndrome and major depressive disorder.

R3's signed Physician Orders dated 10/9/20, included orders for gabapentin (treat restless leg syndrome) 100 mg by mouth 3 times daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m., Buspar (antianxiety) 10 mg by mouth 3 times daily at 8:00 a.m., 2:00 p.m., and 8:00 p.m.

A facility document titled Incident Details dated 12/8/20, indicated R3 had not been given her gabapentin and Buspar medications scheduled to be administered at 2:00 p.m. on 12/1/20. The incident report further indicated the medication error was identified on 12/1/20, at 12:25 a.m. however, R3's provider had not been made aware of the medication error until 12/8/20.

A facility document titled Incident Details dated 12/8/20, indicated R3 had not been given her gabapentin and Buspar medications scheduled to be administered at 2:00 p.m. on 12/8/20. The incident report further indicated the medication error was identified on 12/8/20, at 2:56 p.m., and

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| F 755 | Continued From page 4 | F 755 | | |

R3's provider had been made aware of the medication error on 12/8/20.

R4's Face Sheet printed 11/9/20, indicated R4's diagnoses included dementia and anxiety disorder.

R4's signed Physician Orders dated 7/20/20, included orders for Zoloft (antidepressent) 50 mg tablet by mouth 1 time daily at 8:00 a.m.

A facility document titled Incident Details dated 12/8/20, indicated R4 had not been given her Zoloft medication scheduled to be administered at 8:00 a.m. on 12/1/20. The incident report further indicated the medication error was identified on 12/1/20, at 12:25 a.m. however, R2's provider had not been made aware of the medication error until 12/8/20.

On 12/8/20, at 9:59 a.m. licensed practical nurse (LPN)-B was interviewed and stated there had been numerous concerns brought to the director of nursing (DON) regarding LPN-A's failure to administer residents their prescribed medications. LPN-B stated resident's medications were being signed out by LPN-A, however, they were often times still in the medication bubble packs, indicating they were not given. LPN-B stated on 12/1/20, she had notified the DON of the medication errors for R1, R2, R3, and R4. LPN-B stated photocopies of the individual medication bubble packs had also been given to the DON on 12/1/20. LPN-B further stated after this incident, registered nurse (RN)-A had completed an audit of all facility medication carts.

On 12/8/20, at 11:08 a.m. LPN-A stated she had made medication errors recently and in the past

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| F 755 | Continued From page 5 | F 755 | | |

which included not administering all prescribed medications. LPN-A stated the DON had spoken with her regarding medication administration and medication errors which occurred most recently on 12/1/20.

On 12/8/20, at 12:21 p.m. RN-A stated she had completed audits for all facility medication carts. RN-A stated the DON had instructed her to completed the medication cart audits due to concerns that medications were not being administered as prescribed. RN-A stated the audits revealed LPN-A had not administered medication correctly for R1, R2, R3, and R4. RN-A stated in addition, there were unidentified pills found on the bottom of one of the medication carts. RN-A stated LPN-A was the nurse responsible for the medication errors for R1, R2, R3, and R4. RN-A stated she did not know if the resident's physicians had been notified of the mediation error at the time of the incidents, but they should be updated immediately.

On 12/8/20, at 12:42 p.m. the DON verified he had been notified of the mediation errors on the evening of 12/1/20, which involved medications not administered for R1, R2, R3, and R4. The DON stated a full investigation had not been completed. The DON stated he had spoken with LPN-A, and felt at that time it was a teachable moment. The DON stated providers should have been notified of the medication errors at the time they were identified. The DON verified additional unidentified medication had been found in one of the medication carts, however, they had been destroyed without documentation on a medication destruction form. The DON stated it was important for all medications to be administered as ordered. The DON stated staff had brought to

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| F 755 | Continued From page 6 | F 755 | | |

him other concerns related to LPN-A's medication administration, however, there had not been proof prior to 12/1/20. The DON stated when he had received the reports of LPN-A not administering medication accurately, he did not compete an investigation which should have included medication cart audits.

On 12/9/20, at 7:14 a.m. the administrator and the DON were both interviewed. The DON stated additional medication errors were identified on 12/8/20, at approximately 4:00 p.m. when an audit was completed on LPN-A's medication cart after she had completed her shift. The DON stated the medication errors involved LPN-A once again not administering medication for R2 and R3.

The facility policy Medication Errors undated, directed staff that residents would receive medications in accordance with their physician's order, and in compliance with State and Federal Regulations. indications and procedures for crushing medications.

The facility policy Notification of Significant Changes last reviewed 1/7/19, directed notification to resident's physician and designate resident representative in the event of a significant change which included a need to alter treatment.

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| | 00865 | A. BUILDING: _____ B. WING _____ | C 12/09/2020 |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 12/8/20, through 12/9/20, an abbreviated survey was completed at your facility by the Minnesota Department of Health (MDH) The facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. | 2 000 | | |

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| 2 000 | Continued From page 1<br>Complaint H5258038C was substantiated. No licensing orders were issued.<br><br>The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents. | 2 000 | | |
| 2 440 | MN Rule 4658.0215 Administration of Medications<br><br>The right of residents to self-administer medications must be provided as allowed under part 4658.1325, subpart 4. Medications may be added to food only as provided under part 4658.1325, subpart 6.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders for 4 of 4 resident (R1, R2, R3, and R4) for allegations of medications not being given.<br><br>Findings include:<br><br>R1's Face Sheet printed 11/9/20, indicated R1's diagnoses included CHF.<br><br>R1's signed Physician Orders dated 11/19/20, included orders for potassium chloride-K-Dur (medication to treat or prevent low amounts of potassium in the blood) 20 meq (milliequivalent) by mouth 4 times daily at 5:00 a.m., 10:00 a.m., 2:00 p.m., and 8:00 p.m. | 2 440 | Corrected | 1/22/21 |

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| | 00865 | A. BUILDING: _____ B. WING _____ | C 12/09/2020 |

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| 2 440 | Continued From page 2<br><br>A facility document titled Incident Details dated 12/8/20, indicated R1 had not been given her potassium chloride-K-Dur 20 meq medication scheduled to be administered at 2:00 p.m. on 12/1/20. The incident further indicated the medication error was identified on 12/1/20, at 10:58 p.m., however, R1's provider had not been made aware of the medication error until 12/8/20.<br><br>R2's Face Sheet printed 11/9/20, indicated R2's diagnoses included COPD, major depression and HTN.<br><br>R2's signed Physician Orders dated 11/26/20, included orders for Lexapro (antidepressant) 10 mg (milligram) by mouth 1 time daily at 8:00 a.m., multivitamin 1 tablet by mouth daily at 8:00 a.m., Colace (stool softener) 200 mg dose by mouth 2 times daily at 8:00 a.m. and 5:00 p.m., Lasix (to treat fluid build-up due to heart failure) 20 mg by mouth 1 time daily at 12:00 p.m., Tylenol 650 mg 2 times daily at 12:00 p.m. and 8:00 p.m., potassium 20 meq by mouth 1 time daily at 8:00 a.m., Prednisone (steroid) 2.5 mg by mouth 1 time daily at 8:00 a.m., Prilosec (decreases stomach acid) 10 mg by mouth 1 time daily at 8:00 a.m., vitamin D3 5,000 unit tablet by mouth 1 time daily at 8:00 a.m., and hydrocodone-acetaminophen (narcotic pain medication) 7.5-325 mg by mouth 3 times daily at 8:00 a.m., 2:00 p.m., and 8:00 p.m.<br><br>A facility document titled Incident Details dated 12/8/20, indicated R2 had not been given her Lexapro, multivitamin, colace, Lasix, tylenol, K-Dur, Prednisone, Prilosec, and vitamin D medications scheduled to be administered at 8:00 a.m. on 12/1/20. The report further indicated the medication error was identified on 12/1/20, at 10:58 p.m. however, R2's provider had not been | 2 440 | | |

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| 2 440 | Continued From page 3<br>made aware of the medication error until 12/8/20.<br><br>A facility document titled Incident Details dated 12/8/20, indicated R2 had not been given her hydrocodone-acetaminophen pain medications scheduled to be administered at 2:00 pm. on 12/8/20. The incident report further indicated the medication error was identified on 12/8/20, at 6:01 p.m. and R2's provider had been notified of the medication error on 12/9/20.<br><br>R3's Face Sheet printed 11/9/20, indicated R3's diagnoses included dementia, restless leg syndrome and major depressive disorder.<br><br>R3's signed Physician Orders dated 10/9/20, included orders for gabapentin (treat restless leg syndrome) 100 mg by mouth 3 times daily at 8:00 a.m., 2:00 p.m. and 8:00 p.m., Buspar (antianxiety) 10 mg by mouth 3 times daily at 8:00 a.m., 2:00 p.m., and 8:00 p.m.<br><br>A facility document titled Incident Details dated 12/8/20, indicated R3 had not been given her gabapentin and Buspar medications scheduled to be administered at 2:00 p.m. on 12/1/20. The incident report further indicated the medication error was identified on 12/1/20, at 12:25 a.m. however, R3's provider had not been made aware of the medication error until 12/8/20.<br><br>A facility document titled Incident Details dated 12/8/20, indicated R3 had not been given her gabapentin and Buspar medications scheduled to be administered at 2:00 p.m. on 12/8/20. The incident report further indicated the medication error was identified on 12/8/20, at 2:56 p.m., and R3's provider had been made aware of the medication error on 12/8/20. | 2 440 | | |

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| 2 440 | Continued From page 4<br><br>R4's Face Sheet printed 11/9/20, indicated R4's diagnoses included dementia and anxiety disorder.<br><br>R4's signed Physician Orders dated 7/20/20, included orders for Zoloft (antidepressent) 50 mg tablet by mouth 1 time daily at 8:00 a.m.<br><br>A facility document titled Incident Details dated 12/8/20, indicated R4 had not been given her Zoloft medication scheduled to be administered at 8:00 a.m. on 12/1/20. The incident report further indicated the medication error was identified on 12/1/20, at 12:25 a.m., however, R2's provider had not been made aware of the medication error until 12/8/20.<br><br>SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person could review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days.<br><br>On 12/8/20, at 9:59 a.m. licensed practical nurse (LPN)-B was interviewed and stated there had been numerous concerns brought to the director of nursing (DON) regarding LPN-A's failure to administer residents their prescribed medications. LPN-B stated resident's medications were being signed out by LPN-A, however, they were often times still in the medication bubble packs, indicating they were not given. LPN-B stated on 12/1/20, she had notified the DON of the medication errors for R1, R2, R3, and R4. LPN-B stated photocopies of the individual medication bubble packs had also been given to the DON on 12/1/20. LPN-B further stated after this incident, | 2 440 | | |

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| 2 440 | Continued From page 5 | 2 440 | | |

registered nurse (RN)-A had completed an audit of all facility medication carts.

On 12/8/20, at 11:08 a.m. LPN-A stated she had made medication errors recently and in the past which included not administering all prescribed medications. LPN-A stated the DON had spoken with her regarding medication administration and medication errors which occurred most recently on 12/1/20.

On 12/8/20, at 12:21 p.m. RN-A stated she had completed audits for all facility medication carts. RN-A stated the DON had instructed her to completed the medication cart audits due to concerns that medications were not being administered as prescribed. RN-A stated the audits revealed LPN-A had not administered medication correctly for R1, R2, R3, and R4. RN-A stated in addition, there were unidentified pills found on the bottom of one of the medication carts. RN-A stated LPN-A was the nurse responsible for the medication errors for R1, R2, R3, and R4. RN-A stated she did not know if the resident's physicians had been notified of the mediation error at the time of the incidents, but they should be updated immediately.

On 12/8/20, at 12:42 p.m. the DON verified he had been notified of the mediation errors on the evening of 12/1/20, which involved medications not administered for R1, R2, R3, and R4. The DON stated a full investigation had not been completed. The DON stated he had spoken with LPN-A, and felt at that time it was a teachable moment. The DON stated providers should have been notified of the medication errors at the time they were identified. The DON verified additional unidentified medication had been found in one of the medication carts, however, they had been

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| 2 440 | Continued From page 6<br><br>destroyed without documentation on a medication destruction form. The DON stated it was important for all medications to be administered as ordered. The DON stated staff had brought to him other concerns related to LPN-A's medication administration, however, there had not been proof prior to 12/1/20. The DON stated when he had received the reports of LPN-A not administering medication accurately, he did not compete an investigation which should have included medication cart audits.<br><br>On 12/9/20, at 7:14 a.m. the administrator and the DON were both interviewed. The DON stated additional medication errors were identified on 12/8/20, at approximately 4:00 p.m. when an audit was completed on LPN-A's medication cart after she had completed her shift. The DON stated the medication errors involved LPN-A once again not administering medication for R2 and R3.<br><br>The facility policy Medication Errors undated, directed staff that residents would receive medications in accordance with their physician's order, and in compliance with State and Federal Regulations. indications and procedures for crushing medications.<br><br>The facility policy Notification of Significant Changes last reviewed 1/7/19, directed notification to resident's physician and designate resident representative in the event of a significant change which included a need to alter treatment. | 2 440 | | |