Electronically delivered
January 22, 2021

Administrator
The Waterview Woods Llc
601 Grant Avenue
Eveleth, MN 55734

RE: CCN: 245277
Cycle Start Date: January 12, 2021

Dear Administrator:

On January 12, 2021, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 6, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 6, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 6, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 6, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Waterview Woods Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 6, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 12, 2021 if your facility does not achieve

substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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
	245277	A. BUILDING _____ B. WING _____	C 01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERVIEW WOODS LLC	601 GRANT AVENUE EVELETH, MN 55734

(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 1/11/21, through 1/12/21, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5277052C, with a deficiency cited at F760. The following complaints were found to be substantiated with no deficiencies cited due to actions implemented by the facility prior to survey: H5277050C and H5277051C. 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. 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 760 SS=G	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. This REQUIREMENT is not met as evidenced	F 760		2/2/21

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

Electronically Signed | 01/29/2021

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F 760	Continued From page 1 by: Based on interview and document review, the facility failed to ensure medications were administered to the correct resident for 1 of 3 residents (R3) reviewed for medication administration. This failure resulted in a significant medication error and actual harm to R3, who received medications belonging to R4, and subsequently had a decreased blood pressure, and was transferred to the emergency department for medical treatment. Findings include: R3's Admission Record printed 1/12/21, indicated R3's diagnoses included dementia without behavioral disturbance and adult failure to thrive. R3's quarterly Minimum Data Set dated 11/23/20, indicated R3 had a severe cognitive impairment. R3's Order Summary Report printed 1/12/21, indicated R3 was to receive the following medications in the morning: aspirin 81 milligrams (mg), docusate sodium (stool softener), 100 mg leveothyroxine (thyroid medication) 50 micrograms (mcg), lisinopril (lowers blood pressure) 2 mg, and metformin (lowers blood glucose) 500 mg. R4's Order Summary Report printed 1/12/21, indicated R4 was ordered to receive the following oral medications in the morning: tylenol 650 mg, carvedilol (lowers heart rate and blood pressure) 6.25 mg, clopidogrel bisulfate (blood thinner) 75 mg, isosorbide mononitrate extended release (lowers blood pressure) 30 mg, lasix (reduces fluid volume in the body, which can lower blood pressure) 20 mg, spironolactone (reduces fluid	F 760	F Tag: F760 Immediate Corrective Action: Resident #3 was sent to the ER for monitoring and returned later that afternoon with no medication order changes. LPN-A was given education on the fact that after being interrupted during a medication pass to attend to a resident who had fallen, she could have slowed down when resuming the medication pass and started the 6 medication rights over again for resident #3. Corrective Action as it applies to others: The Policy and Procedure for Medication Administration and Medication Error Procedure were reviewed and remains current. All medication errors were reviewed for the last 3 months and there were no other errors noted that involved the nurse leaving the med cart after medications were set-up. All nurses and TMA's were re-educated on the Medication Administration and Medication Error Procedure. Date of Compliance: 2/2/2021 Recurrence will be prevented by: Medication pass audits will occur for 2 nurses/TMA's 3x weekly x 4 weeks then monthly x 2 months. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits.	

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F 760	Continued From page 2 volume in the body, which can lower blood pressure) 25 mg. Additionally, R4 was ordered Ultram (pain medication) 50 mg every six hours, as needed, for pain. A document titled Teachable Moment dated 12/10/20, indicated, "Resident received another resident's medication which required ER [emergency room] visit." The document further indicated staff was to remember the five rights of medication administration and to "take time" to ensure the correct resident was receiving the correct medication when interrupted. The document was signed by registered nurse (RN)-A and RN-C on 12/10/20. On 12/10/21, an emergency department (ED) physician note indicated R3 was mistakenly administered another resident's medications which included: carvedilol 6.25 mg, lasix 20 mg, isosorbide mononitrate extended release (ER) 30 mg, clopidogrel 75 mg, Ultram 50 mg, and spironolactone 12.5 mg. R3 reported feeling "funny." The ED note further indicated R3 generally had a systolic blood pressure (pressure produced when the heart contracts) of 90 millimeters of mercury (mm/Hg). Upon admission to the ED, R3's systolic blood pressure was between 70-75 mm/Hg. R3 was monitored for six hours, received two liters of intravenous (IV) fluids, and was subsequently discharged when her vital signs "normalized to her range." On 12/10/20, at 1:35 p.m. a progress note indicated R3 was at the ED and "doing well." The note indicated R3's systolic blood pressure was initially 60 mm/Hg, and she was administered two liters of fluids.	F 760	Corrections will be monitored by: DON/Designee	

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F 760	Continued From page 3	F 760		

On 12/10/20, at 4:05 p.m. a progress note indicated R3 returned from the ED. R3 was to have her vital signs checked every four hours for the next 24 hours. R3 appeared at her baseline.

On 1/12/21, at 12:33 p.m. an interview was conducted with RN-A. RN-A stated on 12/10/20, herself and licensed practical nurse (LPN)-A worked day shift together. RN-A stated herself and LPN-A were passing medications and shared the same medication cart. RN-A stated she was working on the side of the medication cart near the narcotics lockbox, and LPN-A worked on the opposite side of the medication cart. RN-A stated she had prepared R3's medications, and LPN-A had prepared R4's medications. RN-A stated at that time, she was notified of a resident fall. RN-A stated herself and LPN-A had prioritized the fall, and R3 and R4's medications were left on the medication cart. RN-A stated she then returned to the medication cart and grabbed a medication cup which was located on the side near the narcotics lockbox. RN-A stated she administered the medications to R3, and R3 had difficulty swallowing the medications. RN-A stated she quickly realized R3 received the incorrect medications, and she instructed R3 to spit the medications out. RN-A stated R3 was unable to spit the medications out and had swallowed them. RN-A stated R3's medications were still on the medication cart on the side near the narcotics lockbox. RN-A stated she learned she mistakenly grabbed R4's medication cup as LPN-A had began working on the side of the medication cart near the narcotics lockbox. RN-A stated she did not realize LPN-A placed R4's medication cup near R3's medication cup. RN-A confirmed R3 received R4's morning medications. RN-A stated she notified facility administration as R4 was

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F 760	Continued From page 4	F 760		

ordered blood pressure medications, and R3's blood pressure normally ran low. RN-A stated she also notified R3's physician and was instructed to transfer R3 to the emergency department. RN-A stated R3 was at her "baseline" upon transfer to the emergency department. RN-A stated she called the hospital and was told R3 was receiving IV treatment. RN-A stated herself and LPN-A had been working "crazy hours." RN-A stated the facility reminded herself and LPN-A of the "six rights" of medication administration.

On 1/12/21, at 1:13 p.m. an interview was conducted with RN-B. RN-B stated she was on vacation when the medication error occurred. RN-B stated she overhead a nurse was called away from a medication cart, and subsequently returned to the medication cart and administered incorrect medications to R3. RN-B reviewed R3's medical record and stated R3 was sent to the hospital and had a low systolic blood pressure. RN-B stated she was not aware of any changes at the facility since the incident occurred. RN-B stated she would had written resident initials on a medication cup if she were called away.

On 1/12/21, at 1:49 p.m., an interview was conducted with the facility nurse consultant, RN-C. RN-C stated the director of nursing (DON) was not at the facility during the incident, so she handled it. RN-C stated LPN-A and RN-A were preparing medications and a resident had a fall. RN-C stated LPN-A and RN-A put the prepared medication cups down and attended to the fall. RN-C stated RN-A returned to the medication cart, grabbed a medication cup, and administered R4's medications to R3. RN-C stated staff called her regarding the incident, and she instructed them to call the doctor right away. RN-C stated

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F 760	Continued From page 5 the resident was transferred to the emergency department and administered IV fluids. RN-C stated R3 remained in the emergency department until medication peek times (highest level of a drug in the bloodstream) were achieved. RN-C stated she conducted immediate education with RN-A. RN-C stated no other staff were educated as no other medication errors of this type occurred before. RN-C stated R3's blood pressure normally ran low. A medication error incident report was requested, but not received. The facility policy Medication Error Procedure reviewed 1/20, directed "Medication errors will be rectified according to standard of practice and the facilities pharmacy policy for preventing and detecting adverse consequences and medication errors."	F 760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 22, 2021

Administrator
The Waterview Woods Llc
601 Grant Avenue
Eveleth, MN 55734

Re: State Nursing Home Licensing Orders
Event ID: 0LCF11

Dear Administrator:

The above facility was surveyed on January 11, 2021 through January 12, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 number and the corresponding text of 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 that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any 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

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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 1/11/21, through 1/12/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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	00583	A. BUILDING: _____ B. WING _____	C 01/12/2021

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THE WATERVIEW WOODS LLC	601 GRANT AVENUE EVELETH, MN 55734

(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 1 The following complaints were found to be SUBSTANTIATED: H5277050C, H5277051C, and H5277052C with a licensing order issued at S1545. 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		
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	21545		2/2/21

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21545	Continued From page 2 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. 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 ensure medications were administered to the correct resident for 1 of 3 residents (R3) reviewed for medication administration. This failure resulted in a significant medication error and actual harm to R3, who received medications belonging to R4, and subsequently had a decreased blood pressure, and was transferred to the emergency department for medical treatment. Findings include: R3's Admission Record printed 1/12/21, indicated R3's diagnoses included dementia without behavioral disturbance and adult failure to thrive. R3's quarterly Minimum Data Set dated 11/23/20, indicated R3 had a severe cognitive impairment.	21545	F Tag: F760 Immediate Corrective Action: Resident #3 was sent to the ER for monitoring and returned later that afternoon with no medication order changes. LPN-A was given education on the fact that after being interrupted during a medication pass to attend to a resident who had fallen, she could have slowed down when resuming the medication pass and started the 6 medication rights over again for resident #3. Corrective Action as it applies to others: The Policy and Procedure for Medication Administration and Medication Error Procedure were reviewed and remains current. All medication errors were reviewed for the last 3 months and there were no other	

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21545	Continued From page 3 R3's Order Summary Report printed 1/12/21, indicated R3 was to receive the following medications in the morning: aspirin 81 milligrams (mg), docusate sodium (stool softener), 100 mg leveothyroxine (thyroid medication) 50 micrograms (mcg), lisinopril (lowers blood pressure) 2 mg, and metformin (lowers blood glucose) 500 mg. R4's Order Summary Report printed 1/12/21, indicated R4 was ordered to receive the following oral medications in the morning: tylenol 650 mg, carvedilol (lowers heart rate and blood pressure) 6.25 mg, clopidogrel bisulfate (blood thinner) 75 mg, isosorbide mononitrate extended release (lowers blood pressure) 30 mg, lasix (reduces fluid volume in the body, which can lower blood pressure) 20 mg, spironolactone (reduces fluid volume in the body, which can lower blood pressure) 25 mg. Additionally, R4 was ordered Ultram (pain medication) 50 mg every six hours, as needed, for pain. A document titled Teachable Moment dated 12/10/20, indicated, "Resident received another resident's medication which required ER [emergency room] visit." The document further indicated staff was to remember the five rights of medication administration and to "take time" to ensure the correct resident was receiving the correct medication when interrupted. The document was signed by registered nurse (RN)-A and RN-C on 12/10/20. On 12/10/21, an emergency department (ED) physician note indicated R3 was mistakenly administered another resident's medications which included: carvedilol 6.25 mg, lasix 20 mg, isosorbide mononitrate extended release (ER) 30 mg, clopidogrel 75 mg, Ultram 50 mg, and	21545	errors noted that involved the nurse leaving the med cart after medications were set-up. All nurses and TMA's were re-educated on the Medication Administration and Medication Error Procedure. Date of Compliance: 2/2/2021 Recurrence will be prevented by: Medication pass audits will occur for 2 nurses/TMA's 3x weekly x 4 weeks then monthly x 2 months. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/Designee	

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spironolactone 12.5 mg. R3 reported feeling "funny." The ED note further indicated R3 generally had a systolic blood pressure (pressure produced when the heart contracts) of 90 millimeters of mercury (mm/Hg). Upon admission to the ED, R3's systolic blood pressure was between 70-75 mm/Hg. R3 was monitored for six hours, received two liters of intravenous (IV) fluids, and was subsequently discharged when her vital signs "normalized to her range."

On 12/10/20, at 1:35 p.m. a progress note indicated R3 was at the ED and "doing well." The note indicated R3's systolic blood pressure was initially 60 mm/Hg, and she was administered two liters of fluids.

On 12/10/20, at 4:05 p.m. a progress note indicated R3 returned from the ED. R3 was to have her vital signs checked every four hours for the next 24 hours. R3 appeared at her baseline.

On 1/12/21, at 12:33 p.m. an interview was conducted with RN-A. RN-A stated on 12/10/20, herself and licensed practical nurse (LPN)-A worked day shift together. RN-A stated herself and LPN-A were passing medications and shared the same medication cart. RN-A stated she was working on the side of the medication cart near the narcotics lockbox, and LPN-A worked on the opposite side of the medication cart. RN-A stated she had prepared R3's medications, and LPN-A had prepared R4's medications. RN-A stated at that time, she was notified of a resident fall. RN-A stated herself and LPN-A had prioritized the fall, and R3 and R4's medications were left on the medication cart. RN-A stated she then returned to the medication cart and grabbed a medication cup which was located on the side near the narcotics lockbox. RN-A stated she administered

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the medications to R3, and R3 had difficulty swallowing the medications. RN-A stated she quickly realized R3 received the incorrect medications, and she instructed R3 to spit the medications out. RN-A stated R3 was unable to spit the medications out and had swallowed them. RN-A stated R3's medications were still on the medication cart on the side near the narcotics lockbox. RN-A stated she learned she mistakenly grabbed R4's medication cup as LPN-A had began working on the side of the medication cart near the narcotics lockbox. RN-A stated she did not realize LPN-A placed R4's medication cup near R3's medication cup. RN-A confirmed R3 received R4's morning medications. RN-A stated she notified facility administration as R4 was ordered blood pressure medications, and R3's blood pressure normally ran low. RN-A stated she also notified R3's physician and was instructed to transfer R3 to the emergency department. RN-A stated R3 was at her "baseline" upon transfer to the emergency department. RN-A stated she called the hospital and was told R3 was receiving IV treatment. RN-A stated herself and LPN-A had been working "crazy hours." RN-A stated the facility reminded herself and LPN-A of the "six rights" of medication administration.

On 1/12/21, at 1:13 p.m. an interview was conducted with RN-B. RN-B stated she was on vacation when the medication error occurred. RN-B stated she overhead a nurse was called away from a medication cart, and subsequently returned to the medication cart and administered incorrect medications to R3. RN-B reviewed R3's medical record and stated R3 was sent to the hospital and had a low systolic blood pressure. RN-B stated she was not aware of any changes at the facility since the incident occurred. RN-B stated she would had written resident initials on a

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medication cup if she were called away.

On 1/12/21, at 1:49 p.m., an interview was conducted with the facility nurse consultant, RN-C. RN-C stated the director of nursing (DON) was not at the facility during the incident, so she handled it. RN-C stated LPN-A and RN-A were preparing medications and a resident had a fall. RN-C stated LPN-A and RN-A put the prepared medication cups down and attended to the fall. RN-C stated RN-A returned to the medication cart, grabbed a medication cup, and administered R4's medications to R3. RN-C stated staff called her regarding the incident, and she instructed them to call the doctor right away. RN-C stated the resident was transferred to the emergency department and administered IV fluids. RN-C stated R3 remained in the emergency department until medication peek times (highest level of a drug in the bloodstream) were achieved. RN-C stated she conducted immediate education with RN-A. RN-C stated no other staff were educated as no other medication errors of this type occurred before. RN-C stated R3's blood pressure normally ran low.

A medication error incident report was requested, but not received.

The facility policy Medication Error Procedure reviewed 1/20, directed "Medication errors will be rectified according to standard of practice and the facilities pharmacy policy for preventing and detecting adverse consequences and medication errors."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or desigee review and/or revise policies and procedures for medication administration. The DON or designee

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21545	Continued From page 7 could ensure all staff responsible for administering medications were re-educated. The DON or designee could observe medication administration to ensure staff are administering medications according to physician's orders and manufacturer's instructions unless otherwise specified by the physician. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		