Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 8, 2026

Administrator
Charter House Inc
211 NORTHWEST SECOND STREET
ROCHESTER, MN 55901

RE: CCN:245282
Cycle Start Date: May 19, 2026

Dear Administrator:

On May 19, 2026, 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 August 19, 2026 (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 November 19, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 8, 2026

Administrator
Charter House Inc
211 NORTHWEST SECOND STREET
ROCHESTER, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: 231EFE-H1

Dear Administrator:

The above facility survey was completed on May 19, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 8, 2026

Administrator
Charter House Inc
211 NORTHWEST SECOND STREET
ROCHESTER, MN 55901

RE: CCN: 245282
Cycle Start Date: May 19, 2026

Dear Administrator:

On July 7, 2026, the Minnesota Department(s) of Health and Public Safety, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 8, 2026

Administrator
Charter House Inc
211 NORTHWEST SECOND STREET
ROCHESTER, MN 55901

Re: Reinspection Results
Event ID: 231EFE-H2

Dear Administrator:

On July 7, 2026, 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 May 19, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charter House Inc	**211 NORTHWEST SECOND STREET , ROCHESTER, Minnesota, 55901**

(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
F0000	INITIAL COMMENTS On 5/18/26 and 5/19/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52827021C (2748718) H52822736C (3011857) with a deficiency issued at F755. 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.	F0000		06/29/2026
F0755 SS = E	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(f). 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 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	F0755	With respect to the four residents identified in the Statement of Deficiencies, the following updates are provided. R1 was discharged to the hospital with a diagnosis of fluid overload on 2/19/26, and the resident did not return to Charter House. R2 no longer resides at the community. Was discharged home on 5/15/26. R3 continues to reside in the community. The resident was assessed by the community's Director of Nursing/designee on 4/8/26 with no negative outcome and again on 5/18/26 with no negative outcome noted. R4 no longer resides in the community. Resident discharged to home on 4/24/26. 2. Director of Nursing/Designee audited current residents' medications regarding medication order transcription, medication administration, laboratory	06/29/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

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Charter House Inc	**211 NORTHWEST SECOND STREET , ROCHESTER, Minnesota, 55901**

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F0755 SS = E	Continued from page 1 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 record review, the facility failed to implement an effective system for medication order transcription, laboratory monitoring, medication availability, and medication administration for 4 of 4 residents reviewed for medication errors (R1, R2, R3, R4). Failures included medication order transcription failures, missed laboratory monitoring, omitted anticoagulants and antiplatelet medications, medication availability failures, failure to implement medication order changes, and delayed medication administration. Findings include: R1: R1's Risk Watch document, incorrectly dated 2/7/26, identified on the future date of 2/19/26, the health care provider (HCP) notified the Director of Nursing (DON) an INR lab ordered for 2/16/26 had not been completed. The document further identified that a subsequent order for warfarin (blood thinning medication) was not obtained resulting in R1 missing three doses of warfarin and the facility's internal investigation process was initiated after notification by the HCP. Immediate actions included notification of the house supervisor, resident, and on-call physician, and a new order was obtained. The document further identified the facility's internal investigation process was initiated after notification by the HCP. Facility reported incident (FRI) dated 2/19/26 at 2:05 p.m., identified the health care provider (HCP) notified the Director of Nursing (DON) an International Normalized Ratio (INR) (blood test used to measure how long it takes blood to clot and	F0755	Continued from page 1 monitoring, medication availability, anticoagulation management, and medication error follow up. Through the audit process, no residents were found to be impacted. 3. Charter House conducted a thorough investigation and assessment of the deficiencies identified in the Statement of Deficiencies and has undertaken several corrective actions to ensure go forward compliance. The Administrator and Director of Nursing (DON)/designee reviewed and revised facility policies and procedures related to medication order transcription, medication administration, laboratory monitoring, medication availability, anticoagulation management, and medication error follow-up. The Administrator and Director of Nursing/designee evaluated the facility's medication management system to ensure physician orders are accurately transcribed, medications are available and administered as ordered, laboratory monitoring is completed timely, and medication holds or discontinued orders are appropriately reconciled and reactivated when indicated. To prevent future non-compliance, the DON/designee will provide education to licensed nursing staff. The education will occur in a variety of formats, including one-to-one, small groups, email (with verification), and during shift huddles. The education will include medication order processing, RightFax procedures, anticoagulant monitoring requirements, emergency medication kit access and use, medication hold procedures, and documentation requirements for omitted or unavailable medications. Education on the following policies, guidelines and processes will be included: Administering Medications, Process for Medications Unavailable, Anticoagulation Management, Medication Holds, Thrifty White Pharmacy Services and Medication System, Adverse Consequences and Medication Errors. The Director of Nursing/designee implemented a system of monitoring, medication transcription, laboratory monitoring, medication availability reviews, anticoagulation tracking, and medication administration record (MAR/TAR) audits to ensure medications and laboratory orders are completed as ordered and medication errors are identified timely. The Director of Nursing/designee will complete medication administration competency validation for nursing staff responsible for medication order transcription and medication administration.	06/29/2026

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F0755 SS = E	Continued from page 2 whether blood thinner medication is working safely and effectively) lab ordered for 2/16/26 had not been completed. The FRI further identified a subsequent order for Warfarin was not obtained resulting in R1 missing three doses of warfarin. The document identified the facility had initiated an internal investigation regarding the medication error. Facility 5-day investigation report summary dated 2/26/26, identified review of R1's care plan, electronic medical record (EMR), medication administration record (MAR), medication orders, and medication administration policies. The report identified care plan interventions directing staff to administer medications as ordered and obtain and monitor INR labs as ordered were not followed. Interview with nurse practitioner (NP)-A identified R1 had an INR scheduled for 2/16/26; however, the results were never sent to the provider care team and NP-A was unsure whether R1 had been receiving Warfarin. Interview with LPN-A identified she missed the INR order because it was typically completed by night shift and she did not question the warfarin order because she did not realize it had been ordered on previous days. The report identified R1's INR scheduled for 2/16/26 was not obtained and warfarin was not administered until 2/19/26 when the omission was identified by the provider. The allegation was verified through review of the EMR and staff interviews identifying the INR test was not completed per provider order and care plan. Nursing leadership initiated corrective actions on 2/20/26 including staff education regarding order transcription accuracy, two-person verification, INR testing tracking, and related policies. Additional prevention interventions included review of INR competency records, refresher training, review of EMR safeguards, audits of newly transcribed orders for compliance with the two-person verification process, staff coaching and re-education for identified variances, and ongoing monitoring of order transcription and point-of-care testing competencies. Informal coaching documentation dated 2/25/26 identified LPN-A was placed on administrative leave related to a missed point-of-care INR resulting in R1 missing doses of warfarin. Nurse manager (NM)-A reiterated the importance of reviewing the medical record including labs and treatments for each resident. NM-A stated the lab order was present; however, LPN-A stated it did not appear on her dashboard. Follow-up coaching dated 2/27/26 identified adjustments were made within the EHR dashboard settings to display lab orders as the default view.	F0755	Continued from page 2 Licensed Nurses who have not completed order transcription and medication administration competencies by 6/29/26 Will have competencies prior to administering medications. 4. To support ongoing compliance and prevent recurrence, the Director of Nursing/designee will implement a structured daily audit. Audit will evaluate new medication orders regarding the following areas: 1. Has medication been transcribed correctly. 2. Laboratory monitoring has been completed for PT/INR. 3. Emergency kit was accessed if required. 4. Medication hold procedure met. 5. Process for omitted or unavailable medications followed. 6. Documentation on MAR/TAR is completed. Audits will be completed by the Director of Nursing/designee, on residents residing at the community daily x 1 month, 3 times weekly for 1 month, 1 time weekly for 1 month, with audits continuing if errors are identified If errors are identified during the audit, they will be corrected and targeted education will be provided to the responsible staff. Audits will be reviewed through the Quality Assurance and Performance Improvement (QAPI) process for ongoing monitoring and compliance.	06/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

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Charter House Inc	**211 NORTHWEST SECOND STREET , ROCHESTER, Minnesota, 55901**

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F0755 SS = E	Continued from page 3 Facility education provided on 3/16/26 through 3/18/26 included order transcription processes within the Unity EMR system including drafting orders, entering frequencies, stop dates, and activation of orders. However, review identified the education did not include a monitoring or double-check system to ensure ordered INR labs were completed and residents requiring anticoagulation management had active warfarin orders in place to prevent missed doses. After review of the facility investigation, the facility identified corrective actions including INR tracking, audits, staff education, and two-person verification related to anticoagulation management and order transcription; however, the facility was unable to provide evidence of audits or monitoring systems regarding following physician ordered INRs had been implemented. R1's face sheet printed 5/18/26, identified diagnoses including heart transplant infection, infective endocarditis (serious infection of the inner lining and valves of the heart), presence of heart valve replacement, history of transient ischemic attack/stroke (history of "mini-stroke" or stroke), chronic heart failure, kidney transplant status, chronic kidney disease, pleural effusion (fluid buildup around the lungs), and atrial fibrillation (irregular heartbeat that increases risk for blood clots). R1's admission Minimum Data Set (MDS) dated 2/12/26, identified moderate cognitive impairment, a major surgical procedure involving the heart or major blood vessels during the prior inpatient hospital stay requiring active care during the skilled nursing facility stay, and receipt of anticoagulant (blood thinner medication used to help prevent blood clots) and antiplatelet (medications used to help prevent blood clots) medications. R1's nurse practitioner (NP) encounter note dated 2/12/26 identified anticoagulation management for tissue aortic and mitral valves plus recent atrial fibrillation with a goal INR of 2.0 to 3.0 with lifelong duration. Comorbid considerations included infective endocarditis of native allograft mitral and aortic valves with severe regurgitation, likely due to right femoral seroma (fluid collection near the groin blood vessel area). The note further identified status post redo sternotomy (repeat open-heart surgery) with bioprosthetic aortic valve replacement and mitral valve replacement on 1/12/26, complicated by multifocal embolic cerebral and cerebellar infarcts	F0755		06/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

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F0755 SS = E	Continued from page 4 (multiple strokes caused by blood clots traveling to the brain), possible small distal M1 aneurysm versus infundibulum on CTA (possible weakened or bulging blood vessel in the brain identified on imaging), pleural effusions status post thoracentesis, chylothorax (lymphatic fluid leaking into the chest cavity around the lungs), persistent debility (ongoing severe weakness and decreased physical functioning), intermittent bradycardia (episodes of abnormally slow heart rate), and new onset atrial fibrillation with rapid ventricular response (irregular heartbeat causing periods of rapid heart rate). The note further identified R1's INR was 2.0 and R1 was to receive Warfarin 2 milligrams daily with repeat INR scheduled for 2/16/26. R1's care plan dated 2/6/26, identified R1 was at risk for bleeding and excessive bruising related to anticoagulant and antiplatelet therapy. Interventions dated 2/6/26, directed staff to monitor INR lab values within acceptable range as determined by the health care provider and observe, record, and report signs or symptoms of bleeding to the health care provider. R1's physician orders dated 2/7/26, identified an order for Warfarin 2 milligram (mg) tablet, take one tablet by mouth daily. The order further identified R1 was to take warfarin 2 mg daily until INR was completed on 2/9/26 and then continue as directed by the skilled nursing facility based on INR monitoring. R1's anticoagulant management nurse practitioner (NP) visit dated 2/12/26. identified R1's INR was 2.1. The note further identified to continue warfarin 2 mg daily and recheck INR on 2/16/26. R1's medication administration record (MAR) dated 2/16/26 to 2/18/26, identified an order for warfarin 2 mg take one time daily for four days begining 2/12/26, next INR check was on 2/16/26 at 6:00 a.m. After reviewing R1's February 26 MAR, warfarin was not administered from 2/16/26 to 2/19/26 when R1 was discharged from the facility. R1's treatment administration record (TAR) dated 2/16/26 identified an order for INR lab monitoring every one day for one day beginning 2/16/26 related to warfarin management. The TAR identified the INR was ordered on 2/12/26, with a note to recheck INR 2/16/26 at 0500. Review of the TAR identified an equal sign documented on 2/16/26 without staff initials, indicating the INR lab was not completed as ordered	F0755		06/29/2026

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F0755 SS = E	Continued from page 5 R1's NP's Follow Up Visit note dated 2/17/26, identified R1 was anticoagulated with warfarin due to atrial fibrillation with a goal INR of 2 to 3. The note did not address the INR lab ordered for 2/16/26 had not been completed and that R1 had no current orders on hand for warfarin. Email correspondence reviewed from nurse practitioner (NP)-A to director of nursing (DON), administrator, and nurse manager (NM)-A dated 2/19/26 at 8:00 a.m., identified the subject line "med error-warfarin." The email identified NP-A had learned R1's INR scheduled for 2/16/26 had not been completed and the results were never sent to her team. The email further identified an INR would be added to the day's labs and NP-A would contact R1's transplant team regarding management of warfarin and INR monitoring. R1's clinical notes reviewed and did not identify any information about R1's missed INR lab on 2/16/26 and did not identify that he missed 3 doses of warfarin from 2/16/26 to 2/18/26. R1's clinical note dated 2/19/26 at 2:16 p.m. identified the facility was notified by the heart transplant service that R1 will be admitted to the hospital from his afternoon appointment. During an interview on 5/19/26 at 3:22 p.m., nurse manager (NM)-A stated R1's INR lab due on 2/16/26 at 6:00 a.m. was missed by licensed practical nurse (LPN)-A resulting in R1 missing three doses of warfarin. NM-A stated the facility investigation identified the root cause was LPN-A did not have pending labs displayed within the My Unity dashboard and the facility lacked a double-check system to identify missed INR testing. NM-A stated if the INR was missed, the corresponding warfarin order would also be missed. NM-A further stated there was no reminder on the MAR identifying a resident receiving warfarin required ongoing INR monitoring and staff were required to have the correct dashboard settings enabled to view pending laboratory orders. NM-A stated the missed INR from 2/16/26 would not continue to display the following day if not completed. NM-A stated facility interventions included review of residents receiving warfarin to identify additional missed INR labs, immediate staff education regarding medication order procedures and reporting requirements, and facility-wide education from 3/16/26 through 3/18/26 regarding order transcription processes. NM-A further stated the facility could not provide evidence of ensuring dashboard settings displayed pending laboratory orders or validating completion	F0755		06/29/2026

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F0755 SS = E	Continued from page 6 of ongoing audits reportedly initiated following the medication error. During an interview on 5/19/26 at 3:29 p.m., director of nursing (DON) stated the Risk Watch incident report incorrectly identified the event date as 2/7/26 and clarified the correct date should have been 2/19/26. DON stated nurse practitioner (NP)-A emailed facility leadership on 2/19/26 regarding a significant medication error involving missed warfarin doses for R1. DON stated R1's INR obtained on 2/19/26 was 3.2. DON stated the INR order due on 2/16/26 was listed on the TAR; however, LPN-A missed the lab order resulting in R1 missing three doses of warfarin. DON stated the facility removed LPN-A from the schedule and provided re-education. DON stated the facility investigation identified the root cause was failure to complete the INR laboratory order as prescribed by the provider, resulting in missed warfarin doses. DON further stated provider orders were expected to be completed as ordered. R2: R2's After Visit Summary (AVS) dated 4/14/26 through 4/17/26 identified R2 was status post right total knee arthroplasty (right total knee replacement surgery). The AVS further identified R2 received anticoagulation treatment while hospitalized to prevent blood clots or deep vein thrombosis (DVT) (blood clot usually occurring in the legs) and was to continue Aspirin 81 milligrams (mg) twice daily for DVT prophylaxis 30 days following surgery. R2's face sheet printed 5/18/26 identified diagnoses including aftercare following right joint replacement, infection/inflammatory reaction related to an internal orthopedic prosthetic device/graft, hypertensive heart disease with heart failure, chronic heart failure, pulmonary hypertension (high blood pressure affecting the lungs and heart), morbid obesity, and obstructive sleep apnea (a condition causing interrupted breathing during sleep). R2's admission Minimum Data Set (MDS) dated 4/23/26, identified no cognitive impairment, a recent knee replacement surgery requiring ongoing skilled nursing care, and receipt of antiplatelet medications. R2's care plan dated 4/17/26, identified R2 was at risk for abnormal ecchymosis (bruising) or bleeding related to anticoagulant and/or antiplatelet medication use. Interventions dated 4/17/26 directed staff to administer medications as ordered, observe for side effects, and observe, record, and report	F0755		06/29/2026

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F0755 SS = E	Continued from page 7 abnormal bruising or signs and symptoms of bleeding to the health care provider. R2's Risk Watch document, incorrectly dated 4/17/26, identified on 4/20/26 an order in RightFax was not transcribed resulting in R2 missing three doses of Aspirin 81 milligrams. The document identified LPN-A was not aware of the order in RightFax. Interventions included education and discussion with nurses to ensure RightFax was checked daily, and orders were transcribed. Immediate actions included assessment of R2, transcription of the order, discontinuation of aspirin, and provider notification. Although the Risk Watch document documented discontinuation of aspirin and reported only three missed doses, subsequent MAR review identified the aspirin order was not appropriately reactivated and R2 experienced a prolonged interruption in ordered DVT prophylaxis. R2's MAR identified R2 received aspirin 81 mg from 4/17/26 through the morning dose on 4/20/26. Review identified the aspirin order was re-entered on 4/20/26; however, the order was again discontinued the same day and was not reactivated on the MAR through 5/14/26. Review of R2's April 2026 MAR identified R2 missed 22 doses from 4/20/26 at 8:00 p.m. through 4/30/26 at 8:00 p.m., due to no active order on the MAR. Review of R2's May 2026 MAR identified R2 missed 27 doses from 5/1/26 at 8:00 a.m. through 5/14/26 at 8:00 a.m. due to no active order on the MAR. Review identified R2 missed a total of 49 doses of aspirin 81 milligrams. R2's medical doctor (MD) progress note dated 4/21/26, did not address R2's aspirin orders for deep vein thrombosis (DVT) prophylaxis. R2's nurse practitioner (NP) progress note dated 4/28/26, identified under assessment and plan: "Arthroplasty Total Knee Replacement Status Post Right." The note further identified DVT prophylaxis with aspirin twice daily for 30 days post-operatively. R2's nurse practitioner (NP) discharge visit note dated 5/12/26 identified R2 was status post right total knee arthroplasty (right total knee replacement surgery) and continued on Aspirin for deep vein thrombosis (DVT) prophylaxis (prevention of blood clots). The note further identified concern for right lower extremity erythema (redness), mild heat, and	F0755		06/29/2026

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F0755 SS = E	Continued from page 8 drainage from the incision site compared to the left leg and identified an ultrasound would be ordered to rule out DVT (blood clot). Discharge orders further identified R2 was to continue aspirin twice daily through 5/14/26. During an interview on 5/19/26 at 4:12 p.m., nurse manager (NM)-A stated the facility initially believed R2 missed only three days of Aspirin doses; however, after review of the medication administration record (MAR), NM-A verified R2 received aspirin from 4/17/26 through 4/20/26 and then did not receive aspirin again from 4/20/26 through 5/14/26 when R2 discharged home. NM-A stated it appeared LPN-A discontinued the aspirin order on 4/20/26. NM-A further verified R2 developed redness and warmth to the right leg requiring an ultrasound to rule out a blood clot and stated the facility had not realized R2 missed that amount of aspirin until the interview and no prevention interventions had been implemented related to the medication error. During an interview on 5/19/26 at 4:23 p.m., DON stated R2's Aspirin 81 mg twice daily ordered for DVT prophylaxis to prevent blood clots following total knee replacement surgery was discontinued on 4/20/26, despite discharge orders identifying aspirin was to continue through 5/14/26. DON stated the root cause identified was LPN-A did not check RightFax and did not enter the restarted aspirin order into the EHR. DON further stated the physician faxed an order discontinuing aspirin on 4/20/26, followed shortly afterward by another order restarting aspirin; however, the restarted order was not entered into the EHR. DON-A verified R2 did not receive aspirin as ordered by the physician and stated this was the first awareness R2 had missed a significant number of aspirin doses and no prevention plan had been implemented because the facility was not aware what had occurred until just now. Further review identified although the facility investigation concluded R2 missed three doses of aspirin, the aspirin order had been discontinued on 4/20/26 and was not reactivated on the MAR for the remainder of the prescribed prophylactic period through 5/14/26. Review of the MAR identified R2 missed a total of 49 doses of aspirin 81 mg. The facility investigation did not identify the prolonged absence of an active aspirin order or the continued omission of physician-ordered DVT prophylaxis. R3:	F0755		06/29/2026

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F0755 SS = E	Continued from page 9 R3's face sheet printed 5/19/26, identified diagnoses including vascular dementia, hemiplegia following cerebral infarction (weakness/paralysis on one side of the body after stroke), and history of digestive system disease. R3's quarterly MDS dated 4/2/26, identified severely impaired cognition and was always incontinent of bowel. R3's care plan dated 12/26/25 identified altered elimination with constipation and bowel irregularity. The care plan identified R3 was to maintain a bowel movement at least every three days or per previous routine. Interventions revised 4/13/26, directed staff to administer an extra dose of Lactulose (bowel medication used to prevent and treat constipation) on day two without a bowel movement, administer a Dulcolax suppository on day three without a bowel movement, administer a tap water enema per standing order if no results from the suppository, and request an order for fecal impaction removal if still no results occurred. Additional interventions directed staff to encourage positioning on the left side to assist with bowel elimination and encourage fluids and meal intake. R3's physician assistant (PA) order dated 4/2/26, identified the previous lactulose order would be discontinued and replaced with lactulose 10 grams/15 ml solution three times daily for constipation. R3's April 2026 MAR identified Lactulose 10 grams/15 milliliters was administered two times daily from 4/2/26 through 4/7/26. Review identified the increased order for lactulose three times daily was not transcribed to the MAR until 4/8/26, resulting in R3 missing the additional ordered daily dose for six days. Review identified the increased lactulose frequency ordered on 4/2/26 was not implemented for six days despite the resident's care plan identifying ongoing constipation management interventions. R3's physician orders dated 4/8/26 identified an order for Lactulose oral solution 10 grams/15 milliliters to be administered by mouth three times daily for constipation. R3's Risk Watch form, incorrectly dated 4/2/26 and should have been dated 4/8/26, identified an order faxed on 4/2/26, to increase Lactulose to three times daily was not transcribed from RightFax and pharmacy did not receive the order. The document	F0755		06/29/2026

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F0755 SS = E	Continued from page 10 identified facility determined the medication error was a system failure. Interventions included staff education regarding checking RightFax and following transcription procedures. Immediate actions included transcription of the order and increasing lactulose to three times daily as ordered. An email sent from NM-A to all nurses dated 4/21/26, identified nurses were expected to check the RightFax inbox throughout evening and night shifts and weekends due to recent medication errors caused by orders not being checked in RightFax over the weekend. The email further identified staff were required to set up RightFax individually on each computer workstation used. Review identified the facility provided links to training videos regarding RightFax use; however, the facility was unable to provide evidence all nursing staff completed the education or evidence staff competency had been evaluated regarding use of the RightFax system. Although the facility reported education regarding RightFax review and medication transcription procedures had been completed with all nursing staff following the medication error, the facility was unable to provide documentation validating the education was completed with all staff or evidence staff competency had been evaluated regarding use of the RightFax system. During an interview on 5/19/26 at 4:29 p.m., NM-A stated R3 was prescribed Lactulose for constipation management and was bedbound. NM-A stated it had been three days since R3 had a bowel movement, R3 refused a suppository, and an increased lactulose dose was ordered on 4/2/26 to increase administration to three times daily; however, the order was not implemented until 4/8/26. NM-A stated the order came through RightFax on 4/2/26; however, she did not know which nurse was responsible for transcription and did not have documentation identifying the responsible nurse. NM-A further stated the facility later identified not all nurses had RightFax set up on their computers. NM-A stated health unit coordinators printed RightFax orders Monday through Friday and nursing staff were responsible for checking RightFax after hours and on weekends. NM-A stated links regarding RightFax setup were emailed to staff on 4/21/26; however, the facility did not have documentation staff completed the setup or training. NM-A further stated the facility's information technology staff ensured nursing staff had access to RightFax; however, she did not know when that occurred and did not have documentation verifying	F0755		06/29/2026

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F0755 SS = E	Continued from page 11 completion. R4 R4's face sheet identified diagnoses including chronic embolism and thrombosis of the left internal jugular vein (long-term blood clot in a major neck vein), atrial fibrillation, history of DVT, history of transient ischemic attack/stroke, coronary artery disease, biventricular heart failure (heart failure affecting both sides of the heart), end stage renal disease requiring dialysis, and kidney transplant status. R4's 5-day prospective payment system (PPS) MDS, dated 4/19/26, identified R4 had moderate cognitive impairment and received anticoagulant medications. R4's care plan dated 4/13/26, identified R4 was at risk for bleeding and excessive bruising related to anticoagulant therapy. Interventions dated 4/13/26, directed staff to observe and report abnormal or unexplained bleeding, including gastrointestinal bleeding, nose bleeds, and bleeding gums, to the nurse practitioner or physician. R4's AVS dated 4/4/26 through 4/13/26 identified R4 was hospitalized for a closed left ankle fracture. The AVS further identified R4's (INR) was 3.2 with orders to administer Warfarin 1 mg on 4/13/26 and then continue daily as directed by the provider. R4's anticoagulant management provider note dated 4/14/26, identified R4's INR was 3.5, hold today and 2 mg Wednesday, recheck INR on 4/16/26. R4's April 2026, MAR identified on 4/13/26, warfarin 2 mg tablet; take ½ tablet (1 mg) on 4/13/26 then take daily as directed by prescriber. Review of the MAR identified no dose was administered on 4/15/26. The MAR further identified that warfarin 2 mg tablet was given on 4/17/26, as initials were documented in the space. Although staff initials were documented on the MAR indicating warfarin 2 mg was administered on 4/17/26, a clinical note dated 4/17/26 at 10:57 p.m. identified the medication was unavailable and not administered. R4's clinical note dated 4/16/26 at 5:17 a.m., identified the on-call physician directed staff to hold warfarin until a new INR was obtained. The note further identified R4 missed a 2 mg dose of warfarin on 4/15/26, the on-call physician was notified, an SBAR was sent to senior services with the updated	F0755		06/29/2026

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F0755 SS = E	Continued from page 12 INR result of 2.4, and nursing leadership was notified. A subsequent note dated 4/16/26 at 6:45 p.m. identified a new order for warfarin 3 mg on Thursday and Saturday and 2 mg on all other days with repeat INR testing ordered for 4/20/26. R4's clinical note dated 4/17/26 at 10:57 p.m., identified R4's warfarin 2 mg tablet was again not administered because the medication was unavailable. The note identified the on-call physician was notified and advised staff to document the missed dose with the next INR testing. An additional note dated 4/18/26 at 6:37 a.m. identified two nurses thoroughly checked the emergency medication kit and the medication was not found. R4's clinical note dated 4/18/26 at 5:44 p.m., identified R4's warfarin dose of 2 mg was taken from the e-kit and that the pharmacy was aware of the order. R4's Risk Watch incident report dated 4/15/26 identified R4 missed a dose of Warfarin 2 mg on 4/15/26 because the medication was not available from the pharmacy. The document identified the on-call physician was notified during the early morning hours of 4/16/26 and advised staff to hold warfarin and send an SBAR to senior services. The report identified R4's INR was 2.4 on 4/16/26. The facility investigation identified warfarin was available within the facility emergency medication kit and staff could have obtained the medication from the emergency kit. The report further identified the medication omission was determined to be an error of omission. Interventions included staff education regarding available options when medications were not received from the pharmacy, including use of the emergency medication kit or obtaining medication from Mayo Pharmacy. Although the Risk Watch incident report identified the 4/15/26 omission was related to medication availability, subsequent record review identified the missed dose on 4/15/26 was associated with transcription/order processing failures, while the missed dose on 4/17/26 occurred because the medication was unavailable from the pharmacy. During an interview on 5/19/26 at 5:00 p.m., nurse manager (NM)-A stated R4 missed two doses of Warfarin due to medication unavailability and staff should have obtained the medication from the emergency medication kit (e-kit). NM-A stated staff were educated following the medication error regarding use of the emergency medication kit. NM-A further stated she was unaware the missed	F0755		06/29/2026

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F0755 SS = E	Continued from page 13 warfarin dose on 4/15/26 was related to a transcription error rather than medication availability. NM-A additionally stated the facility had been experiencing ongoing issues obtaining medications from the pharmacy in a timely manner. During an interview on 5/18/26 at 2:19 p.m., Director of Nursing (DON) stated medication errors were identified by nursing staff, providers, and daily medication order reviews completed by nursing leadership. DON stated medication errors were reviewed weekly during Tuesday risk meetings with leadership and root cause analysis was completed verbally; however, findings were not formally documented. DON stated the facility identified increasing medication errors beginning in February 2026 and implemented nursing education in March 2026 regarding the medication management process from provider order through medication administration. DON further stated the facility identified transcription errors, omitted medications, and medication availability issues as ongoing concerns. DON verified the facility was not currently monitoring medication error trends and did not have data regarding medication error types. DON stated the facility did not currently document medication audits and the EHR did not have the capability to generate reports identifying missed medication doses without manually reviewing each resident's MAR/TAR. DON further stated medication errors continued after interventions were implemented and additional medication errors occurred during April 2026. DON stated more than 50 percent of registered nurses had turned over recently and medication transcription training was completed by preceptors. DON further stated competency validation was not formally completed for all education provided and March 2026 medication education consisted primarily of staff meetings and staff sign-off sheets. Further review identified the facility's corrective actions following medication errors primarily consisted of staff education and verbal reinforcement; however, the facility was unable to provide evidence of competency validation, sustained auditing, trend analysis, or effective monitoring systems to ensure physician orders were accurately transcribed, laboratory monitoring was completed, and medications were administered as ordered Facility policy, "Adverse Consequences and Medication Errors Policy," revised 8/6/24, identified the interdisciplinary team would evaluate medication usage to prevent and detect medication-related problems and adverse consequences. The policy	F0755		06/29/2026

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F0755 SS = E	Continued from page 14 further identified residents receiving medications with potential adverse consequences would be monitored to ensure consequences were promptly identified and reported. The policy identified Charter House would minimize adverse consequences by following clinical guidelines for medication use, administration, and monitoring. The policy further identified medication orders would be evaluated for appropriate dose, administration, and monitoring and significant medication-related errors required immediate action to protect resident safety and welfare. The policy identified significant medication-related errors and adverse consequences were to be reviewed through the Quality Assurance and Performance Improvement (QAPI) process. Facility policy, “Medication Holds Policy,” revised 3/14/24, identified medication hold orders were required to include a restart date or time and hold orders without a restart date or time would be considered discontinued. The policy further identified nursing staff were required to document reasons medications were not administered within the medication administration record (MAR) and the health care provider was required to provide clear direction regarding when medications were to be restarted following a hold order	F0755		06/29/2026

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20000	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 5/18/26 and 5/19/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52827021C (2748718) and H52822736C (3011857) with a licensing order issued at 1550.	20000		06/16/2026

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

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(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
20000	Continued from page 1 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. 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.	20000		06/16/2026
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: R1: R1's Risk Watch document, incorrectly dated 2/7/26, identified on the future date of 2/19/26, the	21550	Corrected.	06/29/2026

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21550	Continued from page 2 health care provider (HCP) notified the Director of Nursing (DON) an INR lab ordered for 2/16/26 had not been completed. The document further identified that a subsequent order for warfarin (blood thinning medication) was not obtained resulting in R1 missing three doses of warfarin and the facility's internal investigation process was initiated after notification by the HCP. Immediate actions included notification of the house supervisor, resident, and on-call physician, and a new order was obtained. The document further identified the facility's internal investigation process was initiated after notification by the HCP. Facility reported incident (FRI) dated 2/19/26 at 2:05 p.m., identified the health care provider (HCP) notified the Director of Nursing (DON) an International Normalized Ratio (INR) (blood test used to measure how long it takes blood to clot and whether blood thinner medication is working safely and effectively) lab ordered for 2/16/26 had not been completed. The FRI further identified a subsequent order for Warfarin was not obtained resulting in R1 missing three doses of warfarin. The document identified the facility had initiated an internal investigation regarding the medication error. Facility 5-day investigation report summary dated 2/26/26, identified review of R1's care plan, electronic medical record (EMR), medication administration record (MAR), medication orders, and medication administration policies. The report identified care plan interventions directing staff to administer medications as ordered and obtain and monitor INR labs as ordered were not followed. Interview with nurse practitioner (NP)-A identified R1 had an INR scheduled for 2/16/26; however, the results were never sent to the provider care team and NP-A was unsure whether R1 had been receiving Warfarin. Interview with LPN-A identified she missed the INR order because it was typically completed by night shift and she did not question the warfarin order because she did not realize it had been ordered on previous days. The report identified R1's INR scheduled for 2/16/26 was not obtained and warfarin was not administered until 2/19/26 when the omission was identified by the provider. The allegation was verified through review of the EMR and staff interviews identifying the INR test was not completed per provider order and care plan. Nursing leadership initiated corrective actions on 2/20/26 including staff education regarding order transcription accuracy, two-person verification, INR testing tracking, and related policies. Additional prevention interventions included review of INR competency records, refresher training, review of	21550		06/29/2026

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21550	Continued from page 3 EMR safeguards, audits of newly transcribed orders for compliance with the two-person verification process, staff coaching and re-education for identified variances, and ongoing monitoring of order transcription and point-of-care testing competencies. Informal coaching documentation dated 2/25/26 identified LPN-A was placed on administrative leave related to a missed point-of-care INR resulting in R1 missing doses of warfarin. Nurse manager (NM)-A reiterated the importance of reviewing the medical record including labs and treatments for each resident. NM-A stated the lab order was present; however, LPN-A stated it did not appear on her dashboard. Follow-up coaching dated 2/27/26 identified adjustments were made within the EHR dashboard settings to display lab orders as the default view. Facility education provided on 3/16/26 through 3/18/26 included order transcription processes within the Unity EMR system including drafting orders, entering frequencies, stop dates, and activation of orders. However, review identified the education did not include a monitoring or double-check system to ensure ordered INR labs were completed and residents requiring anticoagulation management had active warfarin orders in place to prevent missed doses. After review of the facility investigation, the facility identified corrective actions including INR tracking, audits, staff education, and two-person verification related to anticoagulation management and order transcription; however, the facility was unable to provide evidence of audits or monitoring systems regarding following physician ordered INRs had been implemented. R1’s face sheet printed 5/18/26, identified diagnoses including heart transplant infection, infective endocarditis (serious infection of the inner lining and valves of the heart), presence of heart valve replacement, history of transient ischemic attack/stroke (history of “mini-stroke” or stroke), chronic heart failure, kidney transplant status, chronic kidney disease, pleural effusion (fluid buildup around the lungs), and atrial fibrillation (irregular heartbeat that increases risk for blood clots). R1’s admission Minimum Data Set (MDS) dated 2/12/26, identified moderate cognitive impairment, a major surgical procedure involving the heart or major blood vessels during the prior inpatient	21550		06/29/2026

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21550	Continued from page 4 hospital stay requiring active care during the skilled nursing facility stay, and receipt of anticoagulant (blood thinner medication used to help prevent blood clots) and antiplatelet (medications used to help prevent blood clots) medications. R1’s nurse practitioner (NP) encounter note dated 2/12/26 identified anticoagulation management for tissue aortic and mitral valves plus recent atrial fibrillation with a goal INR of 2.0 to 3.0 with lifelong duration. Comorbid considerations included infective endocarditis of native allograft mitral and aortic valves with severe regurgitation, likely due to right femoral seroma (fluid collection near the groin blood vessel area). The note further identified status post redo sternotomy (repeat open-heart surgery) with bioprosthetic aortic valve replacement and mitral valve replacement on 1/12/26, complicated by multifocal embolic cerebral and cerebellar infarcts (multiple strokes caused by blood clots traveling to the brain), possible small distal M1 aneurysm versus infundibulum on CTA (possible weakened or bulging blood vessel in the brain identified on imaging), pleural effusions status post thoracentesis, chylothorax (lymphatic fluid leaking into the chest cavity around the lungs), persistent debility (ongoing severe weakness and decreased physical functioning), intermittent bradycardia (episodes of abnormally slow heart rate), and new onset atrial fibrillation with rapid ventricular response (irregular heartbeat causing periods of rapid heart rate). The note further identified R1’s INR was 2.0 and R1 was to receive Warfarin 2 milligrams daily with repeat INR scheduled for 2/16/26. R1’s care plan dated 2/6/26, identified R1 was at risk for bleeding and excessive bruising related to anticoagulant and antiplatelet therapy. Interventions dated 2/6/26, directed staff to monitor INR lab values within acceptable range as determined by the health care provider and observe, record, and report signs or symptoms of bleeding to the health care provider. R1’s physician orders dated 2/7/26, identified an order for Warfarin 2 milligram (mg) tablet, take one tablet by mouth daily. The order further identified R1 was to take warfarin 2 mg daily until INR was completed on 2/9/26 and then continue as directed by the skilled nursing facility based on INR monitoring. R1’s anticoagulant management nurse practitioner (NP) visit dated 2/12/26. identified R1’s INR was 2.1. The note further identified to continue warfarin 2 mg daily and recheck INR on 2/16/26.	21550		06/29/2026

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21550	Continued from page 5 R1’s medication administration record (MAR) dated 2/16/26 to 2/18/26, identified an order for warfarin 2 mg take one time daily for four days begining 2/12/26, next INR check was on 2/16/26 at 6:00 a.m. After reviewing R1’s February 26 MAR, warfarin was not administered from 2/16/26 to 2/19/26 when R1 was discharged from the facility. R1’s treatment administration record (TAR) dated 2/16/26 identified an order for INR lab monitoring every one day for one day beginning 2/16/26 related to warfarin management. The TAR identified the INR was ordered on 2/12/26, with a note to recheck INR 2/16/26 at 0500. Review of the TAR identified an equal sign documented on 2/16/26 without staff initials, indicating the INR lab was not completed as ordered R1’s NP’s Follow Up Visit note dated 2/17/26, identified R1 was anticoagulated with warfarin due to atrial fibrillation with a goal INR of 2 to 3. The note did not address the INR lab ordered for 2/16/26 had not been completed and that R1 had no current orders on hand for warfarin. Email correspondence reviewed from nurse practitioner (NP)-A to director of nursing (DON), administrator, and nurse manager (NM)-A dated 2/19/26 at 8:00 a.m., identified the subject line “med error-warfarin.” The email identified NP-A had learned R1’s INR scheduled for 2/16/26 had not been completed and the results were never sent to her team. The email further identified an INR would be added to the day’s labs and NP-A would contact R1’s transplant team regarding management of warfarin and INR monitoring. R1’s clinical notes reviewed and did not identify any information about R1’s missed INR lab on 2/16/26 and did not identify that he missed 3 doses of warfarin from 2/16/26 to 2/18/26. R1’s clinical note dated 2/19/26 at 2:16 p.m. identified the facility was notified by the heart transplant service that R1 will be admitted to the hospital from his afternoon appointment. During an interview on 5/19/26 at 3:22 p.m., nurse manager (NM)-A stated R1’s INR lab due on 2/16/26 at 6:00 a.m. was missed by licensed practical nurse (LPN)-A resulting in R1 missing three doses of warfarin. NM-A stated the facility investigation identified the root cause was LPN-A did not have pending labs displayed within the My Unity dashboard and the facility lacked a double-check	21550		06/29/2026

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21550	Continued from page 6 system to identify missed INR testing. NM-A stated if the INR was missed, the corresponding warfarin order would also be missed. NM-A further stated there was no reminder on the MAR identifying a resident receiving warfarin required ongoing INR monitoring and staff were required to have the correct dashboard settings enabled to view pending laboratory orders. NM-A stated the missed INR from 2/16/26 would not continue to display the following day if not completed. NM-A stated facility interventions included review of residents receiving warfarin to identify additional missed INR labs, immediate staff education regarding medication order procedures and reporting requirements, and facility-wide education from 3/16/26 through 3/18/26 regarding order transcription processes. NM-A further stated the facility could not provide evidence of ensuring dashboard settings displayed pending laboratory orders or validating completion of ongoing audits reportedly initiated following the medication error. During an interview on 5/19/26 at 3:29 p.m., director of nursing (DON) stated the Risk Watch incident report incorrectly identified the event date as 2/7/26 and clarified the correct date should have been 2/19/26. DON stated nurse practitioner (NP)-A emailed facility leadership on 2/19/26 regarding a significant medication error involving missed warfarin doses for R1. DON stated R1's INR obtained on 2/19/26 was 3.2. DON stated the INR order due on 2/16/26 was listed on the TAR; however, LPN-A missed the lab order resulting in R1 missing three doses of warfarin. DON stated the facility removed LPN-A from the schedule and provided re-education. DON stated the facility investigation identified the root cause was failure to complete the INR laboratory order as prescribed by the provider, resulting in missed warfarin doses. DON further stated provider orders were expected to be completed as ordered. R2: R2's After Visit Summary (AVS) dated 4/14/26 through 4/17/26 identified R2 was status post right total knee arthroplasty (right total knee replacement surgery). The AVS further identified R2 received anticoagulation treatment while hospitalized to prevent blood clots or deep vein thrombosis (DVT) (blood clot usually occurring in the legs) and was to continue Aspirin 81 milligrams (mg) twice daily for DVT prophylaxis 30 days following surgery. R2's face sheet printed 5/18/26 identified diagnoses including aftercare following right joint replacement,	21550		06/29/2026

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21550	Continued from page 7 infection/inflammatory reaction related to an internal orthopedic prosthetic device/graft, hypertensive heart disease with heart failure, chronic heart failure, pulmonary hypertension (high blood pressure affecting the lungs and heart), morbid obesity, and obstructive sleep apnea (a condition causing interrupted breathing during sleep). R2's admission Minimum Data Set (MDS) dated 4/23/26, identified no cognitive impairment, a recent knee replacement surgery requiring ongoing skilled nursing care, and receipt of antiplatelet medications. R2's care plan dated 4/17/26, identified R2 was at risk for abnormal ecchymosis (bruising) or bleeding related to anticoagulant and/or antiplatelet medication use. Interventions dated 4/17/26 directed staff to administer medications as ordered, observe for side effects, and observe, record, and report abnormal bruising or signs and symptoms of bleeding to the health care provider. R2's Risk Watch document, incorrectly dated 4/17/26, identified on 4/20/26 an order in RightFax was not transcribed resulting in R2 missing three doses of Aspirin 81 milligrams. The document identified LPN-A was not aware of the order in RightFax. Interventions included education and discussion with nurses to ensure RightFax was checked daily, and orders were transcribed. Immediate actions included assessment of R2, transcription of the order, discontinuation of aspirin, and provider notification. Although the Risk Watch document documented discontinuation of aspirin and reported only three missed doses, subsequent MAR review identified the aspirin order was not appropriately reactivated and R2 experienced a prolonged interruption in ordered DVT prophylaxis. R2's MAR identified R2 received aspirin 81 mg from 4/17/26 through the morning dose on 4/20/26. Review identified the aspirin order was re-entered on 4/20/26; however, the order was again discontinued the same day and was not reactivated on the MAR through 5/14/26. Review of R2's April 2026 MAR identified R2 missed 22 doses from 4/20/26 at 8:00 p.m. through 4/30/26 at 8:00 p.m., due to no active order on the MAR. Review of R2's May 2026 MAR identified R2 missed 27 doses from 5/1/26 at 8:00 a.m. through 5/14/26 at 8:00 a.m. due to no active order on the MAR. Review identified R2 missed a total of 49 doses of	21550		06/29/2026

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21550	Continued from page 8 aspirin 81 milligrams. R2's medical doctor (MD) progress note dated 4/21/26, did not address R2's aspirin orders for deep vein thrombosis (DVT) prophylaxis. R2's nurse practitioner (NP) progress note dated 4/28/26, identified under assessment and plan: "Arthroplasty Total Knee Replacement Status Post Right." The note further identified DVT prophylaxis with aspirin twice daily for 30 days post-operatively. R2's nurse practitioner (NP) discharge visit note dated 5/12/26 identified R2 was status post right total knee arthroplasty (right total knee replacement surgery) and continued on Aspirin for deep vein thrombosis (DVT) prophylaxis (prevention of blood clots). The note further identified concern for right lower extremity erythema (redness), mild heat, and drainage from the incision site compared to the left leg and identified an ultrasound would be ordered to rule out DVT (blood clot). Discharge orders further identified R2 was to continue aspirin twice daily through 5/14/26. During an interview on 5/19/26 at 4:12 p.m., nurse manager (NM)-A stated the facility initially believed R2 missed only three days of Aspirin doses; however, after review of the medication administration record (MAR), NM-A verified R2 received aspirin from 4/17/26 through 4/20/26 and then did not receive aspirin again from 4/20/26 through 5/14/26 when R2 discharged home. NM-A stated it appeared LPN-A discontinued the aspirin order on 4/20/26. NM-A further verified R2 developed redness and warmth to the right leg requiring an ultrasound to rule out a blood clot and stated the facility had not realized R2 missed that amount of aspirin until the interview and no prevention interventions had been implemented related to the medication error. During an interview on 5/19/26 at 4:23 p.m., DON stated R2's Aspirin 81 mg twice daily ordered for DVT prophylaxis to prevent blood clots following total knee replacement surgery was discontinued on 4/20/26, despite discharge orders identifying aspirin was to continue through 5/14/26. DON stated the root cause identified was LPN-A did not check RightFax and did not enter the restarted aspirin order into the EHR. DON further stated the physician faxed an order discontinuing aspirin on 4/20/26, followed shortly afterward by another order restarting aspirin; however, the restarted order was not entered into the EHR. DON-A verified R2 did not receive aspirin as ordered by the physician and	21550		06/29/2026

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21550	Continued from page 9 stated this was the first awareness R2 had missed a significant number of aspirin doses and no prevention plan had been implemented because the facility was not aware what had occurred until just now. Further review identified although the facility investigation concluded R2 missed three doses of aspirin, the aspirin order had been discontinued on 4/20/26 and was not reactivated on the MAR for the remainder of the prescribed prophylactic period through 5/14/26. Review of the MAR identified R2 missed a total of 49 doses of aspirin 81 mg. The facility investigation did not identify the prolonged absence of an active aspirin order or the continued omission of physician-ordered DVT prophylaxis. R3: R3's face sheet printed 5/19/26, identified diagnoses including vascular dementia, hemiplegia following cerebral infarction (weakness/paralysis on one side of the body after stroke), and history of digestive system disease. R3's quarterly MDS dated 4/2/26, identified severely impaired cognition and was always incontinent of bowel. R3's care plan dated 12/26/25 identified altered elimination with constipation and bowel irregularity. The care plan identified R3 was to maintain a bowel movement at least every three days or per previous routine. Interventions revised 4/13/26, directed staff to administer an extra dose of Lactulose (bowel medication used to prevent and treat constipation) on day two without a bowel movement, administer a Dulcolax suppository on day three without a bowel movement, administer a tap water enema per standing order if no results from the suppository, and request an order for fecal impaction removal if still no results occurred. Additional interventions directed staff to encourage positioning on the left side to assist with bowel elimination and encourage fluids and meal intake. R3's physician assistant (PA) order dated 4/2/26, identified the previous lactulose order would be discontinued and replaced with lactulose 10 grams/15 ml solution three times daily for constipation. R3's April 2026 MAR identified Lactulose 10 grams/15 milliliters was administered two times daily from 4/2/26 through 4/7/26. Review identified the increased order for lactulose three times daily was	21550		06/29/2026

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21550	Continued from page 10 not transcribed to the MAR until 4/8/26, resulting in R3 missing the additional ordered daily dose for six days. Review identified the increased lactulose frequency ordered on 4/2/26 was not implemented for six days despite the resident's care plan identifying ongoing constipation management interventions. R3's physician orders dated 4/8/26 identified an order for Lactulose oral solution 10 grams/15 milliliters to be administered by mouth three times daily for constipation. R3's Risk Watch form, incorrectly dated 4/2/26 and should have been dated 4/8/26, identified an order faxed on 4/2/26, to increase Lactulose to three times daily was not transcribed from RightFax and pharmacy did not receive the order. The document identified facility determined the medication error was a system failure. Interventions included staff education regarding checking RightFax and following transcription procedures. Immediate actions included transcription of the order and increasing lactulose to three times daily as ordered. An email sent from NM-A to all nurses dated 4/21/26, identified nurses were expected to check the RightFax inbox throughout evening and night shifts and weekends due to recent medication errors caused by orders not being checked in RightFax over the weekend. The email further identified staff were required to set up RightFax individually on each computer workstation used. Review identified the facility provided links to training videos regarding RightFax use; however, the facility was unable to provide evidence all nursing staff completed the education or evidence staff competency had been evaluated regarding use of the RightFax system. Although the facility reported education regarding RightFax review and medication transcription procedures had been completed with all nursing staff following the medication error, the facility was unable to provide documentation validating the education was completed with all staff or evidence staff competency had been evaluated regarding use of the RightFax system. During an interview on 5/19/26 at 4:29 p.m., NM-A stated R3 was prescribed Lactulose for constipation management and was bedbound. NM-A stated it had been three days since R3 had a bowel movement, R3 refused a suppository, and an increased lactulose dose was ordered on 4/2/26 to increase	21550		06/29/2026

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21550	Continued from page 11 administration to three times daily; however, the order was not implemented until 4/8/26. NM-A stated the order came through RightFax on 4/2/26; however, she did not know which nurse was responsible for transcription and did not have documentation identifying the responsible nurse. NM-A further stated the facility later identified not all nurses had RightFax set up on their computers. NM-A stated health unit coordinators printed RightFax orders Monday through Friday and nursing staff were responsible for checking RightFax after hours and on weekends. NM-A stated links regarding RightFax setup were emailed to staff on 4/21/26; however, the facility did not have documentation staff completed the setup or training. NM-A further stated the facility's information technology staff ensured nursing staff had access to RightFax; however, she did not know when that occurred and did not have documentation verifying completion. R4 R4's face sheet identified diagnoses including chronic embolism and thrombosis of the left internal jugular vein (long-term blood clot in a major neck vein), atrial fibrillation, history of DVT, history of transient ischemic attack/stroke, coronary artery disease, biventricular heart failure (heart failure affecting both sides of the heart), end stage renal disease requiring dialysis, and kidney transplant status. R4's 5-day prospective payment system (PPS) MDS, dated 4/19/26, identified R4 had moderate cognitive impairment and received anticoagulant medications. R4's care plan dated 4/13/26, identified R4 was at risk for bleeding and excessive bruising related to anticoagulant therapy. Interventions dated 4/13/26, directed staff to observe and report abnormal or unexplained bleeding, including gastrointestinal bleeding, nose bleeds, and bleeding gums, to the nurse practitioner or physician. R4's AVS dated 4/4/26 through 4/13/26 identified R4 was hospitalized for a closed left ankle fracture. The AVS further identified R4's (INR) was 3.2 with orders to administer Warfarin 1 mg on 4/13/26 and then continue daily as directed by the provider. R4's anticoagulant management provider note dated 4/14/26, identified R4's INR was 3.5, hold today and 2 mg Wednesday, recheck INR on 4/16/26. R4's April 2026, MAR identified on 4/13/26, warfarin	21550		06/29/2026

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21550	Continued from page 12 2 mg tablet; take ½ tablet (1 mg) on 4/13/26 then take daily as directed by prescriber. Review of the MAR identified no dose was administered on 4/15/26. The MAR further identified that warfarin 2 mg tablet was given on 4/17/26, as initials were documented in the space. Although staff initials were documented on the MAR indicating warfarin 2 mg was administered on 4/17/26, a clinical note dated 4/17/26 at 10:57 p.m. identified the medication was unavailable and not administered. R4's clinical note dated 4/16/26 at 5:17 a.m., identified the on-call physician directed staff to hold warfarin until a new INR was obtained. The note further identified R4 missed a 2 mg dose of warfarin on 4/15/26, the on-call physician was notified, an SBAR was sent to senior services with the updated INR result of 2.4, and nursing leadership was notified. A subsequent note dated 4/16/26 at 6:45 p.m. identified a new order for warfarin 3 mg on Thursday and Saturday and 2 mg on all other days with repeat INR testing ordered for 4/20/26. R4's clinical note dated 4/17/26 at 10:57 p.m., identified R4's warfarin 2 mg tablet was again not administered because the medication was unavailable. The note identified the on-call physician was notified and advised staff to document the missed dose with the next INR testing. An additional note dated 4/18/26 at 6:37 a.m. identified two nurses thoroughly checked the emergency medication kit and the medication was not found. R4's clinical note dated 4/18/26 at 5:44 p.m., identified R4's warfarin dose of 2 mg was taken from the e-kit and that the pharmacy was aware of the order. R4's Risk Watch incident report dated 4/15/26 identified R4 missed a dose of Warfarin 2 mg on 4/15/26 because the medication was not available from the pharmacy. The document identified the on-call physician was notified during the early morning hours of 4/16/26 and advised staff to hold warfarin and send an SBAR to senior services. The report identified R4's INR was 2.4 on 4/16/26. The facility investigation identified warfarin was available within the facility emergency medication kit and staff could have obtained the medication from the emergency kit. The report further identified the medication omission was determined to be an error of omission. Interventions included staff education regarding available options when medications were not received from the pharmacy, including use of the	21550		06/29/2026

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21550	Continued from page 13 emergency medication kit or obtaining medication from Mayo Pharmacy. Although the Risk Watch incident report identified the 4/15/26 omission was related to medication availability, subsequent record review identified the missed dose on 4/15/26 was associated with transcription/order processing failures, while the missed dose on 4/17/26 occurred because the medication was unavailable from the pharmacy. During an interview on 5/19/26 at 5:00 p.m., nurse manager (NM)-A stated R4 missed two doses of Warfarin due to medication unavailability and staff should have obtained the medication from the emergency medication kit (e-kit). NM-A stated staff were educated following the medication error regarding use of the emergency medication kit. NM-A further stated she was unaware the missed warfarin dose on 4/15/26 was related to a transcription error rather than medication availability. NM-A additionally stated the facility had been experiencing ongoing issues obtaining medications from the pharmacy in a timely manner. During an interview on 5/18/26 at 2:19 p.m., Director of Nursing (DON) stated medication errors were identified by nursing staff, providers, and daily medication order reviews completed by nursing leadership. DON stated medication errors were reviewed weekly during Tuesday risk meetings with leadership and root cause analysis was completed verbally; however, findings were not formally documented. DON stated the facility identified increasing medication errors beginning in February 2026 and implemented nursing education in March 2026 regarding the medication management process from provider order through medication administration. DON further stated the facility identified transcription errors, omitted medications, and medication availability issues as ongoing concerns. DON verified the facility was not currently monitoring medication error trends and did not have data regarding medication error types. DON stated the facility did not currently document medication audits and the EHR did not have the capability to generate reports identifying missed medication doses without manually reviewing each resident's MAR/TAR. DON further stated medication errors continued after interventions were implemented and additional medication errors occurred during April 2026. DON stated more than 50 percent of registered nurses had turned over recently and medication transcription training was completed by preceptors. DON further stated competency validation was not formally completed for all education provided and	21550		06/29/2026

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21550	Continued from page 14 March 2026 medication education consisted primarily of staff meetings and staff sign-off sheets. Further review identified the facility's corrective actions following medication errors primarily consisted of staff education and verbal reinforcement; however, the facility was unable to provide evidence of competency validation, sustained auditing, trend analysis, or effective monitoring systems to ensure physician orders were accurately transcribed, laboratory monitoring was completed, and medications were administered as ordered Facility policy, "Adverse Consequences and Medication Errors Policy," revised 8/6/24, identified the interdisciplinary team would evaluate medication usage to prevent and detect medication-related problems and adverse consequences. The policy further identified residents receiving medications with potential adverse consequences would be monitored to ensure consequences were promptly identified and reported. The policy identified Charter House would minimize adverse consequences by following clinical guidelines for medication use, administration, and monitoring. The policy further identified medication orders would be evaluated for appropriate dose, administration, and monitoring and significant medication-related errors required immediate action to protect resident safety and welfare. The policy identified significant medication-related errors and adverse consequences were to be reviewed through the Quality Assurance and Performance Improvement (QAPI) process. Facility policy, "Medication Holds Policy," revised 3/14/24, identified medication hold orders were required to include a restart date or time and hold orders without a restart date or time would be considered discontinued. The policy further identified nursing staff were required to document reasons medications were not administered within the medication administration record (MAR) and the health care provider was required to provide clear direction regarding when medications were to be restarted following a hold order SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), pharmacist consultant, or designee could review and revise facility policies and procedures related to medication order transcription, medication administration, laboratory monitoring, medication availability, anticoagulation management, and medication error follow-up. The administrator, DON, pharmacist consultant, or designee could evaluate the facility's	21550		06/29/2026

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21550	Continued from page 15 medication management system to ensure physician orders are accurately transcribed, medications are available and administered as ordered, laboratory monitoring is completed timely, and medication holds or discontinued orders are appropriately reconciled and reactivated when indicated. The facility could provide education to licensed nursing staff regarding medication order processing, RightFax review procedures, anticoagulant monitoring requirements, emergency medication kit access and use, medication hold procedures, and documentation requirements for omitted or unavailable medications. The facility could implement a system of monitoring, such as medication transcription audits, laboratory monitoring audits, medication availability reviews, anticoagulation tracking logs, and medication administration record (MAR/TAR) audits to ensure medications and laboratory orders are completed as ordered and medication errors are identified timely. The facility could further implement competency validation for nursing staff responsible for medication order transcription and medication administration. Findings, trends, and corrective actions could be reviewed through the Quality Assurance and Performance Improvement (QAPI) process for ongoing monitoring and compliance. TIME ALLOWED FOR CORRECTION: Twenty-one (21) days.	21550		06/29/2026