DEPARTMENT OF HEALTH

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

Electronically Delivered

June 15, 2023

Administrator
The Waterview Pines LLC
1201 8th Street South
Virginia, MN  55792

RE: CCN: 245283
Cycle Start Date: May 2, 2023

Dear Administrator:

On June 8, 2023, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

**Please contact me with any questions regarding this letter.**

**Sincerely,**

**Lori Hagen, Compliance Analyst**
**Federal Enforcement**
**Health Regulation Division**
**Minnesota Department of Health**
**Telephone: 651-201-4306**
**E-Mail: Lori.Hagen@state.mn.us**

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June 15, 2023

Administrator
The Waterview Pines LLC
1201 8th Street South
Virginia, MN  55792

Re: Reinspection Results
Event ID:  I0VL12

Dear Administrator:

On June 8, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 2, 2023.  At this time these correction orders were found corrected.

**Please contact me with any questions regarding this letter.**

**Sincerely,**

**Lori Hagen, Compliance Analyst**
**Federal Enforcement**
**Health Regulation Division**
**Minnesota Department of Health**
**Telephone: 651-201-4306**

**E-Mail: Lori.Hagen@state.mn.us**

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Electronically delivered
May 11, 2023

Administrator
The Waterview Pines LLC
1201 8th Street South
Virginia, MN  55792

RE: CCN: 245283
Cycle Start Date: May 2, 2023

Dear Administrator:

On May 2, 2023, 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 2, 2023 (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 2, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245283 | A. BUILDING _____ B. WING _____ | C 05/02/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE WATERVIEW PINES LLC | 1201 8TH STREET SOUTH VIRGINIA, MN 55792 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>On 5/1/23, and 5/2/23, 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.<br><br>The following complaints were reviewed: H52831724C (MN92941, MN92932) with a deficiency issued at F755.<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 755 SS=E | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, | F 755 | | 5/19/23 |

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

Electronically Signed | 05/12/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 755 | Continued From page 1<br>dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure medications were administered as ordered by the physician for 1 of 3 residents (R1) reviewed for medication errors.<br><br>Findings include:<br><br>R1's Admission Record dated 5/2/23, indicated R1 diagnoses included chronic diastolic (congestive) heart failure, type 2 diabetes, severe chronic kidney disease, anemia in chronic kidney disease and hypertension.<br><br>R1's significant change Minimum Data Set (MDS) dated 3/27/23, indicated R1 did not walk. R1 had shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. | F 755 | F755 Pharmacy Services<br><br>Immediate Corrective Action:<br><br>R1 was monitored per provider order. Staff responsible for medication errors were re-educated on medication administration process and what to do if medication is not available.<br><br>Corrective Action as it applies to others:<br><br>The Administering Medications policy was reviewed and remains current.<br><br>All residents MARs were reviewed for the last 2 weeks to ensure that residents have been receiving all ordered medications. | |

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| F 755 | Continued From page 2<br>R1 received insulin injections, diuretic, antipsychotic and antidepressant medications on 7 of 7 days during the assessment period. R1 used oxygen.<br><br>A Brief Interview for Mental Status assessment dated 4/24/23, indicated R1 was cognitively intact.<br><br>R1's Order Summary Report dated 4/7/23, indicated R1 had allergies included lisinopril.<br><br>A report submitted to the State Agency (SA) on 4/20/23, indicated R1 had accidentally received another resident's 9:00 a.m. medications which included a once daily multivitamin, 1000 units of vitamin D supplement, Flexeril (a muscle relaxant), duloxetine (a medication used to manage major depressive disorder, generalized anxiety disorder, fibromyalgia, diabetic peripheral neuropathy, and chronic musculoskeletal pain) 30 milligrams (mg), tramadol (a medication used to relieve moderate to moderately severe pain) 50 mg, lisinopril (a medication used to treat high blood pressure) 40 mg, Metformin (used to control blood sugars) 500 mg, senna (a laxative) 8.6-50 mg and Tylenol 1000 mg. Per the director of nursing (DON) the medication nurse prepared medications before giving to the trained medication aide (TMA) who mistakenly gave R1 another resident's medication.<br><br>A facility Medication Error Reconciliation Form indicated on 4/20/23, at 10:30 a.m. licensed practical nurse (LPN)-A and TMA-A gave R1 the wrong medication. The medication given to R1 included Cholecalciferol (vitamin D3) 25 micrograms (mcg), Cyclobenzaprine (Flexeril) 10 mg, duloxetine 30 mg, lisinopril 40 mg, Metformin | F 755 | All licensed nurses and TMAs received education regarding proper training practices, medication administration, and process for medication reordering and what to do if a medication is not available to be administered. All licensed nurses and TMAs will complete medication administration competencies.<br><br>Date of Compliance: 5/19/23<br><br>Recurrence will be prevented by:<br><br>Clinical leadership will continue to audit all MARs 2x/week x 4 weeks, weekly x 4 weeks, and then monthly x 2 months, ensuring residents receive medications as ordered and, if medications are not given, that adequate documentation is put in and follow-up is completed. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.<br><br>5 medication passes will be audited 2x/week x 4 weeks, weekly x 4 weeks, and then monthly x 2 months to ensure staff are passing medication appropriately. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.<br><br>Corrections will be monitored by:<br><br>DON/Clinical Leadership/Designee | |

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| F 755 | Continued From page 3<br>500 mg, senna 8.6-50 mg, tramadol 50 mg, Tylenol 1000 mg and a multivitamin. The was no outcome noted to R1. R1's blood pressure, blood sugars and other potential adverse effects such as serotonin syndrome and tongue swelling were being monitored. R1's medical provider was notified on 4/20/23, at 11:00 a.m. Orders received from physician's assistant (PA)-A were to monitor for signs and symptoms of hypoglycemia (low blood sugar), monitor for serotonin syndrome, monitor for tongue swelling due to an allergic reaction to lisinopril, check resident hourly for swelling and monitor blood pressures until bedtime, if allergic reaction occurs, administer Benadryl 25 mg immediately with additional doses every 4 to 6 hours as needed. The investigation summary indicated LPN-A was training TMA-A in medication administration. Licensed practical nurse (LPN)-A prepped medications for R2 and instructed TMA-A to administer the medications. TMA-A thought the medications were for R1 and administered the medications to R1. The error was a category B error which was an error that required medication discontinuation or dose modification or the need for treatment or intervention. The error form indicated this was a significant medication error and was reported to the SA. Education follow up actions included all TMAs and licensed nurses were observed doing medication administration competencies. All were assigned modules regarding medication administration on proper training techniques.<br><br>A telephone encounter note signed by PA-A on 4/20/23, indicated R1 had accidentally received another resident's nine morning medication which included lisinopril 40 mg. Per the registered nurse (RN) manager R1 was not currently having any | F 755 | | |

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

tongue swelling. R1 had not received any of her scheduled morning medications. PA-A called the facility's pharmacy for recommendations. Per the pharmacist R1 could have all of her scheduled daily medications. Recommendations were to monitor for hypoglycemia with the additional 500 mg of Metformin to the medication regimen. No additional blood glucose checks were needed since R1's blood glucose was checked four times a day and with snacks. Monitor for serotonin syndrome with the administration of Effexor and Cymbalta and for tongue swelling due to the lisinopril allergy. After a discussion with the RN manager, staff will check on R1 hourly until bedtime to ensure no tongue swelling or additional allergic reaction. If allergic reaction occurred give Benadryl 25 mg immediately with additional doses every 4 to 6 hours as needed. Perform hourly blood pressure checks until bedtime to monitor for hypotension (low blood pressure). Monitor for hypoglycemia (dizziness, shaking, lethargy) and monitor for serotonin syndrome (confusion, diaphoresis/excessive sweating, tremor) with each interaction. Contact the Elder care team or send to the emergency room with concerns.

R1's April 2023 medication administration record indicated on 4/20/23, in the morning R1 should have received the following medications:
Ascorbic Acid (vitamin C) 500 mg every day shift. Documented as given on the MAR.
Ferrous Sulfate (iron) 325 mg every day shift related to anemia in chronic kidney disease. Documented as given on the MAR.
Polyethylene Glycol powder (Miralax) 17 grams (gm) every day shift for constipation. Documented as given on the MAR.
Sodium Zirconium Cyclosilicate (used to treat

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| F 755 | Continued From page 5<br>high blood potassium) one packet by mouth in the morning every other day related to severe chronic kidney disease. Documented as held and to see the nurses notes.<br>Venlafaxine extended release 75 mg, give three tablets by mouth every day related to major depressive disorder. Documented as held and to see the nurses notes.<br>Bumetanide 1 mg by mouth two times a day related to essential primary hypertension (high blood pressure). Documented as held and to see the nurses notes.<br>Metoprolol Tartrate 25 mg, give one tablet by mouth every morning and at bedtime related to essential hypertension. Documented as held and to see the nurses notes.<br>Omeprazole (Prilosec) 20 mg by mouth twice a day related to gastro esophageal reflux. Documented as held and to see the nurses notes.<br>Risperdal 0.5 mg (risperidone) give one tablet by mouth two times a day related to anxiety disorder. Documented as held and to see the nurses notes.<br>Senna-Docusate Sodium 8.6-50 mg, give two tablets by mouth two times a day related to constipation. Documented as held and to see the nurses notes.<br>Tylenol Extra Strength 500 mg, give two capsules by mouth three times a day for pain. Documented as held and to see the nurses notes.<br>Ipratropium-Albuterol Solution 0.5-2.5 (3 mg/3 ml), inhale 3 milliliters (ml) orally four times a day for shortness of breath. Documented as held and to see the nurses notes.<br><br>In addition, R1's April MAR indicated R1 was to receive on 4/6/23, Aranesp (albumin free) injection solution (Darbepoetin Alfa), inject 0.3 ml | F 755 | | |

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| F 755 | Continued From page 6<br>intramuscularly in the morning every four weeks on Thursday related to severe chronic kidney disease. Obtain vital signs prior to injection. Hold if systolic blood pressure (top number) is less than 180 or diastolic blood pressure (bottom number) is less than 105. If so alert the physician or the nurse practitioner. Monitor site for 20 minutes. The MAR indicated the medication was not given and to see the nurse's progress notes. The progress notes lacked documentation on why the medication was not given and if the physician, nurse practitioner or the pharmacy had been notified.<br><br>On 5/1/23, at 11:03 a.m. TMA-A stated it was her first day of TMA training. LPN-A was setting up the medications. They discussed giving R1 her medications but were unable due to R1 having cares done. LPN-A set up R2's medications and handed them to TMA-A. Later LPN-A handed TMA-A a cup of medications and told her to give them to R1. TMA-A told LPN-A she had already given R1 her medications. TMA-A said she knows the residents due to working as a nursing assistant (NA). TMA-A further stated she was given wrong directions.<br><br>On 5/1/23, at 12:23 p.m. PA-A stated R1 had other medication errors in addition to receiving another resident's medications on 4/20/23. Pa-A stated on 4/20/23, it was the TMA's first day of training. The nurse training the TMA set up R2's medication and the TMA gave R1 R2's medication. PA-A contacted the pharmacist for direction as R1 received lisinopril which she was allergic to. PA-A gave orders to give R1 her morning medications as ordered. R1 did not receive her morning medication which indicated another medication error. PA-A stated the nurse | F 755 | | |

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| F 755 | Continued From page 7<br>stated she used her nursing judgement and did not give R1 her morning medications. PA-A stated on 4/25/23 R1 was seen by endocrinology. During the visit it was discovered R1 had been receiving double insulin. The pharmacy had done an interchange from Humalog insulin to Novolog insulin (rapid-acting insulins that are used to treat Type 1 and Type 2 diabetes) and the orders were not transcribed correctly. In addition, R1 did not receive an injection ordered by nephrology on 4/6/23, of Aranesp injection solution. The medication was out and not ordered from the pharmacy. PA-A stated potential outcomes from the errors could have been a severe allergic reaction, respiratory distress, hypoglycemia and possible death.<br><br>During an interview on 5/1/23, at 2:09 p.m. with the director of nursing (DON) and the nurse consultant (NC), the DON stated the facility only had one medication error in the past three months which was on 4/20/23, when R1 received the incorrect medications. When asked about R1 not receiving her scheduled morning medications on 4/20/23, the DON stated R1 was supposed to receive her morning medication. The DON stated LPN-A could not remember RN-A telling her to give R1 her scheduled morning medications. When asked about R1 receiving double insulin the DON stated the pharmacy did a therapeutic interchange where R1's Humalog insulin was changed to Novolog insulin due to the lower cost of Novolog insulin. During the process of the interchange not all of R1's Humalog insulin was discontinued which caused R1 to receive more insulin than she should have. The NC stated the therapeutic interchange occurred on 4/1/23. NC provided a summary of R1's insulin error which consisted of the following: | F 755 | | |

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| | 245283 | A. BUILDING _____ B. WING _____ | C 05/02/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE WATERVIEW PINES LLC | 1201 8TH STREET SOUTH VIRGINIA, MN 55792 |

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| F 755 | Continued From page 8<br><br>R1's current insulin orders with a start date of 4/25/23:<br>Humalog insulin according to carbohydrate count for snacks at 3:00 p.m. and 8:00 p.m.<br>Humalog insulin according to carbohydrate count before meals.<br>Humalog insulin according to sliding scale at 2:00 a.m. and 8:00 p.m.<br>Humalog insulin sliding scale before meals.<br><br>From 4/1/23 to 4/25/23, R1's insulin orders consisted of the following:<br>Humalog insulin 15 units at 2:00 a.m. and 8:00 p.m. R1 refused multiple doses.<br>Humalog insulin 10 units before meals. R1 refused the supper doses multiple times.<br>Novolog insulin according to carbohydrate count after meals.<br>Novolog insulin according to carbohydrate count for snacks at 3:00 p.m. and 8:00 p.m.<br>Novolog insulin according to carbohydrate count if having snack at bedtime.<br>Novolog insulin according to sliding scale after meals. R1 did not consistently receive this.<br><br>Per NC's calculations with R1's refusals at times, R1 received 735 units of scheduled Humalog insulin in error between 4/1/23, and 4/25/23.<br><br>When asked about R1 not receiving her Aranesp in the morning on Thursday 4/6/23, for severe chronic kidney disease the DON stated LPN-A documented as not given on the MAR, and the progress notes lacked documentation of why the medication was not given. The DON stated Aranesp was an expensive medication and required prior authorization each month before the pharmacy would send the medication. NC | F 755 | | |

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| F 755 | Continued From page 9<br>verified this was a medication error, and the provider should have been notified.<br><br>On 5/1/23, at 3:00 p.m. RN-A stated R1's April Aranesp injection was not given. The Aranesp injection was on the April MAR to be given, and was not communicated it had not been given. RN-A spoke with PA-A and nephrology. R1 did not need any further blood work as it was done last on 5/9/23. The PA and nephrology did not specify if to give the Aranesp or not. RN-A stated she would call to clarify.<br><br>On 5/1/23, at 3:15 p.m. LPN-A stated she had worked at the facility for three years. LPN-A stated she was training TMA-A wanted to get R1's medications ready, but R1 was getting a bath. Later, LPN-A then got R1's medications ready, and told TMA-A to give the medications to R1. TMA-A said she had already given R1 her medications. LPN-A stated she would set up medications for someone else to give again. R1 was allergic to Lisinopril, required monitoring but was okay. R1 did not have any tongue swelling and remained at baseline. LPN-A further stated she asked if she should give R1 her medications and was told they would let her know. LPN-A stated she may have told RN-A but did not remember. LPN-A held R1's morning medication except the insulin because she felt nervous about what reaction R1 would have from R2's medications. Regarding R1's Aranesp injection, LPN-A stated the Aranesp was not available. LPN-A called the pharmacy and was told it was a specialty medication. The pharmacy gave LPN-A the telephone number for the specialty pharmacy. LPN-A did not know how that worked. LPN-A gave information to RN-A at end of the day. LPN-A was off the next day. | F 755 | | |

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| F 755 | Continued From page 10<br><br>On 5/1/23, at 3:26 p.m. R1 was interviewed. R1 stated there was one time when she received the wrong medications and was given lisinopril which she was allergic to. R1 did not have any reaction. However, when she took lisinopril before half of her tongue swelled up. R1 did not have any other adverse reactions and nothing out of the ordinary happened. R1 further stated her blood sugars had been running low quite a bit and did not know why. R1 thought it was because she had been eating less than usual. R1 stated she would trust the staff would give her the right medications as per what the doctor had ordered. R1 sated it made her nervous, she was leery now, and wondered how often the medication errors were not caught.<br><br>On 5/2/23, at 1:22 p.m. the consultant pharmacist (CP)-A was interviewed and stated the facility made her aware of R1's receiving extra insulin and of receiving R2's medications in error. CP-A was able to log into the facility's electronic medical record and review R1's blood glucose levels and any adverse reactions such as tongue swelling. CP-A stated she was not contacted regarding the missed Aranesp injection. CP-A directed to send R1 to the emergency room if she had any tongue swelling, as there could have been bad consequences. CP-A stated many of the facility's medication errors included high alert medications, and were treated as not high alert medications by the facility. CP-A stated this was scary as the errors had repeatedly occurred this past quarter. CP-A stated she attended the quality assurance and performance improvement (QAPI) meetings and medication errors were discussed during the meetings. CP-A stated the adverse effects of receiving 735 units of Humalog insulin | F 755 | | |

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| F 755 | Continued From page 11<br>in error could have been R1 being sent to the emergency room or even death. CP-A further stated she would be reaching out to the facility to help them find a solution to reduce or eliminate medication errors.<br><br>The facility's Administering Medications policy dated 4/2019, directed medications were administered in a safe and timely manner and as prescribed. Medications were administered in accordance with prescribed orders including any required time frame. Medication errors were documented, reported and reviewed by the QAPI committee to inform process changes and the need for additional staff training. The individual administering the medications were to verify the resident's identity before giving the resident the medications. Allergies to medications were checked and verified for each resident prior to administering medications. New personnel authorized to administer medications are not permitted to prepare or administer medications until they have been orientated to the medication administration system by the facility. The charge nurse must accompany new nursing personnel on their medication rounds for a minimum of three days to ensure established procedures were followed and proper resident identification methods are learned. | F 755 | | |

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

Electronically delivered
May 11, 2023

Administrator
The Waterview Pines LLC
1201 8th Street South
Virginia, MN  55792

Re: State Nursing Home Licensing Orders
Event ID: I0VL11

Dear Administrator:

The above facility was surveyed on May 1, 2023 through May 2, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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.

Sincerely,

Kamala Fiske-Downing

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

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>On 5/1/23, and 5/2/23, 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 | 2 000 | | |

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| 2 000 | Continued From page 1<br>these orders and identify the date when they will be completed.<br><br>The following complaints were reviewed: H52831724C (MN92941, MN92932) with a licensing order issued at 4658.1305 Subp. 1.<br><br>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.<br>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 | 2 000 | | |

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| 2 000 | Continued From page 2<br>state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |
| 21525 | MN Rule 4658.1305 A.B.C Pharmacist Service Consultation<br><br>A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who:<br>A. provides consultation on all aspects of the provision of pharmacy services in the nursing home;<br>B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br>C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure medications were administered as ordered by the physician for 1 of 3 residents (R1) reviewed for medication errors.<br><br>Findings include:<br><br>R1's Admission Record dated 5/2/23, indicated R1 diagnoses included chronic diastolic (congestive) heart failure, type 2 diabetes, severe chronic kidney disease, anemia in chronic kidney | 21525 | Corrected | 5/19/23 |

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| 21525 | Continued From page 3<br>disease and hypertension.<br><br>R1's significant change Minimum Data Set (MDS) dated 3/27/23, indicated R1 did not walk. R1 had shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. R1 received insulin injections, diuretic, antipsychotic and antidepressant medications on 7 of 7 days during the assessment period. R1 used oxygen.<br><br>A Brief Interview for Mental Status assessment dated 4/24/23, indicated R1 was cognitively intact.<br><br>R1's Order Summary Report dated 4/7/23, indicated R1 had allergies included lisinopril.<br><br>A report submitted to the State Agency (SA) on 4/20/23, indicated R1 had accidentally received another resident's 9:00 a.m. medications which included a once daily multivitamin, 1000 units of vitamin D supplement, Flexeril (a muscle relaxant), duloxetine (a medication used to manage major depressive disorder, generalized anxiety disorder, fibromyalgia, diabetic peripheral neuropathy, and chronic musculoskeletal pain) 30 milligrams (mg), tramadol (a medication used to relieve moderate to moderately severe pain) 50 mg, lisinopril (a medication used to treat high blood pressure) 40 mg, Metformin (used to control blood sugars) 500 mg, senna (a laxative) 8.6-50 mg and Tylenol 1000 mg. Per the director of nursing (DON) the medication nurse prepared medications before giving to the trained medication aide (TMA) who mistakenly gave R1 another resident's medication.<br><br>A facility Medication Error Reconciliation Form indicated on 4/20/23, at 10:30 a.m. licensed | 21525 | | |

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| 21525 | Continued From page 4<br><br>practical nurse (LPN)-A and TMA-A gave R1 the wrong medication. The medication given to R1 included Cholecalciferol (vitamin D3) 25 micrograms (mcg), Cyclobenzaprine (Flexeril) 10 mg, duloxetine 30 mg, lisinopril 40 mg, Metformin 500 mg, senna 8.6-50 mg, tramadol 50 mg, Tylenol 1000 mg and a multivitamin. The was no outcome noted to R1. R1's blood pressure, blood sugars and other potential adverse effects such as serotonin syndrome and tongue swelling were being monitored. R1's medical provider was notified on 4/20/23, at 11:00 a.m. Orders received from physician's assistant (PA)-A were to monitor for signs and symptoms of hypoglycemia (low blood sugar), monitor for serotonin syndrome, monitor for tongue swelling due to an allergic reaction to lisinopril, check resident hourly for swelling and monitor blood pressures until bedtime, if allergic reaction occurs, administer Benadryl 25 mg immediately with additional doses every 4 to 6 hours as needed. The investigation summary indicated LPN-A was training TMA-A in medication administration. Licensed practical nurse (LPN)-A prepped medications for R2 and instructed TMA-A to administer the medications. TMA-A thought the medications were for R1 and administered the medications to R1. The error was a category B error which was an error that required medication discontinuation or dose modification or the need for treatment or intervention. The error form indicated this was a significant medication error and was reported to the SA. Education follow up actions included all TMAs and licensed nurses were observed doing medication administration competencies. All were assigned modules regarding medication administration on proper training techniques.<br><br>A telephone encounter note signed by PA-A on | 21525 | | |

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| 21525 | Continued From page 5<br><br>4/20/23, indicated R1 had accidentally received another resident's nine morning medication which included lisinopril 40 mg. Per the registered nurse (RN) manager R1 was not currently having any tongue swelling. R1 had not received any of her scheduled morning medications. PA-A called the facility's pharmacy for recommendations. Per the pharmacist R1 could have all of her scheduled daily medications. Recommendations were to monitor for hypoglycemia with the additional 500 mg of Metformin to the medication regimen. No additional blood glucose checks were needed since R1's blood glucose was checked four times a day and with snacks. Monitor for serotonin syndrome with the administration of Effexor and Cymbalta and for tongue swelling due to the lisinopril allergy. After a discussion with the RN manager, staff will check on R1 hourly until bedtime to ensure no tongue swelling or additional allergic reaction. If allergic reaction occurred give Benadryl 25 mg immediately with additional doses every 4 to 6 hours as needed. Perform hourly blood pressure checks until bedtime to monitor for hypotension (low blood pressure). Monitor for hypoglycemia (dizziness, shaking, lethargy) and monitor for serotonin syndrome (confusion, diaphoresis/excessive sweating, tremor) with each interaction. Contact the Elder care team or send to the emergency room with concerns.<br><br>R1's April 2023 medication administration record indicated on 4/20/23, in the morning R1 should have received the following medications:<br>Ascorbic Acid (vitamin C) 500 mg every day shift. Documented as given on the MAR.<br>Ferrous Sulfate (iron) 325 mg every day shift related to anemia in chronic kidney disease. Documented as given on the MAR.<br>Polyethylene Glycol powder (Miralax) 17 grams | 21525 | | |

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| 21525 | Continued From page 6<br>(gm) every day shift for constipation. Documented as given on the MAR.<br>Sodium Zirconium Cyclosilicate (used to treat high blood potassium) one packet by mouth in the morning every other day related to severe chronic kidney disease. Documented as held and to see the nurses notes.<br>Venlafaxine extended release 75 mg, give three tablets by mouth every day related to major depressive disorder. Documented as held and to see the nurses notes.<br>Bumetanide 1 mg by mouth two times a day related to essential primary hypertension (high blood pressure). Documented as held and to see the nurses notes.<br>Metoprolol Tartrate 25 mg, give one tablet by mouth every morning and at bedtime related to essential hypertension. Documented as held and to see the nurses notes.<br>Omeprazole (Prilosec) 20 mg by mouth twice a day related to gastro esophageal reflux. Documented as held and to see the nurses notes.<br>Risperdal 0.5 mg (risperidone) give one tablet by mouth two times a day related to anxiety disorder. Documented as held and to see the nurses notes.<br>Senna-Docusate Sodium 8.6-50 mg, give two tablets by mouth two times a day related to constipation. Documented as held and to see the nurses notes.<br>Tylenol Extra Strength 500 mg, give two capsules by mouth three times a day for pain. Documented as held and to see the nurses notes.<br>Ipratropium-Albuterol Solution 0.5-2.5 (3 mg/3 ml), inhale 3 milliliters (ml) orally four times a day for shortness of breath. Documented as held and to see the nurses notes.<br><br>In addition, R1's April MAR indicated R1 was to | 21525 | | |

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| | 00582 | A. BUILDING: _____ B. WING _____ | C 05/02/2023 |

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| THE WATERVIEW PINES LLC | 1201 8TH STREET SOUTH VIRGINIA, MN 55792 |

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| 21525 | Continued From page 7<br><br>receive on 4/6/23, Aranesp (albumin free) injection solution (Darbepoetin Alfa), inject 0.3 ml intramuscularly in the morning every four weeks on Thursday related to severe chronic kidney disease. Obtain vital signs prior to injection. Hold if systolic blood pressure (top number) is less than 180 or diastolic blood pressure (bottom number) is less than 105. If so alert the physician or the nurse practitioner. Monitor site for 20 minutes. The MAR indicated the medication was not given and to see the nurse's progress notes. The progress notes lacked documentation on why the medication was not given and if the physician, nurse practitioner or the pharmacy had been notified.<br><br>On 5/1/23, at 11:03 a.m. TMA-A stated it was her first day of TMA training. LPN-A was setting up the medications. They discussed giving R1 her medications but were unable due to R1 having cares done. LPN-A set up R2's medications and handed them to TMA-A. Later LPN-A handed TMA-A a cup of medications and told her to give them to R1. TMA-A told LPN-A she had already given R1 her medications. TMA-A said she knows the residents due to working as a nursing assistant (NA). TMA-A further stated she was given wrong directions.<br><br>On 5/1/23, at 12:23 p.m. PA-A stated R1 had other medication errors in addition to receiving another resident's medications on 4/20/23. Pa-A stated on 4/20/23, it was the TMA's first day of training. The nurse training the TMA set up R2's medication and the TMA gave R1 R2's medication. PA-A contacted the pharmacist for direction as R1 received lisinopril which she was allergic to. PA-A gave orders to give R1 her morning medications as ordered. R1 did not receive her morning medication which indicated | 21525 | | |

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| 21525 | Continued From page 8<br><br>another medication error. PA-A stated the nurse stated she used her nursing judgement and did not give R1 her morning medications. PA-A stated on 4/25/23 R1 was seen by endocrinology. During the visit it was discovered R1 had been receiving double insulin. The pharmacy had done an interchange from Humalog insulin to Novolog insulin (rapid-acting insulins that are used to treat Type 1 and Type 2 diabetes) and the orders were not transcribed correctly. In addition, R1 did not receive an injection ordered by nephrology on 4/6/23, of Aranesp injection solution. The medication was out and not ordered from the pharmacy. PA-A stated potential outcomes from the errors could have been a severe allergic reaction, respiratory distress, hypoglycemia and possible death.<br><br>During an interview on 5/1/23, at 2:09 p.m. with the director of nursing (DON) and the nurse consultant (NC), the DON stated the facility only had one medication error in the past three months which was on 4/20/23, when R1 received the incorrect medications. When asked about R1 not receiving her scheduled morning medications on 4/20/23, the DON stated R1 was supposed to receive her morning medication. The DON stated LPN-A could not remember RN-A telling her to give R1 her scheduled morning medications. When asked about R1 receiving double insulin the DON stated the pharmacy did a therapeutic interchange where R1's Humalog insulin was changed to Novolog insulin due to the lower cost of Novolog insulin. During the process of the interchange not all of R1's Humalog insulin was discontinued which caused R1 to receive more insulin than she should have. The NC stated the therapeutic interchange occurred on 4/1/23. NC provided a summary of R1's insulin error which consisted of the following: | 21525 | | |

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| 21525 | Continued From page 9<br><br>R1's current insulin orders with a start date of 4/25/23:<br>Humalog insulin according to carbohydrate count for snacks at 3:00 p.m. and 8:00 p.m.<br>Humalog insulin according to carbohydrate count before meals.<br>Humalog insulin according to sliding scale at 2:00 a.m. and 8:00 p.m.<br>Humalog insulin sliding scale before meals.<br><br>From 4/1/23 to 4/25/23, R1's insulin orders consisted of the following:<br>Humalog insulin 15 units at 2:00 a.m. and 8:00 p.m. R1 refused multiple doses.<br>Humalog insulin 10 units before meals. R1 refused the supper doses multiple times.<br>Novolog insulin according to carbohydrate count after meals.<br>Novolog insulin according to carbohydrate count for snacks at 3:00 p.m. and 8:00 p.m.<br>Novolog insulin according to carbohydrate count if having snack at bedtime.<br>Novolog insulin according to sliding scale after meals. R1 did not consistently receive this.<br><br>Per NC's calculations with R1's refusals at times, R1 received 735 units of scheduled Humalog insulin in error between 4/1/23, and 4/25/23.<br><br>When asked about R1 not receiving her Aranesp in the morning on Thursday 4/6/23, for severe chronic kidney disease the DON stated LPN-A documented as not given on the MAR, and the progress notes lacked documentation of why the medication was not given. The DON stated Aranesp was an expensive medication and required prior authorization each month before the pharmacy would send the medication. NC verified this was a medication error, and the | 21525 | | |

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| 21525 | Continued From page 10<br>provider should have been notified.<br><br>On 5/1/23, at 3:00 p.m. RN-A stated R1's April Aranesp injection was not given. The Aranesp injection was on the April MAR to be given, and was not communicated it had not been given. RN-A spoke with PA-A and nephrology. R1 did not need any further blood work as it was done last on 5/9/23. The PA and nephrology did not specify if to give the Aranesp or not. RN-A stated she would call to clarify.<br><br>On 5/1/23, at 3:15 p.m. LPN-A stated she had worked at the facility for three years. LPN-A stated she was training TMA-A wanted to get R1's medications ready, but R1 was getting a bath. Later, LPN-A then got R1's medications ready, and told TMA-A to give the medications to R1. TMA-A said she had already given R1 her medications. LPN-A stated she would set up medications for someone else to give again. R1 was allergic to Lisinopril, required monitoring but was okay. R1 did not have any tongue swelling and remained at baseline. LPN-A further stated she asked if she should give R1 her medications and was told they would let her know. LPN-A stated she may have told RN-A but did not remember. LPN-A held R1's morning medication except the insulin because she felt nervous about what reaction R1 would have from R2's medications. Regarding R1's Aranesp injection, LPN-A stated the Aranesp was not available. LPN-A called the pharmacy and was told it was a specialty medication. The pharmacy gave LPN-A the telephone number for the specialty pharmacy. LPN-A did not know how that worked. LPN-A gave information to RN-A at end of the day. LPN-A was off the next day.<br><br>On 5/1/23, at 3:26 p.m. R1 was interviewed. R1 | 21525 | | |

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| 21525 | Continued From page 11<br><br>stated there was one time when she received the wrong medications and was given lisinopril which she was allergic to. R1 did not have any reaction. However, when she took lisinopril before half of her tongue swelled up. R1 did not have any other adverse reactions and nothing out of the ordinary happened. R1 further stated her blood sugars had been running low quite a bit and did not know why. R1 thought it was because she had been eating less than usual. R1 stated she would trust the staff would give her the right medications as per what the doctor had ordered. R1 sated it made her nervous, she was leery now, and wondered how often the medication errors were not caught.<br><br>On 5/2/23, at 1:22 p.m. the consultant pharmacist (CP)-A was interviewed and stated the facility made her aware of R1's receiving extra insulin and of receiving R2's medications in error. CP-A was able to log into the facility's electronic medical record and review R1's blood glucose levels and any adverse reactions such as tongue swelling. CP-A stated she was not contacted regarding the missed Aranesp injection. CP-A directed to send R1 to the emergency room if she had any tongue swelling, as there could have been bad consequences. CP-A stated many of the facility's medication errors included high alert medications, and were treated as not high alert medications by the facility. CP-A stated this was scary as the errors had repeatedly occurred this past quarter. CP-A stated she attended the quality assurance and performance improvement (QAPI) meetings and medication errors were discussed during the meetings. CP-A stated the adverse effects of receiving 735 units of Humalog insulin in error could have been R1 being sent to the emergency room or even death. CP-A further stated she would be reaching out to the facility to | 21525 | | |

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| 21525 | Continued From page 12<br><br>help them find a solution to reduce or eliminate medication errors.<br><br>The facility's Administering Medications policy dated 4/2019, directed medications were administered in a safe and timely manner and as prescribed. Medications were administered in accordance with prescribed orders including any required time frame. Medication errors were documented, reported and reviewed by the QAPI committee to inform process changes and the need for additional staff training. The individual administering the medications were to verify the resident's identity before giving the resident the medications. Allergies to medications were checked and verified for each resident prior to administering medications. New personnel authorized to administer medications are not permitted to prepare or administer medications until they have been orientated to the medication administration system by the facility. The charge nurse must accompany new nursing personnel on their medication rounds for a minimum of three days to ensure established procedures were followed and proper resident identification methods are learned.<br><br>SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures related to medication errors and administering medications as directed by physician. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21525 | | |