DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 24, 2021

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: CCN: 245399
Cycle Start Date: July 19, 2021

Dear Administrator:

On August 18, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
July 30, 2021

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: CCN: 245399
Cycle Start Date: July 19, 2021

Dear Administrator:

On July 19, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 October 19, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 19, 2022 (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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	C 07/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/19/21, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Little Falls Care Center was found to not be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5399050C (MN74703); with non-compliance cited at F757. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		8/17/21

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

Electronically Signed | 08/06/2021

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F 757	Continued From page 1 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure abnormal laboratory results were clarified and assessed timely to ensure therapeutic dosing of diuretic and potassium supplementation medications for 1 of 3 residents (R1) reviewed for a change of condition. Findings include: R1's Hospital Discharge Summary, dated 7/1/21, identified R1 had been admitted to the hospital with weight loss and nausea. R1 was recorded as having, " ... persistent problem with potassium being low ... did give 40 mEq [milliequivalents] on the day of discharge and she will resume her 40 mEq twice daily in the outpatient setting. I reduced her torsemide (a diuretic) to 60 mg [milligrams] from 80 mg and continue on spironolactone 100 mg daily." Further, the summary outlined a complete metabolic panel which recorded R1's blood potassium level as "3.2 (L)" with a listed reference range of 3.4 - 5.1 mEq/L. R1's admission Minimum Data Set (MDS), dated	F 757	R1 was sent to the hospital on 7/10 due to a change in condition and was readmitted to the facility on 7/16/21 with medication adjustments. The resident did not continue to receive these medications from 7/3/21 to 7/17/21. All residents re-admitted following hospitalization have the potential to have drug regimens that include unnecessary medications. Policies and procedures surrounding drug regimen reviews were reviewed and revised. Staff who participate in the re-admission process were educated on the process of completing drug regimen reviews. All residents who re-admit from the hospital in the next 30 days will be reviewed for unnecessary medications and any discrepancies will be clarified. Then will review 3 readmissions per month for 2 months and then 1 readmission monthly thereafter. Results of audits will be brought to the full QAPI committee for review and further	

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F 757	Continued From page 2 7/8/21, identified R1 had moderate cognitive impairment and required extensive assistance to complete her activities of daily living (ADLs). Further, the MDS outlined R1 consumed diuretic medication on a daily basis, and had consumed antipsychotic medication for two of the previous seven days in the look-back period. On 7/19/21, at 10:05 a.m. R1 was interviewed. R1 explained she had been to the hospital several times since June 2021, for several reasons including dehydration and getting "really shaky." R1 explained she had recently been to the emergency department, since her admission to the nursing home, as she had "maybe got extra [too much] medication." R1 denied any subsequent concerns with her care or services while residing at the nursing home. On 7/19/21, at 11:00 a.m. a telephone call was placed to R1's family member (FM)-A. A return call was provided on 7/20/21, at 8:08 a.m. and FM-A was interviewed. FM-A explained R1 admitted to the nursing home after having throat surgery. FM-A recalled R1 being taken to the ED, and later being hospitalized, and expressed he had been told it was potentially because they had "[given] her too much potassium" and delirium (a serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings). R1's Little Falls Health Services facsimile, sent on 7/2/21, identified R1's name along with a note to her physician which read, "Drug to drug interaction between '[potassium] 40 mEq BID [twice daily]' [and] 'spironolactone 100 mg QD [daily]' ... severe potential of causing renal failure [and] for hyperkalemia ... recommended to	F 757	recommendations.	

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F 757	Continued From page 3	F 757		

routinely monitor potassium levels [and] make adjustments accordingly ... Please advise of lab monitoring?" However, the physician did not respond to this facsimile until 7/9/21 (seven days later), and wrote, "Basic panel [every] month [for] 3 months."

R1's ED (Emergency Department) Provider Notes, dated 7/6/21, identified R1 presented to the ED via ambulance from the nursing home with reports of becoming unruly and refusing to take her medications. R1 was recorded as being "alert but disorientated" and "uncooperative [but] in NAD [no acute distress]" during the physician's examination. A series of blood work was obtained which identified several laboratory values for R1. This included, "Potassium 5.5 (H)," and listed a reference range of 3.5 - 5.1 mmol/L (mole) as being normal. However, the corresponding physician assessment and/or plan lacked any directions or action being taken to address the elevated laboratory value. R1 was written as "medically cleared in the ED," and she was returned to the nursing home with a primary diagnosis of psychosis and a pending appointment with another physician for her mental health needs.

R1's subsequent ED Provider Notes, dated 7/10/21, identified R1 had returned to the ED with dictation reading, "She was seen here [in the ED] on July 6 secondary to some psychotic behavior ... was given 5 mg of Zyprexa [an antipsychotic medication] here and her behavior improved." The note continued, " ... Patient cannot really give me [physician] any information she just cries and says nobody believes her." The note outlined a series of blood work was repeated, including a metabolic panel, which recorded R1's potassium

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F 757	Continued From page 4	F 757		

level now at, "5.8 (*)" with a listed reference range of value being 3.5 - 5.1 mmol/L. R1 was subsequently admitted to the hospital with a primary diagnosis of dehydration and hyperkalemia (elevated potassium).

R1's Physicians Order Sheet, printed 7/19/21, identified R1's medications along with their directions and start/stop date(s). This sheet identified many orders for R1 including: "POTASSIUM CHLORIDE ... Administer 40 mEqs ... By Mouth 2 times per day ...", and, "SPIRONOLACTONE ... Administer 100 mgs ... By Mouth 1 time per day ... ." These medications each had a listed start date of 7/3/21 and continued to be provided until 7/17/21.

R1's medical record was reviewed and lacked evidence the elevated potassium laboratory value on 7/6/21 was clarified or assessed after R1 returned from the ED to ensure the therapeutic dosing of her diuretic and potassium supplement medications. There was no evidence the facility had contacted the ED physician or R1's primary care physician to seek guidance on if the current dosing should be continued, adjusted or held given the elevated result despite the facility having identified them as having "severe potential" for interaction and a potential for hyperkalemia.

On 7/19/21, at 1:27 p.m. registered nurse case manager (RN)-A and registered nurse clinical coordinator (RN)-B reviewed R1's medical record and were interviewed. They verified R1's elevated potassium level on 7/6/21, was drawn by the ED and R1 was returned to the nursing home. RN-B verified R1 continued to be provided the potassium supplement and her ordered diuretics

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F 757	Continued From page 5	F 757		

until her most recent hospitalization on 7/10/21, when they were adjusted and/or discontinued. RN-B acknowledged R1's medical record lacked evidence the elevated value, drawn 7/6/21, had been acted upon or clarified with the physician to ensure appropriate dosing and voiced, "It should [have been] followed up on."

On 7/19/21, at 2:49 p.m. the director of nursing (DON), administrator, RN-A, and RN-B were interviewed. They explained R1 had an extensive psychiatric background and attempts had been made to ensure her hydration and nutrition needs were met at the nursing home. The DON acknowledged the medical record lacked evidence the elevated potassium level drawn on 7/6/21 in the ED had been acted upon or clarified, either by the ED or the nursing home, and stated she expected the nursing home staff to review applicable notes and ensure needed clarifications, such as R1's elevated laboratory value, be acted upon and clarified.

A provided Diagnostic Services policy, dated 01/2017, identified the nursing home would promptly notify the ordering provider of results that "fall outside of the clinical reference ranges in accordance with the follow procedure or per the ordering physician's orders." The policy listed a clinical reference range for potassium of, "<3.0 or >6.0 mEq/dl." However, the policy lacked guidance or procedures to ensure any provided laboratory monitoring, including from the ED upon a residents return, would be screened or reviewed to ensure no additional clarification was needed.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 30, 2021

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

Re: State Nursing Home Licensing Orders
Event ID: DYFV11

Dear Administrator:

The above facility was surveyed on July 19, 2021 through July 19, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00382	A. BUILDING: _____ B. WING _____	C 07/19/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/19/21, a survey was conducted by surveyors from the Minnesota Department of Health (MDH) to determine compliance for state licensure in conjuction with complaint investigation(s): H5399050C (MN74703) As a result, the following correction orders are	2 000		

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2 000	Continued From page 1 issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected. 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 surveyors 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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.	2 000		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure abnormal laboratory results were clarified and assessed timely to ensure therapeutic dosing of diuretic and	21540	Corrected	8/17/21

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21540	Continued From page 3 potassium supplementation medications for 1 of 3 residents (R1) reviewed for a change of condition. Findings include: R1's Hospital Discharge Summary, dated 7/1/21, identified R1 had been admitted to the hospital with weight loss and nausea. R1 was recorded as having, " ... persistent problem with potassium being low ... did give 40 mEq [milliequivalents] on the day of discharge and she will resume her 40 mEq twice daily in the outpatient setting. I reduced her torsemide (a diuretic) to 60 mg [milligrams] from 80 mg and continue on spironolactone 100 mg daily." Further, the summary outlined a complete metabolic panel which recorded R1's blood potassium level as "3.2 (L)" with a listed reference range of 3.4 - 5.1 mEq/L. R1's admission Minimum Data Set (MDS), dated 7/8/21, identified R1 had moderate cognitive impairment and required extensive assistance to complete her activities of daily living (ADLs). Further, the MDS outlined R1 consumed diuretic medication on a daily basis, and had consumed antipsychotic medication for two of the previous seven days in the look-back period. On 7/19/21, at 10:05 a.m. R1 was interviewed. R1 explained she had been to the hospital several times since June 2021, for several reasons including dehydration and getting "really shaky." R1 explained she had recently been to the emergency department, since her admission to the nursing home, as she had "maybe got extra [too much] medication." R1 denied any subsequent concerns with her care or services while residing at the nursing home.	21540		

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21540	Continued From page 4 On 7/19/21, at 11:00 a.m. a telephone call was placed to R1's family member (FM)-A. A return call was provided on 7/20/21, at 8:08 a.m. and FM-A was interviewed. FM-A explained R1 admitted to the nursing home after having throat surgery. FM-A recalled R1 being taken to the ED, and later being hospitalized, and expressed he had been told it was potentially because they had "[given] her too much potassium" and delirium (a serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings). R1's Little Falls Health Services facsimile, sent on 7/2/21, identified R1's name along with a note to her physician which read, "Drug to drug interaction between '[potassium] 40 mEq BID [twice daily]' [and] 'spironolactone 100 mg QD [daily]' ... severe potential of causing renal failure [and] for hyperkalemia ... recommended to routinely monitor potassium levels [and] make adjustments accordingly ... Please advise of lab monitoring?" However, the physician did not respond to this facsimile until 7/9/21 (seven days later), and wrote, "Basic panel [every] month [for] 3 months." R1's ED (Emergency Department) Provider Notes, dated 7/6/21, identified R1 presented to the ED via ambulance from the nursing home with reports of becoming unruly and refusing to take her medications. R1 was recorded as being "alert but disorientated" and "uncooperative [but] in NAD [no acute distress]" during the physician's examination. A series of blood work was obtained which identified several laboratory values for R1. This included, "Potassium 5.5 (H)," and listed a reference range of 3.5 - 5.1 mmol/L (mole) as being normal. However, the corresponding physician assessment and/or plan lacked any	21540		

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directions or action being taken to address the elevated laboratory value. R1 was written as "medically cleared in the ED," and she was returned to the nursing home with a primary diagnosis of psychosis and a pending appointment with another physician for her mental health needs.

R1's subsequent ED Provider Notes, dated 7/10/21, identified R1 had returned to the ED with dictation reading, "She was seen here [in the ED] on July 6 secondary to some psychotic behavior ... was given 5 mg of Zyprexa [an antipsychotic medication] here and her behavior improved." The note continued, " ... Patient cannot really give me [physician] any information she just cries and says nobody believes her." The note outlined a series of blood work was repeated, including a metabolic panel, which recorded R1's potassium level now at, "5.8 (*)" with a listed reference range of value being 3.5 - 5.1 mmol/L. R1 was subsequently admitted to the hospital with a primary diagnosis of dehydration and hyperkalemia (elevated potassium).

R1's Physicians Order Sheet, printed 7/19/21, identified R1's medications along with their directions and start/stop date(s). This sheet identified many orders for R1 including: "POTASSIUM CHLORIDE ... Administer 40 mEqs ... By Mouth 2 times per day ...", and, "SPIRONOLACTONE ... Administer 100 mgs ... By Mouth 1 time per day ... ." These medications each had a listed start date of 7/3/21 and continued to be provided until 7/17/21.

R1's medical record was reviewed and lacked evidence the elevated potassium laboratory value on 7/6/21 was clarified or assessed after R1 returned from the ED to ensure the therapeutic

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dosing of her diuretic and potassium supplement medications. There was no evidence the facility had contacted the ED physician or R1's primary care physician to seek guidance on if the current dosing should be continued, adjusted or held given the elevated result despite the facility having identified them as having "severe potential" for interaction and a potential for hyperkalemia.

On 7/19/21, at 1:27 p.m. registered nurse case manager (RN)-A and registered nurse clinical coordinator (RN)-B reviewed R1's medical record and were interviewed. They verified R1's elevated potassium level on 7/6/21, was drawn by the ED and R1 was returned to the nursing home. RN-B verified R1 continued to be provided the potassium supplement and her ordered diuretics until her most recent hospitalization on 7/10/21, when they were adjusted and/or discontinued. RN-B acknowledged R1's medical record lacked evidence the elevated value, drawn 7/6/21, had been acted upon or clarified with the physician to ensure appropriate dosing and voiced, "It should [have been] followed up on."

On 7/19/21, at 2:49 p.m. the director of nursing (DON), administrator, RN-A, and RN-B were interviewed. They explained R1 had an extensive psychiatric background and attempts had been made to ensure her hydration and nutrition needs were met at the nursing home. The DON acknowledged the medical record lacked evidence the elevated potassium level drawn on 7/6/21 in the ED had been acted upon or clarified, either by the ED or the nursing home, and stated she expected the nursing home staff to review applicable notes and ensure needed clarifications, such as R1's elevated laboratory value, be acted upon and clarified.

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21540	Continued From page 7 A provided Diagnostic Services policy, dated 01/2017, identified the nursing home would promptly notify the ordering provider of results that "fall outside of the clinical reference ranges in accordance with the follow procedure or per the ordering physician's orders." The policy listed a clinical reference range for potassium of, "<3.0 or >6.0 mEq/dl." However, the policy lacked guidance or procedures to ensure any provided laboratory monitoring, including from the ED upon a residents return, would be screened or reviewed to ensure no additional clarification was needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure orders or notations from outside care providers (i.e., ED) are reviewed and discrepancies clarified. They could then provide education to the direct care staff regarding such actions and then audit medical records to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		