Electronically Submitted
August 28, 2020

Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

RE: CCN: 245482
Cycle Start Date: August 11, 2020

Dear Administrator:

On August 11, 2020, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 11, 2020, the situation of immediate jeopardy to potential health and safety cited at F0760 was removed. However, continued non-compliance remains at the lower scope and severity of G.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 12, 2020.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 12, 2020 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 12, 2020, (42 CFR 488.417 (b)).

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Prairie Manor Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 11, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of

correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: 507-206-2727

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 11, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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	245482	A. BUILDING _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917**

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F 000	INITIAL COMMENTS On 8/10/20 through 8/11/2020, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated H5482028C at F Tag 760. The IJ began on 8/2/20, when a physician prescribed order for daily injection of Lovenox was not available in the facility to be administered. R1 did not receive the prescribed Lovenox injection on either 8/2 or 8/3/20. After missing these 2 doses, on 8/4/20, R1 started feeling sick with nausea and vomiting. On 8/5/20, R1 self-reported she was having symptoms of feeling dizzy, headache, and had a small emesis/phlegm which R1 described as symptoms she'd experienced during a previous stroke. R1 was transferred to the emergency room (ER) and was subsequently hospitalized for stroke and pulmonary embolism on 8/5/20. The facility administrator and director of nursing (DON) were notified of the IJ on 8/10/20, at 4:45 p.m. The IJ was removed on 8/11/20, when the facility had implemented an appropriate removal plan. However, non-compliance remained at an isolated scope of actual harm that is not immediate jeopardy (Level G). In addition, an extended survey was completed on 8/11/2020. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are	F 000		

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

Electronically Signed | 09/01/2020

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F 000	Continued From page 1 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a system to avoid significant medication errors of omission. The facility failed to ensure an adequate system for was in place to assure medications were reordered in a timely manner to be available for administration in accordance with physician orders for 1 of 1 resident (R1). The facility's omission of Lovenox injections (an anticoagulation medication, which helps prevent blood clots from forming) resulted in an immediate jeopardy (IJ) level significant medication error when R1 sustained a stoke and pulmonary embolism (PE). The IJ began on 8/2/20, when a physician prescribed order for daily injection of Lovenox was not available in the facility to be administered. R1 did not receive the prescribed Lovenox injection on either 8/2 or 8/3/20. After	F 760	Our plan of correction that was stated in our IJ removal letter is as follow... It was identified by the survey team, and validated by Prairie Manor, that the lack of action from our facility may have contributed to the hospitalization of a resident in our care. Specifically lack of action when it came to the reordering and administering of a prescription drug. If staff here are uneducated on the policies & procedures surrounding medications this poses a plausible risk to all residents here. To extinguish the possibility of a scenario like this happening again, Prairie Manor will do the following education to all staff that are involved with medications (LPN□s, RN□s, Med Aides)& "Retraining on the pharmacy□s recommendation to reorder medication when there is a 3-5 day supply left, or 5-7	8/14/20

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F 760	Continued From page 2 missing these 2 doses, on 8/4/20, R1 started feeling sick with nausea and vomiting. On 8/5/20, R1 self-reported she was having symptoms of feeling dizzy, headache, and had a small emesis/phlegm which R1 described as symptoms she'd experienced during a previous stroke. R1 was transferred to the emergency room (ER) and was subsequently hospitalized for stroke and pulmonary embolism on 8/5/20. The facility administrator and director of nursing (DON) were notified of the IJ on 8/10/20, at 4:45 p.m. The IJ was removed on 8/11/20, when the facility had implemented an appropriate removal plan. However, non-compliance remained at an isolated scope of actual harm that is not immediate jeopardy (Level G). Findings include: R1's admission Minimum Data Set (MDS) assessment dated 7/29/20, identified R1 as having intact cognition and requiring extensive assistance with activities of daily living (ADLs). The MDS also indicated R1 received anticoagulation medication during the 7 day assessment review period. R1's admission record indicated R1 had a history of transient ischemic attack (TIA), cerebral infarction (stroke) without residual deficits, and history of pulmonary embolism. R1's care plan included, "Resident is currently on anticoagulation therapy related to: history of pulmonary embolism." Interventions: Administered anticoagulation medications per MD [medical doctor] orders." R1's physician orders included, "Enoxaparin	F 760	for narcotics. "Education on who is responsible for reordering medications. (Any LPN or RN who discovers it is less than 3 day supply or 5 for narcotics.) "Education on the specific incident that resulted in this Immediate Jeopardy. "When a med error is a VA and how the VA process should be carried out. "The med error process as far as notifying superiors and pharmacy, proper charting and paper trails of an incident. Education will be conducted by the assistant director of nursing, director of nursing, or designee. Education will be completed before any LPN, RN, or Med Aide starts their next shift. To help ensure this we will attempt to call all employees involved and speak with them before they next enter the building. If this is not possible ADON, DON, or designee will stop each applicable employee to train them before they start their shift and begin resident interactions. All applicable staff can be reached and educated by 08/12/2020. ADON, DON, or designee will examine medication cart by 08/11/2020 to ensure that no other prescription drugs have less than a 3-day supply, and that no medications on the MAR have been missed recently. This will solidify that all residents are officially not in an immediate jeopardy of having medications non-accessible or missed. They will also create a cumulative medication reordering policy that elaborates on who should reorder, how to reorder, what to do if no	

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F 760	Continued From page 3 [Lovenox] Sodium Solution 40 MG/0.4ML Inject 0.4 ml subcutaneously (SQ) one time a day related to PERSONAL HISTORY OF PULMONARY EMBOLISM (Z86.711) for 28 Days. R1's medication treatment record indicated R1 did not receive the Enoxaparin [Lovenox]Sodium injections per the physician order on 8/2 or 8/3/20. R1's medication error report (MER) dated 8/5/20 indicated errors were made on 8/2 and 8/3/20. The MER indicated the nurse practitioner was made aware of the errors on 8/5/20, at 4:45 p.m. Medication as ordered Enoxaparin [Lovenox]40 mg/0.4 ml- inject 0.4 ml SQ daily r/t (related to) hx (history) of pulmonary embolism. Description of the error: Two doses not given on 8/2 and 8/3/20. Outcome to the resident: Stroke and PE (pulmonary embolism). Resident sent to ER. Corrective action taken: Re-education of all nurses on reordering supply, what to do if no supply, notification to pharmacy for STAT delivery. Measures taken to prevent reoccurrence of similar error(s): Discussed with pharmacy, process for sending partial supply of orders. R1's record revealed there was no notification to the physician or medication error reports completed on 8/2 or 8/3/20 when the facility initially had not administered the Lovenox. R1's nursing progress notes were reviewed and included: -8/3/20 at 8:24 a.m., Enoxaparin [Lovenox] Sodium Solution 40 MG/0.4ML Inject 0.4 ml subcutaneously one time a day	F 760	medication is available, who to tell, etc. New policy will be created by 08/14/2020 and dispersed to applicable staff. Resident discharged from us before ever returning. No assessment or care plan alteration could be done. To make sure efforts are sustained, the DON, ADON, or designee will audit the med reordering weekly for 5 weeks to make sure all meds are ordered by the cutoffs listed above. These audits will be brought to the next QAPI meeting to be discussed by the interdisciplinary team. All med errors are to be brought to each QAPI meeting indefinitely.	

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F 760	Continued From page 4 related to PERSONAL HISTORY OF PULMONARY EMBOLISM (Z86.711) for 28 Days "No supply" -8/5/20 at 6:17 a.m., "Resident experienced nausea this morning. No emesis. She also stated that she wants to see the nurse manager this morning. She wants to know if she is going to have a stroke because she has hard {sik} it before 2010. VS (vital signs) were taken. At this time, no s/s (signs or symptoms) of stroke. Incoming shift and wing nurse notified to monitor resident. Charge nurse will be informed as soon as she comes in to go and check/reassess resident. -8/5/20 at 7:17 a.m., "Ambulance was called at 6:54 a.m. and they left with her at 7:17 a.m.. In route to [emergency department], husband will meet her there." Review of R1's neuro ICU (intensive care unit) admission note dated 8/5/20 included, "Chief Complaint: Stroke History of Present Illness: [R1] is a 70 y.o. (year old) right-handed female with a history significant for prior strokes, type 2 diabetes mellitus, hyperlipidemia, past history of PE (pulmonary embolis 2018, provoked), obesity, recent humorous fracture repair s/p (status post) internal fixation and debridement (July 2020) who presents to the neurological ICU with subacute cerebellar infarct (stroke) ...Although she had no focal neurological deficits in the ED (emergency department) given concern for headache reported by patient, she underwent a CT (cat scan) of the head/neck (per outside documentation). This imaging showed likely subacute appearing infarcts in the L>R	F 760		

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F 760	Continued From page 5 cerebellum, bilateral parietal lobes. CT abdominal pelvis was obtained given concerns for emesis and possible infection, which identified right lower lobe sub segmental PE which was further confirmed on dedicated CT PE study. Given concerns for subacute cerebrallar infarct, PE and elevated baseline troponin ...patient was transferred [to this hospital] for further management... Patient reports that she was instructed to continue Lovenox injections after discharge from Orthopedics in late July for at least 30 days. Which she was initially getting however, for the last 3 or 4 days the facility told her they had run out and she has not been receiving them ..." The facility's investigative report sent to the State Agency (SA) 8/7/20, included, "In investigation of the medication error there was found to be two issues. One issue was with nursing not following the process for when a medication supply is low and how the med error occurred, and one issue with the pharmacy not delivering medications in a timely manner when ordered. Both of the nurses involved with the medication error have received a corrective action. All the nurses have been re-educated that when supply of any medication is starting to get low, it is to be re-ordered right away and a call is to be placed to the pharmacy if we don't have the ordered medication at the time it is scheduled to be given. If the medication is not available in our E-Kit (emergency kit), the pharmacy will need to be called and complete a STAT (immediate) delivery. In addition, if a medication is not given during the shift that it is scheduled to be given, the nurse must then pass this on to the next shift so it can be given when it arrives on the delivery ...[R1]did miss two	F 760		

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F 760	Continued From page 6 dosages of Enoxaparin [Lovenox] Sodium Solution 40 MG/0.4 ml subcutaneously one time a day. [R1] missed a dose on August 2nd and on August 3rd. August 5th she was transferred to a [ED at a hospital] and was then transferred to [another hospital from the ED]. Her admitting diagnosis to the hospital is acute ischemic cerebellar infarction, left PICA territory, mechanism: suspect paradoxical embolism and acute pulmonary embolism, recurrent ..." During an interview on 8/10/20, at 10:41 a.m. licensed practical nurse (LPN)-A stated when she went to give the Lovenox injection the morning of 8/2/20, there was no supply. LPN-A stated she ordered the Lovenox injections through the computer to the pharmacy and let registered nurse (RN)-A know it was unavailable. LPN-A stated there was a little tab to type in messages in Point Click Care that goes to the pharmacy, and said she'd sent a message to the pharmacy to send the Lovenox ASAP (as soon as possible), although no supply was available. LPN-A stated she did not check the e-kit and stated she did not call the pharmacy for a STAT order. LPN-A stated she had never called the emergency pharmacy to obtain a medication and stated she just let the nurse manager know and the nurse manger had told her the pharmacy was open on Sundays and had gone into her office. LPN-A stated she reported to evening shift that R1 did not receive the Lovenox injection because it was not available at the facility. LPN-A stated when a medication dose is ordered during the day shift ,the evening shift nurse was to try to obtain the medication. LPN-A stated R1 was on the Lovenox injections after surgery to help thin her blood. LPN-A acknowledged the concern R1	F 760		

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F 760	Continued From page 7 could develop blood clots if the Lovenox was not administered. During an interview on 8/10/20 at 11:08 a.m., registered nurse (RN)-A stated she worked in the facility on 8/2/20 providing the RN 8 hour coverage. RN-A confirmed LPN-A had reported the Lovenox medication was not available at the facility, and was going to reorder it. RN-A stated she saw LPN-A reorder the medication online through point click care. RN-A stated she knew you can order it (medications) online and stated the pharmacy sends it automatically. RN-A stated LPN-A should have called the pharmacy to get the medication ordered STAT. RN-A stated LPN-A or other med cart nurses should have ordered the Lovenox medication when they noticed the medication was running low. RN-A stated LPN-A had ordered the medication around 2:00 p.m., and stated she thought it was an evening medication administration so thought the medication would be available to give that evening. RN-A stated she was unaware the Lovenox was to be administered at 8:00 a.m. RN-A further stated R1 had a history of pulmonary embolism and blood clots. RN-A stated R1 was to get the Lovenox injections daily for several weeks. RN-A stated R1 ended up in the ER after she started to have stroke symptoms. RN-A stated on 8/5/20 in the morning, they sent R1 in because the patient herself stated she was experiencing symptoms she'd had in the past when she had a stroke. RN-A said they were notified R1 had experienced a second pulmonary embolism when they called from the hospital to give report. RN-A stated, "I am just sick about this" and stated she would have reordered the medication when the supply	F 760		

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F 760	Continued From page 8 was down to 3 or 4 doses left. RN-A stated there seemed to be a problem with staff waiting to order a medication, waiting until a resident was out of the medication, or on the weekend, and would then them come to the RN charge to let them know the medication supply was gone. RN-A stated this was not fair to the physician or the resident adding, "we need to have communication or a system needs to be implemented so medications are not missed." During an interview on 8/10/20, at 1:43 p.m. LPN-A confirmed having worked on the Friday and Saturday prior to the first missed dose and had administered the Lovenox injection. LPN-A expressed being unable to recall checking to see if the Lovenox refill had been ordered on that Friday or Saturday, and stated she did not order the refill until Sunday morning when there was no dose available to be given. LPN-A stated medications needing refills would normally be ordered a couple days in advance but she had not done that. LPN-A stated medication refills are ordered through the facility's computer system or faxed. LPN-A stated they can check the fax binder, or their computer system to see whether a medication had been ordered for refill. LPN-A stated she had not considered the missed Lovenox dose as a medication error, because it was unavailable, had been reordered and anticipated it would be delivered. LPN-A verified a blood thinner is a critical medication and stated she had communicated to the evening shift nurse that the dose was missed that morning, and a refill ordered. LPN-A said she did not call the pharmacy personally, but stated she assumed the nurse manager would have called the pharmacy. In addition, LPN-A stated she did not	F 760		

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F 760	Continued From page 9 notify the physician of the missed dose. LPN-A stated a medication error was considered if dose not given, wrong dose given, or if a medication was given to the wrong resident. LPN-A confirmed it was not expected a medication error report would be completed in this case, even though the medication was not given. LPN-A stated the pharmacy could deliver on weekends if needed. LPN-A stated although it was reported on Monday that R1 was nauseous, there had been no complaints over the weekend. During an interview on 8/10/20, at 1:18 p.m. pharmacist (P-A) stated orders for medication refills are received via fax on a refill sheet, requested over phone, or requested through the computer system. P-A stated if received through computer system or fax on a weekend, the pharmacy would not process the order until Monday. However, if the medication order was called in by phone, the pharmacy would process the refill request and send it out right away. P-A stated the pharmacy normally asked for a 3 day notification for refills, to allow time for insurance issues and medication availability. P-A stated the pharmacy would want to know before the weekend if medication was going to run out. P-A stated refill medications could be delivered the same day if there were no issues. P-A stated during weekdays there was a delivery early afternoon, and one in the evening, and on weekends there was one delivery in the evening if medications were needed. P-A stated there was an on call phone number to call after hours on the weekend. P-A stated they viewed the computer request for R1's Lovenox on Monday 8/3/20. P-A stated the request had been sent on Sunday but no one from facility had called to	F 760		

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F 760	Continued From page 10 inform the pharmacist the medication was needed that day. P-A stated it would have been delivered Sunday if the pharmacist had known it was needed. P-A stated only a 10 day supply was sent initially due to the type of insurance the resident had. P-A said it was expected the facility would notify them in advance when a refill was needed. P-A stated they would notify the facility via fax or phone if a medication was not available, or if there was an insurance issue. P-A stated they were working with their corporate office to improve the process of computer requests received on weekends as it was previously not an expectation to process computer requests on weekends. P-A acknowledged computer system requests are being used more now versus faxes or phone calls. An interview was conducted on 8/10/20 at 1:58 p.m., with R1's stroke team physician (STP). STP stated, "I will tell you we can never say 100% what caused the stroke or pulmonary embolism however, missing 1 or 2 doses significantly increased the risk. Timing of the evidence indicated the stroke and pulmonary embolism could have been from the missed doses of Lovenox after she had been clot free from sometime. I do really believe this would not likely have happened if she had received her proper Lovenox scheduled medication. Based on the imaging she had a clot in her brain and pulmonary embolism in her lungs. Multiple clots in multiple places after missing her doses of Lovenox make it highly suspicious that the missed doses caused the stroke and pulmonary embolism".	F 760		

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F 760	Continued From page 11 During an interview on 8/10/20 at 2:28 p.m., family member (FM)-A stated R1 had not been on a maintenance blood thinner prior to surgery. FM-A stated R1 had blood clots in the lungs following a previous surgery on same arm. FM-A stated the physicians had wanted to be careful and wanted R1 to be on a blood thinner. FM-A stated, apparently something happened and R1 did not receive the blood thinner for a couple of days. FM-A stated R1 was still in the hospital, and was planning to go to a rehab center within the hospital rather than returning to the facility. During an interview on 8/10/20 at 2:42 p.m., LPN-D stated they are to order refill on medications when there is 4-5 days left. LPN-D stated they order through computer system or fax. LPN-D stated they would order refills prior to the weekend. LPN-D stated they are to check computer system when medication was low to see if medication was ordered and call the pharmacy directly to order if needed. LPN-D stated there was no procedure but it was just a rule to order medications prior to running out. LPN-D stated there had not been any recent education on medication ordering. LPN-D stated a medication error would include if medications were given at wrong time, wrong dose, wrong route, or missed dose. LPN-D stated if a medication could be life threatening such as a blood thinner not being given, it would be considered a medication error. LPN-D stated they are supposed to notify the physician and complete a medication incident report if a medication error occurs. During an interview on 8/10/20, at 2:52 p.m. LPN-C defined a medication error as missed,	F 760		

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F 760	Continued From page 12	F 760		

wrong resident, wrong time, wrong dose, or wrong route. LPN-C stated they are to complete a medication error form, notify physician and were to monitor and assess the resident. LPN-C stated they were to order refills at least 5 days prior to a medication running out. LPN-C stated when she noticed less than 5 days left of a medication, she would check to make sure the medication was ordered and communicate with staff at report to watch for medication. LPN-C said if a medication was needed over the weekend or as soon as possible, they would call the pharmacy directly. LPN-C stated a missed dose of a medication was a medication error. LPN-C stated there was education on medication ordering and medication errors done upon orientation and recently a printout to read in the communication book. LPN-C stated she did not have to sign to acknowledge having read the communication, but that it was an expectation to read the communication book prior to every shift.

During an interview on 8/10/20 at 3:01 p.m., the director of nursing (DON) stated R1 was on Lovenox for the prevention of blood clots and stated it was important for her to receive the medication as ordered so she would not get blood clots. The DON stated she would have expected the staff to order the Lovenox for sure at least when it was getting down to 3 days' worth adding, "you do not want to order it when there is one left". The DON also stated she would have expected the nurse to call the pharmacy and get a STAT order when they did not have any medication available in the facility on 8/2, when the medication was not available to be given. The DON stated a medication error report should have been completed on 8/2 and 8/3/20, when

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F 760	Continued From page 13 the resident missed doses of the Lovenox. The DON further verified the physician was not notified of the missing Lovenox until a medication error report was completed on 8/5/20. The DON stated the physician should have been notified right away for that type of medication omission. The DON stated the missed doses of Lovenox were discovered through chart review and when the nurse management was notified of the missing doses. The DON stated there was not a policy and procedure to implement for ordering medications when getting low, but stated staff were checked off on ordering medications upon hire. The DON stated the facility had immediately completed education with staff following the medication errors. The DON stated they talked to the nurses involved in person and the other nurses were educated through the communication book. The DON stated they (staff) read the communication book everyday in report. The DON verified the facility did not have the nurses sign off they had read the education in the communication book, did not have a post-test, and had not completed any competencies on the education. During an interview on 8/11/20, at 9:56 a.m. LPN-B stated that Monday 8/3/20, had been her first day back to R1's hallway. LPN-B said when she noticed the blood thinner was not available to give, she checked the computer system and saw it had been reordered. LPN-B stated she did not file a medication error report, although stated a missed dose would be considered a medication error. LPN-B stated although the medication was not available at the time it was due, it had been reordered and had been expected to arrive to be able to give. LPN-B stated she did not notify the	F 760		

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physician, and stated the medication did not arrive during the day shift. LPN-B stated R1 had not changes or complaints that day. LPN-B stated she was off Tuesday and worked again on Wednesday. LPN-B stated on Wednesday 8/5/20, she was asked by an aide to assess R1 who had reported to the aide she was not feeling well. LPN-B stated it had also been reported by the overnight staff that R1 had not been feeling well. LPN-B stated she assessed R1 around 6:50 a.m. LPN-B stated staff are able to check the computer system to see what date medications were ordered and on which date it was received. LPN-B stated nurses were to call the pharmacy directly if there were any concerns. LPN-B stated they should reorder refills when a medication has 4-5 days supply left. LPN-B stated when medication had less than a few days left, they would check the computer system to assure the medication was reordered. LPN-B stated they were expected to order medications prior to a weekend, and to call pharmacy directly if a medication was needed over the weekend. LPN-B stated a medication error was considered when a medication was not given or given the wrong way. LPN-B stated they are to notify the nurse, complete a report, and call the physician if there is a medication error. LPN-B stated she did not notice the blood thinner had not been given the prior day, and should have completed a medication error report also as the blood thinner dose was missed the day she worked.

During an interview on 8/11/20 at 10:17 a.m., trained medication aide (TMA)-A stated she was to check if medication was reordered and call the pharmacy if a medication had not been received or was needed. TMA-A stated that there was a

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blue section on the medication cards that indicated when to reorder. TMA-A stated there was not a process for checking medications that were low in supply.

During a follow-up interview on 8/11/20 at 10:55 a.m., the DON stated that there was no specific process for reordering medications, but the nurses were to assess for need to order medications prior to administration. The DON stated staff were to reorder medications via fax, computer system or to call pharmacy directly if medication was needed immediately. The DON stated if a medication was out and was needed immediately the nurse was to call the pharmacy directly to order. The DON acknowledged that if a medication, including an as needed medication, was needed by a resident but not available, the resident would have to wait until it was delivered by pharmacy to receive it, which could be hours or the next day.

The facility's Medication Error Reporting policy last updated 1/22/15, indicated following a medication error the resident should be monitored, a medication error report completed, and notification should be made to the resident's family, physician, and the Department of Health. The policy did not include a definition of a medication error. According to record review and interviews, a medication error report was not completed nor was notification given.

The Pharmacy Services Agreement dated 6/16/17, indicated in the reorder schedule that Thrifty White would work with the director of nursing to establish a re-order schedule that would allow the pharmacy adequate time to

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F 760	Continued From page 16 process refill orders. The agreement also indicated refill orders would be delivered Monday through Friday with a two day turnaround time; Refills ordered on weekends would be delivered with the scheduled delivery on Monday; and in order to reduce the chance for errors, all refill orders should be faxed to the pharmacy on the Thrifty White Reorder Form. The Thrifty White Pharmacy contact and hour of operation undated information, provided by the pharmacy and posted in medication room, included: All new orders must have the original order faxed to the pharmacy; Please fax refill orders to the pharmacy using the Pharmacy Refill Form and reorder labels; Please do not put new orders on the reorder form; Please fax refill orders to the pharmacy by Noon Monday through Friday for same day delivery; and Refill orders faxed to the pharmacy after Noon will be delivered the next business day The Prairie Manor Care Center 28 day cycle fill In-Service undated, included the following: -Any medications not included in the cycle fill must be reordered by nursing. These labels will have a reorder tab for this purpose. This will include the following medications: routinely administered medications dispensed in the manufacturers original packaging, non-formulary over the counter medications, warfarin/Coumadin/Jantoven will not be included in the cycle fill, ODT formulations, all PRN medications, all schedule II-V controlled medications, all unit of use medications (eye drops, inhalers, liquids, powders, ointments, creams). -New orders: fax the original order to pharmacy,	F 760		

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F 760	Continued From page 17 for a stat order or emergency medication to fax the order to the pharmacy and follow up with a phone call to alert the pharmacy. -Refills: peel off the reorder tab and place on refill order form and fax to pharmacy, recommended that medications are reordered when there is a 3-5 day supply left to allow for any clarifications or needed prescription renewals (5-7 days for narcotics). -Discontinued and changed orders should be pulled from the exchange. The immediate jeopardy that began on 8/2/20, was removed on 8/11/20, when the facility's removal plan could be verified through interview and document review, to include training with the pharmacy, staff education on when to order medications timely, staff education for when to complete a medication error report, and the facility had developed a policy and procedure for medication reordering and trained staff on it.	F 760		

Electronically delivered
August 28, 2020

Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

Re: State Nursing Home Licensing Orders
Event ID: S0X411

Dear Administrator:

The above facility was surveyed on August 10, 2020 through August 11, 2020 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:

Jennifer Kolsrud Brown, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: 507-206-2727

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.

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00650	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

(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	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: A complaint investigation was conducted on 8/10/20 and 8/11/20, to investigate complaint H5482028C. As a result the following was identified: The complaint was found to be substantiated: H5482028C with licensing orders issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the	21545		8/14/20

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21545	Continued From page 2 physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a system to avoid significant medication errors of omission. The facility failed to ensure an adequate system for was in place to assure medications were reordered in a timely manner to be available for administration in accordance with physician orders for 1 of 1 resident (R1). The facility's omission of Lovenox injections (an anticoagulation medication, which helps prevent blood clots from forming) resulted in an immediate jeopardy (IJ) level significant medication error when R1 sustained a stoke and pulmonary embolism (PE). The IJ began on 8/2/20, when a physician prescribed order for daily injection of Lovenox was not available in the facility to be administered. R1 did not receive the prescribed Lovenox injection on either 8/2 or 8/3/20. After missing these 2 doses, on 8/4/20, R1 started	21545	Our plan of correction that was stated in our IJ removal letter is as follow... It was identified by the survey team, and validated by Prairie Manor, that the lack of action from our facility may have contributed to the hospitalization of a resident in our care. Specifically lack of action when it came to the reordering and administering of a prescription drug. If staff here are uneducated on the policies & procedures surrounding medications this poses a plausible risk to all residents here. To extinguish the possibility of a scenario like this happening again, Prairie Manor will do the following education to all staff that are involved with medications (LPN□s, RN□s, Med Aides)& "Retraining on the pharmacy□s recommendation to reorder medication when there is a 3-5 day supply left, or 5-7 for narcotics.	

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21545	Continued From page 3 feeling sick with nausea and vomiting. On 8/5/20, R1 self-reported she was having symptoms of feeling dizzy, headache, and had a small emesis/phlegm which R1 described as symptoms she'd experienced during a previous stroke. R1 was transferred to the emergency room (ER) and was subsequently hospitalized for stroke and pulmonary embolism on 8/5/20. The facility administrator and director of nursing (DON) were notified of the IJ on 8/10/20, at 4:45 p.m. The IJ was removed on 8/11/20, when the facility had implemented an appropriate removal plan. However, non-compliance remained at an isolated scope of actual harm that is not immediate jeopardy (Level G). Findings include: R1's admission Minimum Data Set (MDS) assessment dated 7/29/20, identified R1 as having intact cognition and requiring extensive assistance with activities of daily living (ADLs). The MDS also indicated R1 received anticoagulation medication during the 7 day assessment review period. R1's admission record indicated R1 had a history of transient ischemic attack (TIA), cerebral infarction (stroke) without residual deficits, and history of pulmonary embolism. R1's care plan included, "Resident is currently on anticoagulation therapy related to: history of pulmonary embolism." Interventions: Administered anticoagulation medications per MD [medical doctor] orders." R1's physician orders included, "Enoxaparin [Lovenox] Sodium Solution 40 MG/0.4ML Inject 0.4 ml subcutaneously (SQ) one time a day	21545	"Education on who is responsible for reordering medications. (Any LPN or RN who discovers it is less than 3 day supply or 5 for narcotics.) "Education on the specific incident that resulted in this Immediate Jeopardy. "When a med error is a VA and how the VA process should be carried out. "The med error process as far as notifying superiors and pharmacy, proper charting and paper trails of an incident. Education will be conducted by the assistant director of nursing, director of nursing, or designee. Education will be completed before any LPN, RN, or Med Aide starts their next shift. To help ensure this we will attempt to call all employees involved and speak with them before they next enter the building. If this is not possible ADON, DON, or designee will stop each applicable employee to train them before they start their shift and begin resident interactions. All applicable staff can be reached and educated by 08/12/2020. ADON, DON, or designee will examine medication cart by 08/11/2020 to ensure that no other prescription drugs have less than a 3-day supply, and that no medications on the MAR have been missed recently. This will solidify that all residents are officially not in an immediate jeopardy of having medications non-accessible or missed. They will also create a cumulative medication reordering policy that elaborates on who should reorder, how to reorder, what to do if no medication is available, who to tell, etc. New policy will be created by 08/14/2020	

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21545	Continued From page 4 related to PERSONAL HISTORY OF PULMONARY EMBOLISM (Z86.711) for 28 Days. R1's medication treatment record indicated R1 did not receive the Enoxaparin [Lovenox]Sodium injections per the physician order on 8/2 or 8/3/20. R1's medication error report (MER) dated 8/5/20 indicated errors were made on 8/2 and 8/3/20. The MER indicated the nurse practitioner was made aware of the errors on 8/5/20, at 4:45 p.m. Medication as ordered Enoxaparin [Lovenox]40 mg/0.4 ml- inject 0.4 ml SQ daily r/t (related to) hx (history) of pulmonary embolism. Description of the error: Two doses not given on 8/2 and 8/3/20. Outcome to the resident: Stroke and PE (pulmonary embolism). Resident sent to ER. Corrective action taken: Re-education of all nurses on reordering supply, what to do if no supply, notification to pharmacy for STAT delivery. Measures taken to prevent reoccurrence of similar error(s): Discussed with pharmacy, process for sending partial supply of orders. R1's record revealed there was no notification to the physician or medication error reports completed on 8/2 or 8/3/20 when the facility initially had not administered the Lovenox. R1's nursing progress notes were reviewed and included: -8/3/20 at 8:24 a.m., Enoxaparin [Lovenox] Sodium Solution 40 MG/0.4ML Inject 0.4 ml subcutaneously one time a day related to PERSONAL HISTORY OF PULMONARY EMBOLISM (Z86.711) for 28 Days "No supply"	21545	and dispersed to applicable staff. Resident discharged from us before ever returning. No assessment or care plan alteration could be done	

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21545	Continued From page 5 -8/5/20 at 6:17 a.m., "Resident experienced nausea this morning. No emesis. She also stated that she wants to see the nurse manager this morning. She wants to know if she is going to have a stroke because she has hard {sik} it before 2010. VS (vital signs) were taken. At this time, no s/s (signs or symptoms) of stroke. Incoming shift and wing nurse notified to monitor resident. Charge nurse will be informed as soon as she comes in to go and check/reassess resident. -8/5/20 at 7:17 a.m., "Ambulance was called at 6:54 a.m. and they left with her at 7:17 a.m.. In route to [emergency department], husband will meet her there." Review of R1's neuro ICU (intensive care unit) admission note dated 8/5/20 included, "Chief Complaint: Stroke History of Present Illness: [R1] is a 70 y.o. (year old) right-handed female with a history significant for prior strokes, type 2 diabetes mellitus, hyperlipidemia, past history of PE (pulmonary embolis 2018, provoked), obesity, recent humorous fracture repair s/p (status post) internal fixation and debridement (July 2020) who presents to the neurological ICU with subacute cerebellar infarct (stroke) ...Although she had no focal neurological deficits in the ED (emergency department) given concern for headache reported by patient, she underwent a CT (cat scan) of the head/neck (per outside documentation). This imaging showed likely subacute appearing infarcts in the L>R cerebellum, bilateral parietal lobes. CT abdominal pelvis was obtained given concerns for emesis and possible infection, which identified right lower lobe sub segmental PE which was	21545		

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21545	Continued From page 6 further confirmed on dedicated CT PE study. Given concerns for subacute cerebrallar infarct, PE and elevated baseline troponin ...patient was transferred [to this hospital] for further management... Patient reports that she was instructed to continue Lovenox injections after discharge from Orthopedics in late July for at least 30 days. Which she was initially getting however, for the last 3 or 4 days the facility told her they had run out and she has not been receiving them ..." The facility's investigative report sent to the State Agency (SA) 8/7/20, included, "In investigation of the medication error there was found to be two issues. One issue was with nursing not following the process for when a medication supply is low and how the med error occurred, and one issue with the pharmacy not delivering medications in a timely manner when ordered. Both of the nurses involved with the medication error have received a corrective action. All the nurses have been re-educated that when supply of any medication is starting to get low, it is to be re-ordered right away and a call is to be placed to the pharmacy if we don't have the ordered medication at the time it is scheduled to be given. If the medication is not available in our E-Kit (emergency kit), the pharmacy will need to be called and complete a STAT (immediate) delivery. In addition, if a medication is not given during the shift that it is scheduled to be given, the nurse must then pass this on to the next shift so it can be given when it arrives on the delivery ...[R1]did miss two dosages of Enoxaparin [Lovenox] Sodium Solution 40 MG/0.4 ml subcutaneously one time a day. [R1] missed a dose on August 2nd and on August 3rd. August 5th she was transferred to a [ED at a hospital] and was then transferred to	21545		

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21545	Continued From page 7 [another hospital from the ED]. Her admitting diagnosis to the hospital is acute ischemic cerebellar infarction, left PICA territory, mechanism: suspect paradoxical embolism and acute pulmonary embolism, recurrent ..." During an interview on 8/10/20, at 10:41 a.m. licensed practical nurse (LPN)-A stated when she went to give the Lovenox injection the morning of 8/2/20, there was no supply. LPN-A stated she ordered the Lovenox injections through the computer to the pharmacy and let registered nurse (RN)-A know it was unavailable. LPN-A stated there was a little tab to type in messages in Point Click Care that goes to the pharmacy, and said she'd sent a message to the pharmacy to send the Lovenox ASAP (as soon as possible), although no supply was available. LPN-A stated she did not check the e-kit and stated she did not call the pharmacy for a STAT order. LPN-A stated she had never called the emergency pharmacy to obtain a medication and stated she just let the nurse manager know and the nurse manger had told her the pharmacy was open on Sundays and had gone into her office. LPN-A stated she reported to evening shift that R1 did not receive the Lovenox injection because it was not available at the facility. LPN-A stated when a medication dose is ordered during the day shift ,the evening shift nurse was to try to obtain the medication. LPN-A stated R1 was on the Lovenox injections after surgery to help thin her blood. LPN-A acknowledged the concern R1 could develop blood clots if the Lovenox was not administered. During an interview on 8/10/20 at 11:08 a.m., registered nurse (RN)-A stated she worked in the facility on 8/2/20 providing the RN 8 hour	21545		

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coverage. RN-A confirmed LPN-A had reported the Lovenox medication was not available at the facility, and was going to reorder it. RN-A stated she saw LPN-A reorder the medication online through point click care. RN-A stated she knew you can order it (medications) online and stated the pharmacy sends it automatically. RN-A stated LPN-A should have called the pharmacy to get the medication ordered STAT. RN-A stated LPN-A or other med cart nurses should have ordered the Lovenox medication when they noticed the medication was running low. RN-A stated LPN-A had ordered the medication around 2:00 p.m., and stated she thought it was an evening medication administration so thought the medication would be available to give that evening. RN-A stated she was unaware the Lovenox was to be administered at 8:00 a.m. RN-A further stated R1 had a history of pulmonary embolism and blood clots. RN-A stated R1 was to get the Lovenox injections daily for several weeks. RN-A stated R1 ended up in the ER after she started to have stroke symptoms. RN-A stated on 8/5/20 in the morning, they sent R1 in because the patient herself stated she was experiencing symptoms she'd had in the past when she had a stroke. RN-A said they were notified R1 had experienced a second pulmonary embolism when they called from the hospital to give report. RN-A stated, "I am just sick about this" and stated she would have reordered the medication when the supply was down to 3 or 4 doses left. RN-A stated there seemed to be a problem with staff waiting to order a medication, waiting until a resident was out of the medication, or on the weekend, and would then them come to the RN charge to let them know the medication supply was gone. RN-A stated this was not fair to the physician or

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the resident adding, "we need to have communication or a system needs to be implemented so medications are not missed."

During an interview on 8/10/20, at 1:43 p.m. LPN-A confirmed having worked on the Friday and Saturday prior to the first missed dose and had administered the Lovenox injection. LPN-A expressed being unable to recall checking to see if the Lovenox refill had been ordered on that Friday or Saturday, and stated she did not order the refill until Sunday morning when there was no dose available to be given. LPN-A stated medications needing refills would normally be ordered a couple days in advance but she had not done that. LPN-A stated medication refills are ordered through the facility's computer system or faxed. LPN-A stated they can check the fax binder, or their computer system to see whether a medication had been ordered for refill. LPN-A stated she had not considered the missed Lovenox dose as a medication error, because it was unavailable, had been reordered and anticipated it would be delivered. LPN-A verified a blood thinner is a critical medication and stated she had communicated to the evening shift nurse that the dose was missed that morning, and a refill ordered. LPN-A said she did not call the pharmacy personally, but stated she assumed the nurse manager would have called the pharmacy. In addition, LPN-A stated she did not notify the physician of the missed dose. LPN-A stated a medication error was considered if dose not given, wrong dose given, or if a medication was given to the wrong resident. LPN-A confirmed it was not expected a medication error report would be completed in this case, even though the medication was not given. LPN-A stated the pharmacy could deliver on weekends if

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needed. LPN-A stated although it was reported on Monday that R1 was nauseous, there had been no complaints over the weekend.

During an interview on 8/10/20, at 1:18 p.m. pharmacist (P-A) stated orders for medication refills are received via fax on a refill sheet, requested over phone, or requested through the computer system. P-A stated if received through computer system or fax on a weekend, the pharmacy would not process the order until Monday. However, if the medication order was called in by phone, the pharmacy would process the refill request and send it out right away. P-A stated the pharmacy normally asked for a 3 day notification for refills, to allow time for insurance issues and medication availability. P-A stated the pharmacy would want to know before the weekend if medication was going to run out. P-A stated refill medications could be delivered the same day if there were no issues. P-A stated during weekdays there was a delivery early afternoon, and one in the evening, and on weekends there was one delivery in the evening if medications were needed. P-A stated there was an on call phone number to call after hours on the weekend. P-A stated they viewed the computer request for R1's Lovenox on Monday 8/3/20. P-A stated the request had been sent on Sunday but no one from facility had called to inform the pharmacist the medication was needed that day. P-A stated it would have been delivered Sunday if the pharmacist had known it was needed. P-A stated only a 10 day supply was sent initially due to the type of insurance the resident had. P-A said it was expected the facility would notify them in advance when a refill was needed. P-A stated they would notify the facility via fax or phone if a medication was not

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available, or if there was an insurance issue. P-A stated they were working with their corporate office to improve the process of computer requests received on weekends as it was previously not an expectation to process computer requests on weekends. P-A acknowledged computer system requests are being used more now versus faxes or phone calls.

An interview was conducted on 8/10/20 at 1:58 p.m., with R1's stroke team physician (STP). STP stated, "I will tell you we can never say 100% what caused the stroke or pulmonary embolism however, missing 1 or 2 doses significantly increased the risk. Timing of the evidence indicated the stroke and pulmonary embolism could have been from the missed doses of Lovenox after she had been clot free from sometime. I do really believe this would not likely have happened if she had received her proper Lovenox scheduled medication. Based on the imaging she had a clot in her brain and pulmonary embolism in her lungs. Multiple clots in multiple places after missing her doses of Lovenox make it highly suspicious that the missed doses caused the stroke and pulmonary embolism".

During an interview on 8/10/20 at 2:28 p.m., family member (FM)-A stated R1 had not been on a maintenance blood thinner prior to surgery. FM-A stated R1 had blood clots in the lungs following a previous surgery on same arm. FM-A stated the physicians had wanted to be careful and wanted R1 to be on a blood thinner. FM-A stated, apparently something happened and R1 did not receive the blood thinner for a couple of days. FM-A stated R1 was still in the hospital,

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21545	Continued From page 12 and was planning to go to a rehab center within the hospital rather than returning to the facility. During an interview on 8/10/20 at 2:42 p.m., LPN-D stated they are to order refill on medications when there is 4-5 days left. LPN-D stated they order through computer system or fax. LPN-D stated they would order refills prior to the weekend. LPN-D stated they are to check computer system when medication was low to see if medication was ordered and call the pharmacy directly to order if needed. LPN-D stated there was no procedure but it was just a rule to order medications prior to running out. LPN-D stated there had not been any recent education on medication ordering. LPN-D stated a medication error would include if medications were given at wrong time, wrong dose, wrong route, or missed dose. LPN-D stated if a medication could be life threatening such as a blood thinner not being given, it would be considered a medication error. LPN-D stated they are supposed to notify the physician and complete a medication incident report if a medication error occurs. During an interview on 8/10/20, at 2:52 p.m. LPN-C defined a medication error as missed, wrong resident, wrong time, wrong dose, or wrong route. LPN-C stated they are to complete a medication error form, notify physician and were to monitor and assess the resident. LPN-C stated they were to order refills at least 5 days prior to a medication running out. LPN-C stated when she noticed less than 5 days left of a medication, she would check to make sure the medication was ordered and communicate with staff at report to watch for medication. LPN-C said if a medication was needed over the	21545		

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21545	Continued From page 13 weekend or as soon as possible, they would call the pharmacy directly. LPN-C stated a missed dose of a medication was a medication error. LPN-C stated there was education on medication ordering and medication errors done upon orientation and recently a printout to read in the communication book. LPN-C stated she did not have to sign to acknowledge having read the communication, but that it was an expectation to read the communication book prior to every shift. During an interview on 8/10/20 at 3:01 p.m., the director of nursing (DON) stated R1 was on Lovenox for the prevention of blood clots and stated it was important for her to receive the medication as ordered so she would not get blood clots. The DON stated she would have expected the staff to order the Lovenox for sure at least when it was getting down to 3 days' worth adding, "you do not want to order it when there is one left". The DON also stated she would have expected the nurse to call the pharmacy and get a STAT order when they did not have any medication available in the facility on 8/2, when the medication was not available to be given. The DON stated a medication error report should have been completed on 8/2 and 8/3/20, when the resident missed doses of the Lovenox. The DON further verified the physician was not notified of the missing Lovenox until a medication error report was completed on 8/5/20. The DON stated the physician should have been notified right away for that type of medication omission. The DON stated the missed doses of Lovenox were discovered through chart review and when the nurse management was notified of the missing doses. The DON stated there was not a policy and procedure to implement for ordering medications when getting low, but stated staff	21545		

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21545	Continued From page 14 were checked off on ordering medications upon hire. The DON stated the facility had immediately completed education with staff following the medication errors. The DON stated they talked to the nurses involved in person and the other nurses were educated through the communication book. The DON stated they (staff) read the communication book everyday in report. The DON verified the facility did not have the nurses sign off they had read the education in the communication book, did not have a post-test, and had not completed any competencies on the education. During an interview on 8/11/20, at 9:56 a.m. LPN-B stated that Monday 8/3/20, had been her first day back to R1's hallway. LPN-B said when she noticed the blood thinner was not available to give, she checked the computer system and saw it had been reordered. LPN-B stated she did not file a medication error report, although stated a missed dose would be considered a medication error. LPN-B stated although the medication was not available at the time it was due, it had been reordered and had been expected to arrive to be able to give. LPN-B stated she did not notify the physician, and stated the medication did not arrive during the day shift. LPN-B stated R1 had not changes or complaints that day. LPN-B stated she was off Tuesday and worked again on Wednesday. LPN-B stated on Wednesday 8/5/20, she was asked by an aide to assess R1 who had reported to the aide she was not feeling well. LPN-B stated it had also been reported by the overnight staff that R1 had not been feeling well. LPN-B stated she assessed R1 around 6:50 a.m. LPN-B stated staff are able to check the computer system to see what date medications were ordered and on which date it was received.	21545		

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21545	Continued From page 15 LPN-B stated nurses were to call the pharmacy directly if there were any concerns. LPN-B stated they should reorder refills when a medication has 4-5 days supply left. LPN-B stated when medication had less than a few days left, they would check the computer system to assure the medication was reordered. LPN-B stated they were expected to order medications prior to a weekend, and to call pharmacy directly if a medication was needed over the weekend. LPN-B stated a medication error was considered when a medication was not given or given the wrong way. LPN-B stated they are to notify the nurse, complete a report, and call the physician if there is a medication error. LPN-B stated she did not notice the blood thinner had not been given the prior day, and should have completed a medication error report also as the blood thinner dose was missed the day she worked. During an interview on 8/11/20 at 10:17 a.m., trained medication aide (TMA)-A stated she was to check if medication was reordered and call the pharmacy if a medication had not been received or was needed. TMA-A stated that there was a blue section on the medication cards that indicated when to reorder. TMA-A stated there was not a process for checking medications that were low in supply. During a follow-up interview on 8/11/20 at 10:55 a.m., the DON stated that there was no specific process for reordering medications, but the nurses were to assess for need to order medications prior to administration. The DON stated staff were to reorder medications via fax, computer system or to call pharmacy directly if medication was needed immediately. The DON stated if a medication was out and was needed	21545		

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immediately the nurse was to call the pharmacy directly to order. The DON acknowledged that if a medication, including an as needed medication, was needed by a resident but not available, the resident would have to wait until it was delivered by pharmacy to receive it, which could be hours or the next day.

The facility's Medication Error Reporting policy last updated 1/22/15, indicated following a medication error the resident should be monitored, a medication error report completed, and notification should be made to the resident's family, physician, and the Department of Health. The policy did not include a definition of a medication error. According to record review and interviews, a medication error report was not completed nor was notification given.

The Pharmacy Services Agreement dated 6/16/17, indicated in the reorder schedule that Thrifty White would work with the director of nursing to establish a re-order schedule that would allow the pharmacy adequate time to process refill orders. The agreement also indicated refill orders would be delivered Monday through Friday with a two day turnaround time; Refills ordered on weekends would be delivered with the scheduled delivery on Monday; and in order to reduce the chance for errors, all refill orders should be faxed to the pharmacy on the Thrifty White Reorder Form.

The Thrifty White Pharmacy contact and hour of operation undated information, provided by the pharmacy and posted in medication room, included: All new orders must have the original order faxed to the pharmacy; Please fax refill orders to the pharmacy using the Pharmacy Refill

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21545	Continued From page 17 Form and reorder labels; Please do not put new orders on the reorder form; Please fax refill orders to the pharmacy by Noon Monday through Friday for same day delivery; and Refill orders faxed to the pharmacy after Noon will be delivered the next business day The Prairie Manor Care Center 28 day cycle fill In-Service undated, included the following: -Any medications not included in the cycle fill must be reordered by nursing. These labels will have a reorder tab for this purpose. This will include the following medications: routinely administered medications dispensed in the manufacturers original packaging, non-formulary over the counter medications, warfarin/Coumadin/Jantoven will not be included in the cycle fill, ODT formulations, all PRN medications, all schedule II-V controlled medications, all unit of use medications (eye drops, inhalers, liquids, powders, ointments, creams). -New orders: fax the original order to pharmacy, for a stat order or emergency medication to fax the order to the pharmacy and follow up with a phone call to alert the pharmacy. -Refills: peel off the reorder tab and place on refill order form and fax to pharmacy, recommended that medications are reordered when there is a 3-5 day supply left to allow for any clarifications or needed prescription renewals (5-7 days for narcotics). -Discontinued and changed orders should be pulled from the exchange. The immediate jeopardy that began on 8/2/20, was removed on 8/11/20, when the facility's removal plan could be verified through interview and document review, to include training with the	21545		

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21545	Continued From page 18 pharmacy, staff education on when to order medications timely, staff education for when to complete a medication error report, and the facility had developed a policy and procedure for medication reordering and trained staff on it. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were ordered timely and administered correctly. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21545		