Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 18, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

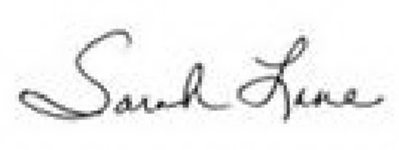
RE: CCN: 245537
Cycle Start Date: January 16, 2025

Dear Administrator:

On February 14, 2025, 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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 18, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

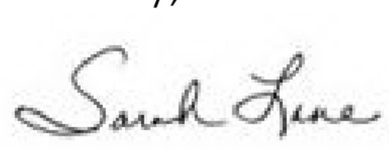
Re: Reinspection Results
Event ID: 174712

Dear Administrator:

On February 14, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 16, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 28, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

RE: CCN: 245537
Cycle Start Date: January 16, 2025

Dear Administrator:

On January 16, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 April 16, 2025 (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 July 16, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

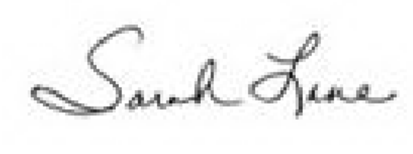
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments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

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 28, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

Re: State Nursing Home Licensing Orders
Event ID: 174711

Dear Administrator:

The above facility was surveyed on January 15, 2025 through January 16, 2025 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.

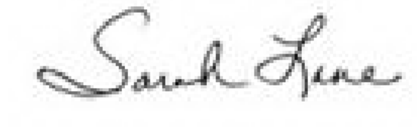
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET STARBUCK, MN 56381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/15/25 through 1/16/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55374522C (MN00109706) with a deficiency cited at F760. H55373921C (MN00109477) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 760 SS=D	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 ensure 1 of 1 resident (R2) reviewed for medication errors was free of significant medication errors when orders for	F 760	Tag F760 Preparation and/or execution of this plan does not constitute admission or agreement by the	2/6/25

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

Electronically Signed | 02/04/2025

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

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F 760	Continued From page 1 Warfarin (Coumadin) (a blood thinner used to reduce the risk of blood clots), was not transcribed into the electronic medical record according to physician's orders and resulted in six missed doses of Warfarin 5 milligrams (mg). Findings include: R2's telehealth visit with cardiologist on 11/20/24, identified stop Amiodarone (used to treat and prevent a number of types of irregular heartbeats) and Eliquis (used to prevent stroke and blood clots in patients with certain heart rhythm problem such as atrial fibrillation (A-fib) (an irregular and often very rapid heart rhythm and can lead to blood clots in the heart, increases the risk of stroke, heart failure, and other heart related complications), start taking Warfarin (Coumadin) 5 mg oral tablet daily according to the international normalized ratio (INR) (used to measure how long it took for blood to clot). R2's progress noted 11/20/24 at 6:58 p.m. R2 was seen by cardiology via telehealth today. Orders: stop Amiodarone and switch Eliquis to Coumadin 5 mg oral tablet daily, and then according to INR levels. Will clarify which clinic the results will go to and when INR checks to start. The communication documents with the Coagulation Clinic, INR nurse from 11/25/24 through 11/29/24 identified the following orders: -11/25/24, R2's finger stick INR result was 1.2 seconds with a therapeutic INR level while on warfarin 2 to 3 seconds. Current order began on 11/21/24, Coumadin 5 mg daily. Next INR scheduled for 11/29/24. Physician order: continue	F 760	provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. facility failed to ensure 1 of 1 resident (R2) reviewed for medication errors was free of significant medication errors when orders for Warfarin (Coumadin) (a blood thinner used to reduce the risk of blood clots), was not transcribed into the electronic medical record according to physician's orders and resulted in six missed doses of Warfarin 5 milligrams (mg). Corrective actions include: 1 Resident R2 received immediate medical evaluation upon discovery of the missed Warfarin doses. The resident's physician was notified, and a new care plan was developed to address the missed medication. 2 The resident's electronic medical record was updated to reflect the correct medication orders, and the resident was monitored closely for any adverse effects due to the missed doses. Actions to Identify Other Potentially Affected Residents 3 A comprehensive review of all residents' medication records will be conducted to identify any	

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F 760	Continued From page 2 5 mg by mouth (po) daily. Note: aware had only taken four doses to date. -11/29/24, R2's finger stick INR result was 2.4 seconds. Current order: Coumadin 5 mg daily. Next INR was scheduled for 12/5/24. Physician order: continue Coumadin 5 mg po daily. R2's primary provider medical doctor (MD) visit on 12/5/24, identified diagnoses: history congestive heart failure (CHF), diabetes mellitus (DM) insulin dependent with chronic kidney disease, atherosclerotic heart disease (buildup of fats, cholesterol and other substances in the artery of the walls called plague and can cause the arteries to narrow, blocking blood flow to organs and tissues), morbid obesity, chronic anticoagulation, deep vein thrombosis (blood clot) in lower extremities, A-fib, inferior vena cava (IVC) (big vein in the abdomen) filter (inserted into the IVC to catch/trap a traveling clot and prevent it from reaching the lung). She was started on Warfarin and a referral was placed to the INR clinic. INR was therapeutic with last check 2.4 on 11/9/24 [sic]. The communication documents with the Coagulation Clinic, INR nurse from 12/5/24 through 12/9/24 identified the following orders: -12/5/24, R2's finger stick INR result was 4.8 seconds. Current order: Coumadin 5 mg daily. Next INR was scheduled for 12/9/24. Physician order: hold today; 2.5 mg on 12/6/24 and 5.0 mg on 12/7/24 and 12/8/24. -12/9/24, R2's finger stick INR result was 2.9 seconds. Current order: Coumadin 5 mg daily. Next INR was scheduled for 12/16/24. Physician	F 760	other individuals potentially affected by transcription errors. 4 This review will include: • An audit of all current medication orders against the electronic medical records. • Verification of transcription accuracy for all residents receiving critical medications such as anticoagulants. Measures to Ensure the Deficient Practice Does Not Recur 5 Staff Education and Training: All nursing staff will receive training on medication transcription protocols and the importance of accurate documentation by 02/06/2025. 6 Policy Review and Revision: Policies and procedures related to medication transcription and verification have been reviewed and revised to align with best practices and regulatory standards. Monitoring to Ensure Effective Implementation of Actions 7 The Director of Nursing or designee will audit 20% of resident medication charts weekly for the next three months to ensure compliance with accurate medication transcription. 8 Results of these audits will be reviewed during the monthly QAPI (Quality Assurance and Performance Improvement) committee meetings. 9 The QAPI committee will assess the audit outcomes and decide if further monitoring or audits are required. Person Responsible to Maintain Compliance	

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F 760	Continued From page 3 order: 2.5 mg on Mondays, Wednesdays, and Friday and 5 mg all other days. R2's December 2023 EMAR indicated: Warfarin 2.5. mg po in the evening on Monday, Wednesday, and Friday related to atrial fibrillation. Start date 12/9/24 at 6:00 p.m. and discontinue date 12/24/24 at 7:56 a.m., was administered on 12/9/24, 12/11/24, 12/13/24, 12/16/24, 12/18/24, 12/20/24, and 12/23/24. R2's December 2023 EMAR indicated: Warfarin 5 mg po in the evening on Tuesday, Thursday, Saturday, and Sunday for treating/preventing blood clots for two administrations. Start date 12/10/24 at 6:00 p.m. and discontinue date 12/24/24 at 5:46 p.m. Staff administered 5 mg on 12/10/24 and 12/12/24. On 12/10/24 the order for Warfarin 5 mg was transcribed inappropriately and entered on the EMAR as two administrations only. R2 did not receive Warfarin 5 mg dose as ordered on 12/14/24, 12/15/24, 12/17/24, 12/19/24, 12/21/24, and 12/22/24 (6 doses). The communication documents with the Coagulation Clinic, INR nurse from 12/16/24 through 1/14/25 identified the following orders: -12/16/24, R2's finger stick INR result was 2.3 seconds. Current order: Coumadin 5 mg Tuesday, Thursday, Saturday, Sunday, and 2.5 mg other days. Next INR scheduled: left blank. Physician order: Coumadin 5 mg po Tuesday, Wednesday, Thursday, and Saturday and Sunday; 2.5 mg Monday, Wednesday, and Friday.	F 760	The Director of Nursing or designee will oversee the implementation and ongoing compliance efforts related to this Plan of Correction. All corrective actions will be completed by 02/06/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 760	Continued From page 4 -12/24/24, R2's finger stick INR result was 1.2 seconds. Current order: 2.5 mg Monday, Wednesday, Friday, and 5 mg all other days. Next INR 12/31/24. Coumadin order: 5 mg tonight and 2.5 mg all other days. Handwritten on bottom of this document by INR clinic nurse was: 12/24/24 at 10:12 a.m. telephone call to staff nurse and upon looking at patient's medication list and EMAR, R2 had not received Coumadin 5 mg since 12/12/24, only the 2.5 mg dose Monday, Wednesday, Friday since then. Dosing of coumadin based on cumulative doses received. -R2's anticoagulant flow sheet dated 12/24/24 identified dosing plan for the week fax received from facility with INR 1.2 today. Telephone call (TC) to facility and checked on any changes or missed doses. Reported she had been getting 2.5 mg on Monday, Wednesday, and Friday but looks like she had not received Coumadin 5 mg tabs since 12/12/24. R2's order was placed wrong in computer, instead of ordered cumulative weekly dose of 27.5 mg she received 22.5 mg the week of 12/8/24 and only 7.5 mg the week of 12/15/24. Will have R2 take 5 mg tonight and then 2.5 mg daily and recheck INR in one week. Orders faxed to facility and pharmacy. -12/31/24, Diagnosis: A-fib. INR result today 1.4 seconds (goal 2 to 3). Dose increase by 12.5 %. Change coumadin dose: 5 mg po Thursday and Saturday and 2.5 mg Sunday, Monday, Wednesday, Thursday, and Friday. Recheck INR 1/7/25 (one week). -1/2/2025 10:05 a.m. R2's progress notes identified, Pharmacist Note: Medications and chart reviewed for monthly medication regimen review (MR) (a thorough evaluation of the	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET STARBUCK, MN 56381

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F 760	Continued From page 5 medication regimen by a pharmacist, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication). No medication irregularities noted at this time. -1/7/25, R2's INR result today 1.6. Change coumadin dose to 5 mg Tuesday, Thursday, Saturday then 2.5 mg on Sunday, Monday, Wednesday, and Friday. Recheck INR on 1/14/25. -1/14/25, R2's INR result today 1.6. Increase dose by 10%. Change coumadin 5 mg po Sunday, Tuesday, Thursday, and Saturday; 2.5 mg Monday, Wednesday, and Friday. Recheck INR on 1/21/25. During an interview on 1/15/25 at 1:55 p.m. R2 stated she had a history of blood clots found in her legs, traveled to her lungs, and a filter was placed in her inferior vena cava. R2's last visit with her cardiologist was December 2024 and she had requested to be taken off Eliquis due to cost and placed on coumadin. She was started on Coumadin 5 mg with a therapeutic goal of INR between two and three and thought she had not received the correct doses of Coumadin. She stated the INR had been checked on Tuesdays and the result of the last one was below 2.0. She was concerned no adjustment had been made on the Coumadin dose and was afraid she was at an increased risk for another blood clot. During an interview on 1/16/25 at 11:30 a.m. medical doctor/medical director (MD) stated the INR clinic nurse helped manage R2's dosing of coumadin and she had written a note on 12/24/24 order form: R2 had not received her	F 760		

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	245537	A. BUILDING _____ B. WING _____	C 01/16/2025

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F 760	Continued From page 6 Coumadin for days due to the wrong order was placed in the computer. He would have expected staff to notify him right away, was out of the office on 12/24/24, and unsure when they discovered the transcription error. MD stated R2's missed doses of Coumadin contributed to a drop in her INR from 2.9 to 1.2, would have been considered subtherapeutic, and placed R2 at an increased risk for blood clots. During an interview on 1/16/25 at 1:45 p.m. registered nurse (RN) stated on 12/9/24, R2 had and INR of 2.9 and she had transcribed and signed off R2's orders for Coumadin 2.5 mg Monday, Wednesday, and Friday and 5 mg Tuesday, Thursday, Saturday, and Sunday. On 12/24/24 R2's INR had dropped to 1.2. She reviewed R2's December EMAR and noticed a transcription error, unsure why it had taken until 12/24/24 to realize this medication error. R2 was placed on Coumadin for her a-fib and when the INR dropped below 2 it increased R2's risk for blood clots. She stated the handwritten message and signature at the bottom of the 12/24/24 order document was the INR clinic nurse and identified the missed doses of Coumadin. During an interview on 1/16/25 at 3:37 p.m. pharmacist consult (PC) stated R2 had been taken off Eliquis, placed on Coumadin, and he was unaware of R2's missed doses of Coumadin. He stated once a resident was started on Coumadin it would have taken three to four days to achieve a therapeutic level versus Eliquis would have taken two days. R2's therapeutic level while on Coumadin was between two and three and if not within that window would have increased her risk of blood clots, stroke, and heart attack.	F 760		

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F 760	Continued From page 7 During an interview on 1/16/25 at 4:30 p.m. director of nursing (DON) stated R2's Eliquis was discontinued and changed to Coumadin per her request due to cost. She stated on 12/24/24 R2's INR had dropped down to 1.2. R2 had missed six doses of Coumadin 5 mg due to a transcription error, probably lowered the INR level, and placed R2 at a risk for blood clots. The medication error was discovered on 12/24/24, and a new order was given that same day. Facility policy Medication Error dated 5/15/24, identified protection would be provided to all residents in the facility for the health, welfare, and rights by ensuring residents received care and services safely in an environment free of significant mediation errors. A mediation error was defined as the administration of medication which was not in accordance with the prescriber's order. Significant medication error was defined as one which jeopardized their health and safety. Medication errors, once identified, will be evaluated to determine if it would be considered significant by using the following guidelines: residents condition required rigid control such as monitoring of labs. Drug Category: if the medication is from a category that usually requires the resident to be titrated to a specific blood level such as medication with a narrow therapeutic index (NTI) such as Warfarin, and if the error occurred repeatedly such as omission of the resident's medication several times. If a medication error occurred the nurse would be expected to assess, examine the resident condition, and notify the physician or health care practitioner as soon as possible, monitor and document actions taken in the medial record, once stable report incident to supervisor,	F 760		

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F 760	Continued From page 8 complete the incident or occurrence report.	F 760		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/15/25 and 1/16/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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

Electronically Signed | 02/04/25

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. H55374522C (MN00109706) with a licensing order issued at 1545. H55373921C (MN00109477) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	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	21545		2/6/25

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21545	Continued From page 3 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. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 resident (R2) reviewed for medication errors was free of significant medication errors when orders for Warfarin (Coumadin) (a blood thinner used to reduce the risk of blood clots), was not transcribed into the electronic medical record according to physician's orders and resulted in six missed doses of Warfarin 5 milligrams (mg). Findings include: R2's telehealth visit with cardiologist on 11/20/24, identified stop Amiodarone (used to treat and prevent a number of types of irregular heartbeats) and Eliquis (used to prevent stroke and blood clots in patients with certain heart rhythm problem such as atrial fibrillation (A-fib) (an irregular and	21545	See F760 Corrected 2/6/25	

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21545	Continued From page 4 often very rapid heart rhythm and can lead to blood clots in the heart, increases the risk of stroke, heart failure, and other heart related complications), start taking Warfarin (Coumadin) 5 mg oral tablet daily according to the international normalized ratio (INR) (used to measure how long it took for blood to clot). R2's progress noted 11/20/24 at 6:58 p.m. R2 was seen by cardiology via telehealth today. Orders: stop Amiodarone and switch Eliquis to Coumadin 5 mg oral tablet daily, and then according to INR levels. Will clarify which clinic the results will go to and when INR checks to start. The communication documents with the Coagulation Clinic, INR nurse from 11/25/24 through 11/29/24 identified the following orders: -11/25/24, R2's finger stick INR result was 1.2 seconds with a therapeutic INR level while on warfarin 2 to 3 seconds. Current order began on 11/21/24, Coumadin 5 mg daily. Next INR scheduled for 11/29/24. Physician order: continue 5 mg by mouth (po) daily. Note: aware had only taken four doses to date. -11/29/24, R2's finger stick INR result was 2.4 seconds. Current order: Coumadin 5 mg daily. Next INR was scheduled for 12/5/24. Physician order: continue Coumadin 5 mg po daily. R2's primary provider medical doctor (MD) visit on 12/5/24, identified diagnoses: history congestive heart failure (CHF), diabetes mellitus (DM) insulin dependent with chronic kidney disease, atherosclerotic heart disease (buildup of fats, cholesterol and other substances in the artery of the walls called plague and can cause	21545		

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21545	Continued From page 5 the arteries to narrow, blocking blood flow to organs and tissues), morbid obesity, chronic anticoagulation, deep vein thrombosis (blood clot) in lower extremities, A-fib, inferior vena cava (IVC) (big vein in the abdomen) filter (inserted into the IVC to catch/trap a traveling clot and prevent it from reaching the lung). She was started on Warfarin and a referral was placed to the INR clinic. INR was therapeutic with last check 2.4 on 11/9/24 [sic]. The communication documents with the Coagulation Clinic, INR nurse from 12/5/24 through 12/9/24 identified the following orders: -12/5/24, R2's finger stick INR result was 4.8 seconds. Current order: Coumadin 5 mg daily. Next INR was scheduled for 12/9/24. Physician order: hold today; 2.5 mg on 12/6/24 and 5.0 mg on 12/7/24 and 12/8/24. -12/9/24, R2's finger stick INR result was 2.9 seconds. Current order: Coumadin 5 mg daily. Next INR was scheduled for 12/16/24. Physician order: 2.5 mg on Mondays, Wednesdays, and Friday and 5 mg all other days. R2's December 2023 EMAR indicated: Warfarin 2.5. mg po in the evening on Monday, Wednesday, and Friday related to atrial fibrillation. Start date 12/9/24 at 6:00 p.m. and discontinue date 12/24/24 at 7:56 a.m., was administered on 12/9/24, 12/11/24, 12/13/24, 12/16/24, 12/18/24, 12/20/24, and 12/23/24. R2's December 2023 EMAR indicated: Warfarin 5 mg po in the evening on Tuesday, Thursday, Saturday, and Sunday for treating/preventing blood clots for two administrations. Start date 12/10/24 at 6:00 p.m. and discontinue date	21545		

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21545	Continued From page 6 12/24/24 at 5:46 p.m. Staff administered 5 mg on 12/10/24 and 12/12/24. On 12/10/24 the order for Warfarin 5 mg was transcribed inappropriately and entered on the EMAR as two administrations only. R2 did not receive Warfarin 5 mg dose as ordered on 12/14/24, 12/15/24, 12/17/24, 12/19/24, 12/21/24, and 12/22/24 (6 doses). The communication documents with the Coagulation Clinic, INR nurse from 12/16/24 through 1/14/25 identified the following orders: -12/16/24, R2's finger stick INR result was 2.3 seconds. Current order: Coumadin 5 mg Tuesday, Thursday, Saturday, Sunday, and 2.5 mg other days. Next INR scheduled: left blank. Physician order: Coumadin 5 mg po Tuesday, Wednesday, Thursday, and Saturday and Sunday; 2.5 mg Monday, Wednesday, and Friday. -12/24/24, R2's finger stick INR result was 1.2 seconds. Current order: 2.5 mg Monday, Wednesday, Friday, and 5 mg all other days. Next INR 12/31/24. Coumadin order: 5 mg tonight and 2.5 mg all other days. Handwritten on bottom of this document by INR clinic nurse was: 12/24/24 at 10:12 a.m. telephone call to staff nurse and upon looking at patient's medication list and EMAR, R2 had not received Coumadin 5 mg since 12/12/24, only the 2.5 mg dose Monday, Wednesday, Friday since then. Dosing of coumadin based on cumulative doses received. -R2's anticoagulant flow sheet dated 12/24/24 identified dosing plan for the week fax received from facility with INR 1.2 today. Telephone call (TC) to facility and checked on any changes or	21545		

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21545	Continued From page 7 missed doses. Reported she had been getting 2.5 mg on Monday, Wednesday, and Friday but looks like she had not received Coumadin 5 mg tabs since 12/12/24. R2's order was placed wrong in computer, instead of ordered cumulative weekly dose of 27.5 mg she received 22.5 mg the week of 12/8/24 and only 7.5 mg the week of 12/15/24. Will have R2 take 5 mg tonight and then 2.5 mg daily and recheck INR in one week. Orders faxed to facility and pharmacy. -12/31/24, Diagnosis: A-fib. INR result today 1.4 seconds (goal 2 to 3). Dose increase by 12.5 %. Change coumadin dose: 5 mg po Thursday and Saturday and 2.5 mg Sunday, Monday, Wednesday, Thursday, and Friday. Recheck INR 1/7/25 (one week). -1/2/2025 10:05 a.m. R2's progress notes identified, Pharmacist Note: Medications and chart reviewed for monthly medication regimen review (MR) (a thorough evaluation of the medication regimen by a pharmacist, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication). No medication irregularities noted at this time. -1/7/25, R2's INR result today 1.6. Change coumadin dose to 5 mg Tuesday, Thursday, Saturday then 2.5 mg on Sunday, Monday, Wednesday, and Friday. Recheck INR on 1/14/25. -1/14/25, R2's INR result today 1.6. Increase dose by 10%. Change coumadin 5 mg po Sunday, Tuesday, Thursday, and Saturday; 2.5 mg Monday, Wednesday, and Friday. Recheck INR on 1/21/25.	21545		

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21545	Continued From page 8 During an interview on 1/15/25 at 1:55 p.m. R2 stated she had a history of blood clots found in her legs, traveled to her lungs, and a filter was placed in her inferior vena cava. R2's last visit with her cardiologist was December 2024 and she had requested to be taken off Eliquis due to cost and placed on coumadin. She was started on Coumadin 5 mg with a therapeutic goal of INR between two and three and thought she had not received the correct doses of Coumadin. She stated the INR had been checked on Tuesdays and the result of the last one was below 2.0. She was concerned no adjustment had been made on the Coumadin dose and was afraid she was at an increased risk for another blood clot. During an interview on 1/16/25 at 11:30 a.m. medical doctor/medical director (MD) stated the INR clinic nurse helped manage R2's dosing of coumadin and she had written a note on 12/24/24 order form: R2 had not received her Coumadin for days due to the wrong order was placed in the computer. He would have expected staff to notify him right away, was out of the office on 12/24/24, and unsure when they discovered the transcription error. MD stated R2's missed doses of Coumadin contributed to a drop in her INR from 2.9 to 1.2, would have been considered subtherapeutic, and placed R2 at an increased risk for blood clots. During an interview on 1/16/25 at 1:45 p.m. registered nurse (RN) stated on 12/9/24, R2 had and INR of 2.9 and she had transcribed and signed off R2's orders for Coumadin 2.5 mg Monday, Wednesday, and Friday and 5 mg Tuesday, Thursday, Saturday, and Sunday. On 12/24/24 R2's INR had dropped to 1.2. She reviewed R2's December EMAR and noticed a transcription error, unsure why it had taken until	21545		

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21545	Continued From page 9 12/24/24 to realize this medication error. R2 was placed on Coumadin for her a-fib and when the INR dropped below 2 it increased R2's risk for blood clots. She stated the handwritten message and signature at the bottom of the 12/24/24 order document was the INR clinic nurse and identified the missed doses of Coumadin. During an interview on 1/16/25 at 3:37 p.m. pharmacist consult (PC) stated R2 had been taken off Eliquis, placed on Coumadin, and he was unaware of R2's missed doses of Coumadin. He stated once a resident was started on Coumadin it would have taken three to four days to achieve a therapeutic level versus Eliquis would have taken two days. R2's therapeutic level while on Coumadin was between two and three and if not within that window would have increased her risk of blood clots, stroke, and heart attack. During an interview on 1/16/25 at 4:30 p.m. director of nursing (DON) stated R2's Eliquis was discontinued and changed to Coumadin per her request due to cost. She stated on 12/24/24 R2's INR had dropped down to 1.2. R2 had missed six doses of Coumadin 5 mg due to a transcription error, probably lowered the INR level, and placed R2 at a risk for blood clots. The medication error was discovered on 12/24/24, and a new order was given that same day. Facility policy Medication Error dated 5/15/24, identified protection would be provided to all residents in the facility for the health, welfare, and rights by ensuring residents received care and services safely in an environment free of significant mediation errors. A mediation error was defined as the administration of medication which was not in accordance with the prescriber's	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00477	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21545	Continued From page 10 order. Significant medication error was defined as one which jeopardized their health and safety. Medication errors, once identified, will be evaluated to determine if it would be considered significant by using the following guidelines: residents condition required rigid control such as monitoring of labs. Drug Category: if the medication is from a category that usually requires the resident to be titrated to a specific blood level such as medication with a narrow therapeutic index (NTI) such as Warfarin, and if the error occurred repeatedly such as omission of the resident's medication several times. If a medication error occurred the nurse would be expected to assess, examine the resident condition, and notify the physician or health care practitioner as soon as possible, monitor and document actions taken in the medial record, once stable report incident to supervisor, complete the incident or occurrence report. SUGGESTED METHOD OF CORRECTION: (DON) or designee could review facility policies and procedures, educate staff and implement an ongoing monitoring system to ensure all resident orders are correctly transcribed and implemented as directed by physician orders. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21545		