Electronically delivered
July 21, 2021

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

RE: CCN: 245544
Cycle Start Date: July 7, 2021

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On July 7, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
Metro C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 7, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 7, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 Victory Health and Rehab is a Special Focus Facility (SFF). On 7/7/21, a standard abbreviated survey was conducted at your facility. Your facility was found to NOT be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5544209C (MN00074434), H5544210C (MN00074458), and H5544211C (MN00074256). The following complaint was found to be SUBSTANTIATED H5544212C (MN00074409), a citation was issued with a deficiency at F760. 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 substantial compliance with the regulations has been attained.	F 000		
F 760 SS=E	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	F 760		8/6/21

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

Electronically Signed | 07/29/2021

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F 760	Continued From page 1 by: Based on interview and document review, the facility failed to ensure medications were administered per physicians orders for 12 out of 20 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11 and R12) reviewed for significant medication errors, when a nurse left ill and no one administered the medications remaining on her shift. Findings include: A facility medication error report form dated 6/29/21, identified R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12 did not receive their scheduled medications for 12:00 p.m. - 2:00 p.m. on 6/28/21. A nurse practitioner was updated, but no investigation into the missed medications had been documented. R1's medication administration record (MAR) for 6/1/21 through 6/31/21, lacked documentation R1 had received Gabapentin (ordered for anxiety) or Buspirone (ordered for anxiety) had been administered at 2:00 p.m. on 6/28/21. R1's current physician orders indicated R1 required these medications for anxiety and had a diagnosis of post traumatic stress disorder (PTSD). R2's physician orders, dated June 2021, included, Novolog (insulin for diabetes) FlexPen Solution (100 units/ml). Inject as per sliding scale: if (blood sugar)150-199 = 5 units; 200-249 =10 units; 250-299 = 15 units; 300-349= 20 units; 350+ =25 units; subcutaneously four times a day for Diabetes Mellitus type two (DM2). R2's MAR dated 6/1/21-6/30/21, lacked indication Novolog Flex Pen 100 units/ml which was scheduled for	F 760	F 760 R 3 and R 7 discharged from the facility. R1, R2, R4, R5, R6, R8, R9, R10, R11 and R12 the physician and family representative will be made aware that medications were missed on evening shift of 6/29/21. A risk management incident will be created, thoroughly investigated and the care plan will be reviewed and updated for R1, R2, R4, R5, R6, R8, R9, R10, R11 and R12. All other residents were reviewed and there were no missed medications noted. No other residents experienced any ill effects from this deficient practice. Future medication errors, the facility policy and procedure will be followed. Licensed nursing staff will be in-serviced on the Medication Error Policy and Procedure with focus on paragraph 2 that for any unforeseen or unanticipated event, the DON and/or designee will be responsible for ensuring resident care and coverage is maintained. In addition, the licensed nurse will be responsible for initiating a resident incident for any resident medication errors. Director of Nursing and/or designee will be responsible for compliance. Audits on medication errors and risk management initiation will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and the Administrator will report audits results at QAPI for review and recommendation.	

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F 760	Continued From page 2	F 760		

11:00 a.m. was given on 6/28/21. Nor was a blood sugar reading documented.

R3's MAR dated 6/1/21 - 6/30/21, included, R3 was to receive Acetaminophen (Tylenol for pain) 1000 mg (milligrams) at 2:00 p.m. Novolog FlexPen 100 units/ml 4 units with meals and per sliding scale for 12:00 p.m. Lyrica (used for pain/neuropathy) 50 mg at 2:00 p.m. and Hydralazine HCl 10 mg (used for high blood pressure) at 2:00 p.m. on 6/28/21. However, these medications were not signed out as given on 6/28/21.

R4's order summary report for June 2021, included a physician's order for Acetaminophen 500 milligrams (mg) three times a day for pain. R4's MAR dated 6/1/21-6/30/21 lacked indication Acetaminophen 1,000 mg scheduled for 2:00 p.m. was given. on 6/28/21.

R6's physician orders for June 2021, included an order for, acetaminophen (325 mg), give two tablets by mouth four times a day for pain, Baclofen (10 mg), give one tablet by mouth three times a day for muscle spasticity, and Hydralazine HCl (25 mg), give one tablet by mouth three times a day for HTN. R5's MAR lacked indication these medications had been given at 2:00 p.m. on 6/28/21.

R7's physician orders for June 2021, included an order for Fosrenol (500 mg), give one tablet by mouth with meals for stomach upset related to end stage renal disease. This medication was not signed out as given on 6/28/21, at 12:00 p.m.

R8's physician orders for June 2021, included an order for Carbidopa-Levodopa (25-100 mg), give

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F 760	Continued From page 3	F 760		

one tablet by mouth three times a day for Parkinson's disease. This medication was not signed out as given on 6/28/21, at 2:00 p.m. Carbidopa-Levodopa is used to treat symptoms of Parkinson's disease such as stiffness and tremors.

R9's physician orders for June 2021, included an order for Gabapentin (400 mg), give two capsules by mouth three times a day for low back pain. This medication was not signed out as given on 6/28/21, at 2:00 p.m.

R10's physician orders for June 2021, included, Acetaminophen (500 mg), give two tablets by mouth three times a day for pain, Cyclobenzaprine HCL (5 mg), give one tablet by mouth four times a day for pain, Diclofenac Sodium Gel 1%, apply to affected areas topically four times a day for chronic pain, Lyrica (150 mg), give 150 mg by mouth three times a day for pain. These medications were not signed out as given on 6/28/21, at 12:00 p.m. or 2:00 p.m.

R11's physician orders for June 2021, included, a physician's order for Lyrica (75 mg), give 75 mg by mouth three times a day for pain. This medication was not signed out as administered on 6/28/21, at 2:00 p.m.

R12's physician orders for June 2021, included, a physician's order for Carbidopa-Levodopa (25-100 mg), give two tablets by mouth two times a day related to Parkinson's Disease and Cal-Gest (500 mg), give one tablet by mouth three times a day related to Parkinson's Disease. This medication was not signed out as being given on 6/28/21, at 2:00 p.m.

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R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12's progress notes dated 6/29/21, indicated a nurse practioner (NP) was notified the resident had not been administered their ordered medications scheduled between 12:00 p.m. and 3:00 p.m. on 6/28/21. The progress notes addressed none of the residents had suffered an adverse reaction to missing the medications.

During an Interview on 7/7/21, at 10:25 a.m. the director of nursing (DON) stated on the morning of 6/29/21, she discovered the resident's who reside on the north wing of the facility hadn't received their medications between the hours of 12:00 p.m. and 3:00 p.m. on 6/28/21. She stated she checked to see which nurse was assigned to work and discovered it was RN-A who left her shift 30 minutes early that day. She also stated she hadn't talked to RN-A yet and had tried to get her phone number but was unsuccessful. The DON also stated she had not notified all of the residents or their responsible parties about the errors. RN-A further stated she is unsure of how she would prevent this from happening in the future because she is a new employee and needs to, "test the waters first and find out what she's actually allowed to do."

During an interview on 7/7/21, at 10:35 a.m. the administrator stated on 6/29/21, the DON told her the resident's residing on the north wing of the facility hadn't received their medications on 6/28/21. She stated RN-A had gotten sick and left. The administrator further stated RN-A told staff she was leaving and gave report to another nurse on duty (RN-B).

During an interview on 7/7/21, at 10:49 a.m. RN-A stated on 6/28/21, she started to feel sick and told

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F 760	Continued From page 5	F 760		

the DON she needed to leave early. The DON told her she couldn't leave so she called the owner and he said she could leave. RN-A stated she counted the narcotics in her medication cart with RN-B, gave report on the resident's she was assigned to, including medications still needed, and gave RN-B the keys to the medication cart. RN-A further stated she left the facility between 11:00 and 12:00 p.m. and had administered all medications up until that time, before she left.

During an interview on 7/7/21, at 11:10 a.m. the owner stated he was not aware of the medication errors until the next day (6/29/21). He also verified RN-A called him on 6/28/21, and asked to leave early because she wasn't feeling well and he told her she could go home.

During an interview on 7/8/21, at 3:00 p.m. RN-B stated RN-A left her shift early but is unsure of the exact time. She stated before RN-A left they counted the narcotics and RN-A gave her the keys to the cart. RN-B took the keys and gave them to administrator and the DON who were standing in the hallway together. RN-B did not administer the medications to R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, or R12 and had not directed any other nurse to do so. RN-A did not have an explanation.

On 7/8/21, at 10:13 a.m. the pharmacist sent an email indicating the potential problems which could have occurred in the following patients resulting from missing their medication. R2 did not receive Novolog which could have resulted in hypoglycemia (low blood sugar). R3 didn't receive Novolog which could have resulted in hypoglycemia. R4 missed Acetaminophen which could have resulted in pain. R6 missed Lyrica

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F 760	Continued From page 6 which could have resulted in pain. The pharmacist would not comment on the other residents missed medications. The facility's policy for administering medications (undated), includes medications shall be administered in a safe and timely manner, and as prescribed. It further includes, medications must be administered in accordance with the orders, including any required time frame.	F 760		

Electronically delivered
July 21, 2021

Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

Re: State Nursing Home Licensing Orders
Event ID: 53QS11

Dear Administrator:

The above facility was surveyed on July 7, 2021 through July 7, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Karen Aldinger, Unit Supervisor
Metro C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

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

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

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	00166	A. BUILDING: _____ B. WING _____	C 07/07/2021

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2 000	Continued From page 1 UNSUBSTANTIATED: H5544209C (MN00074434), H5544210C (MN00074458), and H5544211C (MN00074256). The following complaint was found to be SUBSTANTIATED: H5544212C (MN00074409). The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for	2 000		

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2 000	Continued From page 2 text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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	21545		8/6/21

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21545	Continued From page 3 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 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 medications were administered per physicians orders for 12 out of 20 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11 and R12) reviewed for significant medication errors, when a nurse left ill and no one administered the medications remaining on her shift. Findings include: A facility medication error report form dated 6/29/21, identified R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12 did not receive their scheduled medications for 12:00 p.m. - 2:00 p.m.	21545	Corrected.	

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21545	Continued From page 4 on 6/28/21. A nurse practitioner was updated, but no investigation into the missed medications had been documented. R1's medication administration record (MAR) for 6/1/21 through 6/31/21, lacked documentation R1 had received Gabapentin (ordered for anxiety) or Buspirone (ordered for anxiety) had been administered at 2:00 p.m. on 6/28/21. R1's current physician orders indicated R1 required these medications for anxiety and had a diagnosis of post traumatic stress disorder (PTSD). R2's physician orders, dated June 2021, included, Novolog (insulin for diabetes) FlexPen Solution (100 units/ml). Inject as per sliding scale: if (blood sugar)150-199 = 5 units; 200-249 =10 units; 250-299 = 15 units; 300-349= 20 units; 350+ =25 units; subcutaneously four times a day for Diabetes Mellitus type two (DM2). R2's MAR dated 6/1/21-6/30/21, lacked indication Novolog Flex Pen 100 units/ml which was scheduled for 11:00 a.m. was given on 6/28/21. Nor was a blood sugar reading documented. R3's MAR dated 6/1/21 - 6/30/21, included, R3 was to receive Acetaminophen (Tylenol for pain) 1000 mg (milligrams) at 2:00 p.m. Novolog FlexPen 100 units/ml 4 units with meals and per sliding scale for 12:00 p.m. Lyrica (used for pain/neuropathy) 50 mg at 2:00 p.m. and Hydralazine HCl 10 mg (used for high blood pressure) at 2:00 p.m. on 6/28/21. However, these medications were not signed out as given on 6/28/21. R4's order summary report for June 2021, included a physician's order for Acetaminophen 500 milligrams (mg) three times a day for pain.	21545		

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21545	Continued From page 5 R4's MAR dated 6/1/21-6/30/21 lacked indication Acetaminophen 1,000 mg scheduled for 2:00 p.m. was given. on 6/28/21. R6's physician orders for June 2021, included an order for, acetaminophen (325 mg), give two tablets by mouth four times a day for pain, Baclofen (10 mg), give one tablet by mouth three times a day for muscle spasticity, and Hydralazine HCl (25 mg), give one tablet by mouth three times a day for HTN. R5's MAR lacked indication these medications had been given at 2:00 p.m. on 6/28/21. R7's physician orders for June 2021, included an order for Fosrenol (500 mg), give one tablet by mouth with meals for stomach upset related to end stage renal disease. This medication was not signed out as given on 6/28/21, at 12:00 p.m. R8's physician orders for June 2021, included an order for Carbidopa-Levodopa (25-100 mg), give one tablet by mouth three times a day for Parkinson's disease. This medication was not signed out as given on 6/28/21, at 2:00 p.m. Carbidopa-Levodopa is used to treat symptoms of Parkinson's disease such as stiffness and tremors. R9's physician orders for June 2021, included an order for Gabapentin (400 mg), give two capsules by mouth three times a day for low back pain. This medication was not signed out as given on 6/28/21, at 2:00 p.m. R10's physician orders for June 2021, included, Acetaminophen (500 mg), give two tablets by mouth three times a day for pain, Cyclobenzaprine HCL (5 mg), give one tablet by mouth four times a day for pain, Diclofenac	21545		

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21545	Continued From page 6 Sodium Gel 1%, apply to affected areas topically four times a day for chronic pain, Lyrica (150 mg), give 150 mg by mouth three times a day for pain. These medications were not signed out as given on 6/28/21, at 12:00 p.m. or 2:00 p.m. R11's physician orders for June 2021, included, a physician's order for Lyrica (75 mg), give 75 mg by mouth three times a day for pain. This medication was not signed out as administered on 6/28/21, at 2:00 p.m. R12's physician orders for June 2021, included, a physician's order for Carbidopa-Levodopa (25-100 mg), give two tablets by mouth two times a day related to Parkinson's Disease and Cal-Gest (500 mg), give one tablet by mouth three times a day related to Parkinson's Disease. This medication was not signed out as being given on 6/28/21, at 2:00 p.m. R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12's progress notes dated 6/29/21, indicated a nurse practioner (NP) was notified the resident had not been administered their ordered medications scheduled between 12:00 p.m. and 3:00 p.m. on 6/28/21. The progress notes addressed none of the residents had suffered an adverse reaction to missing the medications. During an Interview on 7/7/21, at 10:25 a.m. the director of nursing (DON) stated on the morning of 6/29/21, she discovered the resident's who reside on the north wing of the facility hadn't received their medications between the hours of 12:00 p.m. and 3:00 p.m. on 6/28/21. She stated she checked to see which nurse was assigned to work and discovered it was RN-A who left her shift 30 minutes early that day. She also stated she hadn't talked to RN-A yet and had tried to get	21545		

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her phone number but was unsuccessful. The DON also stated she had not notified all of the residents or their responsible parties about the errors. RN-A further stated she is unsure of how she would prevent this from happening in the future because she is a new employee and needs to, "test the waters first and find out what she's actually allowed to do."

During an interview on 7/7/21, at 10:35 a.m. the administrator stated on 6/29/21, the DON told her the resident's residing on the north wing of the facility hadn't received their medications on 6/28/21. She stated RN-A had gotten sick and left. The administrator further stated RN-A told staff she was leaving and gave report to another nurse on duty (RN-B).

During an interview on 7/7/21, at 10:49 a.m. RN-A stated on 6/28/21, she started to feel sick and told the DON she needed to leave early. The DON told her she couldn't leave so she called the owner and he said she could leave. RN-A stated she counted the narcotics in her medication cart with RN-B, gave report on the resident's she was assigned to, including medications still needed, and gave RN-B the keys to the medication cart. RN-A further stated she left the facility between 11:00 and 12:00 p.m. and had administered all medications up until that time, before she left.

During an interview on 7/7/21, at 11:10 a.m. the owner stated he was not aware of the medication errors until the next day (6/29/21). He also verified RN-A called him on 6/28/21, and asked to leave early because she wasn't feeling well and he told her she could go home.

During an interview on 7/8/21, at 3:00 p.m. RN-B stated RN-A left her shift early but is unsure of the

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exact time. She stated before RN-A left they counted the narcotics and RN-A gave her the keys to the cart. RN-B took the keys and gave them to administrator and the DON who were standing in the hallway together. RN-B did not administer the medications to R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, or R12 and had not directed any other nurse to do so. RN-A did not have an explanation.

On 7/8/21, at 10:13 a.m. the pharmacist sent an email indicating the potential problems which could have occurred in the following patients resulting from missing their medication. R2 did not receive Novolog which could have resulted in hypoglycemia (low blood sugar). R3 didn't receive Novolog which could have resulted in hypoglycemia. R4 missed Acetaminophen which could have resulted in pain. R6 missed Lyrica which could have resulted in pain. The pharmacist would not comment on the other residents missed medications.

The facility's policy for administering medications (undated), includes medications shall be administered in a safe and timely manner, and as prescribed. It further includes, medications must be administered in accordance with the orders, including any required time frame.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures for medication procedures if a nurse leaves the facility early. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these

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21545	Continued From page 9 measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		