Electronically Submitted
October 5, 2020

Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, MN 56464

RE: CCN: 245563
Cycle Start Date: September 16, 2020

Dear Administrator:

On September 16, 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 September 16, 2020, the situation of immediate jeopardy to potential health and safety cited at 760 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 October 20, 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 October 20, 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 October 20, 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 16, 2020. This prohibition is not subject to appeal. 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.

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. <u>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.</u>

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, Green Pine Acres Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years

effective September 16, 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), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140

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 March 16, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245563	A. BUILDING _____ B. WING _____	C 09/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	**427 MAIN STREET NORTHEAST MENAHGA, MN 56464**

(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 9/10/20, 9/11/20, 9/14/20, 9/15/20 and 9/16/20, an abbreviated survey was conducted to investigate complaint H5563015C. Your facility was found NOT to be in compliance with requirements of 42 CFR Part 483, Subpart B and requirements for Long Term Care Facilities. Complaint H5563015C was found to be substantiated and resulted in an Immediate Jeopardy (IJ) at F760 due to the facility's failure to ensure residents are free from significant medication errors related to an omitted Lasix dose increase for 1 of 1 resident (R1) who received diuretic medications and the resident had experienced increased symptoms of edema and shortness of breath and required additional intravenous Lasix during an emergency room visit. An extended survey was conducted by the Minnesota Department of Health on 9/15/20 and 9/16/20. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/09/2020

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 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 ensure medications were administered without significant error for 1 of 1 resident (R1) who received the incorrect dose of diuretic (fluid reducing) medication for 19 days. This deficient practice caused harm for R1 who experienced increased edema, shortness of breath and required treatment at the emergency room (ER) and received intravenous (IV) medication administration of Lasix. The immediate jeopardy (IJ) began on 8/12/20, when facility staff incorrectly administered R1's dose of Lasix 20 milligrams (mg) and continued to administer the incorrect dose (10 mg) until 9/1/20, when the error was identified. On 8/31/20, R1 was sent to the emergency room, administered IV Lasix and diagnosed with congestive heart failure and fluid overload. The administrator and the director of nursing (DON) were notified of the immediate jeopardy at 4:05 p.m. on 9/14/20. The immediate jeopardy was removed on 9/16/20, at 12:00 p.m., but noncompliance remained at the lower scope and severity level of G, which indicated actual harm that is not immediate jeopardy. Findings include: A facility Nursing Home Incident Reporting form submitted by the facility on 9/1/20, at 4:47 p.m.,	F 760	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility and allegation of compliance. It is the policy of Green Pine Acres to provide quality of care to all our residents, including those receiving diuretics. Going forward, the plan for Green Pine Acres is to prevent future residents with diuretics from incurring medication errors with the diuretics resulting in emergent care required. In doing so, the following plan has been put into place: 1.) Each resident with diuretics has been audited by Director of Nursing (DON)or designee for correct medication ordered, correct medication dose, and what is in the cart (available) on 9/14/2020. DON will audit diuretics for correct medication ordered, correct medication dose, and what is available weekly for 3 months to assure competency, then will continue	9/22/20

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F 760	Continued From page 2 indicated an order was received by the facility on 8/11/20 to increase R1's Lasix from 10 mg daily to 20 mg daily, to start on 8/12/20. R1 did not receive the increased dose of 20 mg daily as ordered, which was discovered by the facility on 9/1/20, when the cassette in R1's medication cart was discovered to have 10 mg tablets, not the 20 mg tablets as ordered. The cassette was labeled to read Lasix 20 mg, take one-half tab by mouth daily. On 8/31/20, R1 was sent to the emergency room (ER) with increase in Lasix ordered, for diagnoses of CHF (congestive heart failure), enlarged heart, pulmonary vascular is cephalic, left lower effusion. R1's quarterly Minimum Data Set (MDS) assessment dated 8/21/20, indicated R1's diagnosis included congestive heart failure, hemiplegia, diabetes and anxiety disorder. R1 had mild impaired cognition and received anti depressant medication on a daily basis. R1's MDS incorrectly indicated R1 did not receive diuretic medication in the 7 day look back period. R1's MDS also indicated R1 experienced shortness of breath at rest, received oxygen therapy and had life expectancy of greater than 6 months. R1's Order Summary Report dated 8/6/20, included oxygen at 3 liters (L) via nasal cannula every shift for hypoxia related to CHF with start date of 4/30/20, and Lasix 10 mg by mouth in the morning for CHF with start date of 4/8/20. R1's Physician Telephone order, dated 8/11/20, at 10:45 a.m. ordered an increase Lasix to 20 mg due to edema and CHF. However, R1's progress notes did not identify R1 was having any symptoms at that time.	F 760	monthly until continued compliance. 2.) High-risk medications and medication error inservice to be completed by pharmacy consultant with nurses and TMAs on 9/15/2020 and 9/17/2020. Those unable to make training received training prior to next shift. Completed 9/18/2020 3.) Medication transcription sheets have been made which allow RN to write on sheet which resident had a medication change(s)along with a checkbox to remind and ensure that the medication has been removed from cart, if applicable. These sheets will go in the report book when RN completes the orders for the day. These sheets will be audited by DON or designee weekly x4 and then monthly until continued compliance. 4.) For orders that are received after the RN has left for the day, they are to be processed and added to the sheet in the report book. These orders will be audited by DON or designee weekly x 4 then monthly until continued compliance. 5.) Nurses and TMAs were trained on new policy and procedure 9/15/2020 and 9/17/2020 for transcribing orders and annually ongoing during med administration competency training. 6.) Medication administration (6 rights) will be added to annual nurse and TMA competency to ensure ongoing competence with medication pass best practice. Competency test completed 9/15/2020 for nurses and TMAs, all Nurses, TMA have demonstrated competency to DON or Education RN. 7.) Pharmacy has changed wording on cassette in their system from "one-half" to	

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F 760	Continued From page 3 R1's ER (emergency room) report dated 8/31/20, indicated R1 presented with abdominal distention and diarrhea. R1's exam revealed evidence of CHF with bilateral rales and peripheral edema. R1's abdomen was distended but non-tender. Chest X-ray showed pleural effusion and cephalization (refers to the redistribution of visible pulmonary vessels into the upper lung fields as pulmonary vascular volume and pressures increase) indicating pulmonary congestion. R1's abdominal CT scan showed ascites (fluid in the abdomen) and signs of cirrhosis (liver disease). R1 was treated with IV Lasix 40 mg. R1's family member declined hospitalization, and R1 returned to the nursing home with Lasix 40 mg by mouth daily with supplemental potassium daily. R1's discharge patient information form dated 8/31/20, indicated R1 was seen in the emergency room for CHF and anemia. Review of R1's progress notes (PN) from 8/10/20 through 9/11/20, revealed the following information: -8/11/20 at 11:04 a.m. indicated an order was received to increase R1's Lasix dose to 20 mg every day for edema and CHF. However, the notes lacked documentation of any symptoms R1 was experiencing at that time. -8/13/20, noted to have 1+ pitting edema and R1 stated she did have gout. -8/19/20, complained of chest pain and shortness of breath and per staff report seemed "off." After 5 minutes, on reassessment, R1'S symptoms had improved.	F 760	"1/2" and changed the font of the cassette label to decrease chance of error. Completed 9/22/20.	

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F 760	Continued From page 4	F 760		

-8/21/20, turning on her call light frequently and calling office and family members. R1 was very upset and staff was unable to answer her questions.

-8/21/20, another note indicated R1 appeared to be having discomfort and shortness of breath. R1 was agitated and anxious. R1's oxygen saturation registered at 84% (normal range-95-100%) with oxygen administered at 3L per nasal cannula and she complained of acid reflux. Staff repositioned R1 and spoke with her regarding her concerns. Staff administered Maalox (an antacid medication) and R1 appeared to relax and interventions appeared effective.

-8/23/20, abdomen seemed firm and distended. R1's bowel sounds were active and R1 had a documented bowel movement every day.

-8/23/20, another note indicated R1 would turn on the call light when staff left the room and rang the call light frequently. R1 complained of not being able to breath. R1's oxygen saturation registered 93% with oxygen on at 3L per nasal cannula.

-8/28/20, continued to have a distended abdomen. Lab work ordered for liver function. R1 was documented to have 2+ bilateral lower extremity edema.

-8/29/20, liver function lab work was within normal limits.

-8/31/20, R1 was noted to be pale and lethargic and had five loose stools. R1's abdomen was extended and firm. Bowel sounds were hyperactive. R1 had 3+ edema in both lower

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F 760	Continued From page 5	F 760		

extremities. Lung sounds were clear and oxygen saturation was 89% with oxygen on at 3L/minute per nasal cannula. R1 was sent to the hospital for an X-ray.

-8/31/20, a later note written by the director of nursing (DON) indicated R1 was noted to have been taking Maalox frequently which was likely cause of loose stools as this is a side effect of that medication along with bloating. The note included R1 was taking the medication for full feeling/GI upset which was due to CHF and fluid overload as per ER report, and returned with medication changes.

-8/31/20, another note indicated R1 had returned to the facility at 5:00 p.m., oxygen saturation was 94% with oxygen at 3L/minute per nasal cannula and had no further loose stools. Shortness of breath was noted only with cares when R1 was lying flat or being moved around.

-9/1/20, order was received for Lasix 40 mg a day, potassium 20 equivalents a day and to follow up with primary MD in one week.

-9/1/20, another noted indicated R1 was up in her wheelchair, visiting with her spouse and had stated she felt better. R1 appeared better in color and abdomen had decreased slightly.

R1's progress notes lacked any documentation of the medication errors that had occurred 8/12/20 through 8/31/20.

R1's weight log from 7/23/20 through 9/1/20, revealed the following weights:

-7/23/20 R1's weight was 206 lbs.

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(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 760	Continued From page 6	F 760		

-7/27/20 R1's weight was 208 lbs.
-8/3/20 R1's weight was 209 lbs
-8/6/20 R1's weight was 210 lbs.
-8/10/20 R1's weight was 216 lbs
-8/17/20 R1's weight was 212 lbs.
-8/24/20 R1's weight was 212 lbs.
-9/1/20 R1's weight was 209 lbs.

R1's weekly weights were not documented in her record for the weeks of 8/3/20, 8/10/20 and 8/17/20.

A copy of the facility's internal investigation of R1's medication errors was requested, and the facility provided a copy of the facility's 5 day investigative report for R1 and a copy of R1's August 2020 medication administration record (MAR) with 5 staff member's individual names handwritten on the MAR, in addition to a document dated 9/2/20.

The note dated 9/2/20, indicated regarding the medication error for R1, a staff member reported the Las label indicated the Lasix in the cassette was 20 mg and in smaller print instructions listed to administer one-half tablet and since the pill was smaller, felt it was difficult to see if the tablet was split. The facility had spoken with the pharmacy and been informed the label is required to identify the strength of the tablet, and would check with their software company to see if the font size of instructions could be made larger.

R1's 5 day investigative report completed by the facility, dated 9/1/20, listed R1 had an increase in Lasix from 10 mg to Lasix 20 mg on 8/11/20, however, R1 continued to receive 10 mg of Lasix in error until after treatment at the ER 8/31/20, when a staff member questioned why R1 had

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	245563	A. BUILDING _____ B. WING _____	C 09/16/2020

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F 760	Continued From page 7	F 760		

"such a jump" in the Lasix from 10 mg to 40 mg. The report listed the same cartridge was present in the medication cart, and pharmacy had not received the new order for Lasix 20 mg. The report identified R1's diagnoses from ER included CHF, enlarged heart, pulmonary vascular cephalized, left lower lobe effusion. The report identified R1 had been hospitalized in the past for CHF, not sure if the medication error contributed to R1's fluid overload diagnosed on 8/31/20.

Review of R1's MAR for August 2020 indicated Lasix 10 mg was administered daily 8/1/20 through 8/11/20. A second order was entered on 8/11/20 to administer Lasix 20 mg daily and was initialed as given daily 8/12/20 through 8/30/20. On 8/31/20, the MAR indicated Lasix 20 mg was not given as R1 was hospitalized. The order was correctly transcribed onto the MAR, however, there is no evidence the pharmacy had been notified of dose change. Review of R1's MAR revealed the Lasix 20 mg was incorrectly signed off as given from 8/12 to 8/31, as staff continued to administer 10 mg of Lasix daily.

On 9/10/20, at 10:27 a.m. R1 was observed seated in her wheelchair in the hallway, with oxygen tubing in her nares. R1 appeared pale, calm with no cough was noted and R1 was able to converse without shortness of breath noted. No edema was observed in her lower extremities.

On 9/10/20, at 8:40 am. LPN-A confirmed she had administered the wrong dose of Lasix to R1. LPN-A stated R1's MAR indicated the correct dose to give was Lasix 20 mg every day, however, the cassette in the cart was filled with the lower Lasix dose of 10 mg. LPN-A verified the increase in Lasix was not recorded in the shift

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F 760	Continued From page 8	F 760		

change report book that was used to alert other staff of resident changes. LPN-A stated she felt if the medication cassettes were double checked against the orders when they came in from pharmacy, the medication administration errors could have been prevented.

On 9/10/20, at 3:34 p.m. RN-A verified she had forgotten to record the medication adjustment on the shift report book. RN-A stated transcription of orders was double checked by the health unit coordinator (HUC) and the nurse, however, the ordering of the medication and removing the discontinued medication did not have a double check system. RN-A stated she felt she was sure she had ordered the increase dosage of Lasix from the pharmacy, however, she had not saved the fax communication form sent to the pharmacy. RN-A verified a medication error had occurred involving 5 different licensed staff over the course of 19 days.

On 9/11/20, at 10:40 a.m. DON confirmed R1 had received the incorrect dose of Lasix between 8/11 and 9/1/20. She indicated she felt the label on the cassette may have been confusing and hard to read. She also stated she felt there was a miscommunication between the pharmacy and the facility. She indicated she had provided 1:1 education with the five licensed staff members directly involved in the significant medication error regarding the 6 rights of medication administration. DON stated prior to R1's medication error, the QA committee had discussed scheduling an in-service on high risk medications and medication errors, however, no dates had been scheduled at the time of the medication error.

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F 760	Continued From page 9	F 760		

On 9/11/20, at 2:15 p.m. the DON stated she had done random, informal spot checks, comparing the individual residents' MAR against the medication cartridges, however, had no documentation of the checks and had not checked all the residents individual medications against the MAR's.

On 9/11/20, at 2:38 p.m. a telephone interview was conducted with the facility's consultant pharmacist. The pharmacist verified the missed increase in the Lasix was a significant medication error and confirmed a missed medication for that length of time was not ideal and would have consequences. The pharmacist stated it was a long time between the medication error and symptoms getting worse, so as far as severity, it would be difficult to tell if the medication error contributed.

On 9/14/20, at 1:00 pm a telephone interview was conducted with R1's primary medical doctor (MD), the MD identified if the Lasix had been administered as ordered and R1 had responded to the increase dose, it could possibly have changed the course of R1's illness and possibly avoided emergency intervention. The physician stated he did not feel the error ultimately contributed to R1's death, in light of the course of her illness and previous hospitalizations.

The facility's policy, titled, Policy for Identifying Early Changes in Condition and Reducing Unnecessary Hospitalizations, dated 4/25/19, identified changes in condition to include residents seeming different than usual, a weight change, being more tired, weak, confuse, or agitated than usual. or having a change in vital signs or respiratory status. The policy directed

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F 760	Continued From page 10	F 760		

staff, if the resident could be safely monitored in the facility, to take appropriate measures to ensure proper communication amongst staff members so that the resident's condition continues to be monitored until the change in condition has resolved.

The facility's policy titled, Medication Ordering, dated 11/20/17, indicated that no resident in the facility shall be with out any of the medications that have been ordered by their primary medical doctor (MD). If a medication that has been ordered has not been delivered, staff needed to notify the unit manager for follow up.

The facility's policy titled, Medication Administration, dated 1/6/20, indicated the six rights of medication administration should be followed with each medication or treatment. These include: right resident, medication, dose, time, route, documentation. The policy also directed staff three checks were to be done with each medication or treatment to ensure they are correct.

The IJ that began on 8/12/20, was removed on 9/16/20, at 12:00 p.m. when the facility developed and implemented the following interventions which were verified through observation, document review and interview:

-audited all residents that received diuretic medications to ensure correct doses where present in their medication cassettes and verified correct dose when compared against resident MAR's and physician orders.
-educated licensed nursing staff and trained medication aides (TMA's) regarding high risk medications and medication errors.

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F 760	Continued From page 11 -development of medication transcription sheets to be used in the shift report book which would list residents with medications changes along with a checkbox to remind and ensure that the medication has been removed from the cart, if applicable. -training licensed nursing staff and TMA's on new policy and procedure for transcribing orders. -competency testing of licensed staff and TMA's to ensure competency with medication pass best practice and will be added to staff's annual review. -consult with pharmacy on changes in medication labels. -developed an auditing system to ensure compliance with diuretic medications is sustained for all residents receiving diuretics.	F 760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 5, 2020

Administrator
Green Pine Acres Nursing Home
427 Main Street Northeast
Menahga, MN 56464

Re: State Nursing Home Licensing Orders
Event ID: 3XEZ11

Dear Administrator:

The above facility was surveyed on September 10, 2020 through September 16, 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:

Gail Anderson, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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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: A complaint investigation was conducted to investigate complaint #H5563015C. See licensing orders. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of	2 000		

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2 000	Continued From page 1 correction in 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 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	21545		9/22/20

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21545	Continued From page 2 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 without significant error for 1 of 1 resident (R1) who received the incorrect dose of diuretic (fluid reducing) medication for 19 days. This deficient practice caused harm for R1 who experienced increased edema, shortness of breath and required treatment at the emergency room (ER) and received intravenous (IV) medication administration of Lasix. The immediate jeopardy (IJ) began on 8/12/20, when facility staff incorrectly administered R1's dose of Lasix 20 milligrams (mg) and continued to administer the incorrect dose (10 mg) until 9/1/20, when the error was identified. On 8/31/20, R1 was sent to the emergency room, administered IV Lasix and diagnosed with congestive heart failure and fluid overload. The administrator and the director of nursing (DON) were notified of the immediate jeopardy at 4:05 p.m. on 9/14/20. The immediate jeopardy was removed on 9/16/20, at 12:00 p.m., but noncompliance remained at the lower scope and severity level of G, which indicated actual harm that is not immediate jeopardy.	21545	9/22/2020	

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21545	Continued From page 3	21545		

Findings include:

A facility Nursing Home Incident Reporting form submitted by the facility on 9/1/20, at 4:47 p.m., indicated an order was received by the facility on 8/11/20 to increase R1's Lasix from 10 mg daily to 20 mg daily, to start on 8/12/20. R1 did not receive the increased dose of 20 mg daily as ordered, which was discovered by the facility on 9/1/20, when the cassette in R1's medication cart was discovered to have 10 mg tablets, not the 20 mg tablets as ordered. The cassette was labeled to read Lasix 20 mg, take one-half tab by mouth daily. On 8/31/20, R1 was sent to the emergency room (ER) with increase in Lasix ordered, for diagnoses of CHF (congestive heart failure), enlarged heart, pulmonary vascular is cephalic, left lower effusion.

R1's quarterly Minimum Data Set (MDS) assessment dated 8/21/20, indicated R1's diagnosis included congestive heart failure, hemiplegia, diabetes and anxiety disorder. R1 had mild impaired cognition and received anti depressant medication on a daily basis. R1's MDS incorrectly indicated R1 did not receive diuretic medication in the 7 day look back period. R1's MDS also indicated R1 experienced shortness of breath at rest, received oxygen therapy and had life expectancy of greater than 6 months.

R1's Order Summary Report dated 8/6/20, included oxygen at 3 liters (L) via nasal cannula every shift for hypoxia related to CHF with start date of 4/30/20, and Lasix 10 mg by mouth in the morning for CHF with start date of 4/8/20.

R1's Physician Telephone order, dated 8/11/20, at

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21545	Continued From page 4	21545		

10:45 a.m. ordered an increase Lasix to 20 mg due to edema and CHF. However, R1's progress notes did not identify R1 was having any symptoms at that time.

R1's ER (emergency room) report dated 8/31/20, indicated R1 presented with abdominal distention and diarrhea. R1's exam revealed evidence of CHF with bilateral rales and peripheral edema. R1's abdomen was distended but non-tender. Chest X-ray showed pleural effusion and cephalization (refers to the redistribution of visible pulmonary vessels into the upper lung fields as pulmonary vascular volume and pressures increase) indicating pulmonary congestion. R1's abdominal CT scan showed ascites (fluid in the abdomen) and signs of cirrhosis (liver disease). R1 was treated with IV Lasix 40 mg. R1's family member declined hospitalization, and R1 returned to the nursing home with Lasix 40 mg by mouth daily with supplemental potassium daily.

R1's discharge patient information form dated 8/31/20, indicated R1 was seen in the emergency room for CHF and anemia.

Review of R1's progress notes (PN) from 8/10/20 through 9/11/20, revealed the following information:

-8/11/20 at 11:04 a.m. indicated an order was received to increase R1's Lasix dose to 20 mg every day for edema and CHF. However, the notes lacked documentation of any symptoms R1 was experiencing at that time.

-8/13/20, noted to have 1+ pitting edema and R1 stated she did have gout.

-8/19/20, complained of chest pain and shortness

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21545	Continued From page 5	21545		

of breath and per staff report seemed "off." After 5 minutes, on reassessment, R1'S symptoms had improved.

-8/21/20, turning on her call light frequently and calling office and family members. R1 was very upset and staff was unable to answer her questions.

-8/21/20, another note indicated R1 appeared to be having discomfort and shortness of breath. R1 was agitated and anxious. R1's oxygen saturation registered at 84% (normal range-95-100%) with oxygen administered at 3L per nasal cannula and she complained of acid reflux. Staff repositioned R1 and spoke with her regarding her concerns. Staff administered Maalox (an antacid medication) and R1 appeared to relax and interventions appeared effective.

-8/23/20, abdomen seemed firm and distended. R1's bowel sounds were active and R1 had a documented bowel movement every day.

-8/23/20, another note indicated R1 would turn on the call light when staff left the room and rang the call light frequently. R1 complained of not being able to breath. R1's oxygen saturation registered 93% with oxygen on at 3L per nasal cannula.

-8/28/20, continued to have a distended abdomen. Lab work ordered for liver function. R1 was documented to have 2+ bilateral lower extremity edema.

-8/29/20, liver function lab work was within normal limits.

-8/31/20, R1 was noted to be pale and lethargic and had five loose stools. R1's abdomen was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00678	A. BUILDING: _____ B. WING _____	C 09/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN PINE ACRES NURSING HOME	427 MAIN STREET NORTHEAST MENAHGA, MN 56464

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21545	Continued From page 6	21545		

extended and firm. Bowel sounds were hyperactive. R1 had 3+ edema in both lower extremities. Lung sounds were clear and oxygen saturation was 89% with oxygen on at 3L/minute per nasal cannula. R1 was sent to the hospital for an X-ray.

-8/31/20, a later note written by the director of nursing (DON) indicated R1 was noted to have been taking Maalox frequently which was likely cause of loose stools as this is a side effect of that medication along with bloating. The note included R1 was taking the medication for full feeling/GI upset which was due to CHF and fluid overload as per ER report, and returned with medication changes.

-8/31/20, another note indicated R1 had returned to the facility at 5:00 p.m., oxygen saturation was 94% with oxygen at 3L/minute per nasal cannula and had no further loose stools. Shortness of breath was noted only with cares when R1 was lying flat or being moved around.

-9/1/20, order was received for Lasix 40 mg a day, potassium 20 equivalents a day and to follow up with primary MD in one week.

-9/1/20, another noted indicated R1 was up in her wheelchair, visiting with her spouse and had stated she felt better. R1 appeared better in color and abdomen had decreased slightly.

R1's progress notes lacked any documentation of the medication errors that had occurred 8/12/20 through 8/31/20.

R1's weight log from 7/23/20 through 9/1/20, revealed the following weights:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21545	Continued From page 7	21545		

-7/23/20 R1's weight was 206 lbs.
-7/27/20 R1's weight was 208 lbs.
-8/3/20 R1's weight was 209 lbs
-8/6/20 R1's weight was 210 lbs.
-8/10/20 R1's weight was 216 lbs
-8/17/20 R1's weight was 212 lbs.
-8/24/20 R1's weight was 212 lbs.
-9/1/20 R1's weight was 209 lbs.

R1's weekly weights were not documented in her record for the weeks of 8/3/20, 8/10/20 and 8/17/20.

A copy of the facility's internal investigation of R1's medication errors was requested, and the facility provided a copy of the facility's 5 day investigative report for R1 and a copy of R1's August 2020 medication administration record (MAR) with 5 staff member's individual names handwritten on the MAR, in addition to a document dated 9/2/20.

The note dated 9/2/20, indicated regarding the medication error for R1, a staff member reported the Las label indicated the Lasix in the cassette was 20 mg and in smaller print instructions listed to administer one-half tablet and since the pill was smaller, felt it was difficult to see if the tablet was split. The facility had spoken with the pharmacy and been informed the label is required to identify the strength of the tablet, and would check with their software company to see if the font size of instructions could be made larger.

R1's 5 day investigative report completed by the facility, dated 9/1/20, listed R1 had an increase in Lasix from 10 mg to Lasix 20 mg on 8/11/20, however, R1 continued to receive 10 mg of Lasix in error until after treatment at the ER 8/31/20, when a staff member questioned why R1 had

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21545	Continued From page 8	21545		

"such a jump" in the Lasix from 10 mg to 40 mg. The report listed the same cartridge was present in the medication cart, and pharmacy had not received the new order for Lasix 20 mg. The report identified R1's diagnoses from ER included CHF, enlarged heart, pulmonary vascular cephalized, left lower lobe effusion. The report identified R1 had been hospitalized in the past for CHF, not sure if the medication error contributed to R1's fluid overload diagnosed on 8/31/20.

Review of R1's MAR for August 2020 indicated Lasix 10 mg was administered daily 8/1/20 through 8/11/20. A second order was entered on 8/11/20 to administer Lasix 20 mg daily and was initialed as given daily 8/12/20 through 8/30/20. On 8/31/20, the MAR indicated Lasix 20 mg was not given as R1 was hospitalized. The order was correctly transcribed onto the MAR, however, there is no evidence the pharmacy had been notified of dose change. Review of R1's MAR revealed the Lasix 20 mg was incorrectly signed off as given from 8/12 to 8/31, as staff continued to administer 10 mg of Lasix daily.

On 9/10/20, at 10:27 a.m. R1 was observed seated in her wheelchair in the hallway, with oxygen tubing in her nares. R1 appeared pale, calm with no cough was noted and R1 was able to converse without shortness of breath noted. No edema was observed in her lower extremities.

On 9/10/20, at 8:40 am. LPN-A confirmed she had administered the wrong dose of Lasix to R1. LPN-A stated R1's MAR indicated the correct dose to give was Lasix 20 mg every day, however, the cassette in the cart was filled with the lower Lasix dose of 10 mg. LPN-A verified the increase in Lasix was not recorded in the shift change report book that was used to alert other

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21545	Continued From page 9	21545		

staff of resident changes. LPN-A stated she felt if the medication cassettes were double checked against the orders when they came in from pharmacy, the medication administration errors could have been prevented.

On 9/10/20, at 3:34 p.m. RN-A verified she had forgotten to record the medication adjustment on the shift report book. RN-A stated transcription of orders was double checked by the health unit coordinator (HUC) and the nurse, however, the ordering of the medication and removing the discontinued medication did not have a double check system. RN-A stated she felt she was sure she had ordered the increase dosage of Lasix from the pharmacy, however, she had not saved the fax communication form sent to the pharmacy. RN-A verified a medication error had occurred involving 5 different licensed staff over the course of 19 days.

On 9/11/20, at 10:40 a.m. DON confirmed R1 had received the incorrect dose of Lasix between 8/11 and 9/1/20. She indicated she felt the label on the cassette may have been confusing and hard to read. She also stated she felt there was a miscommunication between the pharmacy and the facility. She indicated she had provided 1:1 education with the five licensed staff members directly involved in the significant medication error regarding the 6 rights of medication administration. DON stated prior to R1's medication error, the QA committee had discussed scheduling an in-service on high risk medications and medication errors, however, no dates had been scheduled at the time of the medication error.

On 9/11/20, at 2:15 p.m. the DON stated she had done random, informal spot checks, comparing

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21545	Continued From page 10	21545		

the individual residents' MAR against the medication cartridges, however, had no documentation of the checks and had not checked all the residents individual medications against the MAR's.

On 9/11/20, at 2:38 p.m. a telephone interview was conducted with the facility's consultant pharmacist. The pharmacist verified the missed increase in the Lasix was a significant medication error and confirmed a missed medication for that length of time was not ideal and would have consequences. The pharmacist stated it was a long time between the medication error and symptoms getting worse, so as far as severity, it would be difficult to tell if the medication error contributed.

On 9/14/20, at 1:00 pm a telephone interview was conducted with R1's primary medical doctor (MD), the MD identified if the Lasix had been administered as ordered and R1 had responded to the increase dose, it could possibly have changed the course of R1's illness and possibly avoided emergency intervention. The physician stated he did not feel the error ultimately contributed to R1's death, in light of the course of her illness and previous hospitalizations.

The facility's policy, titled, Policy for Identifying Early Changes in Condition and Reducing Unnecessary Hospitalizations, dated 4/25/19, identified changes in condition to include residents seeming different than usual, a weight change, being more tired, weak, confuse, or agitated than usual. or having a change in vital signs or respiratory status. The policy directed staff, if the resident could be safely monitored in the facility, to take appropriate measures to ensure proper communication amongst staff

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21545	Continued From page 11	21545		

members so that the resident's condition continues to be monitored until the change in condition has resolved.

The facility's policy titled, Medication Ordering, dated 11/20/17, indicated that no resident in the facility shall be with out any of the medications that have been ordered by their primary medical doctor (MD). If a medication that has been ordered has not been delivered, staff needed to notify the unit manager for follow up.

The facility's policy titled, Medication Administration, dated 1/6/20, indicated the six rights of medication administration should be followed with each medication or treatment. These include: right resident, medication, dose, time, route, documentation. The policy also directed staff three checks were to be done with each medication or treatment to ensure they are correct.

The IJ that began on 8/12/20, was removed on 9/16/20, at 12:00 p.m. when the facility developed and implemented the following interventions which were verified through observation, document review and interview:

-audited all residents that received diuretic medications to ensure correct doses where present in their medication cassettes and verified correct dose when compared against resident MAR's and physician orders.
-educated licensed nursing staff and trained medication aides (TMA's) regarding high risk medications and medication errors.
-development of medication transcription sheets to be used in the shift report book which would list residents with medications changes along with a checkbox to remind and ensure that the

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21545	Continued From page 12 medication has been removed from the cart, if applicable. -training licensed nursing staff and TMA's on new policy and procedure for transcribing orders. -competency testing of licensed staff and TMA's to ensure competency with medication pass best practice and will be added to staff's annual review. -consult with pharmacy on changes in medication labels. -developed an auditing system to ensure compliance with diuretic medications is sustained for all residents receiving diuretics. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could develop, review and/or revise policies to ensure all resident medications are administered without error and educate all appropriate staff on the policies and procedures. The administrator, DON or designee could review and revise policies for transcribing orders, communicating medications to licensed staff and ordering medication according to evidence based practices/procedures. The DON or designee, could audit all diuretic medications and the administration of the medications and staff awareness of policy/procedures and reports will be made to Quaility Assurance Committee. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21545		