Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 11, 2024

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

RE: CCN: 245626
Cycle Start Date: October 10, 2024

Dear Administrator:

On December 4, 2024, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 11, 2024

Administrator
Rochester Rehabilitation And Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

Re: Reinspection Results
Event ID: 893912

Dear Administrator:

On November 7, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 10, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
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Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2024

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

RE: CCN: 245626
Cycle Start Date: October 10, 2024

Dear Administrator:

On October 10, 2024, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 January 10, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 10, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. BUILDING _____ B. WING _____	C 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER REHABILITATION AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

(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 10/9/24 and 10/10/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H56269380C (MN107206) with a deficiency cited at F609 and 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 that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		11/5/24

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

Electronically Signed | 10/24/2024

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 609	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report a significant medication error (an error that causes the resident discomfort or jeopardizes the residents health and safety) was reported to the state agency (SA) for 1 of 3 (R1) residents reviewed for medication errors. Findings include: An INR (International Normalized Ratio): lab test measures how long it takes your blood to clot and is used to assess your risk of bleeding. INR tests are also used to assess the risk of bleeding or the coagulation status of patients. R1's admission Minimum Data Set (MDS) dated 9/24/24, indicated R1's cognition was intact and diagnoses of permanent Atrial Fibrillation (a heart condition that causes an irregular and often rapid heartbeat in the upper chambers of the heart), presence of prosthetic heart valve (at risk for	F 609	F609 Reporting of Alleged Violations Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Affected Resident(s): • R1 was evaluated by RRLC Nursing and nurse practitioner so ensure that resident is safe. Resident has since discharged to a lower level of care. Potential Affected Resident(s):	

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F 609	Continued From page 2 blood clotting complications), and Factor 5 Leiden syndrome (a mutation of one of the clotting factors in the blood. This mutation can increase your chance of developing abnormal blood clots, most commonly in your legs or lungs). R1's Nurse Practitioner (NP) order dated 9/26/24 at 8:50 a.m., identified a new order for enoxaparin 40 milligrams (mg)/0.4 milliliter (ml) subcutaneous syringe (Lovenox). Directions identified to inject 0.9 ml (90 mg total) under the skin two times a day for 7 days. 0.9 ml (90 mg) subcutaneous (SQ) BID (twice a day) until INR is > 2.0. R1's NP visit dated 9/27/24 at 7:54 a.m., identified a visit was completed for anticoagulation management for atrial fibrillation, bioprosthetic mitral valve and Leiden Factor 5 syndrome. R1's INR goal identified 2.0 to 3.0. Current INR was 1.4. Lovenox was not initiated 9/26/24, check INR daily through 9/30/24 and give SQ Lovenox as ordered until INR > 2.0. R1's Medication Administration Record (MAR), dated 9/27/24 at 2:45 p.m., identified to inject Lovenox injection solution 0.9 ml subcutaneously two times a day for blood clotting prevention until 9/30/24. Give only if INR is below 9/30/24. On 9/27/24 the order should have been implemented for an 8:00 a.m. dose and this was omitted. During an observation and interview on 10/9/24 at 4:25 p.m., R1 was seated in his room on his wheeled walker. R1 stated he had been on anticoagulation medications for almost 20 years due to several cardiac diagnoses and a genetic blood clotting factor. R1 indicated he had a history of development of 2 blood clots in his	F 609	• All incident reports and grievances over the past three month since August 1 will be reviewed to ensure any unreported or underreported incidents. Any unreported incidents will be reported immediately, appropriate notifications made and affected residents will be reassessed for safety. Measures/Systematic Changes: • The Resident/Client Protection Policy was reviewed and remains current. • All Team members will be re-educated on the Resident Protection Policy for reporting abuse, neglect, and mistreatment, including timelines for internal and external reporting. • All Team members will receive a copy of the reporting flow chart. Monitoring: • All Resident progress notes, incidents, and medication errors will be reviewed to ensure any reportable significant medication errors events are reported per policy. • Audits will take place daily for 4 weeks and then weekly for 8 weeks. • DON/designee responsible for compliance. • Results will be reported at QAPI and the need for continued audits will be determined. Date of Alleged Compliance: November 5, 2024	

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F 609	Continued From page 3 lower right leg and a blood clot in his lung. R1 indicated he did receive two injections at night of Lovenox a couple weeks ago when his INR got down to 1.4. R1 stated he has not had to have Lovenox injections for years and has been able to keep his INR within a therapeutic range with his coumadin dosing. R1 further stated the facility did not notify him of any medication errors with his blood clotting medications and stated he would like to be notified if there was an error. During an interview on 10/10/24 at 11:21 a.m., registered nurse (RN)-A stated she was the nurse manager for R1. RN-A stated she was aware that R1 had a medication error when R1 did not receive his Lovenox injection for his morning dose on 9/27/24. RN-A stated NP-A saw R1 on 9/27/24 and had asked her why the order was never initiated. RN-A indicated this significant medication error should have been reported to the state agency. During an interview on 10/10/24 at 5:35 p.m., regional nurse consultant (RNC)-A indicated the facility was aware that R1's Lovenox order was not implemented as ordered and the missed dose would be considered a significant medication error. RNC-A further indicated it should have been reported to the state agency and was not. Facility policy, "Resident/Client Protection Freedom From Abuse, Neglect, and Misappropriation," revised 11/3/22 identified, I. FACILITY/SERVICE MISSION, PHILOSOPHY AND PLAN OBJECTIVE, It is the policy of Volunteers of America that all resident/client/participants/clients are free from abuse and neglect. All VOA facilities and program serving adults will establish and enforce	F 609		

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F 609	Continued From page 4 written policies and procedures related to suspected or alleged maltreatment and will orient residents/clients/participants and mandated reporters to these procedures. In accordance with federal regulation, this Resident/client/participant Protection Plan establishes the policies and procedures for protecting the individuals that live at our facility/service and/or receive our services. Each individual has the right to be free from verbal, sexual, physical, and mental abuse, including injuries of unknown source, misappropriation of resident/participant property, corporal punishment, mistreatment, neglect, and involuntary seclusion. Resident/client/participants must not be subjected to abuse by anyone, including, but not limited to, facility/service staff, other resident/client/participants, consultants or volunteers, staff of other agencies serving the resident/client/participant, family members, or legal guardians, friends, or other individuals. To further that philosophy and as required by law, our facility/service has adopted the Resident/client/participant Protection Plan. The facility/service does not discriminate in providing services on account of membership in any protected class, including, without limitation, race, color, creed, religion, national origin, sex, disability, or sexual orientation ...G. Reporting and Response 1. Employees must always report alleged abuse/neglect (i.e. incidents, mistreatment, abuse, neglect, injuries of unknown and known origin, and misappropriation of resident/client/participant property) immediately to the Supervisor or the Building Supervisor. 2. Anyone who reports abuse/neglect/exploitation in good faith will not be retaliated against. 3. The Executive Director/or designated representative must be contacted immediately by Supervisor or reporter regarding all allegations of	F 609		

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F 609	Continued From page 5 abuse/neglect. Immediate reporting may be reported via voice mail or answering machine. Document date and time of notification ...7. Documentation a. Should be objective b. Statements made by the resident/client/participant should be in quotes c. Statements made by staff should be part of the investigation and given to Administration d. Include immediate interventions to keep the resident/client/participant safe e. Include resident/client/participant's behavior and the environment f. Include who was notified and the time the notification occurred. Note: Acceptable means of notification include fax, voice mail, and answering machine. Email is not acceptable method of notification. g. Include social services or designee in the notification h. Do not include another resident/client/participant's name in the note. If another resident/client/participant was involved refer to them as "another resident/client/participant." ..."Neglect" is the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is: 1) reasonable and necessary to obtain or maintain the vulnerable adults physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult, and 2) which is not the result of an accident or therapeutic conduct. The absence or likelihood of absence of care or services, including but not limited to food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.	F 609		

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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow physician orders, labs, and administer anticoagulant medications and failed to have a system in place to identify, record and report omitted medications as medication errors for 2 of 3 (R1 and R2) residents reviewed for medication errors. Findings include: An INR (International Normalized Ratio): lab test measures how long it takes your blood to clot and is used to assess your risk of bleeding. R1's discharge summary dated 9/18/24, identified to hold warfarin (blood thinning medication) on 9/18/24. Check INR on 9/19/24 to determine ongoing warfarin dosing. R1's physician visit dated 9/19/24, identified R1 had permanent atrial fibrillation (a heart condition that causes an irregular and often rapid heartbeat in the upper chambers of the heart), bioprosthetic mitral valve (at risk for blood clotting complications), history of tricuspid valve repair, coronary artery disease, and Factor 5 Leiden syndrome (a mutation of one of the clotting factors in the blood. This mutation can increase your chance of developing abnormal blood clots, most commonly in your legs or lungs) with prior deep vein thrombosis (DVT). R1 was on chronic anticoagulation with warfarin. Warfarin on hold	F 760	F760 Significant Med Errors Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Affected Resident(s): • R1 and R2 were reviewed immediately to verify orders transcribed appropriately per MD order and medication administered Potential Affected Resident(s): • All other residents receiving anticoagulants will be reviewed to verify orders are transcribed appropriately per MD order and medication administered. Measures/Systematic Changes: • The Policy/Procedure for Medication Administration was reviewed and remains current. • Medications not administered per policy will be followed up on as a	11/5/24

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F 760	Continued From page 7 until next INR, will order today. R1's Medication Administration Record (MAR), dated September 2024, identified on 9/19/24, to check R1's INR. Under INR box was blank indicating INR was not completed. R1's medical record indicated R1's INR was not checked per physician order on 9/19/24, a physician was not notified to resume R1's Coumadin dosing therefore R1's coumadin was not administered on 9/19/24. R1's Nurse Practitioner (NP) visit dated 9/20/24 at 3:17 p.m., identified a visit was completed for anticoagulation management for atrial fibrillation, bioprosthetic mitral valve and Leiden Factor 5 syndrome. R1's INR goal identified 2.0 to 3.0. R1's INR was 2.0, give 2 mg of warfarin daily and recheck INR on 9/23/24. R1's signed medical doctor (MD) verbal order dated 9/20/24 at 4:14 p.m., identified to give warfarin 2.5 mg daily until 9/30/34. R1's NP visit dated 9/23/24, identified R1's INR was 1.4, R1 did not receive warfarin on 9/19/24. On 9/23/24 give 4 mg of warfarin and on 9/24/24 give 3 mg. Recheck INR on 9/25/24. R1's admission Minimum Data Set (MDS) dated 9/24/24, indicated R1's cognition was intact and received anticoagulants. R1's NP visit dated 9/25/24, identified R1's INR was 1.4. On 9/25/24 and 9/26/24 give warfarin 5 mg. Recheck INR on 9/27/24. R1's MAR dated September 2024, identified on	F 760	medication error to determine the root cause • team member Licensed Nurses responsible for passing medication or those who have the potential to pass medication will receive education to ensure medications are being properly administered. • Licensed Nurses will receive education regarding reporting a medication error to Nurse Manager if medication not properly administered. and when to report a medication error . • Licensed Nurses will receive education was initiated regarding the need to verify orders and assure transcription of orders • A medication error checklist was created, implemented and Licensed nurses will be trained on the checklist. • An anticoagulant medication monitoring protocol was reviewed, revised and education of Licensed nurses will be completed. Monitoring: • The DON & Nurse Managers will begin audits of INR, Anticoagulants, medication errors and . order transcription and medications administered timely . Frequency of audits will be daily X 2 weeks, weekly for 2 additional months to ensure medications have been administered and errors reported timely • DON & Nurse Managers will review medication errors for significant errors and summary will be provided to Pharmacy Consultant weekly to confirm medication error classification. This will be	

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F 760	Continued From page 8 9/25/24, R1 did not receive warfarin 5mg as indicated by a blank space. R1's medical record does not identify if a provider was notified of R1's missed warfarin dose on 9/25/24. R1's NP order dated 9/26/24 at 8:50 a.m., identified a new order for (Lovenox-an injectable anticoagulant) 40 mg/0.4 milliliter (ml) subcutaneous syringe. Directions identified to inject 0.9 ml (90 mg total) under the skin two times a day for 7 days until INR is > 2.0. R1's NP visit dated 9/27/24 at 7:54 a.m., identified R1's INR was 1.4. Lovenox was not initiated 9/26/24. Check INR daily through 9/30/24 and give SQ Lovenox as ordered until INR > 2.0. R1's MAR dated September 2024, identified on 9/27/24 at 8:00 a.m., R1 did not receive 90 mg of Lovenox injection, the order was not put in until 9/27/24 at 1:45 p.m. R1's record identified on 9/27/24 that his INR was 1.4 and should have received an injection of 90 mg of Lovenox at 8:00 a.m. which was omitted due to the order being put in late. R1's MAR dated 9/28/24, identified R1's INR was 1.6. R1's MAR dated September 2024, identified on 9/29/24 at 8:00 p.m., R1's INR was 1.8. R1 did not receive 90 mg of Lovenox injection. An "8" was documented that indicated to see progress note. R1's progress note dated 9/29/24 at 9:13 p.m.,	F 760	completed weekly for 12 weeks. • DON/designee responsible for compliance. • Results will be reported at QAPI and the need for continued audits will be determined. Date of Alleged Compliance:November 5, 2024	

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F 760	Continued From page 9 identified Lovenox injection solution was not available. Dosage ends on 9/30/24. R1's record does not identify if R1's provider was notified of missed Lovenox injection. R1's NP visit dated 9/30/24 at 12:41 p.m., identified R1's INR was 2.1. Give 7.5 mg of warfarin on 9/30/24 and 5 mg daily thereafter. Recheck INR on 10/4/24. R1's care plan revised 10/1/24, identified a focus that R1 had anticoagulant use. Interventions dated 9/18/24, identified to do labs and give medications as ordered by provider. During an observation and interview on 10/9/24 at 4:25 p.m., R1 was seated in his room on his wheeled walker. R1 stated he had been on anticoagulation medications for almost 20 years due to several cardiac diagnoses, history of blood clots and a genetic blood clotting factor. R1 indicated he did receive two injections at night of Lovenox a couple weeks ago when his INR got down to 1.4. R1 stated he had not had to have Lovenox injections for years and has been able to keep his INR within a therapeutic range with his warfarin. R1 stated the doctors start to get nervous when my INR gets lower than 2.4 because then it really drops. R1 further stated the facility did not notify him of any medication errors with his blood clotting medications and stated he would like to know if there was an error. During an interview on 10/10/24 at 11:21 a.m., registered nurse (RN)-A stated she was the nurse manager for R1. RN-A stated she was aware that R1 had a medication error when R1 did not receive his Lovenox injection for his morning	F 760		

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F 760	Continued From page 10 dose on 9/27/24. RN-A stated NP-A saw R1 on 9/27/24 and had asked her why the order was never initiated. RN-A stated they later found out that when the provider faxed the order it went straight to the pharmacy, and she didn't remember seeing the order. RN-A verified R1 did not have his INR drawn on 9/19/24 per provider order, missed 5mg dose of warfarin on 9/25/24, and missed dose of Lovenox on 9/27/24 at 8:00 a.m. and 9/29/24 at 8:00 p.m. RN-A was not aware of these medication errors and verified there was nothing documented in R1's medical record that a physician was notified. During an interview on 10/10/24 at 4:09 p.m., RN-B stated that she found a message in R1's chart that (name of lab) lab technicians had messaged the doctor covering for medical doctor (MD)-A on 9/19/24 at 1:35 p.m., that the lab techs had left for the day and if it was ok if they just checked R1's INR on 9/20/24. RN-B stated she called MD-A on 9/20/24 because she noticed R1's INR was not checked on 9/19/24 and there were no current warfarin orders. MD-A told her there was no policy regarding this and we will no longer have that lab following our residents and that we will start doing our own INR's at bedside. RN-B verified R1's warfarin dose was missed on 9/25/24 due to R1 being in the emergency room (ER), but a provider should have been called when he came back about the missed dose. RN-B stated the fax did come on 9/26/24 for R1's Lovenox and it said to take the Lovenox out of the Omnicell. RN-B stated the nurses were struggling with using the Lovenox out of the Omnicell because it was not a prepackaged injection, it came in a vial and the nurses were having struggles trying to figure out the correct dosage to give. R1 missed his Lovenox injection on 9/29/24	F 760		

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F 760	Continued From page 11 because that particular nurse did not have access to the Omnicell and probably could not find R1's medication. RN-B stated that nurse should have notified the provider that the medication was not available. RN-B stated R1 had a genetic clotting factor and several cardiac diagnoses putting him at greater risk for developing a blood clot, heart attack or stroke, especially when his INR was subtherapeutic for almost 8 days. R2 R2's care plan revised 12/21/22, identified a focus of anticoagulant use for a diagnosis of atrial fibrillation, Intervention dated 11/24/22, identified to administer anticoagulant and labs per MD orders and 10/2/24, identified to obtain INR and report to physician as ordered. R2's significant change MDS dated 8/27/24, identified R2's cognition was intact had diagnoses of atrial fibrillation and tricuspid insufficiency. R2 received anticoagulants. R2's NP visit dated 9/23/24 at 1:47 p.m., identified R1's INR was 2.0. Give 1.5 mg of warfarin on Fridays and 2 mg all other days, recheck INR on 10/7/24. R2's MAR dated September 2024, identified an order dated 9/23/24 at 2:06 p.m. to give warfarin 2mg every evening on Monday, Tuesday, Wednesday, Thursday, Saturday, and Sunday until 10/6/24 at 2:06 p.m. R2's warfarin order was discontinued on 10/6/24 at 2:06 p.m. therefore the 2 mg evening dose was not documented as there was no box to document.	F 760		

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F 760	Continued From page 12 R2's NP visit dated 10/7/24 at 10:16 a.m., identified R1's INR was 1.7. Give 3 mg of warfarin on Mondays and Thursdays and 2 mg the rest of the days of the week, recheck INR on 10/14/24. During an observation and interview on 10/10/24 at 9:13 a.m., R2 was seated in her wheelchair and stated she had just finished eating breakfast. R2 stated she had been on warfarin for years due to atrial fibrillation, stated she had prior ablations that did not fix it. R2 stated warfarin is a very important medication and her INR levels must be between 2.0 and 3.0 or she would be at risk for a stroke, heart attack or blood clots. I usually get my INR's checked her at the facility they do a fingerstick, unless I am at an appointment at Mayo then they will do a blood draw. During a phone interview on 10/10/24 at 5:12 p.m., HUC-A stated she does all of the residents INR's through a fingerstick, she will record the INR results in the MAR, will document everything on a tracking sheet and send it to the nursing home desk so NP-A can read the results and give new orders based on the result. HUC-A stated she then puts the order in PCC and will fax the new order to the pharmacy, then I give the new order to the nurse manager so they can doublecheck the order. R1's INR may have been missed because she was on vacation that day and was unaware of who would have covered for her, was guessing the nurse managers. HUC-A stated they have back up medications in the Omnicell but not all nurses have access. HUC-A stated she remembered the mess with R1's Lovenox because it was in a vial in the Omnicell and not everyone had access. HUC-A stated she just hears about medication errors when they	F 760		

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F 760	Continued From page 13	F 760		

happen and stated they do not have discussions about if they are reportable to the state or not. HUC-A stated she was not aware of R2's missed coumadin dose on 10/6/24.

During an interview on 10/10/24 at 10:53 a.m., licensed practical nurse (LPN)-A stated she was the nurse manager for R2. LPN-A stated with a medication error, we would document the error on a paper medication form that instructs us to notify the physician of the error, it does not instruct us to notify the resident or resident representative. We would then give the form to the director of nursing (DON). LPN-A indicated R2 should have received 2 mg of warfarin on 10/6/24, stated it looked like the medication was discontinued too early so there was nothing to alert the nurse to give it. Health Unit Coordinator (HUC)-A does our INR's, sends the results to the provider, when the provider gives new orders, HUC-A will either put the order in or will gives the order to the nurse manager to put into point click care (PCC). LPN-A stated we do not always put the order in the que for a second nurse to doublecheck the orders, but it would be best practice to do that. LPN-A stated R2's medication error would be a significant error due to the fact it's a blood thinner, that would explain why R2's INR was subtherapeutic 1.7 on 10/7/24.

During an interview on 10/10/24 at 12:28 p.m., director of nursing (DON) indicated she had been the current DON for two days, and her understanding as the HUC's do the fingerstick INR's and documents the INR's and the provider orders for anticoagulants in the medical record. DON stated with a medication error she would have to investigate the root cause, notify the provider, may have to file a VA if it can seriously

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F 760	Continued From page 14 impact the residents health. DON stated any anticoagulant medications such as warfarin and Lovenox would be significant medication errors because they are blood thinners and leave the resident at high risk for blood clots, stroke, or heart attack. DON indicated she would document the medication error in the nurses note. DON verified R1 did not have his INR checked per MD order on 9/19/24, missed a 5 mg dose of warfarin on 9/25/24, Lovenox was not implemented as ordered and missed 9/27/24 dose of Lovenox and missed another dose of Lovenox on 9/29/24 at 8:00 p.m. DON further verified R2 missed a dose of warfarin on 10/6/24. During an interview on 10/10/24 at 12:49 p.m., regional nurse consultant (RNC)-A verified there were no medication errors filled out for any of R1 or R2's medication errors. RNC-A stated with medication errors the provider and resident/resident representative should be notified, medication error form should be filled out to determine a root cause of the error to put interventions in place for prevention. During a phone interview on 10/10/24 at 2:31 p.m., pharmacist (P)-A stated with medications involving blood thinners such as warfarin and Lovenox you put the resident at risk of subtherapeutic INR. P-A stated for patients with diagnoses with genetic clotting factors and atrial fibrillation if blood thinners are being missed that would be a significant med error, you wouldn't see the results until about 2 days later. Anytime you are not therapeutic between 2.0 and 3.0 it puts you at risk for clots, heart attack or stroke. During a phone interview on 10/10/24 at 2:48 p.m. NP-A stated she started following residents	F 760		

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F 760	Continued From page 15 at the facility for anticoagulation. NP-A stated she was aware of R1 not having his Lovenox started timely but was not aware of R1's medication errors on 9/25/24 and 9/29/24. NP-A stated she would expect a phone call from the nurse for a missed blood thinner so the resident can be dosed appropriately. NP-A stated when INR levels are below 2.0, they become subtherapeutic putting the resident at risk for the development of blood clots, stroke, or heart attack. Facility policy, "Medication Related Errors," revised 7/1/24, identified a Procedure: 1. Medication Errors. If a medication reaches a resident in error, facility should: 1.1 Notify pharmacy of any possible dispensing occurrence; and 1.2 Notify physician/prescriber and obtain further instructions and/or orders. Facility staff should monitor the resident in accordance with physician's/prescriber's instructions. 2. Prescribing Errors: In the event of a prescribing error, facility staff should follow facility's occurrence/incident policy, associated forms, and performance improvement processes. Examples of prescribing errors include, but are not limited to: 2.1 Incorrect medication selection based on indications, contraindications, known allergies, existing medication therapy, and other factors., 2.2 Dose, dosage form, quantity, route, concentration, rate of administration, or, 2.3 Incorrect instructions for use of a medication ordered or authorized by a physician/prescriber. 3. Dispensing Errors: If facility believes a dispensing error has occurred, facility staff should follow facility policy relating to dispensing errors. See Policy 10.1 (Pharmacy-Related Occurrence Reporting). Examples of dispensing errors include, but are not limited to: 3.1 Unauthorized medication error: Dispensing to the resident a	F 760		

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F 760	Continued From page 16 dose of medication not authorized by Physician/Prescriber for the resident; 3.2 Dose error: Dispensing to the resident of a dose that is greater than or less than the amount originally ordered; 3.3 Route error: Dispensing medication to the resident by a route other than originally ordered; 3.4 Rate error: Dispensing the incorrect rate of administration of a medication to a resident other than that originally ordered; 3.5 Dosage form error: Dispensing to the resident of a medication in a different form than that originally ordered ;3.6 Frequency error: Dispensing to the resident of a medication at an incorrect interval of administration other than that originally ordered 3.7 Dose preparation error: Medications incorrectly formulated or manipulated before administration (e.g., incorrect dilution or reconstitution); 3.8 Medication error: Dispensing to the resident a medication other than that originally ordered; 3.9 Resident/Facility error: Dispensing to a resident or Facility other than the one intended; 3.10 Label error: Dispensing to the resident a medication that has a label affixed which contains information other than that originally ordered or information that is inappropriate for the medication itself; 3.11 Expired medication error: Dispensing to the resident a medication that expires prior to administration; 3.12 Monitoring error: Failure to review a prescribed regimen for appropriateness;3.13 Delivery error: Drug product not received by the resident/facility at the required/expected time; 3.14 Data entry error: Entire order or part of an order was incorrectly entered into computer system by data entry; and 3.15 Transcription error: Entire order or part of an order was incorrectly transcribed from original order. Administration Errors: In the event of an administration error, facility staff should follow	F 760		

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F 760	Continued From page 17 facility policy relating to medication administration errors. Examples of administration errors include, but are not limited to 4.1 Transcription error: Facility incorrectly transcribes to pharmacy an entire order or part of an order; 4.2 Unauthorized medication error: Facility administers a medication dose not authorized for the resident; 4.3 Dose error: Facility administers to the resident a medication dose that is greater than or less than the amount originally ordered ; 4.4 Route error: Facility administers to the resident a medication dose by a route other than that originally ordered by or a wrong site of administration; 4.5 Rate error: Facility administers to the resident a medication dose at any rate other than that originally ordered or as established by facility policy; 4.6 Dosage form error: Facility administers to the resident a medication dose by the correct route but in a different dosage form than that specified by the original order. 4.7 Administration time error: Facility administers to the resident a medication dose greater than sixty (60) minutes from its scheduled administration time or if administration exceeds the time in relation to meals; 4.8 Dose preparation error: Facility staff incorrectly formulates or manipulates a drug product before administration (e.g., incorrect dilution or reconstitution, not shaking a suspension, not keeping a light sensitive medication protected from the light, and mixing incompatible medications); 4.9 Omission error: Facility fails to administer an ordered dose to the resident, unless refused by the resident or not administered because of recognized contraindication; 4.1O Administration technique error: Facility administers a medication dose via the correct route and site, but improper technique is used; and 4.11 Monitoring error: Facility fails to	F 760		

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F 760	Continued From page 18 review a prescribed regimen for appropriateness or fails to use appropriate clinical or laboratory data for adequate assessment of resident response to prescribed therapy. Undated form titled, "Rochester Rehab and Living Center Medication Error Report Form," identified the following: Resident name, Birth date, Date/Time Error Occurred, By Whom, Date/Time Error Discovered, By Whom, Indicate the Type of Error: Incorrect time, Incorrect medication, Incorrect dosage, Incorrect route of administration, Incorrect person received the medication, Missed medication, Transcription error, or pharmacy error. Describe Error In Detail: How could this error have been prevented? Incorrect person received medication, Incorrect documentation, Missed medication, Transcription error, or Pharmacy error. Name of Nurse notified, Date/Time, By whom, Name of prescriber notified, Date/Time and by whom. Ordered response/intervention, Name of others notified, Date/Time and by whom. Signature of the person completing the report and date and time. Licensed nurse signature (if different) and date and time. Education that was provided, signature of the person receiving the education with date and time, signature of the nurse providing the education with date and time, signature of DON with date and time. Form does not include a section to notify the resident/resident representative. Facility policy, "Physician Orders," dated 2006, identified a purpose:1. To provide accurate, consistent care to each resident 2. To provide a system for distribution of Physician's orders PROCEDURE: 1. Admission Orders at time of admission. a. Admit to facility b. Advance	F 760		

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	245626	A. BUILDING _____ B. WING _____	C 10/10/2024

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ROCHESTER REHABILITATION AND LIVING CENTER	1900 BALLINGTON BOULEVARD NW ROCHESTER, MN 55901

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F 760	Continued From page 19 Directive c. Diagnoses d. Rehabilitation potential e. Activity level f. Medications/other allergies g. Food allergies h. Diet i. Generic equivalent drugs? YES or NO j. Discharge planned within 3 months YES or NO k. Medications/treatments and reason (diagnosis/problem). l. Two step PPD (unless contraindicated) m. Any state required orders Notes: If resident will be admitted to a secured unit (i.e. Alzheimer's Unit, CCDI, etc.), a diagnosis which supports this decision is required. Obtain at least above orders at time of admission. Orders are noted and signed (includes date) by licensed Nurse. Medications are ordered at specified pharmacy. Orders are processed according to facility procedure. If orders are not signed by Physician, Licensed nurse calls to verify accuracy of orders and documents the call. If written admission orders are received in the facility, the Licensed Nurse should review the orders for completeness, call the Physician and clarify the orders as necessary. Physician's order sheets are processed/sent to the Physician for a signature according to facility procedure. Medication, treatments, and care items (AOL's, etc.) are transcribed to documentation records by hand or computer generated. Medication and treatment orders required the name of the medication or treatment, dosage, strength, route of administration, frequency, and the reason (diagnosis/problem) as a part of the order. 2. New Orders a. Telephone Orders - If the Physician is contacted by the Licensed Nurse by phone or a new order(s) is received, the Licensed Nurse is responsible to: i. Communicate with the Physician what the actual or probable problem/concern is. ii. Fill out a Telephone Order Form promptly. Note all necessary information Note: Remember to note name of medication or treatment, dosage, and	F 760		

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F 760	Continued From page 20	F 760		

strength, if applicable, ROUTE OF ADMINISTRATION and FREQUENCY. For PRN orders, be sure to note how often PRN (i.e. QD PRN, Q4H PRN, HS PRN, QID PRN, etc.) and also the reason (diagnosis/problem) need to be noted as part of the order. Do not forget to date and sign your name, including your title. iii. Write the new order on the medication/treatment record. Again, be sure it is written on the medication/treatment record exactly as it was written on the telephone order form. Note your initials and the date. iv. a. Write the new order on the current computerized Physician's order that is in the medical record below Physician's signature line. Note your initials and the date. This allows you to have a current comprehensive list of all diagnosis, treatments, and orders. b. If a Health Unit Coordinator or similar person has completed any of the above steps in the transcription of Physician's orders, the Licensed Nurse must check for accuracy and verify by initialing and dating these prior to any implementation of these orders. This includes faxed orders. v. Put the computer input copy in the computer input basket. vi. Place or tape the temporary copy in the appropriate place as designated by your Facility's practice or needs. vii. Put the pharmacy/optional copy in the appropriate place as designated by your Facility's practice or needs. viii. If the Physician makes changes or additions to the telephone order, be sure the designated staff person notifies the Licensed Nurse and the computer input person. Order Processing NOTE: It must be entered into system exactly as it is written/signed; if unclear, clarification must be obtained in the form of another written/signed telephone order. HIM/designee then retain the computer input copies for approximately a month. A designated

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F 760	Continued From page 21 staff member assures that the original copy is signed by the attending Physician and returned to the nurses station as soon as possible or according to state requirements and for removing the temporary copy upon the return of the original signed telephone order and will permanently attach the original telephone order to the medical record. HIM/designee is responsible for picking the new order up from the computer input box, entering it into computer within a day's time, noting that it has been entered in computer by writing IC (in computer) and writing his or her initials and the date on the computer input copy. The frequency that new orders or changes are entered into computer is specific to each facility. If there are a number of orders or changes, it is recommended to update information in computer on a daily basis. At a minimum, Physician's orders in computer should be updated at least weekly or on Monday if the order is received late Friday, Saturday, or Sunday. NOTE: It must be entered into system exactly as it is written/signed; if unclear, clarification must be obtained in the form of another written/signed telephone order. HIM/designee then retain the computer input copies for approximately a month. A designated staff member assures that the original copy is signed by the attending Physician and returned to the nurses station as soon as possible or according to state requirements and for removing the temporary copy upon the return of the original signed telephone order and will permanently attach the original telephone order to the medical record. Guidelines If the Nursing department initiates the process to discontinue a Physician's order, the Nursing department is responsible for the following tasks: 1. Calling/contacting the Physician to obtain permission to discontinue a specific order. 2. Completing documentation of	F 760		

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F 760	Continued From page 22	F 760		

the discontinued order. The discontinued order must be written exactly as the previous order with the notation to discontinue (D/C). The wording must be in the exact language as the order that is being discontinued and must include a notation of "discontinue". 3. When a medication or treatment is discontinued, the Nurse is responsible for the following: a. Write the telephone order per procedure. b. Enter the discontinue date in DIC column on documentation c. Initial the entry. d. Enter "D/C'd" the date, and initials of the Nurse processing the order in documentation e. Cross or line out the remainder of the month. f. If the order being discontinued, will be replaced by a new order, the discontinuation order and the new order may be documented on the same Physician's Telephone Orders. 7. Fax Physician's OrderThe Nursing Department will route to HIM a copy of the Fax Communication to Physician or any Physician's order that have been faxed to the facility. The nurse will transcribe and note any MD orders that have been faxed to the facility onto the current printed Physicians Orders below the physician signature line. If a copy is sent to HIM, file the original fax under the Physicians Orders tab in the medical records.8. Physicians Orders - Written Progress Note The Nursing or HIM will transcribe the new order onto the current printed Physicians Orders below the Physician signature line. 9. Concurrent/On-going Order Review Timelines - the HIM and Nursing departments must work together to determine the amount of time needed to complete the following tasks. a. HIM must determine the amount of time it will take to compare the orders from the printed (paper) Physician's orders in the medical records with the computerized Physician's orders in documentation (e.g., two (2) days). This is

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F 760	Continued From page 23 completed to ensure all orders received or discontinued throughout the month and documented in the record have been updated before printing new documentation records for the next month. b. The nursing department will need to determine the amount of time needed to review the orders for accuracy (e.g., two (2) days). c. Add the number of days the HIM staff will required, to the number of days the nursing staff will require together. This total is then subtracted from the last day of the month. d. Around the 25th of the month (approximately three working days) before the Physician's order forms and medication/treatment records are needed by the Physician and/or Licensed Nurse for review and/or documentation, the HIM/designee will be responsible for printing these forms, tearing them apart and bringing them to the nurse's station. e. The licensed nurse will then be responsible for CAREFULLLY reviewing the orders for accuracy. Both the Physician's order form and the medication/treatment record should be reviewed and compared to each other. If changes/corrections/additions are necessary, be sure to make those changes appropriately (there must be a Physician's order for any change made unless it is just a typographical error) - be sure to initial and date any changes. f. Only after thoroughly reviewing for accuracy, the Licensed Nurse will sign and date the Physicians order form in the CHECKED BY box (lower left-hand side). g. Upon thorough review for accuracy, the licensed nurse will sign and date the medication/treatment record after the written "Reviewed by' statement. h. A designated staff member is responsible for seeing that the Physicians review and signs the Physician's orders/re certifications on a timely basis and	F 760		

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F 760	Continued From page 24 within the limits of state regulations i. If any orders are prescribed and/or discontinued throughout this process, the Nurse will need to manually add or discontinue these to the physician's orders and documentation. j. The nurse notes orders and identifies any changes by the Physician Requested an anticoagulation monitoring policy and was not received.	F 760		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2024

Administrator
Rochester Rehabilitation and Living Center
1900 Ballington Boulevard NW
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: 893911

Dear Administrator:

The above facility was surveyed on October 9, 2024, through October 10, 2024, 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 10/9/24 and 10/10/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed: H56269380C (MN107206) with a licensing order issued at 1545. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as 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	21545		11/5/24

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21545	Continued From page 3 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 observation, interview and document review, the facility failed to follow physician orders, labs, and administer anticoagulant medications and failed to have a system in place to identify, record and report omitted medications as medication errors for 2 of 3 (R1 and R2) residents reviewed for medication errors. Findings include: An INR (International Normalized Ratio): lab test measures how long it takes your blood to clot and is used to assess your risk of bleeding. R1's discharge summary dated 9/18/24, identified to hold warfarin (blood thinning medication) on 9/18/24. Check INR on 9/19/24 to determine ongoing warfarin dosing. R1's physician visit dated 9/19/24, identified R1 had permanent atrial fibrillation (a heart condition that causes an irregular and often rapid heartbeat in the upper chambers of the heart), bioprosthetic	21545	F760 Significant Med Errors Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. Affected Resident(s): • R1 and R2 were reviewed immediately to verify orders transcribed appropriately per MD order and medication administered Potential Affected Resident(s): • All other residents receiving anticoagulants will be reviewed to verify orders are transcribed appropriately per	

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21545	Continued From page 4 mitral valve (at risk for blood clotting complications), history of tricuspid valve repair, coronary artery disease, and Factor 5 Leiden syndrome (a mutation of one of the clotting factors in the blood. This mutation can increase your chance of developing abnormal blood clots, most commonly in your legs or lungs) with prior deep vein thrombosis (DVT). R1 was on chronic anticoagulation with warfarin. Warfarin on hold until next INR, will order today. R1's Medication Administration Record (MAR), dated September 2024, identified on 9/19/24, to check R1's INR. Under INR box was blank indicating INR was not completed. R1's medical record indicated R1's INR was not checked per physician order on 9/19/24, a physician was not notified to resume R1's Coumadin dosing therefore R1's coumadin was not administered on 9/19/24. R1's Nurse Practitioner (NP) visit dated 9/20/24 at 3:17 p.m., identified a visit was completed for anticoagulation management for atrial fibrillation, bioprosthetic mitral valve and Leiden Factor 5 syndrome. R1's INR goal identified 2.0 to 3.0. R1's INR was 2.0, give 2 mg of warfarin daily and recheck INR on 9/23/24. R1's signed medical doctor (MD) verbal order dated 9/20/24 at 4:14 p.m., identified to give warfarin 2.5 mg daily until 9/30/34. R1's NP visit dated 9/23/24, identified R1's INR was 1.4, R1 did not receive warfarin on 9/19/24. On 9/23/24 give 4 mg of warfarin and on 9/24/24 give 3 mg. Recheck INR on 9/25/24. R1's admission Minimum Data Set (MDS) dated	21545	MD order and medication administered. Measures/Systematic Changes: • The Policy/Procedure for Medication Administration was reviewed and remains current. • Medications not administered per policy will be followed up on as a medication error to determine the root cause • team member Licensed Nurses responsible for passing medication or those who have the potential to pass medication will receive education to ensure medications are being properly administered. • Licensed Nurses will receive education regarding reporting a medication error to Nurse Manager if medication not properly administered. and when to report a medication error . • Licensed Nurses will receive education was initiated regarding the need to verify orders and assure transcription of orders • A medication error checklist was created, implemented and Licensed nurses will be trained on the checklist. • An anticoagulant medication monitoring protocol was reviewed, revised and education of Licensed nurses will be completed. Monitoring: • The DON & Nurse Managers will begin audits of INR, Anticoagulants, medication errors and . order transcription and medications administered timely . Frequency of audits will be daily X 2 weeks, weekly for 2 additional months to	

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21545	Continued From page 5 9/24/24, indicated R1's cognition was intact and received anticoagulants. R1's NP visit dated 9/25/24, identified R1's INR was 1.4. On 9/25/24 and 9/26/24 give warfarin 5 mg. Recheck INR on 9/27/24. R1's MAR dated September 2024, identified on 9/25/24, R1 did not receive warfarin 5mg as indicated by a blank space. R1's medical record does not identify if a provider was notified of R1's missed warfarin dose on 9/25/24. R1's NP order dated 9/26/24 at 8:50 a.m., identified a new order for (Lovenox-an injectable anticoagulant) 40 mg/0.4 milliliter (ml) subcutaneous syringe. Directions identified to inject 0.9 ml (90 mg total) under the skin two times a day for 7 days until INR is > 2.0. R1's NP visit dated 9/27/24 at 7:54 a.m., identified R1's INR was 1.4. Lovenox was not initiated 9/26/24. Check INR daily through 9/30/24 and give SQ Lovenox as ordered until INR > 2.0. R1's MAR dated September 2024, identified on 9/27/24 at 8:00 a.m., R1 did not receive 90 mg of Lovenox injection, the order was not put in until 9/27/24 at 1:45 p.m. R1's record identified on 9/27/24 that his INR was 1.4 and should have received an injection of 90 mg of Lovenox at 8:00 a.m. which was omitted due to the order being put in late. R1's MAR dated 9/28/24, identified R1's INR was 1.6.	21545	ensure medications have been administered and errors reported timely • DON & Nurse Managers will review medication errors for significant errors and summary will be provided to Pharmacy Consultant weekly to confirm medication error classification. This will be completed weekly for 12 weeks. • DON/designee responsible for compliance. • Results will be reported at QAPI and the need for continued audits will be determined. Date of Alleged Compliance:November 5, 2024	

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21545	Continued From page 6 R1's MAR dated September 2024, identified on 9/29/24 at 8:00 p.m., R1's INR was 1.8. R1 did not receive 90 mg of Lovenox injection. An "8" was documented that indicated to see progress note. R1's progress note dated 9/29/24 at 9:13 p.m., identified Lovenox injection solution was not available. Dosage ends on 9/30/24. R1's record does not identify if R1's provider was notified of missed Lovenox injection. R1's NP visit dated 9/30/24 at 12:41 p.m., identified R1's INR was 2.1. Give 7.5 mg of warfarin on 9/30/24 and 5 mg daily thereafter. Recheck INR on 10/4/24. R1's care plan revised 10/1/24, identified a focus that R1 had anticoagulant use. Interventions dated 9/18/24, identified to do labs and give medications as ordered by provider. During an observation and interview on 10/9/24 at 4:25 p.m., R1 was seated in his room on his wheeled walker. R1 stated he had been on anticoagulation medications for almost 20 years due to several cardiac diagnoses, history of blood clots and a genetic blood clotting factor. R1 indicated he did receive two injections at night of Lovenox a couple weeks ago when his INR got down to 1.4. R1 stated he had not had to have Lovenox injections for years and has been able to keep his INR within a therapeutic range with his warfarin. R1 stated the doctors start to get nervous when my INR gets lower than 2.4 because then it really drops. R1 further stated the facility did not notify him of any medication errors with his blood clotting medications and stated he would like to know if there was an error.	21545		

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21545	Continued From page 7 During an interview on 10/10/24 at 11:21 a.m., registered nurse (RN)-A stated she was the nurse manager for R1. RN-A stated she was aware that R1 had a medication error when R1 did not receive his Lovenox injection for his morning dose on 9/27/24. RN-A stated NP-A saw R1 on 9/27/24 and had asked her why the order was never initiated. RN-A stated they later found out that when the provider faxed the order it went straight to the pharmacy, and she didn't remember seeing the order. RN-A verified R1 did not have his INR drawn on 9/19/24 per provider order, missed 5mg dose of warfarin on 9/25/24, and missed dose of Lovenox on 9/27/24 at 8:00 a.m. and 9/29/24 at 8:00 p.m. RN-A was not aware of these medication errors and verified there was nothing documented in R1's medical record that a physician was notified. During an interview on 10/10/24 at 4:09 p.m., RN-B stated that she found a message in R1's chart that (name of lab) lab technicians had messaged the doctor covering for medical doctor (MD)-A on 9/19/24 at 1:35 p.m., that the lab techs had left for the day and if it was ok if they just checked R1's INR on 9/20/24. RN-B stated she called MD-A on 9/20/24 because she noticed R1's INR was not checked on 9/19/24 and there were no current warfarin orders. MD-A told her there was no policy regarding this and we will no longer have that lab following our residents and that we will start doing our own INR's at bedside. RN-B verified R1's warfarin dose was missed on 9/25/24 due to R1 being in the emergency room (ER), but a provider should have been called when he came back about the missed dose. RN-B stated the fax did come on 9/26/24 for R1's Lovenox and it said to take the Lovenox out of the Omnicell. RN-B stated the nurses were struggling	21545		

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21545	Continued From page 8 with using the Lovenox out of the Omnicell because it was not a prepackaged injection, it came in a vial and the nurses were having struggles trying to figure out the correct dosage to give. R1 missed his Lovenox injection on 9/29/24 because that particular nurse did not have access to the Omnicell and probably could not find R1's medication. RN-B stated that nurse should have notified the provider that the medication was not available. RN-B stated R1 had a genetic clotting factor and several cardiac diagnoses putting him at greater risk for developing a blood clot, heart attack or stroke, especially when his INR was subtherapeutic for almost 8 days. R2 R2's care plan revised 12/21/22, identified a focus of anticoagulant use for a diagnosis of atrial fibrillation, Intervention dated 11/24/22, identified to administer anticoagulant and labs per MD orders and 10/2/24, identified to obtain INR and report to physician as ordered. R2's significant change MDS dated 8/27/24, identified R2's cognition was intact had diagnoses of atrial fibrillation and tricuspid insufficiency. R2 received anticoagulants. R2's NP visit dated 9/23/24 at 1:47 p.m., identified R1's INR was 2.0. Give 1.5 mg of warfarin on Fridays and 2 mg all other days, recheck INR on 10/7/24. R2's MAR dated September 2024, identified an order dated 9/23/24 at 2:06 p.m. to give warfarin 2mg every evening on Monday, Tuesday, Wednesday, Thursday, Saturday, and Sunday until 10/6/24 at 2:06 p.m.	21545		

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21545	Continued From page 9 R2's warfarin order was discontinued on 10/6/24 at 2:06 p.m. therefore the 2 mg evening dose was not documented as there was no box to document. R2's NP visit dated 10/7/24 at 10:16 a.m., identified R1's INR was 1.7. Give 3 mg of warfarin on Mondays and Thursdays and 2 mg the rest of the days of the week, recheck INR on 10/14/24. During an observation and interview on 10/10/24 at 9:13 a.m., R2 was seated in her wheelchair and stated she had just finished eating breakfast. R2 stated she had been on warfarin for years due to atrial fibrillation, stated she had prior ablations that did not fix it. R2 stated warfarin is a very important medication and her INR levels must be between 2.0 and 3.0 or she would be at risk for a stroke, heart attack or blood clots. I usually get my INR's checked her at the facility they do a fingerstick, unless I am at an appointment at Mayo then they will do a blood draw. During a phone interview on 10/10/24 at 5:12 p.m., HUC-A stated she does all of the residents INR's through a fingerstick, she will record the INR results in the MAR, will document everything on a tracking sheet and send it to the nursing home desk so NP-A can read the results and give new orders based on the result. HUC-A stated she then puts the order in PCC and will fax the new order to the pharmacy, then I give the new order to the nurse manager so they can doublecheck the order. R1's INR may have been missed because she was on vacation that day and was unaware of who would have covered for her, was guessing the nurse managers. HUC-A stated they have back up medications in the Omnicell but not all nurses have access. HUC-A stated she remembered the mess with R1's	21545		

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21545	Continued From page 10 Lovenox because it was in a vial in the Omnicell and not everyone had access. HUC-A stated she just hears about medication errors when they happen and stated they do not have discussions about if they are reportable to the state or not. HUC-A stated she was not aware of R2's missed coumadin dose on 10/6/24. During an interview on 10/10/24 at 10:53 a.m., licensed practical nurse (LPN)-A stated she was the nurse manager for R2. LPN-A stated with a medication error, we would document the error on a paper medication form that instructs us to notify the physician of the error, it does not instruct us to notify the resident or resident representative. We would then give the form to the director of nursing (DON). LPN-A indicated R2 should have received 2 mg of warfarin on 10/6/24, stated it looked like the medication was discontinued too early so there was nothing to alert the nurse to give it. Health Unit Coordinator (HUC)-A does our INR's, sends the results to the provider, when the provider gives new orders, HUC-A will either put the order in or will gives the order to the nurse manager to put into point click care (PCC). LPN-A stated we do not always put the order in the que for a second nurse to doublecheck the orders, but it would be best practice to do that. LPN-A stated R2's medication error would be a significant error due to the fact it's a blood thinner, that would explain why R2's INR was subtherapeutic 1.7 on 10/7/24. During an interview on 10/10/24 at 12:28 p.m., director of nursing (DON) indicated she had been the current DON for two days, and her understanding as the HUC's do the fingerstick INR's and documents the INR's and the provider orders for anticoagulants in the medical record. DON stated with a medication error she would	21545		

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21545	Continued From page 11 have to investigate the root cause, notify the provider, may have to file a VA if it can seriously impact the residents health. DON stated any anticoagulant medications such as warfarin and Lovenox would be significant medication errors because they are blood thinners and leave the resident at high risk for blood clots, stroke, or heart attack. DON indicated she would document the medication error in the nurses note. DON verified R1 did not have his INR checked per MD order on 9/19/24, missed a 5 mg dose of warfarin on 9/25/24, Lovenox was not implemented as ordered and missed 9/27/24 dose of Lovenox and missed another dose of Lovenox on 9/29/24 at 8:00 p.m. DON further verified R2 missed a dose of warfarin on 10/6/24. During an interview on 10/10/24 at 12:49 p.m., regional nurse consultant (RNC)-A verified there were no medication errors filled out for any of R1 or R2's medication errors. RNC-A stated with medication errors the provider and resident/resident representative should be notified, medication error form should be filled out to determine a root cause of the error to put interventions in place for prevention. During a phone interview on 10/10/24 at 2:31 p.m., pharmacist (P)-A stated with medications involving blood thinners such as warfarin and Lovenox you put the resident at risk of subtherapeutic INR. P-A stated for patients with diagnoses with genetic clotting factors and atrial fibrillation if blood thinners are being missed that would be a significant med error, you wouldn't see the results until about 2 days later. Anytime you are not therapeutic between 2.0 and 3.0 it puts you at risk for clots, heart attack or stroke. During a phone interview on 10/10/24 at 2:48	21545		

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21545	Continued From page 12 p.m. NP-A stated she started following residents at the facility for anticoagulation. NP-A stated she was aware of R1 not having his Lovenox started timely but was not aware of R1's medication errors on 9/25/24 and 9/29/24. NP-A stated she would expect a phone call from the nurse for a missed blood thinner so the resident can be dosed appropriately. NP-A stated when INR levels are below 2.0, they become subtherapeutic putting the resident at risk for the development of blood clots, stroke, or heart attack. Facility policy, "Medication Related Errors," revised 7/1/24, identified a Procedure: 1. Medication Errors. If a medication reaches a resident in error, facility should: 1.1 Notify pharmacy of any possible dispensing occurrence; and 1.2 Notify physician/prescriber and obtain further instructions and/or orders. Facility staff should monitor the resident in accordance with physician's/prescriber's instructions. 2. Prescribing Errors: In the event of a prescribing error, facility staff should follow facility's occurrence/incident policy, associated forms, and performance improvement processes. Examples of prescribing errors include, but are not limited to: 2.1 Incorrect medication selection based on indications, contraindications, known allergies, existing medication therapy, and other factors., 2.2 Dose, dosage form, quantity, route, concentration, rate of administration, or, 2.3 Incorrect instructions for use of a medication ordered or authorized by a physician/prescriber. 3. Dispensing Errors: If facility believes a dispensing error has occurred, facility staff should follow facility policy relating to dispensing errors. See Policy 10.1 (Pharmacy-Related Occurrence Reporting). Examples of dispensing errors include, but are not limited to: 3.1 Unauthorized medication error: Dispensing to the resident a	21545		

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21545	Continued From page 13 dose of medication not authorized by Physician/Prescriber for the resident; 3.2 Dose error: Dispensing to the resident of a dose that is greater than or less than the amount originally ordered; 3.3 Route error: Dispensing medication to the resident by a route other than originally ordered; 3.4 Rate error: Dispensing the incorrect rate of administration of a medication to a resident other than that originally ordered; 3.5 Dosage form error: Dispensing to the resident of a medication in a different form than that originally ordered ;3.6 Frequency error: Dispensing to the resident of a medication at an incorrect interval of administration other than that originally ordered 3.7 Dose preparation error: Medications incorrectly formulated or manipulated before administration (e.g., incorrect dilution or reconstitution); 3.8 Medication error: Dispensing to the resident a medication other than that originally ordered; 3.9 Resident/Facility error: Dispensing to a resident or Facility other than the one intended; 3.10 Label error: Dispensing to the resident a medication that has a label affixed which contains information other than that originally ordered or information that is inappropriate for the medication itself; 3.11 Expired medication error: Dispensing to the resident a medication that expires prior to administration; 3.12 Monitoring error: Failure to review a prescribed regimen for appropriateness;3.13 Delivery error: Drug product not received by the resident/facility at the required/expected time; 3.14 Data entry error: Entire order or part of an order was incorrectly entered into computer system by data entry; and 3.15 Transcription error: Entire order or part of an order was incorrectly transcribed from original order. Administration Errors: In the event of an administration error, facility staff should follow facility policy relating to medication administration	21545		

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21545	Continued From page 14 errors. Examples of administration errors include, but are not limited to 4.1 Transcription error: Facility incorrectly transcribes to pharmacy an entire order or part of an order; 4.2 Unauthorized medication error: Facility administers a medication dose not authorized for the resident; 4.3 Dose error: Facility administers to the resident a medication dose that is greater than or less than the amount originally ordered ; 4.4 Route error: Facility administers to the resident a medication dose by a route other than that originally ordered by or a wrong site of administration; 4.5 Rate error: Facility administers to the resident a medication dose at any rate other than that originally ordered or as established by facility policy; 4.6 Dosage form error: Facility administers to the resident a medication dose by the correct route but in a different dosage form than that specified by the original order. 4.7 Administration time error: Facility administers to the resident a medication dose greater than sixty (60) minutes from its scheduled administration time or if administration exceeds the time in relation to meals; 4.8 Dose preparation error: Facility staff incorrectly formulates or manipulates a drug product before administration (e.g., incorrect dilution or reconstitution, not shaking a suspension, not keeping a light sensitive medication protected from the light, and mixing incompatible medications); 4.9 Omission error: Facility fails to administer an ordered dose to the resident, unless refused by the resident or not administered because of recognized contraindication; 4.1O Administration technique error: Facility administers a medication dose via the correct route and site, but improper technique is used; and 4.11 Monitoring error: Facility fails to review a prescribed regimen for appropriateness or fails to use appropriate clinical or laboratory	21545		

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21545	Continued From page 15 data for adequate assessment of resident response to prescribed therapy. Undated form titled, "Rochester Rehab and Living Center Medication Error Report Form," identified the following: Resident name, Birth date, Date/Time Error Occurred, By Whom, Date/Time Error Discovered, By Whom, Indicate the Type of Error: Incorrect time, Incorrect medication, Incorrect dosage, Incorrect route of administration, Incorrect person received the medication, Missed medication, Transcription error, or pharmacy error. Describe Error In Detail: How could this error have been prevented? Incorrect person received medication, Incorrect documentation, Missed medication, Transcription error, or Pharmacy error. Name of Nurse notified, Date/Time, By whom, Name of prescriber notified, Date/Time and by whom. Ordered response/intervention, Name of others notified, Date/Time and by whom. Signature of the person completing the report and date and time. Licensed nurse signature (if different) and date and time. Education that was provided, signature of the person receiving the education with date and time, signature of the nurse providing the education with date and time, signature of DON with date and time. Form does not include a section to notify the resident/resident representative. Facility policy, "Physician Orders," dated 2006, identified a purpose:1. To provide accurate, consistent care to each resident 2. To provide a system for distribution of Physician's orders PROCEDURE: 1. Admission Orders at time of admission. a. Admit to facility b. Advance Directive c. Diagnoses d. Rehabilitation potential e. Activity level f. Medications/other allergies g. Food allergies h. Diet i. Generic equivalent	21545		

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	29822	A. BUILDING: _____ B. WING _____	C 10/10/2024

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21545	Continued From page 16 drugs? YES or NO j. Discharge planned within 3 months YES or NO k. Medications/treatments and reason (diagnosis/problem). l. Two step PPD (unless contraindicated) m. Any state required orders Notes: If resident will be admitted to a secured unit (i.e. Alzheimer's Unit, CCDI, etc.), a diagnosis which supports this decision is required. Obtain at least above orders at time of admission. Orders are noted and signed (includes date) by licensed Nurse. Medications are ordered at specified pharmacy. Orders are processed according to facility procedure. If orders are not signed by Physician, Licensed nurse calls to verify accuracy of orders and documents the call. If written admission orders are received in the facility, the Licensed Nurse should review the orders for completeness, call the Physician and clarify the orders as necessary. Physician's order sheets are processed/sent to the Physician for a signature according to facility procedure. Medication, treatments, and care items (AOL's, etc.) are transcribed to documentation records by hand or computer generated. Medication and treatment orders required the name of the medication or treatment, dosage, strength, route of administration, frequency, and the reason (diagnosis/problem) as a part of the order. 2. New Orders a. Telephone Orders - If the Physician is contacted by the Licensed Nurse by phone or a new order(s) is received, the Licensed Nurse is responsible to: i. Communicate with the Physician what the actual or probable problem/concern is. ii. Fill out a Telephone Order Form promptly. Note all necessary information Note: Remember to note name of medication or treatment, dosage, and strength, if applicable, ROUTE OF ADMINISTRATION and FREQUENCY. For PRN orders, be sure to note how often PRN (i.e. QD PRN, Q4H PRN, HS PRN, QID PRN, etc.) and	21545		

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21545	Continued From page 17 also the reason (diagnosis/problem) need to be noted as part of the order. Do not forget to date and sign your name, including your title. iii. Write the new order on the medication/treatment record. Again, be sure it is written on the medication/treatment record exactly as it was written on the telephone order form. Note your initials and the date. iv. a. Write the new order on the current computerized Physician's order that is in the medical record below Physician's signature line. Note your initials and the date. This allows you to have a current comprehensive list of all diagnosis, treatments, and orders. b. If a Health Unit Coordinator or similar person has completed any of the above steps in the transcription of Physician's orders, the Licensed Nurse must check for accuracy and verify by initialing and dating these prior to any implementation of these orders. This includes faxed orders. v. Put the computer input copy in the computer input basket. vi. Place or tape the temporary copy in the appropriate place as designated by your Facility's practice or needs. vii. Put the pharmacy/optional copy in the appropriate place as designated by your Facility's practice or needs. viii. If the Physician makes changes or additions to the telephone order, be sure the designated staff person notifies the Licensed Nurse and the computer input person. Order Processing NOTE: It must be entered into system exactly as it is written/signed; if unclear, clarification must be obtained in the form of another written/signed telephone order. HIM/designee then retain the computer input copies for approximately a month. A designated staff member assures that the original copy is signed by the attending Physician and returned to the nurses station as soon as possible or according to state requirements and for removing the temporary copy upon the return of the original	21545		

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21545	Continued From page 18 signed telephone order and will permanently attach the original telephone order to the medical record. HIM/designee is responsible for picking the new order up from the computer input box, entering it into computer within a day's time, noting that it has been entered in computer by writing IC (in computer) and writing his or her initials and the date on the computer input copy. The frequency that new orders or changes are entered into computer is specific to each facility. If there are a number of orders or changes, it is recommended to update information in computer on a daily basis. At a minimum, Physician's orders in computer should be updated at least weekly or on Monday if the order is received late Friday, Saturday, or Sunday. NOTE: It must be entered into system exactly as it is written/signed; if unclear, clarification must be obtained in the form of another written/signed telephone order. HIM/designee then retain the computer input copies for approximately a month. A designated staff member assures that the original copy is signed by the attending Physician and returned to the nurses station as soon as possible or according to state requirements and for removing the temporary copy upon the return of the original signed telephone order and will permanently attach the original telephone order to the medical record. Guidelines If the Nursing department initiates the process to discontinue a Physician's order, the Nursing department is responsible for the following tasks: 1. Calling/contacting the Physician to obtain permission to discontinue a specific order. 2. Completing documentation of the discontinued order. The discontinued order must be written exactly as the previous order with the notation to discontinue (D/C). The wording must be in the exact language as the order that is being discontinued and must include a notation of "discontinue". 3. When a medication or	21545		

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21545	Continued From page 19 treatment is discontinued, the Nurse is responsible for the following: a. Write the telephone order per procedure. b. Enter the discontinue date in DIC column on documentation c. Initial the entry. d. Enter "D/C'd" the date, and initials of the Nurse processing the order in documentation e. Cross or line out the remainder of the month. f. If the order being discontinued, will be replaced by a new order, the discontinuation order and the new order may be documented on the same Physician's Telephone Orders. 7. Fax Physician's OrderThe Nursing Department will route to HIM a copy of the Fax Communication to Physician or any Physician's order that have been faxed to the facility. The nurse will transcribe and note any MD orders that have been faxed to the facility onto the current printed Physicians Orders below the physician signature line. If a copy is sent to HIM, file the original fax under the Physicians Orders tab in the medical records.8. Physicians Orders - Written Progress Note The Nursing or HIM will transcribe the new order onto the current printed Physicians Orders below the Physician signature line. 9. Concurrent/On-going Order Review Timelines - the HIM and Nursing departments must work together to determine the amount of time needed to complete the following tasks. a. HIM must determine the amount of time it will take to compare the orders from the printed (paper) Physician's orders in the medical records with the computerized Physician's orders in documentation (e.g., two (2) days). This is completed to ensure all orders received or discontinued throughout the month and documented in the record have been updated before printing new documentation records for the next month. b. The nursing department will need to determine the amount of time needed to review the orders for accuracy (e.g., two (2)	21545		

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21545	Continued From page 20 days). c. Add the number of days the HIM staff will required, to the number of days the nursing staff will require together. This total is then subtracted from the last day of the month. d. Around the 25th of the month (approximately three working days) before the Physician's order forms and medication/treatment records are needed by the Physician and/or Licensed Nurse for review and/or documentation, the HIM/designee will be responsible for printing these forms, tearing them apart and bringing them to the nurse's station. e. The licensed nurse will then be responsible for CAREFULLLY reviewing the orders for accuracy. Both the Physician's order form and the medication/treatment record should be reviewed and compared to each other. If changes/corrections/additions are necessary, be sure to make those changes appropriately (there must be a Physician's order for any change made unless it is just a typographical error) - be sure to initial and date any changes. f. Only after thoroughly reviewing for accuracy, the Licensed Nurse will sign and date the Physicians order form in the CHECKED BY box (lower left-hand side). g. Upon thorough review for accuracy, the licensed nurse will sign and date the medication/treatment record after the written "Reviewed by' statement. h. A designated staff member is responsible for seeing that the Physicians review and signs the Physician's orders/re certifications on a timely basis and within the limits of state regulations i. If any orders are prescribed and/or discontinued throughout this process, the Nurse will need to manually add or discontinue these to the physician's orders and documentation. j. The nurse notes orders and identifies any changes by the Physician	21545		

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21545	Continued From page 21 Requested an anticoagulation monitoring policy and was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered which may include but is not limited to the need for verifying orders and accurately transcribing. The DON or designee should review processes to ensure the pharmacist begins or maintains appropriate oversight of the medication administration process. The DON or designee could develop a system to verify compliance, such as auditing medication administration and or medical records for specific amount of days x___, then weekly x ___, then monthly x___, to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		