



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 1, 2021

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: CCN: 245189
Cycle Start Date: July 23, 2021

Dear Administrator:

On August 10, 2021, we notified you a remedy was imposed. On September 30, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 24, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 25, 2021 be discontinued as of September 24, 2021. (42 CFR 488.417 (b))

In our letter of August 10, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 23, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies. Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 1, 2021

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

Re: Reinspection Results
Event ID: 203G12

Dear Administrator:

On September 30, 2021 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 July 23, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
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Telephone: (651) 201-4112 Fax: (651) 215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
August 10, 2021

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: CCN: 245189
Cycle Start Date: July 23, 2021

Dear Administrator:

On July 23, 2021, 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.

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

REMOVAL OF IMMEDIATE JEOPARDY

On July 23, 2021, the situation of immediate jeopardy to potential health and safety cited at F760 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 25, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 25, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 25, 2021, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 23, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

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

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely

will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Southview Acres Healthcare Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 23, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

**Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220**

P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 23, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Southview Acres Healthcare Center

August 10, 2021

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Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,



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

Southview Acres Healthcare Center

August 10, 2021

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Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/23/2021	
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118			
(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 7/22/21 through 7/23/21, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5189191C (MMN74945 and MN74956) with a deficiency cited at F760. The following complaints were found to be UNSUBSTANTIATED, however related deficiencies were cited at F755 and F759. H5189192C (MN74951) H5189193C (MN74874) The survey resulted in an Immediate Jeopardy (IJ) at F760 when R1 was administered 100 milligrams (mg) of morphine rather than 5 mg as ordered. R1 became somnolent, had fixed/glazed eyes, and died the following morning. The administrator and director of nursing (DON) were notified of the IJ for R1 on 7/22/21, at 5:27 p.m.. The IJ was removed on 7/23/21 at 12:00 p.m. The above findings constituted substandard quality of care, and an extended survey was conducted from 7/22/21 through 7/23/21. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/12/2021

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 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			
F 755 SS=D	Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755			8/19/21

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F 755	Continued From page 2 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement policies and procedures to ensure rapid detection and intervention of potential narcotic diversion for 1 of 6 residents (R5) observed for medication administration. Findings include: R5's quarterly Minimum Data Set (MDS) dated 7/14/21, indicated R5's diagnoses included renal insufficiency and dementia. R5 had severely impaired cognition and received opioid medication. R5's July 2021 Medication Administration Record (MAR) indicated R5 had an active order for morphine sulfate (concentrate) 20 milligrams (mg) / milliliter (mL). Staff were to administer 0.125 mL by mouth three times daily for pain. Review of R5's Individual Narcotic Record (page 140) indicated on 7/20/21, at 8:00 p.m. the amount of morphine sulfate remaining in the bottle was documented as 17.25 mL by RN-D. On 7/21/21, at 6:30 a.m., the amount reconciled by RN-D and licensed practical nurse (LPN)-A was 13 mL, however, there was not documentation or follow-up to account for the missing 4.25 mL of morphine. On 7/22/21, at 9:12 a.m. registered nurse (RN)-D drew 0.125 mL from R5's morphine sulfate	F 755	F 755 R 5 liquid morphine count was investigated and revealed that the morphine count was incorrect for PRN doses that were recorded incorrectly. R 5 was assessed; the MD and family were made aware and there were no ill effects from this deficient practice. A risk management incident was created, thoroughly investigated and a root cause was identified. The root cause for F755 identified that the nurses corrected a count that was off and did not inform their supervisor or the Director of Nursing. Nurses were educated on the policy that the Building Charge Nurse or DON must be notified immediately if there is a discrepancy with the narcotic count. All other residents who receive liquid narcotics i.e., morphine, haldol, dilaudid and lorazepam were audited and their narcotic count was confirmed. Future residents who receive narcotics will have their narcotic count performed per policy. Licensed nurses and TMA staff were in-serviced on the Controlled Substance policy with emphasis on item #9 that if any discrepancies are noted during the narcotic count, the Director of Nursing must be notified. In addition, nurses were in-serviced to ensure that scheduled and PRN doses of narcotic medications are recorded correctly in the narcotic book		

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F 755	Continued From page 3 (concentrate) solution bottle. The morphine sulfate bottle indicated the concentration was 20 mg per mL and 0.125 mL was to be administered by mouth three times daily for pain. RN-D documented 0.125 mL was removed in R5's Individual Narcotic Record on page 140. RN-D documented the amount remaining was 12.22 mL after subtracting the dose removed from the morphine bottle. RN-D administered the medication to R5 at 9:20 a.m. using a syringe. During interview on 7/22/21, at 11:47 a.m. RN-D stated on 7/21/21, he identified there was less liquid morphine in R5's bottle than what was documented as remaining in R5's Individual Narcotic Record. RN-D stated LPN-A and himself reconciled it to the actual amount remaining in the bottle during the narcotics count. RN-D stated after the reconciliation was completed he assumed LPN-A reported the missing amount to a nurse manager or director of nursing (DON) for further follow-up. During interview on 7/22/21, at 11:54 a.m. RN-E stated she was covering for the unit nurse manager and nurses would report a narcotics discrepancy to a unit manger or DON, however, was not aware of the discrepancy related to R5's morphine. RN-E stated when a count was off, she would compare the narcotic log and the medication administration record (MAR) to see if a dose was not documented. RN-E stated when a nurse identified a discrepancy, they were to have a supervisor reconcile with them. During interview on 7/22/21, at 11:58 a.m. the DON stated she was not aware the count of R5's morphine was off. The DON stated if any narcotic count was off, nurses were supposed to let the	F 755	and in the resident electronic medical record. The Director of Nursing and/or designee will be responsible for compliance. Audits on resident narcotic count will begin 3x week for 2 weeks, weekly x 2 weeks, then monthly to ensure sustained compliance. Audits will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendation. Compliance: 8/19/2021		

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F 755	Continued From page 4 supervisor know so they could reconcile and complete an investigation. The DON stated the procedure was the MAR and narcotic log would be compared to make sure each dose dispensed was documented and a bottle would be inspected to see if there was spillage. The DON stated if a count was noted to be correct all nurses that gave the medication from the cart would be interviewed. The DON stated she would follow-up with the concern. During interview on 7/26/21, at 12:15 p.m. the consultant pharmacist (CP) stated she was made aware of R5's missing 4.25 mL of morphine. The CP stated she expected two nurses to complete narcotic reconciliation when a count was off. The CP stated the supervisor was supposed to be notified to follow-up and see if there was a pattern of missing medications. On 7/22/21, at 3:00 p.m. the policy for narcotic reconciliation was requested, but not provided.	F 755			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders without errors for 1 of 6 residents (R6) observed to receive medications. This resulted in a facility medication error rate of 8% (percent).	F 759	F 759 R 5 medication orders were reviewed and there were no ill effects experienced from this event. Residents assigned to RN-B medications were reviewed and no other errors were noted. For future residents		8/19/21

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/23/2021
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118		
(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 759	Continued From page 5 Findings include: R5's Medication Review Report printed 7/23/21, identified R5 had orders for: - Carbamazepine (used to treat seizures) tablet chewable 100 milligrams (mg) give 4 tables (400 mg) by mouth two times a day for nerve pain. - Gabapentin capsule 100 mg give 2 capsules (200 mg) by mouth one time a day and 1 capsule by mouth as needed for agitation/anxiety twice a day. On 7/22/21, at 8:15 a.m. registered nurse (RN)-B was observed preparing R5's medications which included: - Carbamazepine 1 tablet (100 mg) - Gabapentin 1 capsule (100 mg) - Triamcinolone 0.1% cream (used for rash) - Desonide 0.05% cream (used for skin irritation). At 8:18 a.m. RN-B attempted to administer the above medications to R5, however, RN-B was stopped by the surveyor and it was requested RN-B review of R5's medication orders. At 8:20 a.m. RN-B acknowledged R5 was to receive their scheduled dose of Gabapentin and not the as needed order. RN-B proceeded to review the orders and removed a Carbamazepine medication card from the medication cart and removed three additional tablets. RN-B also removed one additional tablet of Gabapentin. RN-B confirmed she did not remove the correct amount of medication during her initial attempt to administer medications to R5. At 8:28 a.m. RN-B returned to R5's room and administered the medications. At 8:32 a.m. RN-B confirmed she made a mistake and would have administered the incorrect doses of medication.	F 759	the five rights of medication administration will be practiced. RN-B was removed from the medication cart and in-serviced on 7-22-21 Licensed nurses along with TMA's were in-serviced on the Medication Administration Policy focusing on the 5 rights of medication administration. The Director of Nursing and/or designee will be responsible for compliance. Audits on medication administration will begin 3x week for 2 weeks, weekly x 2 weeks, then monthly to ensure sustained compliance. Audits will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendation. Compliance: 8/19/2021		

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F 759	Continued From page 6 On 7/22/21, at 10:40 a.m. RN-C stated staff should be performing the 5 rights of medication administration and ensure the right patient, right time, and right dose were being given. RN-C stated staff should be following orders when passing medications. On 7/22/21, at 1:42 p.m. the director of nursing (DON) stated she expected staff passing medications to check the orders, check the actual medication, and then check again. The DON stated she also expected staff to ensure the right person, right dose, and right medication before medication was dispensed. The facility Administering Medications policy reviewed 11/6/19, directed the individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication ..."	F 759			
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure morphine (a narcotic medication) was administered as prescribed for 1 of 3 residents (R1) reviewed for medication errors. This deficient practice resulted in an immediate jeopardy (IJ) situation for R1 who received a morphine dose 20 times greater than was was prescribed, became unresponsive and	F 760	R 1 passed away. All other current resident liquid narcotics were reviewed and changed from milligram dose to millimeter dose amount. Future residents who receive liquid narcotic medication orders will have the dose quantity entered in ml. Licensed Nurses, TMA□s and Health Unit		8/19/21

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F 760	Continued From page 7 subsequently died. The IJ began on 7/18/20, at 11:12 a.m. when R1 was administered 100 milligrams (mg) of morphine rather than 5 mg as ordered. R1 became somnolent, had fixed/glazed eyes, and died the following morning. The administrator and director of nursing (DON) were notified of the IJ at 5:27 p.m. on 7/22/21. The IJ was removed on 7/23/21, at 12:00 p.m., but noncompliance remained at the lower scope and severity level of a D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: R1 diagnoses included vascular dementia without behavioral disturbance, diabetes mellitus, glaucoma, and chronic kidney disease obtained from the admission Minimum Data Set (MDS) dated 7/15/21. The MDS also identified R1 made himself understood and usually understood others. R1 required extensive assistance with transfers, locomotion (off unit/on unit), and supervision eating. R1 had no pain, had not received opioid medications, and received hospice services. R1's physician orders dated 7/9/21, indicated R1 was ordered morphine sulfate (concentrate) 20 mg / milliliter (mL). Give 5 mg (0.25 mL) every 1 hour as needed for pain or dyspnea (shortness of breath). The medication was only to be administered, "after discussion with Hospice." R1's care plan dated 7/13/21, identified R1 was at risk for pain and had as needed pain medication ordered. The care plan directed staff to	F 760	Clerks were in-serviced on Medication Order Policy with focus entering liquid medication in dose quantity and dose conversation education changing milligrams to millimeter dose for liquid medications. A conversion table was created to assist nurses to convert milligrams to millimeters and was distributed to each nurses station and every medication cart for use as a reference when convert milligrams to millimeters. Licensed nurses and TMA's were also in-serviced on Administration of Medication with focus item #7 ensuring that the 3 checks are performed and item # 5 if a dose of medication is excessive or inappropriate, the resident MD will be notified. The Director of Nursing and/or designee will be responsible for compliance. Audits on medication order entry and resident medication administration will begin 3x week for 2 weeks, weekly x 2 weeks, then monthly to ensure sustained compliance. Audits will be reviewed by the Executive Director and the Executive Director will take the audit results to QAPI for review and recommendation. Compliance: 8/19/2021		

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F 760	Continued From page 8 administer medications as ordered, per hospice. R1's Individual Narcotic Record indicated on 7/18/21, at 11:05 a.m. registered nurse (RN)-A signed off removing 5 mL (100 mg) of morphine. This was the first dose out of a 30 mL bottle, 25 mL of morphine remained in the bottle. R1's July 2021 Medication Administration Record (MAR) indicated RN-A documented morphine was administered to R1 on 7/18/21, at 11:12 a.m. for a pain level of 6 out of 10. RN-A documented the medication was "E" (effective). A progress note dated 7/19/21, at 8:05 a.m. indicated R1 died at 7:56 a.m. During interview on 7/22/21, at 10:27 a.m. hospice RN, RN-K stated on 7/19/21, she received a call R1 had died and went to the facility. RN-K stated she was denied access to the medication and the narcotic book by a nurse. During interview on 7/22/21, at 10:38 a.m. family member (FM)-A stated he left R1's room per staff request on 7/18/21, and staff assisted R1 with morning cares. Upon return to R1's room he observed a nursing assistant and RN-A leave the room. RN-A was holding a bottle in his hand. FM-A asked RN-A what the medication was. RN-A verbalized he had just given R1 a dose of morphine as R1 had reported having stomach pain. FM-A told RN-A staff were supposed to consult with hospice and himself prior to giving the medication. Approximately 45 minutes following the administration of morphine, R1 reported feeling nauseous, hot, tired, and requested to be laid down to sleep. Shortly after R1 was laid down R1 went into a deep sleep and	F 760			

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F 760	Continued From page 9 was hard to arouse. FM-A stated he asked one of the nurses how long R1 would be in that state and he was told it would take four to six hours. During interview on 7/22/21, at 12:23 p.m. RN-A confirmed he administered 5 mL (100 mg) of morphine to R1 on 7/18/21, rather than 0.25 mL (5mg). He was not aware he had made a medication error until 7/19/21, when he was informed by the DON R1 had died. The error was realized when hospice and FM-A inquired about the left-over supply of morphine. RN-A stated he believed the morphine was concentrated equally between milligrams and milliliters (meaning 1 mL was the same as 1 mg). During a follow-up interview on 7/22/21, at 2:25 p.m. RN-A stated on 7/18/21, after he administered morphine to R1, FM-A brought R1 back to his room because R1 had reported feeling tired, had nausea, and wanted to be laid down. RN-A stated he took R1's vital signs at that time, however, forgot to document the results as it was a hectic shift due to a heavy medication pass and attending to several hospice patients. He remembered R1's pulse was 60, oxygen saturation was 94 percent, and respirations were 20. RN-A stated that was not an excuse as R1 was administered 20 times the amount of morphine ordered. During interview on 7/22/21, at 1:30 p.m. the facility consultant pharmacist (CP) stated she was made aware of the medication error involving R1 being given the wrong dose of morphine and the facility was developing policies and training processes to make sure the error did not occur again.	F 760			

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F 760	Continued From page 10 During interview on 7/22/21, at 1:45 p.m. the DON acknowledged a significant medication error had occurred involving R1 and stated she expected staff to follow physicians' orders in addition to the five rights of medication administration (right does, route, drug, resident, and time). Following the medication error it was identified R1's medication order was transcribed to give in mg rather mL. The medication error was "avoidable" and RN-A understood the "magnitude of it." After the incident, education on medication administration was implemented, however, the DON did not know if all nurses, trained medication aides (TMA's), and health unit coordinators (HUC's) who administered medications or transcribed medication orders from 7/19/21, through 7/22/21, had received training. During interview on 7/22/21, at 2:47 p.m. R1's primary physician, medical doctor (MD)-A stated it was reported to her R1 received 5 mL (100 mg) of morphine and was, "no longer responding, was somnolent, had fixed or glazed eyes, and the next morning he was found with no pulse or respirations." She believed morphine contributed to R1's death as R1 had a change of condition right after being given the dose. MD-A stated although R1 was not healthy, R1 was still talking and interacting with FM-A leading up to the medication error. MD-A stated morphine overdose side effects were typically a rapid decrease in alertness, mental status, and slowing of breathing unit breathing stopped which would typically occur quickly, but it did not have to happen that way. During interview on 7/22/21, at 5:08 p.m. RN-D stated she worked afternoon shift on 7/18/21,	F 760			

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F 760	Continued From page 11 after RN-A. During report, RN-A verbalized he had administered morphine to R1 for stomach pain. RN-D stated during her shift R1, "did not leave his bed. When we went to the room to tell him it was supper his eyes were closed. When we called his name he would open them and drop them right back. I thought he was resting and he would have woken up at some point, but he was in a deep sleep." She did not know a medication error had occurred until 7/19/21, when she came to work and was informed R1 had died. RN-D stated all nurses and TMA's were supposed to follow the five rights of medication administration and review read instructions when administering medications. Review of facility staff schedules and Inservice Record sheets dated 7/19/21 through 7/22/21, revealed four RNs (RN-M, RN-N, RN-O, RN-P), TMA-B, and licensed practical nurse (LPN)-C had worked since the facility was made aware of the significant medication error, however, had not received education. The DON confirmed not all staff had received education and stated staff would receive training when they worked next. The facility Administering Medications policy reviewed 11/6/19, directed: "3. Medications must be administered in accordance with the orders, including any required time frame." "5. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the	F 760			

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F 760	Continued From page 12 concerns." "7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication ..." The IJ that began on 7/18/21, at 11:12 a.m. and was removed on 7/23/21, at 12:00 p.m. when it was verified through observation, interview, and document review the facility had developed and implemented a systemic plan which included: - The facility educated all licensed nurses, TMA's, and HUCS who were actively working on a dose conversation table, the five rights of medication administration, liquid medications come in different concentrations (mg/mL), order transcription, and staff were to follow all medication details as ordered on 7/23/21. - Licensed nurses, TMA's, and HUCs were notified the above education must be completed prior to working their next scheduled shift on 7/23/21 - The facility reviewed all resident records to ensure liquid suspension medication orders were correct on 7/19/21.	F 760			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 10, 2021

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

Re: State Nursing Home Licensing Orders
Event ID: 203G11

Dear Administrator:

The above facility was surveyed on July 22, 2021 through July 23, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Southview Acres Healthcare Center

August 10, 2021

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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:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Southview Acres Healthcare Center

August 10, 2021

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Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/22/21, through 7/23/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/12/21

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5189191C (MN74945 and MN74956) with a licensing order issued at (1545). The following complaints were found to be UNSUBSTANTIATED: H5189192C (MN74951) and H5189193C (MN74874), however, a related licensing order was 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	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as	21545		8/19/21

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21545	Continued From page 3 prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure morphine (a narcotic medication) was administered as prescribed for 1 of 3 residents (R1) reviewed for medication errors. This deficient practice resulted in an immediate jeopardy (IJ) situation for R1 who received a morphine dose 20 times greater than was prescribed, became unresponsive and subsequently died. Further, the facility failed to ensure medications were administered in accordance with physician orders without errors for 1 of 6 residents (R6) observed to receive medications. This resulted in a facility medication error rate of 8% (percent). The IJ began on 7/18/20, at 11:12 a.m. when R1 was administered 100 milligrams (mg) of morphine rather than 5 mg as ordered. R1 became somnolent, had fixed/glazed eyes, and died the following morning. The administrator and director of nursing (DON) were notified of the IJ at 5:27 p.m. on 7/22/21. The IJ was removed on 7/23/21, at 12:00 p.m., but noncompliance remained at the lower scope and severity level of a D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not IJ.	21545	Corrected.	

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21545	Continued From page 4 Findings include: R1 diagnoses included vascular dementia without behavioral disturbance, diabetes mellitus, glaucoma, and chronic kidney disease obtained from the admission Minimum Data Set (MDS) dated 7/15/21. The MDS also identified R1 made himself understood and usually understood others. R1 required extensive assistance with transfers, locomotion (off unit/on unit), and supervision eating. R1 had no pain, had not received opioid medications, and received hospice services. R1's physician orders dated 7/9/21, indicated R1 was ordered morphine sulfate (concentrate) 20 mg / milliliter (mL). Give 5 mg (0.25 mL) every 1 hour as needed for pain or dyspnea (shortness of breath). The medication was only to be administered, "after discussion with Hospice." R1's care plan dated 7/13/21, identified R1 was at risk for pain and had as needed pain medication ordered. The care plan directed staff to administer medications as ordered, per hospice. R1's Individual Narcotic Record indicated on 7/18/21, at 11:05 a.m. registered nurse (RN)-A signed off removing 5 mL (100 mg) of morphine. This was the first dose out of a 30 mL bottle, 25 mL of morphine remained in the bottle. R1's July 2021 Medication Administration Record (MAR) indicated RN-A documented morphine was administered to R1 on 7/18/21, at 11:12 a.m. for a pain level of 6 out of 10. RN-A documented the medication was "E" (effective). A progress note dated 7/19/21, at 8:05 a.m.	21545		

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21545	Continued From page 5 indicated R1 died at 7:56 a.m. During interview on 7/22/21, at 10:27 a.m. hospice RN, RN-K stated on 7/19/21, she received a call R1 had died and went to the facility. RN-K stated she was denied access to the medication and the narcotic book by a nurse. During interview on 7/22/21, at 10:38 a.m. family member (FM)-A stated he left R1's room per staff request on 7/18/21, and staff assisted R1 with morning cares. Upon return to R1's room he observed a nursing assistant and RN-A leave the room. RN-A was holding a bottle in his hand. FM-A asked RN-A what the medication was. RN-A verbalized he had just given R1 a dose of morphine as R1 had reported having stomach pain. FM-A told RN-A staff were supposed to consult with hospice and himself prior to giving the medication. Approximately 45 minutes following the administration of morphine, R1 reported feeling nauseous, hot, tired, and requested to be laid down to sleep. Shortly after R1 was laid down R1 went into a deep sleep and was hard to arouse. FM-A stated he asked one of the nurses how long R1 would be in that state and he was told it would take four to six hours. During interview on 7/22/21, at 12:23 p.m. RN-A confirmed he administered 5 mL (100 mg) of morphine to R1 on 7/18/21, rather than 0.25 mL (5mg). He was not aware he had made a medication error until 7/19/21, when he was informed by the DON R1 had died. The error was realized when hospice and FM-A inquired about the left-over supply of morphine. RN-A stated he believed the morphine was concentrated equally between milligrams and milliliters (meaning 1 mL was the same as 1 mg).	21545		

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21545	Continued From page 6 During a follow-up interview on 7/22/21, at 2:25 p.m. RN-A stated on 7/18/21, after he administered morphine to R1, FM-A brought R1 back to his room because R1 had reported feeling tired, had nausea, and wanted to be laid down. RN-A stated he took R1's vital signs at that time, however, forgot to document the results as it was a hectic shift due to a heavy medication pass and attending to several hospice patients. He remembered R1's pulse was 60, oxygen saturation was 94 percent, and respirations were 20. RN-A stated that was not an excuse as R1 was administered 20 times the amount of morphine ordered. During interview on 7/22/21, at 1:30 p.m. the facility consultant pharmacist (CP) stated she was made aware of the medication error involving R1 being given the wrong dose of morphine and the facility was developing policies and training processes to make sure the error did not occur again. During interview on 7/22/21, at 1:45 p.m. the DON acknowledged a significant medication error had occurred involving R1 and stated she expected staff to follow physicians' orders in addition to the five rights of medication administration (right does, route, drug, resident, and time). Following the medication error it was identified R1's medication order was transcribed to give in mg rather mL. The medication error was "avoidable" and RN-A understood the "magnitude of it." After the incident, education on medication administration was implemented, however, the DON did not know if all nurses, trained medication aides (TMA's), and health unit coordinators (HUC's) who administered medications or transcribed medication orders from 7/19/21, through 7/22/21, had received	21545		

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21545	Continued From page 7 training. During interview on 7/22/21, at 2:47 p.m. R1's primary physician, medical doctor (MD)-A stated it was reported to her R1 received 5 mL (100 mg) of morphine and was, "no longer responding, was somnolent, had fixed or glazed eyes, and the next morning he was found with no pulse or respirations." She believed morphine contributed to R1's death as R1 had a change of condition right after being given the dose. MD-A stated although R1 was not healthy, R1 was still talking and interacting with FM-A leading up to the medication error. MD-A stated morphine overdose side effects were typically a rapid decrease in alertness, mental status, and slowing of breathing unit breathing stopped which would typically occur quickly, but it did not have to happen that way. During interview on 7/22/21, at 5:08 p.m. RN-D stated she worked afternoon shift on 7/18/21, after RN-A. During report, RN-A verbalized he had administered morphine to R1 for stomach pain. RN-D stated during her shift R1, "did not leave his bed. When we went to the room to tell him it was supper his eyes were closed. When we called his name he would open them and drop them right back. I thought he was resting and he would have woken up at some point, but he was in a deep sleep." She did not know a medication error had occurred until 7/19/21, when she came to work and was informed R1 had died. RN-D stated all nurses and TMA's were supposed to follow the five rights of medication administration and review read instructions when administering medications. Review of facility staff schedules and Inservice Record sheets dated 7/19/21 through 7/22/21,	21545		

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21545	Continued From page 8 revealed four RNs (RN-M, RN-N, RN-O, RN-P), TMA-B, and licensed practical nurse (LPN)-C had worked since the facility was made aware of the significant medication error, however, had not received education. The DON confirmed not all staff had received education and stated staff would receive training when they worked next. The IJ that began on 7/18/21, at 11:12 a.m. and was removed on 7/23/21, at 12:00 p.m. when it was verified through observation, interview, and document review the facility had developed and implemented a systemic plan which included: - The facility educated all licensed nurses, TMA's, and HUCS who were actively working on a dose conversation table, the five rights of medication administration, liquid medications come in different concentrations (mg/mL), order transcription, and staff were to follow all medication details as ordered on 7/23/21. - Licensed nurses, TMA's, and HUCs were notified the above education must be completed prior to working their next scheduled shift on 7/23/21 - The facility reviewed all resident records to ensure liquid suspension medication orders were correct on 7/19/21. R5's Medication Review Report printed 7/23/21, identified R5 had orders for: - Carbamazepine (used to treat seizures) tablet chewable 100 milligrams (mg) give 4 tablets (400 mg) by mouth two times a day for nerve pain. - Gabapentin capsule 100 mg give 2 capsules (200 mg) by mouth one time a day and 1 capsule by mouth as needed for agitation/anxiety twice a day. On 7/22/21, at 8:15 a.m. registered nurse (RN)-B was observed preparing R5's medications which	21545		

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21545	Continued From page 9 included: - Carbamazepine 1 tablet (100 mg) - Gabapentin 1 capsule (100 mg) - Triamcinolone 0.1% cream (used for rash) - Desonide 0.05% cream (used for skin irritation). At 8:18 a.m. RN-B attempted to administer the above medications to R5, however, RN-B was stopped by the surveyor and it was requested RN-B review of R5's medication orders. At 8:20 a.m. RN-B acknowledged R5 was to receive their scheduled dose of Gabapentin and not the as needed order. RN-B proceeded to review the orders and removed a Carbamazepine medication card from the medication cart and removed three additional tablets. RN-B also removed one additional tablet of Gabapentin. RN-B confirmed she did not remove the correct amount of medication during her initial attempt to administer medications to R5. At 8:28 a.m. RN-B returned to R5's room and administered the medications. At 8:32 a.m. RN-B confirmed she made a mistake and would have administered the incorrect doses of medication. On 7/22/21, at 10:40 a.m. RN-C stated staff should be performing the 5 rights of medication administration and ensure the right patient, right time, and right dose were being given. RN-C stated staff should be following orders when passing medications. On 7/22/21, at 1:42 p.m. the director of nursing (DON) stated she expected staff passing medications to check the orders, check the actual medication, and then check again. The DON stated she also expected staff to ensure the right person, right dose, and right medication before medication was dispensed. The facility Administering Medications policy	21545		

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21545	Continued From page 10 reviewed 11/6/19, directed: "3. Medications must be administered in accordance with the orders, including any required time frame." "5. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns." "7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication ..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545			