



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
August 20, 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 informed you of imposed enforcement remedies.

On August 5, 2021, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

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

This Department continues to recommend 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. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 25, 2021.

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.

As we notified you in our letter of August 10, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

An equal opportunity employer.

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 23, 2021.

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us

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 - Health Regulation Division 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

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ 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/lrc_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

Southview Acres Healthcare Center

August 20, 2021

Page 5

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,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a large initial 'K' and a stylized 'F'.

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

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

PRINTED: 09/03/2021
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 08/05/2021
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 8/4/21, through 8/5/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5189197C (MN75219) with a deficiency cited at F689. H5189196C (MN75361) with a deficiency cited at F760. H5189195C (MN75458) with a deficiency cited at F760. The following complaints were found to be UNSUBSTANTIATED. H5189194C (MN75286 & MN75315) H5189198C (MN75423) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689			8/24/21

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

TITLE

(X6) DATE

Electronically Signed

08/23/2021

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 689	Continued From page 1 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor and implement interventions to prevent elopement for 1 of 4 residents (R2) who had a history of wandering behavior. R2's Face Sheet printed 8/5/21, indicated R2's diagnosis included Alzheimer's disease and dementia. R2's quarterly Minimum Data Set (MDS) dated 7/27/21, indicated R2 had a severe cognitive impairment, utilized a wheelchair, and required extensive assistance with locomotion on and off the unit. R2's care plan dated 12/30/20, indicated "Resident is a wanderer r/t (related to) resident wander aimlessly." The care plan directed to assess elopement status quarterly and as needed. Interventions included a Wanderguard (alarm system) on R2's right arm, and "distract" R2 from wandering by offering pleasant diversions and offering structured activities. R2's Physician Orders dated 1/9/21, indicated an order for a Wanderguard, and to check placement each shift. R2's Elopement Risk assessment dated 4/27/21, indicated R2 was at low risk for elopement, and	F 689	F 689 R2 had a wander guard placed, new elopement assessment completed, care plan was initiated for elopement and a risk management incident initiated and was thoroughly investigated and the root cause was identified and changes were implemented. All residents that were identified as at risk for elopement their care plan was reviewed and updated as needed. Future residents will be assessed for elopement and will have a baseline care plan initiated and reviewed quarterly and as needed. Nursing staff along with the IDT team was in-serviced on the Wandering ☐ Unsafe Resident Policy with focus on item # 2 that residents will be assessed to correct causative factors for unsafe wandering. Director of Nursing and/or designee is responsible for compliance. Audits on elopement assessments and care plan initiation will be 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 8/24/2021		

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F 689	Continued From page 2 had a Wanderguard applied on the right wrist. The assessment further indicated frequent monitoring for R2. On 7/14/21, at 4:07 p.m. a progress note indicated due to plumbing/maintenance required on first floor, R2 would be transferred to a room on second floor. On 7/17/21, at 6:50 p.m. a progress note indicated R2 had unsafe wandering into the construction area. R2 made it to the back exit door and activated the Wanderguard alarm as he passed the threshold. R2 stated he was just get some air. R2 was brought back into the facility. On 7/26/21, at 7:17 p.m. a progress note indicated R2 was noted to be wandering into the construction area. R2 activated the Wanderguard alarm as he passed through the door. When asked what he was doing, R2 replied he replied, "I don't know." R2 was brought back into the building. On 7/27/21, at 1:42 p.m. a progress note indicated the interdisciplinary team (IDT) discussed R2's aimless wandering and recent elopement attempt, and decided to move R2 to the 3rd floor. On 8/5/21, at 10:13 a.m. registered nurse (RN)-D was interviewed and stated stated he intercepted R2 during an elopement attempt on 7/17/21. RN-D stated R2 was an aimless wanderer. RN-D notified the unit manager and the director of nursing (DON) R2 had made it off the unit. RN-D stated he didn't know how to put R2 on frequent checks because "if you go to check on him in his room, he is not going to be there." RN-D stated	F 689			

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F 689	Continued From page 3 you had to be within earshot of the Wanderguard system to hear it alarm, and it did not alarm on the units. RN-D stated the elevators did not have Wanderguard alarms. On 8/5/21, at 10:34 a.m. R2 was observed to wander into the common area on the third floor and stated, "I am coming, I am not sure where I am going, but I am coming." R2 then asked, "Where do I go?" On 8/5/21, at 11:10 a.m. nursing assistant (NA)-A stated R2 often wandered into other resident's rooms and required frequent redirection. NA-A verified there were no formal checks in place for R2 and stated, "We don't check on him like every 10 minutes or anything, just when he is out and about." On 8/5/21, at 12:06 p.m. RN-A stated R2 wandered, and she did not believe the elevators had a Wanderguard system in place. RN-A stated, "We have had issues with residents going up and down" the elevator. On 8/5/21, at 3:21 p.m. RN-C stated she was exiting the 3rd floor via the stairwell on 7/26/21, and began to hear the Wanderguard alarm as she descended the stairs. RN-C looked out the 2nd floor exit door and saw R2 in the parking lot. RN-C exited the building and brought R2 back inside. RN-C stated the Wanderguard could not be heard from the 3rd floor prior to entering the stairwell. RN-C stated she did not believe the elevators contained a Wanderguard system and verified prior concerns of residents "wanting to get on the elevator." On 8/5/21, at 4:24 p.m. the DON verified the	F 689			

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F 689	Continued From page 4 Wanderguard alarms are located only on front door and back exit doors, and possibly on the courtyard door in the dining room. The DON stated the elevators did not have Wanderguard alarms. The DON stated she was not aware of R2's first elopement attempt on 7/17/21, and if she would have known, would have reassessed R2 for elopement risk and determine if interventions needed to be changed. The DON verified there were not formal frequent checks in place for R2, but they would be beneficial. The facility policy Wander Guard dated 8/5/21, indicated nursing assessment of each resident must be done on admission and change in status to evaluate if he/she is at risk for falls or elopement, and a plan of care must be formulated with the Interdisciplinary Team to determine the need for the wander guard and management.	F 689			
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 ensure medications were administered as directed by the physician for 2 of 3 resident (R3, R4) reviewed for significant medication errors. Findings include: R3's Admission Record dated 8/5/21, indicated R3's diagnoses included multiple sclerosis,	F 760	F 760 R 3 was assessed, MD and family representative notified. R 3 was observed post incident. A risk management incident was initiated and a root cause was identified and corrective measures were implemented. R 4 was assessed; the MD and family representative was notified. R 4 was observed post incident. A risk		8/24/21

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F 760	Continued From page 5 depression, anxiety, quadriplegia, breast cancer and hypertension. R3's quarterly Minimum Data Set (MDS) dated 6/22/21, indicated R3 was cognitively intact and had mild depression. R3 needed the assistance of staff for all activities of daily living (ADLs), did not walk and used a wheelchair for mobility. R3 received an antidepressant and a diuretic. The facility's investigation indicated R3's family representative (FR)-A called the facility on 7/30/21, and reported R3 had received the roommate's medications on 7/29/21. FR-A stated R3 felt sleepier than normal after receiving the medication in the morning of 7/29/21. R3 knew she received the roommate's medication because there were not enough pills and the nurse brought in an insulin syringe. The investigation also indicated licensed practical nurse (LPN)-A was interviewed and stated she had done an incomplete medication pass to R3. When LPN-A realized she had not given R3 all of the scheduled medications LPN-A gave R3 the rest of the medications. LPN-A denied giving R3 the roommate's medication. 7/29/21, was LPN-A's second shift at the facility. LPN-A did not receive any orientation or informational packet. LPN-A only received report. Further, the investigation indicated R3 stated LPN-A brought in the medication. The LPN-A did not call R3 by name. LPN-A did a blood glucose check. R3 did not have blood glucose checks. After R3 took the pills LPN-A went out into the hall and returned with insulin. R3 told LPN-A she did not take insulin she took metformin (an oral medication to control blood sugar). LPN-A asked R3 if she was Betty of which was R3's roommate's name. R3 stated, "no." LPN-A had a horrified look on her	F 760	management incident was initiated and a root cause was identified and corrective measures were implemented. All other residents in the assignment were assessed and there were no further errors identified. Nurses and TMAs were in-serviced on the Administering Medication policy and procedure with emphasis on items # 7 and 8 to identify the resident and perform three label checks prior to administering the medication. Agency nurses will receive this education prior to the start of the shift. 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: 8/24/2021		

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F 760	Continued From page 6 face. After receiving the medication R3 felt "drugged" and slept all day. The medication prescribed to the roommate believed to have been given to R3 was: Gabapentin (a medication used to treat seizures and nerve pain) 100 milligrams (mg) Hydralazine HCL (a medication used to treat high blood pressure) 25 mg Amlodipine (a medication used to lower blood pressure) 10 mg Escitalopram (an antidepressant) 10 mg Sennosides-Ducosate Sodium (a stool softener) 8.6-50 mg Lansoprazole Delayed Release (used to treat acid reflux and ulcers) 30 mg LPN-A was removed from the facility and would not be returning. On 8/5/21, at 11:08 a.m. R3 was observed receiving the morning medications from registered nurse (RN)-A. RN-A gave R3 her morning medications as ordered. On 8/5/21, at 11:25 a.m. R3 was interviewed. R3 stated she received her medication and then LPN-A checked R3's blood sugar when R3 did not normally get a blood sugar check. LPN-A asked R3 if she got insulin. R3 told LPN-A no, she took metformin. LPN-A asked again and then asked R3 if she was Betty. LPN-A did not tell R3 she had received Betty's medications but kept asking R3 if she was Betty. R3 further stated she felt like she was drugged and slept all day and night. R3 told FR-A that night, and FR-A called the facility and reported it. R3 did not see LPN-A after that. R4's Admission Record dated 8/5/21, indicated R4's diagnoses included Lupus, severe protein	F 760			

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

PRINTED: 09/03/2021
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 08/05/2021
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118		
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F 760	Continued From page 7 calorie malnutrition, heart disease bronchitis, chronic kidney disease and pneumonia due to pseudomonas (bacteria). The MAR further indicated R4's allergies included Amoxicillin (a penicillin type antibiotic), codeine, Erythromycin (used to treat respiratory bacterial infections), Rifampin (used to treat lung infections), Augmentin (antibiotic) and sulfa antibiotics. R4's care plan dated 8/4/21, indicated R4 planned to return home to independent living. R4's 8/21, MAR include orders for Ceftazidime (an antibiotic) 1000 mg intravenously (IV) every eight hour for 15 days for respiratory infection. The facility Medication Error report dated 8/2/21, at 8:25 p.m. indicated when RN-B started R4's IV, RN-B started Ampicillin (antibiotic) instead of Ceftazidime. This medication ran for approximately 35 to 40 seconds before the error was noted and the medication was stopped. Immediate action taken included the physician was notified and indicated no harm. R4 was not allergic to Ampicillin. R4's vital signs were taken and within normal limits. R4 stated she felt fine. The facility's investigation indicated RN-B reported to the RN supervisor (RNS) she had hooked up the wrong IV medication to R4 and it was only on for 30 seconds to one minute. R4 discovered the error and alerted RN-B. RN-B stated she had two IV medications to give at the same time. RN-B had both IV antibiotics of which looked the same on the medication cart. RN-B picked up the other resident's IV antibiotic. On 8/5/21, at 10:19 a.m. R4 stated she did not have any adverse reactions from receiving the	F 760			

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F 760	Continued From page 8 incorrect IV medication. R4 caught the error right away as her routine was to look at the label on the medication before putting the ball shaped bag into her pocket. When R4 discovered the antibiotic was wrong, she clamped the IV tubing and reported to RN-B the antibiotic was not hers. R4 stated the error scared her "immensely" and it "scared the life out of her." The incorrect antibiotic ran for approximately 30 to 45 seconds. RN-B flushed R4's IV and connected the correct antibiotic. On 8/5/21, at 4:03 p.m. the director of nursing (DON) was interviewed. The DON stated the process when a medication error was discovered included notifying the DON, assessing the resident, notifying the physician, depending on the magnitude of the error, pulling the staff off the unit, interviewing, educating staff and proceeding depending on what was learned. Quality assurance reviewed errors for tracking and trending. The DON stated LPN-A was an agency nurse, and LPN-A did not admit to giving the wrong medications to the wrong resident. R3 believed she received the wrong medications. The DON stated RN-B had two IV antibiotics to give at the same time. RN-B pulled both from the refrigerator and placed them on the medication cart to warm. RN-B picked up the wrong antibiotic for R4 and administered it to R4. The DON would expect the five rights and the three checks for medication administration would be done prior to administering medications. The facility policy Administering Medications dated 11/6/19, indicated the person administering medication must check the label three times to verify the right resident, the right medication, the right dose, the right route and the right time.	F 760			

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F 760	Continued From page 9	F 760			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 20, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: VVJR11

Dear Administrator:

The above facility was surveyed on August 4, 2021 through August 5, 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

Southview Acres Healthcare Center

August 20, 2021

Page 2

"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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Southview Acres Healthcare Center

August 20, 2021

Page 3

Health Regulation Division

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2021
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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 8/4/21, through 8/5/21, 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

08/23/21

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5189197C (MN75219) with a licensing order issued at 1665. H5189196C (MN75361) with a licensing order issued at 1545. H5189195C (MN75458) with a licensing order issued at 1545. The following complaints were found to be UNSUBSTANTIATED: H5189194C (MN75286 & MN75315) and H5189198C (MN75423) 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 evidenced 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	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 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. 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor and implement interventions to prevent elopement for	2 830	Corrected	8/24/21

Minnesota Department of Health

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2 830	Continued From page 3 1 of 4 residents (R2) who had a history of wandering behavior. R2's Face Sheet printed 8/5/21, indicated R2's diagnosis included Alzheimer's disease and dementia. R2's quarterly Minimum Data Set (MDS) dated 7/27/21, indicated R2 had a severe cognitive impairment, utilized a wheelchair, and required extensive assistance with locomotion on and off the unit. R2's care plan dated 12/30/20, indicated "Resident is a wanderer r/t (related to) resident wander aimlessly." The care plan directed to assess elopement status quarterly and as needed. Interventions included a Wanderguard (alarm system) on R2's right arm, and "distract" R2 from wandering by offering pleasant diversions and offering structured activities. R2's Physician Orders dated 1/9/21, indicated an order for a Wanderguard, and to check placement each shift. R2's Elopement Risk assessment dated 4/27/21, indicated R2 was at low risk for elopement, and had a Wanderguard applied on the right wrist. The assessment further indicated frequent monitoring for R2. On 7/14/21, at 4:07 p.m. a progress note indicated due to plumbing/maintenance required on first floor, R2 would be transferred to a room on second floor. On 7/17/21, at 6:50 p.m. a progress note indicated R2 had unsafe wandering into the construction area. R2 made it to the back exit	2 830		

Minnesota Department of Health

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2 830	Continued From page 4 door and activated the Wanderguard alarm as he passed the threshold. R2 stated he was just get some air. R2 was brought back into the facility. On 7/26/21, at 7:17 p.m. a progress note indicated R2 was noted to be wandering into the construction area. R2 activated the Wanderguard alarm as he passed through the door. When asked what he was doing, R2 replied he replied, "I don't know." R2 was brought back into the building. On 7/27/21, at 1:42 p.m. a progress note indicated the interdisciplinary team (IDT) discussed R2's aimless wandering and recent elopement attempt, and decided to move R2 to the 3rd floor. On 8/5/21, at 10:13 a.m. registered nurse (RN)-D was interviewed and stated stated he intercepted R2 during an elopement attempt on 7/17/21. RN-D stated R2 was an aimless wanderer. RN-D notified the unit manager and the director of nursing (DON) R2 had made it off the unit. RN-D stated he didn't know how to put R2 on frequent checks because "if you go to check on him in his room, he is not going to be there." RN-D stated you had to be within earshot of the Wanderguard system to hear it alarm, and it did not alarm on the units. RN-D stated the elevators did not have Wanderguard alarms. On 8/5/21, at 10:34 a.m. R2 was observed to wander into the common area on the third floor and stated, "I am coming, I am not sure where I am going, but I am coming." R2 then asked, "Where do I go?" On 8/5/21, at 11:10 a.m. nursing assistant (NA)-A stated R2 often wandered into other resident's	2 830		

Minnesota Department of Health

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2 830	Continued From page 5 rooms and required frequent redirection. NA-A verified there were no formal checks in place for R2 and stated, "We don't check on him like every 10 minutes or anything, just when he is out and about." On 8/5/21, at 12:06 p.m. RN-A stated R2 wandered, and she did not believe the elevators had a Wanderguard system in place. RN-A stated, "We have had issues with residents going up and down" the elevator. On 8/5/21, at 3:21 p.m. RN-C stated she was exiting the 3rd floor via the stairwell on 7/26/21, and began to hear the Wanderguard alarm as she descended the stairs. RN-C looked out the 2nd floor exit door and saw R2 in the parking lot. RN-C exited the building and brought R2 back inside. RN-C stated the Wanderguard could not be heard from the 3rd floor prior to entering the stairwell. RN-C stated she did not believe the elevators contained a Wanderguard system and verified prior concerns of residents "wanting to get on the elevator." On 8/5/21, at 4:24 p.m. the DON verified the Wanderguard alarms are located only on front door and back exit doors, and possibly on the courtyard door in the dining room. The DON stated the elevators did not have Wanderguard alarms. The DON stated she was not aware of R2's first elopement attempt on 7/17/21, and if she would have known, would have reassessed R2 for elopement risk and determine if interventions needed to be changed. The DON verified there were not formal frequent checks in place for R2, but they would be beneficial. The facility policy Wander Guard dated 8/5/21, indicated nursing assessment of each resident	2 830			

Minnesota Department of Health

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2 830	Continued From page 6 must be done on admission and change in status to evaluate if he/she is at risk for falls or elopement, and a plan of care must be formulated with the Interdisciplinary Team to determine the need for the wander guard and management. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee review and/or revise policies and procedures for resident assessment and elopement. The DON or designee could ensure all staff responsible were re-educated. The DON or designee could conduct audits. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
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	21545		8/24/21

Minnesota Department of Health

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21545	Continued From page 7 (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 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 ensure medications were administered as directed by the physician for 2 of 3 resident (R3, R4) reviewed for significant medication errors. Findings include: R3's Admission Record dated 8/5/21, indicated R3's diagnoses included multiple sclerosis, depression, anxiety, quadriplegia, breast cancer and hypertension.	21545	Corrected	

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER SOUTHVIEW ACRES HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118		
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21545	Continued From page 8 R3's quarterly Minimum Data Set (MDS) dated 6/22/21, indicated R3 was cognitively intact and had mild depression. R3 needed the assistance of staff for all activities of daily living (ADLs), did not walk and used a wheelchair for mobility. R3 received an antidepressant and a diuretic. The facility's investigation indicated R3's family representative (FR)-A called the facility on 7/30/21, and reported R3 had received the roommate's medications on 7/29/21. FR-A stated R3 felt sleepier than normal after receiving the medication in the morning of 7/29/21. R3 knew she received the roommate's medication because there were not enough pills and the nurse brought in an insulin syringe. The investigation also indicated licensed practical nurse (LPN)-A was interviewed and stated she had done an incomplete medication pass to R3. When LPN-A realized she had not given R3 all of the scheduled medications LPN-A gave R3 the rest of the medications. LPN-A denied giving R3 the roommate's medication. 7/29/21, was LPN-A's second shift at the facility. LPN-A did not receive any orientation or informational packet. LPN-A only received report. Further, the investigation indicated R3 stated LPN-A brought in the medication. The LPN-A did not call R3 by name. LPN-A did a blood glucose check. R3 did not have blood glucose checks. After R3 took the pills LPN-A went out into the hall and returned with insulin. R3 told LPN-A she did not take insulin she took metformin (an oral medication to control blood sugar). LPN-A asked R3 if she was Betty of which was R3's roommate's name. R3 stated, "no." LPN-A had a horrified look on her face. After receiving the medication R3 felt "drugged" and slept all day. The medication prescribed to the roommate believed to have	21545		

Minnesota Department of Health

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21545	Continued From page 9 been given to R3 was: Gabapentin (a medication used to treat seizures and nerve pain) 100 milligrams (mg) Hydralazine HCL (a medication used to treat high blood pressure) 25 mg Amlodipine (a medication used to lower blood pressure) 10 mg Escitalopram (an antidepressant) 10 mg Sennosides-Ducosate Sodium (a stool softener) 8.6-50 mg Lansoprazole Delayed Release (used to treat acid reflux and ulcers) 30 mg LPN-A was removed from the facility and would not be returning. On 8/5/21, at 11:08 a.m. R3 was observed receiving the morning medications from registered nurse (RN)-A. RN-A gave R3 her morning medications as ordered. On 8/5/21, at 11:25 a.m. R3 was interviewed. R3 stated she received her medication and then LPN-A checked R3's blood sugar when R3 did not normally get a blood sugar check. LPN-A asked R3 if she got insulin. R3 told LPN-A no, she took metformin. LPN-A asked again and then asked R3 if she was Betty. LPN-A did not tell R3 she had received Betty's medications but kept asking R3 if she was Betty. R3 further stated she felt like she was drugged and slept all day and night. R3 told FR-A that night, and FR-A called the facility and reported it. R3 did not see LPN-A after that. R4's Admission Record dated 8/5/21, indicated R4's diagnoses included Lupus, severe protein calorie malnutrition, heart disease bronchitis, chronic kidney disease and pneumonia due to pseudomonas (bacteria). The MAR further indicated R4's allergies included Amoxicillin (a	21545		

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21545	Continued From page 10 penicillin type antibiotic), codeine, Erythromycin (used to treat respiratory bacterial infections), Rifampin (used to treat lung infections), Augmentin (antibiotic) and sulfa antibiotics. R4's care plan dated 8/4/21, indicated R4 planned to return home to independent living. R4's 8/21, MAR include orders for Ceftazidime (an antibiotic) 1000 mg intravenously (IV) every eight hour for 15 days for respiratory infection. The facility Medication Error report dated 8/2/21, at 8:25 p.m. indicated when RN-B started R4's IV, RN-B started Ampicillin (antibiotic) instead of Ceftazidime. This medication ran for approximately 35 to 40 seconds before the error was noted and the medication was stopped. Immediate action taken included the physician was notified and indicated no harm. R4 was not allergic to Ampicillin. R4's vital signs were taken and within normal limits. R4 stated she felt fine. The facility's investigation indicated RN-B reported to the RN supervisor (RNS) she had hooked up the wrong IV medication to R4 and it was only on for 30 seconds to one minute. R4 discovered the error and alerted RN-B. RN-B stated she had two IV medications to give at the same time. RN-B had both IV antibiotics of which looked the same on the medication cart. RN-B picked up the other resident's IV antibiotic. On 8/5/21, at 10:19 a.m. R4 stated she did not have any adverse reactions from receiving the incorrect IV medication. R4 caught the error right away as her routine was to look at the label on the medication before putting the ball shaped bag into her pocket. When R4 discovered the antibiotic was wrong, she clamped the IV tubing	21545		

Minnesota Department of Health

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21545	Continued From page 11 and reported to RN-B the antibiotic was not hers. R4 stated the error scared her "immensely" and it "scared the life out of her." The incorrect antibiotic ran for approximately 30 to 45 seconds. RN-B flushed R4's IV and connected the correct antibiotic. On 8/5/21, at 4:03 p.m. the director of nursing (DON) was interviewed. The DON stated the process when a medication error was discovered included notifying the DON, assessing the resident, notifying the physician, depending on the magnitude of the error, pulling the staff off the unit, interviewing, educating staff and proceeding depending on what was learned. Quality assurance reviewed errors for tracking and trending. The DON stated LPN-A was an agency nurse, and LPN-A did not admit to giving the wrong medications to the wrong resident. R3 believed she received the wrong medications. The DON stated RN-B had two IV antibiotics to give at the same time. RN-B pulled both from the refrigerator and placed them on the medication cart to warm. RN-B picked up the wrong antibiotic for R4 and administered it to R4. The DON would expect the five rights and the three checks for medication administration would be done prior to administering medications. The facility policy Administering Medications dated 11/6/19, indicated the person administering medication must check the label three times to verify the right resident, the right medication, the right dose, the right route and the right time. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee review and/or revise policies and procedures for medication administration. The DON or designee could ensure all staff responsible for	21545			

Minnesota Department of Health

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21545	Continued From page 12 administering medications were re-educated. The DON or designee could observe medication administration to ensure staff are administering medications according to physician's orders and manufacturer's instructions unless otherwise specified by the physician. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545			