DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL265333165M
Compliance #: HL265335235C

Date Concluded: January 3, 2023

Name, Address, and County of Licensee Investigated:
Senior Class Care
4451 East Woodman Street
Pequot Lakes, MN 56472
Crow Wing County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when a medication error occurred. The facility failed to administer warfarin (blood thinning medication) as prescribed for one week and the resident experienced stroke-like symptoms.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident missed six doses of scheduled warfarin, the stroke-like symptoms presented before the medication error occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice staff, coumadin clinic staff, and the pharmacy. The investigation included review of the resident's progress notes, service plan, medication administration records, medication orders, hospice records, and pharmacy records. Also, the investigator observed medication administration at the facility.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included Alzheimer's Disease with late onset and a history of venous thrombosis and embolisms (blood clots). The resident's service plan included assistance with medication administration and medication management. The resident's assessment indicated medications were managed in conjunction with an outside hospice provider.

The hospice provider was responsible to complete the resident's international normalized ratio (INR) lab draw (a lab used to monitor how well blood thinning medication is working) and send the sample to the lab for results. The clinic would then review the INR results, adjust the resident's warfarin dose to ensure the INR remained within a therapeutic range and send the adjusted warfarin orders to the facility. The pharmacy was to dispense the medication in accordance with the orders the facility provided from the INR clinic.

The resident's INR lab was drawn on a Tuesday. Hospice notes from that Tuesday indicated the resident was having mini strokes. No additional concerns or stroke-like symptoms were noted in the subsequent days.

The resident's medication administration record (MAR) indicated the resident missed six days (Tuesday through Sunday) of warfarin medication beginning the same Tuesday the INR lab was obtained.

Records from the pharmacy indicated the pharmacy faxed the facility after they received the resident's INR results, with a request for clarification of the warfarin orders as the dosage orders were cut off from the original message. No follow-up on the pharmacy's request for clarification was documented in the resident's record. The next note in the resident's record regarding the warfarin was entered four days later (Saturday) which indicated the nurse "requested warfarin refill from the pharmacy." The pharmacy records further included multiple faxed requests sent from the facility on Saturday and Sunday for the pharmacy to send the medication as soon as possible. The pharmacy replied to each refill request by informing the facility they needed a copy of the updated warfarin order before the medication could be filled.

Facility staff did not call the pharmacy until Sunday and left a voicemail. The pharmacy made attempts to contact the facility regarding the order request but were unable to contact staff who were familiar with the situation. Pharmacy staff eventually contacted the coagulation (warfarin) clinic directly to obtain a copy of the new medication orders. Upon obtaining the orders, the pharmacy filled the prescription, and the medication was sent to the facility.

On Monday, a note was entered in the resident's chart that the facility received the warfarin medication from the pharmacy.

Hospice records indicated the resident's INR was re-checked a few days after the six doses of warfarin were missed, per the resident's regular INR lab schedule. The resident's INR lab result

was 1.0, a critical value, which was below therapeutic levels. The hospice nurse updated the facility on the results due to the significant change in the INR lab level. It was during this update that the hospice nurse was first informed of the medication error of the six missed doses of warfarin. Facility staff told the hospice nurse the medication was unavailable as the pharmacy “just didn't send it."

Following the critical INR lab value result, new orders for warfarin were obtained. The resident’s INR was re-checked the following week with a result of 2.7, which was back in therapeutic range for the resident.

There was no documentation to support that the resident experienced any stroke-like symptoms during the time the medication was missed.

During an interview, the hospice nurse said that until the critical lab value presented, she was unaware the resident had missed several days of his prescribed warfarin. The hospice nurse was concerned she was not informed of the medication not being available and the warfarin not being administered to the resident.

During investigative interviews, the unlicensed personnel (ULPs) working while the resident was out of his medication, indicated they contacted the nurse each day the resident was out of the medication. The nurse told the ULPs she was aware the medication was out and was working on getting it refilled.

During an interview, the facility nurse stated she was out of the office most of the week the resident missed his warfarin medication. The facility nurse indicated that she was the only on-call nurse for the facility. The nurse said she was unaware the resident’s warfarin was not available and not being administered to the resident until she was informed by the housing director on Saturday. The facility nurse denied being contacted during the week by unlicensed personnel (ULPs) regarding the medication not being available.

During an interview, the facility housing director, who is also a licensed nurse, stated she was the one who discovered the resident had no warfarin left when she came to work that Saturday. The housing director said she was not previously updated by any staff member that the resident’s warfarin had run out. The housing director indicated she was out of the office at a meeting for the last part of the week and would have expected staff to call herself or the registered nurse with any medication concerns.

During an interview, the coagulation (warfarin) clinic nurse stated the clinic was not updated about the resident’s six missed warfarin doses but would have expected to be notified. The resident’s 1.0 INR was a critically sub-therapeutic lab level, so the coagulation clinic forwarded the resident’s chart on to the primary care provider. The provider wrote new orders for warfarin dosing based on the resident’s INR lab value and the missed warfarin doses.

During an interview, the resident and his wife stated they were not notified by the facility of the six missed warfarin doses.

As a result of the investigation, licensing orders were issued related to medication administration and appropriate care and services regarding the missed doses of warfarin.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility worked with hospice to improve their communication process related to INR lab draws and coordination of new warfarin orders.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26533	A. BUILDING: ______ B. WING ______	C 12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CLASS COMMUNITY LLC	**4451 EAST WOODMAN STREET PEQUOT LAKES, MN 56472**

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL265333165M/#HL265335235C On December 6, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 14 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL265335235C/#HL265333165M, tag identification 1760 and 2310.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication	01760		

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Continued From page 1

Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure medication was administered as ordered for one of one residents (R1).

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

MISSED MEDICATION ORDERS
R1's diagnoses included Alzheimer's Disease with late onset and history of venous thrombosis and embolisms (blood clots).

R1's service plan dated February 18, 2022,

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01760	Continued From page 2 indicated the resident received assistance with medication administration, support stockings, toileting, transfers, dressing, grooming, and ambulation. R1's most recent assessment, dated August 1, 2022, indicated the resident's medications were managed in conjunction with hospice. The hospice provider was documented as the person responsible for checking the resident's INR (International Normalized Ratio, a test that measures the amount of time it takes for blood to clot) and the facility nurse would receive orders and medications from the pharmacy. The assessment further indicated the resident was at risk due to complex medication regimen including Warfarin (a medication used to prevent blood clots) adjustment weekly/monthly/as needed by results of INR with orders received by the coagulation clinic. R1's INR was checked by hospice on October 4, 2022. A progress note on October 2, 2022, indicated licensed practical nurse (LPN)-D faxed the pharmacy for a Warfarin refill. A progress note on October 4, 2022, indicated the hospice nurse would be drawing the resident's INR. A progress note on October 8, 2022, indicated LPN-D requested a Warfarin refill from the pharmacy. A progress note on October 10, 2022 at 12:54 p.m. indicated LPN-D clarified with the pharmacy that the facility would receive the Warfarin refill that day. A note at 3:52 p.m. indicated it had been	01760		

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01760	Continued From page 3 received. R1's Medication Administration Record (MAR) for October 2022 indicated the resident did not receive Warfarin as scheduled on the following days: -October 4 -October 5 -October 6 -October 7 -October 8 -October 9 In total, the resident missed six doses of Warfarin. Records from the pharmacy indicated the pharmacy received a new order for Warfarin after the INR was drawn on October 4, 2022. However, the pharmacy was unable to read the orders that were sent from the coagulation clinic. Pharmacy records included a fax sent to the facility on October 4, 2022, asking them to please resend the order as the directions were cut off. No response was noted from the facility. Pharmacy records included a fax from their Eden Prairie location as the facility had contacted that location (incorrect location) requesting a Warfarin refill on October 9, 2022. The Eden Prairie location did not have the patient in their system and sent the phone message to the Saint Cloud location that was responsible for the resident's medications. Pharmacy records indicated LPN-D emailed on October 9, 2022, requesting a Warfarin refill "ASAP." The pharmacy records further indicated a staff member emailed back asking they re-send the order as the first attempt was not readable. The pharmacy staff member also called and spoke with facility staff and documented that facility staff "...had no idea what was going on."	01760		

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Pharmacy records indicated the facility sent an order on October 9, 2022, however it was the same initial order that had the directions cut off. The pharmacy notes indicated the pharmacy staff then contacted the coagulation clinic directly to get a clean copy of the order and once that was received, they sent the medication refill.

Records from hospice indicated the resident's INR was rechecked on October 12, 2022. The resident's INR was 1.0, which was below therapeutic levels and a critical lab result. The hospice records indicated the facility RN was updated due to the significant change in INR levels from the week prior and at that point hospice was notified that the resident missed a week of Warfarin with the facility stating, "the pharmacy just didn't send it."

Records from hospice indicated the resident's INR on October 19, 2022 was 2.7, within therapeutic range for the resident.

On December 6, 2022, at 2:25 p.m., unlicensed personnel (ULP)-C confirmed she worked on two of the days the resident missed his Warfarin. ULP-C recalled contacting registered nurse (RN)-A and informing her the medication was missing. ULP-C stated there were some notes in R Tasks (the facility's electronic medical record) from the nurse to the staff informing them the pharmacy had been contacted about the missing medication.

On December 6, 2022, at 3:10 p.m., RN-A stated she had been out of the office for a meeting most of the week of October 4, 2022, when the resident was supposed to get an INR recheck and new orders for Warfarin. RN-A stated that while there are other nurses employed by the

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facility, she is the only on call nurse so if she is not in the building, staff would contact her. RN-A stated she was not aware the resident's Warfarin had not been refilled and the resident had not been getting his medication until Saturday (October 8, 2022), when LPN-D had notified her of the medication being out. RN-A stated she had not been contacted by any unlicensed personnel prior to LPN-D notifying her.

On December 6, 2022, at 3:40 p.m., LPN-D stated she was the one who had discovered the resident did not have any Warfarin left when she came to work that Saturday (October 8, 2022). LPN-D stated she had not been updated by any staff that the resident's Warfarin had run out. LPN-D stated she had been out of the office at a meeting for the last part of the week and she would have expected staff to call the nurse with any medication concerns.

On December 7, 2022, at 12:20 p.m., ULP-E confirmed she worked on two of the days the resident missed his Warfarin. ULP-E stated they had let nursing staff know numerous times that the Warfarin was out and they weren't able to give it. ULP-E stated both RN-A and LPN-D were contacted and updated of the resident's missing Warfarin. ULP-E stated she was directed by one of the nurses to mark the medication as not in the facility.

On December 7, 2022, at 12:35 p.m., hospice registered nurse (HRN-G) stated the resident's INR was drawn on October 4, 2022, and a new order for Warfarin was sent to the pharmacy, facility, and hospice. HRN-G stated the resident's INR recheck was scheduled for the next week and when it was taken, the resident's INR was 1.0. HRN-G stated at that point, she was not

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aware the resident had missed several days of his prescribed Warfarin. HRN-G stated she contacted her medical director and reached out to the facility and it was at that point she was made aware of the resident missing several doses of Warfarin. HRN-G stated the resident had been on Warfarin for many years and was on a fairly consistent dose to maintain INR levels around 2.5 to 2.7.

On December 7, 2022, at 1:50 p.m., a coagulation clinic nurse (CN)-K stated the facility had not updated them about the resident's six missed doses of Warfarin and they would expect to be notified of that sort of error. CN-K stated since the 1.0 INR was what they would consider critically sub therapeutic, they had forwarded the resident's chart on to the primary care provider for further guidance and were given updated orders considering several doses had been missed.

On December 7, 2022, at 2:30 p.m., ULP-F confirmed she worked on one day the resident missed his Warfarin. ULP-F stated she had contacted RN-A and was told they were still waiting for pharmacy to deliver the medications.

On December 8, 2022 at 11:45 a.m., pharmacist (P)-L stated they received an order for the resident's Warfarin on October 4, 2022, the day the INR was checked, however the order was "garbled" and they were not able to read it. P-L stated they had reached out to the facility that day to let them know they were unable to read the order and needed to have the facility clarify it and send a clear copy to them. P-L said they didn't hear back from the facility for four days, when at that point a facility nurse sent a fax that indicated they needed the Warfarin refilled ASAP. P-L

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01760	Continued From page 7 stated they replied back to the facility that an order was needed first. P-L stated another pharmacy staff member called the facility the next day to follow up and stated "staff had no idea what was going on." P-L stated the facility sent three faxes over two days and they had replied to each refill request by informing the facility they needed to send them the updated order first. P-L stated the facility had called their Eden Prairie location, which did not have the resident in their system and were unable to assist with anything related to the resident. P-L stated it was their process for the facility to provide the right information for orders and they would follow up with the facility directly if there were ever any issues with orders. MEDICATION ERRORS R1's record contained prescriber orders dated Tuesday, October 12, 2022, for 6 milligrams (mg) of Warfarin on October 12 and October 13 and then 4 mg every day until the next INR on October 18, 2022. R1's record indicated the resident's INR was 2.7 on October 19, 2022. The resident's record contained an order dated October 19, 2022, and indicated the resident was to continue with 4 mg of Warfarin daily. The resident's MAR for October 2022 indicated the resident had an order for 6 mg of Warfarin on Wednesday and Thursday, then resume the 4 mg dose. The MAR indicated the following was given: -October 12, 2022, one 4 mg tablet and one 2 mg tablet of Warfarin for a total of 6 mg of Warfarin. -October 13, 2022, one 6 mg tablet of Warfarin -October 18, 2022, two 4 mg tablets of Warfarin for a total of 8 mg of Warfarin, double the amount	01760		

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01760	Continued From page 8 of Warfarin that was prescribed. -October 19, 2022, one 6 mg tablet of Warfarin. The spot for the resident's usual 4 mg of Warfarin was marked as not given as it was "Wednesday today." The resident received 2 mg of extra Warfarin. On December 20, 2022, at 4:15 p.m., RN-A left a voicemail for the surveyor confirming the additional dose of Warfarin had been given as there had been duplicate orders in the MAR. The licensee's Medication & Treatment Orders-Implementing policy, last updated September 16, 2022, indicated medication orders received by the licensee would be implemented within 24 hours of recepit. The licensee's Medication & Treatment Orders-Receiving policy, dated August 1, 2021, indicated orders for all medications would be obtained either in writing, verbally, or electronically by an authorized prescriber. The licensee's Medication & Treatment Orders-Reordering policy, last updated September 16, 2022, indicated when a resident's medications need to be reordered, staff would fax, call, or follow the pharmacy's directions for refilling prescription requests. The licensee's Medication Errors policy, last updated September 16, 2022, indicated if an error occured, staff would document, track, and resolve medication administration errors for quality improvement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 9 days	01760		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with a medication error and also failed to follow up on a missing medication order. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: MISSED MEDICATION ORDERS R1's diagnoses included Alzheimer's Disease with late onset and history of venous thrombosis and embolisms (blood clots). R1's service plan dated February 18, 2022, indicated the resident received assistance with	02310		

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	26533	A. BUILDING: ______ B. WING ______	C 12/06/2022

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medication administration, support stockings, toileting, transfers, dressing, grooming, and ambulation.

R1's most recent assessment, dated August 1, 2022, indicated the resident's medications were managed in conjunction with hospice. The hospice provider was documented as the person responsible for checking the resident's INR (International Normalized Ratio, a test that measures the amount of time it takes for blood to clot) and the facility nurse would receive orders and medications from the pharmacy. The assessment further indicated the resident was at risk due to complex medication regimen including Warfarin (a medication used to prevent blood clots) adjustment weekly/monthly/as needed by results of INR with orders received by the coagulation clinic.

R1's INR was checked by hospice on October 4, 2022.

A progress note on October 2, 2022, indicated licensed practical nurse (LPN)-D faxed the pharmacy for a Warfarin refill.

A progress note on October 4, 2022, indicated the hospice nurse would be drawing the resident's INR.

A progress note on October 8, 2022, indicated LPN-D requested a Warfarin refill from the pharmacy.

A progress note on October 10, 2022 at 12:54 p.m. indicated LPN-D clarified with the pharmacy that the facility would receive the Warfarin refill that day. A note at 3:52 p.m. indicated it had been received.

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02310	Continued From page 11 R1's Medication Administration Record (MAR) for October 2022 indicated the resident did not receive Warfarin as scheduled on the following days: -October 4 -October 5 -October 6 -October 7 -October 8 -October 9 In total, the resident missed six doses of Warfarin. Records from the pharmacy indicated the pharmacy received a new order for Warfarin after the INR was drawn on October 4, 2022. However, the pharmacy was unable to read the orders that were sent from the coagulation clinic. Pharmacy records included a fax sent to the facility on October 4, 2022, asking them to please resend the order as the directions were cut off. No response was noted from the facility. Pharmacy records included a fax from their Eden Prairie location (incorrect location) as the facility had contacted that location requesting a Warfarin refill on October 9, 2022. The Eden Prairie location did not have the patient in their system and sent the phone message to the Saint Cloud location that was responsible for the resident's medications. Pharmacy records indicated LPN-D emailed on October 9, 2022, requesting a Warfarin refill "ASAP." The pharmacy records also indicated a staff member emailed back asking they re-send the order as the first attempt was not readable. The pharmacy staff member also called and spoke with facility staff and documented that facility staff "...had no idea what was going on." Pharmacy records indicated the facility sent an	02310		

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order on October 9, 2022, however it was the same initial order that had the directions cut off. The pharmacy notes indicated pharmacy staff then contacted the coagulation clinic directly to get a clean copy of the order and once that was received, they sent the medication refill.

Records from hospice indicated the resident's INR was rechecked on October 12, 2022. The resident's INR was 1.0, which was below therapeutic levels and a critical lab result. The hospice records indicated the facility RN was updated due to the significant change in INR levels from the week prior and at that point hospice was notified that the resident missed a week of Warfarin with the facility stating, "the pharmacy just didn't send it."

Records from hospice indicated the resident's INR on October 19, 2022 was 2.7, within therapeutic range for the resident.

On December 6, 2022, at 2:25 p.m., unlicensed personnel (ULP)-C confirmed she worked on two of the days the resident missed his Warfarin. ULP-C recalled contacting registered nurse (RN)-A and informing her the medication was missing. ULP-C stated there were some notes in R Tasks (the facility's electronic medical record) from the nurse to the staff informing them the pharmacy had been contacted about the missing medication.

On December 6, 2022, at 3:10 p.m., RN-A stated she had been out of the office for a meeting most of the week of October 4, 2022, when the resident was supposed to get an INR recheck and new orders for Warfarin. RN-A stated that while there are other nurses employed by the facility, she is the only on call nurse so if she is

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not in the building, staff would contact her. RN-A stated she was not aware the resident's Warfarin had not been refilled or that the resident had not been getting his medication until Saturday (October 8, 2022), when LPN-D had notified her of the medication being out. RN-A stated she had not been contacted by any unlicensed personnel prior to LPN-D notifying her.

On December 6, 2022, at 3:40 p.m., LPN-D stated she was the one who had discovered the resident did not have any Warfarin left when she came to work that Saturday (October 8, 2022). LPN-D stated she had not been updated by any staff that the resident's Warfarin had run out. LPN-D stated she had been out of the office at a meeting for the last part of the week and she would have expected staff to call the nurse with any medication concerns.

On December 7, 2022, at 12:20 p.m., ULP-E confirmed she worked on two of the days the resident missed his Warfarin. ULP-E stated they had let nursing staff know numerous times that the Warfarin was out and they weren't able to give it. ULP-E stated both RN-A and LPN-D were contacted and updated of the resident's missing Warfarin. ULP-E stated she was directed by one of the nurses to mark the medication as not in the facility.

On December 7, 2022, at 12:35 p.m., hospice registered nurse (HRN-G) stated the resident's INR was drawn on October 4, 2022, and a new order for Warfarin was sent to the pharmacy, facility, and hospice. HRN-G stated the resident's INR recheck was scheduled for the next week and when it was taken, the resident's INR was 1.0. HRN-G stated at that point, she was not aware the resident had missed several days of

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02310	Continued From page 14 his prescribed Warfarin. HRN-G stated she contacted her medical director and reached out to the facility and it was at that point she was made aware of the resident missing several doses of Warfarin. HRN-G stated the resident had been on Warfarin for many years and was on a fairly consistent dose to maintain INR levels around 2.5 to 2.7. On December 7, 2022, at 1:50 p.m., a coagulation clinic nurse (CN)-K stated the facility had not updated them about the resident's six missed doses of Warfarin and they would expect to be notified of that sort of error. CN-K stated since the 1.0 INR was what they would consider critically sub therapeutic, they had forwarded the resident's chart on to the primary care provider for further guidance and were given updated orders considering several doses had been missed. On December 7, 2022, at 2:30 p.m., ULP-F confirmed she worked on one day the resident missed his Warfarin. ULP-F stated she had contacted RN-A and was told they were still waiting for pharmacy to deliver the medications. On December 8, 2022 at 11:45 a.m., pharmacist (P)-L stated they received an order for the resident's Warfarin on October 4, 2022, the day the INR was checked, however the order was "garbled" and they were not able to read it. P-L stated they had reached out to the facility that day to let them know they were unable to read the order and needed to have the facility clarify it and send a clear copy to them. P-L said they didn't hear back from the facility for four days, when at that point, a facility nurse sent a fax that indicated they needed the Warfarin refilled ASAP. P-L stated they replied back to the facility that an	02310		

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order was needed first. P-L stated another pharmacy staff member called the facility the next day to follow up and stated "staff had no idea what was going on." P-L stated the facility sent three faxes over two days and they had replied to each refill request by informing the facility they needed to send them the updated order first. P-L stated the facility had called their Eden Prairie location, which did not have the resident in their system and were unable to assist with anything related to the resident. P-L stated it was their process for the facility to provide the right information for orders and they would follow up with the facility directly if there were ever any issues with orders.

MEDICATION ERRORS

R1's record contained prescriber orders dated Tuesday, October 12, 2022, for 6 milligrams (mg) of Warfarin on October 12 and October 13 and then 4 mg every day until the next INR on October 18, 2022.

R1's record indicated the resident's INR was 2.7 on October 19, 2022. The resident's record contained an order dated October 19, 2022, and indicated the resident was to continue with 4 mg of Warfarin daily.

The resident's MAR for October 2022 indicated the resident had an order for 6 mg of Warfarin on Wednesday and Thursday, then resume the 4 mg dose. The MAR indicated the following was given:
-October 12, 2022, one 4 mg tablet and one 2 mg tablet of Warfarin for a total of 6 mg of Warfarin.
-October 13, 2022, one 6 mg tablet of Warfarin
-October 18, 2022, two 4 mg tablets of Warfarin for a total of 8 mg of Warfarin, double the amount of Warfarin that was prescribed.

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02310	Continued From page 16 -October 19, 2022, one 6 mg tablet of Warfarin. The spot for the resident's usual 4 mg of Warfarin was marked as not given as it was "Wednesday today." The resident received 2 mg of extra Warfarin. On December 20, 2022, at 4:15 p.m., RN-A left a voicemail for the surveyor confirming the additional dose of Warfarin had been given as there had been duplicate orders in the MAR. The licensee's Medication & Treatment Orders-Implementing policy, last updated September 16, 2022, indicated medication orders received by the licensee would be implemented within 24 hours of recepit. The licensee's Medication & Treatment Orders-Receiving policy, dated August 1, 2021, indicated orders for all medications would be obtained either in writing, verbally, or electronically by an authorized prescriber. The licensee's Medication & Treatment Orders-Reordering policy, last updated September 16, 2022, indicated when a resident's medications need to be reordered, staff would fax, call, or follow the pharmacy's directions for refilling prescription requests. The licensee's Medication Errors policy, last updated September 16, 2022, indicated if an error occured, staff would document, track, and resolve medication administration errors for quality improvement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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