STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	03/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTENNIAL GARDENS FOR NURSING & REHABILITATION	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and document review, the facility failed to ensure 1 of 1 resident (R1), reviewed for medication administration, received an antibiotic as prescribed by the physician. Findings include: R1 was admitted to the facility on [DATE], with admitting [DIAGNOSES REDACTED]. R1's admission Minimum Data Set ((MDS) dated [DATE], indicated R1 had a surgical wound and staff were doing surgical wound care treatment for [REDACTED]. When approached and asked about her medications R1 stated she did not know anything about her medications. When asked about the wound, R1 stated she had a wound which staff assisted her with. During a review of the hospital discharge order summary dated [DATE], it was revealed R1 had an order for [REDACTED]. During a review of the facility medication administration records for [DATE] through [DATE], it was revealed R1 had not received the antibiotic for 30 days, which was 30 doses of the medication. In addition, the medical record lacked documentation of the facility staff notifying the primary provider, group home and wound clinic to clarify if R1 was supposed to receive the medication and what the notation, prescription expired meant. On [DATE], at 9:25 a.m. during a telephone call to the wound clinic, medical records staff, identified R1 had been seen at the clinic on [DATE], and at the this time the wound doctor assumed R1 still received the prescribed antibiotic. The medical records staff indicated when R1 had returned to the clinic on [DATE], they had noted the wound had gotten deeper and when the doctor reviewed the medication list, it was identified the antibiotic was not listed. The wound doctor again wrote the antibiotic prescription on the referral sheet. The medical records staff stated that no one from the facility had contacted the clinic, since R1 was admitted to the facility, to seek clarification about the antibiotic prescription for R1. The medical records staff further stated according to R1's medical record the prescription had been renewed on [DATE], for 12 refills which would have been enough until [DATE]. The medical records staff explained that R1 was to take the antibiotic due to a chronic wound infection. On [DATE], at 9:43 a.m. the director of nursing (DON) reviewed R1's MAR, progress notes, admission orders [REDACTED]. The DON stated she would have expected the staff to have clarified the order. The DON stated she would check with the admitting nurse to see who checked the orders as the nurse was supposed to double check the orders after the health unit coordinator completed entry of them in the orders summary. On [DATE], at 10:31 a.m. during a telephone call to a responsible party, stated she had been informed by the group home manager where R1 lived at prior to the short stay at the nursing home, that R1 had not been receiving her prescribed antibiotic. The responsible party stated after the wound clinic appointment on [DATE], the group home manager informed her the wound on the right thigh had gotten worse since the last time R1 was seen at the wound clinic on [DATE]. On [DATE], at 10:34 a.m. the group home manager stated R1 was currently at the facility due to a surgical wound needing to be packed and that the group home had expected staff at the nursing home to contact them with any questions regarding R1's care, as this was short stay. The group home manager stated all along until [DATE], she thought R1 was receiving the antibiotic and that R1 had a prescription for it. The manager also stated on [DATE], at the wound appointment, the doctor had identified R1 was not receiving the antibiotic. The manager explained that she contacted the facility and left messages regarding this concern, but had not received a return call. On [DATE], at 11:12 a.m. registered nurse (RN)-A unit nurse manager stated she had checked the admission orders [REDACTED]. RN-A acknowledged she did not document this information and she or any other staff did not follow up with the wound clinic, primary provider and group home to clarify the antibiotic prescription. On [DATE], at 11:29 a.m. the administrator stated he had been informed of the concern and would have expected the staff to have followed up with the provider and group home to clarify if R1 was still supposed to take the medication. The facility Administering Medications policy adopted [DATE], directed staff: 5. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns .

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

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.