STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure medications were administered per physician order for [REDACTED]. Findings include: R5's admission Minimum Data Set ((MDS) dated [DATE], indicated R5 was cognitively intact and had [DIAGNOSES REDACTED]. The MDS also indicated R5 reported little interest or pleasure in doing things, feeling down/depressed/hopeless, feeling bad about herself 2-6 days, feeling tired/having little energy, trouble concentrating on things 7-11 days, and thoughts she would be better off dead or of hurting herself in some way 12-14 days of the assessment period. The MDS also indicated R5 had reported trouble falling or staying asleep. R5's Care Plan dated 3/2/20, identified R5 used [MEDICAL CONDITION] medications ([MEDICATION NAME]) related to behavior management, disease process, depression and pain management and directed staff to administer medications as ordered, monitor/document for side effects and effectiveness, consult with pharmacy and physician (MD) to consider dosage reduction when clinically appropriate, discuss with MD and family ongoing need for medication, educate R5 about the risk, benefits and side effects of the medication and to monitor/record occurrence of target behaviors symptoms, inappropriate response to verbal communications, violence/aggression toward staff/others and document per facility protocol. On 3/18/20, at 4:45 p.m. R5 was observed in her room, seated in a recliner. R5 stated she was going to report the facility nurses for falsifying records as she felt the nursing staff were falsely documenting her hours of sleep. R5 stated she had learned at a recent appointment that her records identified she was sleeping 6-8 hours per night which was not true as she was often up at night due to pain and did not sleep 6-8 hours per night. On 3/19/20, at 11:37 a.m. R5 stated she attended an appointment on 3/16/20, for medication management and indicated the doses of her [MEDICATION NAME] and [MEDICATION NAME] had been increased at that time, but she had not received the increased doses yet as the medications had not been received from the pharmacy. R5 stated it frequently took an extended period of time for medication to come from the pharmacy. R5's Physician Visit Review/Orders dated 3/16/20, included the following new orders: -[MEDICATION NAME] 10 milligrams (mg) add to 20 mg dose. 1 per day for depression -[MEDICATION NAME] 5 mg at bedtime. Additional orders/comments included: increase [MEDICATION NAME] to 30 mg Review of R5's Treatment Administration Record (TAR) dated 3/1/20-3/31/20, revealed the following: -[MEDICATION NAME] 10 mg. Give 30 mg by mouth one time daily for depression. Order start date 3/17/20. Documented as administered 3/17/20. The TAR was blank on 3/18/20, and 3/19/20, indicating the medication had not been administered. -[MEDICATION NAME] tablet 20 mg ([MEDICATION NAME]). Give 1 tablet by mouth at bedtime for depression. Order start date 1/6/20. Order discontinue date 3/16/20. -[MEDICATION NAME] tablet 3 mg. Give 1 tablet by mouth every night shift for trouble sleeping. Order start date 1/18/20. Order discontinue dated 3/16/20. Review of R5's Medication Administration Record (MAR) dated 3/1/2020-3/31/2020, revealed the following: -[MEDICATION NAME] Tablet 5 mg. Give 1 tablet by mouth at bedtime for sleep. Order start date 3/16/20. Documented as administered 3/16/20, 3/17/20, 3/18/20, 3/19/20. On 3/20/20, at 9:39 a.m. R5's medications available in the medication cart were reviewed with licensed practical nurse (LPN)-D. The medication cart contained: -two pre-packaged cards of [MEDICATION NAME]. One card held fifteen, 20 mg tablets which had been dispensed from the pharmacy on 3/5/20. Eight tablets had been dispensed from the card and seven tablets remained. -a second card held thirty,10 mg tablets, had been dispensed from the pharmacy on 3/16/20, with direction to take with the 20 mg dose. All 30 tablets remained in the card. -two pre-packaged cards of [MEDICATION NAME] 3 mg tablets. One card held 30 tablets and had been dispensed from the pharmacy on 3/4/20. Seventeen tablets had been dispensed from the card and 13 tablets remained. -a second card containing 30 tablets had also been dispensed from the pharmacy on 3/4/20. One tablet had been dispensed from the card and 29 tablets remained. -At 9:55 a.m. LPN-D verified none of R5's 10 mg [MEDICATION NAME] tablets had been administered with the 20 mg tablets, as ordered. When asked if R5 had any 5 mg [MEDICATION NAME] tablets available in the medication cart, LPN-D stated she would get another nurse. -At 10:13 a.m. LPN-B verified the aforementioned medication review and stated R5 could not have received the correct dose of the [MEDICATION NAME] without having been administered the 10mg tablet along with the 20 mg tablets, as directed. When asked about the [MEDICATION NAME], LPN-B stated R5 could have received the correct dose from the facility stock medication bottle. At this time, the director of nursing (DON) joined the interview and compared R5's available medications in the cart to the MAR and TAR documentation. The DON verified the discrepancy and stated she would verify with the pharmacist. The DON state she thought there might have been an issue with the facility ordering system causing the new orders to not show up on the nurse's laptops used when administering medications. The DON confirmed R5 had not received the [MEDICATION NAME] as ordered. On 3/20/20, at 12:08 p.m. the DON stated she had spoken with the pharmacist who confirmed the aforementioned [MEDICATION NAME] and [MEDICATION NAME] medications had not been administered as ordered which both resulted in medication errors for R5. The DON stated she had started counseling forms with the involved staff and would educate all staff regarding the errors. On 3/20/20, at 1:10 p.m. LPN-B explained medications were entered on both the individual resident's MAR and TAR. LPN-B stated the trained medicaiton aids (TMA) referred to the MAR when passing medications, and the nurse's utilized the TAR when administering medications they were responsible to administer. The undated Administering Medications policy directed medications must be administered in accordance with the orders, including any required time frame. The policy also directed the individual administering medications must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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