STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

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

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F 0760 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to develop and implement a system to avoid significant medication errors of omission. The facility failed to ensure an adequate system for was in place to assure medications were reordered in a timely manner to be available for administration in accordance with physician orders [REDACTED]. The facility's omission of [MEDICATION NAME] injections (an anticoagulation medication, which helps prevent blood clots from forming) resulted in an immediate jeopardy (IJ) level significant medication error when R1 sustained a stoke and [MEDICAL CONDITION] embolism (PE). The IJ began on 8/2/20, when a physician prescribed order for daily injection of [MEDICATION NAME] was not available in the facility to be administered. R1 did not receive the prescribed [MEDICATION NAME] injection on either 8/2 or 8/3/20. After missing these 2 doses, on 8/4/20, R1 started feeling sick with nausea and vomiting. On 8/5/20, R1 self-reported she was having symptoms of feeling dizzy, headache, and had a small emesis/phlegm which R1 described as symptoms she'd experienced during a previous stroke. R1 was transferred to the emergency room (ER) and was subsequently hospitalized for [REDACTED]. The facility administrator and director of nursing (DON) were notified of the IJ on 8/10/20, at 4:45 p.m. The IJ was removed on 8/11/20, when the facility had implemented an appropriate removal plan. However, non-compliance remained at an isolated scope of actual harm that is not immediate jeopardy (Level G). Findings include: R1's admission Minimum Data Set (MDS) assessment dated [DATE], identified R1 as having intact cognition and requiring extensive assistance with activities of daily living (ADLs). The MDS also indicated R1 received anticoagulation medication during the 7 day assessment review period. R1's admission record indicated R1 had a history of [REDACTED]. R1's care plan included, Resident is currently on anticoagulation therapy related to: history of [MEDICAL CONDITION] embolism. Interventions: Administered anticoagulation medications per MD (medical doctor) orders. R1's physician orders [REDACTED]. R1's medication treatment record indicated R1 did not receive the [MEDICATION NAME] ([MEDICATION NAME])Sodium injections per the physician order [REDACTED]. R1's medication error report (MER) dated 8/5/20 indicated errors were made on 8/2 and 8/3/20. The MER indicated the nurse practitioner was made aware of the errors on 8/5/20, at 4:45 p.m. Medication as ordered [MEDICATION NAME] ([MEDICATION NAME])40 mg/0.4 ml- inject 0.4 ml SQ daily r/t (related to) hx (history) of [MEDICAL CONDITION] embolism. Description of the error: Two doses not given on 8/2 and 8/3/20. Outcome to the resident: Stroke and PE (pulmonary embolism). Resident sent to ER. Corrective action taken: Re-education of all nurses on reordering supply, what to do if no supply, notification to pharmacy for STAT delivery. Measures taken to prevent reoccurrence of similar error(s): Discussed with pharmacy, process for sending partial supply of orders. R1's record revealed there was no notification to the physician or medication error reports completed on 8/2 or 8/3/20 when the facility initially had not administered the [MEDICATION NAME]. R1's nursing progress notes were reviewed and included: -8/3/20 at 8:24 a.m., [MEDICATION NAME] ([MEDICATION NAME]) Sodium Solution 40 MG/0.4ML Inject 0.4 ml subcutaneously one time a day related to PERSONAL HISTORY OF [MEDICAL CONDITION] EMBOLISM (Z86.711) for 28 Days No supply -8/5/20 at 6:17 a.m., Resident experienced nausea this morning. No emesis. She also stated that she wants to see the nurse manager this morning. She wants to know if she is going to have a stroke because she has hard {sik} it before 2010. VS (vital signs) were taken. At this time, no s/s (signs or symptoms) of stroke. Incoming shift and wing nurse notified to monitor resident. Charge nurse will be informed as soon as she comes in to go and check/reassess resident. -8/5/20 at 7:17 a.m., Ambulance was called at 6:54 a.m. and they left with her at 7:17 a.m In route to (emergency department), husband will meet her there. Review of R1's neuro ICU (intensive care unit) admission note dated 8/5/20 included, Chief Complaint: Stroke History of Present Illness: (R1) is a 70 y.o. (year old) right-handed female with a history significant for prior [MEDICAL CONDITION], type 2 diabetes mellitus, [MEDICAL CONDITION], past history of PE (pulmonary embolis 2018, provoked), obesity, recent humorous fracture repair s/p (status [REDACTED].Although she had no focal neurological deficits in the ED (emergency department) given concern for headache reported by patient, she underwent a CT (cat scan) of the head/neck (per outside documentation). This imaging showed likely subacute appearing infarcts in the L>R cerebellum, bilateral parietal lobes. CT abdominal pelvis was obtained given concerns for emesis and possible infection, which identified right lower lobe sub segmental PE which was further confirmed on dedicated CT PE study. Given concerns for subacute cerebrallar infarct, PE and elevated baseline troponin .patient was transferred (to this hospital) for further management . Patient reports that she was instructed to continue [MEDICATION NAME] injections after discharge from Orthopedics in late July for at least 30 days. Which she was initially getting however, for the last 3 or 4 days the facility told her they had run out and she has not been receiving them . The facility's investigative report sent to the State Agency (SA) 8/7/20, included, In investigation of the medication error there was found to be two issues. One issue was with nursing not following the process for when a medication supply is low and how the med error occurred, and one issue with the pharmacy not delivering medications in a timely manner when ordered. Both of the nurses involved with the medication error have received a corrective action. All the nurses have been re-educated that when supply of any medication is starting to get low, it is to be re-ordered right away and a call is to be placed to the pharmacy if we don't have the ordered medication at the time it is scheduled to be given. If the medication is not available in our E-Kit (emergency kit), the pharmacy will need to be called and complete a STAT (immediate) delivery. In addition, if a medication is not given during the shift that it is scheduled to be given, the nurse must then pass this on to the next shift so it can be given when it arrives on the delivery .(R1)did miss two dosages of [MEDICATION NAME] ([MEDICATION NAME]) Sodium Solution 40 MG/0.4 ml subcutaneously one time a day. (R1) missed a dose on August 2nd and on August 3rd. August 5th she was transferred to a (ED at a hospital) and was then transferred to (another hospital from the ED). Her admitting [DIAGNOSES REDACTED]. During an interview on 8/10/20, at 10:41 a.m. licensed practical nurse (LPN)-A stated when she went to give the [MEDICATION NAME] injection the morning of 8/2/20, there was no supply. LPN-A stated she ordered the [MEDICATION NAME] injections through the computer to the pharmacy and let registered nurse (RN)-A know it was unavailable. LPN-A stated there was a little tab to type in messages in Point Click Care that goes to the pharmacy, and said she'd sent a message to the pharmacy to send the [MEDICATION NAME] ASAP (as soon as possible), although no supply was available. LPN-A stated she did not check the e-kit and stated she did not call the pharmacy for a STAT order. LPN-A stated she had never called the emergency pharmacy to obtain a medication and stated she just let the nurse manager know and the nurse manger had told her the pharmacy was open on Sundays and had gone into her office. LPN-A stated she reported to evening shift that R1 did not receive the [MEDICATION NAME] injection because it was not available at the facility. LPN-A stated when a medication dose is ordered during the day shift ,the evening shift nurse was to try to obtain the medication. LPN-A stated R1 was on the [MEDICATION NAME] injections after surgery to help thin her blood. LPN-A acknowledged the concern R1 could develop blood clots if the [MEDICATION NAME] was not administered. During an interview on 8/10/20 at 11:08 a.m., registered nurse (RN)-A stated she worked in the facility on 8/2/20 providing the RN 8 hour coverage. RN-A confirmed LPN-A had reported the [MEDICATION NAME] medication was not available at the facility, and was going to reorder it. RN-A stated she saw LPN-A reorder the medication online through point click care. RN-A stated she knew you can order it (medications) online and stated the pharmacy sends it automatically. RN-A stated LPN-A should have called

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

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RN-A said they were notified R1 had experienced a second [MEDICAL CONDITION] embolism when they called from the hospital to give report. RN-A stated, I am just sick about this and stated she would have reordered the medication when the supply was down to 3 or 4 doses left. RN-A stated there seemed to be a problem with staff waiting to order a medication, waiting until a resident was out of the medication, or on the weekend, and would then them come to the RN charge to let them know the medication supply was gone. RN-A stated this was not fair to the physician or the resident adding, we need to have communication or a system needs to be implemented so medications are not missed. During an interview on 8/10/20, at 1:43 p.m. LPN-A confirmed having worked on the Friday and Saturday prior to the first missed dose and had administered the [MEDICATION NAME] injection. LPN-A expressed being unable to recall checking to see if the [MEDICATION NAME] refill had been ordered on that Friday or Saturday, and stated she did not order the refill until Sunday morning when there was no dose available to be given. LPN-A stated medications needing refills would normally be ordered a couple days in advance but she had not done that. LPN-A stated medication refills are ordered through the facility's computer system or faxed. LPN-A stated they can check the fax binder, or their computer system to see whether a medication had been ordered for refill. LPN-A stated she had not considered the missed [MEDICATION NAME] dose as a medication error, because it was unavailable, had been reordered and anticipated it would be delivered. LPN-A verified a blood thinner is a critical medication and stated she had communicated to the evening shift nurse that the dose was missed that morning, and a refill ordered. LPN-A said she did not call the pharmacy personally, but stated she assumed the nurse manager would have called the pharmacy. In addition, LPN-A stated she did not notify the physician of the missed dose. LPN-A stated a medication error was considered if dose not given, wrong dose given, or if a medication was given to the wrong resident. LPN-A confirmed it was not expected a medication error report would be completed in this case, even though the medication was not given. LPN-A stated the pharmacy could deliver on weekends if needed. LPN-A stated although it was reported on Monday that R1 was nauseous, there had been no complaints over the weekend. During an interview on 8/10/20, at 1:18 p.m. pharmacist (P-A) stated orders for medication refills are received via fax on a refill sheet, requested over phone, or requested through the computer system. P-A stated if received through computer system or fax on a weekend, the pharmacy would not process the order until Monday. However, if the medication order was called in by phone, the pharmacy would process the refill request and send it out right away. P-A stated the pharmacy normally asked for a 3 day notification for refills, to allow time for insurance issues and medication availability. P-A stated the pharmacy would want to know before the weekend if medication was going to run out. P-A stated refill medications could be delivered the same day if there were no issues. P-A stated during weekdays there was a delivery early afternoon, and one in the evening, and on weekends there was one delivery in the evening if medications were needed. P-A stated there was an on call phone number to call after hours on the weekend. P-A stated they viewed the computer request for R1's [MEDICATION NAME] on Monday 8/3/20. P-A stated the request had been sent on Sunday but no one from facility had called to inform the pharmacist the medication was needed that day. P-A stated it would have been delivered Sunday if the pharmacist had known it was needed. P-A stated only a 10 day supply was sent initially due to the type of insurance the resident had. P-A said it was expected the facility would notify them in advance when a refill was needed. P-A stated they would notify the facility via fax or phone if a medication was not available, or if there was an insurance issue. P-A stated they were working with their corporate office to improve the process of computer requests received on weekends as it was previously not an expectation to process computer requests on weekends. P-A acknowledged computer system requests are being used more now versus faxes or phone calls. An interview was conducted on 8/10/20 at 1:58 p.m., with R1's stroke team physician (STP). STP stated, I will tell you we can never say 100% what caused the stroke or [MEDICAL CONDITION] embolism however, missing 1 or 2 doses significantly increased the risk. Timing of the evidence indicated the stroke and [MEDICAL CONDITION] embolism could have been from the missed doses of [MEDICATION NAME] after she had been clot free from sometime. I do really believe this would not likely have happened if she had received her proper [MEDICATION NAME] scheduled medication. Based on the imaging she had a clot in her brain and [MEDICAL CONDITION] embolism in her lungs. Multiple clots in multiple places after missing her doses of [MEDICATION NAME] make it highly suspicious that the missed doses caused the stroke and [MEDICAL CONDITION] embolism. During an interview on 8/10/20 at 2:28 p.m., family member (FM)-A stated R1 had not been on a maintenance blood thinner prior to surgery. FM-A stated R1 had blood clots in the lungs following a previous surgery on same arm. FM-A stated the physicians had wanted to be careful and wanted R1 to be on a blood thinner. FM-A stated, apparently something happened and R1 did not receive the blood thinner for a couple of days. FM-A stated R1 was still in the hospital, and was planning to go to a rehab center within the hospital rather than returning to the facility. During an interview on 8/10/20 at 2:42 p.m., LPN-D stated they are to order refill on medications when there is 4-5 days left. LPN-D stated they order through computer system or fax. LPN-D stated they would order refills prior to the weekend. LPN-D stated they are to check computer system when medication was low to see if medication was ordered and call the pharmacy directly to order if needed. LPN-D stated there was no procedure but it was just a rule to order medications prior to running out. LPN-D stated there had not been any recent education on medication ordering. LPN-D stated a medication error would include if medications were given at wrong time, wrong dose, wrong route, or missed dose. LPN-D stated if a medication could be life threatening such as a blood thinner not being given, it would be considered a medication error. LPN-D stated they are supposed to notify the physician and complete a medication incident report if a medication error occurs. During an interview on 8/10/20, at 2:52 p.m. LPN-C defined a medication error as missed, wrong resident, wrong time, wrong dose, or wrong route. LPN-C stated they are to complete a medication error form, notify physician and were to monitor and assess the resident. LPN-C stated they were to order refills at least 5 days prior to a medication running out. LPN-C stated when she noticed less than 5 days left of a medication, she would check to make sure the medication was ordered and communicate with staff at report to watch for medication. LPN-C said if a medication was needed over the weekend or as soon as possible, they would call the pharmacy directly. LPN-C stated a missed dose of a medication was a medication error. LPN-C stated there was education on medication ordering and medication errors done upon orientation and recently a printout to read in the communication book. LPN-C stated she did not have to sign to acknowledge having read the communication, but that it was an expectation to read the communication book prior to every shift. During an interview on 8/10/20 at 3:01 p.m., the director of nursing (DON) stated R1 was on [MEDICATION NAME] for the prevention of blood clots and stated it was important for her to receive the medication as ordered so she would not get blood clots. The DON stated she would have expected the staff to order the [MEDICATION NAME] for sure at least when it was getting down to 3 days' worth adding, you do not want to order it when there is one left. The DON also stated she would have expected the nurse to call the pharmacy and get a STAT order when they did not have any medication available in the facility on 8/2, when the medication was not available to be given. The DON stated a medication error report should have been completed on 8/2 and 8/3/20, when the resident missed doses of the [MEDICATION NAME]. The DON further verified the physician was not notified of the missing [MEDICATION NAME] until a medication error report was completed on 8/5/20. The DON stated the physician should have been notified right away for that type of medication omission. The DON stated the missed doses of [MEDICATION NAME] were discovered through chart review and when the nurse management was notified of the missing doses. The DON stated there was not a policy and procedure to implement for ordering medications when getting low, but stated staff were checked off on ordering medications upon hire. The DON stated the facility had immediately completed education with staff following the medication errors. The DON stated they talked to the nurses involved in person and the other nurses were educated through the communication book. The DON stated they (staff) read the communication book everyday in report. The DON verified the facility did not have the nurses sign off they had read the education in the communication book, did not have a post-test, and had not completed any competencies on the education. During an interview on 8/11/20, at 9:56 a.m. LPN-B stated that Monday 8/3/20, had been her first day back to R1's hallway. LPN-B said when she noticed the blood thinner was not available to give, she checked the computer system and saw it had been reordered. LPN-B stated she did not file a medication error report, although stated a missed dose would be considered a medication error. LPN-B stated although the medication was not available at the time it was due, it had been reordered and had been expected to arrive to be able to give. LPN-B stated she did not notify the physician, and stated the

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F 0760 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) medication did not arrive during the day shift. LPN-B stated R1 had not changes or complaints that day. LPN-B stated she was off Tuesday and worked again on Wednesday. LPN-B stated on Wednesday 8/5/20, she was asked by an aide to assess R1 who had reported to the aide she was not feeling well. LPN-B stated it had also been reported by the overnight staff that R1 had not been feeling well. LPN-B stated she assessed R1 around 6:50 a.m. LPN-B stated staff are able to check the computer system to see what date medications were ordered and on which date it was received. LPN-B stated nurses were to call the pharmacy directly if there were any concerns. LPN-B stated they should reorder refills when a medication has 4-5 days supply left. LPN-B stated when medication had less than a few days left, they would check the computer system to assure the medication was reordered. LPN-B stated they were expected to order medications prior to a weekend, and to call pharmacy directly if a medication was needed over the weekend. LPN-B stated a medication error was considered when a medication was not given or given the wrong way. LPN-B stated they are to notify the nurse, complete a report, and call the physician if there is a medication error. LPN-B stated she did not notice the blood thinner had not been given the prior day, and should have completed a medication error report also as the blood thinner dose was missed the day she worked. During an interview on 8/11/20 at 10:17 a.m., trained medication aide (TMA)-A stated she was to check if medication was reordered and call the pharmacy if a medication had not been received or was needed. TMA-A stated that there was a blue section on the medication cards that indicated when to reorder. TMA-A stated there was not a process for checking medications that were low in supply. During a follow-up interview on 8/11/20 at 10:55 a.m., the DON stated that there was no specific process for reordering medications, but the nurses were to assess for need to order medications prior to administration. The DON stated staff were to reorder medications via fax, computer system or to call pharmacy directly if medication was needed immediately. The DON stated if a medication was out and was needed immediately the nurse was to call the pharmacy directly to order. The DON acknowledged that if a medication, including an as needed medication, was needed by a resident but not available, the resident would have to wait until it was delivered by pharmacy to receive it, which could be hours or the next day. The facility's Medication Error Reporting policy last updated 1/22/15, indicated following a medication error the resident should be monitored, a medication error report completed, and notification should be made to the resident's family, physician, and the Department of Health. The policy did not include a definition of a medication error. According to record review and interviews, a medication error report was not completed nor was notification given. The Pharmacy Services Agreement dated 6/16/17, indicated in the reorder schedule that Thrifty White would work with the director of nursing to establish a re-order schedule that would allow the pharmacy adequate time to process refill orders. The agreement also indicated refill orders would be delivered Monday through Friday with a two day turnaround time; Refills ordered on weekends would be delivered with the scheduled delivery on Monday; and in order to reduce the chance for errors, all refill orders should be faxed to the pharmacy on the Thrifty White Reorder Form. The Thrifty White Pharmacy contact and hour of operation undated information, provided by the pharmacy and posted in medication room, included: All new orders must have the original order faxed to the pharmacy; Please fax refill orders to the pharmacy using the Pharmacy Refill Form and reorder labels; Please do not put new orders on the reorder form; Please fax refill orders to the pharmacy by Noon Monday through Friday for same day delivery; and Refill orders faxed to the pharmacy after Noon will be delivered the next business day The Prairie Manor Care Center 28 day cycle fill In-Service undated, included the following: -Any medications not included in the cycle fill must be reordered by nursing. These labels will have a reorder tab for this purpose. This will include the following medications: [REDACTED]. -New orders: fax the original order to pharmacy, for a stat order or emergency medication to fax the order to the pharmacy and follow up with a phone call to alert the pharmacy. -Refills: peel off the reorder tab and place on refill order form and fax to pharmacy, recommended that medications are reordered when there is a 3-5 day supply left to allow for any clarifications or needed prescription renewals (5-7 days for narcotics). -Discontinued and changed orders should be pulled from the exchange. The immediate jeopardy that began on 8/2/20, was removed on 8/11/20, when the facility's removal plan could be verified through interview and document review, to include training with the pharmacy, staff education on when to order medications timely, staff education for when to complete a medication error report, and the facility had developed a policy and procedure for medication reordering and trained staff on it.