| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245322 | A. Building<br>B. Wing | 05/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Covenant Living of Golden Valley Care & Rehab Ctr | 5825 St Croix Avenue<br>Golden Valley, 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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43082<br><br>Based on interview and document review, the facility failed to discuss discharge instructions with resident and resident representative upon discharge for 1 of 3 resident (R1). Additionally, the facility failed ensure correct disposition of medications for 2 of 3 residents (R1) when R1 received R2's medications upon discharge.<br><br>Findings include:<br><br>R1's face sheet, undated, indicated admitted to the facility of [DATE]. R1's diagnoses included atrioventricular block and unspecified diastolic (congestive) heart failure.<br><br>R1's Minimum Data Set (MDS) dated [DATE], identified intact cognition and no verbal behaviors during the assessment period.<br><br>R2's face sheet, undated, indicated admitted to the facility of [DATE].<br><br>R1's February 2025 Medication Administration Record (MAR) did not indicate administration for sulfamethoxazole or lisinopril.<br><br>R2's February 2025 MAR indicated administration for sulfamethoxazole 800 milligrams one tablet oral two times daily and lisinopril 20 milligrams one tablet by mouth two times daily.<br><br>Facility form titled Discharge Sending Medications Homes dated [DATE], indicated sulfamethoxazole 800 milligrams one tablet oral two times daily was listed on R1's form. Lisinopril pharmacy sticker was not visible on form. Discharge Sending Medication Home indicated, I certify the medication listed (pharmacy card stickers) above are released to me, with R1's signature and dated [DATE]. The form failed to have evidence of a witness/nurse signature.<br><br>During interview on [DATE] at 1:21 p.m., assistant director of nursing (ADON) stated their discharge process included a review of medications with the resident and to answer any questions. ADON was not aware of any medications sent home with the wrong resident and if this were to occur, management should have been notified.<br><br>(continued on next page) |

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.

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

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on [DATE] at 2:42 p.m., registered nurse (RN)-A stated he worked on the transition care unit at the facility and completed discharge process with the residents. RN-A stated he did not recall completing R1's discharge. RN-A denied sending R2's medication, sulfamethoxazole home with R1, discovering the error later, and then ordering more sulfamethoxazole for R2 later. RN-A stated if an error like that occurred, he would contact his supervisor.<br><br>During interview on [DATE] at 3:49 p.m., pharmacist (Pharm) stated on [DATE] there was a request by the facility to fill R2's sulfamethoxazole and the facility would be responsible to pay for the additional medications. Pharm stated the facility reported to have used their emergency kit supply of sulfamethoxazole until requesting more on [DATE]. Lisinopril was not reordered but no doses were verified to be omitted for R2.<br><br>During interview on [DATE] at 4:02 p.m., director of nursing (DON) stated they were not aware of the medication errors until this survey. DON indicated he believed RN-A knew of the error as was the one who ordered more medications for R2, and had not received authorization before ordering. DON stated upon discharge the nurse was to review the discharge paperwork, including the medications that were being sent home with the resident (and/or resident representative). He indicated this was likely not done as the medication disposition error would have been caught at that time if the process was followed. DON added, during their investigation, when reviewing R1's discharge records, the medication sticker for R2's sulfamethoxazole was included in R1's record, solidifying the error.<br><br>Review of R1's discharge paperwork lacked evidence RN-A discussed discharge paperwork and medications with R1 and family. Additionally, no RN signature was found on the Recapitulation of Stay records.<br><br>During interview on [DATE] at 2:47 p.m., R1's family member (FM) stated no discharge paperwork or medications were reviewed at the time of discharge. Upon R1 returning home it was discovered another resident's medications (sulfamethoxazole and lisinopril) were sent home with her. FM recalled R1's medications were handed over from RN-A to the family in a bag. FM indicated a serious concern related to this error as, if his mother would have taken these medications, it could have caused her significant harm.<br><br>Facility policy titled Adverse Consequences and Medication Errors, revised date ,d+[DATE], indicated a procedure was to review the resident's medication regimen for efficacy and actual or potential medication -related problems on an ongoing basis. Monitor the resident for medication-related adverse consequences when there is a medication error (wrong or expired medication). In the event of a significant medication-related error or adverse consequence, take action, as necessary, to protect the resident's safety and welfare. Promptly notify the provider of any significant error.<br><br>Facility polity titled Transfer or Discharge, Resident-Initiated, dated ,d+[DATE], indicated medical record would contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, discharge care plan and document discussions with the resident or representative, containing details of discharge planning and arrangements for post-discharge care. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43082<br><br>Based on interview and record review, the facility failed to maintain confidential clinical records for 2 of 3 residents (R1 and R2) when two of R2's Pharmacy Cards were sent with R1 who was discharging home.<br><br>Findings include:<br><br>R1's Minimum Data Set (MDS) dated [DATE], identified intact cognition.<br><br>R1's February 2025 Medication Administration Record (MAR) did not indicate an order for sulfamethoxazole or lisinopril.<br><br>R2's MDS dated [DATE], identified intact cognition.<br><br>R2's February 2025 MAR indicated an order for sulfamethoxazole 800 milligrams one tablet oral two times daily and lisinopril 20 milligrams one tablet by moth two times daily.<br><br>R2's pharmacy card identified protected information such as his first name, middle initial, last name, his doctor's name and information, the medication and prescribed route/dosage and what the medications were prescribed for (high blood pressure, antibiotic for infection).<br><br>R2 is protected by the Health Insurance Portability and Accountability Act (HIPPA) which includes protected health information includes medical history, test information, and any personally identifiable information. The 18 HIPPA identifiers include patient names, geographical elements, dates related to health or identity, telephone numbers, social security numbers and more.<br><br>During interview on 5/7/25 at 1:21 p.m., assistant director of nursing (ADON) stated upon discharge the nurse was to review medications with the discharging resident and or representative; ADON was not aware wrong medications was discharged with the wrong resident.<br><br>During interview on 5/7/25 at 2:42 p.m., registered nurse (RN) denied sending R1 home with R2's medication.<br><br>During interview on 5/7/25 at 4:02 p.m., director of nursing (DON) stated they were not aware a resident was discharged with another resident's medications but was able to verify R2's medication sulfamethoxazole pharmacy card sticker was in R1's discharge record.<br><br>During interview on 5/9/25 at 2:47 p.m., R1's family member verified and provided pictures of R2's medication sulfamethoxazole and lisinopril which was sent home with R1 upon discharge. |