STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viewcrest Health Center	3111 Church Street Duluth, MN 55811

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40945 Based on interview and document review, the facility failed follow medication administration policy for 1 of 3 residents (R1) reviewed for medication errors. This resulted in an immediate jeopardy (IJ) for R1 when LPN-B administered R2's medications to R1, which resulted in severe bradycardia (slower than normal heart rate) for R1 leading to hospitalization and a surgical intervention of a temporary pacemaker (a small, battery-powered device that prevents the heart from beating too slowly). The facility implemented corrective action prior to the investigation so the deficiency was issued at Past Noncompliance. The IJ began on 5/7/24, when the facility failed follow medication administration policy when LPN-B administered R2's medications to R1, which resulted in severe bradycardia leading to hospitalization and a surgical intervention of a temporary pacemaker. R1 had previously received her a.m. medications and received all of R2's a.m. medications. The facility had implemented corrective action to prevent recurrence by 5/10/24, prior to the start of the survey and was therefore Past Noncompliance. Findings included: R1's Face Sheet printed 5/14/24 indicated R1's diagnoses included longstanding persistent atrial fibrillation (irregular heart beat), history of transient ischemic attack (blockage of blood flow to the brain), and cerebral infarction (stroke). R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact. On 5/7/24, a progress note indicated at approximately 10:00 a.m. R1 was administered her roommate's (R2) prescribed medications. The note indicated licensed practical nurse (LPN)-A had dispensed R2's medications and gave them to LPN-B with instructions to go down the hall, take a left and then a right and go into the shared room. LPN-B then gave R1 R2's a.m. medications which included diltiazem (lowers blood pressure), metoprolol (anti- hypertensive- beta blocker), Cardizem (anti-hypertensive), allopurinol (gout), Cymbalta (antidepressant), doxycycline (antibiotic), famotidine (anti-indigestion), Keppra (anti-seizure), metformin (lowers blood sugar), Wellbutrin (anti-depressant), aspirin (blood thinner), methanamine (treats recurrent urinary tract infections), iron, and gabapentin (anti-seizure). At the time of the medication error, nurse practitioner (NP)-A was in the facility. Nursing staff informed her of the medication error, she completed a bedside assessment on R1, and ordered R1 be sent to the hospital to be monitored. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viewcrest Health Center	3111 Church Street Duluth, MN 55811

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's hospital record dated 5/7/24, indicated R1 arrived via ambulance to the emergency department (ED) after she was inadvertently administered another patient's medications which included a beta blocker and calcium channel blocker. R1's hospital admission diagnoses included accidental overdose, drug induced bradycardia, and atrial fibrillation with slow ventricle response. On 5/8/24, a progress note indicated R1 received a temporary pacemaker which was placed on 5/8/24, at approximately 7:00 p.m. On 5/13/24, at 2:19 p.m. LPN-B stated she was still in her orientation phase on 5/7/24. LPN-A had handed her a medication cup full of medications, and instructed her to go down the hall, take a left and then a right and go into R1 and R2's shared room. She stated she was not given the name of the resident, nor was she shown a picture of the resident. LPN-B stated when she returned to the medication cart, she saw a picture of R2 and told LPN-A she had given the medications to R1, and not R2. On 5/13/24, at 2:52 p.m. registered nurse (RN)-A stated to ensure the resident is receiving the correctly prescribed medications there was a picture of each resident on the medication administration record, along with the room and bed number. She stated the nurse administering medications was to ask the resident's name, and if they were not sure they should ask another staff member prior to administering any medications. The nurse who dispensed medications should be the one who administered the medications. This had not occurred, and led to a medication error in which R1 received multiple incorrect medications, resulting in R1 being sent to the emergency department on 5/7/24, requiring a temporary pacemaker. R1 remained hospitalized . On 5/13/24, at 3:12 p.m. the director of nursing (DON) verified the facility medication administration policy had not been followed. This resulted in a significant medication error in which R1 was hospitalized . After the medication error involving R1 was identified, leadership had added the medication administration policy to be included in the staff meeting scheduled for the afternoon of 5/7/24. The facility also sent out a facility wide text requiring all staff who administer medication to complete computer-based education related to medication administration. The facility also performed medication administration audits. On 5/14/24, at 8:31 a.m. LPN-A verified she had dispensed the medications for R2, handed LPN-B the medications, and instructed LPN-B to go down the hall, take a left and then a right, and go into R1 and R2's shared room. She stated she did not show LPN-B a picture of R2, nor had she given LPN-A the name of the resident. She verified proper procedure for medication administration had not been followed, which led to the medication error. She further verifed she had given R1 all of her prescribed morning medications which included Eloquis (blood thinner), iron, folic acid. Fosamax, gabapentin (anti-seizure), Keppra (anti- seizure), Norvasc (anti-hypertensive), and pantoprazole (anti-indigestion). On 5/13/24, at 1:17 p.m. the hospital cardiology physician assistant (PA)-C stated receiving diltiazem and metoprolol led to R1's to severe bradycardia, resulting in placement of a temporary pacemaker. R1 remained hospitalized . On 5/14/24, at 8:50 a.m. the pharmacist consultant (P)-A stated nurses who are dispensing mediations should verify they are giving the medication to the correct resident. He stated only the nurse who dispensed the medications should be administering medications to ensure the resident is receiving the correct mediations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245414	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viewcrest Health Center	3111 Church Street Duluth, MN 55811

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/14/24, at 10:55 a.m. the medical director (MD)-A stated he had been made aware of the medication error. He stated nursing staff should follow the policy and procedure which included verifying the correct resident to ensure residents are receiving the correct medications prior to administering any medication. The facility's Medication Administration policy dated 8/7/23 directed the facility will ensure all medications will be administered safely according to current standards of practice and regulatory requirements. The policy further directed staff will approach and identify the resident by the eMAR (electronic medication administration record) photograph or if still in doubt, question the identification of a resident with another staff member. The facility document titled The Six Rights of Medication Administration undated, directed staff as follows: 1. Right Individual 2. Right Drug 3. Right Dose 4. Right Time 5. Right Route 6. Right Documentation The facility implemented corrective action to prevent recurrence by 5/10/24. The facility provided education to all staff members responsible for medication administration, which included administration of medications and ensuring the 6 rights of medication administration was being followed. The facility also completed medication administration audits. The corrective actions were verified by observation, interview with staff, audit review and policy review.