STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnewaska Community Health Services	605 Main Street Starbuck, MN 56381

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 43367 Based on interview and document review the facility failed to ensure 1 of 1 resident (R2) reviewed for medication errors was free of significant medication errors when orders for Warfarin (Coumadin) (a blood thinner used to reduce the risk of blood clots), was not transcribed into the electronic medical record according to physician's orders and resulted in six missed doses of Warfarin 5 milligrams (mg). Findings include: R2's telehealth visit with cardiologist on 11/20/24, identified stop Amiodarone (used to treat and prevent a number of types of irregular heartbeats) and Eliquis (used to prevent stroke and blood clots in patients with certain heart rhythm problem such as atrial fibrillation (A-fib) (an irregular and often very rapid heart rhythm and can lead to blood clots in the heart, increases the risk of stroke, heart failure, and other heart related complications), start taking Warfarin (Coumadin) 5 mg oral tablet daily according to the international normalized ratio (INR) (used to measure how long it took for blood to clot). R2's progress noted 11/20/24 at 6:58 p.m. R2 was seen by cardiology via telehealth today. Orders: stop Amiodarone and switch Eliquis to Coumadin 5 mg oral tablet daily, and then according to INR levels. Will clarify which clinic the results will go to and when INR checks to start. The communication documents with the Coagulation Clinic, INR nurse from 11/25/24 through 11/29/24 identified the following orders: -11/25/24, R2's finger stick INR result was 1.2 seconds with a therapeutic INR level while on warfarin 2 to 3 seconds. Current order began on 11/21/24, Coumadin 5 mg daily. Next INR scheduled for 11/29/24. Physician order: continue 5 mg by mouth (po) daily. Note: aware had only taken four doses to date. -11/29/24, R2's finger stick INR result was 2.4 seconds. Current order: Coumadin 5 mg daily. Next INR was scheduled for 12/5/24. Physician order: continue Coumadin 5 mg po daily. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's primary provider medical doctor (MD) visit on 12/5/24, identified diagnoses: history congestive heart failure (CHF), diabetes mellitus (DM) insulin dependent with chronic kidney disease, atherosclerotic heart disease (buildup of fats, cholesterol and other substances in the artery of the walls called plague and can cause the arteries to narrow, blocking blood flow to organs and tissues), morbid obesity, chronic anticoagulation, deep vein thrombosis (blood clot) in lower extremities, A-fib, inferior vena cava (IVC) (big vein in the abdomen) filter (inserted into the IVC to catch/trap a traveling clot and prevent it from reaching the lung). She was started on Warfarin and a referral was placed to the INR clinic. INR was therapeutic with last check 2.4 on 11/9/24 [sic]. The communication documents with the Coagulation Clinic, INR nurse from 12/5/24 through 12/9/24 identified the following orders: -12/5/24, R2's finger stick INR result was 4.8 seconds. Current order: Coumadin 5 mg daily. Next INR was scheduled for 12/9/24. Physician order: hold today; 2.5 mg on 12/6/24 and 5.0 mg on 12/7/24 and 12/8/24. -12/9/24, R2's finger stick INR result was 2.9 seconds. Current order: Coumadin 5 mg daily. Next INR was scheduled for 12/16/24. Physician order: 2.5 mg on Mondays, Wednesdays, and Friday and 5 mg all other days. R2's December 2023 EMAR indicated: Warfarin 2.5. mg po in the evening on Monday, Wednesday, and Friday related to atrial fibrillation. Start date 12/9/24 at 6:00 p.m. and discontinue date 12/24/24 at 7:56 a.m., was administered on 12/9/24, 12/11/24, 12/13/24, 12/16/24, 12/18/24, 12/20/24, and 12/23/24. R2's December 2023 EMAR indicated: Warfarin 5 mg po in the evening on Tuesday, Thursday, Saturday, and Sunday for treating/preventing blood clots for two administrations. Start date 12/10/24 at 6:00 p.m. and discontinue date 12/24/24 at 5:46 p.m. Staff administered 5 mg on 12/10/24 and 12/12/24. On 12/10/24 the order for Warfarin 5 mg was transcribed inappropriately and entered on the EMAR as two administrations only. R2 did not receive Warfarin 5 mg dose as ordered on 12/14/24, 12/15/24, 12/17/24, 12/19/24, 12/21/24, and 12/22/24 (6 doses). The communication documents with the Coagulation Clinic, INR nurse from 12/16/24 through 1/14/25 identified the following orders: -12/16/24, R2's finger stick INR result was 2.3 seconds. Current order: Coumadin 5 mg Tuesday, Thursday, Saturday, Sunday, and 2.5 mg other days. Next INR scheduled: left blank. Physician order: Coumadin 5 mg po Tuesday, Wednesday, Thursday, and Saturday and Sunday; 2.5 mg Monday, Wednesday, and Friday. -12/24/24, R2's finger stick INR result was 1.2 seconds. Current order: 2.5 mg Monday, Wednesday, Friday, and 5 mg all other days. Next INR 12/31/24. Coumadin order: 5 mg tonight and 2.5 mg all other days. Handwritten on bottom of this document by INR clinic nurse was: 12/24/24 at 10:12 a.m. telephone call to staff nurse and upon looking at patient's medication list and EMAR, R2 had not received Coumadin 5 mg since 12/12/24, only the 2.5 mg dose Monday, Wednesday, Friday since then. Dosing of coumadin based on cumulative doses received. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-R2's anticoagulant flow sheet dated 12/24/24 identified dosing plan for the week fax received from facility with INR 1.2 today. Telephone call (TC) to facility and checked on any changes or missed doses. Reported she had been getting 2.5 mg on Monday, Wednesday, and Friday but looks like she had not received Coumadin 5 mg tabs since 12/12/24. R2's order was placed wrong in computer, instead of ordered cumulative weekly dose of 27.5 mg she received 22.5 mg the week of 12/8/24 and only 7.5 mg the week of 12/15/24. Will have R2 take 5 mg tonight and then 2.5 mg daily and recheck INR in one week. Orders faxed to facility and pharmacy. -12/31/24, Diagnosis: A-fib. INR result today 1.4 seconds (goal 2 to 3). Dose increase by 12.5 %. Change coumadin dose: 5 mg po Thursday and Saturday and 2.5 mg Sunday, Monday, Wednesday, Thursday, and Friday. Recheck INR 1/7/25 (one week). -1/2/2025 10:05 a.m. R2's progress notes identified, Pharmacist Note: Medications and chart reviewed for monthly medication regimen review (MR) (a thorough evaluation of the medication regimen by a pharmacist, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication). No medication irregularities noted at this time. -1/7/25, R2's INR result today 1.6. Change coumadin dose to 5 mg Tuesday, Thursday, Saturday then 2.5 mg on Sunday, Monday, Wednesday, and Friday. Recheck INR on 1/14/25. -1/14/25, R2's INR result today 1.6. Increase dose by 10%. Change coumadin 5 mg po Sunday, Tuesday, Thursday, and Saturday; 2.5 mg Monday, Wednesday, and Friday. Recheck INR on 1/21/25. During an interview on 1/15/25 at 1:55 p.m. R2 stated she had a history of blood clots found in her legs, traveled to her lungs, and a filter was placed in her inferior vena cava. R2's last visit with her cardiologist was December 2024 and she had requested to be taken off Eliquis due to cost and placed on coumadin. She was started on Coumadin 5 mg with a therapeutic goal of INR between two and three and thought she had not received the correct doses of Coumadin. She stated the INR had been checked on Tuesdays and the result of the last one was below 2.0. She was concerned no adjustment had been made on the Coumadin dose and was afraid she was at an increased risk for another blood clot. During an interview on 1/16/25 at 11:30 a.m. medical doctor/medical director (MD) stated the INR clinic nurse helped manage R2's dosing of coumadin and she had written a note on 12/24/24 order form: R2 had not received her Coumadin for days due to the wrong order was placed in the computer. He would have expected staff to notify him right away, was out of the office on 12/24/24, and unsure when they discovered the transcription error. MD stated R2's missed doses of Coumadin contributed to a drop in her INR from 2.9 to 1.2, would have been considered subtherapeutic, and placed R2 at an increased risk for blood clots. During an interview on 1/16/25 at 1:45 p.m. registered nurse (RN) stated on 12/9/24, R2 had and INR of 2.9 and she had transcribed and signed off R2's orders for Coumadin 2.5 mg Monday, Wednesday, and Friday and 5 mg Tuesday, Thursday, Saturday, and Sunday. On 12/24/24 R2's INR had dropped to 1.2. She reviewed R2's December EMAR and noticed a transcription error, unsure why it had taken until 12/24/24 to realize this medication error. R2 was placed on Coumadin for her a-fib and when the INR dropped below 2 it increased R2's risk for blood clots. She stated the handwritten message and signature at the bottom of the 12/24/24 order document was the INR clinic nurse and identified the missed doses of Coumadin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/25 at 3:37 p.m. pharmacist consult (PC) stated R2 had been taken off Eliquis, placed on Coumadin, and he was unaware of R2's missed doses of Coumadin. He stated once a resident was started on Coumadin it would have taken three to four days to achieve a therapeutic level versus Eliquis would have taken two days. R2's therapeutic level while on Coumadin was between two and three and if not within that window would have increased her risk of blood clots, stroke, and heart attack. During an interview on 1/16/25 at 4:30 p.m. director of nursing (DON) stated R2's Eliquis was discontinued and changed to Coumadin per her request due to cost. She stated on 12/24/24 R2's INR had dropped down to 1.2. R2 had missed six doses of Coumadin 5 mg due to a transcription error, probably lowered the INR level, and placed R2 at a risk for blood clots. The medication error was discovered on 12/24/24, and a new order was given that same day. Facility policy Medication Error dated 5/15/24, identified protection would be provided to all residents in the facility for the health, welfare, and rights by ensuring residents received care and services safely in an environment free of significant mediation errors. A mediation error was defined as the administration of medication which was not in accordance with the prescriber's order. Significant medication error was defined as one which jeopardized their health and safety. Medication errors, once identified, will be evaluated to determine if it would be considered significant by using the following guidelines: residents condition required rigid control such as monitoring of labs. Drug Category: if the medication is from a category that usually requires the resident to be titrated to a specific blood level such as medication with a narrow therapeutic index (NTI) such as Warfarin, and if the error occurred repeatedly such as omission of the resident's medication several times. If a medication error occurred the nurse would be expected to assess, examine the resident condition, and notify the physician or health care practitioner as soon as possible, monitor and document actions taken in the medial record, once stable report incident to supervisor, complete the incident or occurrence report.