Electronically delivered
April 9, 2021

Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: March 26, 2021

Dear Administrator:

On March 26, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 26, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 26, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	**2319 WEST SEVENTH STREET SAINT PAUL, MN 55116**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 03/25/21 to 03/26/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5028089C (MN71196), H5028090C (MN71241) deficiencies identified at F745 and F755. The following complaint was found to be UNSUBSTANTIATED: H5028088C (MN71157) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a medical escort for	F 745	Submission of this Response and Plan of correction is not a legal admission that a	5/10/21

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

Electronically Signed | 04/16/2021

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F 745	Continued From page 1 resident's safety to and from an invasive procedure appointment for 1 of 1 residents (R3) reviewed for medical related social services. Findings include: R3's quarterly Minimum Data Set (MDS) dated 02/17/21, indicated a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. R3's diagnoses included vascular dementia with behavioral disturbance and weakness. The MDS further indicated R3 needed supervision with one person physical assist for bed mobility, transfers, dressing, toilet use and personal hygiene. R3's care plan revision on 11/08/20, identified R3 had moderately cognitive impairment and directed staff to encourage R3 to participate in daily decisions, offer choices as needed, give medications as prescribed by physician, observed and reported any changes in cognitive status. R3's care plan revision on 11/08/20, R3 had moderately impaired decision-making abilities and impaired short/long term memory which required cues and supervision. Staff was directed to explain all procedure/cares by using simple, one words requests if possible, keep resident informed of activities taking place, provide cueing and prompting for personal care. Staff also needed to provide reassurance to assure resident feels safe and secure, re-orient resident as needed, do not rush, or show impatience, remind resident to use call light and ask for assistance. On 03/24/2021, at 10:15 a.m. R3 arrived to Minnesota Endoscopy Center to have a upper and colon endoscopy procedure done at 11:15	F 745	deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of faulty by the facility, Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. 1. R3 returned from the appointment without any ill effects. The DON received education from the nurse consultant on the process for sending residents out to appointments appropriately dressed and with attendant if cognitively impaired. 2. Residents with cognitive impairment residing in the facility have the potential to be affected. An audit was completed with no other issues noted. 3. Nursing Staff were re-educated on sending residents to appointments which included the appropriate dressing of	

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F 745	Continued From page 2 a.m. When R3 arrived front desk personnel noticed R3 was in a wheelchair and wore only a hospital gown. R3 did not have any paperwork with him from the facility. Front desk personnel was able to obtain his name and looked him up in system. R3 was unaware of where he was at and why he was at the clinic, R3 believed he was in Hong Kong. R3 was unable to consent to the procedure and the clinic canceled the procedure. The transport medical picked up the resident after couple hours to get him back to the facility. On 3/24/21, at 2:14 p.m., R3 was interviewed and was not able to recall the appointment. On 03/24/21, at 2:16 p.m. licensed practical nurse (LPN)-A stated when R3 needed to go out for an appointment, someone would need to wheel him to the transport car and then wheel him back into the building. On 3/24/21, at 2:34 p.m. R3's guardian and confirmed she did not know about R3's appointment, otherwise she would have gone with him. She preferred to have someone with R3 because it was not safe to send him out by himself. On 03/24/21, at 3:14 p.m. nursing assistant (NA)-A stated that R3 was confused and needed reminders and cues. On 03/24/21, at 3:21 p.m. director of nursing (DON) confirmed she knew R3 went out for his appointment and she did not think R3 should have gone out by himself. However, the physician did not have concerns for R3 to go along, so DON let him go alone. DON also stated that R3 had gone out before alone and knew the address	F 745	residents for appointments and the need for an attendant (guardian, responsible Party, or facility staff member) to be present if the resident is cognitively impaired 4. The Medical Records Director / or designee will Audit resident appointments, the need for attendant for the appointment, and appropriate dressing of the resident three times weekly for 4 weeks then weekly for 2 months. The results of the audits will be presented to the quarterly QAPI committee for review / recommendations	

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F 745	Continued From page 3	F 745		

of facility so she thought R3 should be fine.

On 03/24/21, at 3:24 p.m. social services director (DSS) confirmed that R3 should not go out for an appointment by himself. She said she did not know about his appointment, otherwise she would have notified the guardian and the had the guardian go with R3 to the appointment. Per DSS, an appointment was made by the physician and health information assistant, who worked at facility. DSS confirmed R3 went out by himself when transport came. DSS did not even know R3 left the building until he came back.

On 03/24/21, at 3:30 p.m. health information (HI)-C stated the facility had an appointment book located at each nurse's station to notify nurses about residents' appointments. DSS and nursing staff were supposed to check the book daily in the morning. HI-C did not think R3 should go out out by himself and discussed with the physician a few times about it. HI-C also discussed her concerns with the SSD and with the nurse manager. HI-C said the physician spoke with R3 and felt it would be okay for R3 to go alone. HI-C confirmed this was not a first time he went out by himself.

On 03/24/21, at 3:45 p.m. the physician confirmed that R3 should have someone to escort him because he had dementia. She also stated that DON, SSD and HI-C had talked to her about their concerns and after weighing risks and benefit she was fine for him to go out for his appointment by himself.

A policy was requested about escorts to appointment but none was provided.

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F 755	Continued From page 4	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify medication errors for 1 of 3 residents (R2) reviewed for medication	F 755	1. R2 has discharged from the facility. LPN -B was provided additional training on Medication Error prevention via	5/10/21

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F 755	Continued From page 5 documentation. Findings include: R2's face sheet included diagnoses of malignant neoplasm of lower lobe, altered mental status, knee pain, clavicle fracture and lung cancer. R2 was on hospice. R2's quarterly Minimum Data Set (MDS) assessment dated 03/06/21, identified R2 did not verbalize pain and R2's pain goal was 0. R2's care plan dated 03/06/21 included R2 has acute pain related to lung cancer. Goals included R2 will not have discomfort related to side effects of analgesia (painkillers) . R2's interventions included administer analgesia as per orders and give ½ hours before treatment or care, monitor/document for side effects of pain medication and report occurrences to the physician. R2's admission medication orders dated 03/05/21, indicated Morphine Sulfate (Concentrate) Solution 20 milligram(mg)/milliliter(ml) to give 5 mg (0.25 ml) by mouth every two (2) hours as needed for pain or shortness of breath. On 03/25/21, the surveyor and director of nursing (DON) conducted a medication administration review and identified a transcription error. The licensed nursing staff administered 2.5 ml instead of 0.25 ml per physician's order. There was no error report filled out and that was the first the DON knew about the error. The following medication discrepancies were	F 755	Medcom 2. Residents residing in the facility have the potential to be affected. An audit of all narcotics was completed at the time of survey with no other issues noted. 3. Licensed Nursing staff were re - educated on Narcotic Counts, Shift to shift report, transcription of MD orders and process on how to handle medication errors. 4. The DON / or designee will audits of narcotic logs as well as transcription of MD orders will be completed three times a week for 4 weeks then weekly for 2 months. Results of the audits will be presented to the quarterly QAPI committee for review / recommendations.	

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F 755	Continued From page 6	F 755		

identified by the surveyor and DON on 03/25/21, when the narcotic book and electric medication administration record (EMAR) were reconciled:

-On 03/06/21, 03/09/21 and 03/17/21, 2.5 ml of morphine sulfate was given per narcotic book, however there was no record this was given in R2's EMAR.

-On 03/14/21, 2.5 ml of morphine sulfate was given twice by narcotic book and charted once in R2's EMAR.

-On 03/16/21, 0.25 ml of morphine sulfate was documented twice in R2's EMAR but charted once in narcotic book.

-On 03/16/21, the hospice physician discontinued the 2.5 ml of morphine sulfate liquid, however licensed nursing staff still documented in narcotic book liquid medication was given twice daily from 03/18/21 through 03/23/21.

-On 03/21/21, the hospice physician ordered Morphine solutabs 5 mg every 2 hours as needed for pain or shortness of breath. R2's EMAR showed solutabs were given on 03/21/21 and 03/22/21, however nothing was charted in narcotic book.

On 03/25/21, at 10:16 a.m. hospice registered nurse (HRN)-E stated he was called to the facility when R2 passed away. When HRN-E arrived, he reconciled medications with licensed practical nurse (LPN)-B. HRN-E noticed the staff had documented the 60 ml bottle of morphine like a 30 ml bottle, so when medication was administered, staff documented and subtracted doses as if the bottle was 30 ml, not a 60 ml

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F 755	Continued From page 7	F 755		

bottle. HRN-E confronted LPN-B, LPN-B took the narcotic book and scribbled out all the measurements the staff had documented and made the subtraction correct herself.

On 03/25/21, at 11:04 a.m. DON said when the licensed nursing staff ordered a refill of morphine on 3/16/21, the bottle that was delivered was a 60 ml bottle (previous bottle was 30 ml). The staff mistakenly thought it was 30 ml and started to subtract doses as it was a 30 ml and not 60 ml. DON stated it was reported 7 ml of morphine sulfate was missed from R2's 60 ml morphine bottle. DON verified the bottle only had 30 ml left instead of 37.5 ml as the narcotic book stated. DON did not know LPN-B corrected the count in the narcotic book from the error that staff documented the bottle like a 30 ml bottle vs the actual 60 ml bottle. DON confirmed that LPN-B should not have done that and it was against their policy.

On 03/25/21, at 3:50 p.m. LPN-B stated that HRN-E arrived on 03/23/21, around noon and told her the narcotic count was off. LPN-B confirmed she corrected it right in front of HRN-E and with her corrections there was still 7 ml missed. She reported to DON about the discrepancy on the same day. LPN-B stated that she knew R2 got morphine for pain but did not check EMAR to see if it was liquid or tabs. She stated she just gave liquid because that was what he got. She could not recall if she charted in EMAR or not.

On 03/26/21, at 8:16 a.m. pharmacist (Ph)-F reported the facility reviews were done monthly, however they have been remotely because of Covid. She stated that a loss on a liquid medication that is given via med cup an

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estimated variance would be 4 ml per 30 ml bottle, so a 60 ml bottle would be 8 ml variance. She confirmed that it is acceptable to have discrepancy of 7.5 ml for 60 ml bottle.

On 03/26/21, at 09:14 a.m. Ph-G stated she was not onsite since Covid 19 began. She had been doing monthly reviews remotely. She did not have access to internal documents such as narcotic books or signature sheets. She reported it was policy during Covid that all internal documents were to be audited by the facility.

The facility policy of medications errors revised 05/20 indicated the following: "Report all medication errors to the attending physician and the director of nursing or designee. Complete medication error report in the Risk Management system."

The facility policy of Medications controlled revised on 03/14 indicated the following: "Chart medication in appropriate area of medication administration record."

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Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

Re: State Nursing Home Licensing Orders
Event ID: 2H6Z11

Dear Administrator:

The above facility was surveyed on March 25, 2021 through March 26, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 03/25/21 to 03/26/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

Electronically Signed | 04/16/21

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2 000	Continued From page 1 The following complaint was found to be substantiated: H5028089C (MN71196), H5028090C (MN71241) with licensing orders issued. The following complaint was found to be unsubstantiated: H5028088C (MN71157) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405.	21495		5/10/21

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21495	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide a medical escort for resident's safety to and from an invasive procedure appointment for 1 of 1 residents (R3) reviewed for medical related social services. Findings include: R3's quarterly Minimum Data Set (MDS) dated 02/17/21, indicated a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. R3's diagnoses included vascular dementia with behavioral disturbance and weakness. The MDS further indicated R3 needed supervision with one person physical assist for bed mobility, transfers, dressing, toilet use and personal hygiene. R3's care plan revision on 11/08/20, identified R3 had moderately cognitive impairment and directed staff to encourage R3 to participate in daily decisions, offer choices as needed, give medications as prescribed by physician, observed and reported any changes in cognitive status. R3's care plan revision on 11/08/20, R3 had moderately impaired decision-making abilities and impaired short/long term memory which required cues and supervision. Staff was directed to explain all procedure/cares by using simple, one words requests if possible, keep resident informed of activities taking place, provide cueing and prompting for personal care. Staff also needed to provide reassurance to assure resident feels safe and secure, re-orient resident as needed, do not rush, or show impatience, remind resident to use call light and ask for assistance.	21495	Corrected	

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21495	Continued From page 3	21495		

On 03/24/2021, at 10:15 a.m. R3 arrived to Minnesota Endoscopy Center to have a upper and colon endoscopy procedure done at 11:15 a.m. When R3 arrived front desk personnel noticed R3 was in a wheelchair and wore only a hospital gown. R3 did not have any paperwork with him from the facility. Front desk personnel was able to obtain his name and looked him up in system. R3 was unaware of where he was at and why he was at the clinic, R3 believed he was in Hong Kong. R3 was unable to consent to the procedure and the clinic canceled the procedure. The transport medical picked up the resident after couple hours to get him back to the facility.

On 3/24/21, at 2:14 p.m., R3 was interviewed and was not able to recall the appointment.

On 03/24/21, at 2:16 p.m. licensed practical nurse (LPN)-A stated when R3 needed to go out for an appointment, someone would need to wheel him to the transport car and then wheel him back into the building.

On 3/24/21, at 2:34 p.m. R3's guardian and confirmed she did not know about R3's appointment, otherwise she would have gone with him. She preferred to have someone with R3 because it was not safe to send him out by himself.

On 03/24/21, at 3:14 p.m. nursing assistant (NA)-A stated that R3 was confused and needed reminders and cues.

On 03/24/21, at 3:21 p.m. director of nursing (DON) confirmed she knew R3 went out for his appointment and she did not think R3 should have gone out by himself. However, the physician did not have concerns for R3 to go along, so

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21495	Continued From page 4 DON let him go alone. DON also stated that R3 had gone out before alone and knew the address of facility so she thought R3 should be fine. On 03/24/21, at 3:24 p.m. social services director (DSS) confirmed that R3 should not go out for an appointment by himself. She said she did not know about his appointment, otherwise she would have notified the guardian and the had the guardian go with R3 to the appointment. Per DSS, an appointment was made by the physician and health information assistant, who worked at facility. DSS confirmed R3 went out by himself when transport came. DSS did not even know R3 left the building until he came back. On 03/24/21, at 3:30 p.m. health information (HI)-C stated the facility had an appointment book located at each nurse's station to notify nurses about residents' appointments. DSS and nursing staff were supposed to check the book daily in the morning. HI-C did not think R3 should go out out by himself and discussed with the physician a few times about it. HI-C also discussed her concerns with the SSD and with the nurse manager. HI-C said the physician spoke with R3 and felt it would be okay for R3 to go alone. HI-C confirmed this was not a first time he went out by himself. On 03/24/21, at 3:45 p.m. the physician confirmed that R3 should have someone to escort him because he had dementia. She also stated that DON, SSD and HI-C had talked to her about their concerns and after weighing risks and benefit she was fine for him to go out for his appointment by himself. A policy was requested about escorts to appointment but none was provided.	21495		

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21495	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The social worker or designee, could review and/or revise facility policies and procedures related to medically related social services. Responsible personnel could be re-educated on these policies and procedures. Appropriate efforts could be made toward supporting the social service needs of the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for social service needs. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21495		
21585	MN Rule 4658.1325 Subp. 8 Administration of Medications; documentation Subp. 8. Documentation of administration. The name, date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized person who administered and observed the same must be recorded in the resident's clinical record. Documentation of the administration must take place following the administration of the medication. If administration of the medication was not completed as prescribed, the documentation must include the reason the administration was not completed, and the follow-up that was provided, such as notification of a registered nurse or the resident's attending physician.	21585		5/10/21

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21585	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify medication errors for 1 of 3 residents (R2) reviewed for medication documentation. Findings include: R2's face sheet included diagnoses of malignant neoplasm of lower lobe, altered mental status, knee pain, clavicle fracture and lung cancer. R2 was on hospice. R2's quarterly Minimum Data Set (MDS) assessment dated 03/06/21, identified R2 did not verbalize pain and R2's pain goal was 0. R2's care plan dated 03/06/21 included R2 has acute pain related to lung cancer. Goals included R2 will not have discomfort related to side effects of analgesia (painkillers) . R2's interventions included administer analgesia as per orders and give ½ hours before treatment or care, monitor/document for side effects of pain medication and report occurrences to the physician. R2's admission medication orders dated 03/05/21, indicated Morphine Sulfate (Concentrate) Solution 20 milligram(mg)/milliliter(ml) to give 5 mg (0.25 ml) by mouth every two (2) hours as needed for pain or shortness of breath. On 03/25/21, the surveyor and director of nursing (DON) conducted a medication administration review and identified a transcription error. The licensed nursing staff administered 2.5 ml instead of 0.25 ml per physician's order. There was no	21585	Corrected	

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21585	Continued From page 7	21585		

error report filled out and that was the first the DON knew about the error.

The following medication discrepancies were identified by the surveyor and DON on 03/25/21, when the narcotic book and electric medication administration record (EMAR) were reconciled:

-On 03/06/21, 03/09/21 and 03/17/21, 2.5 ml of morphine sulfate was given per narcotic book, however there was no record this was given in R2's EMAR.

-On 03/14/21, 2.5 ml of morphine sulfate was given twice by narcotic book and charted once in R2's EMAR.

-On 03/16/21, 0.25 ml of morphine sulfate was documented twice in R2's EMAR but charted once in narcotic book.

-On 03/16/21, the hospice physician discontinued the 2.5 ml of morphine sulfate liquid, however licensed nursing staff still documented in narcotic book liquid medication was given twice daily from 03/18/21 through 03/23/21.

-On 03/21/21, the hospice physician ordered Morphine solutabs 5 mg every 2 hours as needed for pain or shortness of breath. R2's EMAR showed solutabs were given on 03/21/21 and 03/22/21, however nothing was charted in narcotic book.

On 03/25/21, at 10:16 a.m. hospice registered nurse (HRN)-E stated he was called to the facility when R2 passed away. When HRN-E arrived, he reconciled medications with licensed practical nurse (LPN)-B. HRN-E noticed the staff had documented the 60 ml bottle of morphine like a

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30 ml bottle, so when medication was administered, staff documented and subtracted doses as if the bottle was 30 ml, not a 60 ml bottle. HRN-E confronted LPN-B, LPN-B took the narcotic book and scribbled out all the measurements the staff had documented and made the subtraction correct herself.

On 03/25/21, at 11:04 a.m. DON said when the licensed nursing staff ordered a refill of morphine on 3/16/21, the bottle that was delivered was a 60 ml bottle (previous bottle was 30 ml). The staff mistakenly thought it was 30 ml and started to subtract doses as it was a 30 ml and not 60 ml. DON stated it was reported 7 ml of morphine sulfate was missed from R2's 60 ml morphine bottle. DON verified the bottle only had 30 ml left instead of 37.5 ml as the narcotic book stated. DON did not know LPN-B corrected the count in the narcotic book from the error that staff documented the bottle like a 30 ml bottle vs the actual 60 ml bottle. DON confirmed that LPN-B should not have done that and it was against their policy.

On 03/25/21, at 3:50 p.m. LPN-B stated that HRN-E arrived on 03/23/21, around noon and told her the narcotic count was off. LPN-B confirmed she corrected it right in front of HRN-E and with her corrections there was still 7 ml missed. She reported to DON about the discrepancy on the same day. LPN-B stated that she knew R2 got morphine for pain but did not check EMAR to see if it was liquid or tabs. She stated she just gave liquid because that was what he got. She could not recall if she charted in EMAR or not.

On 03/26/21, at 8:16 a.m. pharmacist (Ph)-F reported the facility reviews were done monthly, however they have been remotely because of

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21585	Continued From page 9 Covid. She stated that a loss on a liquid medication that is given via med cup an estimated variance would be 4 ml per 30 ml bottle, so a 60 ml bottle would be 8 ml variance. She confirmed that it is acceptable to have discrepancy of 7.5 ml for 60 ml bottle. On 03/26/21, at 09:14 a.m. Ph-G stated she was not onsite since Covid 19 began. She had been doing monthly reviews remotely. She did not have access to internal documents such as narcotic books or signature sheets. She reported it was policy during Covid that all internal documents were to be audited by the facility. The facility policy of medications errors revised 05/20 indicated the following: "Report all medication errors to the attending physician and the director of nursing or designee. Complete medication error report in the Risk Management system." The facility policy of Medications controlled revised on 03/14 indicated the following: "Chart medication in appropriate area of medication administration record." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21585		