DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
November 18, 2022

Administrator
Birchwood Health Care Center
604 - 1st Street Ne
Forest Lake, MN  55025

RE: CCN: 245200
Cycle Start Date: October 7, 2022

Dear Administrator:

On November 16, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance.  Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered

November 18, 2022

Administrator
Birchwood Health Care Center
604 - 1st Street Ne
Forest Lake, MN  55025

Re: Reinspection Results
Event ID: 807K12

Dear Administrator:

On November 16, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 7, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Administrator
Birchwood Health Care Center
604 - 1st Street Ne
Forest Lake, MN  55025

RE: CCN: 245200
Cycle Start Date: October 7, 2022

Dear Administrator:

On October 7, 2022, 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 January 7, 2023 (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 April 7, 2023 (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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245200 | A. BUILDING _____ B. WING _____ | C 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BIRCHWOOD HEALTH CARE CENTER** | **604 - 1ST STREET NE FOREST LAKE, MN 55025** |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>On 10/6/22 through 10/7/22, 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.<br><br>The following complaints were found to be SUBSTANTIATED: H52004865C (MN87241) with a licensing order issued at F760.<br><br>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.<br><br>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 760 SS=D | Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and document review the facility failed to ensure residents were free from misadministration of medication for two of three residents (R1 and R3) reviewed for medications. R1's extended release medication morphine sulfate (MS) Contin was crushed, and R3's medication Apixaban (a blood thinning medication | F 760 | The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction | 10/28/22 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 10/24/2022 |

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.

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| F 760 | Continued From page 1<br>used to prevent the development of blood clots) was not administered as prescribed.<br><br>Findings include:<br><br>R1's admission Minimum Data Set (MDS) dated 8/4/22, identified significant cognitive impairment, multiple sclerosis (a disease where their own immune system destroys the brain and spinal cord's protective outer layer leading to nerve damage), dementia, and chronic pain. R1 required extensive assistance of 1 staff member for bed mobility, dressing, toileting, and hygiene.<br><br>R1's hospice medical provider order dated 8/29/22, at 3:37 p.m. identified R1's pain medication was changed to MS Contin 60 milligram (mg) every 12 hours for chronic pain.<br><br>R1's medical administration record (MAR) dated 9/1/22, identified R1 received MS Contin 60 mg on 9/17/22, at 8:00 p.m.<br><br>R1's hospice medical provider ordered on 9/12/22, identified staff could crush R1's medications if she was unable to swallow her pills.<br><br>R1's nursing progress note dated 9/18/22, at 12:15 a.m. identified the nurse was concerned about the resident being over sedated. R1's blood pressure (BP) was 63/39 (normal limits are between 90/60 to 120/60), and her oxygen saturation (the amount of oxygen attached to the red blood cells. A normal reading is considered above 95 percent) was 96 percent. The medical provider ordered nursing staff to check R1's respiratory rate every hour. In addition, nursing staff requested liquid MS because R1 was no | F 760 | prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:<br><br>1. Resident #1 passed away on Hospice, as expected at the facility. With respect to resident #3, resident has been safely discharged to an Assisted Living Facility per discharge goals.<br><br>2. A root cause analysis was completed for the identified residents.<br><br>3. All current residents with orders to crush medications were reviewed for appropriateness. All new admits and hospital returns within the past 30-days were reviewed with assistance from the facility's contracted Pharmacist, for medication order accuracy and crushed medication orders.<br><br>4. All facility licensed staff and trained medication aides will receive education on medication administration policy with focus on crushing medication orders, medications that should not be crushed and two licensed staff verification of new orders by October 28th, 2022<br><br>5. The Director of Nursing, and/or designee will audit 5 medication administration passes for accuracy weekly for one month and then, twice monthly for 2 months thereafter. The data collected from these audits will be presented to the facility QAPI committee by the Director of | |

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| F 760 | Continued From page 2<br>longer able to swallow her non-crushable extended-release pain medication.<br><br>R1's nursing progress note dated 9/18/22, at 6:11 a.m. identified R1's average respiratory rate from 12:36 a.m. to 5:36 a.m. was 13 (normal is 12 to 16) breaths per minute.<br><br>R1's medical provider note dated 9/18/22, 11:02 a.m. identified her current dose of MS Contin extended-release pain medication was changed to liquid morphine because R1 was unable to swallow her pills. In addition, the medical provider stated it would be ok to resume R1's pain medications after it was held on 9/17/22 through 9/18/22.<br><br>During interview on 10/6/22, at 12:55 p.m. FM-A stated she received a phone call from her brother on 9/17/22. Her brother said R1 received her MS Contin extended-release medication after it was crushed. FM-A stated her brother wanted to know if they should send her to the hospital. FM-A stated when she arrived at the facility the next day her mother's respiratory rates had improved.<br><br>During interview on 10/6/22, at 1:31 p.m. the hospice registered nurse (RN-A) assigned to R1's case, stated they were notified about a medication error when a staff member crushed R1's MS Contin. RN-A stated the nurse called the medical provider and was told to watch R1 over a period of time until the medication was out of her system. The hospice medical provider did not feel R1 required emergency care at that time.<br><br>During interview on 10/7/22, at 9:05 a.m. the director of nursing (DON) stated the only medication error at the facility in the past three | F 760 | Nursing and/or designee. The data will be reviewed/discussed at the monthly QAPI Meeting. At this time the QAPI committee will make the decision/recommendation regarding any necessary follow-up studies. | |

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| F 760 | Continued From page 3<br>months happened on 7/23/22, related to the administration of an anticoagulant (blood thinning medication to prevent the development of a blood clot).<br><br>During interview on 10/7/22, at 9:36 a.m. RN-B stated nursing staff are required to update the medical provider when a resident is unable to safely swallow their medication. The provider would then write an order for staff to crush their medication. RN-B added even if there is an order to crush medication, it does not mean you can crush extended-release medication. RN-B stated she has seen a warning on the medication card label do not crush. RN-B stated she had not received any additional training related to medication errors and prevention.<br><br>During interview on 10/7/22, at 10:50 a.m. Pharmacist (PH)-A stated for any extended-release medication they would add an additional "do not crush" sticker next to the medication label to warn the staff of the potential dangers in doing so. PH-A stated the reason why an extended-release medication cannot be crushed is because they would receive the full dose of the medication at one time instead of over a period of 12 hours. PH-A added, the result could cause decreased respiratory function, decreased oxygen intake, and death.<br><br>During interview on 10/7/22, at 12:33 p.m. RN-C stated when a nurse makes a medication error, they are required to notify the medical provider and update the DON. RN-C added, the person making the medication error would document the mistake using the Medication Error Report. RN-C added if a medication error occurred, she would expect the staff involved to be retrained to | F 760 | | |

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| F 760 | Continued From page 4<br>prevent the error from happening again. RN-C stated she had not received any recent medication error prevention training.<br><br>During interview on 10/7/22, at 12:49 p.m. RN-D stated she would contact the supervisor for any medication errors. In addition, she would expect to receive additional training related to the error. RN-D stated she had not received any recent medication error prevention training. RN-D added you cannot crush any extended-release medication and there would be a "do not crush" sticker next to the medication label.<br><br>During interview on 10/7/22, at 12:58 p.m. the DON stated she was not on call when R1 received the crushed MS Contin. The DON stated when she returned to work, she reviewed the incident. The DON stated no error occurred because the patient received Oxycodone, a crushable medication. The DON stated R1 did not have an order for MS Contin. The DON reviewed R1's MAR and found the order for MS Contin with a start date of 8/29/22. DON stated had she known the medication was really MS Contin she would have considered it a medication error. The DON stated they did not use the Medication Error Report document or investigate the incident any further.<br><br>During interview on 10/7/22, at 1:09 p.m. RN-F stated she was on call the weekend when R1 received the crushed MS Contin. RN-F stated she received a call from an agency nurse RN-H that RN-G crushed R1's MS Contin. RN-F stated she spoke with the DON about the medication error, and they discussed the need to provide the nursing staff education about which medications cannot be crushed. RN-F stated she had not | F 760 | | |

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| F 760 | Continued From page 5<br>received any education about medication errors since that conversation.<br><br>During interview on 10/7/22 at 3:19 p.m. the DON stated this medication error was the first one RN-G made. If this was RN-G's second medication errors she would have developed a training plan for the nurse but would not re-educate the rest of the nursing staff how to prevent this error from happening again.<br><br>R3's MAR dated 7/16/22 through 8/5/22, identified R3 received her Apixaban 2.5 milligram (mg) dose in the evening for her atrial fibrillation (an irregular fast heart rate leading to blood clot formation and an increased risk for a stroke).<br><br>R3's admission MDS dated 7/19/22, identified intact cognition, encephalopathy (damage to the brain), history of a stroke, and atrial fibrillation. Required an extensive assistance from one staff to move in bed, transfer, ambulate, toilet, dress, and hygiene needs. MDS identified R3 received an anticoagulant (blood thinning medication to prevent blood clot formation).<br><br>R3's hospital discharge orders dated 7/23/22, at 12:16 p.m. identified R3's discharge orders included a new change to her Apixaban 2.5 mg from once a day to two times a day<br><br>R3's MAR dated 8/6/22, identified the Apixaban order was changed from once a day to two times a day.<br><br>R3's medication error report dated 7/23/22, identified R3's Apixaban dosage was changed during a hospitalization from once a day to two times a day. The error occurred when the MAR | F 760 | | |

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| F 760 | Continued From page 6<br>was not updated with the change. The physician, and family were notified. The physician ordered nursing to correct the order and monitor R3 for signs and symptoms of respiratory distress and stroke for seven days. No harm to R3 occurred. The section for education and counseling was left blank.<br><br>During interview on 10/7/22, at 2:45 p.m. the DON stated R3 had an order for Apixaban to be given once a day. When she returned from the hospital the admitting nurse missed the Apixaban was changed from once a day to two times a day. DON stated this was an isolated event so systematic training was not indicated. After the discovery of the error staff contacted the medical provider and family. As a team they reviewed the medication error during an interdisciplinary department team (IDT) meeting. If this was the nurse's second medication error, they would have done a more extensive re-education with only her and would not include the rest of the nursing staff.<br><br>The facility policy Practice Guideline and Procedures: Medication Administration dated 6/24/18, identified all residents would receive the right medication at the right time based on the medical provider's orders. In the event of a preventable medication error, the incident would be investigated, and staff would develop a process to prevent the same mistake from happening again. The policy included the Medication Error Report tool to identify who, what, where, and when the error occurred. In addition, documented when the physician and family were notified, if the resident met the vulnerable adult definition, and if the facility reported to the appropriate state agency. Actions would include education and counseling used to prevent a | F 760 | | |

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| F 760 | Continued From page 7<br>reoccurrence. | F 760 | | |

Electronically delivered
October 18, 2022

Administrator
Birchwood Health Care Center
604 - 1st Street Ne
Forest Lake, MN  55025

Re: State Nursing Home Licensing Orders
Event ID: 807K11

Dear Administrator:

The above facility was surveyed on October 6, 2022 through October 7, 2022 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00853 | A. BUILDING: _____ B. WING _____ | C 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BIRCHWOOD HEALTH CARE CENTER | 604 - 1ST STREET NE FOREST LAKE, MN 55025 |

| (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 |
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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 10/6/22 through 10/7/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>The following complaint was found to be SUBSTANTIATED: H52004865C (MN87241) with a licensing order issued at (1545).<br><br>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 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 evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction.<br>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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of | 2 000 | | |

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| 2 000 | Continued From page 2<br>state form.<br><br>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. | 2 000 | | |
| 21545 | MN Rule 4658.1320 A.B.C Medication Errors<br><br>A nursing home must ensure that:<br>A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means:<br>(1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or<br>(2) the administration of expired medications.<br>B. It is free of any significant medication error. A significant medication error is:<br>(1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or<br>(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the | 21545 | | 10/28/22 |

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| 21545 | Continued From page 3<br>physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.<br>C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and document review the facility failed to ensure residents were free from misadministration of medication for two of three residents (R1 and R3) reviewed for medications. R1's extended release medication morphine sulfate (MS) Contin was crushed, and R3's medication Apixaban (a blood thinning medication used to prevent the development of blood clots) was not administered as prescribed.<br><br>Findings include:<br><br>R1's admission Minimum Data Set (MDS) dated 8/4/22, identified significant cognitive impairment, multiple sclerosis (a disease where their own immune system destroys the brain and spinal cord's protective outer layer leading to nerve damage), dementia, and chronic pain. R1 required extensive assistance of 1 staff member for bed mobility, dressing, toileting, and hygiene.<br><br>R1's hospice medical provider order dated | 21545 | The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:<br><br>1. Resident #1 passed away on Hospice, as expected at the facility. With respect to resident #3, resident has been safely discharged to an Assisted Living Facility per discharge goals.<br><br>2. A root cause analysis was completed for the identified residents. | |

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| 21545 | Continued From page 4<br><br>8/29/22, at 3:37 p.m. identified R1's pain medication was changed to MS Contin 60 milligram (mg) every 12 hours for chronic pain.<br><br>R1's medical administration record (MAR) dated 9/1/22, identified R1 received MS Contin 60 mg on 9/17/22, at 8:00 p.m.<br><br>R1's hospice medical provider ordered on 9/12/22, identified staff could crush R1's medications if she was unable to swallow her pills.<br><br>R1's nursing progress note dated 9/18/22, at 12:15 a.m. identified the nurse was concerned about the resident being over sedated. R1's blood pressure (BP) was 63/39 (normal limits are between 90/60 to 120/60), and her oxygen saturation (the amount of oxygen attached to the red blood cells. A normal reading is considered above 95 percent) was 96 percent. The medical provider ordered nursing staff to check R1's respiratory rate every hour. In addition, nursing staff requested liquid MS because R1 was no longer able to swallow her non-crushable extended-release pain medication.<br><br>R1's nursing progress note dated 9/18/22, at 6:11 a.m. identified R1's average respiratory rate from 12:36 a.m. to 5:36 a.m. was 13 (normal is 12 to 16) breaths per minute.<br><br>R1's medical provider note dated 9/18/22, 11:02 a.m. identified her current dose of MS Contin extended-release pain medication was changed to liquid morphine because R1 was unable to swallow her pills. In addition, the medical provider stated it would be ok to resume R1's pain medications after it was held on 9/17/22 through 9/18/22. | 21545 | 3. All current residents with orders to crush medications were reviewed for appropriateness. All new admits and hospital returns within the past 30-days were reviewed with assistance from the facility's contracted Pharmacist, for medication order accuracy and crushed medication orders.<br><br>4. All facility licensed staff and trained medication aides will receive education on medication administration policy with focus on crushing medication orders, medications that should not be crushed and two licensed staff verification of new orders by October 28th, 2022<br><br>5. The Director of Nursing, and/or designee will audit 5 medication administration passes for accuracy weekly for one month and then, twice monthly for 2 months thereafter. The data collected from these audits will be presented to the facility QAPI committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly QAPI Meeting. At this time the QAPI committee will make the decision/recommendation regarding any necessary follow-up studies. | |

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| 21545 | Continued From page 5<br><br>During interview on 10/6/22, at 12:55 p.m. FM-A stated she received a phone call from her brother on 9/17/22. Her brother said R1 received her MS Contin extended-release medication after it was crushed. FM-A stated her brother wanted to know if they should send her to the hospital. FM-A stated when she arrived at the facility the next day her mother's respiratory rates had improved.<br><br>During interview on 10/6/22, at 1:31 p.m. the hospice registered nurse (RN-A) assigned to R1's case, stated they were notified about a medication error when a staff member crushed R1's MS Contin. RN-A stated the nurse called the medical provider and was told to watch R1 over a period of time until the medication was out of her system. The hospice medical provider did not feel R1 required emergency care at that time.<br><br>During interview on 10/7/22, at 9:05 a.m. the director of nursing (DON) stated the only medication error at the facility in the past three months happened on 7/23/22, related to the administration of an anticoagulant (blood thinning medication to prevent the development of a blood clot).<br><br>During interview on 10/7/22, at 9:36 a.m. RN-B stated nursing staff are required to update the medical provider when a resident is unable to safely swallow their medication. The provider would then write an order for staff to crush their medication. RN-B added even if there is an order to crush medication, it does not mean you can crush extended-release medication. RN-B stated she has seen a warning on the medication card label do not crush. RN-B stated she had not received any additional training related to medication errors and prevention. | 21545 | | |

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| 21545 | Continued From page 6<br><br>During interview on 10/7/22, at 10:50 a.m. Pharmacist (PH)-A stated for any extended-release medication they would add an additional "do not crush" sticker next to the medication label to warn the staff of the potential dangers in doing so. PH-A stated the reason why an extended-release medication cannot be crushed is because they would receive the full dose of the medication at one time instead of over a period of 12 hours. PH-A added, the result could cause decreased respiratory function, decreased oxygen intake, and death.<br><br>During interview on 10/7/22, at 12:33 p.m. RN-C stated when a nurse makes a medication error, they are required to notify the medical provider and update the DON. RN-C added, the person making the medication error would document the mistake using the Medication Error Report. RN-C added if a medication error occurred, she would expect the staff involved to be retrained to prevent the error from happening again. RN-C stated she had not received any recent medication error prevention training.<br><br>During interview on 10/7/22, at 12:49 p.m. RN-D stated she would contact the supervisor for any medication errors. In addition, she would expect to receive additional training related to the error. RN-D stated she had not received any recent medication error prevention training. RN-D added you cannot crush any extended-release medication and there would be a "do not crush" sticker next to the medication label.<br><br>During interview on 10/7/22, at 12:58 p.m. the DON stated she was not on call when R1 received the crushed MS Contin. The DON stated when she returned to work, she reviewed the | 21545 | | |

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| 21545 | Continued From page 7<br><br>incident. The DON stated no error occurred because the patient received Oxycodone, a crushable medication. The DON stated R1 did not have an order for MS Contin. The DON reviewed R1's MAR and found the order for MS Contin with a start date of 8/29/22. DON stated had she known the medication was really MS Contin she would have considered it a medication error. The DON stated they did not use the Medication Error Report document or investigate the incident any further.<br><br>During interview on 10/7/22, at 1:09 p.m. RN-F stated she was on call the weekend when R1 received the crushed MS Contin. RN-F stated she received a call from an agency nurse RN-H that RN-G crushed R1's MS Contin. RN-F stated she spoke with the DON about the medication error, and they discussed the need to provide the nursing staff education about which medications cannot be crushed. RN-F stated she had not received any education about medication errors since that conversation.<br><br>During interview on 10/7/22 at 3:19 p.m. the DON stated this medication error was the first one RN-G made. If this was RN-G's second medication errors she would have developed a training plan for the nurse but would not re-educate the rest of the nursing staff how to prevent this error from happening again.<br><br>R3's MAR dated 7/16/22 through 8/5/22, identified R3 received her Apixaban 2.5 milligram (mg) dose in the evening for her atrial fibrillation (an irregular fast heart rate leading to blood clot formation and an increased risk for a stroke).<br><br>R3's admission MDS dated 7/19/22, identified intact cognition, encephalopathy (damage to the | 21545 | | |

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| 21545 | Continued From page 8<br><br>brain), history of a stroke, and atrial fibrillation. Required an extensive assistance from one staff to move in bed, transfer, ambulate, toilet, dress, and hygiene needs. MDS identified R3 received an anticoagulant (blood thinning medication to prevent blood clot formation).<br><br>R3's hospital discharge orders dated 7/23/22, at 12:16 p.m. identified R3's discharge orders included a new change to her Apixaban 2.5 mg from once a day to two times a day<br><br>R3's MAR dated 8/6/22, identified the Apixaban order was changed from once a day to two times a day.<br><br>R3's medication error report dated 7/23/22, identified R3's Apixaban dosage was changed during a hospitalization from once a day to two times a day. The error occurred when the MAR was not updated with the change. The physician, and family were notified. The physician ordered nursing to correct the order and monitor R3 for signs and symptoms of respiratory distress and stroke for seven days. No harm to R3 occurred. The section for education and counseling was left blank.<br><br>During interview on 10/7/22, at 2:45 p.m. the DON stated R3 had an order for Apixaban to be given once a day. When she returned from the hospital the admitting nurse missed the Apixaban was changed from once a day to two times a day. DON stated this was an isolated event so systematic training was not indicated. After the discovery of the error staff contacted the medical provider and family. As a team they reviewed the medication error during an interdisciplinary department team (IDT) meeting. If this was the nurse's second medication error, they would have | 21545 | | |

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| 21545 | Continued From page 9<br>done a more extensive re-education with only her and would not include the rest of the nursing staff.<br><br>The facility policy Practice Guideline and Procedures: Medication Administration dated 6/24/18, identified all residents would receive the right medication at the right time based on the medical provider's orders. In the event of a preventable medication error, the incident would be investigated, and staff would develop a process to prevent the same mistake from happening again. The policy included the Medication Error Report tool to identify who, what, where, and when the error occurred. In addition, documented when the physician and family were notified, if the resident met the vulnerable adult definition, and if the facility reported to the appropriate state agency. Actions would include education and counseling used to prevent a reoccurrence.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days. | 21545 | | |