DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 3, 2023

Administrator
St. Clare Living Community Of Mora
110 North 7th Street
Mora, MN 55051

RE: CCN: 245291
Cycle Start Date: October 18, 2022

Dear Administrator:

On December 29, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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Electronically delivered

January 3, 2023

Administrator
St. Clare Living Community Of Mora
110 North 7th Street
Mora, MN 55051

Re: Reinspection Results
Event ID: 1DRS12

Dear Administrator:

On December 29, 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 18, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
October 31, 2022

Administrator
St Clare Living Community Of Mora
110 North 7th Street
Mora, MN 55051

RE: CCN: 245291
Cycle Start Date: October 18, 2022

Dear Administrator:

On October 18, 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 18, 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 18, 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,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING _____ B. WING _____	C 10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLARE LIVING COMMUNITY OF MORA	110 NORTH 7TH STREET MORA, MN 55051

(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 10/14/22 through 10/18/22, 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, Requirments for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H52915071C (MN00087581); however, no deficiencies were cited due to actions implemented by the facitliy prior to the survey. As a result of the investigation deficiencies were issues at F580 and F758. 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		11/29/22

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

Electronically Signed | 11/10/2022

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 580	Continued From page 1 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to	F 580		

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F 580	Continued From page 2 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the primary medical provider was notified timely of a change in condition for 1 of 1 residents (R1) who developed acute changes in alertness level and respiratory status that required the use of supplemental oxygen. Findings include: R1's significant change Minimum Data Set (MDS) dated 10/11/22, identified R1 was severely cognitively impaired; however, she was identified to communicate with clear speech in which she was understood and usually understood others. The MDS also indicated R1 was diagnosed with dementia with behavioral disturbances and required hospice (end of life) care. In addition, the MDS identified R1 lacked the need for supplemental oxygen use or experienced periods of shortness of breath. R1's Care Plan, revised 10/7/22, identified R1 was enrolled in hospice services related to the effects of dementia in which staff were directed to keep R1's medical providers informed of any significant changes in her condition or medical regimen. An initial text message, dated 10/10/22, at 9:20 p.m. identified licensed practical nurse (LPN)-A sent a message to R1's nurse practitioner (NP)-A which updated her R1 was involved in an Ativan medication error event: R1 was administered 0.5ml (milliliters) of Ativan (anti-anxiety	F 580	It is the policy of St. Clare Living Community of Mora to inform/update primary medical provider and resident representative timely for residents who experience change in condition, accident involving injury, and medication/treatment changes. St. Clare Living Community policy for Change in Condition was reviewed and revised on 10/19/22. Licensed nursing staff re-educated regarding facility change in condition policy & appropriate ways to communicate to providers on 10/21/22 and on 10/25/22. Education included thorough assessment of the resident to ensure providers receive a detailed update regarding resident's change in condition. Facility will conduct notification of change and change in condition audits by way of review orders written by NP/MD, accident/incident events, and review of residents nursing progress notes. Audits will be conducted 3 time a week for 1 month, weekly for 3 months, monthly for 3 months, and randomly thereafter. Results of audit will be reported to the QA/QI Committee for further review and recommendations. Further system review and staff education will be provided if indicated by audit results. Ongoing education for resident change in condition and notification of provider through facility on-line education, upon hire, nursing department meetings, and at least annually. The Director of Nursing or designee will be responsible	

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F 580	Continued From page 3 medication) instead of the ordered 0.25ml. At 9:21 p.m. NP-A responded and questioned how many milligrams were in 0.5ml. At 9:30 p.m. LPN-A responded with 1mg. At 9:30 p.m. NP-A responded, "[R1] should be okay." The text message lacked information related to any adverse effects R1 may or may not have experienced related to the medication error. A Safety Events - Medication Error report, dated 10/10/22, at 11:21 p.m. identified R1 had an active order for Ativan 0.25 ml every two hours as needed (PRN); however, at 7:38 p.m. R1 administered an incorrect Ativan dose of 0.5 ml (double dose). The report indicated R1 displayed "slow respiratory rate and O2's (oxygen blood levels)" which averaged between 72 and 95 percent (%) (within normal limits ranges 90-100%) with an "abnormal breath pattern." The report lacked documentation of when R1 was assessed to demonstrate a decreased respiratory decline. A Safety Events - Fall report, dated 10/10/22, at 11:45 p.m. identified R1 sustained an unwitnessed fall in her room at 8:40 p.m. (58 minutes after receiving the double dose of Ativan) The report indicated R1's neurological and mental status checks revealed R1 was "lethargic/drowsy" with "sleepiness" and her speech was unclear with slurred, mumbled words. An intervention section identified R1 was to be monitored throughout the night. A section labeled Notification Guidelines directed staff to notify the medical provider "immediately by phone ..." for certain identified abnormalities. The report identified the following reportable abnormalities were checked: a systolic (top number) blood pressure greater then 180, respirations less than	F 580	for compliance.	

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F 580	Continued From page 4 10 and oxygen saturation less than 90%. A Notification section identified an entered "No" which indicated the "attending" was not faxed, the physician and resident representative were not notified and the care plan was not reviewed. A progress note, dated 10/10/22, at 11:47 p.m. identified R1's fall in which R1 received PRN Ativan at 7:38 p.m. for continued behaviors. Hospice was notified of the fall and arrived at the facility to assess R1's status in which R1 exhibited "abnormal breathing pattern" and O2 levels which averaged between 72 and 95%. Hospice directed staff to monitor R1 throughout the night at "roughly 15 to 30 minute intervals." The progress note indicated R1's family, nurse practitioner, nurse manager were notified. The note lacked detailed information related to R1's Ativan error, specifics related to R1's declined medical status/change in condition, that R1 required supplemental oxygen due to significantly low oxygen saturation levels and periods of apnea (stopped breathing), detailed time line information on R1's status changes, or any identification of NP-A's response to the medication error update. An untitled flow sheet, dated 10/10/22, at 11:30 p.m. through 10/11/22, at 5:00 a.m. identified R1's vital signs (blood pressure, pulse, respirations and oxygen saturation levels) were monitored in which R1 utilized 2 liters of supplemental oxygen between 11:30 p.m. and 4:00 a.m. In addition, R1's systolic blood pressures at 12:00 a.m. 12:15 a.m. and 4:00 a.m. respectively were reported as 181, 190, and 182. R1's Long Term Care Visit medical provider note, dated 10/11/22, signed at 11:33 a.m. , identified	F 580		

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F 580	Continued From page 5 R1 was assessed by her medical doctor (MD)-A in which R1 was free of any acute distress or respiratory concerns while on room air. The note listed Current Outpatient Medications in which the list lacked evidence R1 had an active order for PRN Ativan. In addition, the note identified MD-A reviewed R1's medical record progress notes, medications, and vital signs. The note identified no medication changes were provided during the visit and to follow up in two months. The provider note lacked documentation of R1's Ativan error event, her fall, or her 10/10/22 mental and respiratory status changes. During interview on 10/14/22, at 1:48 p.m. LPN-A stated a resident's change in condition was present if they experienced a "depression in respiratory rate and associated low oxygen" levels, in which she was expected to contact the provider "right away." LPN-A explained, on 10/10/22, she updated NP-A, per a text message, on R1's Ativan error; however, she confirmed she failed to update NP-A on R1's fall and her mental and respiratory status changes that evening. She stated R1's oxygen saturation levels fluctuated from 72 to 95% in which R1 demonstrated periods of apnea and a respiratory rate "about 8 on average," a blood pressure which was "very high" with a systolic reading initially in the 190's, and that R1 required supplemental oxygen. LPN-A explained she should have updated NP-A "immediately" once R1 was assisted into bed after her fall and started to demonstrate changes in her respiratory status. She explained timely provider updates related to changes in a resident's breathing and heart status was very important as such changes could be "detrimental within a short period of time."	F 580		

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F 580	Continued From page 6 When interviewed on 10/14/22, at 4:04 p.m. registered nurse (RN)-A stated she assessed R1 after her fall on 10/10/22. She explained R1 started to demonstrate changes in her status about 15 minutes after staff assisted R1 into bed after her fall in which R1's oxygen saturation levels "dropped slightly below 50[%]" at one point. RN-A performed a sternal rub on R1 to help stimulate her alertness and her breathing and she confirmed R1 required supplemental oxygen to help her maintain her oxygen levels above 90%. RN-A acknowledged R1 experienced a change in her status on 10/10/22. She stated she did not update R1's medical provider; however, she confirmed she expected R1's primary nurse would have updated R1's medical provider "right away" after R1's status changes were identified on 10/10/22. During interview on 10/18/22, at 1:19 p.m. the director of nursing (DON) stated she considered a decline in a resident's respiratory status to be a change in status which she expected the medical provider, or an on-call provider, to be updated at the time the status change was determined, via a phone call and not a text message. The DON explained it was important to update medical providers timely on changes in status in order to decrease any associated risk factors, such as death. When interviewed on 10/19/22, at 1:00 p.m. R1's medical doctor (MD)-A stated he expected staff to contact him, NP-A, or the on-call provider as soon as possible if a resident presented with a change in status. MD-A confirmed he was not updated on R1's status changes 10/10/22 or on 10/11/22 when he performed routine rounds with R1. He explained if the status change information was	F 580		

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F 580	Continued From page 7 relayed to him he would have documented the information in the 10/11/22 rounds progress note and he would have reviewed R1's Ativan order for risk and benefit determinations. During interview on 10/19/22, at 2:49 p.m. NP-A stated she expected to be updated on the same day as a resident presented with changes in their respiratory status, and/or the need for supplemental oxygen as "that person is clearly not stable." NP-A confirmed knowledge R1 was involved in an Ativan medication error; however, she denied knowledge that R1 experienced changes in her status related to it as staff did not update her of any status changes on 10/10/22. She explained if she was updated on R1's changes in status, she would most likely have discontinued the Ativan. A facility Change in Condition policy, dated 3/22, identified staff were expected to immediately consult and notify the resident's physician when a resident experienced a change in their physical, mental, or psychosocial status. In addition, the policy directed staff to chart in the progress notes assessment data, observations, physician notification and/or attempted notification(s), along with the providers name and topic(s) discussed.	F 580		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		11/29/22

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F 758	Continued From page 8 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 9 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and identify target behaviors, appropriate indication for use, and non-pharmacological interventions for scheduled and as needed (PRN) psychotropic medications, failed to monitor and assess those medications for adverse side effects, failed to update care plans to reflect psychotropic medication use, failed to obtain resident representative consent for the administration of psychotropic medications, and failed to offer/attempt non-pharmacological interventions prior to their use in order to ensure necessity and reduce the risk of complications for 2 of 3 residents (R1, R2) reviewed for unnecessary medication usage. In addition, the facility failed to ensure a stop date or specified duration for use identified for PRN anti-anxiety medication for R1. Findings include: R1's significant change Minimum Data Set (MDS) dated 10/11/22, identified R1 was severely cognitively impaired; however, she was identified to communicate with clear speech in which she was understood and usually understood others. The MDS indicated R1 was diagnosed with dementia with behavioral disturbances and depression in which the MDS revealed R1 was free of behaviors and required one day of anti-anxiety medication and seven days of an antidepressant. Her behavioral status remained unchanged from the prior assessment. A hospice Medication Order sheet, dated 10/4/22, identified R1 was ordered lorazepam (anti-anxiety	F 758	It is the policy of St. Clare Living Community of Mora to comprehensively assess, and identify target behaviors, appropriate education for use, non-pharmacological interventions, monitor for adverse effects, obtain consent, and care plan appropriately. Facility's Psychotropic Medication Use reviewed and revised on 10/24/2022. Licensed staff re-educated regarding psychotropic med use policy, individualized resident target behavior monitoring, GDR's, adverse side effects, 14 day stop dates for as needed psychotropics, consents, care planning, tardive dyskinesia, and abnormal voluntary movement scale assessments on 10/25/22. R1 and R2's psychotropic med use, consents, monitoring, individualized resident target behaviors, AIMS assessments, and care plans were reviewed and revised. All other like residents receiving psychotropic medications were reviewed and updated. Electronic health record review included, consents, monitoring, individualized target behaviors, AIMS assessment if applicable, and resident care plans. Psychotherapeutic Drug Review form initiated on 11/10/22 to be completed by nursing leadership quarterly and with significant change to assess for gradual dose reductions. Facility NP will be updated and requests for GDR's via written communication (SBAR) will completed as applicable. Audits will be	

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F 758	Continued From page 10 medication) 2mg (milligrams)/ml (milliliter) concentrate - 0.25ml every two hours PRN for "anxiety/restlessness." R1's medication administration record (MAR), dated 10/1/22 through 10/14/22, identified the 10/4/22 PRN lorazepam order and designated areas for time, reason, and results of the administration. The MAR indicated R1 received one dose of the lorazepam on 10/10/22 at 7:38 p.m. for "other" reasons and a result of "0." A comment section identified "Anxiety" for a reason. The MAR lacked lorazepam target behavior(s) designation and monitoring, non-pharmacological intervention(s) use and effectiveness documentation for any displayed behaviors, and anti-anxiety adverse side effect monitoring. In addition, the MAR's designated diagnosis section for the lorazepam was blank and the order's end date identified it was "Open Ended" (lacked a 14 day stop-date). A review of R1's medical record from 10/4/22 through 10/10/22 lacked evidence the PRN lorazepam was comprehensively assessed by facility staff prior to administration to determine medical necessity, specific R1 conditions or diagnosis for use, behavioral interventions, and/or if the lorazepam was clinically contraindicated. In addition, the medical record lacked a psychotropic medication representative consent for the PRN lorazepam. A copy of the consent and a lorazepam comprehensive assessment were requested: none were provided. R1's Care Plan, revised 10/7/22, identified R1 was enrolled in hospice services related to the effects of dementia with behavioral disturbances and that R1 received Remeron (antidepressant	F 758	conducted 3 time a week for 1 month, weekly for 3 months, monthly for 3 months, and randomly thereafter. Results of audit will be reported to the QA/QI Committee for further review and recommendations. Further system review and staff education will be provided if indicated by audit results. Ongoing education for psychotropic medication use through facility on-line education at least annually, and during nursing department meetings. The Director of Nursing or designee will be responsible for compliance.	

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medication) for depression. The care plan indicated R1 demonstrated mood concerns in which she refused medical treatments and cares and was "skeptical" of staff with initial encounters. The care plan lacked documentation R1 received an anti-anxiety medication, that she had any mood/behavioral diagnosis other than depression, designated target behaviors and/or non-pharmacological interventions for the use of the lorazepam or any additional detailed information related to her diagnosis of dementia with behavioral disturbances.

A Safety Events - Medication Error report, dated 10/10/22, at 11:21 p.m. identified R1 had an active order for lorazepam 0.25 ml every two hours as needed (PRN); however, at 7:38 p.m. R1 was administered an incorrect lorazepam dose of 0.5 ml (double dose). The report indicated R1 displayed "slow respiratory rate and O2's (oxygen blood levels)" which averaged between 72 and 95 percent (%) (within normal limits ranges 90-100%) with an "abnormal breath pattern."

A Safety Events - Fall report, dated 10/10/22, at 11:45 p.m. identified R1 sustained an unwitnessed fall in her room at 8:40 p.m. The report indicated R1's neurological and mental status checks identified R1 was "lethargic/drowsy" with "sleepiness" and her speech was unclear with slurred, mumbled words. A section labeled Notification Guidelines directed staff to notify the medical provider "immediately by phone ..." for certain identified abnormalities. The report identified the following reportable abnormalities were checked: a systolic (top number) blood pressure greater then 180, respirations less than 10 and oxygen saturation

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less than 90%. A Notification section identified an entered "No" which indicated the "attending" was not faxed, the physician and resident representative were not notified and the care plan was not reviewed.

A progress note, dated 10/10/22, at 11:47 p.m. identified R1's fall in which R1 required PRN lorazepam at 7:39 p.m. for continued behaviors where R1 "maintained a close distance" to the nurse and asked "many questions" regarding a move R1 believed was planned for the next day. The nurse attempted to redirect R1 with food, redirection, and a phone call where R1 spoke to her son. These interventions were "to no avail." Hospice was notified of the fall and arrived at the facility to assess R1's status in which R1 exhibited "abnormal breathing pattern" and O2 levels which averaged between 72 and 95%. The note lacked detailed information related to R1's Ativan error, specifics related to R1's declined medical status/change in condition, that R1 required supplemental oxygen due to significantly low oxygen saturation levels and periods of apnea (stopped breathing), detailed time line information on R1's status changes, or any identification of NP-A's response to a medication error update or that NP-A reviewed the PRN lorazepam order due to potential clinical contraindications.

R1's progress notes were reviewed and lacked documentation on 10/10/22, prior to an 11:47 p.m. entry, that R1 displayed behavioral actions, interventions utilized for any noted behaviors and/or effectiveness of interventions, or effects of the lorazepam administration.

R1's Long Term Care Visit medical provider note,

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F 758	Continued From page 13 dated 10/11/22, signed at 11:33 a.m. , identified R1 was assessed by her medical doctor (MD)-A in which R1 was free of any acute distress or respiratory concerns. The note identified R1 was on Remeron for "Mood" in which R1 exhibited suspicious or aggressive behaviors at times. The note listed R1's Current Outpatient Medications; however, the PRN lorazepam was not listed. In addition, the note identified MD-A reviewed R1's medical record progress notes, medications, and vital signs. The note identified no medication changes were provided during the visit and to follow up in two months. The provider note lacked documentation of R1's Ativan error event, her fall, or her 10/10/22 mental and respiratory status changes nor did the note identify rationalization for R1's PRN lorazepam to be extended for longer than 14 days. R2's significant change MDS, dated 8/3/22, identified R2 was severely cognitive impaired and was free of behavioral symptoms. The MDS indicated R2 was diagnosed with dementia and a sleep disorder. R2 was administered an antidepressant seven days a week. A hospice Medication Order sheet, dated 7/27/22, identified R2 was ordered lorazepam 2mg/ml concentrate - 0.25ml every two hours PRN for "anxiety/restlessness." R2's Care Plan, revised 8/1/22, identified R1 was enrolled in hospice services related to heart disease and that R2 received Remeron for sleep disturbances/insomnia. The care plan indicated R2 demonstrated periods where she was "short with staff at times;" otherwise, the care plan was free of behavior references. The care plan lacked R2 received an anti-anxiety medication, that she	F 758		

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F 758	Continued From page 14 had any other diagnosis other than insomnia, or designated target behaviors and/or non-pharmacological interventions for the use of the lorazepam and/or ABH gel. A hospice order sheet, dated 10/1/22, indicated R2 was ordered ABH 1mg/25mg/1mg gel (medication which combined Ativan (lorazepam - anti-anxiety), Benadryl, and Haldol (antipsychotic) which directed staff to apply 1ml to R1's wrist/affected areas topically every six hours (four times a day) for terminal agitation. A Physician Order Report, provider signed 10/11/22, identified R2 received the following psychotropic medications: scheduled Remeron (antidepressant) which lacked a diagnosis for use, PRN lorazepam for anxiety/restlessness, and the ABH gel for agitation. A review of R2's Long Term Care Visit medical provider notes, dated 7/22/22 - 10/11/22, identified R2 was assessed by MD-A or NP-A a total of six times. The progress notes identified R2 had dementia without behavioral disturbances and was enrolled with hospice services. R2's 7/22/22 note identified she demonstrated "ongoing decline and behavioral changes." R2's 8/9/22 note identified R2's mood continued to be labile in which she would be without concerns one moment and then weepy or angry the next. R2's 10/11/22 note indicated R2 was prescribed the PRN lorazepam and the Remeron; however, the current medication list lacked the ABH gel order. R2's provider notes lacked a reason for the Remeron or documentation related to her sleep. In addition, the notes lacked specific documentation related to her lorazepam and/or ABH gel use to ensure both medications were	F 758		

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F 758	Continued From page 15 medically necessary to treat specific conditions/diagnosis in relation to R2's use of two medications that contained lorazepam. R2's MAR, dated 10/1/22 through 10/14/22, indicated R2 received PRN lorazepam 13 times with documented indication for use as "Other" or "Behavior Issue." The associated comment section identified eight reason for use entries: five reported "Anxiety," one "Restless," and one "restless and not sleeping." Eight PRN lorazepam administrations lacked a reason for use comment in the comment section. R2's treatment administration record (TAR), dated 10/1/22 through 10/14/22, directed staff to monitor Remeron target behaviors and adverse side effects each shift and to monitor the target behaviors for the lorazepam. In addition, the TAR directed staff to document Remeron non-pharmacological interventions and effectiveness for anxiety and restlessness. R2's TAR lacked evidence staff monitored for lorazepam and ABH gel adverse side effects, that target behavior monitoring was in place for the ABH gel, or that the ABH gel was monitored for effectiveness of use. A review of R2's progress notes, MAR, and TAR documentation identified R2 lacked specific behavioral documentation to support PRN lorazepam administration and attempted non-pharmacological interventions on the following five days: 10/2/22, 10/7/22, 10/11/22 (three doses), 10/12/22, and 10/13/22. R2's medical record was reviewed and lacked documentation staff assessed R2 for dyskinesias (potential abnormal body movements associated	F 758		

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F 758	Continued From page 16 with antipsychotic medications) in relation to the ABH gel use. In addition, the medical record lacked documentation the PRN lorazepam and ABH gel were comprehensively assessed by facility staff to determine medical necessity, specific R2 conditions or diagnosis for use, behavioral interventions, medication effectiveness, and/or if their use was clinically contraindicated. Furthermore, the medical record lacked a psychotropic medication representative consent for the PRN lorazepam and the ABH gel. A copy of a dyskinesia assessment, consents, and comprehensive psychotropic assessments were requested: none were provided. When interviewed on 10/14/22, at 2:08 p.m. licensed practical nurse (LPN)-A stated a psychotropic medication consent from either the resident and/or the resident's representative was required prior to the first dose of administration in order to ensure the resident and/or representative were in agreement with the medication. LPN-A stated she failed to confirm R1's lorazepam consent prior to R1's initial medication administration on 10/10/22. LPN-A explained, on 10/10/22, R1 continued to follow her during her medication pass that evening in which R1 repeatedly asked her questions as R1 felt she was moving. R1 was provided with nourishment and a phone call with her son; however, the phone call with her son "seemed to have the opposite effect [on R1] and ramped her up." LPN-A stated R1 pulled her away from her focus while she passed her evening medications. LPN-A stated about an hour and a half after R1 received the lorazepam, R1 demonstrated changes to her alertness and respiratory status. Review of R1's administered medications	F 758		

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revealed the lorazepam administration error. LPN-A confirmed she updated nurse practitioner (NP)-A on the error; however, she did not update her on R1's fall, R1's change in medical status, nor did she question NP-A on the continued use or discontinuation of the PRN lorazepam. LPN-A stated R2's ABH gel was "a new addition" which "was provided by hospice." LPN-A explained R2 tended to "get very loud and opinionated" and yelled out for help as she lacked comprehension of time and place. LPN-A stated she believed R2 received the ABH gel "to help maintain some semblance of calm;" however, LPN-A stated she did not think it worked all that well for R2. LPN-A stated she was expected to document behaviors, non-pharmacological approaches utilized prior to PRN psychotropic medication administration, and the medication's effectiveness. She was unsure as to why she failed to document specifics on R1's behaviors and non-pharmacological interventions on 10/10/22, other than the comment of just anxiety, prior to her progress note entry at 11:47 p.m.

During interview on 10/18/22, at 11:48 a.m. registered nurse (RN)-B stated she expected psychotropic medications to have a consent in place prior to the first administration per facility policy, target behavior designation, non-pharmacological interventions to be used prior to use, and adverse side effect monitoring was to be initiated per a nursing order on the MAR/TAR, and if a resident was ordered an antipsychotic (ABH gel) medication a dyskinesia (AIMS - Abnormal Involuntary Movement Scale) assessment was to be completed. She explained the importance of these expectations was to ensure the medication addressed the displayed behaviors and to determine if they were effective

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F 758	Continued From page 18 or not. RN-B explained if psychotropic medications were not assessed, monitored, and evaluated there were potential risks for "endangerment or injury to the resident." RN-B confirmed R1 and R2's medical records lacked psychotropic consents for the lorazepam and ABH gel and that R2's medical record lacked an AIMS prior to the abbreviated survey. In addition, RN-B confirmed R1's PRN lorazepam order lacked a 14 day stop date. She stated she expected staff to be aware of such a regulation and to "address it accordingly" when such information was not present in an order. She denied she conducted audits in relation to psychotropic medications to ensure all the required components were in place. RN-B acknowledged she failed to update NP-A or R1's medical doctor (MD) on R1's lorazepam medication error and/or associated status changes or to question the ongoing medical necessity and/or clinical complication concerns for the lorazepam; however, she identified she expected staff would have updated R1's medical providers. When interviewed on 10/18/22, at 1:19 p.m. the director of nursing (DON) stated she expected psychotropic medications to have at least a verbal consent in place prior to the first administration, target behavior designation, non-pharmacological interventions to be used prior to use, and adverse side effect monitoring initiated per a nursing order on the MAR/TAR for each psychotropic medication and/or classification, identified within the care plan, and if a resident was ordered an antipsychotic (ABH gel) medication an AIMS was to be completed prior to the first dose, quarterly, and with any dosage changes. In addition, she expected more	F 758		

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F 758	Continued From page 19 detailed/specific diagnosis for psychotropic medications versus "anxiety or restlessness." She explained the importance of these expectations was to ensure the right medication addressed the specific target behavior(s), to ensure the lowest possible dose was administered, and to determine effectiveness. The DON explained if psychotropic medications were not assessed, monitored, and evaluated there were potential risks for adverse resident effects. The DON confirmed regulations related to 14 day stop days or provider dictation to support extended use for PRN psychotropics. She explained not all staff appeared to be aware of the requirement or it became "lost in the process." When interviewed on 10/19/22, at 1:00 p.m. MD-A confirmed he was not updated on R1's status changes 10/10/22 or on 10/11/22 when he performed routine rounds with R1. He explained if the status change information was relayed to him he would have documented the information in the 10/11/22 rounds progress note and he would have reviewed R1's Ativan order for risk and benefit determinations. In addition, MD-A stated he expected any medication to be monitored for adverse effects and if any resident displayed adverse medication side effects such information was to be documented in order for the medication to be reviewed for necessity and/or concerns and that psychotropic consents were to be obtained prior to medication administration as this was a facility policy. During interview on 10/19/22, at 2:49 p.m. NP-A stated she expected to see psychotropic monitoring in place when these types of medications were ordered. She explained as a prescriber she felt this was "really important" in	F 758		

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F 758	Continued From page 20 order to help ensure the resident was not over-medicated. NP-A stated there was a breakdown when it came to orders from hospice order "packages" and she commented she would have never ordered lorazepam for R1. She confirmed knowledge R1 was involved in an Ativan medication error; however, she denied knowledge that R1 experienced changes in her status related to it as staff did not update her of any status changes on 10/10/22. She explained if she was updated on R1's changes in status, she would most likely have discontinued the Ativan, even though the original order was provided by hospice providers. NP-A stated she did not review R1's lorazepam order on 10/11/22 during her visit to the facility as MD-A was performing routine rounds with R1 that day and she thought he would review it. A facility policy 6.0 General Dose Preparation and Medication Administration, revised 1/1/13, directed staff, prior to medication administration, they were to verify correct dose, route, rate, time and resident, confirm the MAR reflected the most recent medication order, check medication expiration date, check allergies, and if necessary, obtain vital signs. The policy lacked direction to check if psychotropic medication consent(s) were in place. A facility policy 3.8 Psychotropic Medication Use, revised 11/28/16, identified a psychotropic drug was any medication that affected brain activity associated with mental processes and behavior. The policy directed staff to assess underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions in which residents who exhibited new or worsening behavioral or psychological	F 758		

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	245291	A. BUILDING _____ B. WING _____	C 10/18/2022

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F 758	Continued From page 21 symptoms of dementia were to be evaluated by a health care professional and the care team to identify contributing factors. In addition, the policy directed psychotropic medications were to be monitored, used at the lowest possible dose to address behaviors, only if non-drug approaches and interventions were attempted prior to use, to treat clinical indication(s) and/or specific underlying medical or psychiatric causes of behavioral symptoms, and were to be monitored for efficacy, risks, benefits, and harm or adverse consequences. Furthermore, the policy identified staff were to monitor behavioral triggers, episodes, and symptoms and directed staff to document the number and/or intensity of the symptoms and the resident's response to staff interventions. The policy directed staff were to involve the resident or resident representative in the discussion of non-medication and medication interventions, along with reason for use and any associated risks, and document the discussion in the medical record, and further indicated PRN orders for psychotropic medications were to be limited to 14 days unless documented by the medical provider rationale for an extended order. The policy lacked instructions related to antipsychotic associated AIMS processes.	F 758		

Electronically delivered
October 31, 2022

Administrator
St Clare Living Community Of Mora
110 North 7th Street
Mora, MN 55051

Re: State Nursing Home Licensing Orders
Event ID: 1DRS11

Dear Administrator:

The above facility was surveyed on October 14, 2022 through October 18, 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 10/14/22 through 10/18/22, a complaint survey was conducted at your facility by a surveyor 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	2 000		

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2 000	Continued From page 1 when they will be completed. The following complaint was found to be SUBSTANTIATED: H52915071C (MN00087581), with no deficiency issued. However, as a result of the investigation licensing order were issued at 0265. 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 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. 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	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		11/29/22

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the primary medical provider was notified timely of a change in condition for 1 of 1 residents (R1) who developed acute changes in alertness level and respiratory status that required the use of supplemental oxygen. Findings include: R1's significant change Minimum Data Set (MDS) dated 10/11/22, identified R1 was severely cognitively impaired; however, she was identified to communicate with clear speech in which she was understood and usually understood others. The MDS also indicated R1 was diagnosed with dementia with behavioral disturbances and required hospice (end of life) care. In addition, the MDS identified R1 lacked the need for supplemental oxygen use or experienced periods of shortness of breath. R1's Care Plan, revised 10/7/22, identified R1 was enrolled in hospice services related to the effects of dementia in which staff were directed to keep R1's medical providers informed of any significant changes in her condition or medical regimen. An initial text message, dated 10/10/22, at 9:20 p.m. identified licensed practical nurse (LPN)-A	2 265	It is the policy of St. Clare Living Community of Mora to inform/update primary medical provider and resident representative timely for residents who experience change in condition, accident involving injury, and medication/treatment changes. St. Clare Living Community policy for Change in Condition was reviewed and revised on 10/19/22. Licensed nursing staff re-educated regarding facility change in condition policy & appropriate ways to communicate to providers on 10/21/22 and on 10/25/22. Education included thorough assessment of the resident to ensure providers receive a detailed update regarding resident's change in condition. Facility will conduct notification of change and change in condition audits by way of review orders written by NP/MD, accident/incident events, and review of residents nursing progress notes. Audits will be conducted 3 time a week for 1 month, weekly for 3 months, monthly for 3 months, and randomly thereafter. Results of audit will be reported to the QA/QI Committee for further review and recommendations. Further system review and staff education will be provided if indicated by audit results. Ongoing education for resident change in condition and notification of	

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2 265	Continued From page 4 sent a message to R1's nurse practitioner (NP)-A which updated her R1 was involved in an Ativan medication error event: R1 was administered 0.5ml (milliliters) of Ativan (anti-anxiety medication) instead of the ordered 0.25ml. At 9:21 p.m. NP-A responded and questioned how many milligrams were in 0.5ml. At 9:30 p.m. LPN-A responded with 1mg. At 9:30 p.m. NP-A responded, "[R1] should be okay." The text message lacked information related to any adverse effects R1 may or may not have experienced related to the medication error. A Safety Events - Medication Error report, dated 10/10/22, at 11:21 p.m. identified R1 had an active order for Ativan 0.25 ml every two hours as needed (PRN); however, at 7:38 p.m. R1 administered an incorrect Ativan dose of 0.5 ml (double dose). The report indicated R1 displayed "slow respiratory rate and O2's (oxygen blood levels)" which averaged between 72 and 95 percent (%) (within normal limits ranges 90-100%) with an "abnormal breath pattern." The report lacked documentation of when R1 was assessed to demonstrate a decreased respiratory decline. A Safety Events - Fall report, dated 10/10/22, at 11:45 p.m. identified R1 sustained an unwitnessed fall in her room at 8:40 p.m. (58 minutes after receiving the double dose of Ativan) The report indicated R1's neurological and mental status checks revealed R1 was "lethargic/drowsy" with "sleepiness" and her speech was unclear with slurred, mumbled words. An intervention section identified R1 was to be monitored throughout the night. A section labeled Notification Guidelines directed staff to notify the medical provider "immediately by phone ..." for certain identified abnormalities. The report	2 265	provider through facility on-line education, upon hire, nursing department meetings, and at least annually. The Director of Nursing or designee will be responsible for compliance.	

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2 265	Continued From page 5 identified the following reportable abnormalities were checked: a systolic (top number) blood pressure greater then 180, respirations less than 10 and oxygen saturation less than 90%. A Notification section identified an entered "No" which indicated the "attending" was not faxed, the physician and resident representative were not notified and the care plan was not reviewed. A progress note, dated 10/10/22, at 11:47 p.m. identified R1's fall in which R1 received PRN Ativan at 7:38 p.m. for continued behaviors. Hospice was notified of the fall and arrived at the facility to assess R1's status in which R1 exhibited "abnormal breathing pattern" and O2 levels which averaged between 72 and 95%. Hospice directed staff to monitor R1 throughout the night at "roughly 15 to 30 minute intervals." The progress note indicated R1's family, nurse practitioner, nurse manager were notified. The note lacked detailed information related to R1's Ativan error, specifics related to R1's declined medical status/change in condition, that R1 required supplemental oxygen due to significantly low oxygen saturation levels and periods of apnea (stopped breathing), detailed time line information on R1's status changes, or any identification of NP-A's response to the medication error update. An untitled flow sheet, dated 10/10/22, at 11:30 p.m. through 10/11/22, at 5:00 a.m. identified R1's vital signs (blood pressure, pulse, respirations and oxygen saturation levels) were monitored in which R1 utilized 2 liters of supplemental oxygen between 11:30 p.m. and 4:00 a.m. In addition, R1's systolic blood pressures at 12:00 a.m. 12:15 a.m. and 4:00 a.m. respectively were reported as 181, 190, and 182.	2 265		

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2 265	Continued From page 6 R1's Long Term Care Visit medical provider note, dated 10/11/22, signed at 11:33 a.m. , identified R1 was assessed by her medical doctor (MD)-A in which R1 was free of any acute distress or respiratory concerns while on room air. The note listed Current Outpatient Medications in which the list lacked evidence R1 had an active order for PRN Ativan. In addition, the note identified MD-A reviewed R1's medical record progress notes, medications, and vital signs. The note identified no medication changes were provided during the visit and to follow up in two months. The provider note lacked documentation of R1's Ativan error event, her fall, or her 10/10/22 mental and respiratory status changes. During interview on 10/14/22, at 1:48 p.m. LPN-A stated a resident's change in condition was present if they experienced a "depression in respiratory rate and associated low oxygen" levels, in which she was expected to contact the provider "right away." LPN-A explained, on 10/10/22, she updated NP-A, per a text message, on R1's Ativan error; however, she confirmed she failed to update NP-A on R1's fall and her mental and respiratory status changes that evening. She stated R1's oxygen saturation levels fluctuated from 72 to 95% in which R1 demonstrated periods of apnea and a respiratory rate "about 8 on average," a blood pressure which was "very high" with a systolic reading initially in the 190's, and that R1 required supplemental oxygen. LPN-A explained she should have updated NP-A "immediately" once R1 was assisted into bed after her fall and started to demonstrate changes in her respiratory status. She explained timely provider updates related to changes in a resident's breathing and heart status was very important as such changes could be "detrimental within a short period of time."	2 265		

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2 265	Continued From page 7 When interviewed on 10/14/22, at 4:04 p.m. registered nurse (RN)-A stated she assessed R1 after her fall on 10/10/22. She explained R1 started to demonstrate changes in her status about 15 minutes after staff assisted R1 into bed after her fall in which R1's oxygen saturation levels "dropped slightly below 50[%]" at one point. RN-A performed a sternal rub on R1 to help stimulate her alertness and her breathing and she confirmed R1 required supplemental oxygen to help her maintain her oxygen levels above 90%. RN-A acknowledged R1 experienced a change in her status on 10/10/22. She stated she did not update R1's medical provider; however, she confirmed she expected R1's primary nurse would have updated R1's medical provider "right away" after R1's status changes were identified on 10/10/22. During interview on 10/18/22, at 1:19 p.m. the director of nursing (DON) stated she considered a decline in a resident's respiratory status to be a change in status which she expected the medical provider, or an on-call provider, to be updated at the time the status change was determined, via a phone call and not a text message. The DON explained it was important to update medical providers timely on changes in status in order to decrease any associated risk factors, such as death. When interviewed on 10/19/22, at 1:00 p.m. R1's medical doctor (MD)-A stated he expected staff to contact him, NP-A, or the on-call provider as soon as possible if a resident presented with a change in status. MD-A confirmed he was not updated on R1's status changes 10/10/22 or on 10/11/22 when he performed routine rounds with R1. He explained if the status change information was	2 265		

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2 265	Continued From page 8 relayed to him he would have documented the information in the 10/11/22 rounds progress note and he would have reviewed R1's Ativan order for risk and benefit determinations. During interview on 10/19/22, at 2:49 p.m. NP-A stated she expected to be updated on the same day as a resident presented with changes in their respiratory status, and/or the need for supplemental oxygen as "that person is clearly not stable." NP-A confirmed knowledge R1 was involved in an Ativan medication error; however, she denied knowledge that R1 experienced changes in her status related to it as staff did not update her of any status changes on 10/10/22. She explained if she was updated on R1's changes in status, she would most likely have discontinued the Ativan. A facility Change in Condition policy, dated 3/22, identified staff were expected to immediately consult and notify the resident's physician when a resident experienced a change in their physical, mental, or psychosocial status. In addition, the policy directed staff to chart in the progress notes assessment data, observations, physician notification and/or attempted notification(s), along with the providers name and topic(s) discussed. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop/revise and implement policies and procedures related to updating the medical provider timely when a resident experiences a change in condition and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		

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