

Electronically delivered September 22, 2020

Administrator Carondelet Village Care Center 525 Fairview Avenue South Saint Paul, MN 55116

RE: CCN: 245617 Cycle Start Date: July 30, 2020

Dear Administrator:

On August 12, 2020, we notified you a remedy was imposed. On September 11, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 24, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective August 27, 2020 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 12, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 30, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kumala Piske Downing

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



Electronically delivered

September 22, 2020

Administrator Carondelet Village Care Center 525 Fairview Avenue South Saint Paul, MN 55116

Re: Reinspection Results Event ID: UPGK12

Dear Administrator:

On September 11, 2020 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 July 30, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Your signature block here



Electronically Submitted August 12, 2020

Administrator Carondelet Village Care Center 525 Fairview Avenue South Saint Paul, MN 55116

RE: CCN: 245617 Cycle Start Date: July 30, 2020

Dear Administrator:

On July 30, 2020, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On July 30, 2020, the situation of immediate jeopardy to potential health and safety cited at F760 was removed. However, continued non-compliance remains at the lower scope and severity of G.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 27, 2020.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 27, 2020, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 27, 2020, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 30, 2020. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely

will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Carondelet Village Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 30, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor Licensing and Certification Program Health Regulation Division Minnesota Department of Health Saint Paul, Minnesota 55164-0900 Email: karen.aldinger@state.mn.us

Phone: (651) 201-3794 Mobile: (320) 249-2805

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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 30, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Kumala Piske Downing

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			СОМ	E SURVEY IPLETED
		245617	B. WING	i			C 30/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ELET VILLAGE CAR	E CENTER			525 FAIRVIEW AVENUE SOUTH		
				S	SAINT PAUL, MN 55116		
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F 000	INITIAL COMMENT	rs	F (000			
	survey was comple surveyors from the Health (MDH). The be in compliance w Part 483, Subpart E Term Care Facilities The following comp substantiated: H56 F Tag F760 The survey resulted to resident health a began on 7/30/2020 received 2 doses of than the dose that w unresponsiveness, distress. R1 was n during the overdose naloxone dose that potential to cause s administrator, and I R1 on 7/29/20 at 3: on 7/30/20, at 4:00 In addition, an exter on 7/30/20, related care findings. The facility's plan o as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	blaint (was/were) found to be 617008C. Deficiency issued at d in an immediate jeopardy (IJ) nd safety. An IJ at F760 0, when a resident (R1) f morphine 16 times higher was ordered, this resulted in hypoxia, and respiratory ot monitored as ordered e and did to receive the was ordered. This had the serious injury or death. The DON were notified of the IJ for 51 p.m. The IJ was removed p.m. nded survey was completed to the substandard quality of f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will					
	ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NALUKE		TITLE		(X6) DATE 08/21/2020

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.

PRINTED: 08/24/2020

		AND HUMAN SERVICES & MEDICAID SERVICES		FOI	ED: 08/24/2020 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY
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	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with of Significant Med Errors	F 76	0	8/24/20
	medication errors. This REQUIREMEN by: Based on observat review, the facility for were transcribed ar order for 1 of 3 resi significant medicati immediate jeopardy received a dose of analgesic) sixteen t resulting in unrespon oxygen level) and ro physician ordered a effects of the morpl again transcribed in administered to R1 and via the wrong r resulted in drowsing unresponsiveness, distress for R1 for of The immediate jeop two significant med The facility adminis (DON) and the facil	Anticipation of any significant and administered per providers dents (R1) reviewed for any significant (R1) reviewed for any concerns. This resulted in an (IJ) situation for R1 who morphine (a narcotic imes the dose ordered, posiveness, hypoxia (low espiratory distress. The amedication to reverse the anine overdose, the order was accorrectly and a dose was less than what was ordered oute of administration. This ess and intermittent hypoxia, and respiratory		Carondelet Village 2020 Plan of Correction The Credible Allegation of Compliance has been prepared and timely submitted Submission of the Credible Allegation of Compliance is not a legal admission that deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. F760: Residents are Free of Significant Med Errors	f ta f s, d f

Facility ID: 27189

		& MEDICAID SERVICES			OMB NO.		
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	7/29/20. The immediate jeopardy was removed on 7/30/20, but noncompliance remained at the lower scope and severity level of a G - isolated scope and severity level, which indicated actual harm that is not immediate jeopardy.			R1 remained in the facility ar on hospice care until she par passed away on 8/9/20.	ssed. She		
	Findings include:			An audit was completed on a residents with an order for lic Morphine, as soon as the en known, to verify accurate or	quid ror was lers were in		
	dated 7/1/20, incluct impairment, require	Inge Minimum Data Set (MDS) ded moderate cognitive ed extensive to total assistance of daily living (ADL's), had		place. RN-A and RN-D were administrative leave. RN-A w terminated and reported to the of Nursing per reporting requ	, as ne MN Board		
	pain daily at a level being no pain and f excruciating/unmar of breath with exert (narcotic) medication	8 (on a 0-10 scale with 0		RN-D was given reeducation corrective action per the pro- disciplinary policy and return RN-D was audited on medic administration upon return to	and gressive ed to work. ation		
		re, and Alzheimer's disease.		The Narcan Policy and proce reviewed and were updated. education regarding Narcan/	Staff		
	femur fracture, staf medications as ord	f were directed to provide ered. Hospice care was added 7/20/20 for a diagnosis of		was initiated and is ongoing. audits for 6 weeks will be co the Ekit to ensure adequate available.	Weekly mpleted on		
	dated 7/20/20, inclu Sulfate (concentrate (milligrams per milli	ministration record (MAR) uded an order for, "Morphine e) Solution 20 MG/ML iliters) give 0.25 ml [5 mg] by rs for Pain. DO NOT AWAKE FION."		On 7/28/20 the facility Comp Medication Administration Au Nurses and TMA's. Order Tr Audits were completed on al from 7/25/20 – current and o These audits are to ensure o compliance with order transo	udits on all anscription I new orders ongoing. ongoing		
	p.m. included, "Writh health record] and the [name of nurse]. Soverall does not loce	ess note dated 7/24/20, 2:46 ter reviewed EHR [electronic then spoke with facility nurse he indicated that [R1's name] ok good. She indicated that n.] dose of morphine as patient		staff's ability to safely pass n ensure compliance for 2 wee random weekly for 6 weeks. be reviewed by the QA comr ongoing compliance. The Cli Administrator/Designee is re	nedications to eks and Results will nittee for inical		

Facility ID: 27189

If continuation sheet Page 3 of 15

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	ripi			0938-039 SURVEY	
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F 760		r indicated that would remove	F 70	60	ensuring compliance.			
	part of the order the Writer instructed [m syringe inside chee PRN [as needed] d scheduled dose he up to base line dos [Nurse] also indicat Writer informed he decreasing Haldol often used for agita when in dying proc increase morphine dose. Family is co sleepy. Writer wer sitting in her Broda She did arouse wh acknowledged that explained that patie with [sic] writer can don't feel good.' Sl and did not reply to noted that resps [re 28 BPM [breaths p Asked patient if wa breath, patient state R1's new physician "Morphine 20 mg/n hours around the c transcribed into the (EMR) and the mee (MAR) by health in specialist (HIMS)-A (concentrate) solut mg] by mouth ever mg = 4 ml." This re being 16 times high	at says HOLD IF ASLEEP. purse] regarding how to slide ek if asleep, and also giving a lose when awakens if eld. In this way, will get caught e, to manage symptoms. ted that patient is eating little. r regarding family goal of [an antipsychotic medication ation/hallucinations/delusions ess], but we may need to if pain persists at present ncerned about her being so at to [R1's] room. [R1] was Chair [reclining chair] dozing. en name was stated. [R1] writer was new; writer ent has always been asleep ne into room. Patient stated, 'I he could not elaborate on that, o questions about pain, writer espiratory] rate was elevated at er minute/normal is 12-16] is having difficulty catching			The facility initiated and required all licensed nursing and TMA staff, include any newly hired nurses, to completed education on how to safely and correct determine drug doses when calculation are required. This includes if there is a question about the calculation, that the medication should not be administere and should verify with another license nurse, or the pharmacy which is availa 24 hours a day. Including that EMS me be summoned in acute reversible situations to ensure prompt attention for resident. The education includes correct use of intradermal, intramuscular and subcutaneous syringes for administra Audits will be completed daily for all no orders for 14 days and then random weekly audits thereafter for 6 weeks Results will be reported to the QA committee for ongoing compliance. The Clinical Administrator/Designee is responsible for ensuring compliance. The completion date for certification purposes will be 8/24/2020.	ctly ons any he ed able nay to a rect ation. new		

If continuation sheet Page 4 of 15

		& MEDICAID SERVICES	(X2) MUUTI	PLE CONSTRUCTION). 0938-039 TE SURVEY
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F 760	• · · · · · · · · · · · · · · · · · · ·	ige 4 is double checking the order to	F 76	0		
	ensure accuracy or	n 7/24/20, at 4:20 p.m.				
	and written by RN-/ separate does of 4	dated 7/25/20, at 1:44 a.m. A included, "Writer gave 2 mls of morphine to resident. 4:40 p.m.], second dose at				
	2100 [9:00 p.m.] 8 when it should have evening shift. Orde	mls in total given to resident e been 0.5 ml give for entire r was entered incorrectly in				
	confirmed incorrect medication error oc	are, the facilities EMR]; writer t order and that is how ccurred. 2330 [11:30 p.m.] is				
	resident and found per minute [normal [normal 60-100] an	hurse went to go check on her RR [respiratory rate] 6-8 12-16], HR [heart rate] 74 d 02 sats [oxygen level] 77%				
	liters of 02 [oxygen 02 went to 90% and	Noc nurse put resident on 2.5] via nasal cannula. Resident d later to 98%. Writer called f error and resident condition.				
	Writer corrected er correct dosing of 0. received order to g	ror in PCC [the EMR] to reflect 25 mls per 4 hours. Writer ive 2mg of naloxone [a				
	injection to resident and to proceed with 2 hours, then check	edication] STAT [immediately] t, up to 10 mgs, until rousable n 15 minute checks 8 times for ks every hours for 6 hours.				
	Writer then called F error and resident of	able after one administration. POA [power of attorney] about condition. Resident is currently sats are 97%. RR 16-18 per				
	7/25/20, at 12:42 a	Homes Hospice order dated .m. included, "Naloxone 2 mg now- May be repeated every				

Facility ID: 27189

If continuation sheet Page 5 of 15

		AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`´´		LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245617	B. WING	i			C 30/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARONI	DELET VILLAGE CAR	E CENTER			325 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	 q [every] 15 min. [m 1 hr [hour] x 6. Call services] for additional naloxone." However by RN-A as, "Nalox Dose: 2 mg to 10 m Diagnosis: Overdo mg to 10 mg." The indicate the 2 mg car minutes up to a tota omission of vital sig if correct dose of Na R1's progress note included, "Resident through the night ar [respiratory rate] 16 sats 94-97% 2.5L N periods of apnea [te breathing] observed when name spoken appropriately to sim additional schedule during the night." R1's Medication Va indicated R1 did no route of the naloxon taken from the eme contained Naloxon been given to R1. given the 0.4 mg of syringe, in which the medication under the ordered from the ph available when nee 	age 5 hinutes] x 8 then VS checks q EMS [emergency medical onal support if not arousable, naloxone, or if not able to get er, the orders was transcribed tone. Route inj [injection], ng. Frequency 2 mg to 10 mg, use. Additional directions: 2 e order as transcribed failed to ould be repeated every 2-3 al dose of 10 mg along with the gns transcribed or to call EMS aloxone was not available. dated 7/25/20, at 7:27 a.m. t VS checked QH [every hour] nd remained stable. RR 6/min visually observed; O2 NC [nasal cannula]. No emporary cessation of d. Resident rouses easily n and verbally responds hple yes/no questions. No ed morphine administered triance Report dated 7/25/20, ot receive the correct dose or ne. The naloxone had been ergency kit, which only e 0.4 mg/ml and only 1 ml had The report indicated RN-A had f Naloxone with a tuberculin e needle is made to inject he skin, not into the muscle as n, the Naloxone had not been harmacy and therefore not eded in the morning for R1 unresponsive again with	F	760			

If continuation sheet Page 6 of 15

		AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		245617	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARONE	ELET VILLAGE CAR	E CENTER			525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	included, "7:30 a.m that resident is arou b/m [breaths per m no questions. 7:45 set of vital signs; re saturation: 94% on oxygen; BP [blood [temperature] 98.2;	dated 7/25/20, 4:08 p.m. . Night shift reported to writer usable and respiration is 16 inute]; and response to yes or -10:00 a.m. writer took the full spirations: 8-10 b/m, oxygen 2l/min [2 liters per minute] pressure] 110/70; t- p-[pulse] 76 b/m [beats per	F 7	760			
	minute]; hospice nursesidents ongoing h that she did not get naloxone was order stat [immediate] ord that it will take 2 hr arrival; family mem the resident ongoin [sic] give the option resident to the hosp she would like [sic] hospice nurse and hospice nurse; hos family member war and leave the decise hospice nurse; hos	The proper dose of naloxone; red from the pharmacy as a der however the pharmacy told [hours] for the process and bers was informed regarding g health condition and and if she would like to send the bital; responsible party told that rely on the decision of the would like to meet with the pice nurse was informed that at to meet the hospice nurse ion of the resident to the pice nurse arrived around ember was informed about the					
	included, 10:30 a.m arousable accompa hospice nurse stays received informatio for family member t if resident will be se not." 10:50 a.m. "R	dated 7/25/20, 2:12 p.m. a. "Seen resident not anied by hospice nurse; ed with resident in room; n that hospice nurse is waiting to come in and make decision ent to ER [emergency room] or desident's POA [power of ade the decision of not to					

If continuation sheet Page 7 of 15

		AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245617	B. WING				C 30/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CARONE	DELET VILLAGE CAR	E CENTER			525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 760	admit the resident t the Narcan [brand r delivered; clinical ad administrator [sic] w with pharmacy re: pharmacist informe processing it and w R1's progress note included, "Writer ch clinical administrator their E-kit; AL clinical writer to check thein Narcan nasal spray called AL clinical ad and gave a go signa "11:05 a.m. Writer a asked that since Na pharmacy is still no Narcan Nasal Spray will secure the orde a.m. Hospice nurse Nasal Spray, writer a.m. Resident beca conversant; accom "12:45 p.m. Narcan pharmacy; writer ve [sic] which form of I to be given; hospice the using the spray orders." R1's progress note included, "Resident [cubic centimeters] portion of the cherry nurse and her siste reported that she in	o the hospital and to wait for name for naloxone] to be dministrator and clinical vas aware. Writer followed up time of arrival of Narcan and d writer that they are ill be sent ASAP." dated 7/25/20, 11:00 a.m. becked with AL [assisted living] or for availability of Narcan in al administrator informed r medication room; found r in their medication cart, liministrator again to inform al to use it if appropriate." approached hospice nurse and arcan medication from t available, if we can use the ay; hospice nurse verbalized, "I er later for the spray." "11:10 e administered 4 mg of Narcan present as witness." "11:25	F	760			

If continuation sheet Page 8 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245617	B. WING	÷			C 30/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CARONE	ELET VILLAGE CAR	E CENTER			525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 760	make short verbal r "Resident is respon- accompanied by he R1's progress note included a respirator 90% on oxygen at 5 arousable. 5:40 p.r supper. 6:30 p.m. u sleeping, respirator of 99%. 9:00 p.m. I one eye during bed p.m. respirations ha Narcan was admini unable to arouse ar held. Although R1 she continued to ha depression and unr the medication error R1's progress note noted respirations s apnea and did resp When interviewed of HIMS-A stated RN- for the change in m transcribed the orde Care). However, the Morphine 20 mg/ml was no milliliter equ would not take the of milliliter designated stated she did the n	e to speech and touch; able to responses." 2:10 p.m. sive to speech and touch; still er sister." dated 7/25/20, 4:00 p.m. ory rate of 12, oxygen level 5 lpm, and resident was not m. unable to open mouth for nable to arouse. 7:30 y rate of 12 and oxygen level R1 was not arousable. opened bath and made a noise. 10:20 ad dropped to 8 and the stered again. 11:00 p.m. nd all medications had been had received doses of Narcan, ave symptoms of respiratory esponsiveness as a result of r. dated 7/26/20, 7:29 a.m. stable through the night, no ond verbally when spoken to. on 7/28/20, at 2:30 p.m. D had written a verbal order orphine on 7/24/20, HIMS-A er into the EMR (Point Click e order was written as , 5 mg every 4 hours, there tivalent and the PCC system order unless there was a for the amount. HIMS-A nath/drug calculation, by	F	760	,		
	4 milliliters, but was this correctly. She	by the 5 mg and came up with unsure she had calculated had never been trained to es, so she had RN-B review it					

Facility ID: 27189

If continuation sheet Page 9 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/24/2020 APPROVED 0938-0391	
STATEMENT OF AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED	
		245617	B. WING			C 07/30/2020		
NAME OF PROV	VIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CARONDEL	ET VILLAGE CARI	ECENTER			25 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
an the ord off Wi sta in it, s be do sig sh as twi Wi na [Ri an ha mi err R1 ord an be RN ord giv syu tub fro wa RN ph the the	e facility policy to l ders processed by f on the order late hen interviewed o ated, she had see the computer as i she had assumed een done correctly bing the dosage ca gned what [HIMS- ie had given R1 th i twas transcriber ice during her shi hen the night shif protic count toget N-D] noted there ind checked on R1 wing apnea with r inute. This was h ror. She called ho d's condition. Hos dered the naloxor dadministered the exame responsive N-A did not find ou der wrong for the ven the wrong dos ringe until the nex berculin syringes om the emergency as only 0.4 mg ins narmacy, since this e emergency kit, k	is good. She identified it is have a nurse check off on any y an HIMS, so RN-A signed	F 7	760				

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	08/24/2020 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	0	(X3) DATE COM	E SURVEY PLETED
		245617	B. WING	i				C 30/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP C	ODE	-	
CARONI	DELET VILLAGE CAR	E CENTER			25 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 760	stated HIMS-A requ morphine order for done so and approv the dosage calculat incorrect, but had n "was most likely be When interviewed of director of nursing (naloxone in the em- mg/ml and only con could not have give had stated she use very short needle, w been given into a m DON stated they had transcribing physici after the error was of training did not inclu which was the root When interviewed of consultant pharmado needs a medication medication from the pharmacy to get a co or night. The pharm to assist with drug of naloxone 0.4 mg/m used in nursing hor higher dose, they w medication STAT. When interviewed of overdose would be stated that a dose of	ested she review the R1 on 7/24/20, and she had ved it. RN-B acknowledged ion for the morphine was ot noticed it at the time as, tween tasks at the time." on 7/29/20, at 10:45 a.m. the DON) stated the dose of ergency kit only contained 0.4 tained 1 ml, therefore RN-B n the correct dose, and RN-B d a tuberculin syringe, with a which means it could not have suscle as ordered either. The ad started to re-train nurses on an orders starting on 7/25/20, discovered. However, the ude drug dosage calculations,	F	760				

If continuation sheet Page 11 of 15

		AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245617	B. WING				C 30/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARONI	DELET VILLAGE CAR	E CENTER			25 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116		
					·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 760	Continued From pa	ge 11	F 7	760			
		ally it could end their life."					
	MD-A stated they w	vere in the process of					
		ge of naloxone available in the y kit and increasing it to 2 mg.					
		ave called EMS for support or					
	to get additional nal	loxone if not able to get the					
	correct dose STAT.						
	When interviewed a	on 7/29/20, at 10:47 a.m.					
		G stated they had arrived at					
		d R1 continued to be					
		a respiratory rate of 8 breathes epeating pattern of 4 breathes					
		ond periods of apnea. RN-G					
	informed RN-E and	RN-F to administer any					
		in the facility. RN-H returned					
		isted living section with a I mg nasal spray, which was					
		R1 began to respond and					
	apnea ceased.						
		on 7/30/20, at 9:27 a.m. RN-E					
		ne into work on 7/25/20, at					
		d R1 unresponsive with a					
		0. Hospice was contacted ould come to the facility to					
		checked the emergency kit					
		s one 1 ml vial of naloxone					
	0	g. RN-E discussed with RN-F macy and discovered the					
		er received the order for the					
	naloxone 2 mg STA	AT. They would fill it ASAP.					
		ecided to await the arrival of					
		before determining whether to e, even though R1 was					
	unresponsive with a						
	When interviewed	on 7/30/20, at 10:12 a.m. RN-F					
		sessed R1 on 7/25/20,					

If continuation sheet Page 12 of 15

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039* STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245617 B. WING 07/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH CARONDELET VILLAGE CARE CENTER ONUMBER ONUMBER		AND HUMAN SERVICES			FORM A	APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED COMPLETE						
245617 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 07/30/2020 525 FAIRVIEW AVENUE SOUTH 525 FAIRVIEW AVENUE SOUTH 525 FAIRVIEW AVENUE SOUTH						
245617 B. WING 07/30/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH					l c	;
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH		245617	B. WING _			
525 FAIRVIEW AVENUE SOUTH	NAME OF PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	CARONDELET VILLAGE CAR			525 FAIRVIEW AVENUE SOUTH		
SAINT PAUL, MN 55116				SAINT PAUL, MN 55116		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)						
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATECOMPLETION DATEDATEDATEDATE						COMPLETION DATE
DEFICIENCY)				DEFICIENCY)		
F 760 Continued From page 12 F 760	F 760 Continued From pa	ige 12	F 76	60		
between 7:00 a.m. and 8:00 a.m. R1 had a						
respiratory rate of 8-10 per minute, had apnea,						
and was unresponsive. RN-F stated the pharmacy was contacted to find out where the						
naloxone was and found out they had not						
received the order. The emergency kit only	received the order.	The emergency kit only				
contained 0.4 mg of naloxone. The correct dose						
was ordered as STAT and RN-F and FN-E decided to wait until the hospice nurse, RN-G						
arrived to determine next steps.						
When interviewed on 7/30/20, at 11:57 p.m. nurse						
practitioner (NP)-A stated, R1 had become						
severely hypoxic (low oxygen) following the						
morphine overdose and a possible consequence to this could be death.						
When interviewed on 7/30/20, at 12:03 p.m. the						
DON stated, HIMS should not do drug dose						
calculations, nurses need to double check the work of HIMS with medication transcriptions to						
ensure accuracy. STAT orders should be						
processed and ordered from the pharmacy						
immediately, if the correct dose of naloxone was	immediately, if the	correct dose of naloxone was				
not in the e-kit, staff should have contacted the						
ordering physician, or contacted EMS for support.						
In the case of an overdose, the nurse could use their critical thinking and use the naloxone dose						
that is available even if less than ordered.						
Nurses should be knowledgeable about how to	Nurses should be k	nowledgeable about how to				
administer each route of medication.	administer each ro	ute of medication.				
The facility submitted a training entitled	The feellity submitt	ad a training antitlad				
The facility submitted a training entitled Intradermal Injection/Subcutaneous						
Medication/Intramuscular, and Medication						
Administration Education, which included	Administration Edu	cation, which included				
medication order processing, which showed						
facility nurses had been retrained on 7/25/20. However, the training lacked any education						

If continuation sheet Page 13 of 15

PRINTED: 08/24/2020

		AND HUMAN SERVICES				FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·			(X3) DATI COM	E SURVEY PLETED
		245617	B. WING				C 30/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	. <u> </u>	
				5	25 FAIRVIEW AVENUE SOUTH		
	ELET VILLAGE CAR	ECENTER		S	SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 760	Continued From par notification of physis monitoring resident calculation drug dos appropriate syringe The facility Medicat dated December 20 transcription of orde licensed nursing sta other staff who coul orders. The policy in administration reco- medication, dosage other information in required prior to ad The facility Order P February 2016 indig medication orders as frequency of the med- the route of adminis The immediate jeop was removed on 7/ educated all license calculation, correct injectable medication are input into the El observation of the r error/overdose, not there is no access to medications and ut needed, ordering S pharmacy, and how dose of medication responsible for input	ge 13 cian with condition change, 's after medication error, sages, or how to choose the for injections. ion Administration Policy 018, identified accurate ers is the responsibility of aff. The policy did not indicate ld transcribe medication ncluded, the medication rd will include the name of the e, route, frequency, and any cluding specific monitoring ministration of medication. rocessing Policy dated cates that physician should include time and edication and should include stration. oardy that began on 7/24/20, 30/20, when the facility ed nurses on dosage syringes and techniques for ons, how to verify orders that MR by unlicensed staff, resident after a medication ification of physician when to the correct dose of STAT ilization of the EMS system if TAT medications from the <i>r</i> to recognize an inappropriate . In addition, Mollies staff utting orders into the EMR	1	760			
	were retrained and nurse when in doub	educated to consult with a ot of an order. The facility also on all liquid medications to					

If continuation sheet Page 14 of 15

		AND HUMAN SERVICES					FORM	08/24/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245617	B. WING					30/2020
NAME OF	PROVIDER OR SUPPLIER	•	. I		REET ADDRESS, CITY, STATE, ZII	P CODE		
CARONI	DELET VILLAGE CAR	ECENTER			5 FAIRVIEW AVENUE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 760	ensure accuracy in on all new orders, w days and be re-eva medication aides (7 medication adminis observation, intervi the surveyors on 7/ noncompliance rem severity level of a 0 not immediate jeop when she received morphine and beca respiratory distress the reversal medica	age 14 the EMR. Audits were started which were to continue for 14 duated. All nurses and trained TMA's) were audited for stration. This was verified by ew and document review by '30/20. However, the nained at the lower scope and 6, isolated actual harm that is ardy, because R1 was harmed the incorrect doses of ame unresponsive with , received the wrong dose of ation and the unresponsive ratory distress continued for	F 7	760				

Facility ID: 27189



Electronically delivered August 12, 2020

Administrator Carondelet Village Care Center 525 Fairview Avenue South Saint Paul, MN 55116

Re: State Nursing Home Licensing Orders Event ID: UPGK11

Dear Administrator:

The above facility was surveyed on July 28, 2020 through July 30, 2020 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 <u>only a suggestion</u> 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:

Karen Aldinger, Unit Supervisor Licensing and Certification Program Health Regulation Division Minnesota Department of Health Saint Paul, Minnesota 55164-0900 Email: karen.aldinger@state.mn.us Phone: (651) 201-3794 Mobile: (320) 249-2805

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

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

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

Minnesc	ta Department of He	ealth				ATTROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE COMP	SURVEY PLETED
		27189	B. WING		07/3	C 80/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CARONE	DELET VILLAGE CAR	F CENTER	VIEW AVENU AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surver found that the defice herein are not corre- not corrected shall with a schedule of f the Minnesota Depa Determination of wi corrected requires of requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	survey was conduc with State Licensur	TS: 17/30/30, an abbreviated ted to determine compliance e. Your facility was found not with the MN State Licensure.				
	The following comp SUBSTANTIATED:					
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE 08/21/20

Electronically Signed

If continuation sheet 1 of 17

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		27189	B. WING	'ING		C 07/30/2020	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ARONE		F CENTER	VIEW AVENUE AUL, MN 5511				
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2 000	Continued From pa	ge 1	2 000				
	signature is not req page of state form. Although no plan of required that the fac the electronic docur Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." For	nent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for ne assigned tag number eft column entitled " ID Prefix tute/rule out of compliance is ary Statement of Deficiencies' es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met ollowing the surveyors findings Method of Correction and					
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a Department of Heal you electronically. is necessary for Sta enter the word "corr	in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf licensing orders are ttached Minnesota lith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic					

Minnesota	Department of He	alth			i oran a	PROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPLE	
		27189	B. WING		C 07/30/	2020
NAME OF PRO	VIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
	ET VILLAGE CAR	E CENTER 525 FAIF	RVIEW AVENU	IE SOUTH		
OARONDEL		SAINT P	AUL, MN 551	16		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETE DATE
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F "F A T IS C	OURTH COLUMN PROVIDER'S PLA PPLIES TO FEDE HIS WILL APPEA NO REQUIREMI ORRECTION FOI	ARD THE HEADING OF THE N WHICH STATES, IN OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES.				
21545 M	IN Rule 4658.1320	0 A.B.C Medication Errors	21545		8	/24/20
pu G 4: th S in pu au m el di sa to pu to pu to pu	ercent as describe guidelines for Code 2, section 483.25 (and State Operation urveyors for Long- incorporated by refe urposes of this part (1) a discrepart rescribed and what dministered to res (2) the administered to res (2) medications. B. It is free of a reconstruction of jeopa afety; or (2) medication equires the medicate redication error co recipitate a reoccu- poxicity. All medication rescribed. An inc	ast ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of as Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually idents in the nursing home; or stration of expired any significant medication medication error is: which causes the resident rdizes the resident's health or on from a category that usually ation in the resident's blood to cific blood level and a single ould alter that level and urrence of symptoms or ions are administered as ident report or medication e filed for any medication error				

Minnesota Department of Health STATE FORM

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If continuation sheet 3 of 17

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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	27189	B. WING		07/30/	
PROVIDER OR SUPPLIER					
DELET VILLAGE CAR	E CENTER				
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physician or the phy resident or the resid designated represe must be made in th C. All medication prescribed. An inci- report must be filed occurs. Any signifi- resident reactions r physician or the phy resident or the resid designated represe	ysician's designee and the dent's legal guardian or entative and an explanation be resident's clinical record. ons are administered as ident report or medication error d for any medication error that cant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation				
by: Based on observative review, the facility for the facility of the facility for the faci	ion, interview, and document ailed to ensure medications and administered per providers idents (R1) reviewed for ion errors. This resulted in an y (JJ) situation for R1 who morphine (a narcotic times the dose ordered, onsiveness, hypoxia (low espiratory distress. The a medication to reverse the hine overdose, the order was neorrectly and a dose was less than what was ordered route of administration. This ess and intermittent hypoxia, and respiratory		Corrected		
	OF CORRECTION PROVIDER OR SUPPLIER DELET VILLAGE CAR SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From pa that occurs. Any si resident reactions r physician or the ph resident or the resid designated represe must be made in th C. All medicati prescribed. An incl report must be filed occurs. Any signifi resident reactions r physician or the ph resident or the resid designated represe must be made in th C. All medicati prescribed. An incl report must be filed occurs. Any signifi resident reactions r physician or the ph resident or the resid designated represe must be made in th This MN Requirem by: Based on observat review, the facility f were transcribed and order for 1 of 3 resis significant medicati immediate jeopard received a dose of analgesic) sixteen f resulting in unresponding oxygen level) and r physician ordered a effects of the morp again transcribed in administered to R1 and via the wrong r resulted in drowsin unresponsiveness,	OF CORRECTION IDENTIFICATION NUMBER: 27189 27189 PROVIDER OR SUPPLIER STREET AL DELET VILLAGE CARE CENTER 525 FAIR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES Continued From page 3 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. C. All medications are administered as prescribed. An incident report or medication errors or resident reactions must be reported to the physician or the physician's designee and the resident reactions must be reported to the physician or the physician's designee and the 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. This MN Requirement is not met as evidenced	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 27189 B. WING	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 27189 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SELET VILLAGE CARE CENTER S25 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116 PROVIDER'S PLAN OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFX TAG Continued From page 3 21545 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 legal guardian or designated representative and an explanation must be filed for any medication errors or report must be filed for any 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. Corrected This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were transcribed and administered per providers order for 1 of 3 residents (R1) reviewed for significant medication errors. This resulted in an immediate jeopardy (UI) situation for R1 who received a dose of morphine (a narcotic analgesic) sixteen times the dose ordered, resulting in urresponsiveness, hpoxia (low oxygen level) and respiratory distress. The physician ordered a medication to reverse the effects of the morphine overdose, the order was again transcribed incorrecity and a dose was administered	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 27189 B. WING 07/ PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE SAINT PAUL, MN 55116 SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL ID REQUATORY ON LG DEMITY WO INFORMATION) ID PREFX PROVIDER'S PLAN OF CORRECTION NUMBER: ID REQUATORY ON LG DEMITY WO INFORMATION) Continued From page 3 21545 CRUSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY Continued From page 3 21545 CRUSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY Continued From page 3 CAIL INFORMATION) 21545 CRUSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 3 CAIL INFORMATION) CRUSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY Continued From page 3 CAIL INFORMATION CRUSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY Continued From page 3 CAIL INFORMATION INCLOSED CRUSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY Continued From page 3 CAIL INFORMATION INCLOSED CONTROLED CRUSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 3 CAIL INFORMATION INCLOSED CONTROLED CONTROLED That

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
ARONE	DELET VILLAGE CAR	E CENTER	VIEW AVENUE AUL, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21545	Continued From pa	age 4	21545				
	The facility adminis (DON) and the faci notified of the imme 7/29/20. The imme on 7/30/20, but nor lower scope and se	lication errors occurred for R1. strator, director of nursing lity campus administrator were ediate jeopardy at 3:51 p.m. or ediate jeopardy was removed acompliance remained at the everity level of a G - isolated level, which indicated actual mediate jeopardy.					
	Findings include:						
	R1's significant change Minimum Data Set (I dated 7/1/20, included moderate cognitive impairment, required extensive to total assis with most activities of daily living (ADL's), ha pain daily at a level 8 (on a 0-10 scale with 0 being no pain and 10 being excruciating/unmanageable pain), had short of breath with exertion, and received an opio (narcotic) medication 7 out of the 7 day look period. R1 had diagnoses that included, hip fracture, heart failure, and Alzheimer's disea	ded moderate cognitive ed extensive to total assistance of daily living (ADL's), had 8 (on a 0-10 scale with 0 10 being nageable pain), had shortness tion, and received an opioid on 7 out of the 7 day look back gnoses that included, hip	3				
	femur fracture, staf medications as ord	ed 7/15/20, included a recent f were directed to provide ered. Hospice care was added 7/20/20 for a diagnosis of e.					
	dated 7/20/20, inclu Sulfate (concentrat (milligrams per mill	Iministration record (MAR) uded an order for, "Morphine e) Solution 20 MG/ML iliters) give 0.25 mI [5 mg] by rs for Pain. DO NOT AWAKE FION."					
	p.m. included, "Wri	ress note dated 7/24/20, 2:46 ter reviewed EHR [electronic then spoke with facility nurse					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		27189	B. WING		07/	30/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CARONE	ELET VILLAGE CAR	F CENTER	VIEW AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	ge 5	21545			
	overall does not loo held 0800 [8:00 a.m was asleep. Writer part of the order tha Writer instructed [m syringe inside chee PRN [as needed] d scheduled dose hel up to base line dose [Nurse] also indicat Writer informed her decreasing Haldol [often used for agita when in dying proce increase morphine dose. Family is cor sleepy. Writer wen sitting in her Broda She did arouse whe acknowledged that explained that patie with [sic] writer cam don't feel good.' Sr and did not reply to noted that resps [re 28 BPM [breaths pe Asked patient if was breath, patient state R1's new physician "Morphine 20 mg/m hours around the cl transcribed into the (EMR) and the med (MAR) by health inf	he indicated that [R1's name] k good. She indicated that n.] dose of morphine as patient indicated that would remove at says HOLD IF ASLEEP. urse] regarding how to slide k if asleep, and also giving a ose when awakens if d. In this way, will get caught e, to manage symptoms. ed that patient is eating little. regarding family goal of an antipsychotic medication tion/hallucinations/delusions ess], but we may need to if pain persists at present neerned about her being so t to [R1's] room. [R1] was Chair [reclining chair] dozing. en name was stated. [R1] writer was new; writer ont has always been asleep ne into room. Patient stated, 'I ne could not elaborate on that, questions about pain, writer spiratory] rate was elevated at er minute/normal is 12-16] s having difficulty catching ed yes." order dated 7/24/20, included, nl, give 5 mg po/sl, every 4 ock." However, the order was electronic medical record dication administration record ormation management as, "Morphine sulfate				
	mg] by mouth every	on 20 MG/ML, give 4 ml [80 / 4 hours for Pain/Dyspnea, 5 esulted in the morphine dose				

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		27189	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
	ELET VILLAGE CAR		VIEW AVENUE AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	age 6	21545			
	ordered by the phys (RN)-A signed off a	ner than the dose actually sician. Registered nurse is double checking the order to n 7/24/20, at 4:20 p.m.				
	and written by RN-/ separate does of 4 First dose at 1640 2100 [9:00 p.m.] 8 when it should have evening shift. Orde PCC [Point Click C confirmed incorrect medication error of when NOC [night] r resident and found per minute [normal [normal 60-100] an [normal 95-100%]. liters of 02 [oxygen 02 went to 90% and hospice to inform of Writer corrected er correct dosing of 0. received order to gin narcotic reversal m injection to resident and to proceed with 2 hours, then check Resident was rousa Writer then called F	dated 7/25/20, at 1:44 a.m. A included, "Writer gave 2 mls of morphine to resident. [4:40 p.m.], second dose at mls in total given to resident e been 0.5 ml give for entire r was entered incorrectly in are, the facilities EMR]; writer t order and that is how ccurred. 2330 [11:30 p.m.] is nurse went to go check on her RR [respiratory rate] 6-8 12-16], HR [heart rate] 74 d 02 sats [oxygen level] 77% Noc nurse put resident on 2.5] via nasal cannula. Resident d later to 98%. Writer called of error and resident condition. ror in PCC [the EMR] to reflect .25 mls per 4 hours. Writer ive 2mg of naloxone [a redication] STAT [immediately] t, up to 10 mgs, until rousable n 15 minute checks 8 times for ks every hours for 6 hours. able after one administration. POA [power of attorney] about condition. Resident is currently				
	R1's Presbyterian F 7/25/20, at 12:42 a IM [in the muscle] r	sats are 97%. RR 16-18 per Homes Hospice order dated .m. included, "Naloxone 2 mg now- May be repeated every eded until client is rousable,				

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	27189	B. WING			
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
DELET VILLAGE CAR	F CENTER				
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 7	21545			
q [every] 15 min. [m 1 hr [hour] x 6. Call services] for additional naloxone." However by RN-A as, "Nalox Dose: 2 mg to 10 m Diagnosis: Overdo mg to 10 mg." The indicate the 2 mg co minutes up to a tota omission of vital sig if correct dose of N R1's progress note included, "Resident through the night an [respiratory rate] 16 sats 94-97% 2.5L N periods of apnea [te breathing] observed when name spoker appropriately to sim additional schedule during the night." R1's Medication Va	hinutes] x 8 then VS checks q EMS [emergency medical anal support if not arousable, naloxone, or if not able to get er, the orders was transcribed one. Route inj [injection], ng. Frequency 2 mg to 10 mg, se. Additional directions: 2 order as transcribed failed to ould be repeated every 2-3 al dose of 10 mg along with the gns transcribed or to call EMS aloxone was not available. dated 7/25/20, at 7:27 a.m. VS checked QH [every hour] nd remained stable. RR 5/min visually observed; O2 IC [nasal cannula]. No emporary cessation of d. Resident rouses easily n and verbally responds aple yes/no questions. No d morphine administered				
route of the naloxor taken from the eme contained Naloxone been given to R1.	ne. The naloxone had been ergency kit, which only e 0.4 mg/ml and only 1 ml had The report indicated RN-A had				
syringe, in which th medication under th ordered. In addition ordered from the ph	e needle is made to inject ne skin, not into the muscle as n, the Naloxone had not been narmacy and therefore not				
	OF CORRECTION PROVIDER OR SUPPLIER DELET VILLAGE CAR SUMMARY STA (EACH DEFICIENCY) REGULATORY OR L Continued From par with max dose of 10 q [every] 15 min. [m 1 hr [hour] x 6. Call services] for additional naloxone." However by RN-A as, "Nalox Dose: 2 mg to 10 m Diagnosis: Overdo mg to 10 mg." The indicate the 2 mg ca minutes up to a tota omission of vital sig if correct dose of N R1's progress note included, "Resident through the night ar [respiratory rate] 16 sats 94-97% 2.5L N periods of apnea [te breathing] observed when name spoker appropriately to sim additional schedule during the night." R1's Medication Va indicated R1 did no route of the naloxon been given to R1. given the 0.4 mg of syringe, in which th medication under th ordered. In addition ordered from the ph	OF CORRECTION IDENTIFICATION NUMBER: 27189 27189 PROVIDER OR SUPPLIER STREET AI SELET VILLAGE CARE CENTER 525 FAIR SAINT P. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 525 FAIR SAINT P. Continued From page 7 with max dose of 10 mg. VS [vital signs] checks q [every] 15 min. [minutes] x 8 then VS checks q 1 hr [hour] x 6. Call EMS [emergency medical services] for additional support if not arousable, or to get additional naloxone, or if not able to get naloxone." However, the orders was transcribed by RN-A as, "Naloxone. Route inj [injection], Dose: 2 mg to 10 mg. Frequency 2 mg to 10 mg, Diagnosis: Overdose. Additional directions: 2 mg to 10 mg." The order as transcribed failed to indicate the 2 mg could be repeated every 2-3 minutes up to a total dose of 10 mg along with the omission of vital signs transcribed or to call EMS if correct dose of Naloxone was not available. R1's progress note dated 7/25/20, at 7:27 a.m. included, "Resident VS checked QH [every hour] through the night and remained stable. RR [respiratory rate] 16/min visually observed; O2 sats 94-97% 2.5L NC [nasal cannula]. No periods of apnea [temporary cessation of breathing] observed. Resident rouses easily when name spoken and verbally responds appropriately to simple yes/no questions. No additional scheduled morphine administered during the night." R1's Medication Variance Report dated 7/25/20, indicated R1 did not receive the correct dose or route of the naloxone. The naloxone had been taken from the emergency kit, which only contained Naloxone 0.4 mg/ml and only 1 ml had been given the 0.4 mg of Naloxone with a tube	OF CORRECTION IDENTIFICATION NUMBER: 27189 A. BUILDING: B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST 525 FARRVIEW AVENUE SAINT PAUL, MN 55111 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 7 21545 with max dose of 10 mg. VS [vital signs] checks q [every] 15 min. [minutes] x 8 then VS checks q 1 hr [hour] x 6. Call EMS [emergency medical services] for additional support if not arousable, or to get additional support if not arousable, or to get additional naloxone, or if not able to get naloxone." However, the orders was transcribed by RN-A as, "Naloxone. Route inj [injection], Dose: 2 mg to 10 mg. Frequency 2 mg to 10 mg, Diagnosis: Overdose. Additional directions: 2 minutes up to a total dose of 10 mg along with the omission of vital signs transcribed or to call EMS if correct dose of Naloxone was not available. R1's progress note dated 7/25/20, at 7:27 a.m. included, "Resident VS checked QH [every hour] through the night and remained stable. RR [respiratory rate] 16/min visually observed; O2 sats 94-97% 2.5L NC [nasal cannula]. No periods of apnea [temporary cessation of breathing] observed. Resident rouses easily when name spoken and verbally responds appropriately to simple yes/no questions. 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How error the orders was transcribed by RN-A as, "Naloxone. Route inj [injection]. Dose: 2 mg to 10 mg. The order as transcribed route as transcribed failed to indicate the 2 mg could be repeated every 2.3 minutes up to a total dose of 10 mg along with the omission of vital signs transcribed or to call EMS [for crrect dose of Naloxone was not available. R1's progress note dated 7/25/20, at 7:27 a.m. included, "Resident VS checked QH [every hour] through the night and remained stable. RR [respiratory rate] 16/min visually observed; O2 sats 94-97% 2.5L NC [nasal cannula]. No periods of apnea [temporary cessation of breathing] observed. Resident rouses easily when name spoken and verbally responds appropriately to simple yes/no questions. No additional scheduled morphine administered during the night." R1's Medication Variance Report dated 7/25/20, indicated RN-A had given the 0.4 mg of Naloxone with a tuberculin syringe, in which the needle is made to inject medication under the skin, not into the m	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 27189 B. WING 077 PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 525 FAIRVIEW AVENUE SOUTH SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAND OF CORRECTION IREGULATORY ON LGC DEFICIENCIES ID PROVIDER'S PLAND OF CORRECTION IREQUARTY ON LGC DEFICIENCIES ID PRETURE CORRECTION MORE DEFINICIES With max dose of 10 mg, VS (vital signs) checks q IF INTA 1 hr (hourty A, G. Call EMS (Remergency medical services) for additional support if not arousable, or to get additional nanoxone, or if not able to get additional nanoxone, or if not able to get additional nanoxone, or if not able to get nanoxone. "However, the orders was transcribed by RN-A as, "Naloxone Route as transcribed failed to indicate the 2 mg could be repeated every 2-3 minutes up to a total dose of 10 mg along with the omission of vital signs transcribed or to call EMS R1's progress note dated 7/25/20, at 7:27 a.m. included, "Resident VS checked QH (Pervy hour)] R1's progress note dated 7/25/20, at 7:27 a.m. included, "Resident VS checked QH (Pervy hour)] R1's Medication Variance Report dated 7/25/20, indicated R1 di not receive the correct dose or route of the naloxone. The naloxone had been taken from the emergency KI, which only contained Naloxone With a tuberculin syringe, in which the needie is made to inject medication variance Report dated 7/25/20, indicated R1 di not receive the correct dose or route of the naloxone. The naloxone had been taken from the em

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		27189	B. WING		C 07/30/202	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CARONE	ELET VILLAGE CAR	E CENTER	VIEW AVENUE AUL, MN 5511			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLETI DATE
21545	Continued From pa	ge 8	21545			
	periods of apnea.					
	R1's progress note	dated 7/25/20, 4:08 p.m.				
		. Night shift reported to writer				
	that resident is arou	usable and respiration is 16				
		inute]; and response to yes or				
	•	-10:00 a.m. writer took the full spirations: 8-10 b/m, oxygen				
		2l/min [2 liters per minute]				
) 	oxygen; BP [blood]					
		p-[pulse] 76 b/m [beats per				
		irse was informed about the				
		ealth condition and informed				
		the proper dose of naloxone;				
		red from the pharmacy as a der however the pharmacy tolo				
		[hours] for the process and				
		bers was informed regarding				
		g health condition and and				
		if she would like to send the				
		pital; responsible party told that	t			
		rely on the decision of the would like to meet with the				
		pice nurse was informed that				
		It to meet the hospice nurse				
	and leave the decis	ion of the resident to the				
		pice nurse arrived around				
	10:20 and family marrival of the nurse.	ember was informed about the ")			
	R1's progress note	dated 7/25/20, 2:12 p.m.				
		n. "Seen resident not				
		anied by hospice nurse;				
	hospice nurse staye	ed with resident in room;				
		n that hospice nurse is waiting				
		to come in and make decision				
		ent to ER [emergency room] or Resident's POA [power of				
	ποι. τυ:50 a.m. "R					
		ade the decision of not to				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		27189	B. WING			C 30/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CARONE	ELET VILLAGE CAR	F CENTER	VIEW AVENUE AUL, MN 55110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	the Narcan [brand r delivered; clinical a administrator [sic] v with pharmacy re: pharmacist informe processing it and w R1's progress note included, "Writer ch clinical administrato their E-kit; AL clinic writer to check their Narcan nasal spray called AL clinical ac and gave a go sign. "11:05 a.m. Writer a asked that since Na pharmacy is still no Narcan Nasal Spray will secure the orde a.m. Hospice nurse Nasal Spray, writer a.m. Resident beca conversant; accom	hame for naloxone] to be dministrator and clinical vas aware. Writer followed up time of arrival of Narcan and d writer that they are				
	pharmacy; writer ve [sic] which form of I to be given; hospice	erified with hospice nurse if Narcan (spray or injection) is a nurse confirmed to stick with as indicated in the recent				
	included, "Resident [cubic centimeters] portion of the cherry nurse and her siste reported that she in cannula; resident is	dated 7/25/20, 1:00 p.m. drank approximately 60 cc of apple juice and ate a small y cake as reported by hospice r." 1:30 p.m. "Hospice nurse crease O2 @ 5 lpm via nasal resting comfortably, sleepy e to speech and touch; able to				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	Сом	E SURVEY PLETED
		27189	B. WING		07/30/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CARONE	DELET VILLAGE CAR	F CENTER	VIEW AVENUE AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21545	Continued From pa	ge 10	21545			
	"Resident is respon accompanied by he	sive to speech and touch; still r sister."				
	included a respirato 90% on oxygen at 5 arousable. 5:40 p.r supper. 6:30 p.m. u sleeping, respirator of 99%. 9:00 p.m. I one eye during bed p.m. respirations ha Narcan was admini unable to arouse ar held. Although R1 she continued to ha depression and unr the medication erro R1's progress note	dated 7/25/20, 4:00 p.m. bry rate of 12, oxygen level 5 lpm, and resident was not m. unable to open mouth for inable to arouse. 7:30 y rate of 12 and oxygen level R1 was not arousable. opened bath and made a noise. 10:20 ad dropped to 8 and the stered again. 11:00 p.m. and all medications had been had received doses of Narcan ave symptoms of respiratory esponsiveness as a result of r. dated 7/26/20, 7:29 a.m. stable through the night, no)			
	apnea and did resp When interviewed of HIMS-A stated RN- for the change in m transcribed the orde Care). However, the Morphine 20 mg/ml was no milliliter equ would not take the of milliliter designated stated she did the n dividing the 20 mg b 4 milliliters, but was	ond verbally when spoken to. D had written a verbal order orphine on 7/24/20, HIMS-A er into the EMR (Point Click e order was written as , 5 mg every 4 hours, there tivalent and the PCC system order unless there was a for the amount. HIMS-A nath/drug calculation, by by the 5 mg and came up with a unsure she had calculated had never been trained to				

UPGK11

If continuation sheet 11 of 17

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27189	B. WING		C 07/30/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	ELET VILLAGE CAR	E CENTER	VIEW AVENUE AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	age 11	21545			
	off on the order late	er in the shift.				
	stated, she had see in the computer as it, she had assume been done correctly doing the dosage c signed what [HIMS she had given R1 th as it was transcribe twice during her shi When the night shift narcotic count toge [RN-D] noted there and checked on R1 having apnea with n minute. This was h error. She called h R1's condition. Hos ordered the naloxof and administered th became responsive RN-A did not find o order wrong for the given the wrong do syringe until the nex tuberculin syringes from the emergency was only 0.4 mg ins RN-A did not order pharmacy, since th the emergency kit, the wrong dose.	on 7/28/20, at 12:45 p.m. RN-A en the order for R1's morphine needing a nurse to sign off on d the dosage calculation had y and signed off on it without alculation herself. "I just -A] had written." RN-A stated he incorrect dose of morphine ed, the 4 ml to equal 80 mg ift, not noting the discrepancy. ft came on duty they did a ther and the night nurse was too much morphine used I who was unresponsive and respirations of only 8 per now they found the medication ospice to report the error and spice returned the call and ne, she processed the order he naloxone to R1 who then e and no longer had apnea. ut she had transcribed the e naloxone or that she had se, using the wrong type of xt day. She used 2 -1 ml and used the vial of naloxone by kit, she did not recognize it stead of the 2 mg ordered. the STAT naloxone from the is medication was already in but did not recognize it was				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					с	
		27189	B. WING		07/30/2020	
AME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
	DELET VILLAGE CAR	E CENTER	VIEW AVENUE AUL, MN 5511			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21545	Continued From pa	age 12	21545			
		not noticed it at the time as, tween tasks at the time."				
	director of nursing naloxone in the em mg/ml and only cor could not have give had stated she use very short needle, v	on 7/29/20, at 10:45 a.m. the (DON) stated the dose of ergency kit only contained 0.4 ntained 1 ml, therefore RN-B en the correct dose, and RN-B ed a tuberculin syringe, with a which means it could not have				
	When interviewed of consultant pharmac needs a medication from the pharmacy to get a for night. The pharm to assist with drug naloxone 0.4 mg/m used in nursing hor	nuscle as ordered either. on 7/29/20, at 10:21 a.m. the cist (CP)-I stated if the facility n STAT, they can take the e emergency kit and call the delivery at any time of the day macy is also always available calculations as needed. The I is a common dose to be mes, if the order was for a would have to order the				
	medical director (M dose of naloxone to overdose would be stated that a dose of reduce respirations lethargy. Theoretics MD-A stated they w reviewing the dose	on 7/29/20, at 11:30 a.m. ID)-A indicated that a normal o treat a severe opioid naloxone 2-4 mg IM. MD-A of 80 mg of morphine, "Would and cause sleepiness and ally it could end their life." were in the process of ge of naloxone available in the y kit and increasing it to 2 mg.				
	hospice nurse, RN- the facility and note unresponsive with	on 7/29/20, at 10:47 a.m. -G stated they had arrived at ed R1 continued to be a respiratory rate of 8 breathes epeating pattern of 4 breathes				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27189	B. WING		C 07/30/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	ELET VILLAGE CAR		VIEW AVENUE AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	age 13	21545			
	informed RN-E and naloxone available from the facility ass bottle of naloxone	ond periods of apnea. RN-G d RN-F to administer any in the facility. RN-H returned sisted living section with a 4 mg nasal spray, which was R1 began to respond and				
	stated they had con 7:45 a.m. and foun respiratory rate of 7 and stated RN-G w assess R1. RN-E and noted there wa 0.4mg/ml remaining and called the phar pharmacy had neve naloxone 2 mg ST/ RN-E stated they d the hospice nurse I	on 7/30/20, at 9:27 a.m. RN-E me into work on 7/25/20, at d R1 unresponsive with a 10. Hospice was contacted yould come to the facility to checked the emergency kit as one 1 ml vial of naloxone g. RN-E discussed with RN-F rmacy and discovered the er received the order for the AT. They would fill it ASAP. lecided to await the arrival of before determining whether to e, even though R1 was apnea.				
	stated, they had as between 7:00 a.m. respiratory rate of 8 and was unrespons pharmacy was con naloxone was and received the order. contained 0.4 mg c was ordered as ST	on 7/30/20, at 10:12 a.m. RN-F sessed R1 on 7/25/20, and 8:00 a.m. R1 had a 3-10 per minute, had apnea, sive. RN-F stated the tacted to find out where the found out they had not The emergency kit only of naloxone. The correct dose AT and RN-F and FN-E il the hospice nurse, RN-G e next steps.				
	practitioner (NP)-A	on 7/30/20, at 11:57 p.m. nurse stated, R1 had become ow oxygen) following the				

	IT OF DEFICIENCIES OF CORRECTION				COM	E SURVEY PLETED
	27189		B. WING			C 30/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
CARONI	DELET VILLAGE CAR	F CENTER	VIEW AVENUE AUL, MN 5511			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21545	Continued From pa	ge 14	21545			
	morphine overdose to this could be dea	and a possible consequence th.				
	DON stated, HIMS calculations, nurses work of HIMS with r ensure accuracy. S processed and orde immediately, if the o not in the e-kit, staff ordering physician, In the case of an ow their critical thinking that is available even Nurses should be k administer each rou The facility submittee Intradermal Injection Medication/Intramu	ed a training entitled				
	medication order pr facility nurses had to However, the training notification of physic monitoring resident	ocessing, which showed been retrained on 7/25/20. Ing lacked any education cian with condition change, 's after medication error, ages, or how to choose the				
	dated December 20 transcription of orde licensed nursing sta other staff who coul orders. The policy in administration reco medication, dosage	ion Administration Policy 018, identified accurate ers is the responsibility of aff. The policy did not indicate Id transcribe medication ncluded, the medication rd will include the name of the e, route, frequency, and any cluding specific monitoring				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27189	B. WING			C 30/2020
NAME OF F	IE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
CARONE	ELET VILLAGE CAR	F CENTER	VIEW AVENUE AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	ge 15	21545			
	February 2016 india medication orders as frequency of the me the route of adminis The immediate jeop was removed on 7/ educated all license calculation, correct injectable medicatio are input into the El observation of the r error/overdose, not there is no access t medications and uti needed, ordering S pharmacy, and how dose of medication responsible for inpu- were retrained and nurse when in doub conducted an audit ensure accuracy in on all new orders, w days and be re-eva medication aides (T medication adminis observation, intervie	rocessing Policy dated cates that physician should include time and edication and should include stration. bardy that began on 7/24/20, 30/20, when the facility ed nurses on dosage syringes and techniques for ons, how to verify orders that MR by unlicensed staff, esident after a medication ification of physician when to the correct dose of STAT lization of the EMS system if TAT medications from the v to recognize an inappropriate. In addition, nonlicensed staff utting orders into the EMR educated to consult with a ot of an order. The facility also on all liquid medications to the EMR. Audits were started which were to continue for 14 luated. All nurses and trained TMA's) were audited for tration. This was verified by ew and document review by 30/20. However, the	I			
	severity level of a G not immediate jeop when she received	nained at the lower scope and 6, isolated actual harm that is ardy, because R1 was harmed the incorrect doses of	ł			
	respiratory distress the reversal medica	me unresponsive with , received the wrong dose of ation and the unresponsive ratory distress continued for				

Minnesota Department of Health STATE FORM

6899

UPGK11

If continuation sheet 16 of 17

Minnesc	Minnesota Department of Health								
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		27189	B. WING		07/3	; 0/2020			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE					
CARONI	DELET VILLAGE CAR		VIEW AVENU UL, MN 551						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE			
21545	Continued From pa	age 16	21545						
	The director of nurs review and revise p medication errors. designee could dev and develop a mon medication were co quality assurance of measures to ensure TIME PERIOD FOR (21) days	THOD OF CORRECTION: sing (DON) or designee could policies and procedures for The director of nursing or velop a system to educate staff itoring system to ensure prrectly administered. The committee could monitor these e compliance. R CORRECTION: Twenty One							
Minnesota D	epartment of Health								